NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 26 September 2023 at 9.30
Small 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 item**	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 item**	5	To receive
4.	**9.38**	**Minutes from previous Trust Board meeting held 25 July 2023**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 25 July 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

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	**9.55**	**Chair's remarks**	Chair	**Verbal item**	3	To receive
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 5 2022/23	Executive Directors	**Paper**	45	To receive
10.	**10.50**	**Risk and Assurance**				
	10.50	10.1 Serious Incidents Quarterly report	Chief Nurse & Director of Quality and Professions	**Paper**	5	To receive
	10.55	10.2 Medical appraisal / revalidation annual report	Chief Medical Officer	**Paper**	5	To approve
	11.00	10.3 Response to Lucy Letby trial and verdict	Chief Nurse & Director of Quality and Professions/Director of Finance, Estates and Resources	**Paper**	10	To receive
	11.10	10.4 Consideration of CAMHS report for Tees, Esk and Wear Valley NHS Foundation Trust and associated learning	Chief Nurse & Director of Quality and Professions	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.20	10.5 Patient Experience Annual report	Chief Nurse & Director of Quality and Professions	**Paper**	10	To approve
	11.30	10.6 Assurance and receipt of minutes from Trust Board Committees and Members' Council - Collaborative Committee 8 August 2023 - Mental Health Act Committee 15 August 2023 - Members Council 16 August 2023 - People and Remuneration Committee 11 September 2023 - Quality and Safety Committee 12 September 2023 - Equality, Inclusion and Involvement Committee 13 September 2022 - Finance, Investment & Performance Committee 18 September 2023 - WYMHLDA Collaborative Committees in Common 26 July 2023	Chairs of committees/Members' Council	**Paper**	10	To receive
	11.40	*Break*			*10*	
11.	**11.50**	**11. Integrated Care Systems and Partnerships**				
	11.50	11.1 South Yorkshire update including 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 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	**Paper**	5	To receive
12.	**12.15**	**Governance matters**				
	12.15	12.1 NHSE fit and proper persons framework	Director of Finance, Estates and Resources	**Paper**	5	To receive
	12.20	12.2 Trust Seal	Chair	**Paper**	2	To receive
13	**12.22**	**Strategies and Policies**				
	12.22	13.1 Customer Services Policy	Chief Nurse & Director of Quality and Professions	**Paper**	10	
14.	**12.32**	**Trust Board work programme for 2023/24**	Chair	**Paper**	3	To receive
15.	**12.35**	**Any other business**	Chair	**Verbal item**	3	To note
16.	**12.38**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 31 October 2023	Chair	**Verbal item**	2	To note
	12.40	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 25 July 2023
Rooms 3 and 4, Laura Mitchell Clinic, Halifax

Present:	Marie Burnham (MBu)	Chair
	Mike Ford (MF)	Senior Independent Director
	Mandy Rayner (MR)	Deputy Chair
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
Apologies:	Kate Quail (KQ)	Non-Executive Director
	Prof.Subha Thiyagesh (ST)	Chief Medical Officer
In attendance:	Sue Barton (SB)	Interim Director of Strategy and Change
	Lindsay Jensen (LJ)	Deputy Chief People Officer
	Sean Rayner (SR)	Director of Provider Development
	Dr. Kiran Rele	Consultant Psychiatrist (on behalf of Prof.Subha Thiyagesh)
	Andy Lister (AL)	Company Secretary (author)
	Julie Williams (JW)	Deputy Director of Corporate Governance
Apologies:	Greg Moores (GM)	Chief People Officer
	Dr.Rachel Lee (RL)	Associate Non-Executive Director
Observers:	1 x governor	

TB/23/62 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 this is a meeting held in public and there is no dial in facility, but members of the public have been invited to attend and one of the Trust's public governors is in attendance today.

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

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

TB/23/63 Declarations of interest (agenda item 2)

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

TB/23/64 Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/65 Minutes from previous Trust Board meeting held 27 June 2023 (agenda item 4)

Darryl Thompson (DT) advised he had reduced the board story narrative to focus on learning and Andy Lister (AL) has updated the minutes to this effect.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 27 June 2023 as a true and accurate record.

TB/23/66 Matters arising from previous Trust Board meeting held 27 June 2023 and board action log (agenda item 5)

Mark Brooks (MBr) asked the Board to note the amount of work being added to the Clinical Governance Clinical Safety committee workplan and to ensure this remains manageable.

Nat McMillan (NM) reported the workplan is manageable at present, but there is a risk if the workplan continues to grow effectiveness may be compromised.

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

TB/23/67 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Beth Murphy (BM) and Laura Bentley (LB) who both work in Children and Adolescent Mental Health Services (CAMHS). BM introduced herself as the team manager of the Calderdale and Kirklees CAMHS Crisis Team and reported LB is a member of her team. The story is about a service user who has been with the team and has now moved on to adult services.

LB explained the crisis team covers Huddersfield, Halifax and Dewsbury and since the Covid-19 pandemic, the team have experienced a significant rise in A&E referrals. The majority of referrals are between the ages of 15 to 18 with suicidal thinking and deliberate self-harm behaviours.

As a result, the crisis team has changed how it works. It now holds clients for longer periods of time, on a workload, to aid transition to adult services, if required, in order to reduce repeated A&E attendance and reduce risk. This has led to improved feedback from service users and better staff retention.

LB reported she was asked to support a service user aged 17 years and nine months through her transition into adult services. She had been known to the service for two years, engaging in risky behaviours with repeated attendance at A&E. LB worked with the service user for three months to her 18th birthday and then for three months during her transition into adult services. During this time, they developed a very strong therapeutic relationship and LB supported her to improve herself worth and perception of self.

LB told the Board she had received positive feedback from the service user after their time together and presented a letter the service user had written to the Board. This included

compliments such as (amongst many others); you were there for me when I needed it most, letting me run to a hug and feel safe, watching you watch me sing, sitting on my bedroom floor feeling seen, understood, accepted, trusted, respected and cared for.

LB read the thank you letter to the Board in which the service user stated she would miss LB and thanked her for her support and acknowledged how much she had helped her.

MBu thanked LB and BM for the story and stated stories like this make everything the Trust does worthwhile.

BM stated LB has worked differently to support this service user in a way that suited her presentation and it had been very effective.

MBr stated the Trust mission is to help people reach their potential and live well in the community and this story exemplifies this mission. At Board meetings we talk about numbers and statistics, but behind every number is a person, their family, and friends. Stories such as todays remind the Board that it is the experience people have of using Trust services that really matters.

MBr stated he had been fortunate to visit BM and her team recently and asked her to explain the difference in presentations since the pandemic and how they had adjusted their practice to meet this demand.

BM reported there is more complexity in presentations, and this has been impacted upon by the pandemic, social media and the cost-of-living crisis. There is a lot of pressure on families and young people at the moment.

The pandemic has affected young people as “doing nothing” became normal, and there is lots of catastrophising. Normal life problems are sometimes exacerbated into something much larger. There is also variance in the appropriateness of referrals received from schools and GPs and the team are carrying out work to improve this.

BM stated that because of the team holding cases to treat people for longer this has a led to a reduction of repeat A&E attendance through effective risk management and care coordination. There are also now trainee nurse associates, some of whom have been support workers, and for the young people with a first low risk presentation at A&E they can get support from qualified staff on recovery work which can be very effective.

CH asked if the young person who had written the feedback would be willing to let the Trust share her feedback for learning and perhaps to use for recruitment for CAMHS vacancies to show what the roles aim to do and what outcomes can be achieved.

Action: Carol Harris

MBu thanked BM and LB for their story and insight into the CAMHS team.

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

TB/23/68 Chair’s remarks (agenda item 7)

MBu reported the following items will be discussed in the private Board session in the afternoon:

- Private risk register
- Complex incidents report

It was RESOLVED to NOTE the Chair’s remarks.

TB/23/69 Chief Executive’s report (agenda item 8)

Chief Executive's report

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

- The NHS long term workforce plan has been published. The three themes are train, retain and reform. The People and Remuneration Committee will have oversight of the plan and the Board will go through the plan in some detail in strategic Board in August.
- A 'rapid review' into data on mental health inpatient units chaired by Dr Geraldine Strathdee has been published. This rapid review sets out 13 recommendations aimed at integrated care systems, provider trusts, and provider collaboratives. The Trust will review the report and what it means for us as an organisation.
- The latest round of industrial action by junior doctors has just finished, with consultant action due to follow shortly after. Safe services have been maintained throughout thanks to hard work by our staff.
- Operationally, demands on our services continue to be high. This is reflected in the number of referrals in some services, along with high levels of acuity and complexity. Out of area bed placements remain stubbornly high despite intensive focus and work on bed management and flow.
- We have engaged with the development of joint forward plans for both the South and West Yorkshire systems. These are due to be published in between the date of writing this report and the Trust Board meeting. A link has been provided to all Board members separately to the joint forward plans. In addition, both systems are developing revised operating models in response to the requirement to make significant savings to running costs.

NM reflected on recent CGCS and Finance and Investment and Performance Committee (FIP) meetings and queried if there should be a review taking place of the out of area bed position.

MBr stated out of area beds was a real challenge for the Trust in 2017 and 2018. The Trust carried out some strong work with the data we have, and reviewed our processes, and made significant reductions. The same team is still in place, and so we have the right team, with the right values, to carry out the work. This was discussed at last week's executive management team (EMT) meeting, and CH and the executive team are looking at this, and considering whether an external review would be a positive step forward.

A general discussion took place regarding what measures the Trust had utilised previously.

Mandy Rayner (MR) noted in relation to industrial action, there have been reports in the press of doctors leaving to go overseas.

Dr.Kiran Rele (KR) reported this may be the case for newer graduates who were finding work in Australia, New Zealand and Canada, but this did not appear to be the case for established doctors.

CH noted that although the Trust is managing industrial action well, the longer-term impact is yet to be realised.

MBu queried if the Trust's objectives and plans aligned with those of the integrated care systems and MBr confirmed this to be the case.

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

TB/23/70 Risk and Assurance (agenda item 9)

TB/23/70a Board Assurance Framework (agenda item 9.1)

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

- Risk 4.3 – Failure to support the wellbeing of staff – the proposal is to move from amber to yellow. We have a lot in place to support staff and performance indicators and benchmarking support this.
- Risk 2.4 – Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. This is a new risk and EMT is going through the process of grading this risk.
- Risk 1.2 – Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. The wording of this risk has been revised to reflect the true position.

Mike Ford (MF) queried if the Trust currently has a higher level of risk due to issues such as continued demand and acuity, industrial action, staff turnover, and queried if holding risks at their current level is getting harder and as such should be reflected in the gradings.

MBr suggested the Board needs to look at the organisational risk register (ORR) as well, to answer this question. The Board Assurance Framework represents our strategic risks, which are longer term in nature.

MF queried if 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 – is on track given the recent pay award and ICS challenges.

AS reported, this will be picked up in the ORR discussions. The question is whether the issue is immediate or in the longer term and therefore should it be reflected in the ORR or the BAF. AS reported as the Trust starts to develop a medium-term plan, we can look at the strategic risk and consider its grading.

Action: Adrian Snarr

MF noted the CQC rating is still shown as good from 2018, do we need to look at this assurance point.

MBr noted it is important we reflect the current rating but also acknowledge the level of assurance we can reasonably take from it due to its age.

NM noted that in the Finance, Investment and Performance (FIP) committee there had been discussions regarding finance and asked for consideration to be given to a private board discussion on the immediate and longer-term financial position of the Trust.

MBr reported this is going to form part of the strategic Board meeting in August.

MF stated he had received a paper from Price Waterhouse Coopers on the risk profile of NHS organisations so that a sense check can take place against the Trust's risks.

Action: Adrian Snarr

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

TB/23/70b Corporate/Organisational Risk Register (agenda item 9.2)

AS introduced the item and highlighted the following points:

- New risk - Maintaining people who are clinically ready for discharge in an inpatient bed, impacts on bed capacity - This risk has been developed in relation to the number of people clinically ready for discharge who continue to stay in acute mental health inpatient and learning disability services, which is having an impact on bed capacity.
- New risk – The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight - There is more work to do but important to log the risk

at this time. This risk will be monitored reviewed by the People and Remuneration Committee and the Clinical Governance and Clinical Safety Committee.

- Reduction in score (16-12) - The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care - We currently have successful mitigation in place for this risk and industrial action has been well managed to date.
- Increase in score (6-9) - Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided - AS reported the Trust can give a high level of assurance regarding the financial position for this year but can see financial challenges coming through for next year. This risk will be kept under review and the consideration will be given as to whether this affects the strategic or operational risk grading as part of the process.

MBr informed the Board that the current appraisal system has different levels of effectiveness across the organisation, and doesn't link with ESR, which affects the Trust's monitoring of data, often requiring manual inputting. Under Lindsay and Greg's leadership we are assessing our plans.

MF suggested the risk is worded as though it is affecting turnover.

MBr reported effective appraisal is important for retention and if the appraisal system is not working effectively, it cannot be determined if the correct conversations are taking place about the development of staff to support retention.

MR reported Greg Moores was asking for new starters to have appraisal discussions after six months to tackle any potential issues early on.

MF queried if acuity and demand is influencing appraisal rates?

CH reported most wards are up to 100% appraisal rates. There are some outliers at late 75-80%. Staff are overcoming issues by having good appraisal conversations but there are system issues that are affecting reported performance metrics.

NM reported the delayed discharge risk will be reviewed through the clinical governance clinical safety committee.

Board agreed the new appraisal risk should be affiliated to people, remuneration committee.

Action: Adrian Snarr

EM noted the improving care metrics have declined in the ORR and questioned if this change flows into the BAF as having an effect on strategic objectives?

AS reported the BAF and ORR are reviewed in parallel and the timescale and timeline for ORR risks and how quickly they can be mitigated.

Board agreed an objective review of both documents is required to make sure changes are accurately reflected in both documents.

Action: EMT

MBr also reflected the volume of controls and assurances should be reviewed as part of this work.

It was RESOLVED to NOTE 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, it was RESOLVED to:

- **AGREE to add the new risk - Maintaining people who are clinically ready for discharge in an inpatient bed, impacts on bed capacity.**
- **AGREE to add the new risk - The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight.**
- **AGREE to the reduction in risk score for risk 1758**
- **AGREE to an increase in risk score for risk 1114**

TB/23/70c Health and safety annual report (agenda item 9.3)

AS introduced the item and highlighted the following points:

- Although the title is health and safety report it covers most of Nick Phillps's (NP) portfolio as deputy director of estates and facilities, including fire safety, security and emergency preparedness.
- In year the work of the team was heavily impacted by Covid-19, noting some of the performance measures are still strong despite those challenges.
- Fire compliance remains good, and there is a desire to move to more face-to-face training
- The Emergency Preparedness, Resilience and Response team were impacted by Covid-19, and they now have a clear work programme in place.
- The report provides a good level of assurance of health and safety across the Trust.
- The appendices represent plans for 2023/24.

NP reported health and safety updates go to every operational management group (OMG) andEMT, and regular updates are taken to the Audit Committee.

MBr noted executive directors and senior managers cover health and safety and emergency planning at least twice a month. The Board has a statutory responsibility for health and safety across the organisation and MBr asked if the non-executive directors are assured by the report that statutory requirements are being met.

EM agreed the report does provide assurance and meets the criteria as there are no exceptions in the report. Any exceptions that are identified in year would need to be reported to Board outside of the annual report.

MF noted other reports to Board show us a self-assessment against the requirements e.g., adherence to the NHS constitution. Does a similar process take place with this report?

NP reported for health and safety, emergency planning and security it is read into this report. For fire safety EMT receive a certificate each year to demonstrate compliance.

MBr suggested for the appendices to this report for next year, it needs to show all the other reports and where they are presented to for approval.

Action: Adrian Snarr

NM queried if the report provides assurance or reassurance and we maybe need to think about that.

MF reported that the Audit Committee provides assurance updates in reports to Board for the reports that go through Audit Committee, but the appendices suggested by MBr would be a helpful addition.

DW noted Riddor (reporting of injuries, diseases, and dangerous occurrences regulations) incidents and that the integrated performance report shows a target of zero. DW noted

Riddor incidents do occur in the Trust, and future reports should provide more detail on these incidents and their outcomes.

Action: Adrian Snarr

NP reported that Riddor incidents are presented to both OMG and EMT when they occur, and agreed more detail will be included in future annual reports.

Action: Adrian Snarr

It was RESOLVED to APPROVE the annual report for 2022/23 and NOTE the work plan for 2023/24 for safety services.

TB/23/70d Freedom to speak up (FTSU) annual report (agenda item 9.4)

AS introduced the item and asked to take the paper as read:

- Normal process would be to complete comparative work against national data, but at the time of the writing this report the national data was not available.
- The number of people using FTSU is increasing, which is positive.
- There is good track record of the team dealing with, and resolving issues, in a timely manner.
- There is more work to do, but the report shows positive progress.

MF as lead non-executive director for FTSU, noted development of a self-assessment tool is underway that will be presented to Board in November 2023.

MR reported the annual report was taken to a bespoke PRC meeting on 13 July 2023. Estelle Myers (full time FTSG guardian) presented the report to the committee. MR noted the positive mandatory training compliance and the work safety elements of the report. The report was supported to come to the Board for approval.

NM noted the report has improved but the thematic part of what are we are hearing through freedom to speak up and how it aligns to the organisational development strategy and people plans is missing. We know staff experience discrimination from the staff survey results and we need to look at FTSU themes and triangulate them with other sources of information. NM also noted the FTSU guardian should also present the report directly to Board.

Action: Adrian Snarr

MF noted that despite the increase in referrals the timeliness of responses has improved significantly.

It was RESOLVED to APPROVE the freedom to speak up annual report and subsequent publication.

TB/23/70e Premises led assessments of the care environments (PLACE) scores (item 9.5)

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

- The PLACE process has been impacted by Covid-19, but performance remains strong across the board.
- The site with lower scores is leased through a private finance initiative (PFI) and we have less influence as a Trust. There is no cause for concern despite it presenting slightly lower scores.

MBr noted the report is positive, but there is need to be careful about complacency. This year we have been able to use volunteers and governors again to gain different perspectives.

Outside of the PLACE report we have been looking at alignment with quality monitoring visits, complaints, and other feedback to get a good level of assurance.

NM queried how do we feed this report back to service users and patients? NM referenced a recent ward visit where the variety of food was mentioned.

CH reported the operations team, and the estates team work closely with the dieticians. Complaints about food tend to be from forensics patients and people who have been with the Trust for some time and experience repetition. The food team attend service user meetings to take feedback and make improvements.

It was RESOLVED to RECEIVE the report.

TB/23/70f_Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9.6)

Audit Committee (AC) 11 July 2023
MF reported on the following:

- The Committee received a limited assurance internal audit report on e-rostering. The issues relate to the system implementation.
- Received a limited assurance audit on risk assessments and care plans.
- DT reported in respect of the risk assessment and care planning audit, it looked at the quality of the risk assessment and has identified risks followed into the care plan. This work is already in progress in care groups as part of a quality improvement approach. MF noted the concern is the performance work has affected the quality of risk assessment and care planning.

MBr reported EMT have asked the exact same question. When we have looked at the detail, we believe this is a timing issue. Improvement in completion of risk assessments and sharing of care plans was seen about 4/5 months ago and the audit was carried out at a similar time. The audit plan is there to give us challenge and identify areas where we can learn. An assurance paper needs to come back to Board to confirm this is the case.

Action: Darryl Thompson

DT reported discussions with quality leads across care groups have asked if pressure is so great that quality is declining, and the responses have stated this is not the case.

- Updates regarding actions to mitigate the risks assigned to the Committee were discussed; further consideration was requested from management regarding the risk re the lack of capacity to deliver the Trust's strategic objectives in the current financial year.
- Declarations of interests have achieved 100% compliance.
- Monitoring treasury investment is being monitored in light of higher interest rates.

Clinical Governance & Clinical Safety Committee (CGCS) 24 July 2023
Nat McMillan (NM) reported the following:

- NM reported there is a proposal to change of name of the Committee to "quality and safety committee" – Board approved.
- A focused review on the medical devices risk and received a highlight report on mitigation against this risk and assurance of the progress.
- The committee agreed the new risk being developed around delayed discharge should be aligned to the committee.
- The committee were made aware of work being undertaken to review demand given the experience of staff that it is increasing but this not necessarily being reflected in the data.
- Appraisal rates are continuing to improve.

- The recent industrial action has seen staff work hard to mitigate the risk and impact on service users and patients, with no patient safety incidents reported at the time.
- The committee received and commented on the draft Physical Health strategy.
- The committee was assured about the improvement that had taken place on Waterton ward between the previous visit in November 2022 and the Quality Monitoring Visit that took place on 9th May 2023.
- The committee received and discussed the Apparent Suicide Report and noted in particular, the comprehensive analysis that can be utilised to try and take action and have a positive impact by reducing suicide rates.
- The committee received the Patient Experience Update, the Patient Safety Strategy Update and Drugs and Therapeutic Annual Report.
- The board is asked to note that a previous action was for the committee to receive a report on learning from the independent report into CAMHS incidents at Tees, Esk and Wear Valley. This was received as was assurance around the learning.

MR noted it is good to see appraisals being triangulated through a number of committees.

People and Remuneration Committee 13 July 2023
MR highlighted the following:

- The July meeting was cancelled, and September's meeting has been brought forward
- The extraordinary meeting received FTSU report was received as presented at Board today.
- Due to the pressures in the people directorate at present, the deputy chief people officer has increased her hours

Finance, Investment and Performance Committee 17 July 2023
DW highlighted the following:

- Agency continues to be a challenge.
- The AI tool, the potential investor has now pulled out. Lessons learned are taking place.

MBr noted there were issues from our perceived pace on the AI tool from an NHS perspective, as we were awaiting a clinical study report to be produced, evaluated and peer reviewed.

EM noted the agency spend forecast is for £8.9m and queried if there are any ramifications for the Trust?

AS reported it is part of a range of indicators, and the Trust is currently an outlier on agency spend, but not for other indicators. If the Trust achieves its plan but fails on agency spend will this balance out? We may be asked questions by our partners who are hitting their agency target and we are not.

MR queried what the Trust vacancy rates are like in comparison to other trusts?

AS reported if we reduce agency staffing usage, we might see a rise in out of area beds. Agency spend is affiliated to a small number of high-cost medics and a high number of registered and unregistered, all on inpatient units.

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

TB/23/71 Performance (agenda item 10)

TB/23/71a Integrated Performance Report (IPR) Month 3 2023/24
AS introduced the item and highlighted the following:

- The full IPR is in the papers and development work on the IPR continues.

- Stability is a theme of this month's IPR, with many metrics remaining stable, with one or two exceptions, one being paediatric audiology, which is skewed by low patient numbers.
- Delayed discharges have increased this month from 2.1% to 4.6%, this is being reviewed.
- The IPR now separates the Trust's core financials from provider collaborative business.
- The West Yorkshire Provider Collaborative is currently forecasting a surplus, and this needs to be monitored.

CH reported appraisals and performance in care groups and reported there are only 5 appraisals still to be completed across all staff on the nine acute wards.

EM noted restraints have increased.

DT reported there is a low threshold for restraint, and this is also a reflection of acuity. The Care Quality Commission (CQC) have reported there is a national noted increase in demand and acuity. All restraint incidents are reviewed by Reducing Restrictive Practices and Interventions (RRPI) team.

CH reported specialist bean bags are being used to assist restraints and prevent taking people directly to the floor.

NM noted the narrative on agency spend suggested the increase is due to sickness, but sickness numbers have reduced.

AS reported the Trust is currently trying to understand agency use by service area, and it is heavily dominated by inpatient units, due to the need to maintain numbers on wards at times of sickness/absence. AS agreed, there is a need to provide better explanation in the narrative about what is driving agency use and where.

Action: Adrian Snarr

MBr reported EMT discussions have recently been focussing on a couple of key areas. One is 72hr follow up after discharge, and we are seeing positive performance in this area. Ligature work completion has increased significantly, to in excess of 90%. MBr noted this metric became a point of focus through being introduced into the IPR, and this level of focus has brought improvement.

MBr noted, in relation to people metrics, the Trust has amongst the lowest turnover and best staff number stability rates of like organisations in the region. There are challenges and there is no room for complacency but focussed work is bringing results. In reference to quality metrics, learning disability commencing delivery of treatment in 18 weeks remains persistently amber, and work is taking place to address this.

MBr suggested racial abuse incidents on wards should be an area of focus for the equality, inclusion and involvement committee.

Action: Sue Barton

DW queried RRPI training and noted a business case has been approved and queried what the timeline was for getting training levels back on track?

DT reported part of the business case is to explore options with partners and will report back on timelines.

Action: Darryl Thompson

TB/23/72 Integrated Care Systems and Partnerships (agenda item 11)

TB/23/72a South Yorkshire updated including South Yorkshire Integrated Care System (SYBICS) (agenda item 11.1)

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

- The integrated care board (ICB) meeting received a helpful presentation about the use of virtual wards, and the benefits for service users.
- The joint forward plan was discussed in terms of engagement and submission.
- A one-year review took place of the ICB, including achievements so far and looking to the future.
- Industrial action and the challenges presented across the South Yorkshire region.
- There was focus on the running cost allowances and it was noted this is a very challenging time for those whose jobs may be a risk.
- The level of financial risk in South Yorkshire was discussed.
- The annual report and accounts were approved.
- The Mental Health Learning Disability and Autism alliance – it was noted there are a number of newly appointed chairs and chief execs in August.
- There is capital available for perinatal mental health, but this may be challenging due to timescales.
- Discussions took place regarding what is commissioning and what does the commissioning hub need to do.
- Chair of South Yorkshire MHLDA Provider Collaborative- the proposal for Sharon Mays to be the next Chair of the SY MHLDA Provider Collaborative was approved.

MBr updated the Board on the following points relating to Barnsley:

- The meeting was a development session with a focus on Barnsley hospice and what its role is.
- The Barnsley place has a challenge with financial sustainability.
- There has been a positive uptake for physical health checks for people with a learning disability.
- Some specific work has also been taking place to improve health for migrants.
- Barnsley place plan is on today's board agenda.

It was RESOLVED to NOTE the SYB ICS update.

TB/23/72b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism (MHLDA) Collaborative and place-based partnership update (agenda item 11.2)

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

- The joint forward plan and running costs update was an area of focus.
- A wide range of meetings have been attended across the ICB and updates are included in the papers.

MBu noted there was a suggestion in the papers that as a result of the running costs work there could be a reduction in focus on mental health.

MBr report the focus on mental health in the West Yorkshire system is strong and future system meeting agendas support this.

MF referenced today's board story and the impact of the pandemic on children's mental health and school attendance levels and queried what is taking place at a system level.

CH reported schools are being supported by the mental health support teams and the Trust is part of the collaborative for Tier 4 beds. There is an event coming up to look at crisis services for children.

MBr reported that ICSs don't include education but do have representation from the local authority.

SB reported there is a Children's Trust in Barnsley where health and education meet to discuss issues.

SB reported at neighbourhood level, local academies are feeding into conversations.

CH reported it has been identified at collaborative level, there is a need for better working relationships with local authority.

MBr noted "right care right person" which affects both ICSs. This is a national partnership agreement, working with local police services and other NHS organisations to make sure everyone knows what their individual responsibilities are for processes such as detention under 136 of the Mental Health Act. The Trust is engaged in these discussions and Trust Board will continue to be updated.

MBr also noted that people in mental health crisis are now being encouraged to use the 111 service, this is being reviewed to understand if there will be any unintended consequences as a result of this, and what impact there may be on demand on the service.

It was RESOLVED to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:
West Yorkshire Health and Care Partnership;
Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees and RECEIVE the minutes of relevant partnership boards/committees.

TB/23/72c Provider Collaboratives and Alliances (agenda item 11.3)

AS presented the item and asked to take the report as read:

- West Yorkshire adult secure collaborative had a strategy day which AS and CH attended, which included a review of the last twelve months. There has been success in repatriation, which has given some financial headroom allowing for the review of pathways.
- South Yorkshire adult secure collaborative continue to establish good governance processes. There is a focus on a community pathway for the whole of South Yorkshire demonstrating a good level of ambition. There is a higher level of financial challenge in South Yorkshire at present.
- Where the Trust is a partner but doesn't lead the collaborative, in West Yorkshire, CAMHS and adult eating disorders are feeling pressure due to an increase in referrals.

MBu queried if good pathways are established in West Yorkshire will there be an opportunity to mirror this in South Yorkshire?

AS reported, this should be possible once a baseline position has been established.

It was RESOLVED to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives Update and RECEIVE and NOTE the Terms of Reference of the South Yorkshire and Bassetlaw Provider Collaborative Partnership Board.

TB/23/73 Governance matters (agenda item 12)

TB/23/73a Assessment against the NHS constitution (agenda item 12.1)

AS introduced the item and highlighted the following points:

- This is an annual return and a self-assessment with evidence presented against each of our requirements and follows a well-established process.

- AS asked the Board to note that waiting time standards stipulated are not applicable to many mental health services.

A discussion followed in respect of service user rights and opportunities.

Julie Williams (JW) reported the framework is based on acute care and for the majority of our services, we don't have "dear doctor" referrals.

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

TB/23/73b Barnsley Place Plan 2023-25 (agenda item 12.2)

MBu introduced Joe Minton (JM) from Barnsley place who works on strategy and health management, and partnerships. JM highlighted the following points:

- The plan has already been approved by the place partnership and is now being presented to all partner organisations.
- It is a product of conversations and engagement with colleagues and patients.
- It has been developed in response to the South Yorkshire health and care strategy published in April 2023 and the NHS operating guidelines.
- It doesn't cover everything that all partners will be doing but does show where we can work together to tackle health inequalities.

JM presented the plan on a page including the five main ambitions:

- A better start in life for children and young people
- A joined-up approach to tackling ill health.
- Better and fair access for all
- Coordinated care in the community.
- Improve impact on environment, economy and employment.
- JM shared with the Board the plan priorities, objectives, deliverables and measures of success.

SB reported the Trust has been heavily involved in the work towards this plan.

NM noted how the presentation shows that the Barnsley plan is aligned to the work of the Trust.

MF queried if charities will be able to be involved to support this plan.

JM reported that Barnsley place is keen to work with the voluntary and charity sectors to look at shared solutions to issues.

SB reported Creative Minds work across all of areas of the Trust and carry out work to support service users. SB noted there is a Creative Minds project working with Barnsley football club currently looking at dementia.

EM reported as Chair of the Trust's charity committee, evidence shows the Trust charities make a difference to people's lives on a micro level, and queried if there is a forum where we could look at how we can support areas such as Barnsley as a collective?

JM reported work has been undertaken with Barnsley voluntary and charity sector to create a network and be able to approach them to work on shared solutions to issues.

SB reported there is a group in Barnsley which links us with the Barnsley hospital charity and the voluntary and community sector. SB asked the Board to note that acute hospital charities

differ in how they operate, they don't tend to have linked charities but focus more on raising money to support things for themselves, and work is ongoing to develop this.

MR liked the plan on a page, and the key enablers, and queried what challenges there may be against capability and capacity in the two-year time period.

JM reported there are challenges in the running cost changes, there are areas where we would like to see capability strengthened, digital would be an example, but there is still a lot of development work at this point. JM reported SWYPFT provides a strong level of support to work in Barnsley.

MBr reported the Board should be able to see the positive relationship we have with partners in Barnsley. The objectives and priorities are mutually agreed, and MBr fully endorses the plan.

It was RESOLVED to RECIEVE the plan and note the alignment to the work of the Trust.

TB/23/74 Strategies and Policies (agenda item 13)

TB/23/74a Estates Strategy (agenda item 13.1)

AS introduced the item and NP highlighted the following point:

- This is a ten-year plan 2023 - 2033 and is a high-level strategy.
- The strategy recognises the wider involvement of the integrated care systems and the NHS long term plan.
- It is aligned to Trust clinical planning through OMG.
- The strategy is ambitious, and NP reported the Trust receives and annual allocation of capital from the West Yorkshire ICS.Some of the larger projects will require national capital if they are to come to fruition.
- The strategy looks at where are we now and where do we want to be.
- The appendices show plans and timelines, and it will be a live document.

DW reported this is good document and noted on page 12 it references we should consider our activity against IFRS (international finance reporting standards) 16? Should we be letting an accounting standard dictate what we do?

AS reported, there isn't enough capital for everything the Trust wants to do. Historically if NHS trusts couldn't build, they would lease, but trusts can't lease to the same extent as previously given the impact of these lease accounting rules.

DW noted the three key areas include environmental impact, but should there be reference to digital as well as this will have an impact?

NP agreed this was a fair challenge and would update the document to this effect.

Action: Adrian Snarr

EM supported the comprehensive Equality Impact Assessment (EIA) and suggested an order of priority would be helpful and should include what would proceed and what won't.

AS supported the prioritisation request and noted there is a need to be careful that the Trust doesn't limit itself by putting things in a strict order in case opportunities become available in the future that we aren't aware of at this time. There will be priorities included in the strategy and we need to think about how these will be communicated with the Board.

Action: Adrian Snarr

EM queried if any planning conversations have taken place with local authorities?

AS explained it will be the clinical strategy that drives the estate changes.

MF reflected that the Trust is considered to have relatively good estate and suggested therefore applications for capital may be challenged.

MBr reported we have established some principles and this strategy gives us sufficient flexibility to adjust to the climate in which the Trust operates. There is a risk where we might want to invest in Barnsley, but it is the the West Yorkshire ICB that agrees our capital allocation so we will need to work carefully around this.

Action: Adrian Snarr

MBu noted the strategy needs to be flexible and be able to align to the planning process each year. The Trust doesn't have a comprehensive clinical strategy. We have service strategies but there needs to be an overarching clinical strategy. DT reported conversations have already started to develop a clinical strategy.

Action: Executive Trio

It was RESOLVED to APPROVE the Estates Strategy in line with comments made.

TB/23/75 Trust Board work programme 2023/24 (agenda item 14)

MF noted the digital strategy and workforce strategy are both due in March 2024.

MBr reported the strategies will be subject to necessary engagement and will both go through relevant committees prior to presentation to Board.

It was RESOLVED to NOTE the work programme.

TB/23/76 Any other business (agenda item 15)

TB/23/77 Date of next meeting (agenda item 16)

The next Trust Board meeting in public will be held on 26 September 2023.

Signature: Date:

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

= completed actions

Actions from 25 July 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/67	CH to contact the young person who had written the feedback in relation to the CAMHS crisis team to ask if she would be willing to let the Trust share her feedback for learning and perhaps to use for recruitment for CAMHS vacancies to show what the roles aim to do and what outcomes can be achieved.	Carol Harris	September 2023	The CAMHS team contacted the young person who agreed that the information can be used. Plans in place to use it in a regional transitions event, CAMHS governance forum and potentially for recruitment. It has been shared with the involving people team also.
TB/23/70a	BAF 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" grading to be considered in conjunction with the full year financial plan	Adrian Snarr	October 2023	
TB/23/70a	MF to share a paper from Price Waterhouse Coopers on the risk profile of NHS organisations so that a sense check can take place against the Trusts risks.	Adrian Snarr	October 2023	MF has shared the report with AS for consideration against the Trust risk profile and will be reviewed through Audit Committee in October 2023.
TB/23/70b	Board agreed the delayed discharge risk will be reviewed through the quality and safety committee. The new appraisal risk should be affiliated to people, remuneration committee.	Adrian Snarr	September 2023	ORR updated; action complete.
TB/23/70b	EMT to objectively review ORR and BAF to make sure changes are reflected in both documents.	EMT	October 2023	

TB/23/70c	The health and safety annual report should have appendices showing all other reports that are covered as part of this annual process.	Adrian Snarr	September 2023	Additional reports will be added as appendices in next years health and safety annual report.
TB/23/70c	The health and safety annual future reports to include more detail on RIDDOR these incidents and their outcomes.	Adrian Snarr	September 2023	Additional detail in relation to RIDDOR reports will be added to next year's health and safety annual report.
TB/23/70d	FTSU annual report to include the themes of what is being heard through freedom to speak up and how it aligns to the organisational development strategy and people plans is missing. Need to look at FTSU themes and triangulate them with other sources of information. It was also noted the FTSU guardian should also present the report directly to Board.	Adrian Snarr	September 2023	The lead freedom to speak up guardian is to attend Board in November and present a bi-annual update.
TB/23/70f	MF noted a concern that performance work has affected the quality of risk assessment and care planning. MBr reported EMT have asked the exact same question. When we have looked at the detail, we believe this is a timing issue. Improvement in risk assessments and care planning was seen about 4/5 months ago and the audit was carried out at a similar time. An assurance paper needs to come back to Board to confirm this is the case.	Darryl Thompson	October 2023	Care plan and risk assessments continue to be a priority piece of work for the Trust. An update paper has been presented to Executive management team and Quality and Safety Committee which details the work of the improvement group. Within this paper it details the interdependency of performance and quality and the impact that improvements might have on each of these measures throughout the test phase of changes. These impacts are being monitored by the improvement group.
TB/23/71a	NM noted the narrative on agency spend suggested the increase is due to sickness, but sickness numbers have reduced. AS reported the Trust is currently trying to understand agency use by service area, and is heavily dominated by inpatient units, due to the need to maintain numbers on wards at times of sickness/absence. AS agreed, there is a need to provide better explanation in the narrative about what is driving agency use and where.	Adrian Snarr	September 2023	The IPR to be presented in September has updated narrative and explanation in relation to agency.

TB/23/71a	MBr suggested racial abuse incidents on wards should be an area of focus for equality, inclusion and involvement committee.	Sue Barton/Dawn Lawson	October 2023	
TB/23/71a	DW queried RRPI training and noted a business case has been approved and queried what the timeline was for getting training levels back on track? DT reported part of the business case is to explore options with partners and will report back on timelines.	Darryl Thompson	September 2023	The RRPI leadership team are completing a Training Needs Analysis with Learning and Development colleagues. This will factor in the additional resources and the ability to run two courses concurrently. This will also factor in the additional requirement for training due to high volumes of new starters on Trust bank to reduce agency spend and improve patient experience. The collaborative bank is due to start in October 2023 and will support conversations about partnership delivery of training.
TB/23/74a	Estates Strategy - DW noted the three key areas include environmental impact, but should there be reference to digital as well as this will have an impact on this? NP agreed he would update the document to this effect.	Adrian Snarr	September 2023	Estates strategy has been updated as requested.
TB/23/74a	Estates Strategy - The reference to the replacement for Folly Hall for 2025 needs to be changed, the lease expires in 2025. There is a risk where we might want to invest in Barnsley, but the West Yorkshire ICB that approves our capital, and we will need to work carefully around this.	Adrian Snarr	September 2023	Estates strategy has been updated as requested.
TB/23/74a	MBu identified the Trust doesn't have a comprehensive clinical strategy. We have service strategies but there needs to be an overarching clinical strategy. DT reported conversations have already started around a clinical strategy.	Executive Trio	September 2023	A Clinical Strategy planning paper was discussed in detail at the executive management team timeout on 14 September. This included discussions around scope, stakeholders, timescales and alignment with other Trust strategies. Preparation work is already underway, a lead author is in place, and an updated paper will be presented to EMT in October.

Actions from 27 June 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/52	Mark Brooks (MBr) thanked CM for sharing her story. MBr firstly noted he would like the Trust to speak to CM about how our service can best support people who experience substance misuse and domestic abuse.	Sue Barton	September 2023	Sue Barton has met up with CM and discussed her experiences and reflections. Her reflections have been shared so they can be used to influence future developments where possible .
TB/23/55	EM queried if there is any way SPA demand and acuity can be built into figures in the IPR in the fullness of time? CH agreed to look into this with AS and see what could be presented to the Board.	Adrian Snarr/Carol Harris	September 2023	This will be shared through the more detailed care group performance reports planned for private Board.
TB/23/55	NM asked how the Board are going to see the trajectory around agency. SY suggested agency can become part of the priority programme section of the IPR through improving the use of resources. Highlights could come through the priority programme section of the IPR to Board and the detail can be presented to one of the Board committees.	Adrian Snarr	September 2023	A paper is going to private board in respect of a full year financial forecast. Agency spend added to priority programmes section of the IPR as suggested.
TB/23/55	Agency to be monitored through PRC	Greg Moores/Lindsay Jensen	September 2023	An Agency Scrutiny Group is now set up and this is monitored by PRC and included in the Triple A report.
TB/23/57c	MBu asked for a meeting with AS and SR to look at the current situation in respect of provider collaboratives across both counties. Dr.Rachel Lee also asked to attend.	Adrian Snarr/Sean Rayner	September 2023	Date to be arranged following collaborative committee review of provider collaborative original business case ambitions. This review will be presented to October collaborative committee.

Actions from 25 April 2023

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	P and C's details have been shared with the integrated change team to make contact in relation to the older peoples service transformation.
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	September 2023	On the September Board agenda
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	September 2023	Presented to Board in August as part of the strategic meeting.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 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:	**Much has already been written and published on the recent verdict against Lucy Letby regarding child deaths at the Countess of Chester Hospital**. When I attend our staff welcome events, I am always struck by how consistent people are when they say why they do the job they do, which is wanting to improve lives and make a positive difference. To staff in the NHS these crimes are particularly abhorrent, and our thoughts are with those families who have lost a child or whose child has been severely harmed by these crimes. We have a separate Board paper on our own initial response. There has been much discussion locally, regionally, and nationally on what our response needs to be, especially to ensure there is a culture where staff are confident to speak up and know they will be listened to. October is freedom to speak up month and we will have a considered approach to how this is promoted to best effect in the Trust. **Considerable work has been taking place in both the South and West Yorkshire integrated care systems on updated operating models**. This is in response to the need to make 30% savings to running costs. Consultation processes with staff have now commenced. In addition to the reductions in operating costs of integrated care systems, re-structuring at NHS England is taking place with an aim to reduce its own running costs by 40% **The financial position across the NHS and wider public sector is becoming increasingly challenging**. The West Yorkshire Integrated Care System (ICS) has become the first in the country to declare it will not achieve its break-even target for this financial year, forecasting a £25m deficit. West Yorkshire is unlikely to be the only ICS in this position in the coming months.		

There will no doubt be further controls and scrutiny applied on all Trust finances given this climate, including our own. On a similar theme, Kirklees Council has announced its own significant financial challenges given a projected deficit. A number of measures are being assessed including redundancies. We continue to work closely with all of our partners to ensure we can understand any potential implications on service provision.

Since the July Board meeting there has been further industrial action by junior doctors and consultants, with more planned for mid-September and early October. There is one day when both junior doctors and consultants are taking action. Junior doctors have re-balloted and the results of this provide a mandate for further strike action. In line with previous instances of industrial action, plans have been put in place to ensure we can continue to provide safe care and thanks are once again offered to our staff who have supported this by planning and providing cover. This remains a very challenging situation for our colleagues to manage and the work involved to plan for and cover these days cannot be under-estimated.

The government has published a new suicide prevention strategy for England, 2023 to 2028, which sets out the vision and aim to prevent self-harm and suicide and improve support. A separate action plan has also been published. The strategy identifies suicide prevention as the responsibility of multiple government departments, and wider public, private and voluntary, charity and social enterprise (VCSE) sector organisations and aims for initial reductions in two and a half years' time. The strategy also aims to improve data and evidence regarding suicide to ensure interventions are evidence-informed and stresses the importance of this data being timely and of high-quality. Areas where tailored and targeted support for priority groups are identified, such as children and young people, autistic people and people in contact with mental health services, with a key focus on early intervention. We are touched by the tragedy of suicide in our services all too often and working within the Trust and with partners we will ensure any further learning from this strategy is incorporated into how we provide care.

We regularly discuss workforce challenges at our Trust Board. One such challenge is the available number of learning disability nurses. **A recent report has shown that the number of qualified learning disability nurses has decreased by 45% since 2009**. This comes at a time when there is great need to address health inequalities for people with a learning disability. It is positive the long-term workforce plan recognises the need to boost this particular workforce and we will need to work creatively with partners to address this key issue. On a similar theme NHS England has provided some resources to support the retention of mental health nurses. We will consider how we best use these resources to complement the work and interventions we already have in place.

The focus of this Board meeting is on performance and monitoring. Given the efforts and commitment of our staff, our performance is typically holding up well. There are known challenges with out of area bed placements given the level and acuity of demand we are experiencing, and also with achievement against target of some workforce metrics, including a small number of mandatory training figures. These are often associated with the backlog that built up during the Covid-19 pandemic and agreed actions are in place to improve.

Operational pressures remain high. A recent report from NHS Providers shows that demand on mental health services nationally has increased by 26% since the period before the pandemic started.

The winter period in 2022/23 proved to be extremely challenging for the NHS. **Winter planning commenced in earnest in July for 2023/24**. Providers of mental health services have typically seen an increase in length of stay in recent months and we are not an exception to this, so further focus will be applied to our bed management and discharge processes. The use of virtual wards, which have been successfully introduced in Barnsley, are a key component in winter planning.

Flu and covid vaccination guidance has been received and we are acting upon this. We will be providing the flu vaccines to our staff ourselves and will be promoting the take up of this important vaccine as we aim to reduce the risk in our interactions with our own staff and service users, particularly in consideration of those who are vulnerable. Our Covid restrictions remain in line with national guidance, so these are currently minimal. We have experienced some outbreaks on our wards in recent weeks and enhanced measures are put in place when this occurs. We will similarly be promoting the Covid booster vaccine and sign-posting staff to where they can take up the offer of a vaccine.

There has been much focus on the implementation of Right Care Right Person in recent weeks, which will enable trusts, local authorities, and the police to work to together to ensure people with mental health needs receive treatment by the most suitable professionals. We are engaging closely with colleagues and partners in both South and West Yorkshire on this with Carmain Gibson-Holmes, our deputy director of nursing, quality & professions, leading on behalf of the Trust. These changes will need to be carefully managed and communicated. Wider engagement with Trust leaders is taking place at an extended executive management team meeting at the end of September. It is particularly important the forthcoming changes are jointly agreed by the NHS and police.

It was very disturbing to read and hear about the reported incidences of sexual harassment and assault against female surgeons recently. As I wrote in The View this has no place in any workforce, not least in a place of such trust and safety like the NHS. We need to ensure our Trust is a safe place not only to receive care but also to work, with the knowledge that any issue raised will be taken seriously. We have carried out a lot of work on sexual safety and continue to focus heavily on speaking up, but we must not be complacent. NHS England has recently published a sexual safety charter for trusts to sign. We intend to sign this charter. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024.

We regularly discuss the mental health challenges faced by young people at Trust Board. A number of recent reports help to highlight this. Analysis of NHS data by YoungMinds shows the number of children in mental health crisis has reached record levels in England. For the first time, urgent referrals of under 18s to mental health crisis teams reached more than 3,500 in May, three times

	higher than in May 2019. The charity also found that in the year to March 2023 there were 21,555 urgent referrals to mental health crisis teams, up 46% on 2022. Research by Unmind suggests more than half of young workers have taken sick leave in the past six months because of mental health problems. Among 16 to 24-year-olds questioned for a survey, 56% said that they needed time off because of stress, anxiety and depression. This report clearly articulates a number of challenges in our operating environment at the moment. **It is important to also recognise the excellent and innovative work our staff continue to do.** Creative Minds, together with Artworks, have recruited 28 creative practitioners to work across our Trust inpatient wards, helping to support people through their recovery journey and improve wellbeing. Visitors to Trust buildings can find out more about the fascinating history of mental health care through the Mental Health Museum's new Stanley Royd roadshow. Display cases have been installed in several Trust buildings housing unique artefacts from the museum's collection. A group of young people supported by the Trust have teamed up with one of the UK's leading stammering charities to raise awareness and acceptance of stammering in schools. **I would like to extend a warm welcome to Dr.Dawn Lawson to the Trust as our new Director of Strategy & Change.** Dawn brings a wealth of improvement and partnership experience to us, and I am sure will prove to be a real asset as we continue on our journey to become an outstanding organisation. Unfortunately, Greg Moores, our chief people officer is currently on long-term sick**. Lindsay Jensen will continue to act as chief people officer for this period of absence**.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

24 August 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

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

Carmain Gibson-Holmes and Carol Harris visited the Croft, a children's recovery home in Wakefield, and heard all about the great partnership working between the CAMHS team and the local authority to provide the best support to children in care. The team also shared information about their wellbeing wall and box of resources for staff to share.

Our priorities for 2023-24

NHS
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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 health: We are connected into the work on inequalities in each of our places and have seen some excellent improvements recently in the uptake of annual health checks for people with a learning disability in Barnsley and Calderdale.

Improving care: Our older people's mental health transformation is continuing. The business case is being finalised, which presents 3 options which we will consult staff, partners and the public on.

Making the Trust a great place: A group has been established to support work on how, as a Trust and as a workforce, we 'live our values'. This work is led by our people directorate, with specialist support from the integrated change team, equality and involvement, and includes our trauma informed work.

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.

***Save the date* -** West Yorkshire ICB mental **health and wellbeing** event, 10 October 2023.
The health and wellbeing event, hosted by the ICB and delivered by the West Yorkshire Staff Mental Health and Wellbeing Hub, will be held online from 9.30am to 1.15pm on Tuesday 10 October, on World Mental Health Day. Keep an eye on the Headlines for more information.

Patient feedback to Yorkshire Ambulance Service around mental health support. The Mental Health Programme in YAS focuses on improving the care available to patients in mental health crisis, and this **survey** is designed to get feedback from patients and their friends and family, about their care under Yorkshire Ambulance Service.

Smokers living in Calderdale that want to quit smoking are able to access free vape kits in a new trial funded by Yorkshire Cancer Research and delivered through **Yorkshire Smokefree**. Nicotine replacement therapies such as patches will continue to be available free of charge. **Sheffield Smokefree** are officially launching their new offer in October.

New course for veterans to start at Wakefield Recovery and Wellbeing College. The first course of its kind in the North of England, called 'Veterans Moving Forward' is being launched at the 5 Towns Veterans Support Hub. The face-to-face course has been developed by Help for Heroes and was co-designed by veterans for veterans.

HELP for HEROES

We are working with Barnsley Council's public health team on a campaign aimed at people suffering a **stroke**. If you would like to be involved please contact comms.

Call for people in West Yorkshire to contribute to the 'Book of Cope'. The **'Book of Cope'** will celebrate and share the different strategies people from West Yorkshire use to boost their mental wellbeing, to help others when facing their own challenges.

Improving Health
Our performance in July

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- **50.8%** of people completing Talking Therapies treatment and moving into recovery
- **99.8%** of Talking Therapies referrals beginning treatment within 18 weeks. **99.2%** within 6 weeks.
- **87.7%** of MH service users followed up within 72 hours of discharge from inpatient care
- **87.2%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **95.3%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **83.8%** of people died in a place of their choosing
- **84%** in CAMHS services waiting less than 18 weeks for treatment

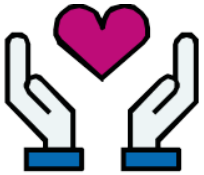
Our recovery colleges (18+) and the discovery college (16-25) are calling for staff to help co-produce and co-facilitate their courses. Please get in touch with the team if you can support Wakefield, Barnsley or Calderdale and Kirklees to co-facilitate or co-produce. The course topics currently covered can be found on the intranet.

Take part in training for the Connecting People programme. Use your voice and lived experience to help us improve services in your community. Training dates can be found on the intranet.

Staff shortlisted in Social Worker of the Year awards
Congratulations to senior mental health practitioner Edward Lim, who's been nominated in the Mental Health Social Worker of the Year category, and to team leader and social worker Eleanor Hinchliffe, who's a finalist in the Children's Services Team Leader of the Year category.

Make sure you follow the correct process when reporting an issue to service desk. Please log all IT issues through the service desk. If you need to escalate your ticket or you aren't happy with the resolution, you should follow the **service desk escalation process**.

Improving Care
Our performance in July



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- **603** inappropriate out of area bed days
- **1** young person under 18 admitted onto adult inpatient wards
- **52.5%** waiting for referral to assessment within 2 weeks
- **4.8%** of service users clinically ready to discharge
- **87.5%** of service users on CPA offered a copy of their care plan
- **96.8%** of our service users have their ethnicity equality data recorded, **45.1%** their disability status, **44.7%** their sexual orientation, and **99.8%** deprivation (postcode)

93% of respondents in the friends and family test rated our general community services either good or very good; **90%** in our mental health services, **82%** CAMHS, **70%** for learning disability services, and **75%** for ADHD.

Falls prevention week 18-22 September. The theme for this year is 'awareness to action'. There will be drop in sessions held in each locality throughout the week, where staff are welcome to come and find out more about falls prevention. There are also extra activities happening on our wards and units, and specific events for members of the public.
Find out more on the intranet.

Patients Know Best (PKB), a new personal health record for our service users, went live at the end of July. Over 2,000 people have registered since go-live (8% of our service users). This is on top of 2,300 service users already registered. Nearly 3,000 service users have logged in to PKB more than once since registering which is extremely positive. Service users can see their appointments, allergies and demographics, with more functionality to be added over time. Training sessions are available. Further information is available on the intranet.

Congratulations to the **Wakefield ReACH team** who have been shortlisted in the RCPsych awards as psychiatric team of the year in the quality improvement category. Well done everyone!

Improving Care Incidents in July

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In July we reported:

- **1,117** incidents – **742** rated green (no/low harm)
- **300 were rated yellow and 62 rated amber**
- **13** rated as red (incident severity is reviewed and may be downgraded)
- **95%** of incidents resulted in no or low **actual** harm, or were external to our care
- **26** patient safety incidents that resulted in moderate or severe harm or patient safety related death. They were **12** category 3 pressure ulcer incidents and **1** category 4 pressure ulcer incident, **2** tissue viability incidents, **6** self harm incidents, **2** slip, trip or fall, **1** substance misuse incident and **2** apparent suicides.

We had **145** restraint interventions in July, a decrease from 201 in June. **95.2%** 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 July, which is a **decrease of 4** from the previous month. There is an area of the intranet for falls prevention, this includes updated inpatient information.

We had 33 pressure ulcers in July. One lapse in care have been identified in these.

World suicide prevention day 2023, 10 Sept 2023 – creating hope through action. All of us can take a small action to help prevent suicide. Here's some quick ideas: take the 20 minutes to save a life training, read about how to create hope through language, and spend 10 minutes looking at resources, guides and support for staff on the suicide prevention intranet pages.

Think. Check. Share.

There were **13 confidentiality breaches** in July, down from 14 last month. All of us can reduce the number of patient data or sensitive information breaches.

Improving care: Triangle of Care
Partnership with carers

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The Triangle of Care means that we include carers at all levels of care, giving them equity in the service user journey. It will help promote safety, support recovery and improve wellbeing.

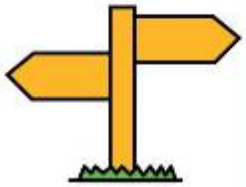
Our Trust has been successful in our application to be a member of the Triangle of Care which is a three-stage recognition process for services who commit to self-assessing their existing services and action planning to ensure the Triangle of Care standards are achieved.

Six key standards of the Triangle of Care:

Carers, and the essential role they play, are identified at first contact or as soon as possible thereafter.

Staff are 'carer aware' and trained in carer engagement strategies.

Policy and practice protocols about confidentiality and sharing information are in place.



Defined post(s) responsible for carers are in place.

A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.

A range of carer support services are available.

Search for Triangle of care on the intranet

We are introducing the Triangle of Care model in all services across our Trust.

Our Trust is far along in meeting many of the Triangle of Care standards. But there are some areas where we can improve.

To help, we are asking teams to complete a self-assessment to see where they are on the Triangle of Care journey. Self-assessment forms and further information is available on the intranet.

With **all of us** in mind.

Friends and Family Test feedback
Adult ADHD and autism service

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The problem: extremely low response rates for Friends and Family Tests (FFT) in the adult ADHD and autism service which can lead to an unfair reflection of the service. Colleagues in other areas also report difficulties in collecting feedback from service users using the FFT.

What we did:

- A volunteer has been supporting the service to collect feedback to understand service user experience.
- Involvement work to look at feedback collection methods and how to improve the service.
- This resulted in more relevant feedback, the majority was positive.
- Text messaging and cards are also used to collect FFT feedback.

Improvement work:
Following feedback from service users several improvements, to the service offer, as well to the facilities that are used by the team have been made…

The FFT told us…	We did…
Give clearer instructions in the initial pack. About how to fill out the forms and what to expect of the process step by step.	The service now offers a telephone consultation to help with completing the initial pack.
I was led to a room with horrible lights and lots of background noise of stomping of the stairs and clocks.	The lighting has been changed within the rooms at Manygates. These now have less harsh lighting, a dimmer switch and were possible use natural light only. Additional carpet has been installed and soundproofing has been added to the stairs.
The time between steps in the process was very long with little indication on what to expect until shortly before the appointment.	The service is working with commissioners to expand capacity of the service.

Managing risk

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

Key areas of risk identified in the risk register are:

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

We have recently seen an increase in **COVID** cases and outbreaks. This is in line with national data which suggests cases are once again rising. We strongly encourage you to do everything you can to keep yourself, your colleagues, your patients, and your loved ones safe, including good hand hygiene and good ventilation in all areas. If you develop any respiratory symptoms please inform your line manager to ensure a risk assessment can be completed before continuing at work. Facemasks should be in use if any staff are working under risk assessment. Further advice can be found on the **intranet.**

If you are eligible please book in your COVID booster when you can, and look out for the start of our flu vaccination campaign soon.

Improving resources
Our finances in July

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£0.7m	£0m
Agency Spend	£3.7m	£10m
Financial sustainability and efficiencies	£2.7m	£12m
Cash	£77.9m	£76.9m
Capital	£1.1m	£8.8m
Better Payment Practice Code	97%	

A deficit of £0.2m has been reported in July 2023, reducing the year-to-date surplus to £0.7m. This is £0.6m behind plan. Pressures need to be mitigated in order to secure the planned breakeven position.

Our Trust agency spend target is £8.7m and we are forecasting to spend in excess of this. Spend in July is £855k which is a reduction from the exceptional level reported in June.

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

The Trust cash position remains strong at £77.9m. This is higher than plan.

To date capital expenditure is £1.1m with spend profiled to increase in the coming months.

97% of all invoices have been paid within 30 days of receipt.

A great place to work

Our performance in July

- **5.1%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.3%**
- In July we had new **43** starters to the Trust, and **53** leavers
- We currently have **4,289** substantive members of staff
- **76.5%** of staff have a completed annual appraisal

Industrial action - thank you to all our teams and services for their continued work throughout the industrial action. Prospective dates have been announced by consultants for further strike action on 19 and 20 Sept, this will be an emergency care only level of service. Junior doctors are re-balloting, which closes on 31 Aug. We always welcome feedback from our staff, so please let us know if there is anything we can support with – speak to your line manager, union representative, or come and Talk to the Trio.

Our Trust has now supported over 100 staff to take an internal transfer. An internal transfer supports staff into a like-for-like job in our Trust, with the potential to learn new skills and gain new experiences. The scheme is open to anyone who has been employed with the Trust in a substantive post for more than six months. More information on the staff transfer scheme pages is on the intranet.

Suicide specific supervision – supporting all staff affected by suicide. The loss of a service user or patient to suicide can have a huge impact on our staff, teams and services. We are rolling out a suicide-specific supervision model for all staff directly or indirectly affected by suicide, which can be used across our whole workforce. This model is based on your feedback on what support you need following a critical incident, thank you to everyone who shared their experiences.

Annual Member's Meeting – 10am-2pm, 27 September, Al-Hikmah Centre, Batley
This year's theme is 'All of You' and the importance of putting people first and of recognising and valuing lived experience. The event is open to all. If you would like to attend you can find out more and book a place here.

Naomi Fernandez has joined the Trust as our new head of people experience. We will be sharing more information from Naomi, including her ambitions for the Trust shortly.

A great place to work
Raising concerns at work

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We want everyone to feel safe, comfortable, and confident to speak up about a work concern or issue. It might be about professional conduct, standards of care, harassment, bullying, abuse, or general workplace issues.

If you can't resolve the issue yourself, your first point of contact to raise an issue should be your line manager. In addition, there are other sources of support available to you.

Civility and respect champions.
Behaviours such as bullying, harassment or rudeness can be resolved with a Trust champion. Our civility and respect champions are Robert Shaw, Catherine Musegedi, Lesley Cooper, Simon Ramsden, Sue Threadgold, Colin Hill, Inga Child, Grey Phiri and Michelle Williams.

Equity guardians.
Equity guardians provide advice and support to front line staff who experience hate crimes and racial abuse while at work. Our equity guardians are Jacob Agoro, Richard Watterston, Fareena Rasaq, Mubashshir Fazlee, Dr Jon Millard, and Rachel Chislett. You can also email the guardians direct on equityguardians@swyt.nhs.uk.

Freedom to speak up guardians.
Our Freedom to Speak Up Guardians can provide confidential advice and support on how to raise concerns. Our guardians are Estelle Myers and Ruth Neil.

With **all of us** in mind.

More information on the support available can be found on the intranet and in our 'raising concerns at work' leaflet.

Take home messages

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

Take up any vaccine offers this Autumn and Winter to help you keep well and protect those around you.

Help us to help our partners by getting involved with Barnsley's stroke campaign, and by sharing the YAS survey.

Get involved in our suicide prevention work for world suicide prevention day. It may help you save someone's life.

Help us to better connect with our local communities by attending our Connecting People training.

Our support for carers is important to us. Help us with our Triangle of Care work by completing the self-assessment.

Have your say and get involved by attending our annual member's meeting.

Make sure you and your teams know about all the ways you can raise concerns at work.

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	**Adrian Snarr - Director of Finance & Resources/Director of Strategy & Change**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for August 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 Integrated Care Boards (ICB) 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 August 2023. 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 96.7% against a target of 90%. For the Trust derived indicators, as at August 2023, disability 45.5%, sexual orientation 44.8% (both slightly increased from previous month) 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. 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale, currently 73.5% of those had been reviewed within 12 months.
- Referral to assessment within 2 weeks for mental health single point of access continues to be impacted by demand and capacity, mainly in the Barnsley, Calderdale and Kirklees service, the overall Trust position increased to 65.7% from 52.5% reported in July against a target of 75%. Single point of access (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. Rapid improvement work in (SPA) together with some progress in recruitment has contributed to an improved performance this 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 397 days used in August, this is an improvement compared to the previous month (582). Need for use of these beds mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 11 people placed in out of area beds at the end of August. 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 (paediatric audiology) within 6 weeks decreased to 64.1% in August from 66.7% reported in July, 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 service are also reporting a number of appointments being cancelled by parents/carers, or children not being brought to their appointments. **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 and risk assessments** Although the focus has been on performance against target the main driver for change is of care plans and risk assessments, therefore the care plan and risks assessment improvement group are monitoring whether improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance. The August data for care planning shows performance of 87.4% and has now sustained performance above the 80% threshold since April 23. For risk assessments, the August data shows an increase in performance from the previous month within inpatient services (88%) and community services (94.7%) who continue to achieve threshold for the second month running. 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 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 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 66.1% (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. Reduction in performance in August (impacting 19 people) is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.

- 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 incidents reported in August 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

- The number of restraint incidents sustained a lower level of incidences for the second consecutive month with 146 incidents reported (145 in July). 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.
- 90% of prone restraint incidents were for a duration of three minutes or less, there was one incident out of ten over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service users and staff involved in the incident.
- There were 16 information governance personal data breaches during August 23 which is an increase on previous months. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. The marketing and communications team has worked with information governance colleagues to identify real life and recurrent themes, which has been developed into case studies. This provides a real and identifiable example of an issue and highlights the impacts of the breach to the individual. The case studies will be shared throughout Trust internal communication channels from the 1 October.
- The number of inpatient falls in August was 33, which is the same as the number reported in July and the lowest level reported in the previous 12 months. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.
- There was one pressure ulcer due to a lapse in the Trust's care during August. Further details on the case are within the main report. The Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Quality and Safety Committee as part of the Chief Nurse report.

Our People

- The Trust had robust plans in place to minimise the impact to patients of the junior doctor and consultants strike during August. The Trust has an established oversight group to plan and review impact of strikes and as a result, impact to service provision to date has been minimal and risk to patients has been reduced.
    - 20 July - 27 appointments cancelled (incudes 14 individual inpatient reviews - Unity and Ward 19 specifically reported disruption)
    - 21 July - 28 appointments cancelled (includes 20 individual inpatient reviews)

	○ 1 older adult community patient had to be referred to community mental health team as they couldn't wait for an appointment after their clinical appointment was cancelled. • Proportion of staff in senior leadership roles who are from BME background and females are now included in the IPR. Other protected characteristics will be included as data becomes available. Of the 1064 band 7 and above staff (including consultants, excluding bank staff) 126 (11.8%) are from BME population. Number of women in these roles is 769 (72.3%). • The Trust had 14 violence and aggression incidents against staff on mental health wards involving race during August - any increases are monitored by the Patient Safety team and Equity guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role. • Our substantive staff in post position continues to remain stable and has increased slightly in August. The number of people joining the Trust outnumbered leavers in August. Year to date, we have had 281.9 new starters and 251.7 leavers during the first five months of the year. Focus remains on recruitment and retention. • Overall turnover rate in August was 13.1% and has been almost static for the last three months and improved on the 22/23 position. • Sickness absence in August was 4.7% and below local threshold, with a rolling 12-month position of 5.3%. • Rolling appraisal compliance rate for August saw a deterioration, from 76.5% to 74.5%. An improvement trajectory of 78% was set by the Executive management team (EMT) in May, this will be reviewed at the end of September 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 92.5% compliance which exceeds the Trust target of 80%, this has increased marginally from last month 92.1%. Cardiopulmonary resuscitation is the only area in month below the Trust target (79.9%). 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 Trust position for reducing restrictive practice interventions training saw an increase in August to 82.6% from 76.2% reported at the end of July and is now above the 80% threshold. **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 August, these are as follows:

	• 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, and this has resulted in the continued use of agency staff. 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 continue to be supported through Trust wide recruitment and retention programme. • The Trust currently has higher than usual levels of vacancies in mental health 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. • Demand into the Single Point of Access (SPA) and capacity issues have led 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. This increases the risk of routine triage and assessment being delayed. Work to maintain patient flow continues, with the use of out of area beds being closely managed and the numbers have reduced during August compared to previous months this year. • The 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. • During August, there was an increase in the overall number of cases that were clinically ready for discharge, increasing from 4.8% to 5.7%, this has been identified as a risk and is being managed on the organisational risk register, due to the continued 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. • 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 continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed. **Finance** • A surplus of £449k, being £449k better than plan, was reported in August 2023. The year-to-date position is a surplus of £1,171k which is slightly behind plan. • The estimated impact of the Medic pay awards (income and expenditure) has been included in month. This is expected to be paid, and income received, in September 2023.

	• Agency spend in August was £810k which is a slight decrease on Julys position which was £855k. • 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 £79.1m; this is higher than plan. • Out of area placements have continued to reduce in August. Overall this is £255k underspent against plan in month and is now £392k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated. • Performance against the Better Payment Practice Code is 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

August 2023

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for August 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 96.7% against a target of 90%. For the Trust derived indicators, as at August 2023, disability 45.5%, sexual orientation 44.8% (both slightly increased from previous month) 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 coves 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. 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale, currently 73.5% of those had been reviewed within 12 months.

• Referral to assessment within 2 weeks for mental health single point of access continues to be impacted by demand and capacity, mainly in the Barnsley, Calderdale and Kirklees service, the overall Trust position increased to 65.7% from 52.5% reported in July against a target of 75%. Single point of access (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. Rapid improvement work in (SPA) together with some progress in recruitment has contributed to an improved performance this 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 397 days used in August, this is an improvement compared to the previous month (582). Need for use of these beds mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 11 people placed in out of area beds at the end of August. 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 (paediatric audiology) within 6 weeks decreased to 64.1% in August from 66.7% reported in July, 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 service are also reporting a number of appointments being cancelled by parents/carers, or children not being brought to their appointments.

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 and risk assessments

Although the focus has been on performance against target the main driver for change is of care plans and risk assessments, therefore the care plan and risks assessment improvement group are monitoring whether improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance.

The August data for care planning shows performance of 87.4% and has now sustained performance above the 80% threshold since April 23.

For risk assessments, the August data shows an increase in performance from the previous month within inpatient services (88%) and community services (94.7%) who continue to achieve threshold for the second month running. 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 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 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 66.1% (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. Reduction in performance in August (impacting 19 people) is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.
• 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 incidents reported in August 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents sustained a lower level of incidences for the second consecutive month with 146 incidents reported (145 in July). 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.

• 90% of prone restraint incidents were for a duration of three minutes or less, there was one incident out of ten over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

• There were 16 information governance personal data breaches during August 23 which is an increase on previous months. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. The marketing and communications team has worked with information governance colleagues to identify real life and recurrent themes, which has been developed into case studies. This provides a real and identifiable example of an issue and highlights the impacts of the breach to the individual. The case studies will be shared throughout Trust internal communication channels from the 1st October.

• The number of inpatient falls in August was 33, which is the same as the number reported in July and the lowest level reported in the previous 12 months. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

• There was one pressure ulcer due to a lapse in the Trust's care during August. Further details on the case 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.

Our People

• The Trust had robust plans in place to minimise the impact to patients of the junior doctor and consultants strike during August. The Trust has an established oversight group to plan and review impact of strikes and as a result, impact to service provision to date has been minimal and risk to patients has been reduced.

o 20 July - 27 appointments cancelled (incudes 14 individual inpatient reviews - Unity and Ward 19 specifically reported disruption)

o 21 July - 28 appointments cancelled (includes 20 individual inpatient reviews)

o 1 older adult community patient had to be referred to community mental health team as they couldn't wait for an appointment after their clinical appointment was cancelled.

• Proportion of staff in senior leadership roles who are from BME background and females are now included in the IPR. Other protected characteristics will be included as data becomes available. Of the 1064 band 7 and above staff (including consultants, excluding bank staff) 126 (11.8%) are from BME population. Number of women in these roles is 769 (72.3%).

• The Trust had 14 violence and aggression incidents against staff on mental health wards involving race during August - any increases are monitored by the Patient Safety team and Equity guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.

• Our substantive staff in post position continues to remain stable and has increased slightly in August. The number of people joining the Trust outnumbered leavers in August. Year to date, we have had 281.9 new starters and 251.7 leavers during the first five months of the year. Focus remains on recruitment and retention.

• Overall turnover rate in August was 13.1% and has been almost static for the last three months and improved on the 22/23 position.

• Sickness absence in August was 4.7% and below local threshold, with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for August saw a deterioration, from 76.5% to 74.5%. An improvement trajectory of 78% was set by the Executive management team (EMT) in May, this will be reviewed at the end of September 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 92.5% compliance which exceeds the Trust target of 80%, this has increased marginally from last month 92.1%. Cardiopulmonary resuscitation is the only area in month below the Trust target (79.9%). 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 Trust position for reducing restrictive practice interventions training saw an increase in August to 82.6% from 76.2% reported at the end of July and is now above the 80% threshold.

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 August, these are as follows:

• 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, and this has resulted in the continued use of agency staff. 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 continue to be supported through Trust wide recruitment and retention programme.
• The Trust currently has higher than usual levels of vacancies in mental health 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.
• Demand into the Single Point of Access (SPA) and capacity issues have led 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. This increases the risk of routine triage and assessment being delayed. Work to maintain patient flow continues, with the use of out of area beds being closely managed and the numbers have reduced during August compared to previous months this year.
• The 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.
• During August, there was an increase in the overall number of cases that were clinically ready for discharge, increasing from 4.8% to 5.7%, this has been identified as a risk and is being managed on the organisational risk register, due to the continued 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.
• 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 continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

Finance

• A surplus of £449k, being £449k better than plan, was reported in August 2023. The year-to-date position is a surplus of £1,171k which is slightly behind plan.
• The estimated impact of the Medic pay awards (income and expenditure) has been included in month. This is expected to be paid, and income received, in September 2023.
• Agency spend in August was £810k which is a slight decrease on Julys position which was £855k.
• 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 £79.1m; this is higher than plan.
• Out of area placements have continued to reduce in August. Overall this is £255k underspent against plan in month and is now £355k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated.
• Performance against the Better Payment Practice Code is 97%.

The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2023/24.
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.

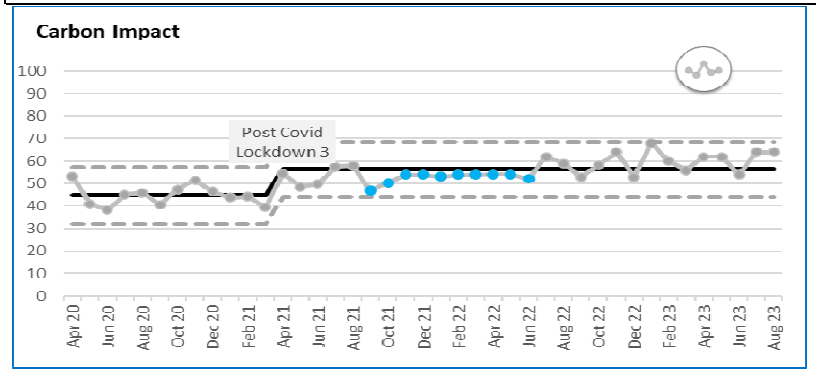
Strategic Objective	Priority Programme	Headlines
Improving health	Address inequalities involvement and equality in each of our places with our partners	A quarterly update will be provided following Equality, Inclusion and Involvement Committee or by exception. Update not due this month.
Improving care	Transform our Older People inpatient services	Key deadlines for the next phase: Business case finalisation including Equality Impact Assessment: shared into governance, September 2023 Governance approvals: • Integrated Care Board – Reach approval to establish joint committee – September, Joint committee to held October 2023 • SWYPFT Governance: Finance Investment and Performance Committee September, Clinical Governance and Safety Committee – October, Trust Board October • NHS England assurance review: 3 October • Joint Oversight and Scrutiny Committee – late October Public consultation planning: ongoing – video filming September, consultation document revision and approval September. Consultation start: late 2023
	Improve our mental health services so they are more responsive, inclusive and timely	1. Inpatient priority programme: A complete working group is being created for therapeutic inpatient care that will include Trauma Informed Care, Reducing Restrictive Practices Improvement and creative practitioners. Work continuing with the other three workstreams including a Menti staff survey to inform retention initiatives and career progression. A training package is ready to support staff in using the inpatient outcomes dashboard and the discharge oversight group are beginning to look at a full review of existing systems and processes. The working groups will identify any risks associated with their plans and the key performance indicators/metrics will be confirmed. 2. Care closer to home (OOA): Workstream leads have now been confirmed and a staff survey based on the quality priorities outlined in the action plan will be sent out to internal teams prior to the individual workstream group meetings. These outcomes will provide the outline plan for a workshop/summit to take place in January 2024. A preliminary data review has been completed with further data capture identified. 3. Improving access to care: • All community learning disabilities services have transitioned onto standardised SystmOne waiting list framework and currently in testing phase. This had been designed in collaboration with services across the localities and SystmOne waiting list project team for measuring, reporting, and managing waiting lists. • Evolve contract expected to end in October. • Transfers of those on waiting list aged 17+ to adult Attention Deficit Hyperactivity Disorder (ADHD) from Kirklees CAMHS neurodevelopmental services commenced. • Core psychology demand and capacity and process mapping commenced – starting in Barnsley. • Work continues to codevelop the service demand review and waiting list report and make improvements to the way that the data is displayed, with statistical measures being incorporated to better understand the extremes and why they are happening. • Work continues to identify an appropriate methodology whereby protected characteristics can be overlayed across a variety of metrics, for the purposes of individualised service level improvement working collaboratively with Barnsley system colleagues and cardiac rehabilitation service. 4. Community mental health transformation: The group will be focused on reconfiguring community mental health service design across all four localities of SWYPFT in line with the NHS England roadmap for transformation with clear and concise pathways of care. The group had its first meeting and has defined the scope and focus of the internal programme of work and maintaining active involvement in each locality, this will begin focused on updating how the place-based models have been configured and in turn mapping how SWYPFT aligns into them.
	Improve safety and quality	Care Planning and Risk Assessment: A quarterly update will be provided following Clinical Governance and Clinical Safety Committee or by exception. Update not due this month. Personalised care (moving on from care programme approach): Work is on track for workstreams: communication and engagement plan, developing and piloting of Patient Rated Outcome Measures (PROM's) tool, defining keyworker functions and roles. Other workstreams have been identified and are on schedule for commencement. Communications have gone out across the Trust as part of the planned stage 1 work.

Improving use of resources	Spend money wisely and increase value	A quarterly update report will be provided following finance investment and performance committee (FIPC) meeting or by exception. Next update scheduled for October 2023.
	Make digital improvements	Digital Dictation: Procurement and contract award of single digital dictation supplier by September 2023. On target. Preferred supplier chosen and contract to be issued following 10-day standstill period. Dedicated project manager in place to oversee implementation by December 2023. On target. Recruitment underway with interviews scheduled for w/c 18th September 2023. Implementation plan in place by December 2023 On target. The implementation will be led by the Integrated Change Team (ICT) and work will commence with the chosen supplier following contract award.
Great place to work	Inclusive recruitment, retention and wellbeing	A quarterly update will be provided following Equality, Inclusion and Involvement Committee or by exception. Update not due this month.
	Living our values	A quarterly update will be provided following Equality, Inclusion and Involvement Committee or by exception. Update not due this month.

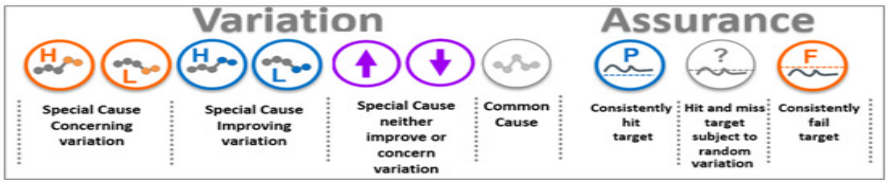
Improving health

Metrics	Threshold	Jun-23	Jul-23	Aug-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	*90%*	96.8%	96.8%	96.7%		
Percentage of service users who have had their equality data recorded - disability	To be determined for 23/24	44.3%	45.1%	45.5%		The threshold for 23/24 has been developed and will go to the next equality inclusion and involvement sub committee for approval. Once approved the thresholds will be included in the report to be monitored against.
Percentage of service users who have had their equality data recorded - sexual orientation		44.0%	44.7%	44.8%		
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	Service timely completeion - 75%	67.7% Service	77.3% Service	73.5% Service		All services have an EIA in place. We have previously agreed with Equality including involvement committee that the threshold for this is 75% and have therefore aligned this report to reflect this.
	Policy - 95%	96.1% Policy	97.4% Policy	97.4% Policy		
Completion of equality mandatory training	>=80%	97.0%	95.1%	95.9%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	1	0	0		2023/24 to be used as a baseline
Carbon Impact (tonnes CO2e) - business miles	76	54	64	64		Data showing the carbon impact of staff travel / business miles. In August staff travel contributed 64 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%	65.0%	Due November 2023			Q1 - 65.0% 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 has had the upper and lower control levels recalculated following the last Covid-19 lockdown in April 2021. It is understood that the lockdowns that happened as a result of the Covid-19 outbreak impacted on our carbon impact due to the changes in ways of working and move away from face to face contacts. Since then you can see we have entered a steady state and remain in common cause variation. Levels are not expected to return to those seen pre-Covid-19 as a more blended approach to working is expected going forward.

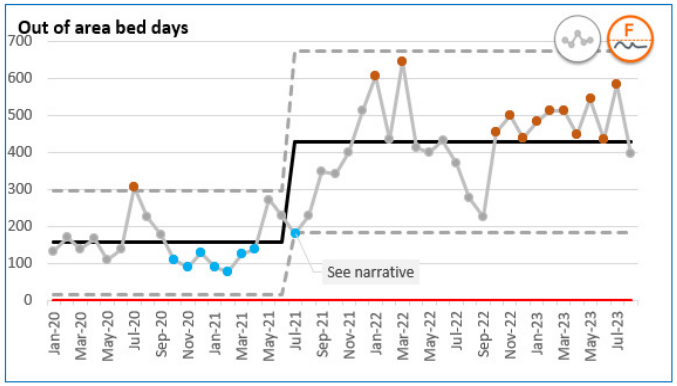


Improve Care

Metrics	Threshold	Jun-23	Jul-23	Aug-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%	86.7%	87.2%	*88.0%*		August data shows an increase in performance within both inpatient and community services. Risk assessment completion is based upon completion within a set timeframe but does not account for a robust and high quality risks assessment which might take a little longer. 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.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		85.7%	92.9%	*94.7%*		
% Service users on CPA offered a copy of their care plan	80%	86.6%	87.5%	87.4%		The care plan and risk assessment improvement group continue to look at performance as well as quality of care planning and risk assessments. Part of the improvement work is to identify how we measure the quality (co-production, outcomes, timeliness) as well as the quantity (completed and shared), this may require a change to the way in which we report through the IPR.
Registered substantive staff in post mental health and learning disabilities services	Establishment					Defintions, thresholds and targets to be agreed as part of the IPR development plan by November 2023.
Staff in neighbourhood teams	Establishment					
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	15	14	14		Any increases will be monitored by the Patient Safety team. Equity guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	435	582	397		See statistical process chart overleaf for further detail.
% service users clinically ready for discharge	<=3.5%	4.6%	4.8%	5.7%		The risk is being managed through the organisational risk register. 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.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	774	760	747		This calculates length of wait in days for those discharged that month. Clients are seen in order of need and not by how long they have waited. Onset of Right to Choose has impacted on the number choosing to come to SWYPFT for assessment. The numbers of assessments taking place every month outweighs current numbers coming in so the waiting list numbers will start to reduce. There is still a backlog of individuals who will have waited a long time for assessment from referral. Work continues with our partners and West Yorkshire collaborative.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	493	531	581		Calderdale - The longest wait for those seen in the month was 811 days, the shortest was 561 days. Number on waiting list at end of August - 203. The longest waiter on the waiting list had waited 874 days. Kirklees - The longest wait for those seen in the month was 1071 days, the shortest was 246 days. Number on waiting list at end of August - 1681. The longest waiter on the waiting list had waited 1099 days.
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	82.1% 64/78	81.3% 52/64	66.1% 37/56		Reduction in performance in August (impacting 19 people) is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	92.6%	87.7%	89.0%		
Community health services two hour urgent response standard	70%	86.2%	88.1%	89.5%		
Referral to assessment within 2 weeks (external referrals)	75%	80.5%	52.5%	65.7%		See statistical process charts overleaf for further detail. Rapid improvement work in (SPA) together with some progress in recruitment has contributed to an improved performance this month.

Improve Care

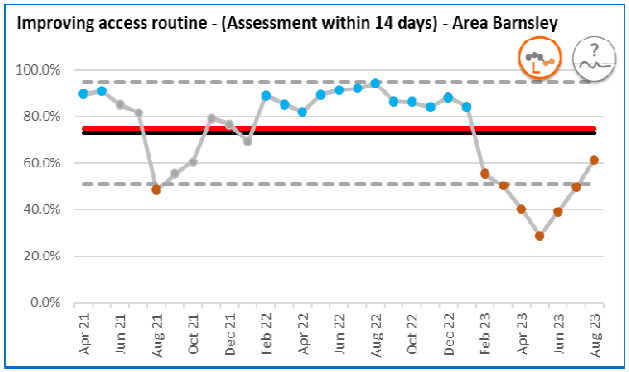
What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

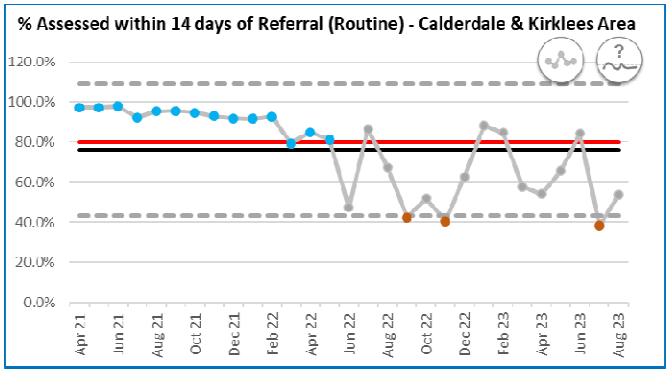


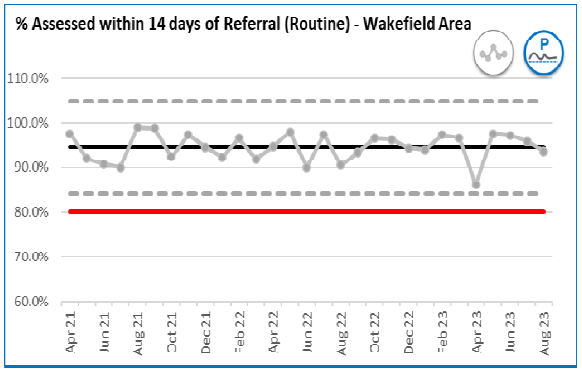
There has been a step change increase in out of area bed usage from summer 2021 onwards. There are several reasons for the increase including staffing pressures across the wards, increased acuity, covid outbreaks and challenges to discharging people in a timely way. See the National Metrics section for further analysis of this key performance indicator.

The Trust had 11 people placed in out of area beds at the end of August 2023.

Referral to assessment within 2 weeks (external referrals)







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 remains below target performance in Barnsley, Calderdale & Kirklees. Performance in Wakefield remains above threshold and the learning is being shared across all other areas.

Improve resources

Metrics	Threshold	Jun-23	Jul-23	Aug-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	£19k	(£373k)	£446k		A surplus of £449k, being £449k better than plan, was reported in August 2023. The year to date position is a surplus of £1,171k which is slightly behind plan. The estimated impact of the Medic pay awards (income and expenditure) has been included in month. This is expected to be paid, and income received, in September 2023.
Capital spend against plan (monthly)	£8.8m	(£442k)	(£287k)	£256k		The year to date position is £437k behind plan with spend of £1.1m. Work continues to ensure that the full capital allocation is appropriately utilised in year.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£1,002k	£855k	£808k		Although the in-month expenditure on agency staff has reduced this remains higher than plan (both in month and year to date).
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£177k	£906k	£1,137k		The cumulative savings to date are £3.6m and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	9	Due October 2023			
Estates Urgent Response Times - Service level agreement (SLA)	95%	98.9%	95.2%	96.9%		Service level agreement 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 & Effectiveness
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	100%	93.8%	61.8%	100.0%		Estates senior management have reviewed this metric and from August 23 only jobs screened as category SLA 2 will be included going forward due to some inconsistencies in the categorisation of jobs when initially logged.

Make SWYPFT a great place to work

Metrics	Threshold	Jun-23	Jul-23	Aug-23	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	13.1%	13.0%	13.1%		Rolling turnover increased by 0.1% to 13.1%
Registered workforce growth	3% (by March 24)	1.6%				
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month reduced to 4,7%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	>=78%	78.5%	76.5%	74.5%		For the month of August, the percentage rate decreased by 2% to 74.5% and continues to remain below threshold.
% staff recommending the Trust as a place to work	65%	65.0%		N/A		Quarterly pulse survey
% staff recommending the Trust as a place to receive care and treatment	65%	67.0%		N/A		
Staff supervision rate	80%	Due October 23				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 October with planned trajectory for improvements.
Mandatory training - Cardiopulmonary resuscitation	80%	81.3%	81.0%	79.9%		Slight decline in mandatory training compliance in August due to seasonal variation. This is noted annually over the summer months. Expected improvement during September.
Mandatory training - Reducing restrictive practice interventions	80%	76.7%	76.2%	82.6%		Performance has improved in August and is now above threshold. Actions being taken to address the compliance rate 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. Executive management team have approved a business case for recruitment of additional training capacity.
Mandatory training - Fire	80%	92.8%	92.0%	91.4%		
Mandatory training - Information governance	95%	96.8%	96.9%	95.3%		

Reducing Inequalities

Equality, involvement and addressing inequalities is a national and local priority and one of the Trust golden threads in the delivery of our objectives and annual priorities. This year one of our priority programmes is to improve health by addressing inequalities, involvement, and equality in each of our places with our partners.

We have made the following progress against our Trust wide equality and involvement action plans 2023/2024:

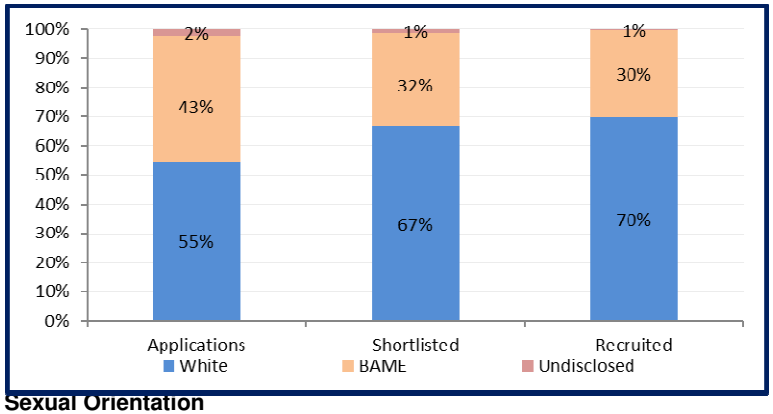
An Equality Impact Assessments (EIAs) digital platform on SharePoint is developed. This supports sharing of information to generate collective EIAs aimed at addressing inequalities in services and priority programmes.

We continue to improve on the collection of our equality data using the 'All of You' campaign.
Trust continues to deliver equality themed lunch box sessions to staff. Themes for this quarter:
Autism
LGBT
Carers
All of you: Race Forward now has a workplan which aligns the programmes of work taking place across the Trust. A dedicated intranet has materials and tools to support staff.
The FLAIR survey identified areas of improvement and work to deliver against the recommendations through identified actions is progressing.
Staff in the Kirklees and Calderdale Talking Therapies Team had training, on how to work effectively with interpreters and translators. This has led to a Trust wide session being booked for October for all staff.
Improving prayer facilities at Fieldhead site has resulted in an Imam being recruited as a Trust wide volunteer so Friday prayers can be hosted in the prayer room at Fieldhead.
The Trust has provided funding for the third year to the voluntary and community sector (VCS). The theme is addressing inequalities and we have several community stories which demonstrate the outcome of this work.
The Trust have launched an asset-based approach to involvement called Connecting People. The approach includes recruitment of staff, volunteers, voluntary and community sector colleagues which consist of 3 x 2-hour training modules. 45 people have been trained to date.
A volunteer has been recruited to work at Urban House to support creative approaches for people who reside there.
A project to address health inequalities in Kirklees is being supported by our Trust charity EyUp. The work involves providing targeted funding to organisations who can demonstrate they can support improvements in our identified 20% most deprived local areas.
An approach to ensure we improve our involvement of young people in the Trust is progressing. The aim of the work is to increase young voice and look at how we can involve young people as members.
We continue to capture our community feedback though our quarterly insight report which captures feedback from Healthwatch, governors and partners.

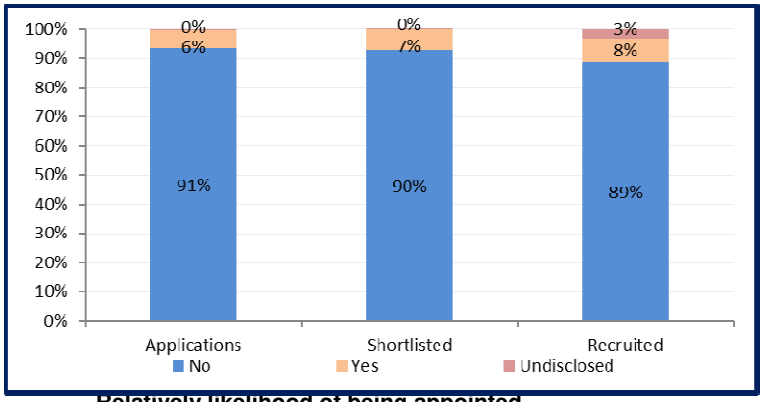
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024

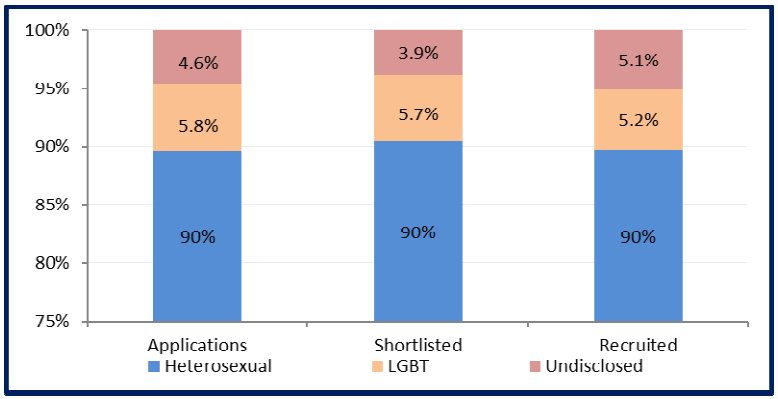
Ethnicity



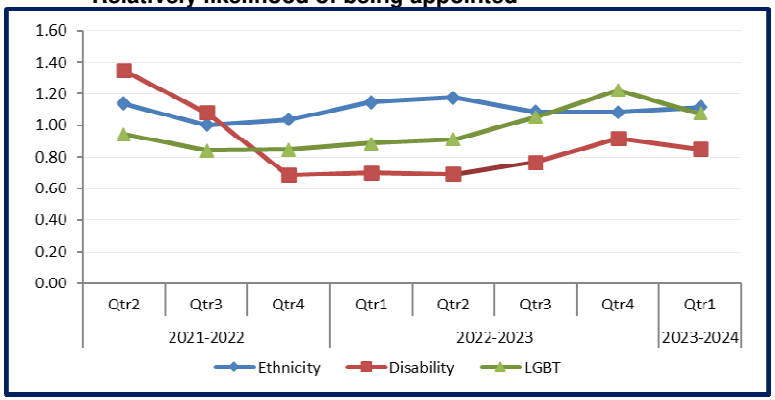
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 1 2023-2024:	BAME:	Disability:	LGBT:
	1.11	0.85	1.08

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024 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.

Please note, data includes any records where the relevant date (application submitted, applicant shortlisted, applicant recruited) falls within the rolling 12 months to the end of the reporting quarter

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

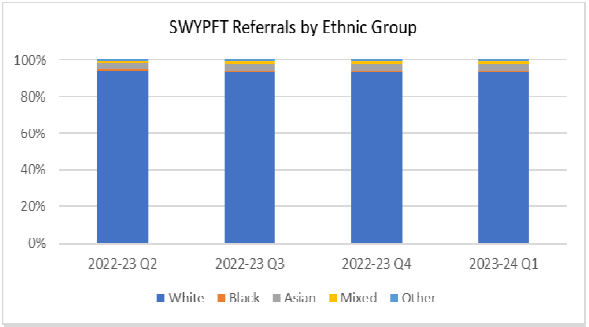
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.11
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.85
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 1.08
NB Relatively large proportions of undisclosed could unintentionally skew the data

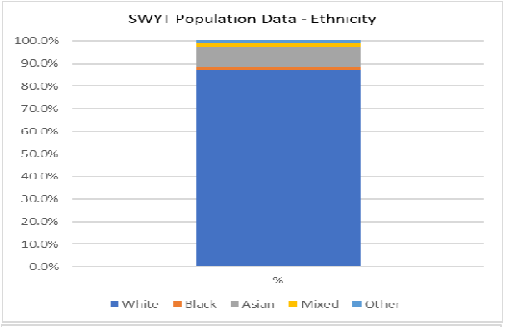
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

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

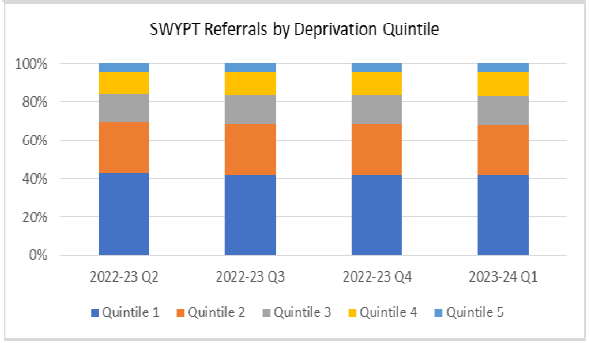
Reducing Inequalities

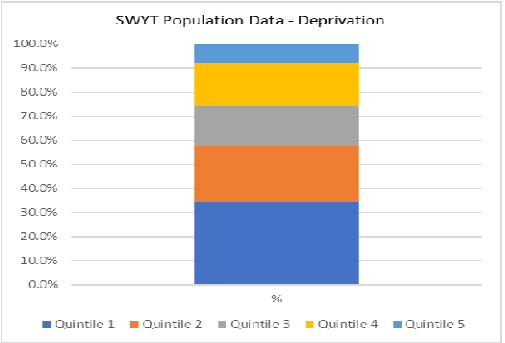
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	97.7%	93.1%	93.2%	93.1%	87.1%
Black	1.1%	1.0%	1.2%	1.3%	1.4%
Asian	3.3%	3.8%	3.5%	3.4%	8.9%
Mixed	1.0%	1.1%	1.2%	1.2%	1.6%
Other	0.9%	0.9%	0.9%	0.9%	1.1%



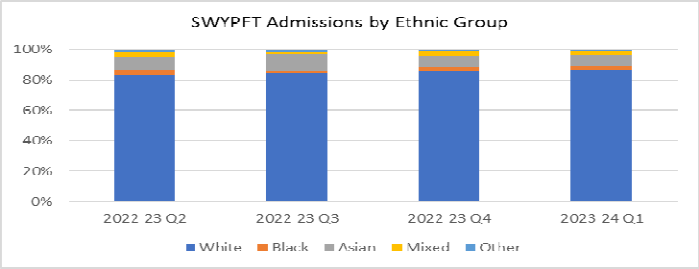


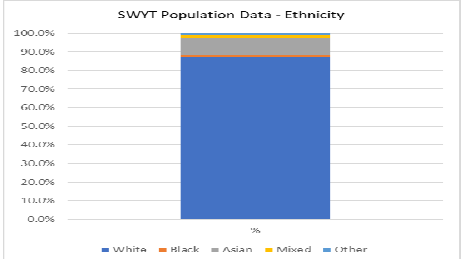
Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	42.8%	41.7%	41.8%	41.9%	34.1%
Quintile 2	26.4%	26.5%	26.6%	26.1%	23.4%
Quintile 3	15.2%	15.6%	15.2%	15.5%	17.0%
Quintile 4	11.0%	11.5%	11.6%	11.8%	17.8%
Quintile 5	4.7%	4.7%	4.8%	4.7%	7.8%

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.

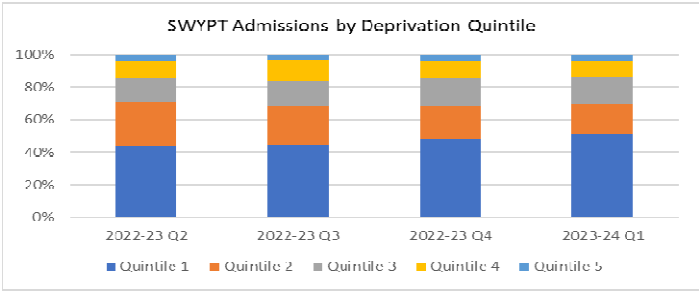
Reducing Inequalities

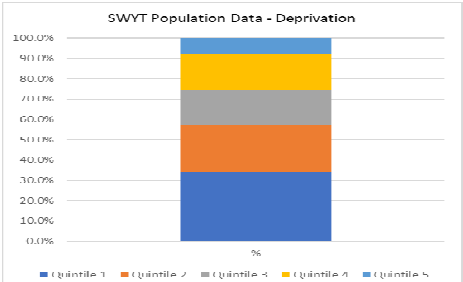
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	83.6%	84.4%	86.1%	86.6%	87.1%
Black	3.2%	1.7%	2.5%	2.2%	1.4%
Asian	8.6%	11.1%	7.6%	8.0%	8.9%
Mixed	2.7%	1.5%	2.7%	2.2%	1.6%
Other	1.8%	1.3%	1.1%	1.0%	1.1%





Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	43.6%	44.4%	47.8%	51.3%	34.1%
Quintile 2	27.4%	23.8%	20.5%	18.1%	23.4%
Quintile 3	14.5%	16.1%	17.3%	16.4%	17.0%
Quintile 4	10.7%	12.1%	10.5%	10.5%	17.8%
Quintile 5	3.8%	3.5%	3.9%	3.7%	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 1 for people from a white ethnic group were in line with that of the population the Trust serves.
- Admissions for people with a mixed ethnic group were slightly higher 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. 51.3% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
- The number of admissions from the least deprived areas (quintile 5) is in line with the previous 3 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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	84.0%	84.0%	81.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 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	16% 3/19	19% 3/16	17.6% (3/17)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	Reporting commenced in March 2023						29% (4/14)	27% (4/15)	38% (3/8)	17% (2/12)	29% (4/14)	38% (5/14)	
Service User Experience	Friends and Family Test - Mental Health	84%	85%	84%	86%	85%	83%	85%	83%	82%	85%	91%	90%	90%	1
	Friends and Family Test - Community	95%	93%	93%	93%	94%	93%	95%	97%	94%	97%	96%	93%	97%	1
Quality	Number of compliments received	N/A	13	5	28	39	83	22	26	50	66	33	35	22	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	35	32	33	30	40	30	33	25	34	23	22	22	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	0	2	2	2	3	2	2	1	1	2	1	1	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	2	1	0	0	0	2	1	0	1	1	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	86.6%	87.5%	87.4%	1
	Number of Information Governance breaches 3	<12	13	11	13	8	12	8	13	12	9	14	13	16	2
	% of inpatients clinically ready for discharge	3.5%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	4.6%	4.8%	5.7%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	90%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	87.7%	86.7%	87.2%	*88.0%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	90%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	92.9%	85.7%	92.9%	*94.7%*	2
	Total number of reported incidents	Trend monitor	1168	1243	1308	1188	1247	1196	1250	1196	1325	1257	1154	1179	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	32	26	30	25	34	26	33	17	33	18	22	34	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	3	3	7	6	3	3	2	3	2	4	1	4	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	2	3	0	2	3	2	1	5	2	1	2	3	
	Safer staff fill rates	90%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	123.7%	123.9%	123.8%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	93.1%	93.6%	92.1%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	43	49	48	39	55	46	38	29	42	40	36	42	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	1	1	1	4	0	2	1	2	1	0	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%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	89.5%	95.2%	90.0%	1
	Number of Falls (inpatients)	Trend monitor	58	68	63	59	51	49	39	34	41	43	33	33	
	Number of restraint incidents	Trend monitor	160	169	223	189	212	223	203	192	186	201	145	146	
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	92.1%	87.8%	83.8%	81.8%	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	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	
	Overall CQC rating		Good												
	CQC well - led rating		Good												

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 August there were 146. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less was 90% and remains green. Further detail can be seen in the relevant section of the report.
• Performance for children's and adolescent mental health service (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 lapse in care identified in August - Category 4 pressure ulcer - the care plan was not completed leading to a delayed appointment. The service are currently reviewing the incident.
• The number of people with a risk assessment/staying safe plan in place within timescale improved to 88% for inpatient services. For community services, the target of 95% has been achieved.
• The percentage of service users on care programme approach offered a copy of their care plan was 87% and remains above threshold.
• Clinically ready for discharge (previously delayed transfers of care) - This has increased in August and remains above threshold at 5.7%. 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 August there were 33 fall incidents. Further detail is provided in the relevant section of this report.
• The number of information governance breaches in relation to confidentiality breaches has increased to 16 during the month and remains above threshold - further detail is provided in the relevant section of this report.
• Complaints - number of responses provided within six months of the date a complaint received - improvement programme is established to address backlog reviewing the processes, including sign off to optimise response times. Investment in the customer services team made to reflect the demand and capacity and support quality improvements.

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated Performance Report (IPR), we have been working on our preparations for implementing the PSIRF. This is a 12 month programme with the plan to start implementation in late autumn 2023. We have drafted our plan and policy and these are currently going through our internal governance processes. We have also shared content with internal and external stakeholders for consideration. Information for staff is being prepared. Our plan and policy will be available on our internet pages upon approval.

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 be in the process of completing the transition to LFPSE - this will be implemented following thorough testing.
A further upgrade to the test system with the enhanced LFPSE functions took place on 24/08/2023. There remain issues nationally with Datix and the LFPSE functionality. We are awaiting a further upgrade to the test system before a live up grade can be arranged. Information for staff is being prepared.

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record (ESR). Level 1 will become mandatory from November 2023. This is currently progressing well at 88% completed. Level 3 training (investigation and oversight) is currently being delivered for those in specialist or oversight roles. Training on engagement and involvement of those affected by patient safety incidents will be available later in the year.

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.

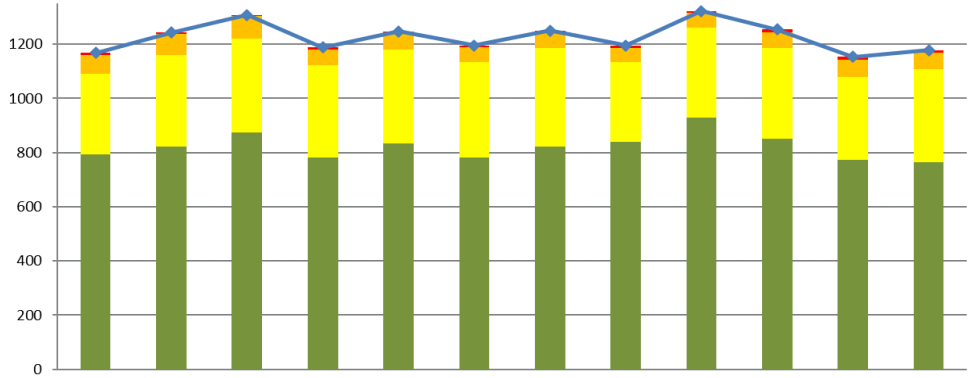
The 'Degree of Harm' is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they 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 August 2023 resulted in no harm or low harm or were not under the care of SWYPFT. This is based on the degree of actual harm.
Further details about severity and degree of harm can be found in the Incident Reporting and Management Policy.

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. Data in this report is refreshed monthly.

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



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Red (should not be compared with SIs)	8	6	3	8	8	7	9	10	8	11	11	11
Amber	68	76	85	58	59	56	56	52	55	59	63	61
Yellow	299	339	346	341	345	352	364	293	330	334	308	342
Green	793	822	874	781	835	781	821	841	930	851	772	765
Total	1168	1243	1308	1188	1247	1196	1250	1196	1323	1255	1154	1179

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. As further information is received and decision made about review processes, red deaths may be regraded to green, e.g. when confirmed not related to a patient safety incident.

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

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

No never events reported in August 2023

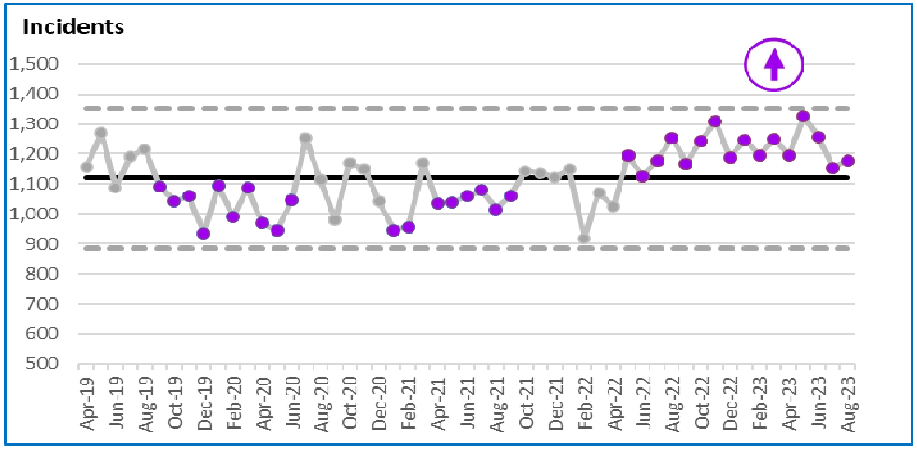
Safety First cont…

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.

In August 2023 there were 34 moderate harm incidents including pressure ulcer (category 3), tissue viability, self harm, slip, trip or fall. Four severe harm incidents were recorded including pressure ulcers (category 4) and there were three patient safety related deaths. These are following our normal review processes.

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

Patient Safety Alerts

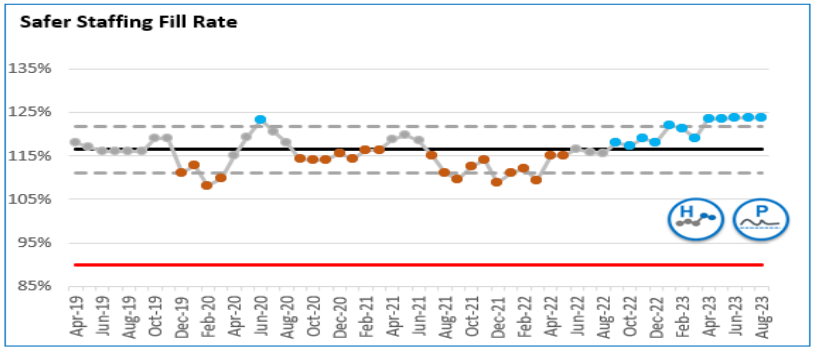
Patient safety alerts issued in August 2023

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 reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

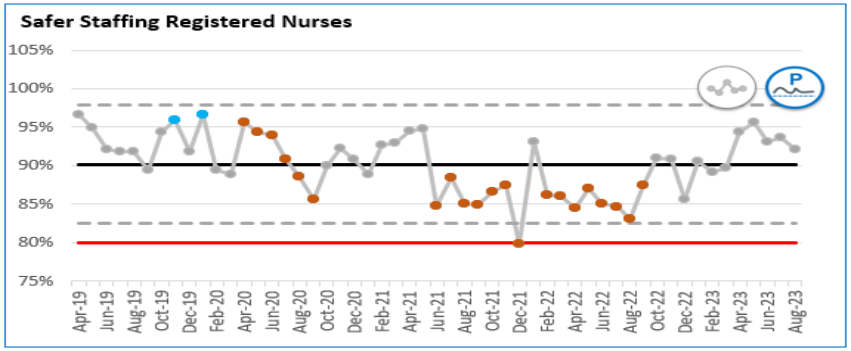
There were no patient safety alerts not completed by the deadline of August 2023.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	30/08/2023	Task and finish group established to confirm	01/03/2024	

Safer Staffing Inpatients



The chart above shows that as at August 2023 due to the continued increasing staffing rate, we remain in a period of special cause improving variation. Please see narrative below for further information.



The chart above shows that in August 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 decrease on demand of the flexible staffing pool with a total of 182 less shift requests. The number of shifts filled has increased by 25 shifts to a total of 5,542 and overall fill rates for inpatient areas decreased by 0.1%. The continued high fill rate of requested shifts (90.87%) is due to the availability of staff, increasing the bank resource, continued engagement with our master agency partner and the ongoing flexibility and contingency planning of the operational colleagues. The cancellation of shifts by wards that have not been filled has had a negligible impact on the number of unfilled shifts.
A reduction or increase in requests does not equate to a reduction or increase in acuity. This should not be seen as achieving our requirements as this describes our fill rate compared to our budgeted figures (capacity) and not our acuity (demand). Historically August has shown a decrease in fill rates as staff have increased childcare responsibilities and annual leave plans over the holiday period. This has particularly affected the registered nursing (RN) fill rates and was supported by an increase in the health care assistant (HCA) fill rate as we shall see later in the report. We continue to monitor staffing related Datix, and review hotspots and trend analysis of staffing deficits.
Both bespoke adverts and centralised recruitment continues and there are 3 assessment centres throughout September for band 5 and 2 substantive posts, as well as band 5 and 2 bank posts (73 bank offers made already). There has been an increased trend of agency colleagues, particularly band 2, applying to join the bank as we decrease engagement with agencies.
We have flattened the recruitment process for students both on bank and externally. We have completed a review of medical recruitment onto bank as well as the mapping process of bank recruitment. We are reviewing all agency block bookings to replace with bank if feasible.
With band 5 RNs we continue with bespoke adverts and, due to its success, we are reviewing the international recruitment (IR) program. To date we have had 79 IR band 5 nurses with 70 being on the wards throughout the Trust, including on the Neuro Rehabilitation Unit. We were successful with a renewed funding bid with NHSE which will enable us to complete this years program.
Escalation and continuity plans are followed to ensure the delivery of safe and effective care, and these are supported by the flexible staffing resource. We continue to monitor the hours that staff work, and any working time directive breeches, to support staff wellbeing.
The Trust has an ongoing agency scrutiny group to look at our agency usage and plans for a reduction are discussed and we have a dedicated session planned for the end of September looking at medical locums.
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 (EMT) and are ongoing. SafeCare has gone live in the Oakwell Centre on the 11th September following an intensive training programme.
Although we continue to sustain the overall fill rate, we continue to fall short of the RN fill rate for day shift and will continue to look at ways of improving this. This has meant that 13 wards, a decrease of three on the previous month, have fallen below the 90% RN day fill rate. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to deliver a high quality of care, as well maintaining safety, and this has impacted on Section 17 leave being taken at times as well as 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).
In August one ward fell below the 90% overall fill rate threshold which was Enfield Down in Calderdale and Kirklees (83.1%) this is an increase of one on the previous month. Inpatient areas continue to experience high acuity as identified above. There is ongoing interventions, projects, and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. With a decrease of one ward on the previous month, there were 23 (73.6%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 23 wards, 15 (an increase of two on the previous month) achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts.

Safer Staffing Inpatients cont…

Although safe and effective staffing remains a priority in all our teams, and the systems wide increase of acuity, the focus for the flexible staffing resources has been Forensic services and the Oakwell Centre. 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 decreased by 4.5% to 83.5% in August compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have increased by 1.4% in August to 100.7% compared with the previous month.
Overall Registered Rate: 92.1% (decreased by 1.5% on the previous month)
Overall Fill Rate: 123.8% (decreased by 0.1% on the previous month)
Health Care Assistants showed an increase in the day fill rate of 3.5% to 147.8% and the night fill rate decreased by 0.2% to 152.1%.
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.

The figures below indicate that the number of unfilled RN shifts has decreased across the inpatient areas as has the number of unfilled HCA requests.

The figures below shows that we had a decrease of 182 in overall requests. Staffing deployment decisions are met after consideration is given to the skill mix of staff available, reallocations/utilisation of any resources has been considered before requesting bank or agency cover. Without the overtime fill rate, the requested sum of additional shifts, indictive of acuity including sickness absence, decreased by 182 to 6,105 (1,220 (-106) RN and 4,885 (+284) HCA) shifts.

Unfilled Shifts						Filled Shifts	
Categories	No. of Shifts		Total Hours	Unfilled Percentage			
Registered	345	(-112)	3780.83	29.8%	(-5.97%)	**869**	**-75**
Unregistered	218	(-97)	2368.6	4.5%	(-2.07%)	**4885**	**(+239)**
Grand Total	**563**	**(-209)**	**6149.43**	**9.1%**	**(-3.15%)**		

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

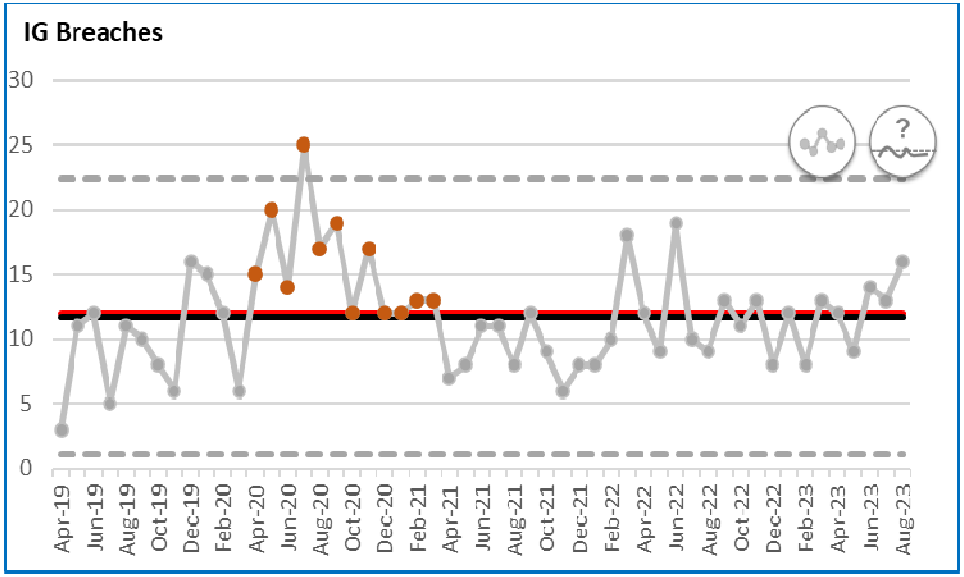
Information Governance (IG)

16 personal data breaches were reported during August, which is the highest number reported so far during the current financial year. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity. A number of services reported multiple incidents and improvement activity will be focused on these.

14 breaches involved information being disclosed in error. They were largely due to:

- letters being sent to the wrong address,
- emails sent to the wrong recipient,
- documents being shared with the wrong recipient,
- confidential discussions being overheard,
- wrong party being connected to a telephone meeting, and
- sharing information with relatives when it is recorded that the patient has refused to share.

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



This SPC chart shows that as at August 2023 we remain in a period of common cause variation. Though we are over the threshold of 16 breaches.

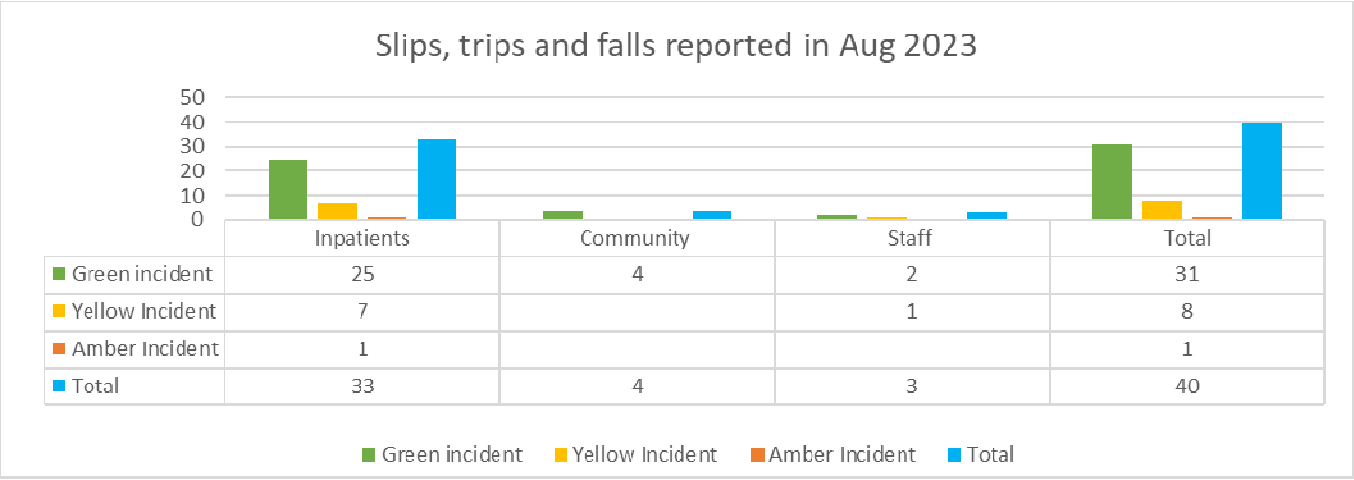
Commissioning for Quality and Innovation (CQUIN)

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. Submission for quarter one was undertaken at the end of August and anticipated performance for all applicable metrics in the quarter is 100%. Some risk has been associated with full achievement of the following metrics: staff flu vaccinations and outcome monitoring in children and young people and community perinatal mental health services - actions plans are in place to mitigate this as far as possible and performance will continue to be reviewed via the CQUIN leads group.

Trustwide Falls

During August 2023 there were 40 slips, trips and falls related Datix reports. Below is a breakdown of falls and where they occurred. This is decrease of 2 from July.



	Inpatients	Community	Staff	Total
Green incident	25	4	2	31
Yellow Incident	7		1	8
Amber Incident	1			1
Total	33	4	3	40

The highest number of falls were within inpatient settings.

Amber: There has been one amber incident reported, relating to a service user fall on an older adult ward resulting in a fracture. This is currently undergoing a fact find.

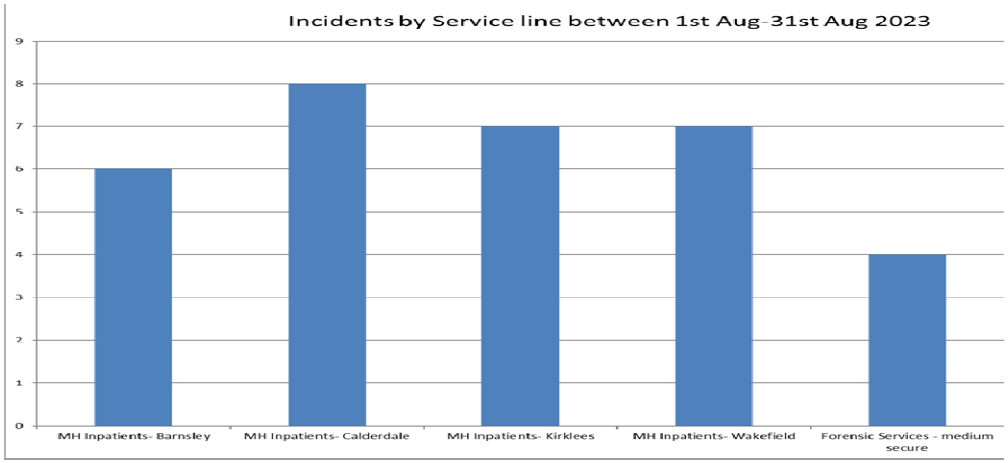
Yellow: 8 yellow incidents have occurred for service users and one member of staff.
One service user was off the ward with a member of staff and fell resulting in a fracture. All appropriate measures took place and it has been agreed an SBAR will be completed to alert staff of physical health and mobility needs when leaving the ward with a staff member. One staff member slipped on the ward corridor on some spilt fluid.

Green: 31 reported slips, trips or falls were graded as green, indicating no harm or low-level injury. Two of these Datix reports occurred whilst service users were on leave from the ward. Reviewing the Datix incidents there were generalised words which suggested service users had 'stumbled', 'lost their balance', or 'become wobbly'.

Inpatient related falls: 33 reported slips, trips and falls for service users

• 55% of all inpatient falls occurred on older adult wards. 30% occurred in the adult care group.
• Only 24% of service users had a previous falls history. 76% of falls occurred where the service user had not had a fall before. Reviewing these type of falls incidents showed that some falls were directly linked to deteriorating physical health, others reported one person was pulled over by another service user, one person fell when they became dizzy smoking a cigarette, some falls were linked to stumbling when getting dressed or putting shoes on.
• 100% of the falls risk screening tool (FRAT-18) had been completed, 21% of these continued to report 'unknown' risk after several weeks on the ward.
• 0% of service users with a previous falls history had received a multifactorial risk assessment.
• 70% of all reported falls were unwitnessed, and service users were either found by staff, or the fall reported to staff after the event.
• 100% of service users received a high-quality physical health intervention, and where appropriate, had a medication review and physiotherapy intervention.
• 36% of post falls protocols had not been completed following an inpatient fall.
• Nostell ward had 2 falls in August 2023, they are a lower risk area for falls. The staff provided an excellent response to the falls, with service user intervention including urine testing, blood glucose and blood pressure testing, omission of night sedation and a review of their fluid and nutrition.

Falls by care group: 56% of inpatient falls occurred on 2 wards, the Poplars and ward 19. Both wards have a service user with high complexity, agitation, and significant falls history.



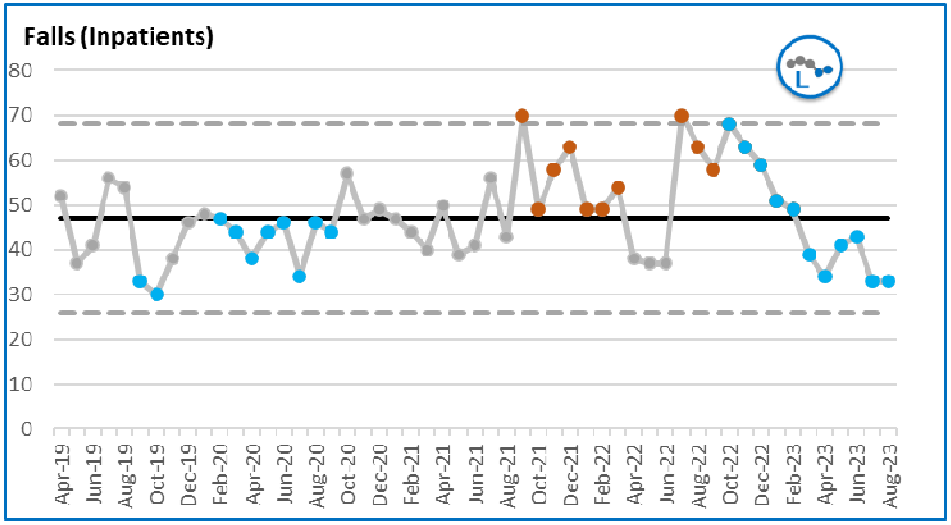
Across all our inpatient services between April – July 2023 we had on average 2.89 falls per 1000 bed days. This indicates a slightly lower number of falls than the national average of 3-5 falls per 1000 bed days.

Staff training:
We continue to record a low uptake of falls eLearning from staff in higher risk falls areas. In August 2023, 14 staff fully completed the falls eLearning. 50% of these were from Ward 19, with a further small uptake from Beechdale and Willow ward staff. Two staff started and left the training incomplete.

Actions:
• Datix reports are continuing to be reviewed to seek themes and areas of potential improvement
• The falls coordinator is liaising with locality matrons regarding the completion of post falls protocol paperwork
• The falls coordinator
  is liaising with higher risk ward areas to improve staff uptake of falls eLearning
  is liaising with our Trust Quality Improvement and Assurance Team regarding a review of falls risk paperwork, as presently staff are not following our falls and bone health policy. The paperwork is repetitive and does not guide staff to complete a multifactorial falls assessment
• Falls awareness week starts 18th September 2023. We have arranged several initiatives across our Trust including ward falls awareness quizzes and activities, information stands at our four main hospital sites and a stall at Barnsley market

Falls (Inpatient)

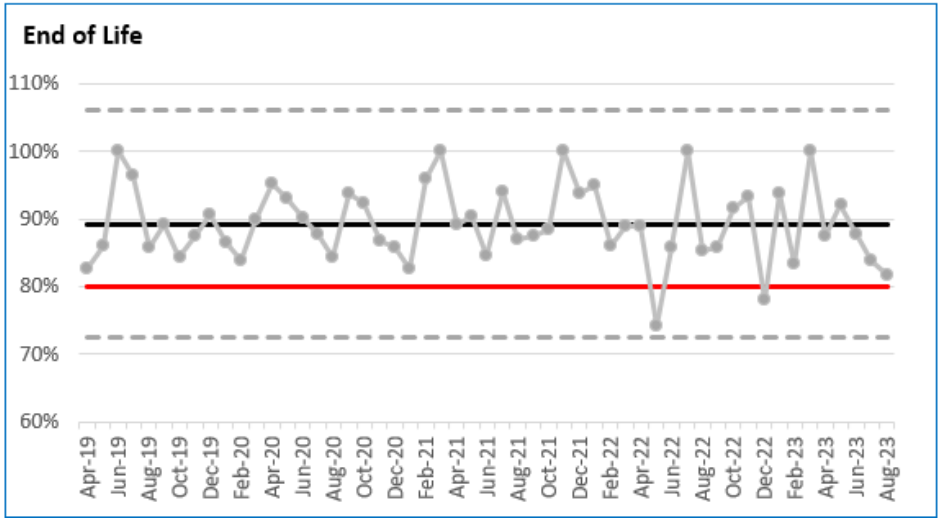
The total number of inpatient falls was 33 in August. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in August 2023 we remain in a period of special cause improvement. 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 81.8% in August.



The chart above shows that in August 2023 the performance against this metric remains in common cause variation and therefore within normal range. As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test shows

- 97% would recommend community services
- 90% would recommend mental health services

	Target	August	July	June
Mental health community	85%	90%	94%	92%
Mental health inpatient	85%	92%	83%	92%
Learning Disabilities	85%	91%	70%	100%
ASD/ ADHD	85%	75%	75%	50%
CAMHS	75%	100%	82%	80%
Forensic	60%	100%	80%	100%
Mental health overall	84%*	**90%**	**90%**	**91%**
Barnsley Gen ops	95%	**97%**	**93%**	**97%**
Trustwide	**85%**	93%	91%	94%

** weighted for 2023/24*

- The response rating across the care groups has seen an increase in the positive rating received during August.
- Work continues in the ADHD service to engage with service users carers, and families to understand the best way to capture feedback about their experience.
- There is a dip in the number of responses received in August, this is likely due to school holidays and is consistent with previous years.
- The number of responses received for CAMHS in July was significantly high due to responses being entered incorrectly on the system since April. The feedback was correctly input in July. We'd expect to see an increase in responses in September.
- Due to the nature of Forensic services friends and family test feedback is collected through a larger patient experience survey every six months. Friends and family test cards are available in services to support collection of feedback.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Communication
	3. Patient care	3. Access and waiting times
Community	1. Staff	1. Staff
	2. Communication	2. Access and waiting times
	3. Access and waiting times	3. Admission and discharge
Mental Health	1. Staff	1. Staff
	2. Communication	2. Communication
	3. Patient care	3. Access and waiting times

The Patient Experience Group is looking at how we develop a practical way to collect actions being taken because of feedback.

The themes from Friends and Family Test feedback are in the table below. Themes can be both positive and negative in nature.

Safeguarding

Safeguarding Adults:
In August 2023, there were 48 Datix categorised as Safeguarding Adults. 27 of these were graded as green, 17 were graded as yellow, and four were amber.
The sub-categories of the Safeguarding Adults Datix were commonly related to emotional/psychological abuse, neglect concerns and financial abuse.

The amber incidents were related to neglect, sexual abuse, domestic abuse and neglect. Appropriate actions such as contacting the police, making a referral to the local authority and undertaking an internal fact find.

In addition to the Safeguarding Adults Datix, there were 18 Sexual Safety Datix 16 were graded as green and two yellow. In eight of these Datix, inpatient service users were the affected persons, within these eight, four incidents involved both service users and staff who were affected. In ten of the Datix's a member of staff was the affected person. In all cases reviewed appropriate actions were taken and local authority safeguarding referrals were made where required.

Safeguarding Children:
In August 2023 there were 19 DATIX incidents categorised as Safeguarding Children. Ten of these were graded as green, eight were graded as yellow and one was graded as amber.

The subcategories of the safeguarding children Datix were commonly related to physical abuse, sexual abuse and neglect.

The amber DATIX incidents categorised as sexual abuse were due to a disclosure made about historical sexual abuse. Appropriate advice was sought by the practitioner from the Safeguarding team and appropriate referrals have been made to the Local Authority Designated Officer (LADO).

The incident relating to the child admitted to a mental health ward - there was no contact to the trust safeguarding team however the patient was placed under level 2 observation. The patient is now aged 18 years old.

In all of the 19 DATIX incidents submitted, 11 referrals were made to local authority safeguarding children teams, the Trust safeguarding team were contacted for advice in 10 cases and one LADO referral was made.

Infection Prevention Control (IPC)

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

Mandatory training figures are healthy and above the 80% threshold:
Hand Hygiene-Trust wide Total – 96%
Infection Prevention and Control- Trust wide Total – 94%

Outbreaks
There have been
• 2 Covid-19 outbreaks in August 2023
• 4 areas, monitored due to an increase in prevalence of Covid-19
• 2 areas, monitored due to diarrhoea and vomiting no causative organism established.

Covid-19 Clinical Cases: There has been an increase in positive Covid-19 cases this is in line with national prevalence.

Complaints

• Acknowledgement and receipt of the complaint within three working days –17/17 (100% of formal complaints)
• Number of responses provided within six months of the date a complaint received – 5 (38%), increase from 4 in July and 2 in June
• Number of complaints waiting to be allocated to a customer service officer – 12 (improvement from 13 in July)
• Number of cases which breached the six months target who have not had a conversation to agree a new timeframe for completion 0%
• Longest waiting complainant to be allocated to a customer service officer –10 weeks. This continues to improve month on month.
• There were 17 new formal complaints in August 2023
• 22 compliments were received.
• 13 formal complaints were closed in August 2023.
• Number of concerns (informal issues) raised and closed in August 2023 – 34
• Number of enquiries responded to in August 2023 - 104
• Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 1

Reducing Restrictive Physical Intervention (RRPI)

There were 146 reported incidents of reducing restrictive physical interventions used in August 2023 this was an increase of 1 (0.7%) incidents from July.

90% of prone restraints in August 2023 lasted under 3 minutes.

In August 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 10 times out of 221, a reduction of 11 (52%) from last month.

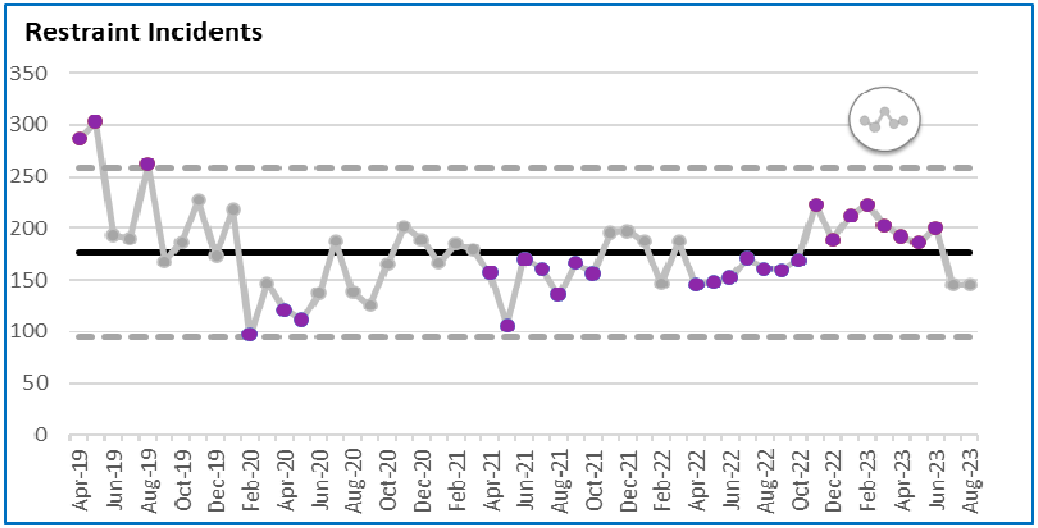
Incidents of prone greater than 3 minutes:
Ward 19 reported an incident of prone restraint which lasted 4 – 5 minutes. The prolonged duration was due to aggressive and sexually inappropriate behaviour. Each incident of prone reported via the Datix reporting system is reviewed by RRPI specialist advisors.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	98	44.3%
Seated	39	17.6%
Supine	18	8.1%
Prone	10	4.5%
Safety Pod	29	13.1%
Restricted escort	8	3.6%
Kneeling	3	1.4%
Side	8	3.6%
Prone then rolled	8	3.6%

Team Using Prone Restraint	Total
Horizon Centre Assessment and Treatment	1
Walton PICU	2
Ashdale Ward	1
Elmdale - The Dales, Calderdale	2
Nostell ward, Wakefield	1
Bronte, Forensics	1
Ward 18 - Kirklees	1
Ward 19 - Kirklees	1

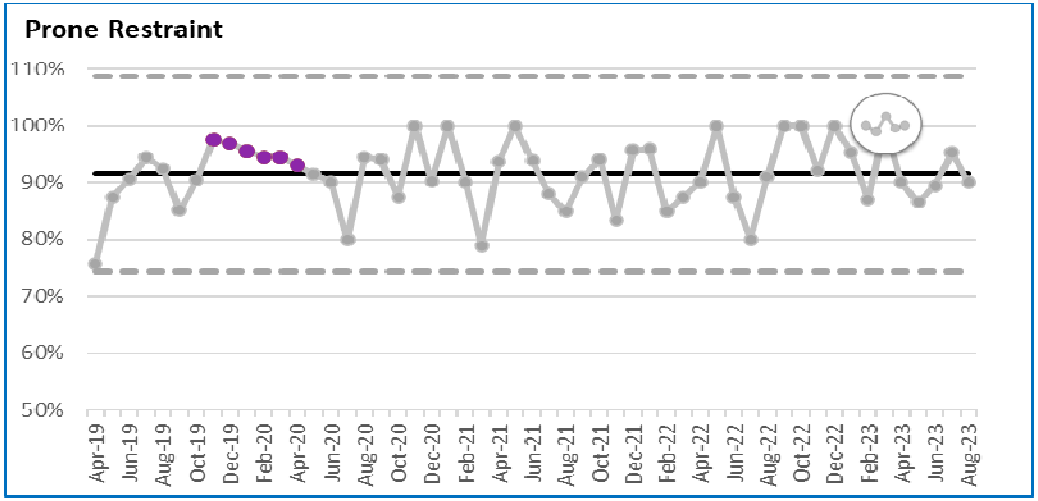
Duration of Prone Restraint Position	Total
0 - 1 minute	3
1 - 2 minutes	6
2 - 3 minutes	0
3 - 4 minutes	0
4 - 5 minutes	1

Reducing Restrictive Physical Intervention (RRPI)



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

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 August 2023 means that we remain in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Establishment	Improving Resources	Well Led	-	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	5,193.8	5,196.6	5204.8
Employed Staff (ESR last day in the month)			-	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	4,273.6	4,289.5	4,311.6
Vacancies			-	816.5	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0	818.4	796.1	772.1
Vacancy rate			<10%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%	15.8%	15.3%	14.8%
Turnover external (12 month rolling)			>12% - <13%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%	13.1%	13.0%	13.1%
Starters			-	69.5	56.9	50.5	26.6	65.4	70.2	58.1	47.2	59.3	57.5	53.9	64.0
Leavers			-	51.6	48.2	40.6	27.5	60.1	38.5	43.1	58.8	39.6	37.0	54.3	61.9
Number of international nurses recruited				Reporting commenced August 23											9
% Bank Fill Rates - Registered Nurses															47.8%
% Bank Fill Rates - Health Care Assistants															69.8%
Proportion of staff in senior leadership roles who are from BME background (relates to staff in posts band 7 and above, excludes bank staff) *			1064												126 (11.8%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			1064												769 (72.3%)
Sickness absence - Rolling 12 month			<=4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%	4.6%	5.1%	4.7%
Employees with long term sickness over 12 months			-	2	2	2	2	4	2	2	1	0	0	0	0
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%	78.5%	76.5%	74.5%
Employee Relations - Suspensions (over 90 days)			-	2	2	2	3	3	1	1	0	0	0	3	3
Mandatory Training - TOTAL	Improving Care		>=80%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%	92.0%	92.1%	92.5%
Mandatory Training - Reducing Restrictive Practice Interventions				72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%	76.7%	76.2%	82.6%
Mandatory Training - Cardiopulmonary Resuscitation				75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%	81.3%	81.0%	79.9%
Mandatory Training - Clinical Risk				96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%	95.4%	95.2%	94.8%
Mandatory Training - Display Screen Equipment				95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%	97.0%	97.1%	97.4%
Mandatory Training - Equality & Diversity				94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%	96.2%	96.0%	95.9%
Mandatory Training - Fire Safety				86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%	92.8%	92.0%	91.4%
Mandatory Training - Food Safety				79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%	86.4%	87.8%	89.4%
Mandatory Training - Freedom To Speak Up (FTSU)				89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%	94.0%	94.3%	94.7%
Mandatory Training - Infection Control & Hand Hygiene				88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%	94.1%	94.3%	94.3%
Mandatory Training - Information Governance (Data Security)			>=95%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%	96.8%	96.9%	95.3%
Mandatory Training - Moving & Handling			>=80%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%	95.2%	95.1%	95.6%
Mandatory Training - Nat Early Warning Score 2 (New S2)				86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%	93.8%	94.7%	95.2%
Mandatory Training - Mental Capacity Act/Dols				93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%	93.7%	93.4%	94.0%
Mandatory Training - Mental Health Act				90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%	91.2%	91.1%	92.2%
Mandatory Training - Prevent				95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%	92.1%	94.1%	94.2%
Mandatory Training - Safeguarding Adults				89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%	89.3%	89.5%	89.7%
Mandatory Training - Safeguarding Children				90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%	91.1%	91.2%	91.7%

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.

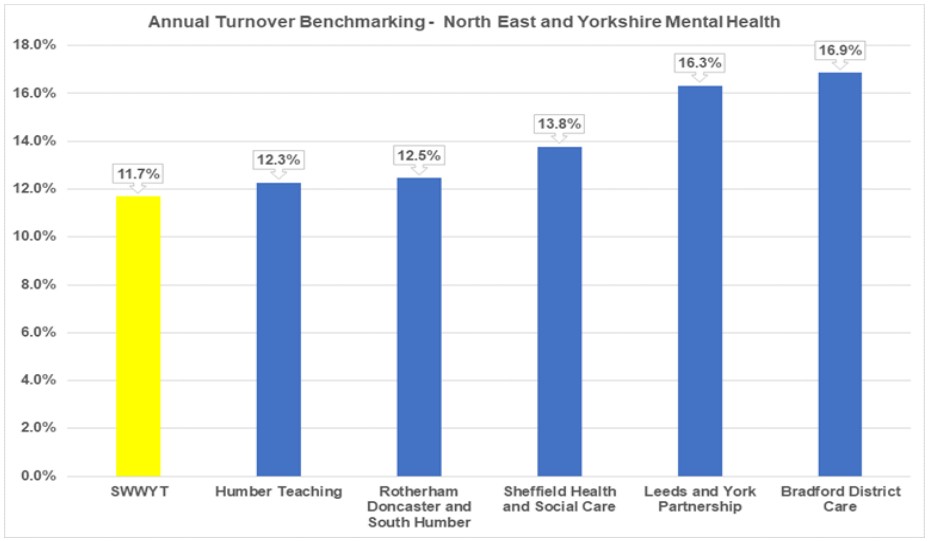
• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.

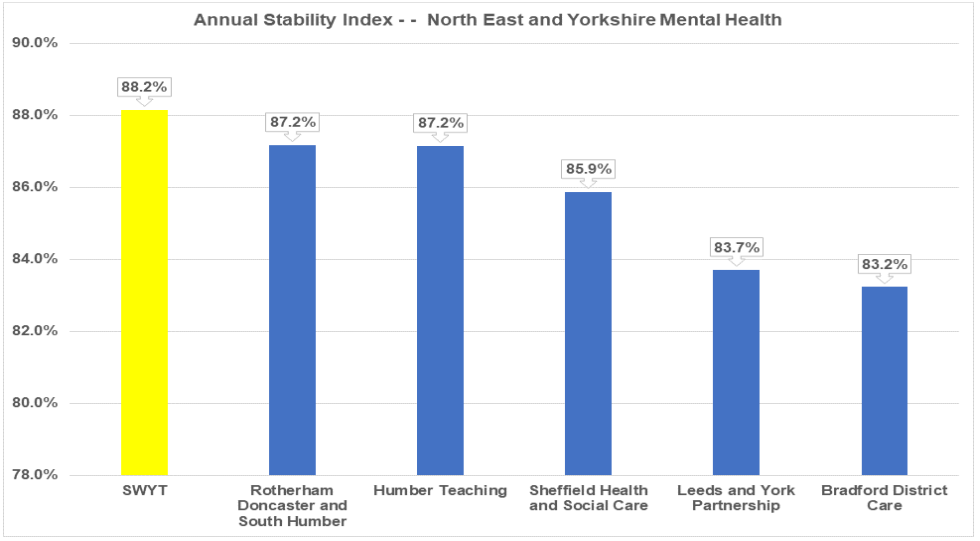
• Sickness absence - from April 23 - the reported figure is rolling 12 month. For earlier months this was year to date.

* 5 records not stated

Stability of the Workforce

• There has been a reduction in agency spend between July and August (163 whole time equivalents (WTE) in July down to 144 WTE in August). Work within the agency scrutiny performance to remove unnecessary and/or address some long term spend has partly affected this and is taking effect. In the main, however we have seen our substantive staff undertake more additional hours (overtime and additional shifts) within July and there has also been a slight increase in bank shifts worked which has also had a positive effect.
• The number of starters in August was slightly higher than the number of leavers (64 v 61.9 WTE). Overall since April we are still seeing more starters than leavers (281.9 v 251.7 WTE).
• As a result our vacancy rate continues to reduce and we have now seen a reduction for the fourth month in a row (15.3% to 14.8%). It remains significantly lower than last year (15.9% Aug 22).

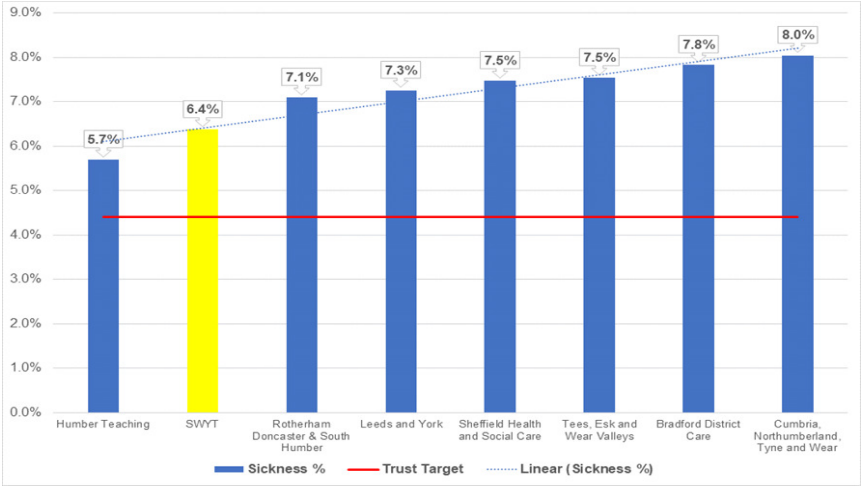




Keep Fit & Well

Absence

• 12 month rolling absence rate remains at 5.3%.
• Overall absence (in month) has reduced by 0.4% to 4.7%, but the overall rolling rate remains unchanged at 5.3%. Majority of care groups saw a slight reduction in the monthly sickness position. There are no specific care group areas who have seen significant increases and this is being seen across most staff groups. The Forensics human resource business partner role is working closely with Forensics to identify hotspots and targeted reduction as the rate within Forensics has reduced by 1% in month to from 9.3% to 8.3%.
• Estates and Facilities absence remains high in August (6.4% year to date) - focus remains on sickness meetings, monthly reports to individual managers and increased personal development support to address this increase.
• 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

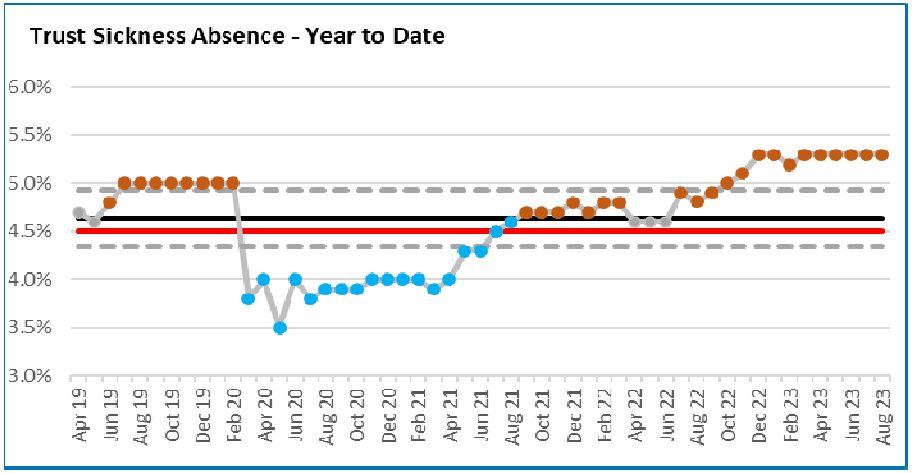
Appraisals

• Overall appraisal rate has reduced slightly from 76.5% to 74.5% in August. Discussions with Workpal ongoing with a view to resolving known issues with the reporting. An improvement trajectory of 78% was set by the Executive management team (EMT) in May, this will be reviewed at the end of September to be clear on how the Trust will achieve the 90% target in year.

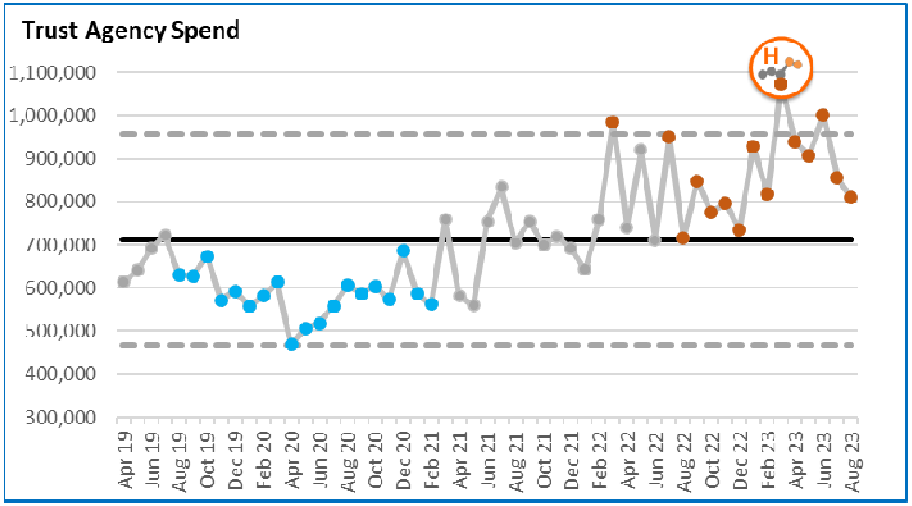
Mandatory Training

• Overall mandatory training reports 92.5% 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. Decline in cardiopulmonary recusation mandatory training compliance has been seen in August due to seasonal variation. This is noted annually over the summer months. Expected improvement during September.

Analysis



The SPC chart shows that in August 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 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 and commenced in June for all care groups to focus on individual long term agency placement (September group focus on medical locum/agency reduction)
• The Trust have been working with Liaison Contingency Workforce since April to understand our efficiency in utilisation of eRostering, bank, agency and workforce management. The outcome of that work is due in September with following recommendations and report due into Agency Scrutiny Group.
• Trustwide eRostering roll out continuing – Barnsley inpatient nearing completion. Target rollout end of December on course.
• Alternative marketing campaigns to engage wider markets. Several national and local recruitment events booked between now and November (Liverpool, Glasgow, Birmingham) alongside targeted hard to reach groups with Touchstone which includes on the day suitability interviews.
• Significant increase in assessment centre recruitment events – 11 since April (usually 1 per month). Centres run in September (3) have seen over 170 potential candidates into bank and substantive healthcare support worker and nurse posts. (80 offers made to bank posts in September). This will have a positive impact upon agency provision in future months. Further additional assessment centres planned to cater for demand in application (3 in October, 1

National Metrics

Data as of : 21/09/2023 16:36:44

NHS South West Yorkshire Partnership NHS Foundation Trust

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

The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their 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 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.

This table only includes operational metrics, there are a number of other workforce, quality and finance metrics that are reported in the relevant section of the IPR.

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0	?	H	196	406	453	408	451	483	480	434	545	435	582	397
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		74.2%	91.5%	85.4%	85.3%	92.6%	91.4%	74.4%	87.1%	87.8%	88.2%	90.3%	92.3%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		53.0%	51.4%	40.6%	52.4%	57.1%	53.8%	53.8%	52.5%	53.4%	53.2%	50.5%	51.4%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	88.5%	86.9%	89.5%	93.5%	95.1%	95.7%	97.5%	97.9%	99.0%	99.6%	99.0%	99.5%
M7	72 hour follow-up from psychiatric in-patient care		80%	?	L	89%	87.8%	89.6%	88.9%	87.9%	89.6%	87.2%	92.5%	90.6%	92.6%	87.7%	89.8%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		20	13	10	0	8	30	43	15	11	29	9	18
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		2	2	2	0	1	2	2	3	1	1	1	2
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	97.9%	98.0%	98.5%	98.5%	97.7%	97.6%	98.1%	97.8%	98.6%	99.4%	99.2%	98.3%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		100%	100%	99.9%	99.5%	99.8%	100%	99.8%	99.8%	99.8%	100%	99.8%	99.8%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		80%	100%	90%	100%	87.5%	80%	87.5%	50%	80%	100%	70%	66.7%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		75%	78.4%	79.3%	88.2%	88.6%	100%	95.8%	77.8%	95.8%	100%	92%	91.3%
M15	Data Quality Maturity Index		95%	P		99.5%	99.2%	99%	99.1%	99.4%	98.2%	98.2%	99.4%	99.2%	99.5%	98.8%	99.3%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1333	1399	1542	1192	1641	1414	1533	1306	1603	1579	1470	1404
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		98.4%	99.0%	97.8%	98.5%	98.1%	99.1%	98.9%	98.9%	98.4%	99.0%	99.2%	99.7%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?		19	16	29	36	36	44	30	25	34	26	36	38
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					107	65	66	70	72	51	81	51	67	53	64	60

National Metrics

Data as of : 21/09/2023 16:36:44

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
M30	Number of detentions under the Mental Health Act (MHA)					87	91	86	90	100	94	86	93	101	93	99	100
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					21.8%	23.1%	20.9%	21.1%	18%	19.1%	23.3%	20.4%	18.8%	12.9%	26.3%	20%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			95.7%	96.2%	96.5%	97.6%	96.4%	95.6%	97.9%	97.5%	97.6%	97.9%	98.3%	98.3%
M34	% Clients in settled accommodation	⚠	60%	P	L	86.9%	86%	85.8%	85.2%	84.4%	84.4%	84.6%	84.2%	84%	84.3%	83.8%	84.3%
M35	% Clients in employment	⚠	10%	P	H	11.8%	12%	11.6%	11.4%	11.7%	11.4%	11.2%	11.2%	11.5%	11.7%	12.0%	12.3%
M41	Completion of a valid NHS number		99%	P	L	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0 %	100.0 %	100.0 %
M42	Completion of ethnicity coding for all service users		90%	P	H	99.3%	99.4%	99.3%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.4%	99.4%	99.4%
M43	Community health services two hour urgent response standard		70%	P		89.2%	88.1%	88.4%	84.3%	87.6%	85.0%	83.7%	87.3%	86.6%	86.2%	88.1%	89.5%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500										1523	1719	2335	1509	1667
M45	The number of incomplete Referral to Treatment (RTT) pathways		2400													1782	1982
			2500										1933	1835	1592		
M46	Count of 2-hour urgent community response first care contacts delivered					668	757	862	771	796	648	761	826	953	911	936	1019
M47	Virtual ward occupancy		80%										82.9%	44.3%	92.9%	51.4%	57.1%
M48	Community services waiting list		5430													5024	5170
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses												3895	3904	3897	3886	3860
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact												10957	11094	11098	11111	10926
M170	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%		L	94.7%	98.7%	100%	86.2%	88%	91.6%	79.8%	60.7%	53.3%	82.5%	66.7%	64.1%
M171	% Admissions gate kept by crisis resolution teams		95%	P		98.8%	100%	98.7%	100%	98.9%	99%	98.2%	100%	99%	100%	96.6%	100%

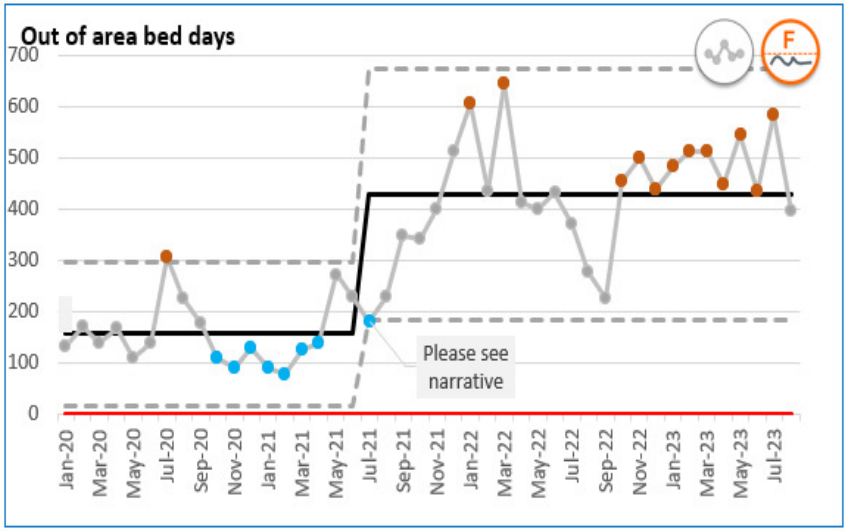
National Metrics

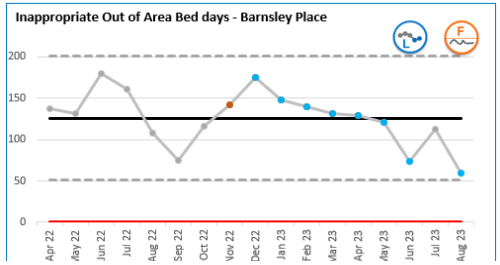
Data as of : 21/09/2023 16:36:44

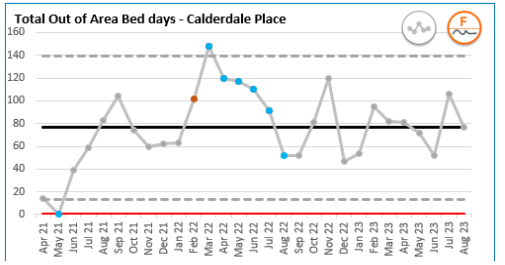
NHS South West Yorkshire Partnership NHS Foundation Trust

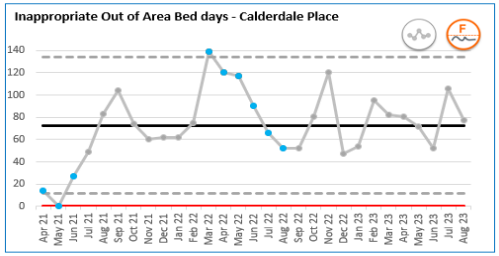
The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

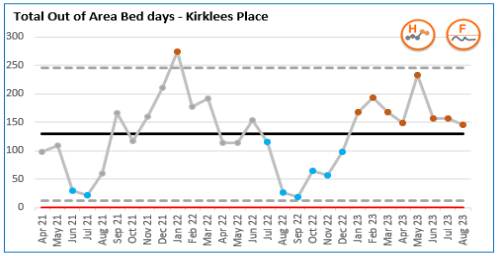
• The percentage of service users waiting less than 18 weeks from point of referral to treatment remains above the target threshold at 99.5%
• 72 hour follow up remains above the threshold at 89.0%.
• The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service remains below threshold at 64.1% in August. This has now entered a period of special cause concerning variation (please see SPC chart). 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 they will have any capacity to run additional clinics over spring and summer and therefore it is not anticipated that the service will meet 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 and routine who access treatment in 4 weeks both remain below threshold in August though low numbers do impact these significantly. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.
• During August 2023, there were two service users aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 18 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 50.8% for July. This metric is 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 August. This metric remains in 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.
• Virtual ward occupancy - Occupancy levels for August 23 were 57.1% which is below the 80% target. Onboarding numbers to the acute respiratory infection pathway remain low, there is further engagement work ongoing with acute staff to explore how we can increase numbers on the pathway. In addition, there continues to be some gaps in the virtual ward nurse workforce which impact on the number of patients who can be onboarded and safely supported on the pathway.











Inappropriate Out of Area Bed Days – This metric shows the total number of bed days occupied by clients who have been placed in a bed outside the geographical footprint of the Trust.

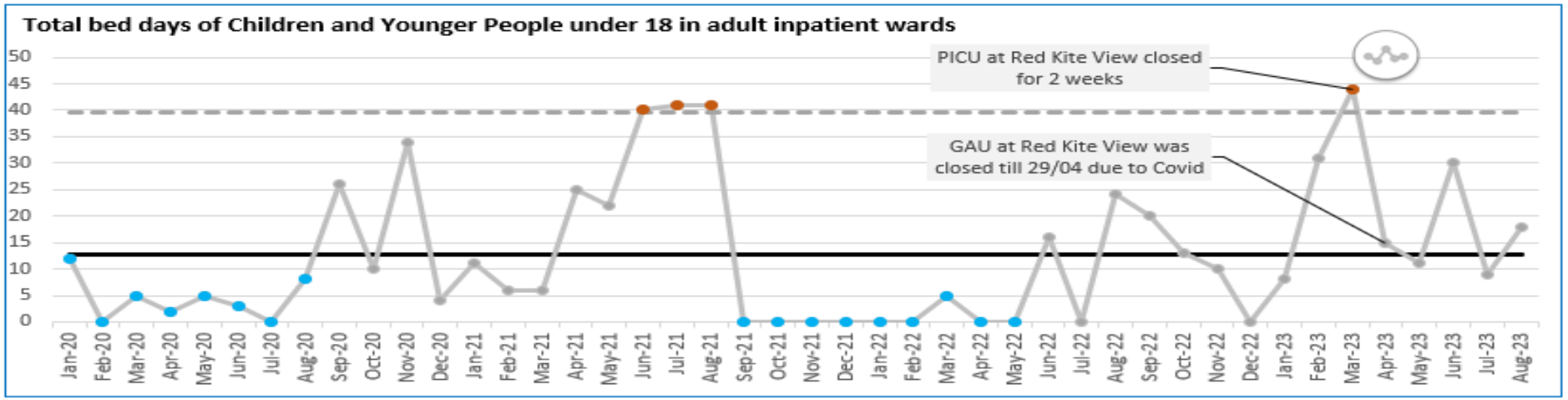
Summary	Actions	Assurance
The Trust continues to have an increasing number of bed days for clients placed out of area. Place based data is provided but decisions are made on the appropriateness of the placement to meet the person's needs, so for example it cannot be assumed that Wakefield demand is higher because the out of area is higher.	The improvement programme is focussing on: Addressing barriers to discharge and reducing delays for people who are clinically ready for discharge Effective coordination out of area care to ensure people are repatriated. Addressing workforce issues to improve the care and treatment offer. Improving community treatment options as alternative to inpatient care	The improvement programme reports through the assurance framework to Board. Out of area placements are reported to EMT against the trajectory. System wide work streams report through the ICS.

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

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

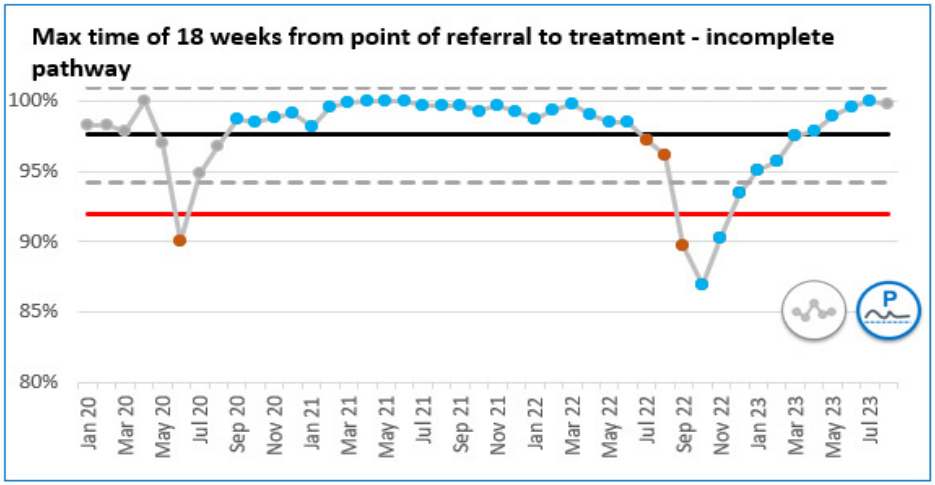
- The reporting for employment and accommodation shows 16.4% of records have an unknown or missing employment and/or accommodation status. This has been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

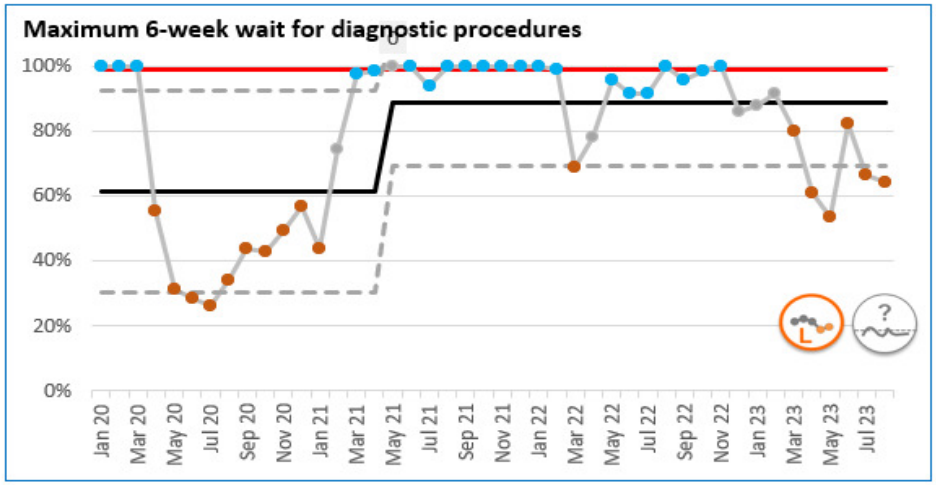
Analysis



The statistical process control chart (SPC) above shows that in August 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards.

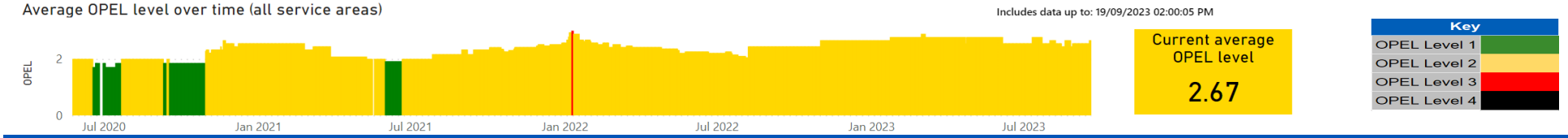
Analysis





The SPC charts above show that for August 2023 we are currently in a period of common cause variation for clients waiting a maximum of 18 weeks from referral to treatment and we estimated to achieve the target against this metric. 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 remain below the threshold.

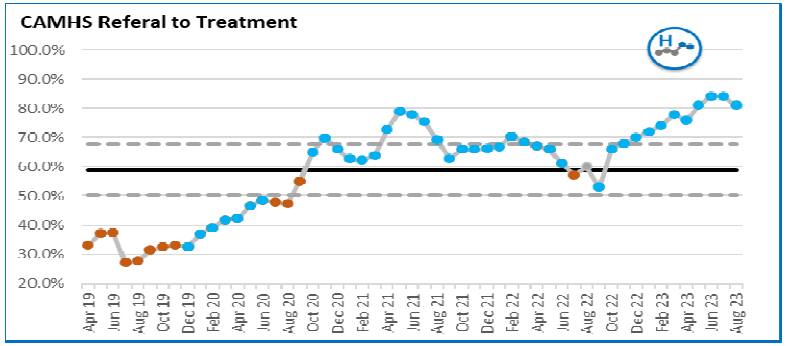
The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group, and performance for the reporting month is stated along with variation/assurance for each metric where applicable.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



Child and adolescent mental health services (CAMHS)

CAMHS

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	74.7%	71.3%	
% Complaints with staff attitude as an issue	< 20%	40% (2/5)	0% 0/2	
CAMHS - Crisis Response 4 hours	N/A	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.5%	80.1%	
Eating Disorder - Routine clock stops	95%	92.0%	91.3%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	66.7%	
Information Governance training compliance	>=95%	96.1%	94.4%	
Reducing restrictive practice interventions training compliance	>=80%	75.2%	69.0%	
Sickness rate (Monthly)	4.5%	4.5%	4.4%	
% rosters locked down in 6 weeks				



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

Alert/Action

- Waiting numbers for Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans are in place (with Transformation Programme support) but the shortfall between commissioned capacity and demand remains. Evolve contract (Kirklees) ends September which would reduce assessment capacity by 21 per months. Discussions in progress with commissioners to escalate risk but extension appears unlikely.
- Shortage of specialist residential and tier 4 places due to reduced capacity nationally and ongoing capacity issues locally. Pressures less evident in this reporting period but issue remains on the Trust risk register and work continues to improve patient flow.
- The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues due to specific issues in relation to recruitment of band 6 nursing staff.
- Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.

Advise

- Waiting times from referral to treatment in Wakefield remain an outlier. Brief intervention and group work service offer continues to be strengthened, and medium term improvement is anticipated. Additional mental health support team investment has been confirmed which will enable further development of the schools-based offer.
- Eating disorder caseloads remain under pressure due to case acuity/complexity
- 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. Financial pressures in local council has impacted adversely on resource envelope. The 'Keep in Mind' programme will be launched April 2024.
- Evident increase in sickness rates. Small number of long term sickness cases adversely impacting.
- Mandatory training – reducing restrictive proactive interventions and cardiopulmonary resuscitation – in amber. Limited availability of face to face training offer.
- Business cases have been submitted in Barnsley with respect to the specialist support offer for children with learning disabilities/special educational needs and to tackle secondary waits for psychology
- A work programme is underway as part of West Yorkshire Collaborative arrangements to ensure more seamless transition to adult ADHD/ASC pathways.
- Friends and family test results 100%

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.
- The Trust has proactively engaged with provider collaboratives in South Yorkshire and Bassetlaw and West Yorkshire to strengthen the interface with inpatient providers and improve access to specialist beds

Adults and Older People Mental Health

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	75.1%	76.3%	
% Assessed within 14 days of referral (Routine)	75%	52.5%	65.7%	
% Assessed within 4 hours (Crisis)	90%	96.9%	94.5%	
% Complaints with staff attitude as an issue	< 20%	20% (1/5)	22% (2/9)	
% service users followed up within 72 hours of discharge from inpatient care	80%	87.7%	89.0%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.1%	98.3%	
% Treated within 6 weeks of assessment (routine)	70%	96.3%	98.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.9%	79.9%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	92.9%	*94.7%*	
Information Governance training compliance	>=95%	97.7%	97.1%	
Reducing restrictive practice interventions training compliance	>=80%	71.6%	68.3%	
Sickness rate (Monthly)	4.5%	4.0%	3.6%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	60.7%	62.6%	
% Bed occupancy	85%	96.0%	87.4%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	25% (1/4)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.7%	0.801	
% of clients clinically ready for discharge	3.5%	6.7%	8.0%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.2%	*88.0%*	
Inappropriate Out of Area Bed days	152	582	397	
Information Governance training compliance	>=95%	95.2%	93.5%	
Physical Violence (Patient on Patient)	Trend Monitor	17	20	
Physical Violence (Patient on Staff)	Trend Monitor	46	68	
Reducing restrictive practice interventions training compliance	>=80%	82.8%	82.1	
Restraint incidents	Trend Monitor	84	***101***	
Safer staffing	90%	130.0%	131.3%	
Sickness rate (Monthly)	4.5%	5.7%	5.5%	
% rosters locked down in 6 weeks				

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, the numbers have reduced this month.
- 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 led 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 we are expecting performance to be below target in Barnsley, Calderdale and Kirklees this month. Action plans remain in place, with specific improvement work taking place in Barnsley.
- Rapid improvement work in SPAs and implementation of business continuity plans in Calderdale & Kirklees together with some progress in recruitment should contribute to an improved performance in the coming months.
- The Kirklees Talking Therapies recovery rate for August has been finalised as 50.18% just achieving the national standard of 50%. This is likely to be a seasonal trend as a similar reduction was noted in 2022-23 August data. The recovery rate during this period has been affected by an increased number of non-recovered patients dropping out of treatment in addition to lower recovery rates of developing trainee Psychological Wellbeing Practitioners (PWPs). Individual clinician performance is being monitored through supervision with development plans to support and improve performance from trainee PWPs.
- 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 some progress in all areas for those on the (Care Programme Approach) CPA who have had a staying-well plan within 7 days and those who have had a formulation within 7 days against trajectory. Inpatient performance for those admitted who have had a staying-well plan within 24 hours is working towards achieving and sustaining improvement against trajectory.
- 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 areas, 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 well-being 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 achieving the target of all appraisals being completed.
- We are looking at our performance regarding Friends and Family Tests both in content of responses and numbers completed and developing actions to improve, with all areas now above threshold other than Barnsley where significant improvement has taken place.
- 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

- 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

Barnsley General Community Services

Barnsley General Community Services

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	80.7%	79.1%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/0)	
% people dying in a place of their choosing	80%	83.8%	81.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.2%	79.3%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	96.2%	96.7%	

Barnsley General Community Services

Metrics	Threshold	Jun-23	Jul-23	Aug-23	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.6%	99.0%	99.8%	
Maximum 6 week wait for diagnostic procedures	99%	82.5%	66.7%	64.2%	
Reducing restrictive practice interventions training compliance	>=80%	57.1%	50.0%	33.3%	
Safer staffing (inpatient)	90%	114.4%	105.4%	107.9%	
Sickness rate (Monthly)	4.5%	4.6%	5.0%	4.3%	
% rosters locked down in 6 weeks					

Alert/Action

Urban House (UH):

• The band 7 nurse prescriber left the service in November 2022, leaving 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. We are currently working with pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary. One of the band 6s within the service is to start the INP (Independent Nurse Prescriber) course in September 2023 and the team is also supported by a INP from within general community services.
• The service continues to have a high level of sickness absence which is causing additional pressures in the team.
• We continue to explore how we can strengthen the capacity and skills within the team.
• Neurological Rehabilitation Unit (NRU) is closed to admissions as currently we do not have safe trained staffing levels. A paper highlighting the issues is being prepared and will be sent to the executive management team (EMT).

Advise

• Notification that Yorkshire Smokefree (YSF) Doncaster will be out for tender, and it is anticipated this will be around the end of September. Preparation will start in early September with the service manager and the contracting team.
• Yorkshire Smoke Free are procuring for a social media company and the tender will be released in early September. Currently Bigfoot are the company that look after the social media for YSF; they will remain in place until the end of December.
• Awaiting service level agreement (SLA) review update for the Diabetic Foot Clinic, working with BHNFT contracts team - significant changes sighted in new SLA proposal. All appropriate SWYPT teams involved and awaiting BHNFT response.
• Being made aware that equipment & adaptations are not receiving any revenue from Barnsley Metropolitan Borough Council re blue badge assessment service. Meeting arranged for 12/9/23 with internal contracting & finance teams re-clarification and next steps.
• Recent recruitment issues around lack of communication and time between preferred candidate being contacted and sent conditional offers of employment. This has resulted in several appointees giving back word and seeking alternative employment. Escalated to recruitment lead and introduction of employing individuals at risk if all preemployment checks have been completed with only outstanding DBS approval.
• ICB led review of intermediate care pathways (bedded and community element) continues with options paper developed and discussed at partnership delivery group, who agreed a model moving forward. Short term (2 year) option for bed base (LA led soft market testing continuing) with a longer-term plan to look at new build / building refurbishment moving forward. Estates, medical model, service specification and workforce/finance discussions ongoing with key personnel involved from SWYPFT. Focus will move to looking at the community element of the pathway (currently provided by SWYPFT). Internally undertaking some demand and capacity modelling and costings based on predicted demand moving into the new model.
• Further to August '23 update, SWYPFT still awaiting a response from ICB in relation to the previously submitted mini business case for lymphoedema service in Barnsley. To note SWYPFT is currently not receiving any income for this service provision.
• Urgent out of hours pathway work with local authority and GP federation continues looking at colocation and development of integrated pathways / working to support patients in crisis out of hours.
• Virtual ward digital/remote monitoring procurement exercise update. SWYPFT staff participated in tender scoring led by SYICB. Currently awaiting further outcome on the preferred supplier with some delay in finalising so we can provide an update to EMT on the successful bidder and process undertaken. To note: SWYPFT will be holding the contract on behalf of Barnsley.
• Paediatric epilepsy nursing service is currently facing staffing pressures due to ongoing secondments and a breakdown of planned backfill for these. It is hoped that this will be resolved soon.
• Paediatric audiology service will be recommencing school hearing screening in September for the first time since pre-covid. We do not currently have the capacity to deliver the same level service as we did pre-covid and therefore some changes are being made to the offer in the short term.
• Waits continue to be longer in children's speech and language therapy. Recruitment is gradually increasing. New staff members are newly qualified and will need additional support/supervision.
• Children's community services are deemed a priory group in terms of vulnerability for measles exposure. If exposed, staff will require a 21-day absence from their role if they cannot provide evidence of having had two measles containing vaccines or immunity to the disease. Staff are being encouraged to check with occupational health. Potential for low staffing. We are represented at the Trust Measles Preparedness meetings.

Assure

• Work has been undertaken during August '23, to review and reduce the number of IMC spot purchase beds being supported by Neighbourhood Rehabilitation service workforce. This has reduced significantly and agreement sort that for the small numbers in spot purchase beds, BHNFT staff will support. This was instigated due to the ongoing demand, above commissioned thresholds, for NRS support. This reduction then allows for NRS staff to focus on delivering high quality, intensive rehabilitation to patients and will help facilitate a reduction in length of stay on the pathway and hopefully improved outcomes for our patients. *This is linked to the IMC external review discussions in the alert section*
• Neighbourhood Teams management team have commenced on the Affina Team Performance inventory (ATPI) working with the Trusts People Directorate. The first stage questionnaire is now complete and 2 further meetings are booked in with the general manager and team in October for feedback and next steps.
• Collaborative project between children and young people who stammer in Barnsley and Action for Stammering Children with the support of the Children's Speech and Language Therapy Service, Barnsley.
A small group of young people have been working with Action for Stammering Children (ASC) to produce some posters for schools. It came about when one young person commented that she had never seen information in schools about stammering.
#AboutMyStammer – New posters designed by young people who stammer! - Action For Stammering Children
We are anticipating a small piece in the Barnsley Chronicle (local newspaper) in support of the children's work.
• Stroke Early Supported Discharge team participated in the South Yorkshire Stroke Conference in May 2023. The team presented two posters – BP@Home and Life After Stroke Programme as well as two workshops – Vocational Rehab and Stroke Support Cafes. We are pleased that one of our posters won the competition.
• In August we welcomed two social prescribers to the team, who will offer additional support to patients on the Stroke Rehabilitation Unit and Early Supported Discharge team.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Services

LD, ADHD & ASD

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	65.4%	71.1%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/2)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	41.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	82.1%	
% of clients clinically ready for discharge	3.5%	50.0%	60.2%	
Information Governance training compliance	>=95%	96.4%	94.5%	
LD – First face to face contact within 18 weeks	90%	81.3%	66.1%	

LD, ADHD & ASD

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	33	12	
Reducing restrictive practice interventions training compliance	>=80%	78.0%	72.0%	
Safer staffing	90%	144.7%	137.3%	
Sickness rate (Monthly)	4.5%	4.4%	4.5%	
Restraint incidents	Trend Monitor	27	***12***	
% rosters locked down in 6 weeks				

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

Alert/Action

- Referral rates for ADHD - remain high and waiting lists continue to grow. There are currently over 4000 people waiting for an ADHD assessment. This is a national challenge.
- Referral rates for Autism - remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. This is because of the screening and triage step in place in those areas (which is a recommendation of the NHSE Guidance for ICB's published in April 2023)
- Friend & Family Test – 75% which represents a significant improvement.
- West Yorkshire ICB Neurodiversity Project – the service continues to contribute to this project.

Advise

- All vacancies have been recruited to but challenges in recruitment are delaying start dates.
- A business case proposal has been submitted to support Barnsley community paediatrics 16-18 service. The 17+ pathway and funding is in the final stages of agreement.
- The collaboration with Bradford District Care Foundation Trust is also going well. Service users are screened via a face-to-face appointment within four weeks of referral date.

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.

Learning disability services:

Alert/Action

Community Services
- Resource requirements identified to support the ADHD pathway for people with a learning disability (LD) and a business case for funding currently being drafted.
- Detailed work underway on ensuring the Patient Knows Best app is LD friendly.
- LD Transforming Care Partnerships have now divided into South Yorkshire (Barnsley services) and West Yorkshire (Calderdale, Kirklees and Wakefield services). Service trio are now members at both.
- Increased number of people transitioning into services require intellectual assessments in Wakefield. A meeting has been scheduled with the commissioner to discuss and agree a way forward.

ATU (Assessment & Treatment Unit)
- The speech and language therapist post remains vacant and now back out to advert.
- Improvement work undertaken on the 12-point discharge planning process.
- Improvement actions are being progressed and the service is now assessing itself against QNLD standards (Quality Network for Inpatient Learning Disability) internally and are sharing both ways with the Bradford ward seeking support from national peers.

Advise

Community Services
- Challenges continue with the recruitment of specialists in speech and language and occupational therapy.
- Wakefield Local Authority have commissioned a review of LD services on behalf of the Wakefield Alliance.

ATU (Assessment & Treatment Unit)
- Vacancies in nursing are being addressed and support is made available for less experienced staff.
- Improvement work continues to be embedded into the service.

Assure

Community Services
- Newly established internal LeDeR (learning from deaths review programme) group now in place to ensure joined up learning from South and West Yorkshire and disseminating learning to all LD staff.
- Waiting list training for staff completed and some final amends being made before the new way of working goes live.
- Locality trios and senior clinicians' teams are now embedding with more clarity on decision making and escalation processes.

ATU (Assessment & Treatment Unit)
- Improvements continue to strengthen processes, approaches and positive culture on the ward.
- Interim occupational therapist and psychologist now in place which has strengthened multidisciplinary team working and care planning for our service users. A more recent reduction in incidents has been noted.

Forensic Services

Forensic

Metrics	Threshold	Jul-23	Aug-23	Variation/ Assurance
% Appraisal rate	>=90%	72.5%	61.7%	
% Bed occupancy	90%	86.5%	86.6%	
% 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%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	79.3%	
% 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%	96.5%	96.5%	
Physical Violence (Patient on Patient)	Trend Monitor	1	4	
Physical Violence (Patient on Staff)	Trend Monitor	16	12	
Reducing restrictive practice interventions (RRPI) training compliance	>=80%	83.0%	81.3%	
Restraint incidents	Trend Monitor	28	***18***	
Safer staffing	90%	114.6%	110.1%	
Sickness rate (Monthly)	5.4%	9.3%	8.3%	
% rosters locked down in 6 weeks				

Alert/Action

• Bed Occupancy – Newton Lodge 84.10%↑, Bretton 90.09%↓ (remains green), Newhaven 84.07%↑. Occupancy has been highlighted by the commissioning hub as a risk to the provider collaborative given the number of out of area placements. Work has commenced within the service to explore service user flow across the pathway.
• Sickness absence – continues to be a concern particularly at the Bretton Centre. Managers within the service are working with the People Directorate to support staff to return to work.
• Vacancies & Turnover – Turnover has risen in month to 13.3% and managers continue to encourage staff to provide feedback through exit conversations. Recruitment and retention remains a priority and projections for the number of new starters looks positive.

Advise

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative and the options appraisal for commissioning arrangements moving forward is in the final stages of completion.
• Mandatory training overall compliance:
  Newton Lodge – 92.3↓
  Bretton – 90.4%↓(impacted by high sickness figures)
  Newhaven –90.1↓
  The above figures represent the overall position for each service. There are some hotspots for RRPI and CPR and there are plans to target staff who need to attend.
• The roll out of Trauma Informed Care is going well and training sessions for staff continue to be well attended the service will continue to develop the roll out with a planned phase 2.
• Appraisal (61.7%) & supervision remain a priority.
• The well-being of staff also remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying 3 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 and risk management) being completed within 3 months of admission.
• Friends and family test 100%
• CPA 100%
• 25 hours of meaningful activity 100%.
• All Equality Impact Assessments across forensic services have been completed for 23/24.
• Positive feedback received from the commissioning hub relating to our quarterly submissions and presentations at contract meetings.

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£1.2m	£0m	A surplus of £0.4m has been reported in August 2023 and a year to date surplus of £1.2m. This has improved the position and is now £0.2m behind plan. Excluding the provider collaboratives, the core Trust position is breakeven in month.
2	Agency Spend	£4.5m	£10.2m	The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in August is £0.8m which is in line with historical run rates but exceeds the plan trajectory. The year to date position is 16% above plan.
3	Financial sustainability and efficiencies	£3.6m	£12m	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 and is on track for the year to date. This target remains challenging due to the increasing profile and the need to identify new opportunities.
4	Cash	£79.1m	£76.9m	The Trust cash position remains strong at £79.1m.
5	Capital	£1.1m	£8.8m	Excluding the impact of the impact of IFRS 16 (leases), year to date expenditure is £1.1m. Although there are some delays in schemes, mainly IM&T schemes in August 2023, this is still forecast to deliver in full in year. Expenditure is forecast to significantly increase in the next quarter.
6	Better Payment Practice Code	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 97% 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.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 5 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to Date	Forecast 2023 / 24	Narrative
1	Surplus / (Deficit)	£1.2m	£0m	A surplus of £0.4m has been reported in August 2023 and a year to date surplus of £1.2m. This has improved the position and is now £0.2m behind plan. Excluding the provider collaboratives the core Trust position is breakeven in month.
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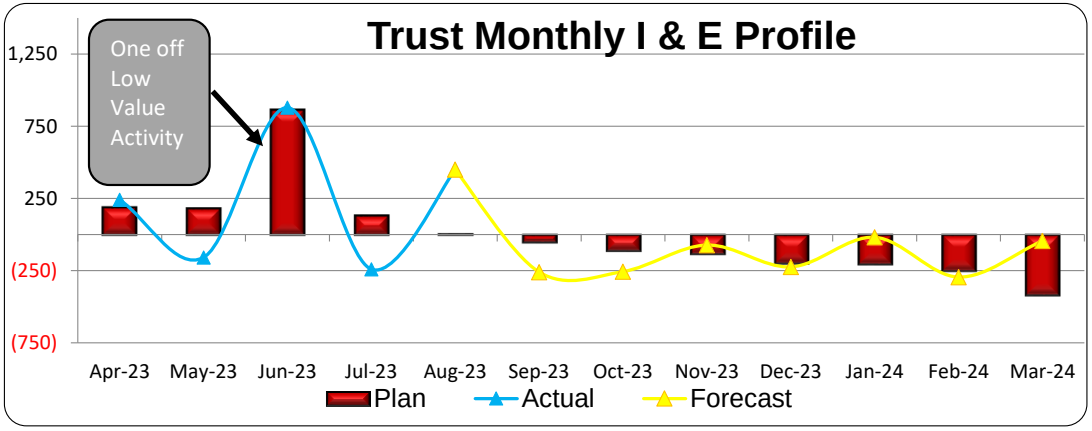
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

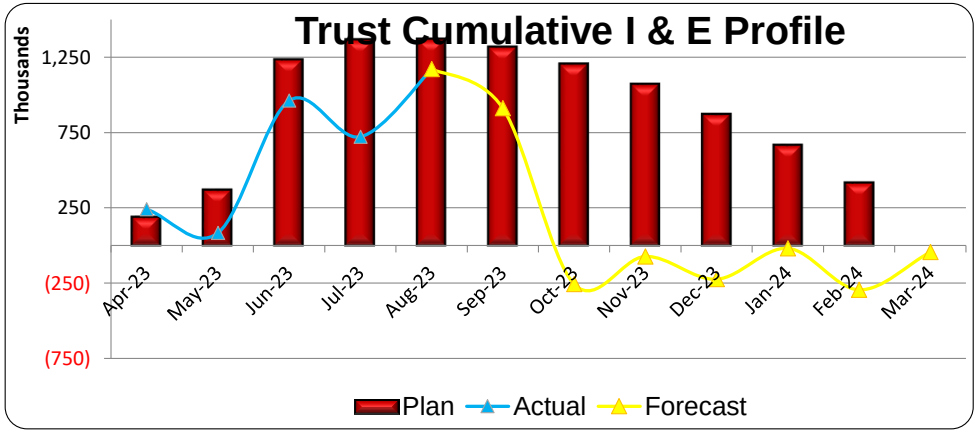
2.0 Income & Expenditure Position 2023 / 24

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					33,507	33,581	74	163,785	164,116	330	392,227	393,121	894
Other Operating Revenue					1,064	1,267	203	5,052	5,473	421	12,454	12,842	388
Total Revenue					**34,571**	**34,848**	**277**	**168,838**	**169,589**	**751**	**404,682**	**405,963**	**1,282**
Pay Costs	4,854	4,856	2	0.0%	(20,956)	(20,746)	210	(101,271)	(100,865)	406	(245,134)	(244,638)	495
Non Pay Costs					(13,188)	(13,350)	(162)	(64,019)	(65,763)	(1,744)	(154,521)	(157,132)	(2,611)
Gain / (loss) on disposal					0	0	0	0	5	5	0	5	5
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,854**	**4,856**	**2**	**0.0%**	**(34,143)**	**(34,096)**	**48**	**(165,290)**	**(166,623)**	**(1,333)**	**(399,655)**	**(401,765)**	**(2,111)**
EBITDA	**4,854**	**4,856**	**2**	**0.0%**	**428**	**753**	**325**	**3,548**	**2,966**	**(582)**	**5,027**	**4,198**	**(829)**
Depreciation					(503)	(508)	(5)	(2,559)	(2,566)	(8)	(5,949)	(5,991)	(42)
PDC Paid					(179)	(179)	0	(895)	(895)	0	(2,148)	(2,148)	0
Interest Received					258	384	126	1,272	1,666	394	3,070	3,941	871
Surplus / (Deficit) - ICB performance measure	**4,854**	**4,856**	**2**	**0.0%**	**4**	**449**	**446**	**1,366**	**1,171**	**(196)**	**(0)**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(97)	(97)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,854**	**4,856**	**2**	**0.0%**	**4**	**430**	**426**	**1,366**	**1,074**	**(292)**	**(0)**	**(232)**	**(232)**





2.0 Impact of provider collaboratives

Since 2022 the Trust has taken on a co-ordinating role for a number of provider collaboratives. This has significantly increased the total income and expenditure reported within the overall consolidated financial position. The table below separately shows the relationship of Trust to collaboratives and how this consolidates to the total position. This replicates the segmental reporting approach included within the Trust Annual Accounts.

Provider Collaborative consolidation - year to date actual

Description	Total consolidated	West Yorks Adult Secure	Forensic CAMHS	South Yorks Adult Secure	SWYPFT
	£k	**£k**	**£k**	**£k**	**£k**
Healthcare contracts	164,116	28,036	465	14,976	120,639
Other Operating Revenue	5,473				5,473
Total Revenue	**169,589**	**28,036**	**465**	**14,976**	**126,112**
Pay Costs	(100,865)	(650)	(51)	(301)	(99,863)
Non Pay Costs	(65,763)	(27,386)	(315)	(14,569)	(23,493)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	**(166,623)**	**(28,036)**	**(366)**	**(14,870)**	**(123,350)**
EBITDA	**2,966**	**0**	**98**	**106**	**2,762**
Depreciation	(2,566)				(2,566)
PDC Paid	(895)				(895)
Interest Received	1,666				1,666
Surplus / (Deficit) - ICB	**1,171**	**0**	**98**	**106**	**967**
Depn Peppercorn Leases (IFRS16)	(97)				(97)
Revaluation of Assets	0				0
Surplus / (Deficit) - Total	**1,074**	**0**	**98**	**106**	**870**

The year to date financial performance of each provider collaborative, which SWYPFT is lead for, is shown on the left.

The West Yorkshire collaboratives are subject to a financial risk / reward share agreement. This arrangement includes CAMHS and Adult Eating Disorder services which are co-ordinated by Leeds & Yorkshire Partnership NHS Foundation Trust, and at this stage are not incorporated into the reported SWYPFT financial position. The current risk is factored into the forecast scenario.

The South Yorkshire collaboratives do not currently have a risk / reward share arrangement and the full financial impact is shown against SWYPFT. Discussions continue to progress this issue.

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					24,493	24,304	(189)	121,289	120,639	(649)	290,256	289,118	(1,139)
Other Operating Revenue					1,064	1,267	203	5,052	5,473	421	12,454	12,842	388
Total Revenue					**25,557**	**25,571**	**14**	**126,341**	**126,112**	**(228)**	**302,711**	**301,960**	**(751)**
Pay Costs	4,832	4,832	0	0.0%	(20,800)	(20,535)	266	(100,501)	(99,863)	638	(243,350)	(242,202)	1,148
Non Pay Costs					(4,504)	(4,724)	(220)	(22,292)	(23,493)	(1,201)	(54,334)	(55,194)	(860)
Gain / (loss) on disposal					0	0	0	0	5	5	0	5	5
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,832**	**4,832**	**0**	**0.0%**	**(25,304)**	**(25,259)**	**45**	**(122,793)**	**(123,350)**	**(558)**	**(297,684)**	**(297,390)**	**294**
EBITDA	**4,832**	**4,832**	**0**	**0.0%**	**253**	**312**	**59**	**3,548**	**2,762**	**(786)**	**5,027**	**4,570**	**(457)**
Depreciation					(503)	(508)	(5)	(2,559)	(2,566)	(8)	(5,949)	(5,991)	(42)
PDC Paid					(179)	(179)	0	(895)	(895)	0	(2,148)	(2,148)	0
Interest Received					258	384	126	1,272	1,666	394	3,070	3,941	871
Surplus / (Deficit) - ICB performance measure	**4,832**	**4,832**	**0**	**0.0%**	**(171)**	**9**	**180**	**1,366**	**967**	**(400)**	**(0)**	**372**	**372**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(97)	(97)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,832**	**4,832**	**0**	**0.0%**	**(171)**	**(10)**	**161**	**1,366**	**870**	**(496)**	**(0)**	**140**	**140**

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 Consolidated Position	4,854	4,856	2	0.0%	4	449	446	1,366	1,171	(196)	(0)	(0)	(0)
Provider Collaboratives	22	24	2	6.9%	175	440	265	0	204	204	0	(372)	(372)
Total excluding Collaboratives (as shown above)	**4,832**	**4,832**	**0**	**0.0%**	**(171)**	**9**	**180**	**1,366**	**967**	**(400)**	**(0)**	**372**	**372**

Income & Expenditure Position 2022 / 23

August 2023, excluding the financial impact of the provider collaboratives, is a £9k surplus. This is £180k better than plan.

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 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 (both agenda for change and medic), and gap compared to commissioner income uplifts, presents a significant financial pressure to this plan position.

The impact of the medic pay award, both the income and expenditure aspects, have been incorporated in month. This has been back dated to 1st April 2023 and will be paid / received in month 6 / September 2023.

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. The most significant variances relate to activity recharges and are offset by underspends in pay / non-pay. Additional risk, such as against CQUIN performance, are included within the Trust forecast scenario modelling.

Pay

Pay expenditure has increased in month. This includes overall workforce growth and also through the impact of the medic pay award which has been accounted for in August (expected to be paid in September). Workforce growth is forecast to continue across the remainder of the year.

Agency spend has reduced slightly in August compared to July. Overall the run rate remains similar to the previous year and, therefore, above target.

Non Pay

The non pay analysis highlights that most categories are overspent against plan although overall non pay spend is lower than the previous year. Pressures continue (both volume and inflationary cost increases) but there has been positive reductions in out of area placement spend in month which is shown within the purchase of healthcare highlight report.

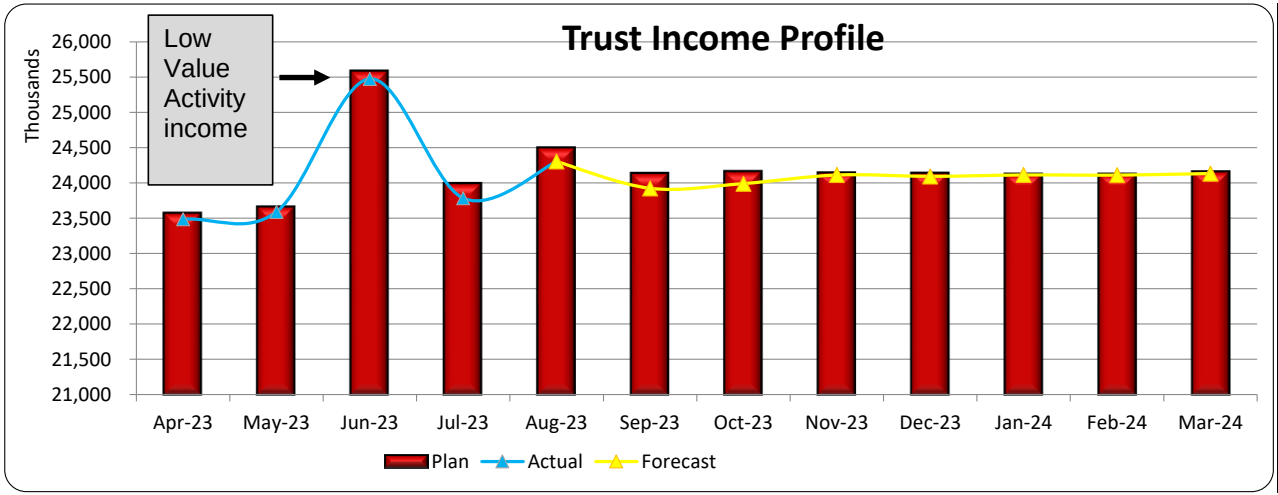
2.1 Income Information

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 for mental health collaboratives. This is reported separately.

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	21,396	19,968	20,628	19,983	20,042	20,163	20,146	20,132	20,130	20,154	**241,916**	**220,257**
ICS / System / Covid	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**6,243**
Specialist Commissioner	2,752	2,753	2,881	2,804	2,578	2,743	2,743	2,743	2,743	2,743	2,743	2,743	**32,970**	**26,001**
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**9,058**
Local Authority	490	516	510	318	481	481	532	532	532	546	546	546	**6,032**	**5,311**
Partnerships	514	584	546	591	472	580	538	538	538	556	556	556	**6,569**	**5,052**
Other Contract Income	197	96	144	102	144	136	136	136	135	135	135	135	**1,631**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,783**	**24,304**	**23,924**	**23,991**	**24,113**	**24,094**	**24,113**	**24,111**	**24,134**	**289,118**	**274,177**
2022 / 23	20,679	20,725	20,039	20,358	21,057	22,784	24,206	24,485	24,831	24,657	23,559	26,796	**274,176**	



Income has increased in month primarily due to clarification relating to the national negotiation on software licences. An income deduction, by the ICB, was made in July 2023 but this has been reversed in August 2023.

This will be factored into the forecast risk scenario as this could be re-applied again in future months. This scenario will include the impact of CQUIN performance and the current assessment of income risk relating to investment slippage.

Known shortfalls in income, against plan, are factored into the current position such as Sheffield Stop Smoking (less activity) and the Youth Offender contract (recruitment slippage). These will continue to be monitored.

2.2 Pay Information

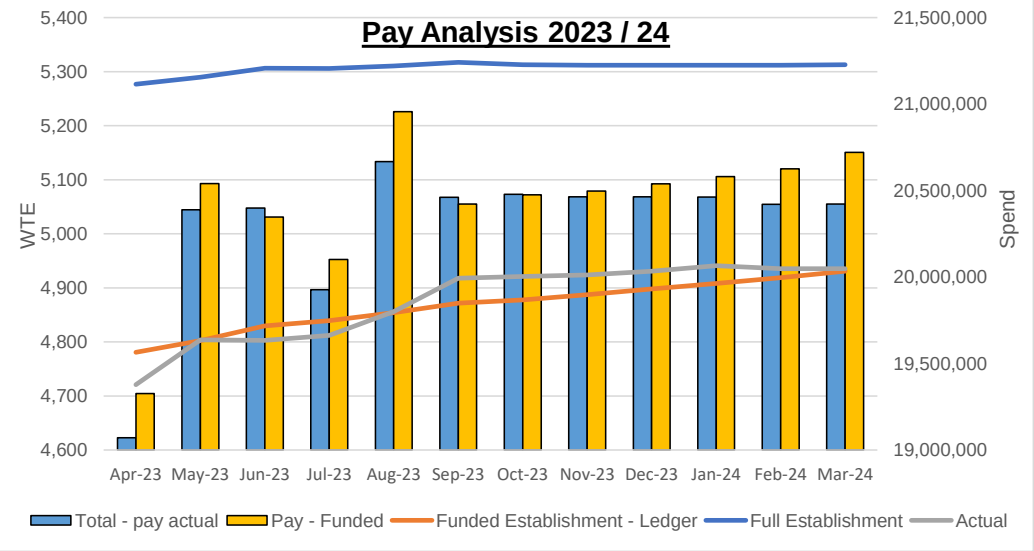
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	17,149	18,033	17,939	17,603	18,244	18,103	18,138	18,144	18,162	18,175	18,172	18,167	**216,030**
Bank & Locum	849	1,355	1,337	1,360	1,481	1,371	1,382	1,364	1,372	1,378	1,362	1,372	**15,982**
Agency	939	908	1,002	855	810	862	836	838	813	791	769	767	**10,190**
Total	**18,936**	**20,296**	**20,277**	**19,819**	**20,535**	**20,337**	**20,355**	**20,346**	**20,347**	**20,345**	**20,304**	**20,305**	**242,202**
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%	6.6%	6.9%	7.2%	6.7%	6.8%	6.7%	6.7%	6.8%	6.7%	6.8%	6.6%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.2%	4.1%	4.1%	4.0%	3.9%	3.8%	3.8%	4.2%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,312	4,329	4,356	4,426	4,429	4,435	4,443	4,453	4,455	4,454	**4,397**
Bank & Locum	222	314	326	321	356	343	346	341	342	344	339	341	**328**
Agency	157	161	164	163	144	149	147	148	146	144	141	140	**150**
Total	**4,721**	**4,804**	**4,803**	**4,812**	**4,856**	**4,918**	**4,921**	**4,924**	**4,931**	**4,941**	**4,935**	**4,936**	**4,875**
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**



Pay expenditure has increased in month with the impact of the medic pay award, dated back to April 2023, included. In addition there is continued workforce growth as shown by the increasing WTE worked. This is on both substantive and bank lines. There has been a reduction in agency worked WTE in month.

Overall WTE in August is in line with plan. This is forecast to increase in September through additional recruitment (newly qualified students intake) and continued international recruitment.

The impact on agency and bank will be seen in future months after initial induction periods of substantive staff.

The forecast models an additional 80 worked WTE by March 2024.At 4,936 this represents an increase of 345 WTE compared to the prior year. This is also an increase of 52 WTE from that forecast in July 2023. This movements have a significant impact on the overall forecast scenario and future plan modelling.

2.2 Agency Expenditure Focus

Agency spend is £808k in August. 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.

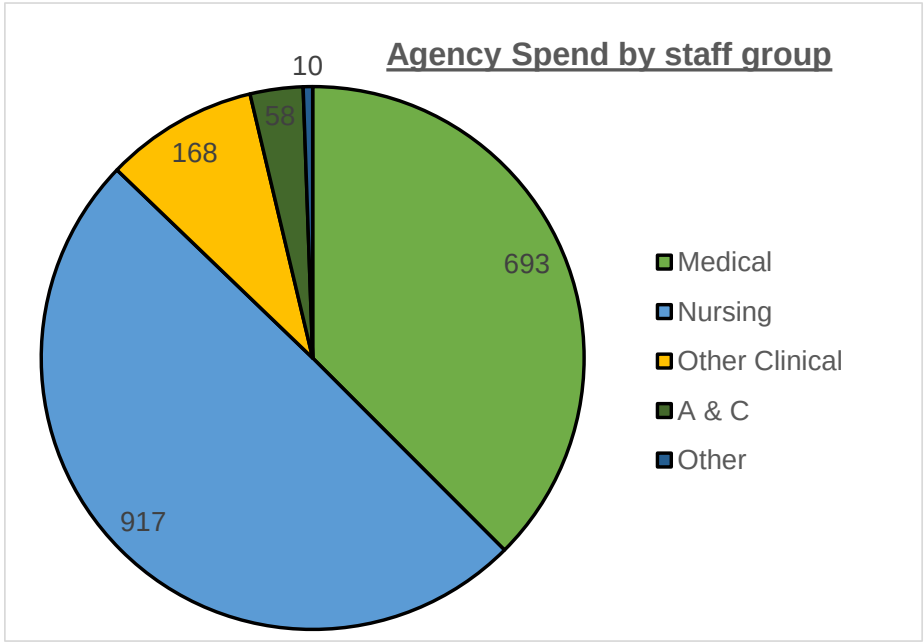
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

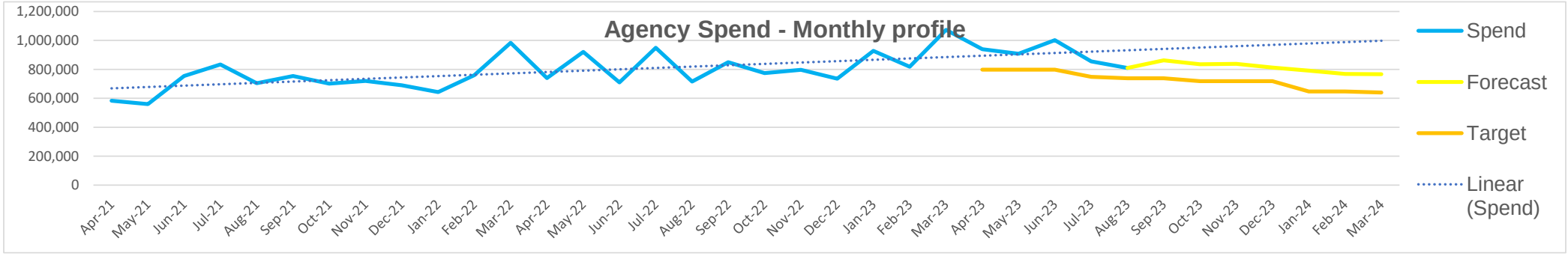
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23 and the target trajectory is outlined in the graph below.

The Trust agency scrutiny and management group continues to provide oversight ensuring that Trust processes are followed and agency spend is appropriate and minimised. The Trust will continue to assess need based upon safety, quality and financial implications.

August 2023 spend is £808k, which is the second consecutive month of reduction, and is slightly lower than the average run rate in 2022 / 23. Although this still remains higher than the monthly target. The current modelled trajectory has some reductions profiled, as shown by the yellow line, but this is above target for each month and consequently over in total.

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. All of these have establishment reviews ongoing and are the focus on trust workforce growth through substantive recruitment.



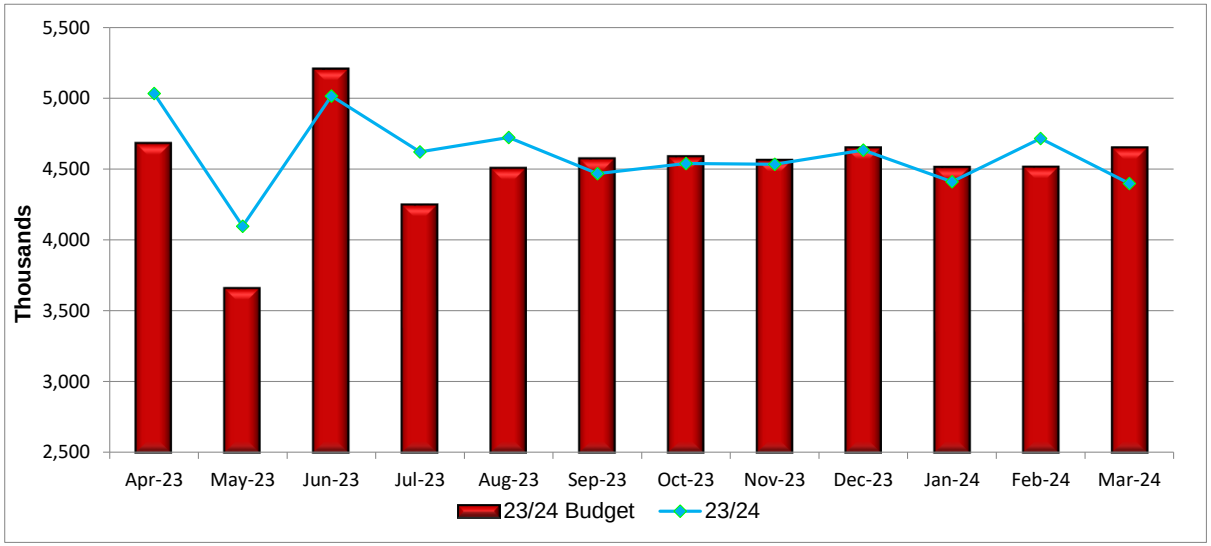


2.3 Non Pay Expenditure

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	5,035	4,097	5,016	4,621	4,724	4,468	4,540	4,535	4,634	4,410	4,716	4,398	**55,194**
2022/23	4,213	4,350	4,271	4,080	4,917	4,694	4,130	4,767	4,010	7,142	4,797	6,931	**58,303**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	1,709	1,577	(132)
Establishment	3,629	4,007	378
Lease & Property Rental	3,631	3,523	(108)
Premises (inc. rates)	2,239	2,551	312
Utilities	867	902	35
Purchase of Healthcare	3,727	3,865	138
Travel & vehicles	2,111	2,097	(14)
Supplies & Services	2,823	3,016	193
Training & Education	726	738	12
Clinical Negligence & Insurance	442	444	3
Other non pay	389	773	384
Total	**22,292**	**23,493**	**1,201**
Total Excl OOA and Drugs	**16,857**	**18,051**	**1,194**



Key Messages

Non pay expenditure budgets were reset for 2023 / 24 based on historical trends and estimates of inflationary price increases. Budget adjustments, and alignments, continue as normal. Although spend is above plan it remains at a lower level than the prior year.

The non pay review group, and general review of all expenditure, as part of the value for money workstream, continues.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is overspent against plan. Out of area placements (adult and PICU), which forms part of this spend, is currently underspent against plan.

Other non pay includes all other items not categorised into the above headings. Due to the nature of Trust expenditure this can be wide ranging. Where possible costs will be allocated into the main headings above which are in line with Trust Annual Accounts categorisation.

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.

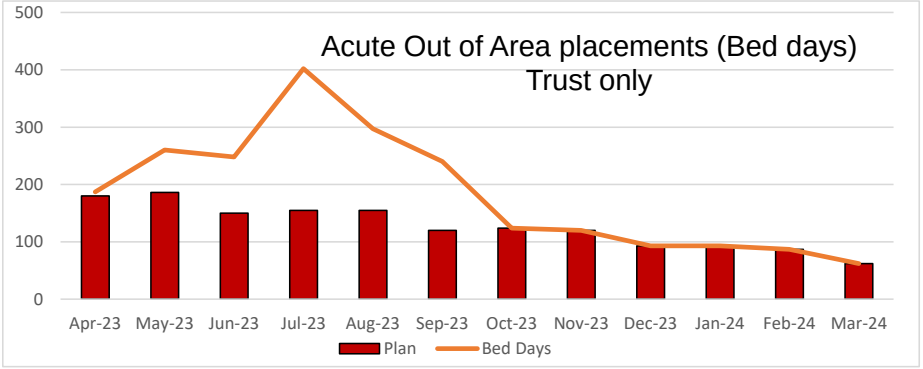
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

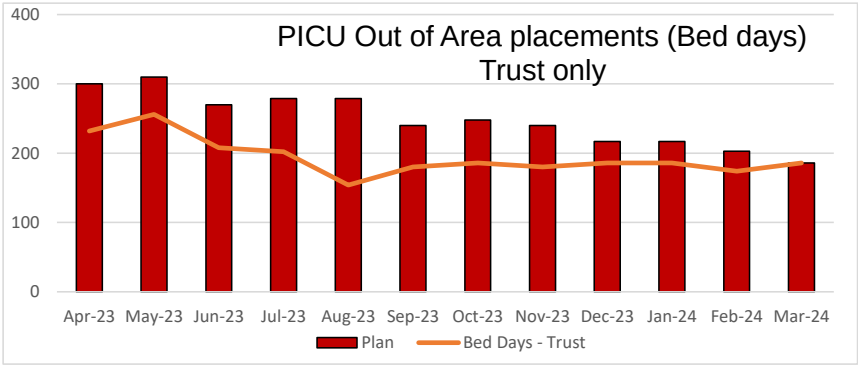
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

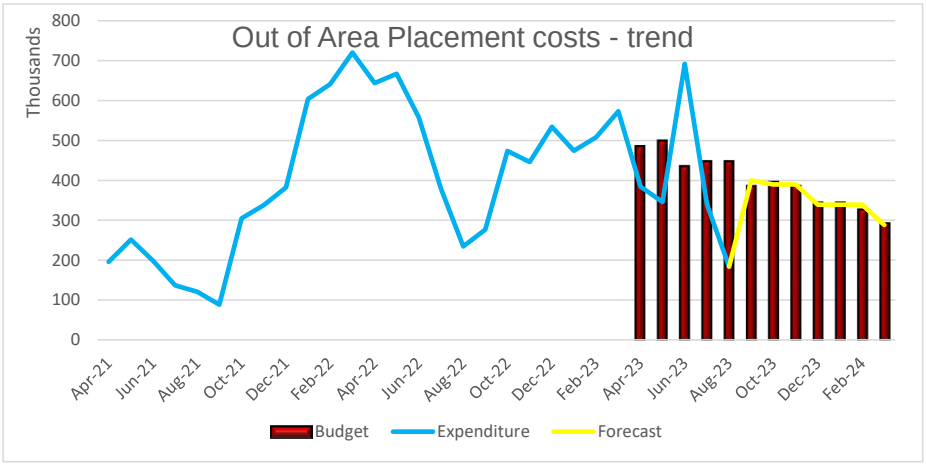
On such occassions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	628	861	233
PICU	1,625	1,001	(624)
Locked Rehab	951	1,113	162
Services - NHS	137	161	25
IAPT	73	221	148
Yorkshire Smokefree	34	13	(21)
Other	279	494	215
Total	**3,727**	**3,865**	**138**







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

Overall expenditure on out of area placements is £392k lower than plan for the year to date. This is an increase in the underspend from July with reduced activity in both acute and PICU in month. Updates on the work undertaken, and the impact seen, has been shared within the Trust; work continues to ensure that this is maintained / improved.

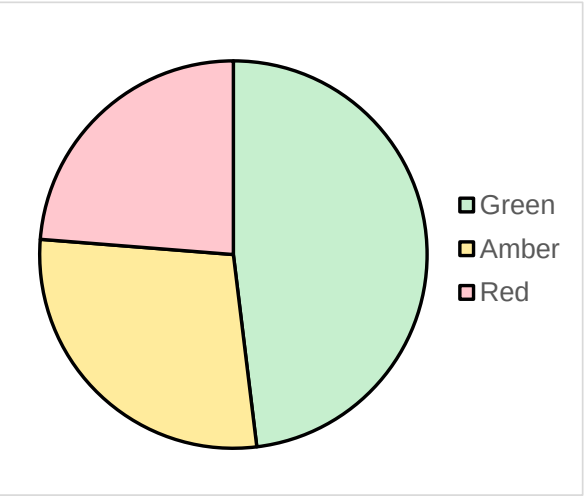
Continuation of this trend remains a risk and is reflected in the current forecast trajectory, as shown above. This models a continued reduction of acute placements towards the planned level, but some future increases in PICU activity.

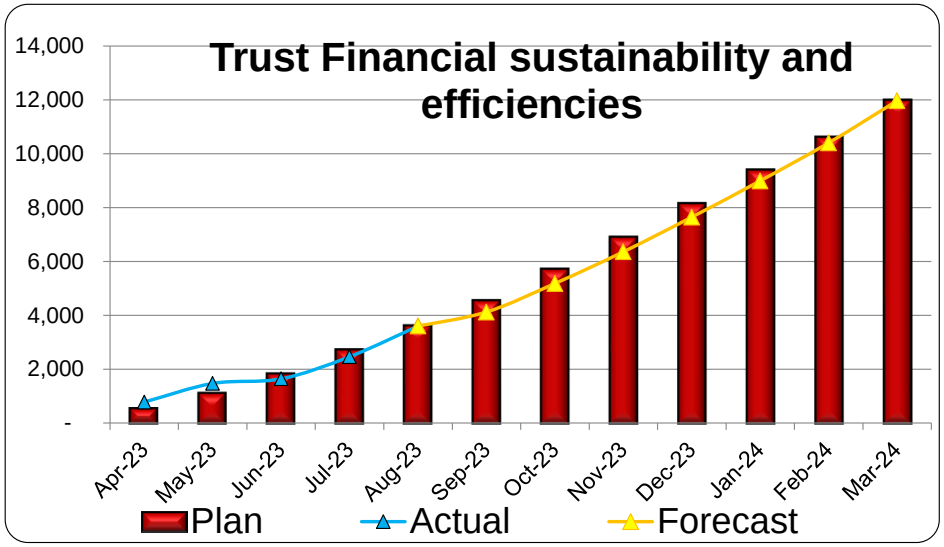
2.4 Value for Money, Financial sustainability and efficiency

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**	**Target**	**Green**	**Amber**	**Red**
Out of Area Placements	Pg. 10	859	1,214		3,197	1,214	2,328	
Agency & Workforce	Pg.	1,070	341	406	4,380	785	495	
Medicines optimisation		167	132		400	172		
Non Pay Review		313	0		1,048		550	2,842
Income contributions		210	96		500	267		
Interest Receivable	Pg. 4	583	977		1,400	2,271		
Provider Collaborative	Pg.	433	433		1,044	1,044		
Total		**3,634**	**3,194**	**406**	**11,969**	**5,753**	**3,374**	**2,842**
Recurrent		3,331	3,194		10,943	5,753	3,374	
Non Recurrent		303		406	1,026			2,842





Value for money performance for the year to date is £49k behind plan and further work, as highlighted by the pie chart showing the RAG rating of schemes, is required to ensure that the programme delivers in full and supports the delivery of the overall financial target.

Elements of this delivery, specifically those linked to workforce strategies, have been identified non recurrently and longer term recurrent mitigations will need to be secured. Overall there is slippage, both year to date and forecast. There is also slippage on the non pay schemes.

There have been mitigated by better than plan performance on interest receivable, which is forecast to continue, and current out of area placements expenditure. Future months are still reported as amber due to the volality of this area. Current performance is no guarantee of future performance.

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	167,808	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	946	
Non NHS Trade Receivables (Debtors)	2,853	1,122	
Prepayments	3,482	4,926	
Accrued Income	9,372	4,723	2
Cash and Cash Equivalents	74,585	79,127	Pg 15
Total Current Assets	**92,097**	**91,076**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(7,619)	3
Capital Payables (Creditors)	(739)	(366)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,003)	4
Accruals	(32,952)	(29,384)	4
Deferred Income	(4,172)	(1,925)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(57,366)	1
Total Current Liabilities	**(104,062)**	**(104,663)**	
Net Current Assets/Liabilities	**(11,965)**	**(13,587)**	
Total Assets less Current Liabilities	**153,210**	**154,221**	
Provisions for Liabilities	(4,319)	(4,213)	
Total Net Assets/(Liabilities)	**148,891**	**150,008**	
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	85,062	
Total Taxpayers' Equity	**148,891**	**149,966**	

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 significant increases had already been included in the plan). This results in increases in both assets and liabilities.

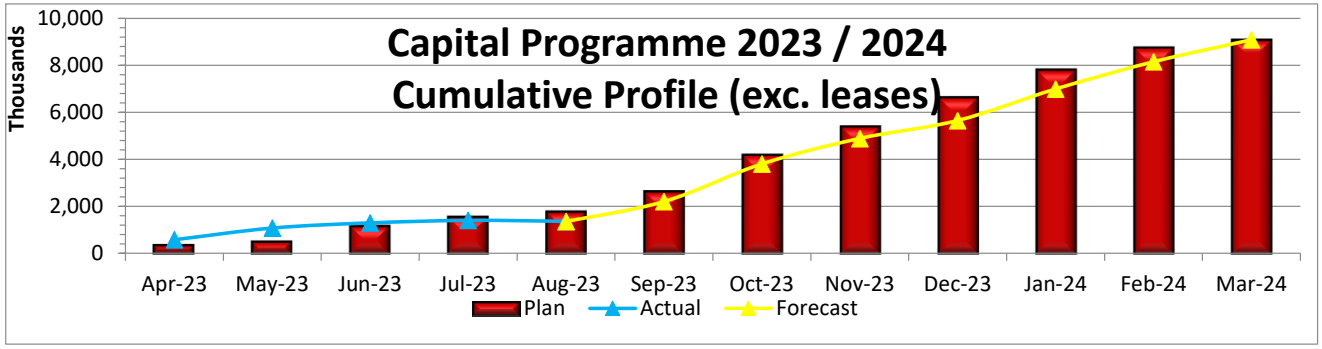
2. Accrued income, and maintaining at a low level, remains a focus in order to reduce risk and maximise cash balances. As we approach Month 6 and the quarter end, this should reduce as invoices are raised.

3. Trade payables remain high, £3.4m relates to purchase orders receipted but not invoiced. Housekeeping is being undertaken for any old orders that need closing.

4. Accruals remain at a high level, work is ongoing to ensure that invoices are received and processed. A significant element of this relates to the South Yorkshire Adult Secure Collaborative (c. £5m to other NHS providers).

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	15	15	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	115	1	(114)	713	428
Safety inc. ligature & IPC	990	255	389	134	1,326	336
Compliance	430	430	0	(430)	302	(128)
Backlog maintenance	510	0	0	0	120	(390)
Sustainability	300	0	7	7	225	(75)
Plant & Equipment	40	0	22	22	53	13
Other	1,223	69	625	556	1,039	(184)
IM & T						
Digital Infrastructure	1,100	350	0	(350)	1,200	100
Digital Care Records	180	30	0	(30)	70	(110)
Digitally Enabled Workforce	815	248	0	(248)	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**	**1,497**	**1,059**	**(437)**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	7,358	2,155	7,366	2,163
New lease	303	283	300	17	324	21
TOTALS	**14,274**	**6,983**	**8,717**	**1,734**	**16,457**	**2,183**



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.

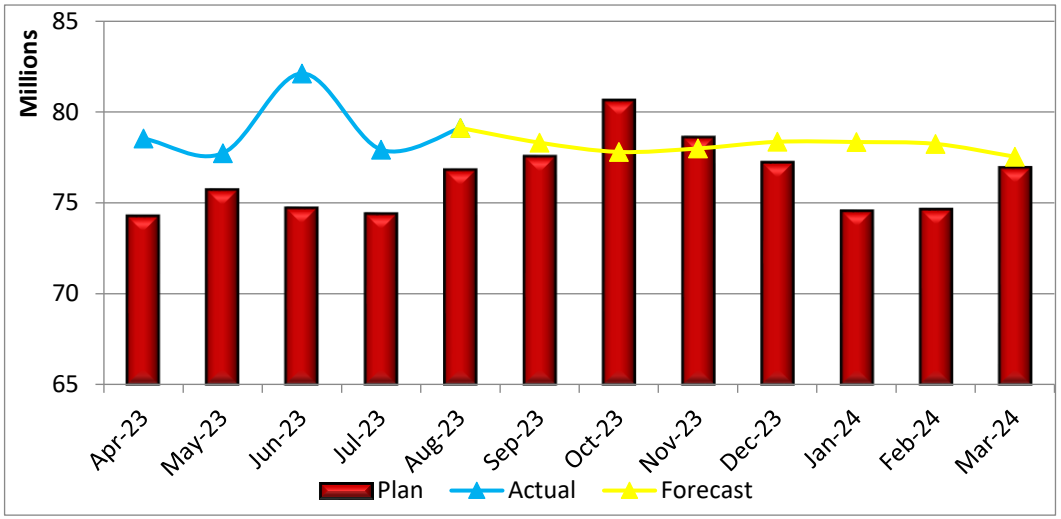
Changes, implemented under IFRS 16 (leases), mean that these costs are now included within the NHS England Capital Departmental Expenditure Limits (CDEL) but is separate from the ICB capital allocation so is presented below the line here.

Maintenance / minor capital 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 (not in the plan).

Major scheme spend is profiled to commence later in the year although there are indications that the site infrasture scheme will be split with part completed in year.

IM & T spend is behind plan with the digital infrastructure due to progress to approval now delayed until September. Digitally enabled workforce is progressing with the procurement exercise now complete.

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

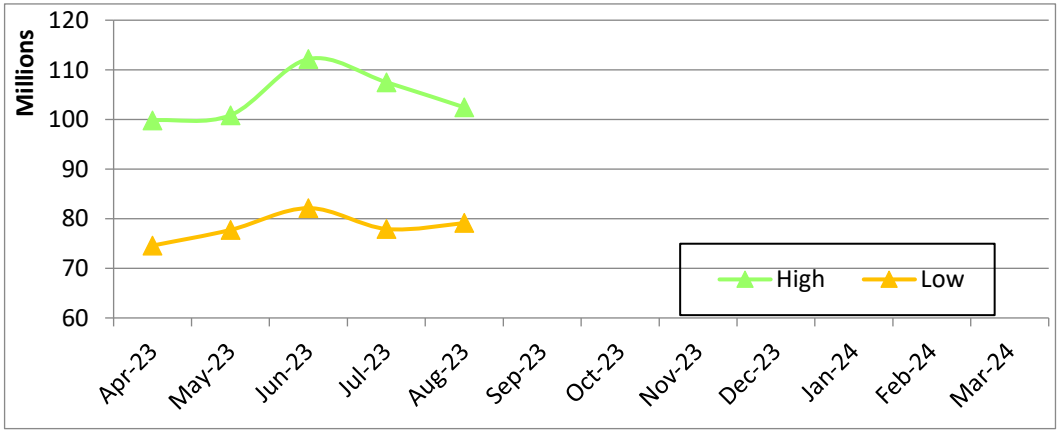


The Trust cash position remains positive.

Cash has increased slightly at the end of the month, this is expected to reduce in September as we make the PDC payment.

The Trust continues to monitor interest rates to assess the optium time to invest.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	76,818	79,127	2,309



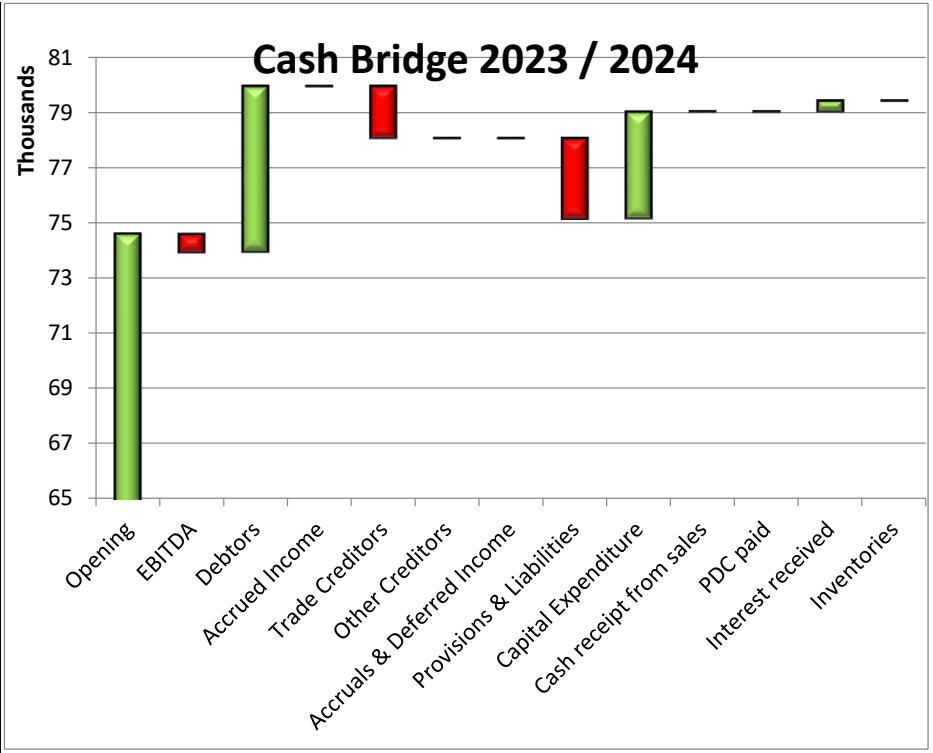
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £102.4m
The lowest balance is: £79.1m

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)	7,285	6,631	(654)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(785)	5,218	6,003	
Trade Payables (Creditors)	(1,175)	(3,052)	(1,877)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	567	(2,353)	(2,920)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(4,932)	(1,059)	3,872	
Cash receipts from asset sales	0	5	5	
Leases	0	(2,515)	(2,515)	
PDC Dividends paid	0		0	
PDC Dividends received	0		0	
Interest (paid)/ received	1,272	1,666	394	
Closing Balances	**76,818**	**79,127**	**2,309**	



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 £2.3m higher than plan, capital is a driver behind this as we are behind plan and this will continue for the next quarter.

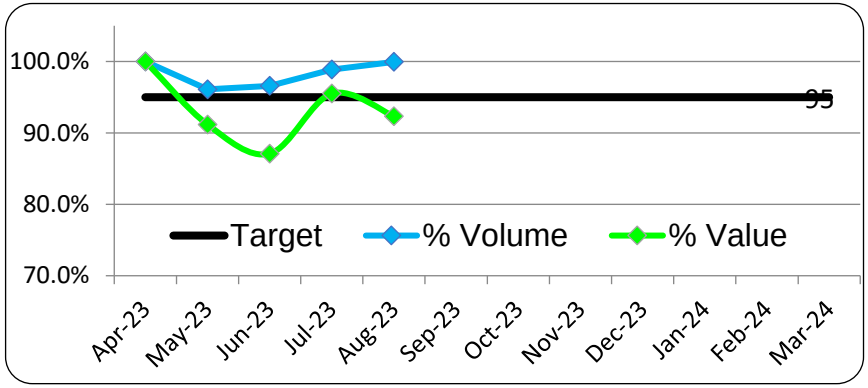
4.0 Better Payment Practice Code

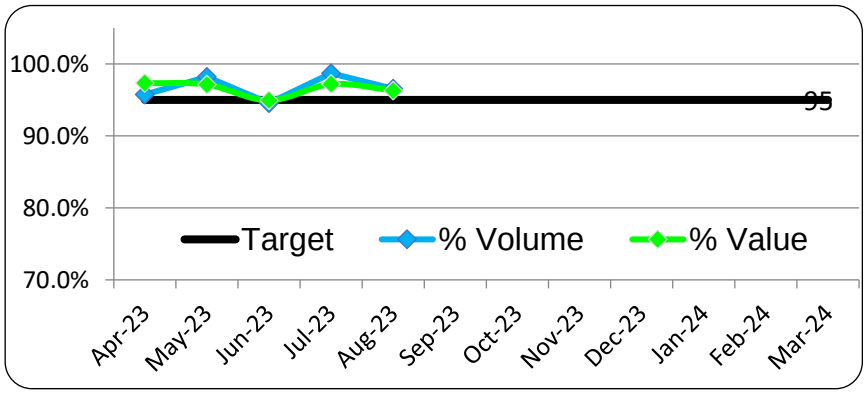
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently. NHS performance by number has been targeted in month to reverse the downward trend, this will continue to be monitored. Following a slight dip in month, action has been taken to increase NHS payment runs.

NHS	Number %	Value %
In Month	100%	92%
Cumulative Year to Date	98%	94%

Non NHS	Number %	Value %
In Month	97%	96%
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 (£)
24-Jul-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5086	800,000
15-Aug-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999988	666,894
01-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS37	544,330
16-Aug-23	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	203543	519,424
01-Aug-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008187	337,679
01-Aug-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 275	245,869
02-Aug-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foun	4400000237	230,447
28-Jul-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000171	186,496
01-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS14	185,000
08-Aug-23	Purchase of Healthcare	Kirklees	Northorpe Hall Child & Family Trust	INV0546	172,704
21-Aug-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5127	159,820
01-Aug-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008183	120,179
18-Jul-23	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	FDN00865	105,133
10-Aug-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC015INV	102,998
03-Aug-23	IT Services	Trustwide	Daisy Corporate Services	3I513277	90,250
15-Aug-23	Purchase of Healthcare	Kirklees	Kirklees Council	8608201371	85,000
09-Aug-23	Purchase of Healthcare	Barnsley	Barnsley Hospital NHS Foundation Trust	6027029	73,695
30-Aug-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	324628	71,956
11-Aug-23	Drugs	Trustwide	Lp Hcs Ltd	HCSLP119	67,344
17-Aug-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1000000	64,961
31-Jul-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5125	60,049
15-Aug-23	Purchase of Healthcare	Kirklees	Kirklees Council	8608201339	56,500
21-Aug-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 11209	56,000
04-Jul-23	Purchase of Healthcare	AS Collaborative	Spectrum Community Health Cic	SINV6376	48,868
02-Aug-23	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72485641	47,313
02-Aug-23	Drugs	Trustwide	Edf Energy Customers Ltd	000016199274	42,620
25-Jul-23	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400000720	42,605
24-Aug-23	Computer Hardware	Trustwide	Family Lives	2478	39,709
02-Aug-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001054EPC	35,280
12-Aug-23	Computer Hardware	Trustwide	Vodafone Ltd	104402906	33,800
12-Jul-23	Computer Hardware	Trustwide	Vodafone Ltd	104212358	33,055

31-May-23	Computer Hardware	Trustwide	Cinnamon Digital Applications Ltd	INV127	32,703
04-Aug-23	Computer Hardware	Trustwide	Humber Teaching NHS Foundation Trust	59893328	30,255
31-Jul-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	BLA0300665	29,543
22-Aug-23	Utilities	Trustwide	Leeds & York Partnership NHS Foundation Trust	1000046	28,944
31-Jul-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WKE0300980	28,693
01-Aug-23	Drugs	Trustwide	Ieso Digital Health Ltd	UK001345	28,672
01-Aug-23	Purchase of Healthcare	Trustwide	Cheadle Royal Hospital	2900022762	26,955
01-Apr-23	Purchase of Healthcare	OOA	NHS Providers	0000008164	26,908
02-Aug-23	Mobile Phones	Trustwide	Edf Energy Customers Ltd	000016189594	25,916
04-Jul-23	Advocacy Service	Forensic	St Andrews Healthcare	90124151	25,281
02-Aug-23	MFD	Trustwide	St Andrews Healthcare	90125253	25,281
06-Jul-23	Purchase of Healthcare	Forensic	Voluntary Action Calderdale	INV00741	25,000

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

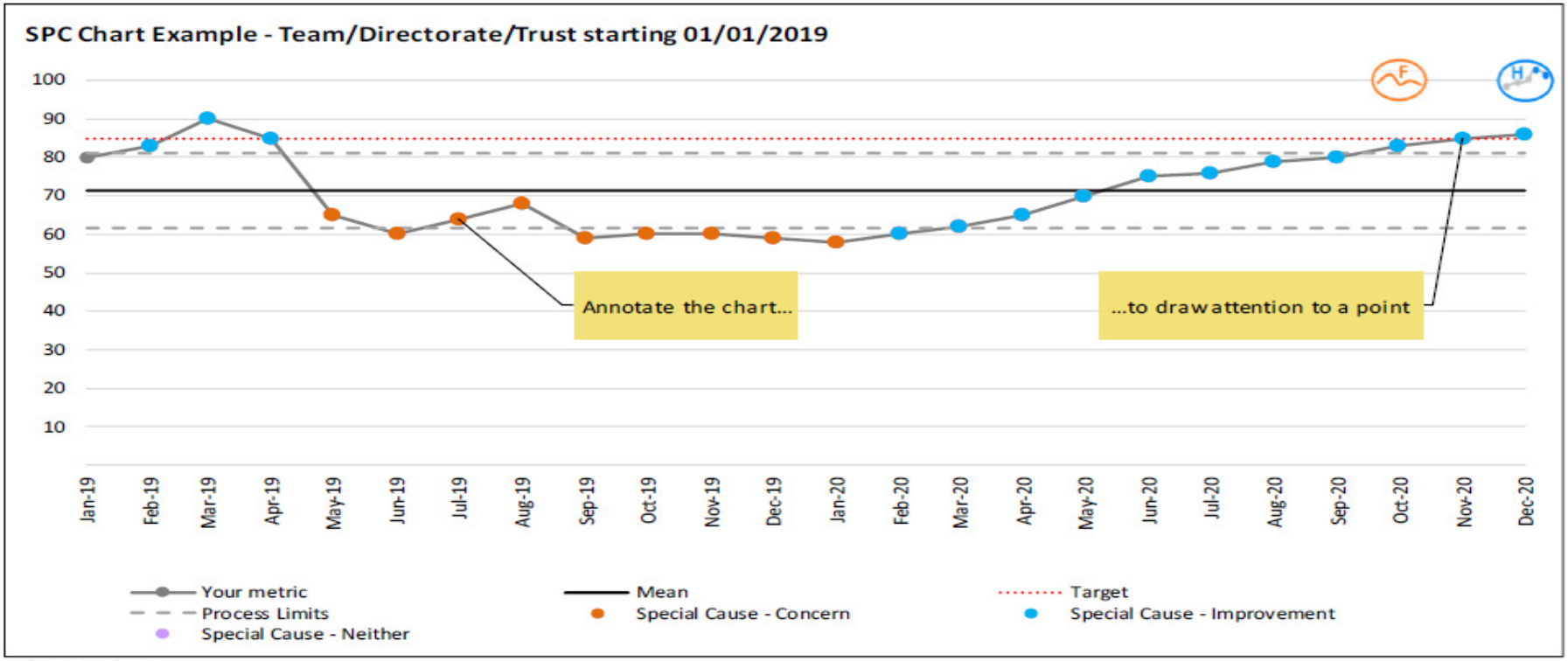
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Trust-wide Incident Management Report - Quarter 1 2023/24**		
Paper presented by:	Darryl Thompson, Chief Nurse & Director of Quality and Professions		
Paper prepared by:	Laura Brook, Datix and Incident Support Manager 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:	This report provides information in relation to incidents recorded in Quarter 1 2023/24 and more detailed information regarding serious incidents. It also provides assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2023/24 deaths. The learning from healthcare deaths section of this report will be published on the Trust website. The report also contains examples of learning from incidents.		
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. Any learning to prevent future risk and avoid harm, specifically in relation to patient safety, can 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:	Quality and Safety Committee and Trust Board have received quarterly and annual Incident Management reports. Quality and Safety Committee recommended this report to Board for approval in September 2023.		

Executive summary:	This report was produced by the Patient Safety Support Team and shows the data for incidents. Data is also available at service line/team level via Datix. All managers have access to Datix dashboards to interrogate data further. Key headlines follow: <u>Incident Management Trust-wide report</u> • The number of incidents reported in Q1 2023/2024 was 3733. • Reporting rates remain within normal variation. • 96% 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. <u>Learning from incidents</u> We have incorporated learning from experience into the report (section 3). This shares the learning from incidents in Q1 2023/2024 and examples of learning in practice. This is a new section, previously this was provided annually and has been changed to enable provision of more current information. <u>Serious Incidents</u> • There were 4 serious incidents reported in Q1 2023/2024. • Serious incidents account for 0.11% of all incidents. • 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 Patient Safety Incident Response Framework (PSIRF). • During Q1 2023/24 there were no 'Never Events'. <u>Learn from Healthcare Deaths</u> • 92 deaths were reported in Q1 2023. • 70 of the 92 deaths were in scope for mortality review. • There are no areas of special cause variation that require further exploration. Quarterly data on deaths is published on the internet page.
Recommendation:	**Trust Board is asked to RECEIVE the quarterly report on incident management.**

South West Yorkshire Partnership NHS Foundation Trust

Trust-wide Incident Management Report

Quarter 1 2023/24

Incorporating Learning from Healthcare Deaths reporting for the period 1 April 2023 to 30 June 2023

Report prepared by Patient Safety Support Team

August 2023

Contents

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust-wide information on incident activity during Quarter 1 2023/24 (01/04/2023 to 30/06/2023) including reported serious incidents, learning from healthcare deaths and learning from experience.

Please note that figures within this report may vary from those in other reports due to re-coding/grading changes of incidents whilst producing the reports from a live system.

This report refers to Care Groups and Business Delivery Units (BDUs), because at the time of data extraction, the Datix system had not been updated to implement the change from BDU to Care Group. This move was completed in July 2023.

The Patient Safety Support Team have recently undertaken the Making Data Count course and are currently reviewing the use of statistical process control (SPC) charts to developing our reporting. Where we were able to in this report, we have included SPC charts. This will be developed further in the Quarter 2 2023/24 report.

2. Incident Reporting Analysis

This report has overall figures for incident reporting. In Quarter 1 2023/24 there were 3733 incidents reported. Incident reporting rates remain within normal variation.

96% of all incidents reported on Datix are classed as “low” or “no harm”. This shows a positive culture of risk management; low or no harm incidents reported indicates action taken proactively at an early stage before harm occurs[1].

Headlines

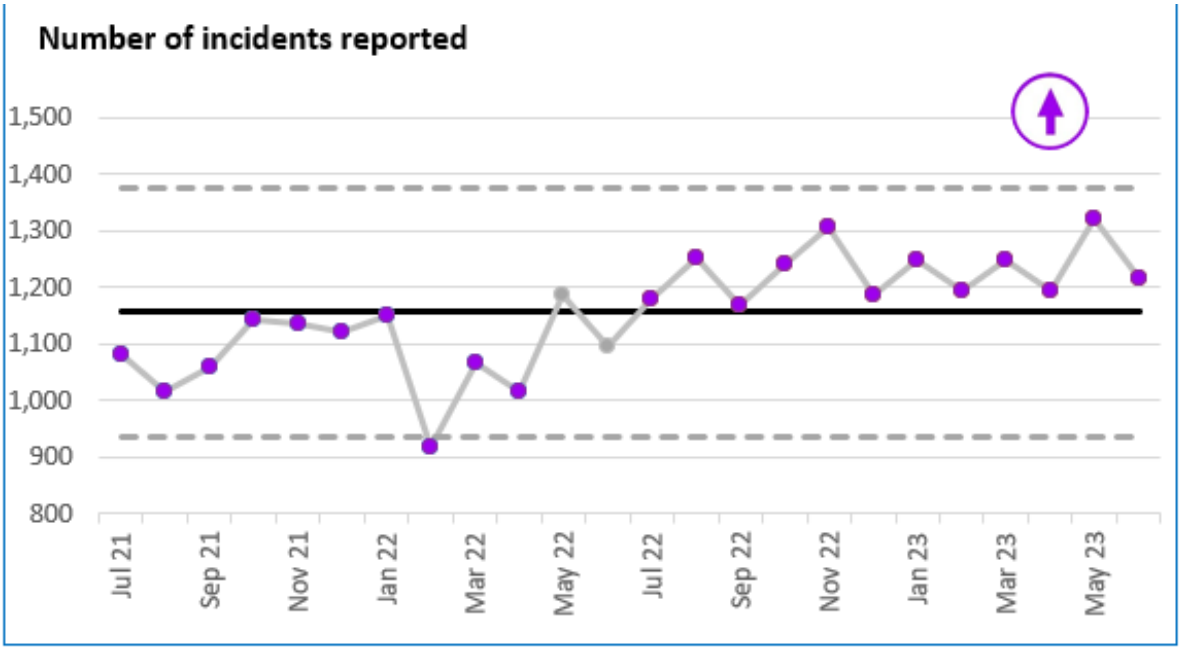
Quarter 1 2023/2024 Headlines

- **3,733** incidents reported
- **Reporting rates remain within normal variation**
- **96%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no / low harm is indicative of a positive safety culture

[1] NaPSIR NHS England 2022

Figure 1 below shows the pattern and number of incidents reported between 1/7/2021 to 30/6/2023 in a SPC chart. This shows that reporting remains within normal variation but rates in more recent months are consistently above the average (mean) for the Trust. Increased reporting of incidents does not in itself bring cause for concern whilst our overall proportion of no harm / low harm sustains and could be attributable to continuing work to raise awareness regarding the importance of reporting incidents. We continue to monitor data on a monthly basis.

Figure 1 Statistical Process Control chart of all incidents reported 1/7/2021 to 30/6/2023.



Severity

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

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

Figure 2 All incidents reported Trust wide between 01/07/2022 – 30/06/2023 by severity and financial quarter.

	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/2024
Green	2376	2477	2435	2575
Yellow	1007	1026	1062	966
Amber	199	219	171	165
Red	19	17	24	27
Total	**3601**	**3739**	**3692**	**3733**

In Figure 2, Quarter 1 has seen a decrease in the number of yellow and amber incidents reported. Analysis of the data shows that on average, we usually see around 28% of all incidents in a quarter graded as yellow, and 5% as amber. In Quarter 1 the figure was 26% yellow and 4% amber. The percentage of each severity against the total for the quarter remains relatively consistent but may appear higher where the total for the quarter is higher. The number of red incidents reported has continued to increase in Quarter 1. The increase in red incidents in Quarter 1 is due to the number of deaths that have been reported (19). The highest category of death was suicide (incl apparent) – community team care – current episode (6) within the quarter. As described above, severity relates to potential risk and actual harm.

The Patient Safety Support Team regularly review red incidents and deaths to ensure that the severity grading is as accurate as it can be when the incident is reported to ensure thorough review (e.g., risk panel) and re-grading occurs as needed when further information is received.

As an example of regrading of incidents, in the Quarter 2 2022/23 incident report, it was reported there were 32 red incidents. This figure has now reduced to 19. This data is live data at the point of producing the report. The incident may be initially graded red for several reasons. An example would be a death (for all healthcare deaths we encourage staff to report on Datix) which later is updated as natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on Strategic Executive Information System (StEIS), it can take some time to get this information. Most red incidents do not meet the criteria for a serious incident (see section 4).

When reviewing incidents by the actual harm caused, 96% of all incidents resulted in no or low harm or were unrelated to care within the Trust. All amber and red incidents are reviewed at weekly Clinical Risk Panel, including details of the manager's 48-hour review, which gives an overview of the summary of care, and enables the manager to raise any early learning, concerns, and good practice. This informs the level of review required and can result in subsequent regrading of incidents.

Please see Appendix 1 for the breakdown of all incidents reported Trust-wide between 01/07/2021 – 30/06/2023 by severity, using statistical process control (SPC) charts to give a context to any variance. The time period that data is reviewed in can affect how it appears, for example quarterly may not reveal a rise in one month's data. Data for red incidents in Quarter 1 is special cause variation, however, we do expect this for the reasons described earlier.

Figure 3 shows the severity breakdown for Quarter 1 by Care Group (where possible we have tried to align BDU's to Care Groups).

Direct comparisons between Care Group data should be viewed with caution as it does not provide a like for like comparison.

Figure 3 All incidents reported Trust wide between 01/04/2023 – 30/06/2023 by severity and care group.

Care group	BDU	Green	Yellow	Amber	Red	Total
Mental health inpatient and community care group	Mental Health Inpatient Services	1161	486	45	3	1695
	Kirklees Community Mental Health Services	76	32	5	7	120
	Wakefield Community Mental Health Services	60	20	6	2	88
	Calderdale Community Mental Health Services	42	25	8	2	77

Forensic care group	Forensic Service	409	205	20	1	635
Barnsley Integrated care group	Barnsley General Community Services	484	83	65	6	638
	Barnsley Community Mental Health Services	70	36	6	5	117
Learning Disability and Adult ASD/ADHD care group	Learning Disability services	197	48	6	1	252
	ADHD and Autism services	0	0	0	0	0
CAMHS and Children's care group[2]	CAMHS Specialist Services	51	22	1	0	74
Trust wide (Corporate support services)		25	9	3	0	37
	Total	**2575**	**966**	**165**	**27**	**3733**

Type and Category of incidents

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

The Patient Safety Support Team review incident data monthly through the production of the Integrated Performance Report (IPR) and clinical risk report for Operational Management Group (OMG). Where any potential changes in incident reporting patterns are identified, these are raised with the relevant specialist advisor for investigation and/or explanation, as they also review patterns and trends. The team has dedicated time to review incident types using statistical process control to look for changes in data.

[2] Barnsley Children's services current remain within Barnsley General Community Services

Figure 4 Type of incident reported in Quarter 1 by Care Group.

Care group	Barnsley Integrated care group		Mental health inpatient and community care group				Forensic care group	Learning Disability and Adult ASD/ADHD care group		CAMHS and Children's care group[1]	Trust wide (Corporate services)	**Total**
	Barnsley Community Mental Health Services	Barnsley General Community Services	Calderdale Community Mental Health	Kirklees Community Mental Health	Wakefield Community Mental Health	Mental Health Inpatient	Forensic Service	Learning Disability services	ADHD and Autism services	CAMHS Specialist Services		
Violence and Aggression	9	8	12	15	15	569	310	174	0	11	4	**1127**
Care Pathway, Clinical and Pressure Ulcer Incidents	21	413	7	5	9	79	9	4	0	8	0	**555**
Self-Harm	13	28	10	9	11	298	51	3	0	1	0	**424**
Medication	20	62	6	24	5	159	30	10	0	1	14	**331**
Health and Safety (including fire)	7	24	6	8	7	102	39	16	0	2	6	**217**
All Other Incidents	2	16	4	3	1	102	58	2	0	5	4	**197**
Slips, Trips and Falls	0	20	4	2	2	98	10	2	0	1	2	**141**
Legislation and Policy	1	1	1	3	0	102	14	12	0	0	0	**134**
Safeguarding Adults	3	24	9	12	12	28	21	9	0	0	0	**118**
Security Breaches	1	9	2	2	5	27	55	3	0	5	2	**111**
Death (including suspected suicide)	23	6	12	19	11	3	1	8	0	0	0	**83**
Missing/absent service users	0	0	0	1	0	57	10	1	0	2	0	**71**
Information Governance Incidents	6	14	1	7	6	8	4	5	0	11	2	**64**
Sexual Safety incident	1	0	1	0	1	44	16	0	0	0	0	**63**
Safeguarding Children	6	6	2	5	1	1	2	0	0	23	0	**46**
IT Related Issues	2	0	0	5	2	7	2	2	0	4	2	**26**
Infection Prevention/Control	2	7	0	0	0	11	3	1	0	0	1	**25**
Total	**117**	**638**	**77**	**120**	**88**	**1695**	**635**	**252**	**0**	**74**	**37**	**3733**

Figure 5 Trust-wide Top 10 most frequently reported incident categories (01/07/2022 – 30/06/2023)

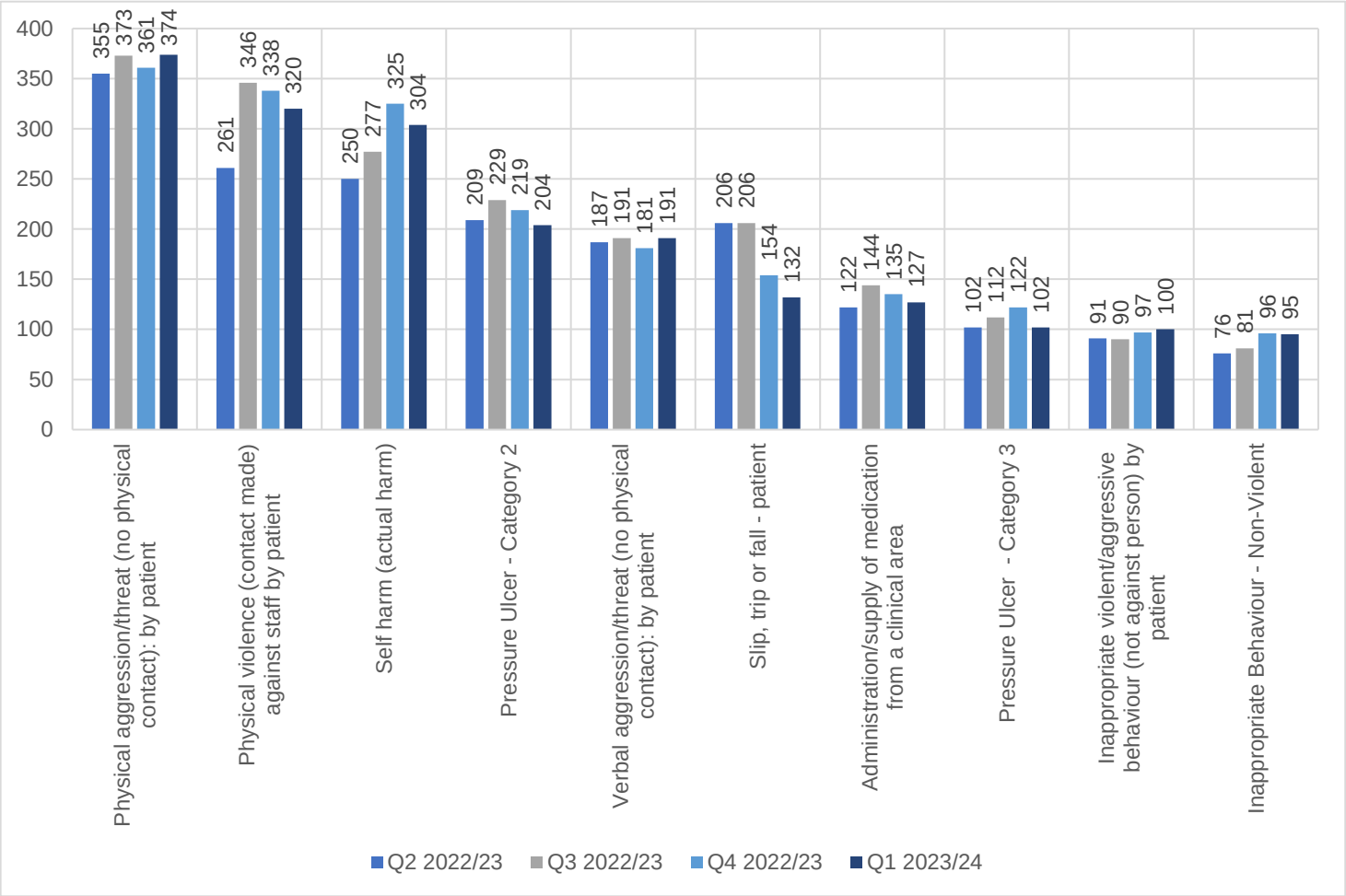


Figure 5 shows that in Quarter 1 2023/24, physical aggression/threat (no physical contact) by patient remained the highest reported category of incident. This represents incidents where violence and aggression incidents did not escalate to the point of physical contact and when analysed further, this was primarily attempted violence by patients towards staff. This varies across teams, with some seeing increases (often due to individual patient presentation) and other areas have reduced.

The second highest category is 'physical violence (contact made) against staff by patient – the last three quarters have been higher, again affected by individual patient presentation and clinical acuity.

The third highest category of incident is 'self-harm (actual)'. Self-harm data has been explored through the Patient Safety Incident Response Framework (PSIRF) Implementation Groups to identify where we need to identify new learning, and what improvement work may be required going forward.

Category 2 Pressure ulcers remain in the top 10 reported incidents, and analysis of these incidents shows that 56 of the 204 incidents developed under the care of the Trust (27%). Of the remaining 148 incidents, 142 incidents developed under other providers' care (care home/acute hospital) or in the patient's own home (six were pending further information at the time of reporting). These are reported on Datix to enable thorough review of our care, capturing our actions taken and escalation to the responsible organisation where required. There are a further six pressure ulcer incidents currently pending updates. This is similar

with Category 3 pressure ulcers; of the 102 incidents, 44 developed under the care of the Trust (43%), and 56 under other providers/own home. There are a further two pressure ulcer incidents currently pending updates. Please note, all pressure ulcers that develop whilst the person is in the care of the Trust are reviewed using a root cause analysis model, to ensure any lapses in care are identified. Lapses in care are currently reported in the Integrated Performance Report. This will change with the introduction of PSIRF where the Trust will introduce new tools to help screen for system issues and new learning opportunities.

Patient falls reduced in the last two quarters; most falls relate to patients falling on level surfaces, being found on the floor, or falling from their bed or chair. Analysis by our falls specialist revealed that a high number of incidents were attributable to a very small number of individuals on older people's wards.

Reporting to National Reporting and Learning System

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 since 2004. All Patient Safety Incidents go through an internal management review and governance processes before being uploaded to NRLS. Data can also be refreshed if details change.

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

Patient Safety Incidents do not include non-clinical incidents, or where staff were the affected party (e.g., violence against staff incidents). These are not reportable to NRLS as the harm/potential harm was not to a patient. The NRLS scores the **actual** degree of harm caused, as opposed to including potential harm as collected locally via Severity.

As reported previously, 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)

NHS England have 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 be in the process of completing the transition to LFPSE - this will be implemented following thorough testing.

The upgrade to the test system with the enhanced LFPSE functions took place on 17/07/2023. There remain issues nationally with Datix and the LFPSE functionality which will be resolved by the timescales given above for trusts to transition to LFPSE. The upgrade was scheduled to take place on 24 August; however this was suspended on the day by

[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.

RLDatix Ltd due to technical issues. The live upgrade remains pending release by RLDatix Ltd.

In Quarter 1, 2,129 incidents were reported to the National Reporting and Learning System compared to 1,530 in Quarter 4 2022/23.

3. Learning from incidents

This section of the report provides links to our summary of learning examples in Quarter 1 2023/2024. This is a new introduction to this quarterly report, previously only seen annually. We are aiming to prepare quarterly as an ongoing process.

Learning from incidents presentation

Appendix 3 gives an illustration of our learning presentation that brings together some of the learning from Quarter 1 2023/2024. The full set of slides are available here. Previous reports are also available on this page.

4. Trust-wide Serious Incident (SI) Report[4]

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." [5]

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

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

- the unexpected or avoidable death of one or more patients, staff, visitors, or members of the public
- serious harm to one or more patients, staff, visitors, or members of the public or where the 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*[6].

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

National Update

The NHS Patient Safety Strategy[7] was published in July 2019. This sets out how the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)

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

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

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

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

- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

There are three major changes arising from the NHS Patient Safety Strategy relating directly to incident reporting and management. Both projects were delayed during COVID-19 but now underway. These are:

- Learn from Patient Safety Events (LFPSE) – this will be a new section of Datix incident reporting system and will replace NRLS and StEIS systems. Please see information in this report in the section Reporting to National Reporting and Learning System for further information.
- Patient Safety Incident Response Framework (PSIRF) - will replace the Serious Incident Framework. We are working on preparing for implementation in line with the framework preparation phases and anticipate we will go live late Autumn 2023.
- Patient Safety training – Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 will become mandatory from November 2023. This is currently at 86% compliant. Level 3 training (investigation and oversight) is currently being delivered for those in specialist roles. Training on engagement and involvement of those affected by patient safety incidents will be available later in the year.

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 such as where significant care and service delivery issues are identified.

Serious Incidents reported during Quarter 1 2023/2024

Headlines

During Quarter 1 2023/24, there were **four serious incidents reported** to the relevant commissioning body (e.g. integrated care boards (ICB), provider collaborative) via the NHS England Strategic Executive Information System (StEIS) as shown in figure 6.

Quarter 1 2023/2024 Headlines

- 4 serious incidents reported
- Serious incidents account for 0.11% of all incidents
- No homicides
- No Never Events

Never Events[8] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no 'never event' incidents reported by the Trust in Quarter 1 2023/2024. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 01/02/2018. This is available on the Trust intranet.

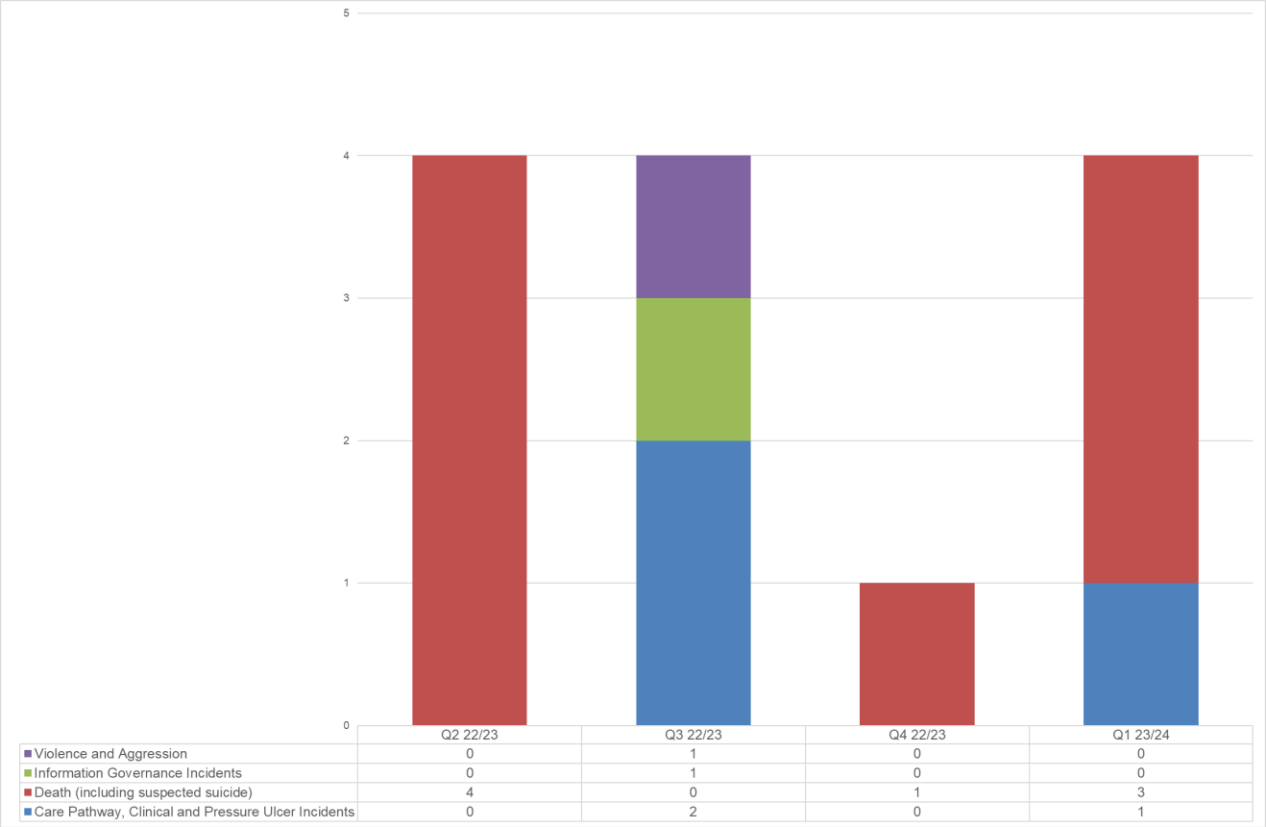
Figure 6 Serious incidents (StEIS) reported to commissioners by financial year and quarter up to 30/06/2023 (2019/20 – 2023/2024)

Financial Quarter	19/20	20/21	21/22	22/23	23/24
Quarter 1	12	8	8	6	4
Quarter 2	12	10	5	4	
Quarter 3	8	8	8	4	
Quarter 4	15	6	1	1	
Total	47	32	22	15	4

Figure 7 shows a breakdown of the 13 serious incidents in a rolling 12-month period (01/07/2022 to 30/06/2023) by the type of incident and the month reported. The number of SIs reported in any given period can vary and given the relatively small numbers involved and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However, it is important that any underlying trends or concerns are identified through analysis.

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

Figure 7 Types of All Serious incidents reported on STEIS in the 12-month period (01/07/2022 – 30/16/2023)



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

Figure 8 Serious incidents reported by team and care group during Q1 2023/2024

	Adult and Older People Care Group - Community	Adult and Older People Care Group - Inpatient	Barnsley Integrated Care Group	Total
Beechdale Ward, The Dales Unit	0	2	0	**2**
Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale	1	0	0	**1**
Neighbourhood Team - North East (Barnsley)	0	0	1	**1**
Total	**1**	**2**	**1**	**4**

Figure 9 Serious incidents reported by category and care group during Q1 2023/2024

	Adult and Older People Care Group - Community	Adult and Older People Care Group - Inpatient	Barnsley Integrated Care Group	**Total**
Suicide (incl apparent) - inpatient care - current episode	0	1	0	**1**
Suicide (incl apparent) - inpatient care - discharged	1	0	0	**1**
Death - confirmed from infection	0	1	0	**1**
Pressure Ulcer - Category 3	0	0	1	**1**
Total	**1**	**2**	**1**	**4**

Serious Incident Investigations completed during Quarter 1 2023/2024

This section of the report focusses on the serious incident investigation reports that were completed and submitted to the relevant commissioners during Quarter 1 2023/2024. Please note this is not the same data as those incidents reported in this period as investigations take several months to complete. The term 'completed' is used in this section to describe this.

Headlines

- **5** SI Investigation reports have been completed
- **3** SI investigations closed by the commissioners
- **12** SI investigations remained under investigation (as at 03/07/2023)
- From the completed investigations, the top action themes were:
  1 Communication
  2 Staff education, training & supervision
  3 Carers/family

The Trust works to the national guidance on serious incident reporting and management (Serious Incident Framework 2015, NHS England) which will cease when we are live with Patient Safety Incident Response Framework later this Autumn. The 2015 framework included a 60 working day timescale for completion of investigations. However, during the

COVID-19 pandemic, this timescale was suspended by NHS England and this remains in place. Instead, we have been advised to move towards agreeing timescales with families, in line with the new requirements with the new Patient Safety Incident Response Framework (PSIRF).

We try to complete SI investigations in a timely manner; however, we have the support of commissioners to complete a quality report above a timely report. The Trust requests extensions from commissioners where required to agree revised dates and the investigators also keep families informed.

Of the 12 investigations that are underway (as at 03/07/2023), these are at different stages of progress. This is reported weekly into Clinical Risk Panel and progress is monitored at the weekly investigator meeting. Six of the 12 cases under investigation remain within the 60 working day timeframe. The other six cases have passed the 60 working days for a number of reasons, including family engagement in the SI process, including listening to the family's voice to defer discussions about investigation process until after anniversary dates, and ensuring families have sight of the draft report before organisational approval; absence within the team, newly recruited investigators and sign off process. Families are kept informed of any delay.

Staff support

There are a range of support mechanisms in place to support staff involved in or affected by serious incidents. The service has the responsibility to provide support, this is explored through the investigation process and any unmet needs are shared with the service.

Our staff support arrangements will be reviewed as part of our preparations for the Patient Safety Incident Response Framework that will go live in Autumn 2023. We are currently reviewing the documentation.

Serious Incident learning and themes

During Quarter 1 2023/24, five investigations were completed and sent to commissioners. There were 19 separate actions made to improve the system or process to prevent recurrence. All five investigations took longer than the 60 working days to complete.

This number of actions excludes a standard recommendation to share learning. This is to support learning being shared across the teams, service, care group, Trust, and wider health economy. These recommendations have been removed from the analysis below.

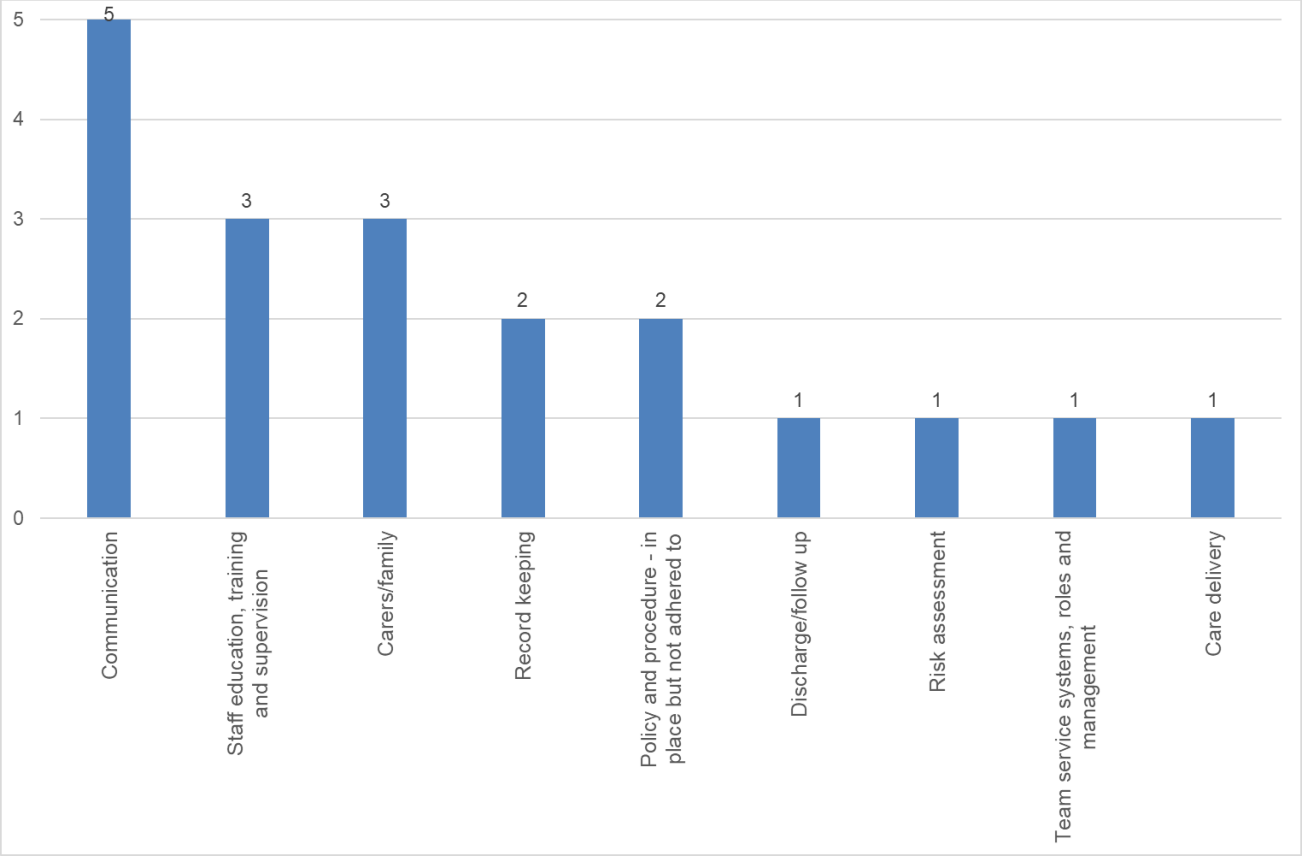
Categorisation of recommendations/actions

In analysing the actions, it is not always straightforward to identify which theme an action should be included in - some do not easily fit into any theme, and some could be included under more than one. The analysis undertaken has included each action under the issue/theme that seemed the best match. To gain consistency, the theming of actions is undertaken by the Lead Serious Incident Investigators.

Many actions take some time to implement. These are monitored through the Operational Management Group and Care Group governance groups.

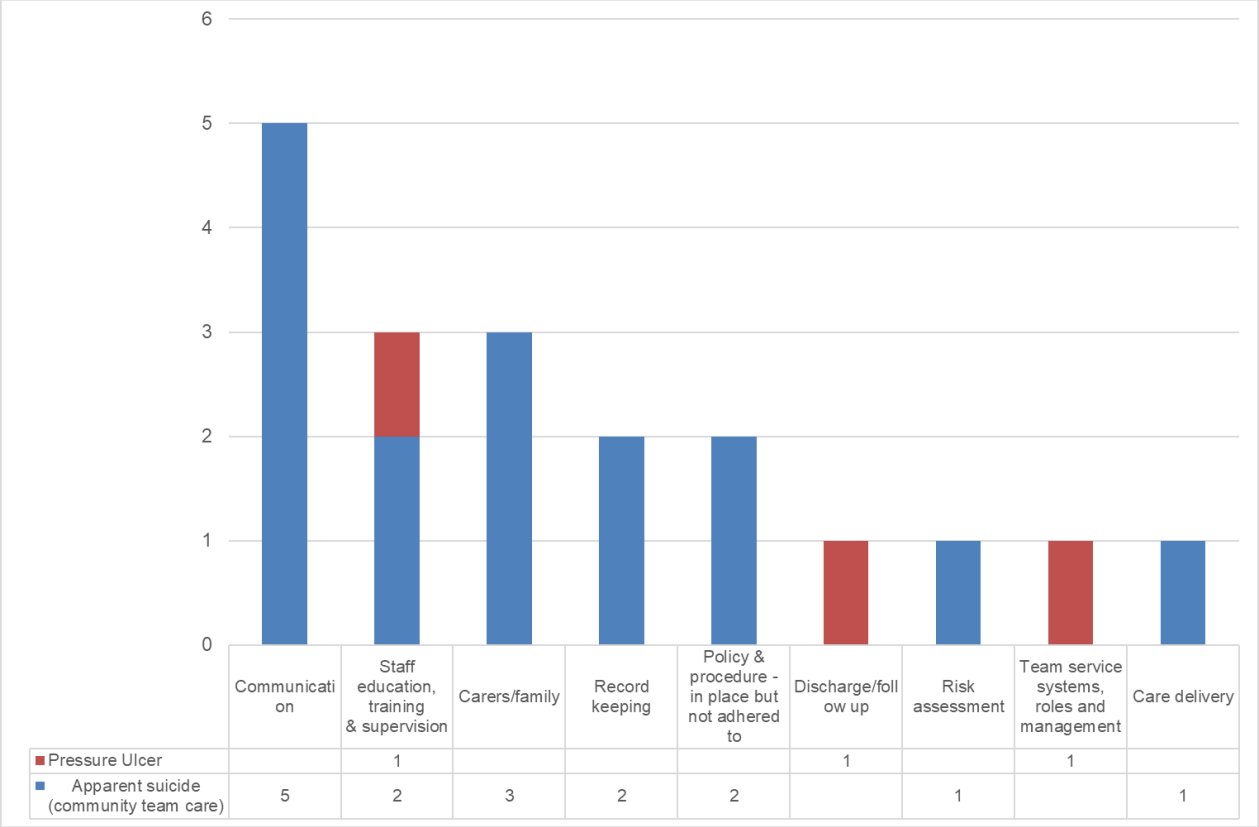
Figure 10 shows the action themes arising from the five serious incidents completed and sent to commissioners during Quarter 1 2023/2024.

Figure 10 Quarter 1 2023/2024 completed Serious Incident investigations, by action theme.



As shown in Figure 11, 16 of the actions came from investigations into apparent suicides (four cases). The themes from these are shown in the graph.

Figure 11 Comparison of action themes from completed Serious Incident investigations in Quarter 1 2023/2024, by action theme and serious incident type.



Top themes this quarter:
An overview of recommendations from serious incident investigations completed in Q1, are detailed below by action theme:

Communication	
Discharge planning	The ward should review their process for ensuring community teams are invited to the ward review, especially where a decision to discharge is anticipated. This should be done via a phone call to the community team or using the generic community team email with attendance to be confirmed by the community team. In the exceptional case of a community team being unable to attend in person or via Microsoft Teams, the community team must provide the ward with a view to discharge prior to the Multi-Disciplinary Team (MDT) meeting.
	It is good practice that community team members of staff should use the out of office facility on their email when away from the office.
Relevant records from internal/external services not shared	It is recommended that there is a review of SWYPFT services in respect of data access and sharing to ensure that information about service users can be easily shared with our neighbouring Trusts. This could be electronic sharing or local sharing agreements so that information can be obtained in urgent cases such as this.

	It is recommended that there is a review of the process when a service user is being discharged back to the Trust's care from another Trust or healthcare provider, to ensure all information is received to assist in the formulation of risk assessments and care planning. This learning will also be shared with the hospital in Norfolk.
Record keeping	Where it has not been possible to involve family and carers in discharge planning the reasons should be recorded in the clinical record.

Staff education, training, and supervision	
Tissue viability	Wound Assessment Training for categories and how to document arranged/planned
Safeguarding	It is recommended that the workforce would benefit from bespoke domestic abuse training, in particular to increase awareness and understanding in regard to the dynamics of an abusive relationship and insight to the complexities of this and associated risks.
Risk assessment	It is recommended that further training with respect to collaborative assessment of suicide risks is undertaken. The investigator acknowledges that care was taken to record the risk of suicide.

Carers/family	
Involving Service User and Families and Carers in Care Planning	It is recommended that family are engaged proactively at key points through the journey with mental health services and they are aware of an individual's risks and how to access support.
	It is recommended that family are engaged proactively at key points through the journey with mental health services, including when seeking an inpatient bed.
	It is recommended that family are engaged proactively at key points throughout the person's journey with mental health services, including when seeking an inpatient bed or when a person is discharged into a community mental health team.

Record keeping	
Communication with other agencies	It is recommended that when teams are communicating with external agencies such as the police or another Trust, a clear rationale for decisions made with respect to an individual's care is documented.
Contemporaneous recording	When an inpatient has been missing and is returned to the ward there must be a thorough review of the reasons the person failed to return, and where appropriate care plans should be reviewed.

Policy and procedure - in place but not adhered to	
CPA policy	It is recommended that there is a review of the process of caseload management, including when staff members are off sick.
Risk assessment	It is recommended that the service review the caseload of the IHBTT team to ensure that even with a high caseload, policy in respect of carer and family engagement and FIRM risk assessment can still be adhered to and Trust quality standards maintained. This can be achieved through audit and supervision.

Discharge/follow up	
Discharge Planning	Liaise with acute Trust re - discharge planning

Risk assessment	
Training	It is recommended that the IHBTT team revisit the FIRM risk assessment training to ensure that they understand that it is a framework for staff to use, to record clinical judgements about risk and to inform management and care plans.

Team service systems, roles and management	
Allocation of tasks	Allocation of visits/tasks to Registered Nurse due to intensity of wounds.

Care delivery	
Communication with patient and/or family/carers	It is recommended that the service user's voice is heard, considered and recorded, including when referring onwards or considering discharge from the service.

Learning and Improvement

We have developed methods of sharing actions from SI investigations with policy leads to aid changes that may be required:

- Investigators contact policy leads to raise issues and discuss when identified
- Data from all themes from actions is extracted from Datix on a three-monthly basis as a data resource for policy leads to use through the Trust's Clinical Policy Ratification Group.
- As part of the implementation of the Patient Safety Incident Response Framework from late Quarter 2 2023/24, we will monitor the outputs from learning responses.

Top themes

There are ongoing pieces of work in the Trust to address some of the SI themes including the Risk Assessment and Care planning improvement group.

The Patient Safety Incident Response Framework (PSIRF) implementation by Autumn 2023 will bring the requirement to have clear improvement plans for specific areas which may include areas such as themes from SIs.

5. Learning from Healthcare Deaths Report - Annual Cumulative Report 2023/2024 (covering the period 1/4/2023 – 30/6/2023)

5.1 Background context

5.1.1. Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. In line with the National Quality Board report published in 2017, the Trust has 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.

Nationally, most people will be in receipt of care from the NHS in the weeks, months or years leading up to their death. However, for some people, their experience is of 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 is 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.

5.1.2. Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting.

The Trust Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed. Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

In scope deaths should be reviewed using one of the 3 levels of scrutiny:

1	Death Certification	Details of the cause of death as certified by the attending doctor.
2	Case record review	Includes: (1) Managers 48-hour review (2) Structured Judgement Review
3	Investigation	Includes: Service Level Investigation Serious Incident Investigation (reported on STEIS) Other reviews e.g. LeDeR, safeguarding.

5.2 Annual Cumulative Dashboard Report[9] 2023/2024 covering the period 1/4/2023 – 30/6/2023

Figure 12 Summary of 2023/2024 Annual Death reporting by financial quarter to 30/6/2023

Reporting criteria		2022/ 2023 total	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	2023/ 2024 Total (to date)
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[10]	2918	511				**511**
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	379	92				92
3	Total Number of deaths which were in scope	253	70				70
4	Total Number of deaths reported on Datix that were not in the Trust's scope	126	22				22

As shown in Figure 1, row 2 shows that 92 deaths were reported on Datix during Q1 2023/2024. Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the 3 levels as described earlier.

Figure 2 below shows an SPC chart of all reported deaths (by reported date) between 1/4/2021-30/6/2023. There is natural variation in the data as you would expect. There are no areas of special cause variation that require further exploration.

[9] Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

Figure 13 Statistical Process Control Report of all deaths reported 1/4/2021 – 30/6/23 by date reported.

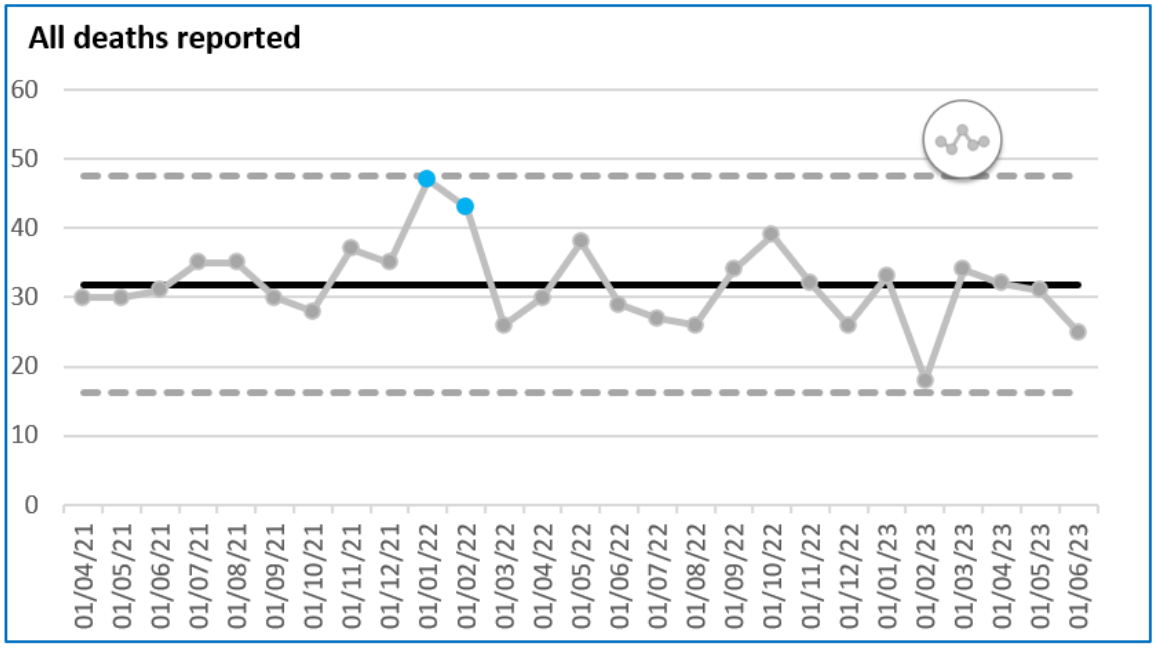


Figure 14 Breakdown of the total number of in scope deaths reviewed in 2023/2024 by care group by financial quarter.

Financial quarter - date reported	Barnsley Integrated Care Group	Adults and Older People Mental Health Care Group	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	CAMHS and Children services	Total
2023/2024 Q1	19	42	8	1	0	70
2023/2024 Q2						
2023/2024 Q3						
2023/2024 Q4						
Total	19	42	8	1	0	70

The Trust reports the death of any patient with a Learning Disability to the Learning Disability Mortality Review Programme (LeDeR). It should be noted that the figures may not tally with the figures above by Care Group. This is because the Trust identifies learning disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for in the Trust.

Figure 15 Summary of total number of all in scope deaths in 2023/2024 to the end of Quarter 1 by the respective mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation			
	Death certified	Manager's 48-hour review	Structured Judgment Review	Serious Incident Investigation	Learning Disability Death process (LeDeR)	Other review	Total
2023/2024 Q1	25	28	6*	3	9	0	70
2023/2024 Q2							
2023/2024 Q3							
2023/2024 Q4							
Total	25	28	6*	3	9	0	70

*One Structured Judgement review was also reported to LEDER.

Figure 4 above shows the total number of all in scope deaths in 2023/24 to date. The number of deaths in scope for Q1 (n=70).

There was one Structured Judgement Review in Q1 which was also reported to LeDeR.

In line with national reporting of deaths, we separate our reporting of in scope deaths into learning disability deaths and all other deaths.

Learning Disability deaths

Figure 5 below shows number of learning disability deaths and their status of being reported to the Learning Disability Review Programme (LeDeR).

Figure 16 Summary of total number of in scope deaths in 2023/2024 by the Review process (excluding Learning Disability deaths)

	Learning Disability Death process (LeDeR)
2023/2024 Q1	9
2023/2024 Q2	
2023/2024 Q3	
2023/2024 Q4	
Total	**9**

Of the nine learning disability deaths which were reported on LEDER, all had the manager's 48 hour review completed. Six deaths were certified at time of reporting. One death also has a Structured Judgement Review underway.

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not have a learning disability and what level of review was completed. All deaths reported have the manager's 48 hour review completed to ensure we have considered the care and treatment we have

provided leading up to a death, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 17 Summary of total number of in scope deaths in 2023/2024 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation		
	Death certified	Manager's 48-hour review	Structured Judgment Review	Serious Incident Investigation	Other review	Total
2023/2024 Q1	25	28	5	3	0	**61**
2023/2024 Q2						
2023/2024 Q3						
2023/2024 Q4						
Total	25	28	5	3	0	**61**

Inpatient deaths

Figure 7 below shows that over the year 2023/2024 to date, there were four inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services.

Figure 18 Trust wide Inpatient deaths in 2023/2024 by date reported.

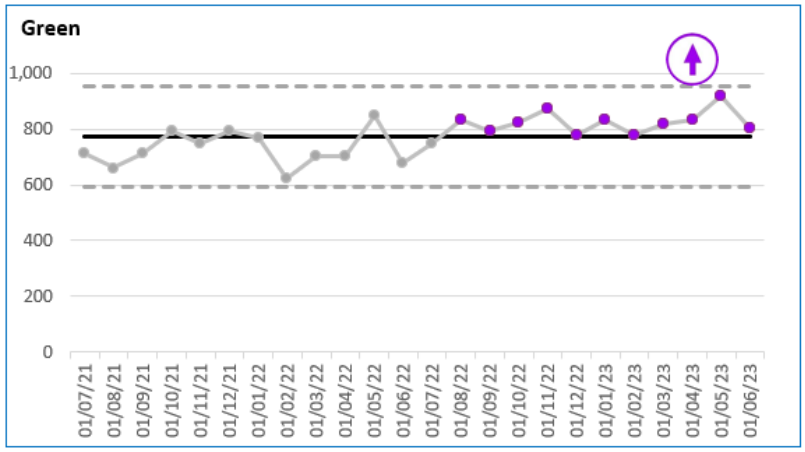
Care Group	Ward	Financial quarter - date reported				Total
		2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	
Adults and Older People Mental Health Care Group (Inpatient)	Beechdale Ward, The Dales Unit	1				**1**
	Ward 19 (OPS)	1				**1**
	Ashdale Ward	1				**1**
Forensic Services Care Group	Johnson Ward	1				**1**
Total		**4**				**1**

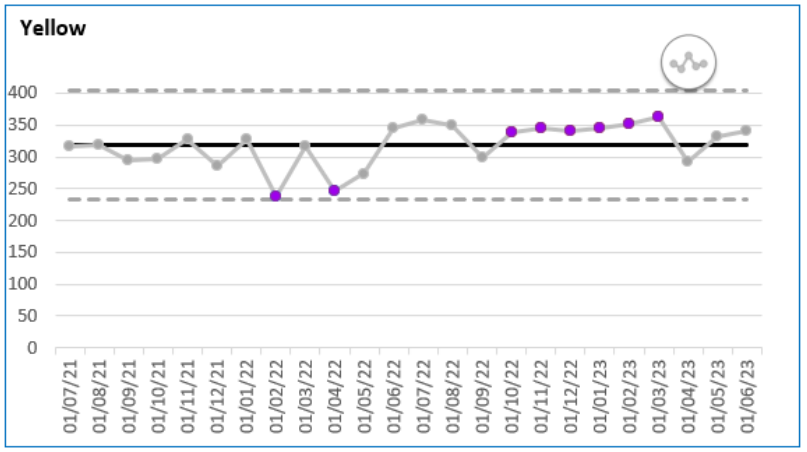
5.3 Next Steps

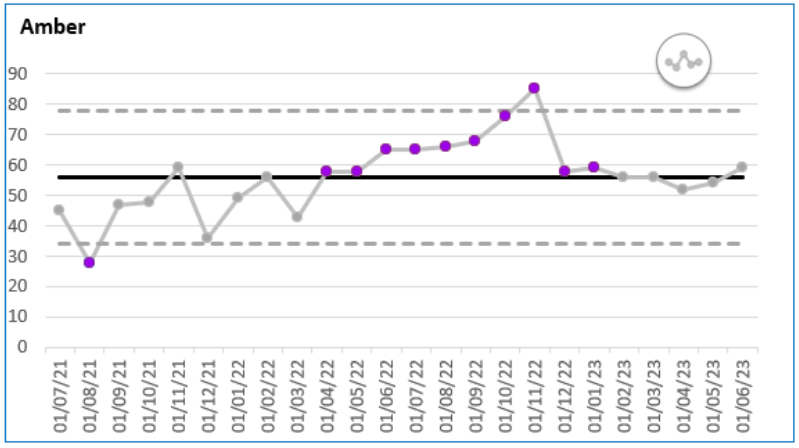
The Trust's work to support learning from deaths continues, and includes:

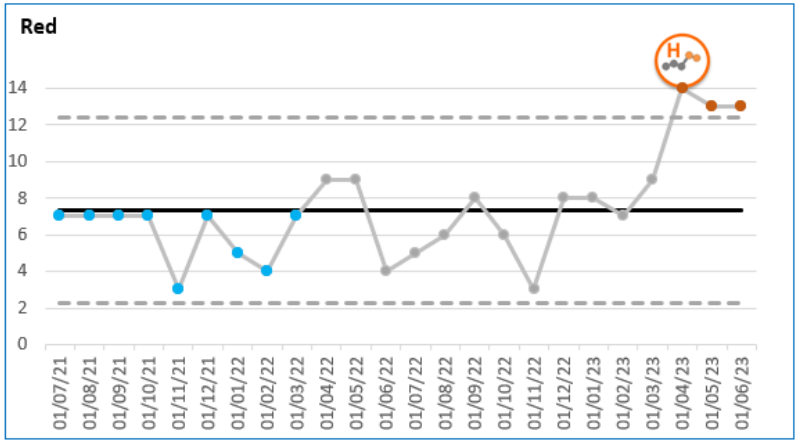
- The recently appointed Family Liaison Professional commenced in post in August 2023. This role will focus on engaging, involving and supporting bereaved families through the incident learning response and investigation process and ensuring families are linked into the support of the coroner's court.
- We are attending Regional Mortality Meetings hosted by the Improvement Academy and Northern alliance of mental health trusts to share best practice in relation to the scrutiny/review/learning from deaths.
- We will be reviewing our Learning from Deaths policy to reflect the upcoming implementation of the Patient Safety Incident Response Framework.

Appendix 1 – Statistical Process Control charts for all incidents reported Trust wide between 01/07/2021 – 30/06/2023 by severity









Although graph 4 (red incidents) shows special cause variation in recent months, this is expected. We usually see a higher number before incidents are re-graded as more information comes to light and are reflected in grading changes in the live Datix system.

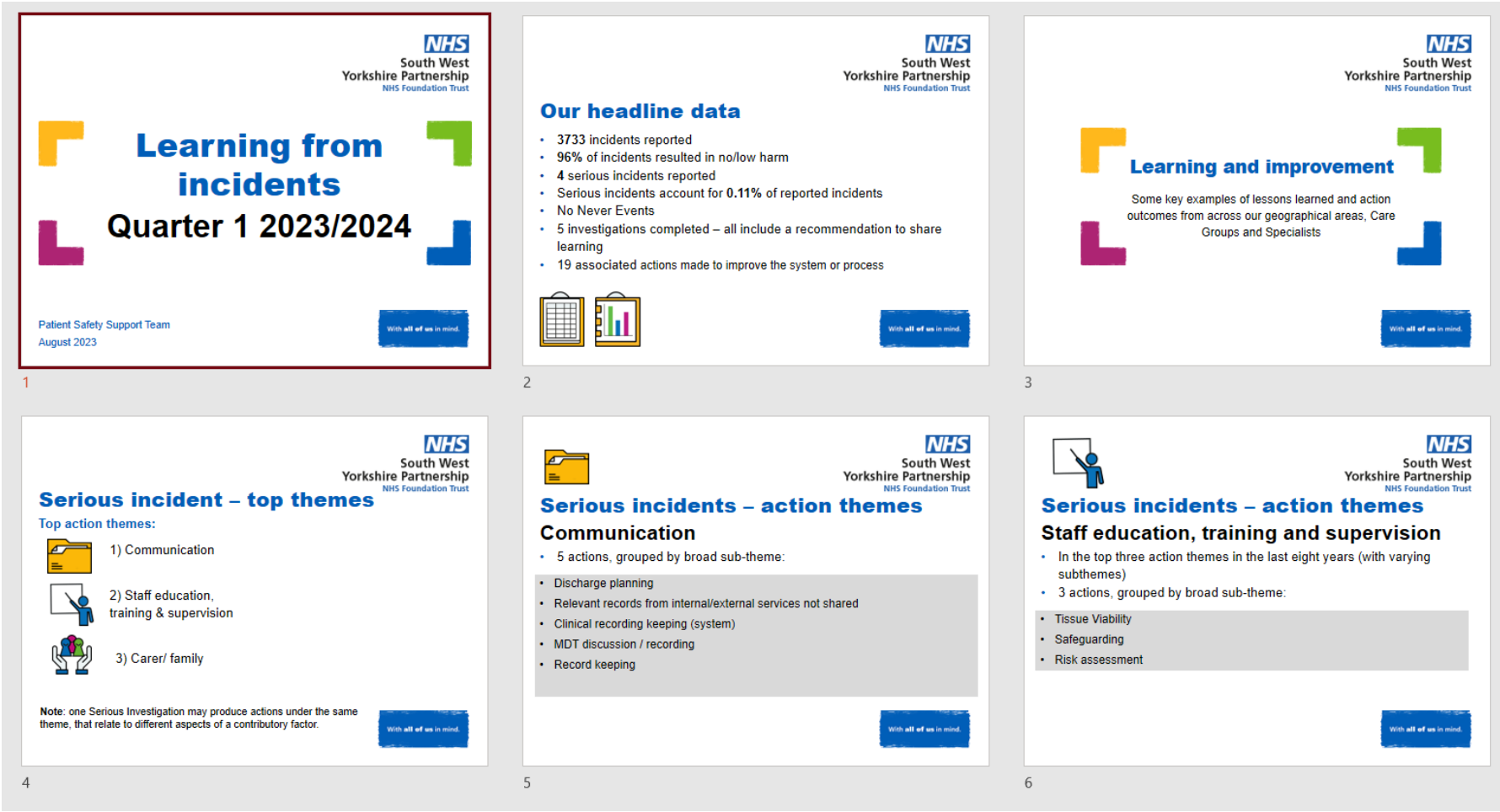
Appendix 2 – Learning Library summaries Quarter 1 2023/2024

Title	Summary
SBAR police portal Update June 2023	The Police Partnership Intelligence Portal has been developed by West Yorkshire Police to submit information (soft intelligence) about criminality that partners feel would be of interest.
SBAR Lewisham Safeguarding Adults Review	**Please note, some of the content of this SBAR may be distressing.** In November 2022, Lewisham Safeguarding Adults Board (SAB) published a Safeguarding Adults Review into the death of a 93-year-old woman who was residing in a local care home at the time of her death. The Care Act 2014 requires SABs to carry out Safeguarding Adults Review: • when there is reasonable cause for concern about how partner organisations worked together to safeguard the adult •and a) the adult died, and the SAB knows or suspects that the death resulted from abuse or neglect, • or if b) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect. The overall purpose of a Safeguarding Adults Review is to promote learning and improve practice.
SBAR Choking as a form of self-harm	There has been a recent increase of incidents, where service users are using choking as a form of self-harm, this is not just food.
SBAR Seclusion and Safety Pod	A service user with a diagnosis of dementia presented with a significant and immediate risk of violence and aggression to others requiring a period of seclusion on two separate occasions. During both episodes of seclusion, the service user was enabled to sleep on the safety pod rather than using a seclusion mattress however the decision-making process for this was not clearly articulated within the clinical records.
SBAR Management of Physical Health Care Plans on SystmOne during an inpatient admission	A patient was admitted to an acute trust with a category two pressure ulcer. They were not discharged from the neighbourhood nursing team caseload and subsequently did not receive timely intervention upon discharge.
SBAR Learning Library Ealing thematic child safeguarding practice review	A thematic child safeguarding practice review - child and adolescence mental health was conducted by Ealing safeguarding children partnership board. The review was created to consider three cases involving adolescent self-harm, alongside young people involved within the partnership reporting daily struggles with their mental health.

SBAR Referral process improved by PDSA cycle	The Kirklees Admiral Nursing Team have recently been undertaking a small but significant Quality improvement project with an aim of reducing the number of days taken from receiving a referral to completing an initial assessment.
SBAR Adults who are not brought to appointments	Most adults who access Trust services have a choice around whether to engage with appointments. However, some adults that use our services may: • Lack capacity to make decisions about attending appointments • Rely on others to inform them of/arrange their appointment (e.g., if they are unable to read a letter or speak on the phone) • Rely on others to support them to attend an appointment (e.g., they are unable to attend without support due to a physical disability) All staff need to be aware that service users who meet any of these criteria and 'do not attend' appointments may have not been able to attend without appropriate support.

Appendix 3 – Learning from incidents slides

Below is an illustration of our Learning presentation that brings together some of the learning from Quarter 1 2023/2024. The full set of slides are available here along with previous years learning.



Serious incidents – action themes

Carer/ family

- 3 actions, grouped by broad sub-theme:

- Discharge planning
- Relevant records from internal/external services not shared
- Record keeping

7

Learning from Serious Incidents

Outcomes from Serious incident investigations highlighted that there are areas for continued improvement around the themes of family engagement, FIRM risk assessment, training and communication.

8

Learning from Serious Incidents

Outcomes from Serious incident investigations highlighted:

- That there was a need for additional training within our community teams in respect of Wound assessment for categories and how to document.
- That there was a need to liaise with our colleagues within acute trusts in respect of discharge planning.
- Multi-disciplinary team meeting discussions should be documented with outcomes added to SystmOne records.
- That further training with respect to collaborative assessment of suicide risks is undertaken.

9

Learning from Serious Incidents

- That rationale for decisions made with respect to an individual's care are clearly documented, particularly when communication with external partners has contributed to the decision-making process.
- That the service users voice is heard, considered and recorded during their journey with mental health services.
- That discharge processes and planning are collaborative between services, inpatient and community teams and the service user and their carers/ family.
- That family and carers are actively engaged throughout the journey with mental health services and that they are aware of the individuals risks and how to access support.

10

Learning from Serious Incidents

- That the workforce would benefit from bespoke domestic abuse training, in particular to increase awareness and understanding in regard to the dynamics of an abusive relationship and insight to the complexities of this and associated risks.

11

Learning from Service Level Investigations (SLI)

Risk assessment mitigation and management

Learning identified that:

- FIRM risk assessments had not been completed as a part of psychiatry referral screening appointment in one incident, and that risk assessment updates into the FIRM documentation were identified as needing to be timelier during a period of increased risk and crisis.
- Risk assessments that may be conducted over the telephone, including unplanned calls alongside planned calls are inclusive of a risk assessment and that this risk assessment update be added to the FIRM template to support the discussion and the safety plan also clearly documented.
- A full risk assessment had not been recorded in line with the risks management policy for service users under standard care. The incident identified that this should be included and updated, there was learning also to ensure that standard care risk assessments are monitored for quality and assurance.

12

Learning from SLIs

Documentation and recording:

Learning identified that:

- Having clarity on care and treatment plans including timescales for interventions would be of benefit and improve demonstration of collaboration with service user and carer/family.
- There was a need to ensure that the safety plans are updated following review.
- On the sharing of information with service users and carers/families, a recommendation to consider an alternative for information such as e-packs with details on the Intensive Home-Based Treatment Team be considered for development and that communication with the Trust internal communications team be held as to the development of QR read codes that may help team members share team knowledge should they forget to stock up on paper information packs.

13

Learning from SLIs

Documentation and recording:

Learning identified that:

- The Initial Health Screening as part of the detention checklist had not been completed at part of the initial detention process, there was no supporting documentation entered as to how or why this had been omitted. This was linked to additional learning in respect to the monitoring of blood glucose and other physical health checks where the risk was associated with disordered eating, no food or fluid charts were started in this case which was identified as a key area of learning specific to the persons care needs.
- Teams should agree who is responsible for updating documentation in care records on decision making on care and treatment pathways when more than one service is involved in the process; in this case a bed had been identified in an adult unit but not utilised due to an appropriate bed at a CAMHS unit having been identified. There was no record made of this decision by the Patient Flow team or other team.

14

Learning from SLIs

Documentation and recording:

Learning identified that:

- Discharge letters should ensure that summary care interventions are provided along with clear discharge plans.
- The community nursing teams on the importance of full assessments being completed in respect to recognising risk of pressure damage at the earliest opportunity (first visit) and to ensure this incorporates advice and guidance to the patient and those around them. Completion of an holistic assessment and advance care planning may have helped to improve the patient's overall comfort and ensure individual preferences identified, this should be holistic and alert to other factors in a person's health state that may need additional care interventions or could increase the risk to pressure damage.

With **all of us** in mind.

15

Learning from SLIs

Family and carer engagement and involvement:

Learning identified that:

- In improving staff recognition of carer burnout and the impact that supporting someone with continued high risk can have on a person's own wellbeing. Staff providing education and support under these circumstances was recognised as valuable.
- Following on from an incident there was apparent learning in the reaching out to family/friends and significant others to ensure that the offer of support was made and to consider the Duty of Candour requirements and clearly documented as to any exceptions or barriers to complete.
- An Intensive Home-Based Treatment Team investigation identified an opportunity to consider what information is available that can be shared with families where suicide risk has been a primary reason for referral; to assist in educating and supporting families when meeting the needs of individuals who experience suicidal ideas/actions or behaviours.

16

Learning from SLIs

Family and carer engagement and involvement:

Learning identified that:

- Communication with the Trust Carers Project Lead to consider conducting a snapshot audit of cases to review communication with family and carers; to help the continued good work of the carer lead roles and share excellence in practice across the Trust.
- Trust medical staff are alert to the findings of the investigation on the involvement and engagement of families/carers and significant others when identifying and treating psychiatric conditions, this should include awareness raising on the increased risk to suicide in co-existing physical health conditions, and information sharing on diagnosis and medications prescribed. Consideration to be given to the most appropriate forum in which to share this learning with all medical staff to improve learning dissemination and support/supervision of medical staff post incident investigations and encourage the sharing of best practice examples from across the Trust.
- Families/carers and significant others are actively engaged in the discharge planning process and provided with information to support discharge plans.

17

Learning from SLIs

Organisational learnings:

Learning identified that:

- The process for the identification of an inpatient bed for informal patients and the waits would benefit from further exploration.
- Delays in transferring service users to inpatient units are escalated to managers and Trust Leads. A contributory factor was noted to be the absence of direction provided within the Standard Operating Procedure for the 136 Suite and the escalation process for issues such as delays in identifying a bed for under 18s. Where there are delays of more than 24 hours in transferring a person under 18 from the 136 suite to a CAMHS bed the service should make use of an adult inpatient bed where one can be identified.

18

Learning from SLIs

Organisational learnings:

Learning identified:

- What the organisation can be doing to support staff in establishing what access to harmful media service users have had and how to go about verifying the details if given anonymously. Additional support should be provided to staff on when it may be appropriate to engage families/ nearest relatives (breaking confidentiality if needed) to make them aware of the content of such discloses online.
- From a pressure ulcer investigation and aspects of areas for improvement regarding closer co-ordination and communication across teams, follow ups in referrals and escalations of any areas of concerns will be utilised as examples to support the current work streams focus on the development of a holistic and personalised approach to care and treatment and feed into the creation of amended holistic core assessment, developments of care plans and escalation process. The outcomes following review will continue to feed into the improvement works.

19

Learning from SLIs

Communication across Teams and organisations:

Learning identified that:

- There was identified learning for staff in the Intensive Home-Based Treatment Team to ensure that when contacted out of hours in respect to young people known to the CAMHS services, that the details of the out of hours CAMHS team staff members be sourced, and information communicated across for engagement in decision making for care interventions. The young person was directed to wait until the following morning in this particular case.
- Comprehensive and robust information is provided for initial referrals to inpatient units to enable definite decision making on accepting admissions (in this case young person) and clarity on details relating to delays in transfer be added.

20

Learning from SLIs

Communication across Teams and organisations:

Learning identified that:

- Where a service user is engaging with Drug and Alcohol services, outside of the Trust that care is taken to ensure communication is held with the service as part of joint agency working and that risk reflections are documented in order to improve insights across the system.
- Information for a referral to community nursing services was delayed due to a delay in the partner organisation, this information was shared across organisations to improve referral and information sharing on patient needs and care pathways.
- A Training offer to care home arranged by Tissue Viability as a part of programme of support and education was noted to have been unused, E-learning is accessible training and so TVN team continue to monitor numbers of reported pressure ulcers by care home facilities and encourage the use of training accessible to the homes.

21

Learning from SLIs

Operational policy and procedure:

Learning identified that:

- The Intensive Home-Based Treatment Team (IHBTT) Operational procedure requires additional clarity on the need for the comprehensive assessment template to be completed by IHBTT staff members when undertaking assessments.
- In order to support the continued quality improvement measures in place within the IHBTT teams quarterly monitoring and reviews should take place around the completion of comprehensive assessments and updates to risk assessments in keeping with the policy and procedure and learning shared with the teams.

22

Learning from SLIs

Operational policy and procedure:

Learning identified that:

- The need to review the operational policy to ensure that the 136 detention checklist include additional checks, assessments and care planning where there are significant delays in transferring a service user to an inpatient bed and where a temporary adult bed is not available and to ensure that a clear escalation process for children and young people under 18 is added with medical responsibilities, transfer checklist and clarity in lead roles for ensuring handovers take place.
- The application of CPA and the convening of a review at the end of episodes of care in this case therapy. This was identified as being beneficial for the discussion of future care plans centred around the service user's future wants and needs. It was noted this is a deviation away from current policy but that the CPA policy and Process is currently under review and will be changed in the future.

23

Learning Library

Below is a summary of learning that has been shared through our Learning Library in Quarter 1:

- Referral process improved by PDSA cycle
- Adult who are not brought to appointment
- Thematic child safeguarding practice review
- Management of Physical health care plans on SystmOne during an inpatient admission
- Seclusion and safety pod
- Choking as a form of self-harm
- Lewisham Safeguarding adult review
- Police portal update (June 2023)

24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and be outstanding
Learning Network
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Below is a summary of learning that has been shared at our Learning Network forum: (3rd May)
• Stanley – Learning from an Amber Datix (Patient incident during episode of leave)
• Under 18 Pregnancy Safeguarding Proforma SBAR
• Learning from the experience of family's, carers, and significant others – a thematic review of 3 years incident investigations

25


Bluelight Alert
Bluelight alerts
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
• Concealed blades in pens
• UK emergency Alert
• Tampering of seclusion, bedroom and bathroom environments
• Identification of incorrect hypodermic needles for drawing from glass ampules
• Potential to create an anchor point for a fixed ligature within a doorframe
With all of us in mind.

26


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.

27

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 10.2

Private/Public paper:	**Public paper**		
Title:	**Medical Appraisal/Revalidation Annual Board Report 2022-23**		
Paper presented by:	**Prof. Subha Thiyagesh - Chief Medical Officer / Responsible Officer**		
Paper prepared by:	Michelle Goth - Medical Directorate Business Manager		
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHS England (NHSE) Designated Body Annual Board Report Statement of Compliance (Annex D), which will be completed to complement the 2022-23 Annual Board report.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and sustainability of safer staffing levels.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	This report demonstrates that the Trust has systems and process in place to ensure that its medical staff are compliant with medical appraisal and revalidation.		
Any background papers/previously considered by:	Quality and Safety Committee 12 September 2023		
Executive summary:	• 150 doctors had a prescribed connection with the Trust as of 31st March 2023. - 98% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2022/23, which is a further increase on last year. - 11% of the doctors had late meetings or late submissions. One 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. • 19 revalidation recommendations were made between 1st April 2022 and 31st March 2023.		

- 19 doctors had positive recommendations made.
- All of these recommendations led to revalidation of the doctors by the General Medical Council (GMC).

- There are no long-standing post-Covid-19 implications to the medical appraisal and revalidation process.

Next steps

- It has been agreed that a training video will be recorded for the AMD to use during induction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically.
- The number of appraisers and appraiser trainers will continue to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance, and all appraisers are asked to encourage new doctors into the appraiser roles if there are qualities and interest highlighted in a doctor's appraisal.
- The Trust is in the process of finalising a response to the GMC document *Fair to Refer*, which relates to the fair and equitable response to doctors facing complaints and/or referrals to the GMC and is awaiting further input from other colleagues.
- The Trust has nominated 3-4 doctors to attend the next Case Investigator training, with scheduled opportunities from June 2023 onwards, to complement the existing Case Investigator.
- The Trust is in the process of developing a MWRES (Medical Workforce Race Equality Standard) Lead job description with the assistance of the People Directorate and the Equality, Diversity and Inclusion team.

Risk appetite

The trust continues to have a good governance system of reporting and investigating incidents including serious incidents.

The following are areas of potential difficulty for the Trust:

- The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

Mitigating factors:

- Appraisers have time allocated in their job plans for the role.
- The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group.
- Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained.
- Early selection of an appraiser has been highlighted as a potential problem area and we have requested that appraisees actively choose their appraiser for the following year as soon as their current appraisal has been completed, and no later than 6 months prior to their next appraisal. We have also requested whether automated notifications on L2P can be implemented at 6 months, rather than the current 2 month notifications.

Due to staffing vacancies and ongoing difficulties with workload, it is acknowledged that late appraisals and late submissions of appraisals by both the appraisees and the appraisers is likely to continue. The Appraisal Team

	will continue to monitor this and ensure support is available for any doctor struggling with engaging in the appraisal process in a timely manner.
Recommendation:	**The Board is asked to RECEIVE and APPROVE this report noting that it will be shared with NHS England (NHSE).** • **The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.** • **The Board is finally asked to APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of this report, confirming that the Trust, as a Designated Body, is in compliance with the regulations.**

South West Yorkshire Partnership NHS Foundation Trust

MEDICAL APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2022-23

1. Introduction

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

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

In addition, the Responsible Officer for South West Yorkshire Partnership Foundation Trust (SWYPFT) is also RO for Barnsley Hospice.

The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex D), which will be completed to complement the 2022-23 Annual Board report.

2. Executive Summary

1.1 150 doctors had a prescribed connection with the Trust as of 31st March 2023.
- 98% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2022/23, which is a further increase on last year.
- 11% of the doctors had late meetings or late submissions. One of these late submissions was not approved. The rest were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate.

1.2 19 revalidation recommendations were made between 1st April 2022 and 31st March 2023.
- 19 doctors had positive recommendations made.
- All of these recommendations led to revalidation of the doctors by the General Medical Council (GMC).

1.3 There are no long-standing post-Covid-19 implications to the medical appraisal and revalidation processes.

3. Purpose of Paper

This report is presented to the Board:

2.1 For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.
2.2 To inform of progress in medical appraisal and revalidation during 2022/23.

4. Background

3.1 2022/23 was the eleventh year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession. As this is the eleventh year, most doctors in the Trust are into their third 5-year revalidation cycle.
3.2 L2P, the e-appraisal web-based system that the Trust utilises, is based on NHS England's medical appraisal guide (MAG) model appraisal form.

3.3 Each doctor must have a Responsible Officer (RO) who must oversee a range of processes including annual appraisal, and who will at five-yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.
3.4 The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.
3.5 The RO for SWYPFT is also the appointed RO for Barnsley Hospice through an internal Service Level Agreement.
3.6 Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards/executive teams will oversee compliance by:

3.6.1 Monitoring the frequency and quality of medical appraisals in their organisation.
3.6.2 Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
3.6.3 Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
3.6.4 Ensuring that appropriate pre-employment background checks (including pre-employment for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

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

4. Governance

4.1 Trust's Revalidation Team

- Responsible Officer – Professor Subha Thiyagesh
- Associate Medical Director for Revalidation – Dr Mike Ventress
- Business Manager, Medical Directorate – Michelle Goth (in post substantively from August 2022)
- Medical Directorate Coordinator – Charlotte Lyons (until February 2023)
- People Directorate Business Partner with responsibility to support Revalidation – Diane Taylor/Jane Murgatroyd

4.2 Main Tools Utilised Centrally

- L2P (web based) – e-appraisal system
- Datix (Trust system) – provision of incident, complaints and compliments data
- HR Online (Trust system) – provision of sickness data and mandatory training – updated to ESR Manager Self-service early 2023
- GMC Connect (web based) – designated body list

4.3 Designated Body List

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

4.4 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. The Medical directorate Business Manager, with the support of the Appraisal and Revalidation Team, complete the Annual Organisational Audit/Statement of Compliance (Annex D) along with quarterly reports to the Board and have been submitting quarterly reports to be included in the Integrated Performance Report.

4.5 Internal Oversight

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

4.5.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon. Where a meeting is not possible, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

4.5.3 The Revalidation Team have Revalidation Review meetings to formally consider those doctors with a revalidation recommendation required within the following 12 months.

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

4.5.5 The Revalidation Oversight Group has the aims :

- To advise the Responsible Officer of delivery of appraisal and revalidation processes and overall direction in terms of strategic, policy and performance.
- To advise the Responsible Officer of delivery of the improvements to revalidation based on the recommendations from Sir Keith Pearson's Taking Revalidation Forward [TRF] report.

The group has a volunteer lay member to provide independent scrutiny and service user input.

4.6 Independent Verification

4.6.1 Independent verification is required to be undertaken every 5 years. In December 2022 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust and the resulting report will be shared with NHS England and as part of this report to Board.

Medical Appraisal

5.1 Appraisal and Revalidation Data

N	Consultant		SAS* & Trust Grade (LAS)		Fixed Term	
Number of doctors as of 31st March 2023 who have a prescribed connection to the Trust	80		61		9	
Number of completed appraisals during 2022/23:	78	97.5 %	37	60.6 %	9	100 %
Number of missed/ incomplete appraisals during 2022/23(see reasons in appendix 1):	0	0%	1	2.7%	0	0%
Number of doctors in remediation:	0	0%	0	0%	0	0%
Number of doctors in disciplinary processes	0	0%	0	0%	0	0%

**SAS* – Specialty Doctors, Associate Specialist/Specialist doctors*

NB: Please note that not all doctors with a prescribed connection will be eligible for an appraisal during April 2022-March 2023. Reasons for this would include being on a short-term contract or being new to the UK during this time period.

5.2 Appraisers as of 31st March 2023

5.2.1 Number of appraisers – 35 (27 consultants, 8 SAS doctors)

5.2.2 Support activities undertaken:

- A full day new and refresher training session was provided on 24.11.2022 for 4 new appraisers and 8 additional existing appraisers and was facilitated by one experienced Trust appraiser trainer and one new appraiser trainer who is an experienced Trust appraiser. The next session is scheduled for 20.04.2023.
- Medical Appraiser forums were held on 21.04.2022, 19.08.2022 and 17.01.2023. The forums continue to provide an opportunity for appraisers to share ideas about good practice and discuss areas of concern/difficulty.
- Continuous improvement of the appraisal process in the Trust is also an important topic for discussion in the forums, and areas of good practice and reasons for appraisals being referred back for further work are highlighted by the AMD.

5.3 Quality Assurance Processes

5.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.

5.3.2 The Trust utilises the multisource feedback tool embedded within L2P. This automatically flags with the doctors when they are required to undertake the colleague and patient feedback (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are only released to the doctor if they have gained the minimum number of responses (and undertaken their self-assessments) or a request for release to the Revalidation Team is agreed.

5.3.3 The Trust has adopted an alternative tool to obtained feedback from services users within Learning Disabilities or their carers to improve usability for this group of service users in order to improve and increase response rate.

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

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

satisfactory. Those appraisals where the AMD was appraiser are similarly reviewed by the RO.

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

5.3.7 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 5.6). This process is embedded in the L2P system. This feedback is combined with other objective measures and observations of the AMD who provides feedback in writing to appraisers on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.

5.3.8 The reviews undertaken by the AMD and RO also often raise agenda items for the Appraiser Forums, where, for example, inconsistencies are identified.

5.3.9 The appraisers receive further group feedback during Appraiser Forum meetings.

5.3.10 Such issues are also discussed at the refresher training, which appraisers are required to attend every 2 years.

5.3.11 Due to previous issues of a minority of doctors leaving their request to have a particular appraiser until shortly before the appraisal meeting itself (which has meant appraisers may lack availability and therefore a delay in allocation or of the appraisal taking place), it has been agreed that appraisers should be chosen six months before the appraisal date. A prompt will be provided through L2P to this effect.

5.3.12 Doctors are now being asked to start collecting patient feedback a year in advance of the appraisal meeting. This is because some specialties have particular difficulty in getting sufficient responses due to low patient numbers or the health conditions of the patients themselves.

5.3.13 Of note, in SWYPFT no doctor is appraised by their line manager unless there are exceptional circumstances to consider. By comparison, the medical line manager of Barnsley Hospice staff generally does appraise their direct reports. This is noted in the Barnsley Hospice Medical Appraisal Policy as an acceptable arrangement that works well in the Barnsley Hospice setting.

5.4 Access, security and confidentiality

5.4.1 The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2022/23.

5.4.2 Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Medical Director (MD), AMD and the Revalidation Team and any other person to whom the doctor provides access (via their own login).

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

5.5 Clinical Governance

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

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

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

5.6 Appraisal feedback

Of the 117 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	50% (53%)	43% (41%)	4% (4%)	0% (1%)	3% (0%)
Your professional development	51% (56%)	46% (39%)	2% (4%)	0% (1%)	1% (0%)
Your preparation for revalidation	54% (61%)	41% (41%)	4% (4%)	1% (1%)	0% (0%)
Promoting quality improvements in your work	50% (54%)	43% (39%)	5% (7%)	1% (1%)	1% (0%)
Improving patient care	50% (53%)	44% (39%)	5% (8%)	1% (0%)	1% (1%)

Number of hours	<1	1-2	2-3	3-4	>4
Duration of appraisal discussion	3% (4%)	69% (56%)	17% (26%)	7% (9%)	4% (4%)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The appraisal was satisfactory	71% (70%)	29% (26%)	0% (3%)	0% (1%)	0% (1%)
I was able to collect all the necessary supporting information from the organisation	59% (62%)	37% (30%)	1% (6%)	3% (1%)	0% (1%)

***() are the 2021/22 results.**

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

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

6. Revalidation Recommendations (1.4.22 to 31.3.23)

Number of recommendations	19
Recommendations completed on time	18
Positive recommendations	19
Deferral requests	0
Non engagement notifications	0

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

6.2 As an outcome of this process, all but one of the recommendations due in 2022/23 were submitted on time. The additional short notice bank holiday in May 2022 resulted in a 1-day late submission.

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

6.4 Of note, In April 2023, the GMC stipulated that a revalidation recommendation could be made up to 12 months prior to a doctor's expiry date, which is a continuation of an agreement implemented during COVID-19 that has been adopted on an ongoing/permanent basis.

See Appendix 3; Audit of revalidation recommendations

7. Recruitment and engagement background checks

7.1 Substantive and Fixed Term appointments

During 2022/23, the Trust employed 28 doctors, on a mix of substantive and fixed term contracts. These figures exclude medical trainees.

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

7.1.2 For consultants, all interviewees are required to complete a 16PF (16 personality factors) questionnaire and the resulting assessment report is considered by the Advisory Appointment Committee.

7.1.3 For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.

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

7.1.5 Reference checks from the previous 3 years of employment are undertaken by Medical Staffing and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.

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

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

7.1.8 The Chief Medical Officer checks and approves the final offer letter prior to sending.

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

* if requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

7.2 Agency Locum appointments

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

7.2.2 The Trust engages with PlusUs which offers a Direct Engagement service solution through a system which will source the market for available doctors across the framework suppliers and a direct engagement service which provides a temporary Trust contract that does not attract VAT. They also provide an on-line portal which advertises / searches temporary clinical roles across the full range of approved framework suppliers.

7.2.3 The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas. In 2022, a Medical Recruitment Officer was appointed within the Medical Directorate administrative team to assist with this process and provide additional support with collating and centralising data in connection to agency locums

7.2.4 PlusUs provides suitable CVs and references through an online portal.

7.2.5 If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.

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

7.2.7 In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.

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

8. Monitoring Performance

8.1 Doctors are generally monitored through their team management structures.

8.2 In addition, a doctor's performance is monitored via the appraisal system, which includes a Trust requirement for feedback from service users and 360° feedback from colleagues on a three-yearly basis, or within 12 months for a new doctor commencing work in the Trust. **Please note that this stipulation is more frequent that the 5-yearly expectation from GMC guidance.**

8.3 Information in relation to whether a doctor is involved in serious incidents or subject to complaints is also included in the appraisal system.

8.4 Serious incidents are investigated using the Trust investigation procedures, carried out by trained investigators.

8.5 In the event that any concerns are raised, these are referred to the Chief Medical Officer who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

9. Responding to Concerns and Remediation

9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved in June 2018 and reviewed and approved in September 2021.

9.2. As at 31.3.23 the Trust had 1 trained Case Manager and 1 trained Case Investigator, both of whom are medical consultants. Additional Case Investigator training has been requested and is scheduled to take place in June 2023 for other doctors in the Trust to become Case Investigators.

9.3. A Responding to Concerns Advisory Group meets monthly. It is chaired by the RO and is also attended by the Chief Medical Officer (currently both roles are held as one), Chief People Officer or Deputy, the AMD for Revalidation, Director of Nursing, Quality and Professions or Deputy, and the Medical Directorate Business Manager or alternative cover as required. Relevant representatives may attend as and when required.

This approach ensures a consistent and open approach is taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.

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

10. Appraisal and Revalidation Peer to Peer Review

Please see Appendix 5 for the full report.

The Appraisal and Revalidations teams of SWYPFT and Leeds and York Partnership NHS Foundation Trust (LYP) met on 6th December 2022 to conduct a peer to peer review of Trust appraisal and revalidation process. Please see below summary of the report provided by LYP:

Good practice which could benefit all designated bodies

- The Trust has clear and comprehensive structures and processes which underpin its approach to appraisal, revalidation and managing concerns about doctors.
- The use of a minimum data set ensures that all relevant supporting information is collated and reflected on at appraisal.
- The inclusion of individuals from outwith the Trust's Appraisal/Revalidation team as members of the Trust's various groups/meetings relating to appraisal, revalidation and managing concerns about doctors (e.g. the Chief Nurse, People Directorate, lay representative) provides a further degree of scrutiny to the issues under consideration.
- Specifically, The Trust has in place a Revalidation Oversight group with lay membership that meets 3 times a year, which is an added level of scrutiny into governance processes and offers the opportunity for input and review of the Annual Board Report.

Areas for consideration

- The Trust may wish to consider the appointment of a Consultant Appraisal Lead and SAS Appraisal Lead so as to provide leadership opportunities for appraisers and additional support for the AMD for Appraisal in their role
    - The capacity of the AMD role will continue to be monitored in line with the number of appraisers and appraiser trainers available to support the AMD in their role.

- The Trust may wish to consider the appointment of a Medical Workforce Race Equality Standards Lead to support the medical workforce with particular

reference to GMC referrals, complaints, investigations and revalidation for Black, Asian and Minority Ethnic (BAME) doctors.

- The Trust has compiled a Medical Workforce Race Equality Standards job description, which is being finalised to be advertised as an additional role for a substantive doctor, in order to support the wider Workforce Race Equality Standards lead.

11. Risk and Issues

The following are areas of potential difficulty for the Trust:

10.1 The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

Mitigating factors:

- Appraisers have time allocated in their job plans for the role.
- The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group.
- Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained.
- Early selection of an appraiser has been highlighted as a potential problem area and we have requested that appraisees actively choose their appraiser for the following year as soon as their current appraisal has been completed, and no later than 6 months prior to their next appraisal. We have also requested whether automated notifications on L2P can be implemented at 6 months, rather than the current 2 month notifications.
- Due to staffing vacancies and ongoing difficulties with workload, it is acknowledged that late appraisals and late submissions of appraisals by both the appraisees and the appraisers is likely to continue. The Appraisal Team will continue to monitor this and ensure support is available for any doctor struggling with engaging in the appraisal process in a timely manner.

11. Actions, Improvements and Next Steps

An action plan for medical appraisal/revalidation is regularly reviewed and updated by the AMD and Business Manager and periodically reviewed with the RO.

The Appraisal team continues to monitor appraisal activity during the year to try to ensure appraisals are evenly placed throughout the year, continuing to avoid March 2023 due to board report being due for finalisation.

11.1 Improvements Implemented 2022-23

11.1.1 Continuing to ensure the quality and relevance of appraiser training is maintained with the introduction of new trainers, and the trainers now conduct training without the requirement for the AMD to be present.

11.1.2 There are minimal restrictions on a doctor's ability to collect MSF, having completely returned to pre-pandemic levels, ACP360 as an alternative, user-friendly options for service user feedback questionnaires have been adopted for our doctors working in Learning Disabilities. Options to feedback also include online and via text to increase response rates. Flexibility continues to be applied to releasing feedback for reflection; however doctors are requested to continue to gather feedback on an ongoing basis and to commence requesting feedback as early as possible, up to 12 months prior to due date and collection can commence as early as 3 years prior to due date

11.1.3 The wellbeing section remains in appraisal and will continue on an ongoing basis, and the importance of maintaining wellbeing conversations within the appraisal process is a lesson learnt across the Trust, as wellbeing of all staff remains a priority. All resources available for supporting doctors i.e. health and wellbeing, OH, mentoring have been reviewed and updated and sent out to all doctors, added to the Trust's intranet and L2P resources tab.

11.1.4 The Trust has adopted the separated version of the Appraisal 2022 format, which means that the elements of appraisal, including CPD, QIA, feedback fields are kept separate in L2P as a preferred format to be able to easily locate information within an appraisal.

11.1.5 The Trust has offered a series of Suicide Support sessions for any doctors wishing to discuss in a safe and confidential space the impact a suicide or death can have on individuals and teams. These sessions have been followed up by a wider session in the monthly academic meeting in the Trust to include all doctors in a wider discussion, with the offer of widening the conversations to other teams within the Trust

11.1.6 Wellbeing conversations and scores from appraisal are reviewed and there is a process for checking in with colleagues throughout the year with regard to health and wellbeing, not purely linked to appraisal.

11.2 Next Steps (2023-24 Actions)

11.2.1 It has been agreed that a training video will be recorded for the AMD to use during introduction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically.

11.2.2 The number of appraisers and appraiser trainers will continue to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance, and all appraisers are asked to encourage new doctors into the appraiser roles if there are qualities and interest highlighted in a doctor's appraisal.

11.2.3 The Trust is in the process of finalising a response to the GMC document *Fair to Refer,* which relates to the fair and equitable response to doctors facing complaints and/or referrals to the GMC, and is waiting for input from our People Directorate colleagues.

11.2.4 The Trust has nominated 3-4 doctors to attend the next Case Investigator Training, which is scheduled to take place in June 2023, to complement the existing Case Investigator.

11.2.5 The Trust is in the process of developing a MWRES (Medical Workforce Race Equality Standard) Lead Job Description with the assistance of the People Directorate and the Equality, Diversity and Inclusion Team.

12. Recommendations

12.1 The Board is asked to receive this report, noting that it will be shared with NHSE.

12.2 The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.

APPENDIX 1
AUDIT OF LATE APPRAISALS DURING 2022/23

DOCTOR FACTORS	**CONSULTANT**	**SAS/TRUST GRADE**
Parental Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	0	0
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	0
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	1 (late submission by doctor due to workload pressures. This had not been submitted by 31st March 2023)
Lack of engagement of doctor	0	0
Other doctor factor e.g. bereavement, sickness, or other time factors not applicable elsewhere	4 (1 x late submitting by 3 days due to annual leave), 1 x late meeting by 8 days due to sickness, 1 x late meeting by 21 days due to sickness, and 1 x late submission by 42 days due to annual leave)	1 (doctor left the Trust before this could be finalised)
APPRAISER FACTORS	**NUMBER**	
Unplanned absence of appraiser	1	1
Lack of time of appraiser	2	0
Other appraiser factor (describe)	1 (late submitting by 4 days due to annual leave)	2 (1 x late submitting by 15 days due to system error followed by annual leave, 1 x late submitting by 27 days due to separate periods of leave

ORGANISATION FACTORS	NUMBER	
Administration or management factors	0	1
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe) – suspension of appraisal due to Covid-19	0	0

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

APPENDIX 2
QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED – 127*		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.22-31.3.23)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	127	127
Is continuing professional development compliant with GMC requirements?	127	127
Is quality improvement activity compliant with GMC requirements?	127	127
Has a patient feedback exercise been completed?	127	127
Has a colleague feedback exercise been completed?	127	127
Have all complaints been included and appropriately reflected on?	127	127
Have all significant events been included and appropriately reflected on?	127	127
Is there sufficient supporting information from all the doctor's roles and places of work?	127	127
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	127	127
Other reason	127	127
APPRAISAL OUTPUTS		
Appraisal summary	127	127
Appraiser statement	127	127
PDP	127	127

All deficits were addressed satisfactorily after the appraisal had been referred back.
*Please note one doctor had 2 appraisal meetings within the 2022/23 window.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2022 to 31 March 2023)

Recommendations completed on time (within GMC recommendation window)	18
Late recommendations (completed, but after the GMC recommendation window closed)	1
Missed recommendations (not completed)	0
TOTAL	19
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe). Revalidation team meeting was missed due to short notice bank holiday given in May 2022. This resulted in a 1-day late recommendation. There were no implications with regard to this short delay and the recommendation was still within the GMC accepted timeframe.	1
TOTAL (sum of late and missed)	1

APPENDIX 4
AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	1	0	2
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short-term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.22 and 31.3.23)				0
Number of doctors who have had local restrictions placed on their practice in the last 12 months				0
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.22 and 31.3.23				1
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.22 and 31.3.23				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.22 and 31.3.23				1
Number of doctors who had their registration / licence suspended by the GMC between 1.4.22 and 31.3.23				0
Number of doctors who were erased from the GMC register between 1.4.22 and 31.3.23				0
NHS Resolution ACTIONS				
Number of doctors about whom NHS Resolution has been contacted between 1.4.22 and 31.3.23				0
Reason for contacts:				
For advice				
For investigation				0
For assessment				0
Number of NCAS investigations performed				0
Number of NCAS assessments performed				0

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

APPENDIX 5

Peer Review
of: South West Yorkshire Partnership NHS Foundation Trust's
Appraisal & Revalidation Processes

by: Leeds and York Partnership NHS Foundation Trust
on: 6th December 2022

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided Leeds and York Partnership NHS Foundation Trust (LYPFT) with a data pack of the following information:

i. Annual board report
ii. AOA Statement of Compliance *(within above document)*
iii. Appraisal and Revalidation Board Report
iv. Medical Appraisal policy
v. Responding to concerns and remediation policy
vi. Minutes
    - Revalidation Oversight
    - Revalidation Review Group
    - Medical Appraisal Forum
    - Responding to Concerns Advisory Group
vii. Terms of Reference (ToR)
    - Revalidation Oversight Group
    - Revalidation Review (Advisory) Group
    - Medical Appraisal Forum
    - Responding to Concerns Advisory Group
viii. Team Structure
ix. Action Plan
x. Minimum data set

This information was considered by LYPFT prior to the review meeting of 6 December 2022 and the key themes were collated as per the Peer Review Template prior to the meeting and informed the review meeting discussion.

IN ATTENDANCE AT THE REVIEW:

SWYPFT	LYPFT
Subha Thiyagesh, Responsible Officer	Wendy Neil, Responsible Officer
Mike Ventress, Associate Medical Director for Medical Appraisal and Revalidation	Priyanka Bichala, Associate Medical Director for Medical Appraisal and Revalidation
Michelle Goth, Medical Directorate Business Manager	Vickie Lovett, Medical Directorate Manager
Charlotte Lyons, Medical Directorate Co-Ordinator	Joanne Chapman, Medical Directorate Administrator
	Peter Niblock, SAS Appraisal Lead
	Robin Owen, Consultant Appraisal Lead

REVIEW AGENDA:
The review meeting followed the suggested agenda as provided by NHS England as is provided in Appendix A.

KEY POINTS:
Key points noted at the peer review were:

A: Appraisal and Revalidation Recommendations

There was noted to be robust internal oversight of the Trust's appraisal and revalidation processes with regular meetings between Appraisal/Revalidation team members.

Work has taken place since the last peer review to effectively increase the number of appraisers within the Trust to a total of 33 trained medical appraisers and 5 medical appraiser trainers. It was noted that appraisers are enabled to fulfil their role through robust job-planning thus enabling organisation-wide consistency and the involvement of the Clinical Leads. Appraiser performance is overseen through reviews of L2P data which are presented at the ADF, together with individual feedback provided in written form from the AMD for Appraisal.

It was noted that allocation of appraisers is led by the doctor however overseen by the Medical Directorate Administrator so as to ensure that there are no conflicts of interest and that, wherever possible, doctors are allocated the same appraiser for three consecutive years.

Supporting information is monitored and triangulated by the Medial Directorate Business Manager, Medical Directorate Administrator and escalated to the AMD for Appraisal as necessary. The AMD's role in scrutinising colleague and patient MSF ensures that there is an appropriate range of contributors to colleague feedback. All submitted appraisals are

checked by the RO and AMD with particular emphasis on ensuring that reflections on SUIs and other relevant information is included in the appraisal discussions. Updates are inputted into L2P for both the doctors and the appraiser to review in the following appraisal year and to comment on through reflection.

The Trust has a specific group for the purpose of reviewing revalidation recommendations. This meets monthly and considers those revalidation recommendations due to be made in the following 3 months. It also scans for potential issues for other doctors who have revalidation dates up to 12 months ahead.

Reflections: Despite a relatively small number of staff within the Medical Directorate the Trust appears to manage its appraisal and revalidation processes efficiently and effectively. There are clear structures in place with the process for the provision and checking of supporting information (including compliments, complaints, SUIs and coroner involvement) a particular strength. The Trust may wish to consider the appointment of a Consultant Appraisal Lead and SAS Appraisal Lead so as to provide leadership opportunities for appraisers and additional support for the AMD for Appraisal in their role.

B: Performance

The process for managing concerns is covered by relevant Trust policy and regular meetings which include diverse representation (including from HR and Nursing) take place within the Trust. Complaints regarding doctors in the Trust are automatically sent to the Medical Directorate Business Manager who scrutinises and escalates to the RO and AMD for Appraisal.

Although the number of cases which require investigation are low in the Trust it was noted that the Trust currently has only one trained case manager and one trained case investigator. There are plans for the Trust to increase their number of trained case investigators.

Reflections: The diverse membership of the Trust's Responding to Concerns Advisory Group enables challenge to be provided as to how concerns are dealt with and ensures consistency of approach. The Trust may wish to consider increasing the number of trained case managers and providing opportunities for case investigators/case managers to participate in action learning sets or equivalent to ensure their skills and knowledge in case investigation remains updated

C: General

The implications for the Trust of the 2020 NHS England WRES Indicators for the medical workforce was discussed. It was identified that the Trust does not currently have an identified lead for this work.

Reflections: The Trust may wish to consider the appointment of an MWRES lead to support the medical workforce with particular reference to GMC referrals, complaints, investigations and revalidation for BAME doctors.

D: Checklist

The presence of a lay member on the revalidation oversight committee is a particular strength with respect to the Trust's patient and public involvement in the revalidation process.

The Trust has a single case manager and a single case investigator. The case manager's role is quality assured by their external RO, the case investigator's role is quality assured though the scrutiny of outputs from case investigations by the Responding to Concerns Advisory group.

There is a robust process for triangulation of information for appraisal and concerns

SUMMARY

Good practice which could benefit all designated bodies

- The Trust has clear and comprehensive structures and processes which underpin its approach to appraisal, revalidation and managing concerns about doctors.
- The use of a minimum data set ensures that all relevant supporting information is collated and reflected on at appraisal
- The inclusion of individuals from outwith the Trust's Appraisal/Revalidation team as members of the Trust's various groups/meetings relating to appraisal, revalidation and managing concerns about doctors (e.g. the Director of Nursing, HR, lay representative) provides a further degree of scrutiny to the issues under consideration.
- Specifically, The Trust has in place a Revalidation Oversight group with lay membership that meets 3 times a year, which is an added level of scrutiny into governance processes and offers the opportunity for input and review of the Annual Board Report.

Areas for consideration

- The Trust may wish to consider the appointment of a Consultant Appraisal Lead and SAS Appraisal Lead so as to provide leadership opportunities for appraisers and additional support for the AMD for Appraisal in their role
- The Trust may wish to The Trust may wish to consider the appointment of an MWRES lead to support the medical workforce with particular reference to GMC referrals, complaints, investigations and revalidation for BAME doctors.

Areas for NHS England to address: -

- To consider sharing the good practice and learning from the review at future network events

Learning taken by LYPFT:

- To explore the possibility of developing a minimum data set to improve the capture and triangulation of supporting information for appraisal
- To explore enhanced utilisation of the various reporting etc functionalities of L2P

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: The Chief Medical Officer of the Trust is also the Responsible Officer Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: To continue to monitor resources and address any challenges as appropriate Comments: No requirements have come to light with regard to additional resources. The administrative support role for the RO has been vacant from February 2023 to present. The post has been appointed to and the new postholder has commenced employment with the Trust in August 2023. The duties are currently being managed by the Business Manager. Action for next year: To continue to monitor and address as required.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: The Revalidation Team ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal and regularly monitored to account for new starters and leavers, and given that individual doctors can add themselves to GMC. To facilitate this, the Revalidation admin team liaises with Medical Staffing to continuously obtain accurate information. Action for next year: Training and induction of new administrator to continue to manage the processes in place.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Medical Appraisal Policy approved May 2021 and Responding to Concerns & Remediation Policy approved September 2021. These policies will be routinely reviewed in 2024 unless local or National changes need addressing earlier. Action for next year: To commence policy review process in good time.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Fulfil commitment to attend peer review, which was scheduled for November 2022, and later changed to early December 2022 to accommodate a face to face meeting.

Comments: The revalidation peer review took place approximately 5 years' following the last one, on 6th December 2022 with Leeds and York Partnership NHS Foundation Trust. The Trust will share the report alongside this document with NHSEI by 31st October 2023.

Action for next year: N/A

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A

Comments: All doctors working in the Trust work under the Trust's governance processes. The Trust's processes to engage agency locums includes appraisal and revalidation checks. Doctors on short-term contract within the Trust undertake appraisal within the Trust's processes as appropriate and have access to study leave as per substantive doctors.

Action for next year: N/A

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Continue to work with L2P with regard to appropriate rewording (of elements of the L2P platform) to capture all eventualities,

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

including the option of sharing elements of appraisal with job planning participants and vice versa.

Comments: All doctors are provided with a PDF formatted record (including a nil response in appropriate) of their incidents, complaints and sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's electronic appraisal record on L2P. Those doctors also undertaking work outside of the Trust are required to provide supporting information from their other places of work.

Action for next year: Continue to work with L2P to make any necessary amendments in order to improve function and engagement with the appraisal process

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: Where this supporting information is missing, this is picked up in the review process (all appraisals are reviewed by the Associate Medical Director for Revalidation and the Responsible Officer) and the doctor would be asked to provide the information or explain the reason for its absence prior to final sign-off of an appraisal.

Action for next year: N/A

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Medical Appraisal Policy approved by executive management in May 2021, review due May 2024.

Action for next year: As above, commence the policy review in good time for the May 2024 renewal due date.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N/A

Comments: The AMD and Revalidation Team continues to promote opportunities to recruit new appraisers and identify individuals who have expressed an interest. The team is happy with the current number of

appraisers and the processes are working effectively; however, any potential risks are monitored continuously.

Action for next year: N/A

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: N/A

Comments: Medical Appraiser Forums are held 3 times per year. It is an expectation that an appraiser attends a minimum of 50% of forums across a 2-year period (i.e. 3 per 24 months) in order to be deemed suitable to continue appraising. A designated refresher training session is also expected to be attended every 2 years. In addition, the AMD for Revalidation provides individual annual feedback to each appraiser.

Action for next year: Due to the aforementioned administrative vacancy, there has been a delay in feedback letters being sent out for the 2022/23 appraiser year, which will be prioritised once the new postholder has commenced.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A Comments: A comprehensive Annual Appraisal and Revalidation Board report is submitted, which details the Quality Assurance processes in place. There is also a Revalidation Oversight Group with a lay representative in attendance, to monitor performance and quality of the processes, and to review the draft Board report prior to submission. Action for next year: L2P contract is due for renewal consideration by 31st March 2024 and feedback will be requested in order for the Trust to make an informed procurement decision.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**150**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**127**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**1**
Total number of agreed exceptions	**0**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A

Comments: A process is in place to ensure timely recommendations are made. Due to a last minute bank holiday announcement and leave arrangements, one recommendation was made 1 day late in 2022/23. There were no adverse outcomes in relation to this oversight.

Action for next year: To ensure early conversations continue to take place, in particular, in light of the recommendation period being extended to 12 months prior to revalidation date to ensure all recommendations are made timely.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: The RO / AMD would confirm with a doctor if a deferral were to be recommended, providing the reasons for this decision. In most cases, discussions would have already taken place with the doctor around a possible deferral. In the case of non-engagement, a specific robust process is in place, involving extensive efforts to assist and support any doctor with difficulties engaging in the appraisal process, making every effort to avoid such an outcome. Any doctor would be fully informed that a non-engagement recommendation was about to be made.

Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: Clinical Governance for doctors is overseen by the Trust's Clinical Governance and Clinical Safety Committee (CGCSC). The committee's remit is to provide assurance to the Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation, through receipt of exception reports from relevant directors to demonstrate that they have discharged their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical

education, safeguarding, research and development, compliance, and health and safety.

Action for next year: The Trust has developed a Medical Workforce Race Equality Standard (MWRES) Lead Job description with the aim to appointing a designated lead in the medical workforce to work alongside our Diversity, Inclusion and Belonging Lead.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/A

Comments: The Medical Directorate collates information from reporting systems for complaints and significant incidents relating to doctors. This together with sickness data is uploaded to a doctor's appraisal document. Other relevant information, such as involvement with coroners' inquests, is also noted on the document. Doctors are also required to upload their mandatory training matrix to their appraisal document. Job planning is also completed on the same electronic system to allow easier sharing of information across the two processes. Colleague and patient feedback collection occurs at least every 3 years and is automatically uploaded to the appraisal form, and collection of feedback is requested within 12 months of all new doctors commencing employment in the Trust. Triangulation of all above data and review of content of appraisal occurs before sign-off by the RO.

Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A

Comments: The Trust has a Responding to Concerns and Remediation Policy. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO/Chief Medical Officer, and also includes the Chief People Officer or deputy, the Associate Medical Director (AMD) for Appraisal and Revalidation, Chief Nurse and Director of Quality and Professions or deputy, and the Medical Directorate Business Manager who is also note-taker, or another appropriate note-taker. Relevant general management and other representatives e.g. Diversity,

Inclusion and Belonging team members are invited to attend as and when required. This ensures there is a consistent and open approach taken across the Trust in the investigation of concerns relating to doctors. The meeting group terms of reference are included in the Responding to Concerns and Remediation policy.

In addition to this, the Trust is in the process of finalising a Trust response to the GMC: Fair to Refer document, which was published prior to COVID-19, to include good practice already undertaken in the Trust, along with an action plan for future improvements to processes and support offered within the Trust to ensure equality, diversity, inclusion and belonging are at the forefront of the Trust's values and ongoing agenda.

Action for next year: Finalisation of GMC: Fair to Refer Trust response, which includes input from People Directorate, Diversity, Inclusion and Belonging team and other sources Trust-wide.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: N/A

Comments: There is a pathway to receive concerns which includes the Chief Medical Officer / RO. The Responding to Concerns Advisory Group ensures there is consistency in the investigations, management and documentation of concerns across the Trust. The Annual Appraisal and Revalidation Board Report is submitted to Clinical Governance and Clinical Safety Committee and Trust Board, and includes a table detailing numbers, types and outcomes of concerns.

Action for next year: N/A

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: N/A Comments: There is a standardised form for exchange of information from RO to RO between Trusts. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A Comments: Equality Impact Assessments are conducted in the Trust for every policy, procedure and strategy. The Responding to Concerns Advisory Group monitors process and data for any patterns where meaningful analysis could be undertaken; however the low numbers involved have precluded this to date. Action for next year: N/A

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A Comments: The Medical Staffing team within the People Directorate undertakes pre-employment checks for all employed doctors in line with Trust agreed procedures. CVs, references and identity checks are required for agency locum staff, together with interview with the Medical Clinical Lead prior to commencing work in the Trust. Action for next year: The appointment of a Medical Recruitment Officer in the directorate has enabled collaborative discussions to take place with Medical Clinical Leads and Medical Staffing, with an action plan to centralise some processes and relevant information for agency locums to bolster the current processes within each of the separate Care Groups.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report N/A**
- **Actions still outstanding N/A**
- **Current Issues: An administrative vacancy within the Appraisal and Revalidation team has meant some delays to general administrative duties, which will be addressed once the new postholder is appointed, by August 2023.**
- **New Actions:**
    - **To continue to monitor demand on current resources and take appropriate action**
    - **Onboarding and training/induction of new Appraisal and Revalidation administrator**
    - **To commence Medical Appraisal Policy review process in good time, to meet expected renewal date of May 2024**
    - **Continue to work with L2P to make any necessary amendments in order to improve function and engagement with the appraisal process**
    - **To ensure 2022/23 Appraiser feedback letters are completed and distributed as soon as possible, and make every effort to ensure there are no further delays in 2023/24**
    - **Obtain feedback in relation to renewing contract with L2P in March 2024**
    - **To ensure all revalidation recommendations are made in good time**
    - **Appoint a Medical Workforce Race Equality Standard Lead for the Trust**
    - **Finalisation of GMC: Fair to Refer Trust response**
    - **Improve on centralisation of key documentation and processes with regard to agency locums, with the Medical Recruitment Officer working alongside Medical Clinical Leads and Medical Staffing to cement our current robust processes.**

Overall conclusion: This has been a very positive year despite the various challenges including recovery from covid19 pandemic, workforce issues and more recently from industrial action. It has been very satisfying to receive very positive feedback from an external peer review of the appraisal and revalidation system and process with particular comment on the robustness of the process, whilst maintaining values-based compassionate and person centred approach to all our medical colleagues. The feedback from our doctors on the appraisers remains positive. We have continued to provide high quality service to our connected organisation and these are supported through regular senior meetings and review of governance processes. We continue to maintain our focus to review of our processes to ensure appropriate systems are in place to support our doctors in

their journey to remain up to date, provide high quality patient care and be able to be revalidated.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 10.3

Private/Public paper:	**Public**		
Title:	**Response to Lucy Letby trial verdict**		
Paper presented by:	**Darryl Thompson - Chief Nurse & Director of Quality and Professions** **Adrian Snarr - Director of Finance, Estates & Resources**		
Paper prepared by:	**Julie Williams - Deputy Director of Corporate Governance**		
Purpose:	To provide the Trust Board with the response to the Lucy Letby verdict including overview of the Trusts current freedom to speak up (FTSU) and fit and proper persons test processes (FPPT) to support discussion on Trust position and identify any actions.		
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. 2.4 Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. 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. 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 Trusts processes for FTSU and FPPT ensure that the Trust has governance systems and processes in place to safeguard patients, their families, staff and the public across the places we serve.		
Any background papers / previously considered by:	• FTSU annual report presented to Board July 2023		

	• Integrated performance report (to Board monthly), which includes a summary of all serious incidents and data for FTSU mandatory training compliance. • Complex incidents report (to Board eight times a year) • Serious incidents report (to Board quarterly) • Annual incident management report (including learning from healthcare deaths) • Alert, Advise, Assure reports from Quality and Safety Committee, and People and Remuneration Committee • Equality and diversity annual report (Board) • Patient Experience annual report (Board) • FPPT NHS England revised framework summary and actions presented September 2023.
Executive summary:	Lucy Letby's appalling crimes have shocked not just the NHS, but the nation and our thoughts are with all the families affected. As a Board we share NHS England's commitment to doing everything we can to prevent anything like this happening again. On the 18 August 2023 the Trust received a letter from NHS England, following the verdict on the 8 August 2023, describing its commitment to doing everything possible to prevent anything like this happening again, and actions already being taken, namely: • The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems. • This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients. • The letter also reminded NHS leaders of the importance of NHS listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level. Want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response. • Last year NHS England rolled out a strengthened Freedom to Speak Up (FTSU) policy. (All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest). The letter also focused on good governance being essential, reminding NHS leaders and Boards that they must ensure proper implementation and oversight. Specifically, boards must urgently ensure: • All staff have easy access to information on how to speak up. • Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

	• Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place. • Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well. • Boards are regularly reporting, reviewing and acting upon available data. The letter also reflected the strengthened the Fit and Proper Person Framework which will bring in additional background checks, including a board member reference template. This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record (ESR) so that it is transferable to other NHS organisations as part of their recruitment processes. A paper on the FPPT strengthened assessment is presented separately to Trust Board this month. The letter also asked integrated care boards (ICB) to consider how all NHS organisations have accessible and effective speaking up arrangements. Subsequently (22 August 2023) the Trust received a request from the South Yorkshire ICB asking for a response to the above statements, this was sent on the 25 August 2023. This report provides a summary of that response on both FTSU and FPPT arrangements in the Trust.
Recommendation:	**Trust Board is asked to RECEIVE the Trust response to the Lucy Letby trial verdict and COMMENT accordingly.**

1. Introduction

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Subsequent to the verdict on the 8 August 2023, on the 18 August 2023 the Trust received a letter from NHS England describing its commitment to doing everything possible to prevent anything like this happening again, and actions already being taken, namely:

- The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.
- This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.
- The letter also reminded NHS leaders of the importance of NHS listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level. Want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.
- Last year NHS England rolled out a strengthened Freedom to Speak Up (FTSU) policy. (All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest).

The letter also focused on good governance being essential. Reminding NHS leaders and Boards that they must ensure proper implementation and oversight. Specifically, boards must urgently ensure:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for
- communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

- Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, NHS England also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements. Subsequently (22 August 2023) the Trust received a request from the South Yorkshire ICB asking for a response to the above statements. This was was sent on the 25 August 2023, this report provides a summary of that response on both FTSU and FPPT in the Trust.

All NHS organisations were also reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations. Our response includes the Trust arrangements for FPPT. A paper on the FPPT strengthened assessment is presented separately to the Trust board this month

The Trust recognises the importance of creating an organisational culture where staff feel able and safe to raise concerns at work including malpractice, service user and staff safety issues, harassment and bullying and fraud. To support this, the Trust has one full-time and three part-time Freedom to Speak Up Guardians (FTSUG).

The FTSUGs continue to proactively develop and promote a more open and transparent culture to enable the delivery of the organisational priority to support staff to feel safe and to encourage staff to raise concerns as appropriate.

Freedom to speak up training is mandatory for all staff; and a network of civility and respect champions and equity guardians has been launched to help signpost and support staff.

In addition, senior Trust managers, including executive directors, are required to complete follow up training, which explains the ways to embed a culture of speak up, listen up and follow up.

FTSUGs ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. A freedom to speak up steering group has been established to further strengthen the Trust's arrangements.

The Trust raising concerns/freedom to speak up (whistleblowing) policy was revised and approved in April 2023 to adopt the national freedom to speak up policy (to be adopted by January 2024).

Following the Lucy Letby trial verdict, and as part of the planning for freedom to speak up month (October) a special edition of the View to cover the case and our response, this will be sent to all staff including bank and agency staff, students, and trainees across all specialties, reminding them of the importance of speaking up and raising concerns and how to do so.

To demonstrate good governance, and proper implementation and oversight of freedom to speak up, processes are in place in the Trust, please find below our responses to the following statements, contained in the letter from NHS England.

All staff have easy access to information on how to speak up.

The Trust has a dedicated intranet page for FTSU, which provides staff with information and support. In addition, posters are sited in all Trust buildings, individual departments, and staff specific areas e.g., staff rooms.

The Trust operates across a wide geographical area, and to ensure that all staff are aware of guardians, their role and how to access them, one of the key activities of the full-time guardian is to increase visibility and promote speaking up channels for staff.

The full time Guardian does this through a rolling programme of face-to-face visits into services, developing promotional materials, one to one meetings, attending the Trust's "welcome events" and providing training to the individuals joining the trust through the care certificate programme.

In 2022/23 the FTSU guardian visited all 30 Trust inpatient wards on several occasions and has been key trained to allow her to drop in to low and medium secure services to be accessible to staff.

Staff in posts who don't have regular access during working hours to the Trust intranet e.g., housekeeping, and domestic staff now have access via their personal devices to the intranet. In addition, the Trust team briefing system takes place face to face across all Trust sites to ensure this group of staff have access to information from the Board.

In addition to speaking to staff the full-time guardian has:

- Delivered speak up training to staff studying the care certificate and to volunteers working in the recovery college.
- Delivered "listen up" and follow up training to members of operational management group (OMG) and senior Trust managers.
- Implemented FTSU screensavers being continually visible on all computers.
- Promoted awareness through the annual Freedom to Speak week across the Trust.
- Distributed of FTSU branded water bottles, tote bags, pens, and business cards across the Trust.
- Been a regular attender at the fortnightly Staff side and People directorate meetings to share and pick up any intelligence.

We are currently finalising planning communication events across the Trust for the 2023, Freedom to Speak Up Month (October), the theme this year is "Breaking Barriers".

Relevant departments and functions, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

Senior people managers and FTSUGs are aware of the Speaking up Support Scheme and would refer staff if necessary. This has not been required in the Trust to date.

Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

The Trust has several care group based, civility and respect champions, who can help operational staff. These champions have supportive conversation/s with colleagues who are concerned about issues in their workplace, including patient care and bullying and harassment. Their role is to provide short term advice/guidance and for more serious matters, signpost staff to other available sources of support such as staff side trade union representatives, FTSUG, People directorate, senior managers, or professional leads.

Equity guardians are also in place to support staff from minority backgrounds who have been subject to hate crimes and racial abuse.

As described above the FTSUG does on site visits including being available during shift handovers to be visible to staff who don't have access to computers as part of their daily work.

The FTSUG attends the Race Equality and **Cultural Heritage Network (**REaCH) and other staff network meetings on a regular basis.

Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

Trust Board receive the FTSU annual report as part of their annual work programme as well as updates from the lead committee (People and Remuneration Committee) via its Alert, Assure Advise report, FTSU is a standing agenda item at each meeting of this committee. The Board will also receive the Trust FTSU self-assessment prior to submission in early 2024.

All FTSU concerns are shared with the chief executive, chief nurse, chief operating officer, and chief people officer upon receipt to ensure senior executives are sighted and able to monitor the progress of the concern and how staff are being supported.

The Audit Committee chair is the non-executive director lead for FTSU matters and meets the full-time guardian, deputy director of corporate governance (line manager to FTSU guardian) and deputy chief people officer every six weeks to review cases, ensure staff speaking out are being supported, suffering no detriment and any identified learning.

Governance was further strengthened in 2022/23 with the establishment of a steering group. Membership includes senior clinical staff, equity guardians, staff-side colleagues, deputy

chief people officer, learning and development and safeguarding. The group is jointly chaired by the chief nurse and deputy director of corporate governance.

As a foundation trust there is a members' council consisting of appointed and elected governors from across the Trust geography. Non-executive directors alongside these governors take part in regular quality monitoring visits across Trust services which include a range of options to hear the experience of operational staff including individual interviews and anonymous questionnaires prior to the visit.

Boards are regularly reporting, reviewing and acting upon available data.

As part of the Trust annual cycle of business the Trust Board receives the following reports:

- Integrated performance report (monthly), which includes a summary of all serious incidents and data for FTSU mandatory training compliance.
- Complex incidents report (eight times a year)
- Serious incidents report (quarterly)
- Annual incident management report (including learning from healthcare deaths)
- Alert, Advise, Assure reports from Clinical Safety Clinical Governance Committee, and People and Remuneration Committee
- FTSU annual report
- Equality and diversity annual report
- Patient Experience annual report

Following review of these reports, actions will be taken by members of the executive management team where required. Actions are monitored by Trust Board through the action management system. All reports submitted to Trust Board have been scrutinised by the relevant sub-committee of the Board and where appropriate the Members Council (board of governors) that follows the Board.

Fit and Proper Persons requirement for Board members

Any new appointments to the Board are assessed under the fit and proper persons requirements prior to appointment. In March each year, all members of the Board make a declaration in relation to their interests, fit and proper person requirement and where applicable their declaration of independence. The Trust is in the process of reviewing the new fit and proper persons guidance disseminated by NHSE and will be presenting a paper to Board in September 2023 documenting key changes to process.

At the time of this response the following processes are in place:

Non-executive Director declaration of independence

NHS England's Code of Governance for NHS Provider Trusts and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear

to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect.

Fit and proper person requirement

Although the requirement is in relation to new director appointments, Trust Board took the decision to ask existing directors to make a declaration as part of the annual declaration of interest's exercise. All directors sign a declaration stating they meet the fit and proper person requirements. In addition, the corporate governance team oversee the following checks:

- Registers
  - Bankruptcy and Insolvency Registers
  - Disqualified Directors Register

- Google searches – the websites searched are www.google.com, www.bing.com, www.theconsultanthub.com,www.linkedin.com,www.facebook.com, www.twitter.com, using the following:
  - "name" plus the word "complaint"
  - "name" plus the word "scandal"
  - "name" plus the word "fraud"
  - "name" plus the word "suspended"
  - "name" plus the word "healthcare"

- Professional registration – note, this is only required if a specific qualification was needed for the role

- Good Conduct and Character Reference

- Date of current DBS check

- The annual Trust Board fit and proper test, declaration of interest, and declaration of independence self-declaration forms

- The last annual appraisal – date of completion

2. Conclusion

As a Trust we are committed to ensuring robust systems, policies and procedures are in place to provide safe high-quality care for our patients and their families, and that we fulfil our duties to have robust systems in place and a respectful, honest, open and transparent culture across the Trust. Enabling staff to speak up and speak out to prevent and learn from patient safety incidents, adverse events and complaints and take action to minimise the risk of occurrence of adverse events.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 10.4

Private/Public paper:	**Public**		
Title:	**Report into the independent investigation into Child and Adolescent Mental Health Services (CAMHS) in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)**		
Paper presented by:	**Darryl Thompson, Chief Nurse & Director of Quality and Professions**		
Paper prepared by:	Darryl Thompson, Chief Nurse & Director of 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:	The purpose of the paper is to provide oversight of the report findings and assurance for our Trust against the findings identified within the report.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 3.2 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives. 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		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Each provider Trust within an integrated care system is governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from feedback and action is taken to address any findings. Regulatory bodies also identify areas of strength and good practice. Understanding our current position, areas of strength and areas for improvement allows us to be an engaged member of the integrated care systems.		
Any background papers / previously considered by:	Earlier versions of this paper have been discussed in detail at the executive management team meeting (EMT) and Quality and Safety Committee (formerly Clinical Governance and Clinical Safety Committee).		

Executive summary:	Niche Health and Social Care Consulting (Niche) were commissioned by NHS England in November 2019 to undertake an independent investigation into the governance at West Lane Hospital, Middlesbrough between 2017 up to the hospital closure in 2019. This report and its findings was published in March 2023 and is available publicly at www.tewv.nhs.uk. West Lane Hospital delivered Tier 4 child and adolescent mental health inpatient services (CAMHS). The review incorporated the care and treatment findings for three young people. A total of 12 recommendations were made to TEWV, and these are included in the paper. Our Trust is committed to learn from national reviews and investigations such as the Niche report. Our self-assessment against the themes from these recommendations has been discussed in detail in the executive management team and in Quality and Safety Committee. Further work is underway to collate the learning from several current national reports for discussion in the Executive Management Team meeting and Quality and Safety Committee. Any areas of concern will be escalated to Board as required. **Risk appetite** The Trust continues to maintain and provide assurance on the quality of our services by the Nursing, Quality and Professions directorate. This includes review and oversight of reports from external organisations which may hold learning for our Trust and in which we can review against, learn and take improvement action against any shortfalls.
Recommendation:	**Trust Board is asked to RECEIVE the report.**

Report into the independent investigation into CAMHS services at West Lane Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Niche Health and Social Care Consulting (Niche) were commissioned by NHS England in November 2019 to undertake an independent investigation into the governance at West Lane Hospital, Middlesbrough between 2017 up to the hospital's closure in 2019. This report was published in March 2023 and is available publicly here.

This report has previously been discussed in detail in the Quality and Safety Committee (formerly the Clinical Governance and Clinical Safety Committee), and is brought to Board today for further review, and consideration of opportunities for learning for the Trust.

As a result of the findings of the Niche investigation at TEWV, a total of twelve recommendations were made to TEWV and other health and care partners and national bodies, and these are reported below, with the initials of the organisation who that recommendation applied to alongside. A glossary of the abbreviations used can be found at the end of the paper.

Recommendation 1 (TEWV):
It is clear from our research that patients and their families (and some staff) were ignored and that their concerns and complaints are now found to be, on the whole, justified. The Trust must seek assurance that complaints, concerns and feedback are taken seriously and managed in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 particularly in relation to recording receipt of a formal complaint. Additionally, feedback and concerns on a service must be comprehensively reported and reviewed on a frequent basis, and importantly, that feedback is acted upon.

Recommendation 2 (TEWV):
Formal corporate decision-making processes and outcomes were difficult to trace and evidence. The Trust should seek assurance that there is a ratified minute of key organisational decisions.

Recommendation 3 (TEWV):
Action plans relating to West Lane Hospital were not connected to improvement programmes or risk registers. The Trust should ensure that there is strategic oversight of actions through the Board, Committee or working group where multiple interventions are involved. This will ensure that actions are not duplicated with other activities or overlooked. Using a programme approach around improvement plans and risk registers increases the accountability and enforceability around actions.

Recommendation 4 (TEWV): There were issues with the consistent application of Duty of Candour at the Trust. The Trust should seek assurance that there are now mechanisms in

place to assess that the Duty of Candour Policy is effectively implemented. Additionally, where there has been a death in a service, whether through self-harm/suicide or homicide, that families are given appropriate, meaningful, timely and compassionate family liaison and support through personal contact with a nominated officer of the Trust.

Recommendation 5 (TEWV, CNTW, North East & North Cumbria ICB, Middlesborough Council, NHSE and provider collaborative, and CQC):
TEWV, CNTW and System Partners need to seek assurance that they have resolved the problems associated with the clinical transitions phase (between services and child to adult). A compound recommendation is required to address this deficit:

a) TEWV must provide assurance that a full gap analysis between the 2018 Healthcare Safety Investigation Branch (HSIB) investigation and its own position has been completed. As the Trust still delivers Tier 3 CAMHS services they should expedite a review of processes and procedures in relation to transitions.
b) CNTW need to expedite a review of processes and procedures in relation to transition of CNTW young person inpatient to adult services.
c) Patient as well as stakeholder feedback associated with transitions between CAMHS and other services (such as AMHT) should be sought and incorporated into service redesign by all parties.
d) Effective governance surrounding transitions was not always in place. The good practice relating to transitions which is described within NICE Guidance should be translated into practice and delivered by all parties.
e) Where a young person is in receipt of T4 care and transferring back to T3, there must be a joint response between health and the relevant local authority children's services (in this case Middlesborough Council) so that the young person is prepared for life in the community and can be properly supported and their risks appropriately managed.
f) ICBs, NHSE and provider collaboratives must ensure that providers with a PICU have a written protocol that details the pathway for discharge, including timescales for involving in arrangements, the families and the young person. This will ensure that, wherever possible, a young person is not suddenly transferred without adequate preparation.

Recommendation 6 (TEWV):
There was a gap between the development and successful implementation of important care initiatives (such as least restrictive practice), plans and evidence-based changes to practice. The Trust must seek assurance that there are implementation plans for new initiatives, policies or procedures and that these are evidence-based, being implemented correctly within services and monitored appropriately.

Recommendation 7:
There was a lack of systematisation in relation to the identification, mitigation and actioning of known risks at a ward, service and corporate level. A compound recommendation is required to address this deficit:

a) TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.

b) TEWV must ensure that proper training is provided to staff around clinical risk management and how to ensure that action is taken consistently.
c) TEWV must provide assurance that it meets the requirements of the new Patient Safety Incident Response Framework by 2023.
d) The North East & North Cumbria Integrated Care Board (ICB), NHSE, and provider collaborative must seek assurance that TEWV has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process (including risks identified on Tunstall Ward).
e) North East & North Cumbria Integrated Care Board must assure themselves that CNTW are following the NHS Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder service specification and the QNIC standards for use of mobile phones and social media access in inpatient environments.
f) The application of robust risk assessment forms part of the CQC regulatory framework. The CQC should routinely examine the quality and consistent application of TEWV's clinical risk assessment, clinical risk training and the relationships to local and corporate risk registers.

Recommendation 8 (TEWV):
The function of Executive team [ET] meetings in terms of operational involvement lacked clarity. The Executive team meetings must clearly define and record actions which they are directly responsible for, or, where actions have been delegated. The ET should recognise that it has the mandate to form task and finish groups.

Recommendation 9:
Safeguarding between mental health providers and system partnerships was insufficient to protect young people in West Lane Hospital. Despite the availability of Working Together Guidance, responsibilities and obligations internally and externally between agencies (providers and system colleagues) were confused, interpreted differently by individuals and consequently gaps developed. A compound recommendation is required to address this deficit:

a) NHS England Specialised Commissioning, the North East & North Cumbria ICB and provider collaborative and the South Tees Safeguarding Children Partnership Board and LADO should now all reflect upon matters raised within this report and determine whether further internal review is required to ensure proper learning occurs within each respective agency. All relevant Safeguarding Children's partnerships need to ensure that there are sufficient mechanisms in place to prevent a recurrence of the same.
b) The North East & North Cumbria ICB and provider collaboratives should obtain assurance that provider organisations have sound systems and processes to safeguard young people in mental health facilities, and these provide regular robust assurance to NHS England Specialised Commissioning of effective working.
c) Middlesbrough Council and Health providers/ key partners must ensure that there is clarity about the roles and responsibilities of each agency in the planning and delivery of care to young people in Tier 4 CAMHS provision to ensure that support is holistic and meets the educational; social; physical health and emotional needs of children and young people as well as their mental health needs.

d) Local Authorities and Health providers must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.
e) Durham County Council must ensure that responses to referrals are completed within expected time frames, and subsequent assessments always incorporate the views of the family and young person.
f) North East and North Cumbria Integrated Care Board and the Provider Collaborative must consider the impact and risks on Tier 4 CAMHS if a local Safeguarding Board is found to be weak or inadequate, or a local provider is found to have a major staffing issue.
g) Where Safeguarding concerns are raised about a child, these must include a formal consideration of other vulnerable family members for the lifespan of care.
h) Middlesbrough Council must respond formally to serious concerns raised about the care and treatment of a young person under their care and explore concerns with the family and the young person.

Recommendation 10 (TEWV):
Reporting structures were disconnected between various tiers of governance, and this prevented the 'drill-down' required for effective oversight and effective learning. The Trust must ensure rounded reporting arrangements to support proper Board assurance consisting of both hard evidence and soft intelligence. This should include a 'trigger tool' when a ward or department is experiencing 'stress', such as failing to complete training, debriefs, high sickness absence, low staff morale and this should be viewed alongside patterns of incidents, harms and complaints.

Recommendation 11: There were gaps in relation to both the commissioning of effective services and in relation to the regulatory oversight in relation to West Lane Hospital. Assurance seeking activity was weak with a lack of sufficient scrutiny of both hard and soft intelligence. A compound recommendation is required to address this deficit:

a) NHS England Specialised Commissioning and the Care Quality Commission
b) (CQC) must ensure that when there is enhanced surveillance of services following quality concerns, the themes and patterns of all incidents are rigorously scrutinised and analysed.
c) NHS England Specialised Commissioning, the provider collaborative and the North East & North Cumbria ICB, should work together with the Directors of Children's Services in the North East region. This is to ensure that services are commissioned which will meet the needs of the growing number of young people with complex needs and challenging behaviours that require integrated health and social care responses.
d) A demand and capacity review (under the provider collaboratives programme and in association with each local authority) should be undertaken to ensure services have the appropriate capacity locally to minimise placing children out of area and to ensure the availability of suitable specialist care.
e) TEWV/NHS England, the provider collaborative and Middlesbrough Council must provide assurance that all looked after children specifically with a diagnosis of autism have care provided that is in line with the NICE guidance on autism spectrum

disorder in under 19s: support and management, recognising the challenges in the system.

Recommendation 12: (NHS England)
A full assurance review of progress against the recommendations contained within this report must be completed in 6-12 months. This should include all recommendations and all participant bodies.

Considering the learning from the Niche review for this Trust
An earlier version of this report was discussed in detail in Quality and Safety Committee (formerly the Clinical Governance and Clinical Safety Committee) in July 2023. This highlighted the work that has been undertaken to compare the findings of the Niche report with systems and processes within South West Yorkshire Partnership NHS Foundation Trust. Further work is underway to collate the learning from several current national reports, for discussion in the Executive Management Team meeting and Quality and Safety Committee. Any areas of concern will be escalated to Board as required.

Glossary

- AMHT – adult mental health team
- CAMHS – child and adolescent mental health services
- CNTW – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- CQC – Care Quality Commission
- LADO – Local Authority Designated Officer (the person responsible for managing allegations against adults who work with children)
- NHSE – NHS England
- NICE – National Institute for Health and Care Excellence
- North East & North Cumbria Integrated Care Board (ICB)
- PICU – psychiatric intensive care unit
- TEWV – Tees, Esk and Wear Valleys NHS Foundation Trust
- T3 – specialist CAMHS services, e.g. community crisis services
- T4 – Tier 4 CAMHS general in-patient services for children and young people

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 September 2023
Agenda item 10.5

Private/Public paper:	**Public**		
Title:	**Patient Experience (including complaints) Annual Report 2022/23**		
Paper presented by:	**Darryl Thompson, Chief Nurse & Director of Quality and Professions**		
Paper prepared by:	Sarah Lobley - Customer Services Team Manager Suzie Barton - Portfolio Lead, Quality Improvement and Assurance Team Sarah Whiterod - Associate Director of Nursing, Quality and Professions		
Mission/values:	We must support people to fulfil their potential and live well in their community, we do this though our values: We put the person first and in the centre We know that families and carers matter We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow		
Purpose:	To provide an annual report (2022/23) of patient experience, including complaints.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work		
BAF Risk(s):	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 1.4 Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy. 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	Positive service user and carer experience is integral to delivering high quality services. Each Trust or provider within an integrated care system is responsible for delivering high quality care, being open to receiving and learning from feedback. It is essential that service users and carers can see the changes made based upon their feedback.		

With **all of us** in mind.

Care Board/Place based partnerships	
Any background papers / previously considered by:	Quality and Safety Committee recommended this report to Board for approval in September 2023.
Executive summary:	Feedback from service users, carers and staff is collated in a number of ways within the Trust. Key sources of feedback are via our customer services team, the friends and family test (FFT), and staff are able to provide feedback through the Trust freedom to speak up guardians. This report provides data and information about feedback gathered through the above routes. Themes from feedback are used to support quality improvement across our services, and enable service user, carer and staff experience to be captured within the work we do, and the care we provide. In response to previous committee and Board feedback, the report includes insight and information from all of the above sources. Highlights of the report include: • During 2022/23 the customer services team received and processed 758 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 2.5% decrease compared to the previous year (2021/22) when 777 items of feedback were received. • Of these 758 items, 86 of these were formal complaints and this compares with 119 during the previous year. These are complaints where consent has been received from the complainant and the scope of investigation agreed and an investigation started. • The friends and family test has seen an increase in responses over the previous 12 months and an increase in the number of people who rate our services as 'good' or 'very good'. • 'You said, we listened' actions following insight information about services The majority of both complaints and compliments, per caseload size, are received by mental health inpatient services, and feedback rate by service area is included within the report. Performance in response to "closure of a complaint within 6 months of receipt" has deteriorated over 2022/23, with a range of factors impacting on this situation. An improvement approach is being utilised to address identified issues and this detailed in the attached report. A backlog of complaints awaiting allocation to a complaints case handler has reduced from a peak of 61 in autumn 2022, to 40 at the end of 2022/23, with further and sustained reduction since. The Trust received eight requests for information from the Parliamentary and Health Service Ombudsman (PHSO) in 2022/23 with five of these cases

	having been brought by two complainants. Four of these cases have been closed by the PHSO with no further action or recommendations. The Trust is still waiting for the outcome of the PHSO's scrutiny of the four other cases. The PHSO have advised that it also has a significant backlog of cases awaiting review and will only investigate those where there has been the biggest hardship. **Review of the Patient Experience report 2023/24** A full review of this annual report is planned for February 2024. This will be this will take place through the Patient Experience Group and will include: • Customer Services feedback • Insight data and information • Friends and Family test and other patient experience surveys A proposal for the new report will be shared with Quality and Safety Committee in March 2024.
Recommendation:	**Trust Board is asked to RECEIVE and APPROVE the annual report on Patient Experience (including complaints) and to NOTE the next steps identified.**

South West Yorkshire Partnership NHS Foundation Trust

Patient Experience (including Complaints)

Annual Report 2022/23

With **all of us** in mind.

CONTENTS

Executive Summary

Feedback from service users, carers and staff is collected in a number of ways across the Trust with one key source being the customer services team. Feedback is also received through the friends and family test (FFT), insight information provided to Healthwatch, Trust governors and partners. Staff are also able to provide feedback in a number of ways including through the freedom to speak up guardians.

This report provides data and information about feedback gathered through the above routes. Themes from feedback are used to support quality improvement across our services and enable service user, carer, and staff experience to be captured within the work we do and the care we provide everyday.

During 2022/23 the customer services team received and processed 758 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 2.5% decrease compared to the previous year (2021/22) when 777 items of feedback were received.

Of these 758 items, 86 (11%) were formal complaints (where consent was received and scope of the investigation agreed) which compares with 119 during the previous year. There were at total of 265 complaints across all categories (no further action/no consent, awaiting consent, awaiting allocation and awaiting questions/scope).

The complaints received into the Trust typically contain several issues which require investigating. The customer services team have noted that complaints have typically become more complex in nature, with a change in the expectation of the complainant about what can be achieved through the complaints process.

During the reporting period there have been six complaints which have been re-opened following a complaint being completed. This is a lower number than previous years.

The customer services team monitors and reports the progression of formal

complaints against the statutory guidance set out in the NHS Complaints (England) Regulations 2009, which details that a response should be provided within 6 months from the date that a complaint is received. Further detail of our compliance with this timeframe is contained within the report, together with our plans to improve this compliance.

The associated impact of the COVID-19 pandemic of less clinical staff being available to investigate complaints, alongside internal capacity and resourcing pressures within customer services, has meant that the Trust currently has a backlog of complaints waiting to be allocated to a named handler and therefore responded to. The team has been working hard to reduce this from the high of 61 complaints on the waiting list to be allocated in September 2022 to 31 at the end of 2022-23, which is a 49% decrease [of note, this has continued to decrease in 2023/24).

Of the 758 items of feedback received, 493 were comments/concerns. This is an increase from 2021/22 where 426 comments/concerns were received.

Alongside the 758 items of feedback, the Trust also received 324 compliments during 2022/23. This is a small increase of 6% compared to 307 in 2021/22. The number of compliments can fluctuate year on year and per month, which can be due to how often compliments received by clinical services are shared with the customer services team for formal recording. Formal recording of compliments through the customer services team supports staff morale and sharing best practice examples across the Trust.

The friends and family test has seen an increase in responses over the previous 12 months and an increase in the number of people who rate our services as ‘good’ or ‘very good’.

Data and insight gathered from Healthwatch, through Trust governors and partners has also supported a number of improvements across our services.

1. Introduction

This aim of this report is to provide data and information related to the feedback we receive into the Trust, an analysis of this information and an overview of actions taken as a result of the feedback received.

There are four parts to this report. The main focus is on the customer services function and the complaints, comments, concerns and compliments received by the team and across the Trust. Within this report there is also data and information about feedback captured through the friends and family test (FFT), through insight provided to Healthwatch, Trust governors and partners.

Feedback is received into the customer services team through email, letter or phone call. Complaints received can be responded to initially in an informal manner, with the relevant service reviewing and if appropriate contacting the complainant for an initial discussion about their complaint. A number of complaints do not progress through a formal process as they are able to be resolved informally through this discussion. Those that are requested to be formal from the outset, or those where an informal resolution has not been possible, will then be managed through the formal Trust process for the handling of complaints. This report provides data on complaints resolved informally and those which undergo a formal process. Of note, complaint themes are outlined, broken down and reported at service level.

Information about the numbers of comments and compliments is also detailed within this report. A comment is something that is unrelated to direct care and treatment, for example feedback about parking or food provision.

The freedom to speak up guardian continues to work closely with staff and support staff to raise concerns through a number of channels. This learning is covered within the annual Freedom to Speak Up guardian's report.

The friends and family test (FFT) is key source of service user and family/carer feedback into the Trust regarding the care they receive. The

use of electronic collection methods has supported an increase in the amount of feedback received during the reporting period. The feedback from the FFT is used to support improvements to services and some examples of this are shared within the report.

2.Customer Services

The NHS Complaints (England) Regulations 2009 remain unchanged since the pandemic and the statutory framework is that a response to a complaint should be provided within 6 months from the date it was first received. The Parliamentary Health Service Ombudsman (PHSO) is guided by this and asks that organisations keep complainants updated about when they expect to respond.

All complaints which are received by the customer services team are risk assessed using the Trust's risk matrix. This is undertaken by the customer services manager or their deputy, and any complex or high-risk complaints are discussed with the associate director of nursing, quality and professions and the assistant director of legal services as required.

Work is continuing to improve Customer Services processes to ensure that the Trust responds in a way that maximises opportunities for learning and becomes more responsive where service issues arise. This means services will see the issues raised in the first instance, with a view to being able to resolve them quickly and informally, before proceeding to a formal complaint process within Customer Services.

2.1. The Customer Services team

The customer services team is made up of staff trained in the management of complaints, and they are highly skilled specialists in complaint handling and investigation.

Throughout the second half of the year an improvement programme was established to support reducing a backlog of complaints which had built up during the complexities of the previous years (during the pandemic) and also to review the process for managing complaints across the Trust. Quality improvement methodology has been utilised to support this work. Through scoping and understanding the problems and identifying change ideas, a number of actions are underway, using a PDSA (plan, do, study, act) method, which are supporting a reduction in the backlog of complaints.

Significant work has been undertaken as part of the improvement programme including reviewing the process for how complaints are managed within each Service, identifying delays in the process, including making the sign off process more efficient and understanding individual responsibilities for investigation of complaints.

This improvement programme will continue during 2023. The next steps are to utilise process mapping to review the whole process for complaint management and identify where there are potential blocks, inefficiencies and good practice to further streamline the process.

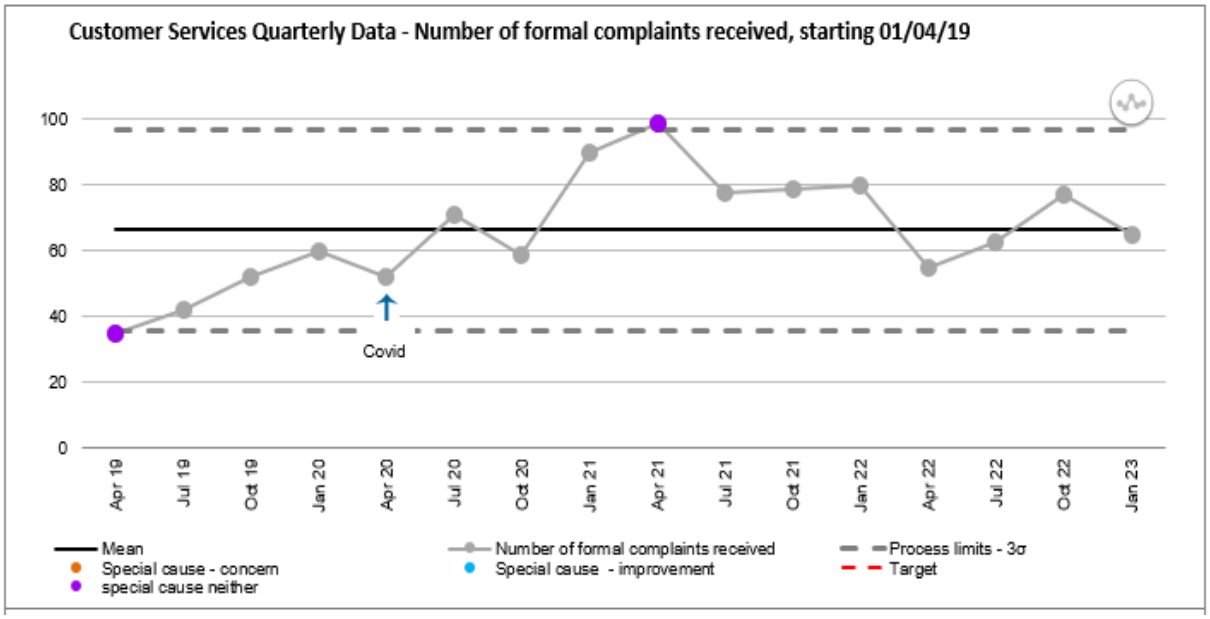
2.2. Managing complex complaints

Complaints are often complex and longstanding in nature and require thorough investigation to resolve the issues raised. Individuals often require support to understand the potential outcomes of a complaint, as there are occasions where a complainants' expectations of what can be achieved through the complaints process may be unachievable.

The numbers of complainants who make multiple or continuous complaints require a large amount of resource which often includes corporate governance and legal services. The management of these complaints requires a coordinated approach across the Trust and places increased workload on teams.

3. Formal Complaints

3.1. Total number of formal complaints received into the Trust via Customer Services



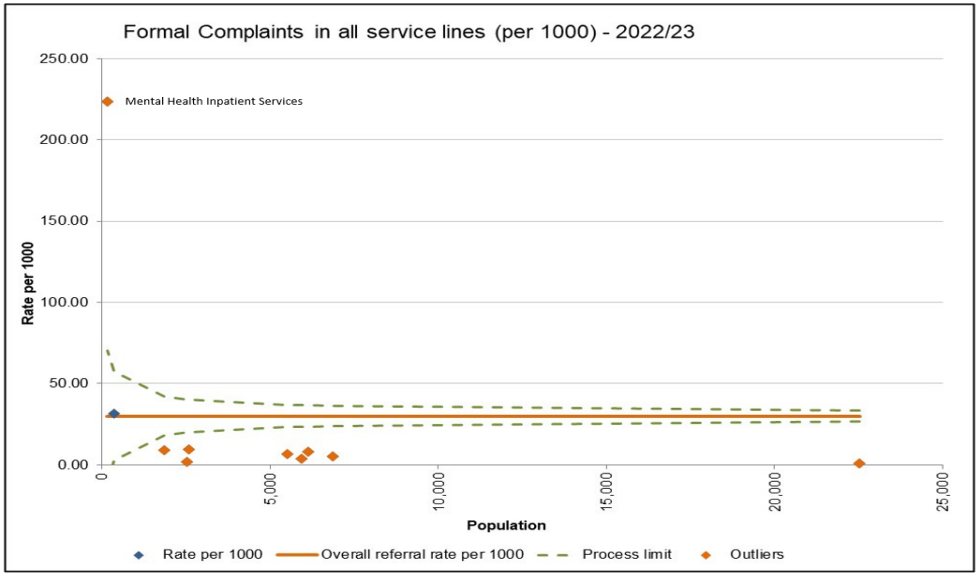
The data above is presented in a statistical processing control (SPC) chart. SPC charts are simple graphical tools that enable process performance to be monitored over time, using upper and lower control limits and allowing for easy identification of changes that are outside of these normal limits.

The data remained in normal variation with a peak number of formal complaints received January to April 2021. This corresponds to the third national lockdown and could be indicative of the increased restrictions around face-to-face

contact. No other reasons for this anomaly have been established and the numbers of complaints returned to within expected volumes by the middle of 2021.This appears to be in line with national reporting on formal complaints (NHS Digital) where data for 2021/22 shows an increase of 25.8% from 2020/21, and then a return towards pre-pandemic levels.

The number of formal complaints continues to be above average and also above pre-pandemic levels, 2019/20 levels. There has been a steadily increasing trend in the number of formal complaints received by the team since the pandemic began in March 2020. This is likely attributable to the increased demand on services since the COVID-19-19 pandemic, which has led to delays within NHS services and systems and a backlog of patients and service users waiting for treatment and remaining on waiting lists for longer periods.
Section 3.9 reports on themes from complaints and whilst waiting times is not a significant theme, access to treatment and drugs remains the top reported reason for complaints for the second year in a row.

3.2. Formal complaints by Service



Service	Complaints received as a proportion of individual caseload size (per 1000)
Mental Health Inpatient Services	223.60
Forensic Services	31.70
Calderdale CMH Services	9.70
ADHD and Autism Services	9.20
Kirklees CMH Services	7.99
Wakefield CMH Services	6.53
CAMHS Specialst Services	5.39
Barnsley CMH Services	3.88
LD Services	1.98
Barnsley General Community Services	0.71

A funnel plot, such as the one shown above, are widely used to support data analysis. These charts show the measure of interest on the vertical axis (in this case rate per 1000) and the sample size on the horizontal axis (in this case population).

The funnel plot shows the number of formal complaints received by each service across 2022/23. It considers the total number of complaints received by each service as a proportionate rate against their individual average caseload size for 2022/23.

Mental health inpatient services are an outlier and shows a high rate of complaints for its caseload size. However, there has been a positive shift in this rate since 2021/22, when the data reported a rate of 263 complaints per 1000. Many

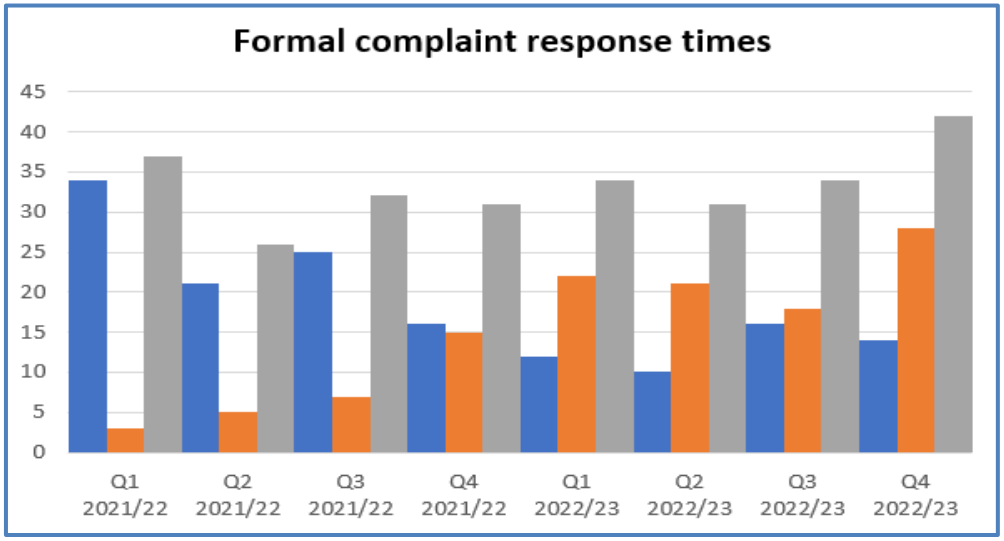
people treated within inpatient services are acutely unwell and are treated under legal frameworks. This can impact on the type and number of complaints made.

Many of the services receive a lower-than-expected number of complaints which is likely to be an indication of service user, carer or relative satisfaction. However, we should be mindful that it may also indicate hesitancy about making a complaint and/or uncertainty about the complaint process.

3.3. Complaints Key Performance Indicators (KPIs)

The Trust's KPI is to close formal complaints within 6 months of receipt, which is in line with NHS Complaints (England) Regulations 2009.

Blue – closed within 6 months
Orange – over 6 months
Grey – total number



In the first three quarters of 2021/22, the majority of complaints were closed within 6 months of receipt. In Q1 2021/22 a record high of 92% of responses were closed within 6 months. Performance declined to 81% in Q2 and 78% in Q3. From Q4 2021/22 the Trust's performance in meeting the 6-month target has continued to decline and the rolling average for 2022/23 is now 37%. Work is underway to further analyse data related to the process for complaints to understand this in more detail.

There are multiple factors that impact on our ability to meet this target. Further detail is provided in the next section.

3.4. Responding in a timely manner

The Customer Services standard and the NHS Complaints Regulations stipulate complaints must be acknowledged within three working days. During 2022/23, 96% (n=254/265) of formal complaints met this target. Of the 10 that missed the target, five were specifically related to human factors and these have been addressed. There were also other issues identified including human error, the Datix system being down (so the electronic database that we use to manage complaints was unavailable), annual leave within the team and awaiting clarification as to which organisation would lead a complaint.

Timescales for responding to a complaint are negotiated on an individual basis (but remain within regulatory requirements), with each complainant offered regular updates on the progress of their complaint until the issues are resolved to their satisfaction or a full explanation has been provided.

A complaint investigation should be proportionate to the concerns raised. The target in which a complainant can expect to receive a formal response is agreed between the customer services officer and the complainant.

All complaints are dealt with as quickly as possible. Service directors and general managers across services are kept updated on the progress of complaint investigations. The customer services team works with individual services to support the identification of lead investigators who have capacity and dedicated time for conducting investigations.

During 2022/23 141 formal complaints were closed and 63% of these were closed within the six-month target. The customer services team conducted an in-depth analysis of Trust timeframes for responding to formal complaints between September 2022 and February 2023 which is a 6-month period and identified the following:

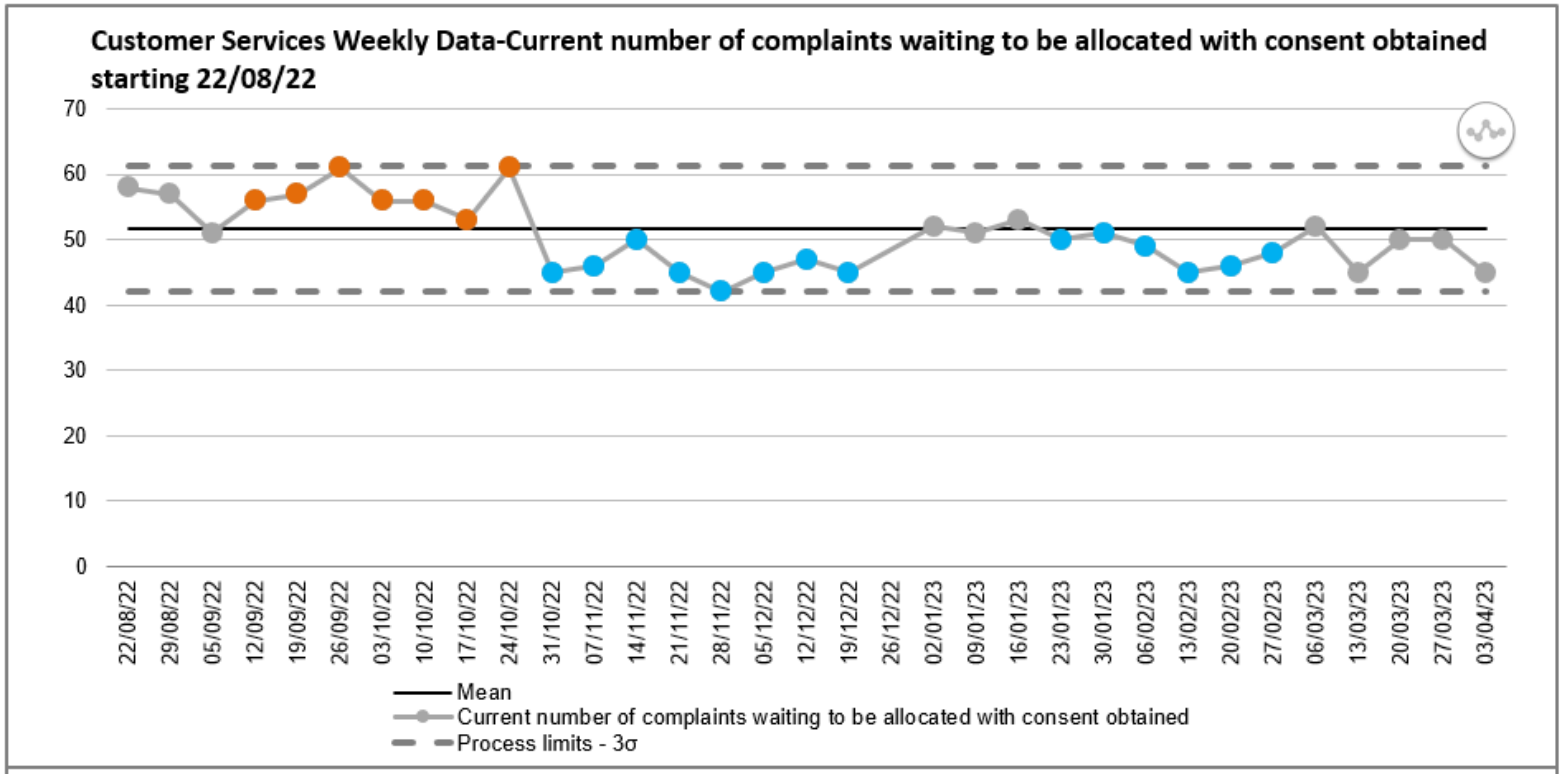
- 42% of complaints were delayed being allocated a lead investigator (LI) which currently has 5 working days built into the process.
- 46% of complaints were delayed having the toolkit returned to the customer services team from services, to enable a response to be formulated. This stage of the process (scope agreed to toolkit returned) currently has 20 working days built in.

- 77% of drafted responses were delayed during the sign off process. There are 22 working days built in from returning the toolkit to closure of the complaint.
- A single complaint can be delayed at multiple stages throughout the process.

The result of this in-depth analysis is supporting the improvement project around streamlining the process for complaints management.

3.5. Complaints backlog

The following statistical processing chart shows the number of complaints waiting to be allocated to a complaints officer within the customer services team (the backlog). This shows weekly data from August 2022.



The graph highlights the stabilisation of complaints in the backlog from November 2022 when focussed reduction began. The improvement work has supported a reduction in the number of complaints in the backlog towards the end of quarter 4 and into quarter 1 of 2023. It is anticipated that this will continue to reduce and be eradicated completely during quarter 2 of 2023.

3.6. Risk Grading – Complaints

All complaints which are received by the customer services team are risk assessed using the Trust's risk matrix. This is undertaken by the customer services manager or their deputy, and any complex or high-risk complaints are discussed with the associate director of nursing, quality and professions and the assistant director of legal services as required.

The customer services manager attends the weekly clinical risk panel, to allow for escalation of any concerns related to a complaint and discussion through the risk panel to agree a way forward. Clinical risk panel is attended by the executive trio, this being the Chief Operating Officer, Chief Nurse / Director of Quality and Professions, and the Chief Medical Officer. Any complaint graded as red is presented at clinical risk panel. This also provides assurance that actions relating to the most serious Trust complaints are fully implemented into clinical services.

The table below is for all complaints received into the Trust for 2022/23 regardless of whether these progressed through a formal process i.e., some were closed due to no contact/consent.

All 265 complaints across Trust services were risk graded, with the majority (71%) were being graded as green (minor impact/no harm) in 2022/23 which is positive. Only 1 complaint was graded as red (catastrophic impact) which involved a service user death. This indicates that most complaints raised with the Trust do not relate to concerns regarding the safety of service users in respect of care delivery and treatment.

There were 76 complaints (29%) that were graded as amber (moderate impact or intervention) and the Forensic Service had 55% of complaints rated as amber followed by Mental Health Inpatient Services at 42%.
The table below shows risk grading for all complaints received into the Trust, broken down by service.

Service	Green	Amber	Red	Total
ADHD and Autism Services	14	3	0	17
Barnsley Community Mental Health Services	19	5	0	24
Barnsley General Community Services	15	5	0	20
Calderdale Community Mental Health Services	17	8	0	25
CAMHS Specialist Services	29	9	0	38
Forensic Service	5	6	0	11
Kirklees Community Mental Health Services	38	11	0	49
Learning Disability Services	5	0	0	5
Mental Health Inpatient Services	23	16	0	38
Trust wide (Corporate support services)	0	1	0	1
Wakefield Community Mental Health Services	23	12	1	36
Total	**188**	**76**	**1**	**265**

3.7. Regulation: Parliamentary and Health Service Ombudsman (PHSO)

The PHSOs were set up by Parliament to provide an independent complaint handling services for complaints that have not been resolved by the NHS in England and UK government departments. The PHSO look into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right (ombudsman.org.uk).

The Trust received eight requests for information from the PHSO in 2022/23 with five of these cases having been brought by two complainants.

The Trust received notification that four of these cases have been closed by the PHSO with no further action or recommendations.

The Trust is still waiting for the outcome of the PHSO's scrutiny of four cases.

During the previous reporting year, 2021/22, the Trust received 10 requests for information from the PHSO. All requests were responded to, and information shared with the PHSO to enable them to review and decide whether to investigate complaints at the second and final stage of the NHS complaints process and make any recommendations.

As a result of the pandemic, the PHSO advised that it has a significant backlog of cases awaiting review and will only investigate those where there has been the biggest hardship.

It is difficult to determine whether the number of complaints handled by the Trust which were escalated to the PHSO is in line with other NHS Trusts, due to the differences in patient population, services offered, and volumes of complaints handled by each Trust. Eight cases escalated to the PHSO out of the 86 formal complaints handled by the Trust equates to less than

10%. Further information about the numbers of complaints re-opened is detailed in the next section and this provides a further indication of the robust management of complaints within the Trust.

3.8. Reopened complaints

During 2022/23 there were six formal complaints which were re-opened after the complaint had been investigated and an outcome letter sent to the complainant. This is the same as the number re-opened during 2021/22 and suggests that nearly all complainants are satisfied with the response they receive to their complaint. Further work to understand complainant satisfaction is planned for 2023/24.

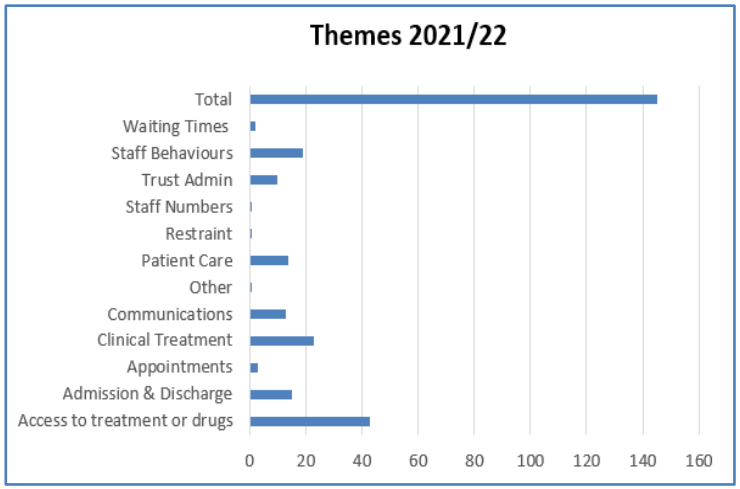
Once the individual has received the Trust's formal response to a complaint, any new or outstanding issues this generates should be raised within a reasonable time – a guideline the PHSO uses is twelve months from receipt of the response, although it very much depends on individual circumstances. As a Trust, we ask complainants to come back to us with any outstanding concerns within one month. In such cases, the complaint file is reopened, and further investigation will take place to ensure that the Trust has addressed all the issues raised and a further response is sent to the individual with the findings. In some cases, a second opinion or clinical advice will be sought. The Trust will endeavour to resolve reopened complaints through stage one of the complaint process (local resolution). However, once it is considered by the Trust that this is completed/exhausted the individual is advised of their right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) for independent scrutiny.

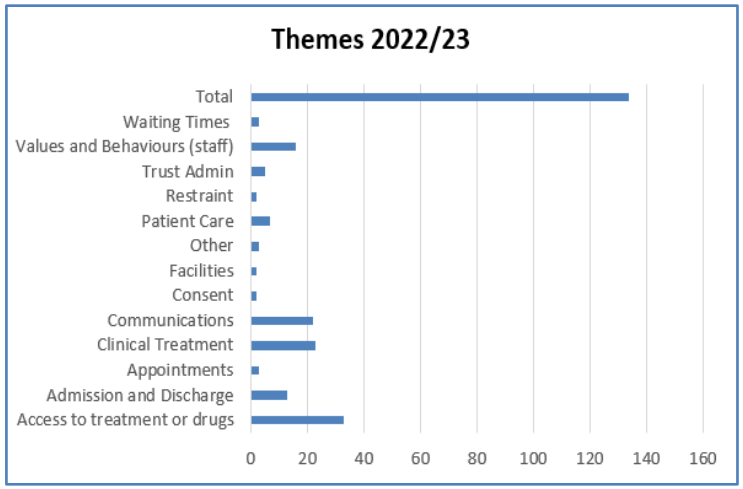
Analysis of reopened complaints is complex. The reported figures are those that were reopened within 2022/23, regardless of when the complaint was initially responded to, were around complainants coming back to tell us they were not satisfied with their response. This could potentially be seen as a positive indicator they have not lost faith in our organisation's ability to resolve their concerns as they have actively chosen to come back to us rather than approach the PHSO directly.

In line with the NHS Complaints (England) Regulations 2009, issues that the Trust has already responded to and is unable to provide any further meaningful comments will not be reopened or re-investigated. The complainant is informed of this decision by letter and information about the

Parliamentary Health Service Ombudsman (PHSO) is shared so they know how to access further support with their complaint.

3.9. Themes from complaints





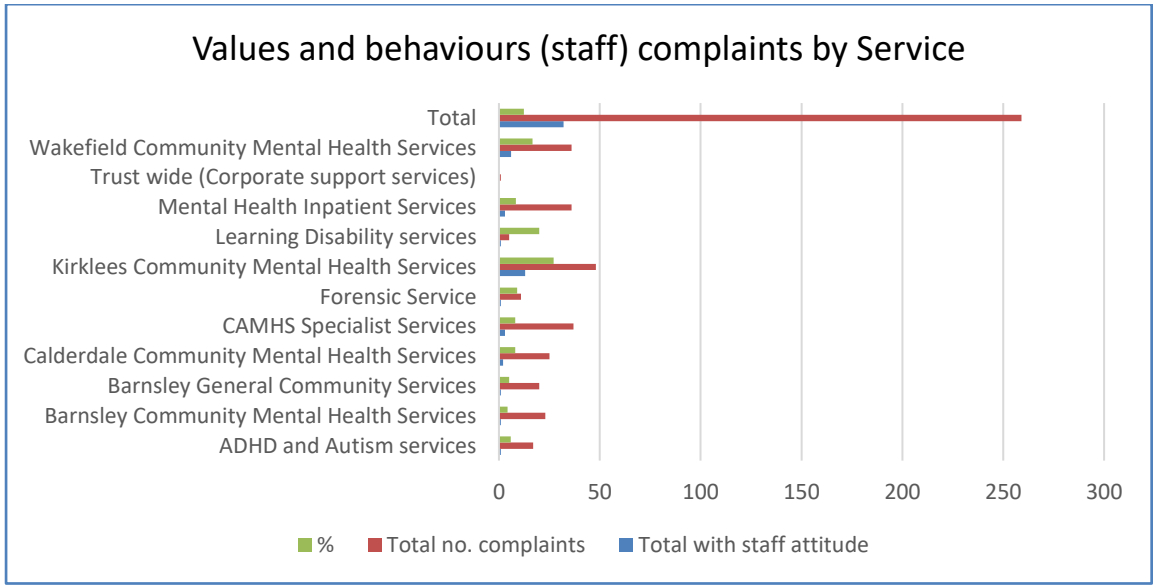
Complaints typically contain multiple themes/issues and in 2022/23 there were 134 themes recorded across 13 categories. This is similar to the data from 2021/22 where there were 145 themes recorded across 12 categories. The themes across the two years vary slightly with staff numbers not being a theme in 2022/23.

- Access to treatment or drugs has remained the top primary subject for complaints across both years.
- Clinical treatment (17%) was the second most common theme (n=23) for complaints in 2022/23 closely followed by communications (n=22, 16%).
- Clinical treatment (16%) was the second most common theme (n=23) for complaints in 2021/22 followed by staff values and behaviours (n=19, 13%).

- These have been the top themes within complaints for the last five years.

Themes from complaints and learning are picked up and discussed within Care Group clinical governance groups and inform local improvement plans. Learning is shared through Care Group forums.
Further work to share and embed the learning and ensure that positive changes are made as a result of feedback will be prioritised as part of the ongoing improvement programme during 2023/24 and as part of the development of the overall patient experience work.

3.10. Formal complaints involving values and behaviours (staff)



The Trust received 32 complaints (12%) in 2022/23 out of a total of 265 complaints which included values and behaviours (staff) as a primary subject/theme. Kirklees Community Mental Health Services received the highest percentage (27%) of complaints with staff attitude as a primary issue (n=13). However, this is a small number relative to the caseload for this service and the total number of contacts service users have every day with Trust staff. The learning disability service received the second highest percentage (20%) of complaints in this area although again this was a very small sample size (n=5) followed by Wakefield community mental health services (17%).

This data should be viewed with caution. The number of complaints where staff attitude is a theme is relatively small, when compared with the caseload and number of patient contacts that staff have on a daily and weekly basis.

Where a staff member is named in a complaint, this will be addressed by the investigator and as part of clinical and management supervision, to allow for reflection and learning.

Work on communication skills and human factors can support with reducing this as a theme within complaints. The customer services team works closely with the quality improvement and assurance team to share themes. Quality assurance processes, including quality monitoring visits review culture concerns that have been highlighted in specific areas/wards.

3.11. Member of Parliament (MP) Contacts

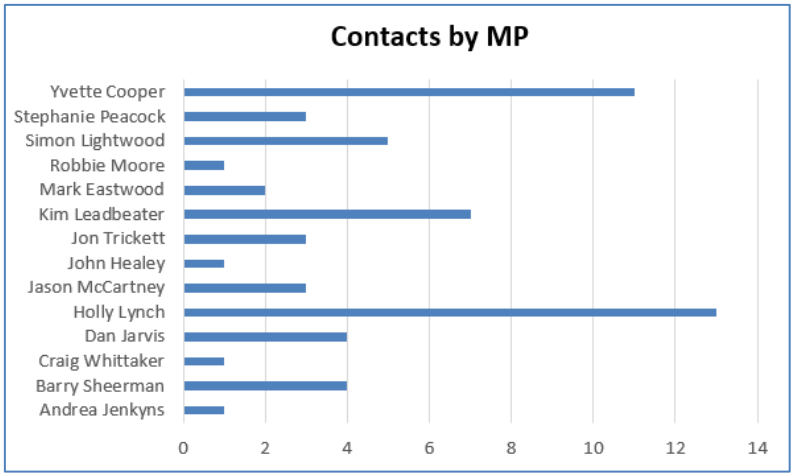
During 2022/23 the customer services team received 59 MP contacts which has remained relatively stable from 2021/22 (n=58). The customer services team have attended meetings with MPs when these have been requested, such as Holly Lynch (Calderdale) along with clinical services to provide updates on specific cases.

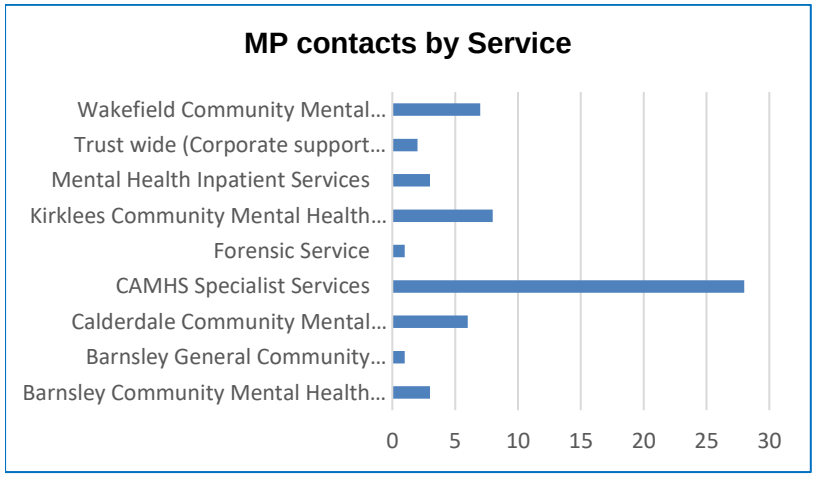
Holly Lynch (Calderdale) submitted the majority (22%) of MP contacts in 2022/23 followed by Yvette Cooper (Wakefield) at 19%, and Kim Leadbeater (Kirklees) at 12%.

The service which receives the most MP contacts is child and adolescent mental health services (CAMHS) specialist services at 47% which is a consistent trend over the last few years, and this is primarily about access to treatment for children and young people.

CAMHS Wakefield received the highest number of MP contacts at 36% followed by Kirklees at 25%, Calderdale at 21% and Barnsley at 18%.

Kirklees Community Mental Health Services received the second and Wakefield Community Mental Health Services the third most MP contacts at 14% and 12%.





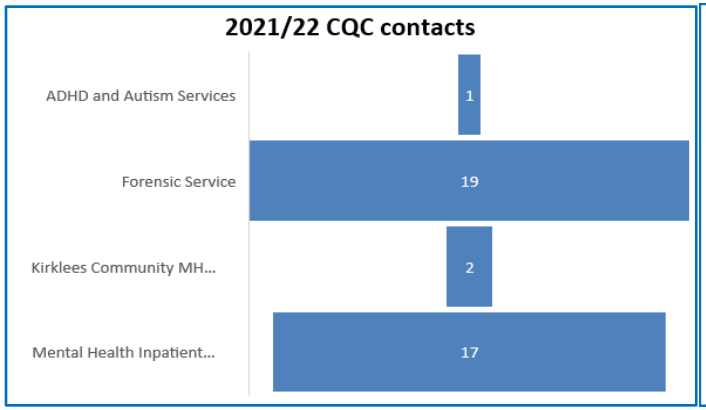
3.12. Care Quality Commission (CQC) complaints

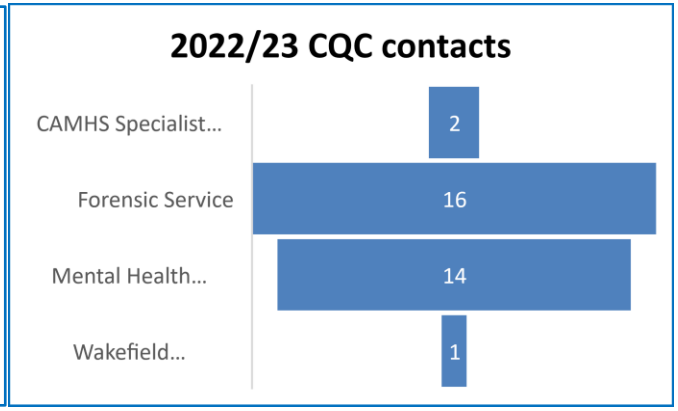
During 2022/23 the customer services team received 33 contacts from the CQC whereby the complainant had approached them directly. This compares to 39 CQC contacts in 2021/22 and is a reduction of 15%.

The tables below show the number of CQC contacts by service for the last two financial years and the trend remains that the forensic service receives the highest number, closely followed by mental health inpatient services. There are common themes for both services such as Section 17 leave, disputes about diagnosis and concerns about care and treatment.

Due to the increase in CQC contacts for the Forensic Service between 2020/21 and 2021/22, an engagement poster was designed to encourage service users to discuss their concerns with the service provider in the first instance. There was a reduction of three complaints via the CQC for forensic services in 2022/23.

When a complaint is received via the CQC the customer services team triangulate information with the Quality Improvement and Assurance Team (QIAT) and the Safeguarding team to identify if other contact has been received from the service user/complainant. This ensures that investigations and responses are consistent.



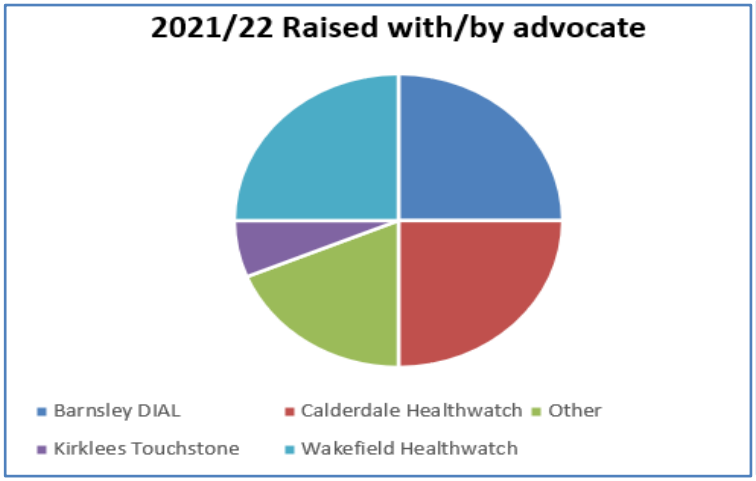


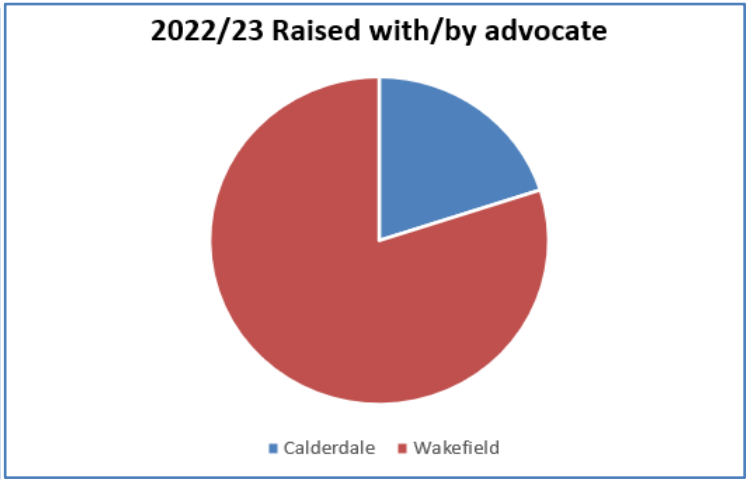
3.13. Independent Complaints Advocacy Services (ICAS)

NHS complaints advocacy provides practical support and information for those wishing to make a complaint about an NHS service they or someone they know has received and advocates are independent from the Trust.

The customer services team provide all complainants with details of local advocacy services when the formal acknowledgement information pack is issued. Advocates can provide support and help the complainant to compile all the relevant issues and facts that they wish to highlight as part of their complaint.

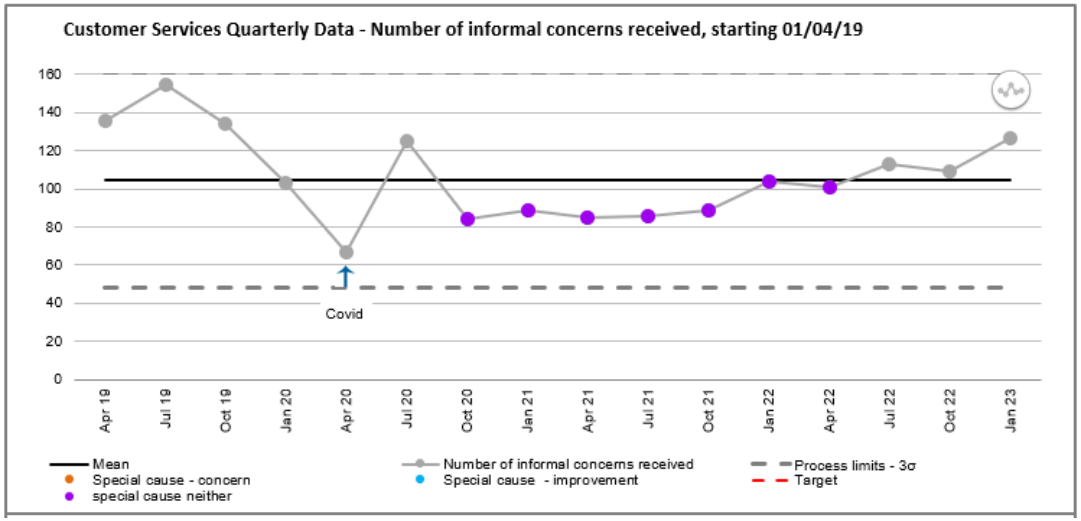
The customer services team monitor the uptake of advocacy support and work closely with advocates. Advocates covering all areas of the Trust have attended customer services team meetings (virtually) over the past year to foster positive working relationships and enable them to provide feedback to support service improvements. During 2022/23 there were five complaints/feedback that were raised with/by an advocate. This is compared with 16 during 2021/22, which is a decrease of 69%. Feedback from advocates suggests that waiting lists for support from advocates may be impacting the numbers of complaints which are coming via an advocate. Advocates have also noted that there has been an increase in challenging behaviour from complainants and an increase in the complexity of issues.





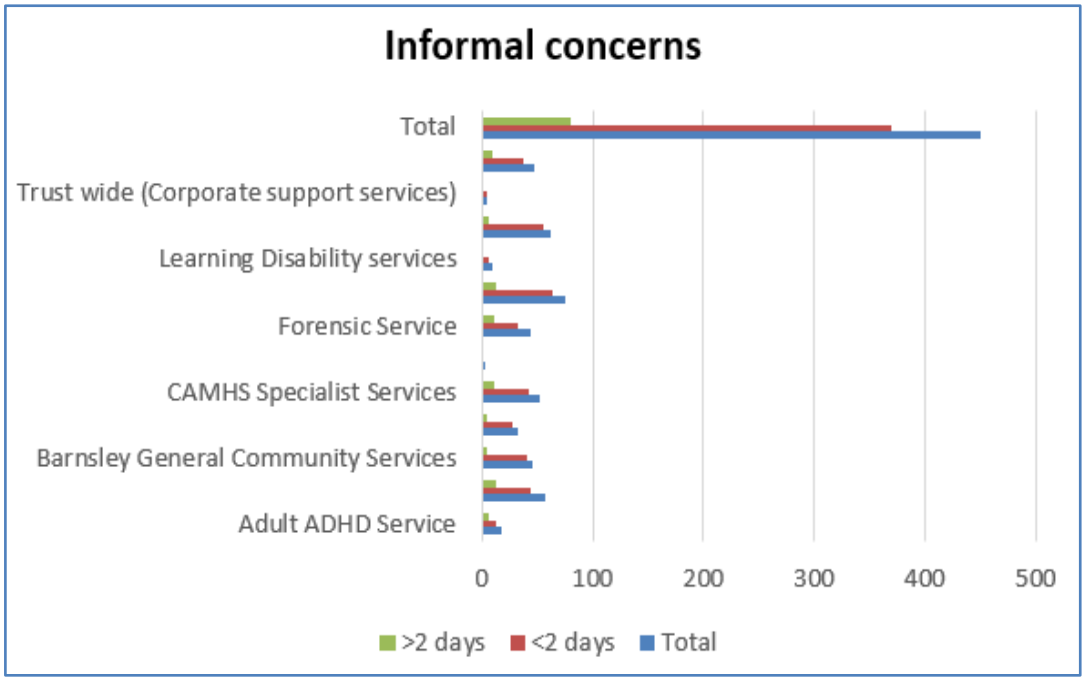
4. Other feedback

4.1. Number of informal concerns made into customer services per quarter



Overall, the number of informal concerns remains within normal variation with the lowest number received in April 2020 which is likely to be linked to the first national lockdown where support for the NHS was high. Data should be closely monitored going forward as there is evidence of a rising trend in the number of informal concerns received.

4.2. Response times for informal concerns



The Trust's complaints process supports local resolution in the first instance and contact with the service provider to resolve concerns directly at source. The customer services team works closely with clinical services to ensure that informal concerns are responded to by services within 2 working days. However, with agreement from the complainant, this statutory timeframe can be extended.

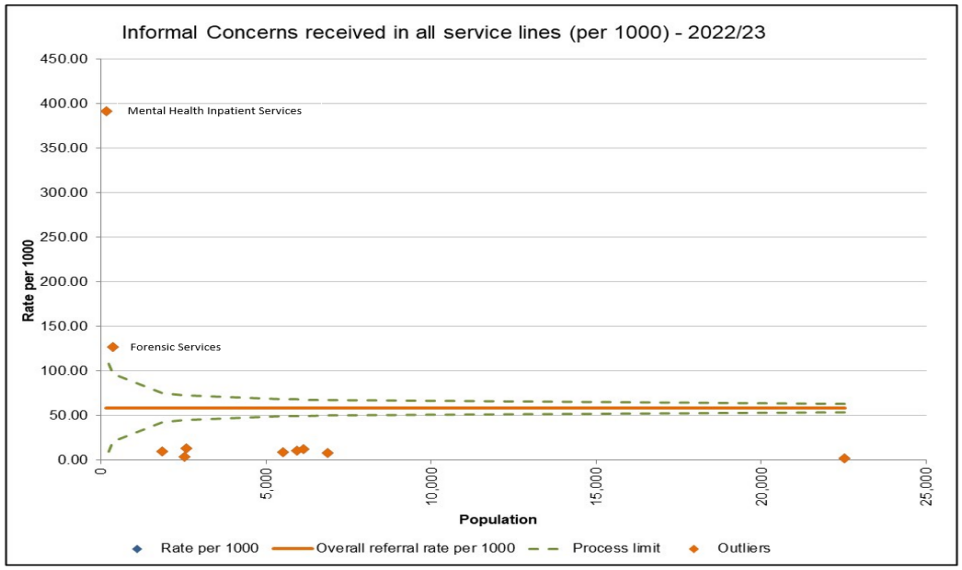
This revised approach means we are dealing with significantly more informal concerns – 450 informal concerns were dealt with in 2022/23 compared to 370 in 2021/22, an increase of 22%. Of these, 82% (n=370) were closed within 2 working days.

During 2022/23 79 informal concerns (18%) exceeded the two working days target; the average number of working days to resolve for these was 19 days.

Feedback to confirm if an informal concern has been resolved by the service is not always received by the customer services team. This can delay the process for escalating to a formal complaint or allowing the case to be closed on the system. Collaborative work between the customer services team and clinical services is underway to ensure the process for sharing feedback is robust.

Kirklees Community Mental Health Services received the highest number of informal concerns followed by Mental Health Inpatient Services and both had over 80% compliance for resolving within 2 working days.

4.3. Informal concerns by Service



Service	Informal concerns received as a proportion of individual caseload size (per 1000)
Mental Health Inpatient Services	391.30
Forensic Services	126.80
Calderdale CMH Services	12.42
Kirklees CMH Services	12.22
Barnsley CMH Services	9.79
ADHD and Autism Services	9.74
Wakefield CMH Services	8.53
CAMHS Specialst Services	7.87
LD Services	3.57
Barnsley General Community Services	2.00

The funnel plot above shows the number of informal concerns received by each service throughout 2022/23. It considers the total number of informal concerns received by each service as a proportionate rate against their individual average caseload size for 2022/23.

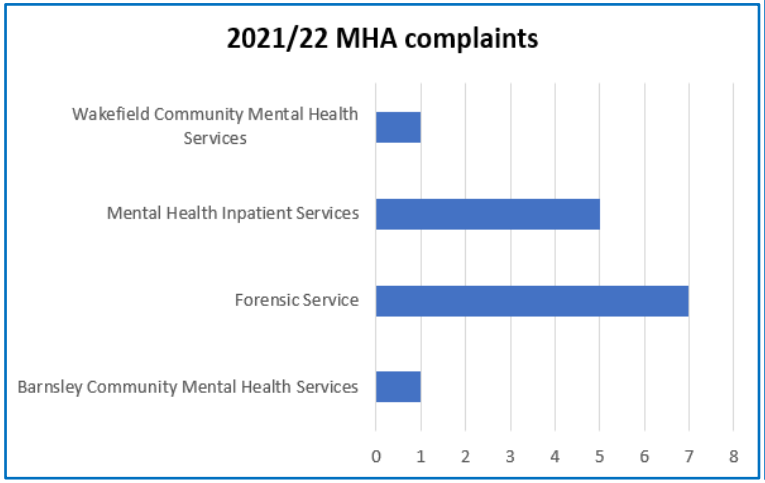
Mental health inpatient services and forensic services are outliers and show a higher than expected rate of informal concerns for their caseload size. This may also reflect the service user population who may not understand that they are acutely mentally unwell and often detained under the Mental Health Act against their will. Analysis is planned to fully understand the nature of the informal concerns received across mental health inpatient services and how this may vary across individual wards.

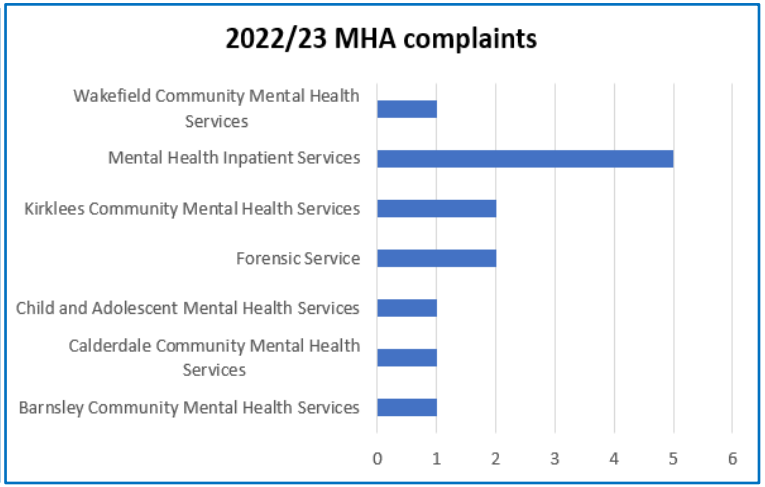
All other services received a lower-than-expected number of informal concerns which is likely to be an indication of service user, carer or relative satisfaction. We are working to ensure that the reporting culture is embedded in the same way across all of our services.

5. Mental Health Act complaints

Information on the numbers of complaints regarding application of the Mental Health Act (MHA) is routinely reported to the Mental Health Act Committee.
In 2022/23 there were 13 complaints which included the MHA as one of the subjects/themes of the complaint compared to 14 in 2021/22. The complaints cover a number of the services, with the highest number being for inpatient services as would be expected. The Trust liaises with the CQC regarding these complaints.
The most common reason for the complaint is that the complainant does not believe the individual should have been detained and the response provides a detailed written explanation about the MHA and the criteria used to make this decision.

One specific complaint received within the 2022/23 year received national media attention as this involved the detention of a female professional rugby player who it later emerged was suffering from encephalitis. The Trust was able to demonstrate that there were robust attempts in collaboration with colleagues within acute general health services to establish whether there may be an underlying physical cause to the service user's presentation at that time.



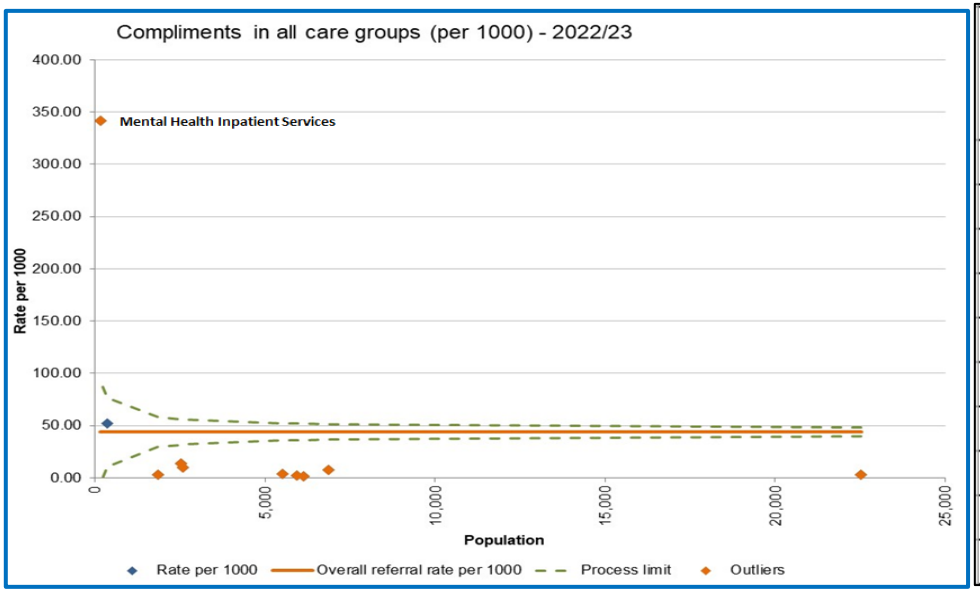


6. Joint working

National guidance emphasises the importance of organisations working jointly where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single coordinated response.

Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaint process when this involves more than one organisation and improve accessibility for users of health and social care services.

7. Compliments

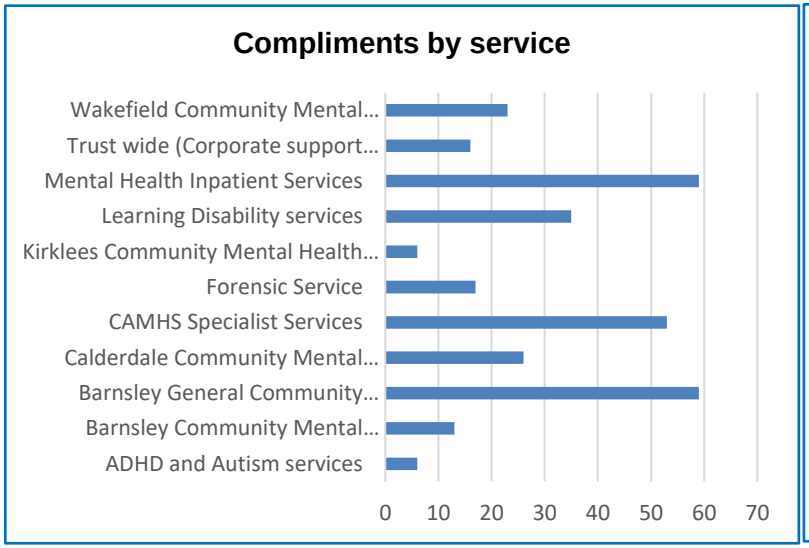


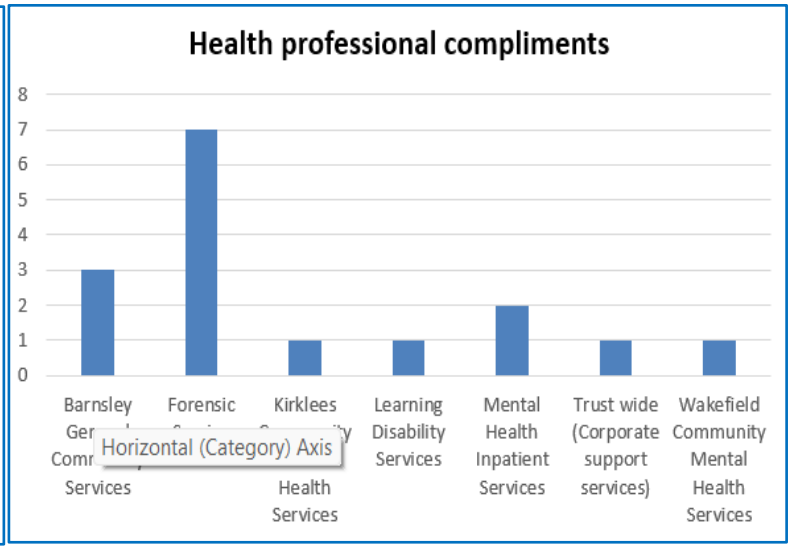
Service	Compliments received as a proportion of individual caseload size (per 1000)
Mental Health Inpatient Services	341.61
Forensic Services	51.87
Calderdale CMH Services	10.09
Kirklees CMH Services	1.30
Barnsley CMH Services	2.36
ADHD and Autism Services	3.25
Wakefield CMH Services	3.81
CAMHS Specialst Services	7.58
LD Services	13.87
Barnsley General Community Services	2.57

The funnel plot above shows the number of compliments received by each service across 2022/23. It considers the total number of compliments received by each service as a proportionate rate against their individual average caseload size for 2022/23. The previous data presented for complaints and concerns highlighted the challenges faced by mental health inpatient services as they balance the expectations of service users, their families and carers.

In this graph we see the positive support received by mental health inpatient services in the form of the number of compliments received about the care they provide. This should be commended as individuals tend only to provide compliments when service exceeds expectations. All other services receive a lower-than-expected number of

compliments which supports the understanding that there is a general level of satisfaction felt by service users, their families and carers and also the challenge around gathering feedback from service users, families and carers.





During the year 2022/23 329 compliments were recorded in total which is a small increase of 7% compared to 302 in 2021/22.There were 313 compliments received about care and treatment, service and/or a named staff member as reflected in the above table. The services with the joint highest number of compliments (n=59, 19%) is Barnsley general community services and mental health inpatient services followed by CAMHS Specialist Services (n=53, 17%).

There were 16 compliments from another professional and the service with the highest number of these types of compliments was the forensic service (n=7) at 44% followed by Barnsley general community services (n=3) at 19%.

This can include compliments from students who have been on placement with the Trust.

7.1. Examples of compliments received

Nothing could have been done any better, I met the practitioner for a second time and already feel as though she has made such a difference, she has listened to me in a non-judgemental way, listened attentively, suggesting ideas and resources that can help me. She has also given me the medication and confidence to go forward and do my BA at university. Thank you so much!
Adult ADHD/Autism Service

Staff member is truly amazing lady and really special to me. We all know that I don't like people at all! But I genuinely look forward to you coming and talking to you. It is not like I am talking to my nurse, it's like I am talking to a friend and I can just be myself and completely honest and open. I trust you totally and am so grateful for all your help and support.
Barnsley Community Mental Health Services

I just wanted to let you know about the fantastic care I have received whilst attending for weekly appointments to help heal my horrific leg injury. They are the most amazing, caring nursing staff I have ever met. Nothing is too much trouble for them and they have put me at ease (especially when I was traumatised at the start). Thanks to the team my leg is on the way to recovery and I have now been discharged.
Barnsley General Community Services

Thank you so much for your insight, wisdom and kindness. You have helped me start the journey and given me the tools.
Calderdale Community Mental Health Services

I just want to say thank you to you and everyone who worked on the response. When my daughter died the Trust's initial report left me feeling that no one there cared. This response has changed that. Thank you.
Trust wide (Corporate support services)

Thank you for coming into our lives and offering help. Thank you for seeing things that nobody else saw. Thank you for being there when others weren't. But most of all, thank you for showing us there will come a time when we can eventually let you go.
CAMHS

I took service user to her dad's funeral and numerous members of her family approached me to express their gratitude and thanks to all of the ward staff, for all our care and all the support she has been offered by everyone. They were so pleased that she could spend so much time with him prior to his passing and wanted to pass on how appreciative they are.
Forensic Service

Thank you – you have been a lifeline.
Kirklees Community Mental Health Services

Thank you so much for your prompt and professional response to support my sister who has Down's syndrome and early onset dementia. Your clear instruction for the staff has allowed her to maintain her dignity. This means so much and I cannot thank you enough.
Learning Disability Services

You took me out of the darkness and put me on the path of light and good future. I am and will always be thankful. Thank you all very much.
Mental Health Inpatient Services

We had a home visit to speak with and assess my mum regarding her hallucinations and medication. I was very impressed by the doctor and her kind, patient manner whilst listening to my mum who has dementia and is extremely frightened and worried about her future. The doctor reassured my mum that her fears were noted and her choices would be considered. She talked directly to my mum and also listened to our family's concerns. It was a pleasure to talk to such a caring doctor.
Wakefield Community Mental Health Services

8. Customer services priorities 2023/24

The Customer Services team will prioritise the following improvement actions over the coming year:

- Enhance our improvement work by undertaking a Lean improvement project (quality improvement and management system which focusses on improving flow and removing waste from a process) to support the flow of complaints and improve the timeliness of response (see section 8)
- Continue the improvement work with regards to the backlog of complaints awaiting allocation, with the expectation of no backlog
- Refresh key performance indicators and internal reporting mechanisms
- Continue to work with ambition to meet the core expectations of acknowledging complaints within three days and for the person to have received a response within six months of us receiving the complaint.
- Provide coaching and training to identified staff within the service lines incorporating root cause analysis to support the complaint investigation
- Work with Care Groups to support the embedding of learning from complaints within Care Group governance
- Re-establish the online complaints satisfaction surveys – complainants, Trust staff and partner organisations and analysis with support of Trust volunteers
- Establish a responsive children and young people led complaints process and resources to support young people to share experiences of care
- Continue to focus on gathering insight into service user experience and to support teams to develop action plans to change and improve services because of feedback, working in collaboration with the equality, inclusion and involvement team and patient experience lead
- Increase the emphasis on gaining insight into people's experience of using services to influence how services are organised and new services are planned
- Engagement work regarding PHSO Complaint Standards

- Review and analyse data from complainant with protected characteristics to understand:

    1. If and how we are receiving feedback on services from people with protected characterises

    2. Understand complaints and feedback which relates to protected characteristics

9. Customer services improvement programme

Since October 2022 the customer services function and processes have been reviewed and supported through an improvement project. This remains underway at the time of writing. The improvement project has been impacted by the Quality Improvement lead leaving the Trust and by the Customer Services manager being absent from work due to long term sickness.

9.1. Problem statement

There are delays in the management of complaints. A formal complaint can currently wait up to 21 weeks before it enters the complaints management process and then may take up to a further 23 weeks before a response is provided. These delays primarily happened when the complaint management was paused and staff were redeployed during COVID-19 and the team has been unable to clear the backlog with current capacity.

The following risk was added to the risk register in August 2022:

The customer services department are currently experiencing delays with allocating and investigating concerns raised to the complaints department this will have an impact on service user experience, cause delays to learning lessons and implementing changes required, cause reputational risks to the Trust and have an impact on staff wellbeing.

There are staffing vacancies within the Customer services team which has an impact on the allocation of the work and the wait for complaints to be responded to, this is having an impact on service user experience and staff experience.

There have been delays in the process caused by quality issues, these are impacting on further delays to complaint response times, which in turn impacts on the allocation of new cases and the staff and service user experience.

The main factors contributing to the problem are:

- Customer services team capacity and capability (unsustainable administrative role and Customer Services Officer capacity including training and capacity to engage with services to train and support)
- Demand management (effective management of enquiries, concerns and complaints both in Customer Services and Operational Services)
- Bottlenecks causing delays and rework in the complaint management process (identification of lead investigator, completion of toolkit (particularly complicated complaints), sign-off of complaint responses).

There is variation in the management of concerns and complaints across Care Groups and gaps in assurance about how issues and actions are managed.

9.2. Aim statement

To:

- reduce the backlog of formal complaints to zero
- to implement changes in the system that improve the experience of people who raise concerns and complaints
- to ensure smooth flow of complaints through the process, removing delays and unnecessary steps.

Actions and achievements to date

- Reduction of complaint backlog from 61 complaints awaiting allocation to a customer services officer at the peak. This reduced to 40 at the end of the year (2022/23) and during quarter 1 of 2023/24 further reduced to 10 (as at end July 2023) through focussed work by the customer services team
- Highlight report submitted to Chief Nurse and Director of Quality and Professions on a fortnightly basis
- Development of a problem statement, aims and objectives of the project
- Review of the current process and planned in a lean improvement session to identify waste and bottlenecks in the process
- Discussion with operational services about Care Group processes for the handling and management of complaints
- Project plan set up and overseen by Associate Director of Nursing, Quality and Professions and Director of Services/Quality lead for Barnsley Integrated Care Group
- Utilising customer services team skills to scope complaints and formulate

responses
- Recruitment of an additional band 3 administrator to support the team
- Secured additional funding to the end of 2023-24 to expand the team

9.3. Next steps

The improvement project continues to progress. The following next steps have been identified for 2023-24 (list not exhaustive):

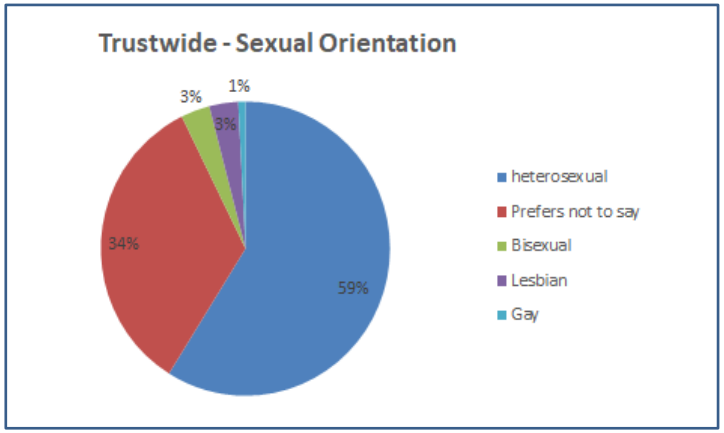
- Development of training for investigators
- Lean process mapping of the customer services process for the management of complaints (September 2023)
- Review and update of the customer services policy to incorporate any changes to statutory requirements and learning from the improvement work
- A review of how complaint responses are formed, including understanding whether removal of the toolkit and allowing lead investigators to write the response supports a more timely response and one which is person centred
- Set up of power business intelligence dashboards to support with reporting and monitoring of various aspects of complaints management and reduce workload and time spent undertaking a manual pull from Datix. This will enable reporting and monitoring to be more robust and enable the impact of any changes to be easily identified
- Consider options for complaint resolution which may help efficiency
- Consideration and identification of any additional staffing needs for the customer services team and review of current function of the team roles

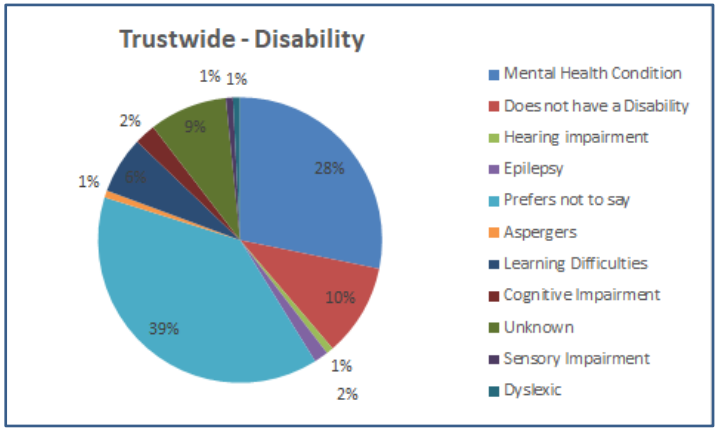
10. Equality data related to complaints

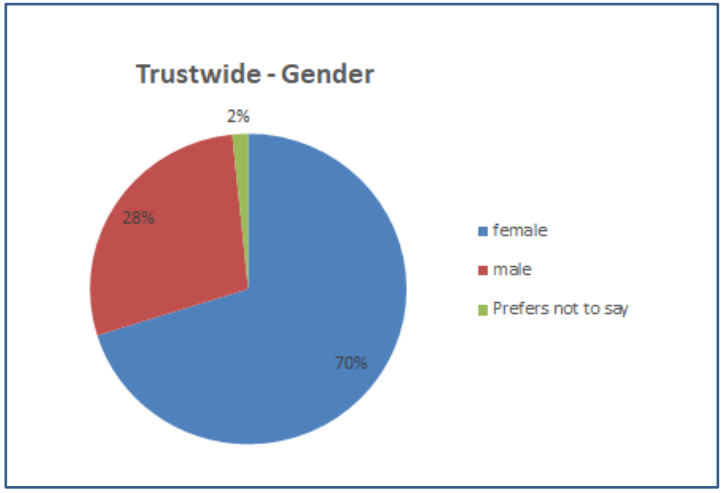
Equality data is a key indicator of who accesses the formal complaints process. It is about the person raising the complaint i.e., the complainant, and they are not necessarily the person receiving the service i.e., the service user. Where possible, data is captured at the time a complaint is made or at a later date when the equality form is returned. Complainants are informed why collection of this data is important to measure equality of access to the complaints process.

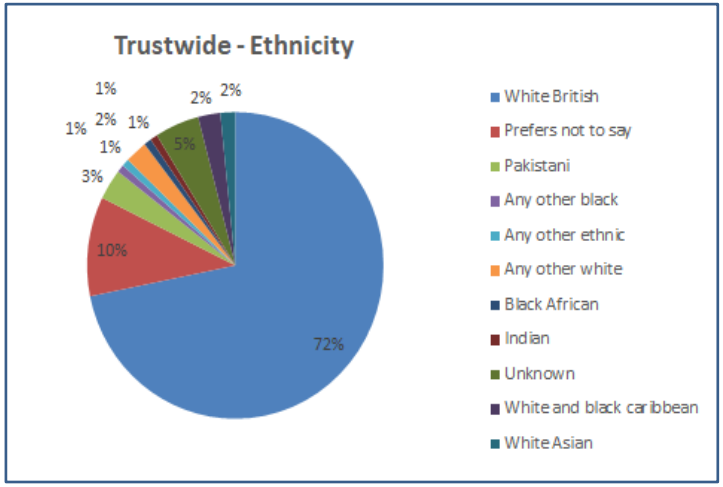
The equality form includes the nine protected characteristics: age, disability, gender reassignment, ethnicity, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. We also ask whether the complainant is a carer and if they are registered with their General Practitioner (GP) as one. This is in keeping with the types of services we offer and the Trust includes the additional characteristic which is given the same importance as the nine other protected characteristics.

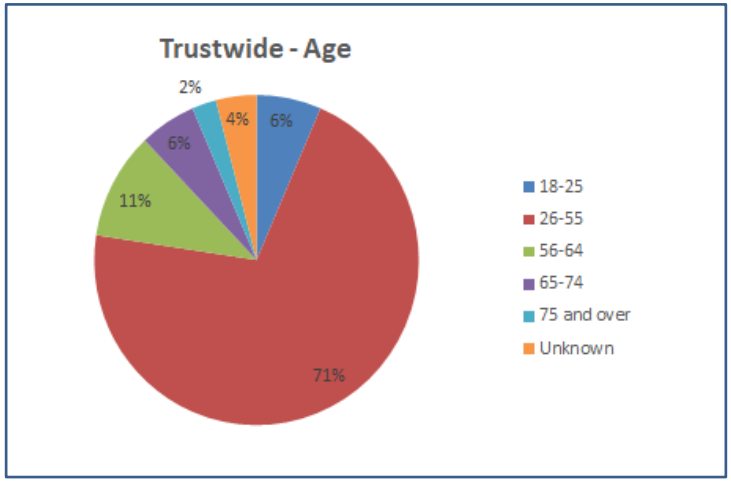
We offer assurance that providing equality data has no impact on care and treatment or the progression of a complaint.
Data is not collected for third party agents which includes MPs and advocates. The team continues to explore best practice for equality data capture, both internally within the team and externally with partner organisations and networks and incorporates any learning to routine processes. The pie charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability,


Trustwide - Sexual Orientation
3%
1%
3%
34%
59%
heterosexual
Prefers not to say
Bisexual
Lesbian
Gay


Trustwide - Disability
1%
1%
2%
9%
1%
6%
28%
10%
39%
1%
2%
Mental Health Condition
Does not have a Disability
Hearing impairment
Epilepsy
Prefers not to say
Aspergers
Learning Difficulties
Cognitive Impairment
Unknown
Sensory Impairment
Dyslexic


Trustwide - Gender
2%
28%
70%
female
male
Prefers not to say


Trustwide - Ethnicity
1%
1%
2%
1%
1%
3%
2%
2%
5%
10%
72%
White British
Prefers not to say
Pakistani
Any other black
Any other ethnic
Any other white
Black African
Indian
Unknown
White and black caribbean
White Asian



Comparing the data presented above with the charts below which provide an oversight of equality characteristics of people who use our services, there is evidence to suggest that people who raise concerns and complaints are representative of service users within our services. Appendix 2 contains charts which show the ethnicity data and protected characteristics data for the population of service users under the care of the Trust.

People who are raising complaints and concerns with the Trust represent service users from ethnic minority groups and those with a disability. This appears to be in line with the proportion of people accessing our services and, in some cases, for example people with a disability, 42% of people raising a complaint report having a disability, compared with 8% using mental health services and 20% using community services. 72% of people raising a complaint consider themselves to be white British, compared with the Trust service user population of between 70-95%.

This data demonstrates that raising a concern or making a complaint is accessible to people with a protected characteristic, although more analysis is needed to draw conclusive comparisons.

For 2023-24 further in-depth analysis will be completed to understand this in more detail and to identify if there are areas which require specific focus and further work to support people to make complaints. This will also include where a complaint is related to a protected characteristic.

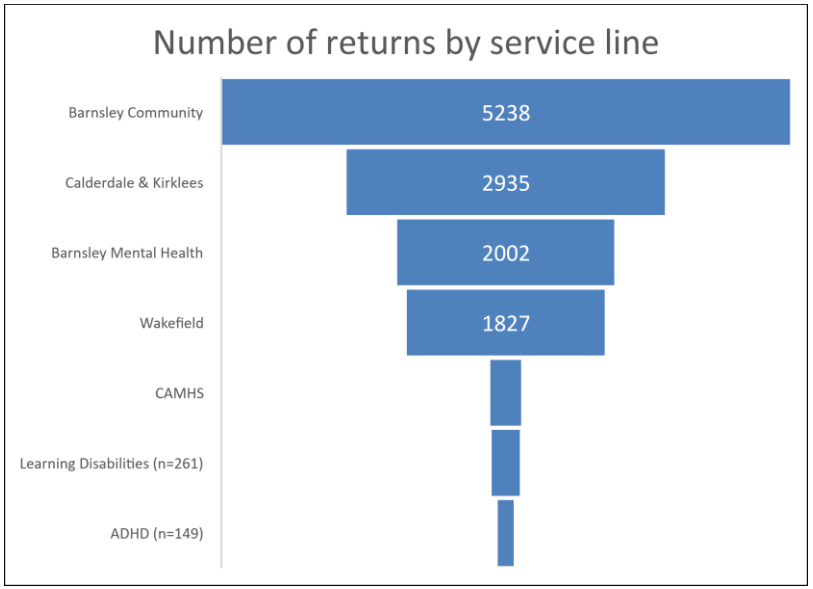
11. Friends and Family Test – Trust overview

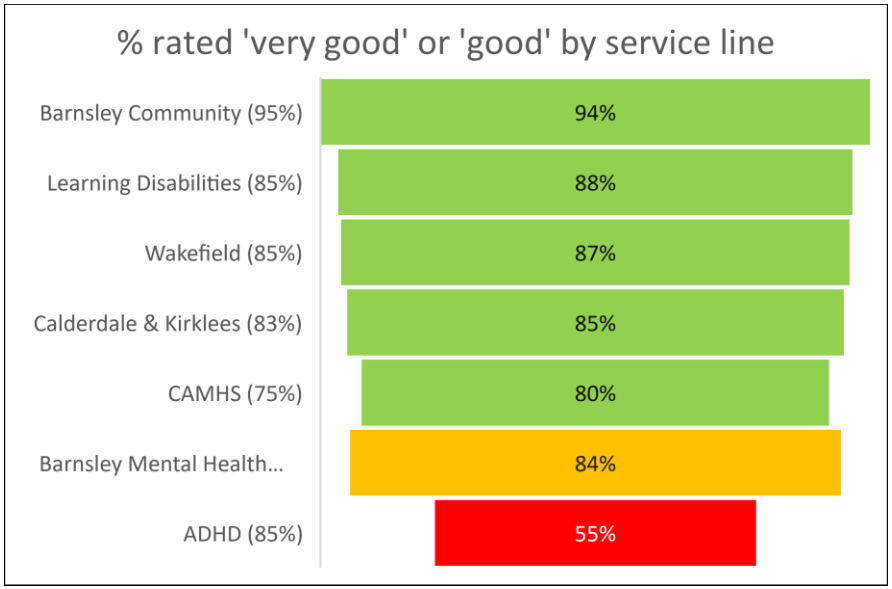
The friends and family test (FFT) is an important feedback tool which that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

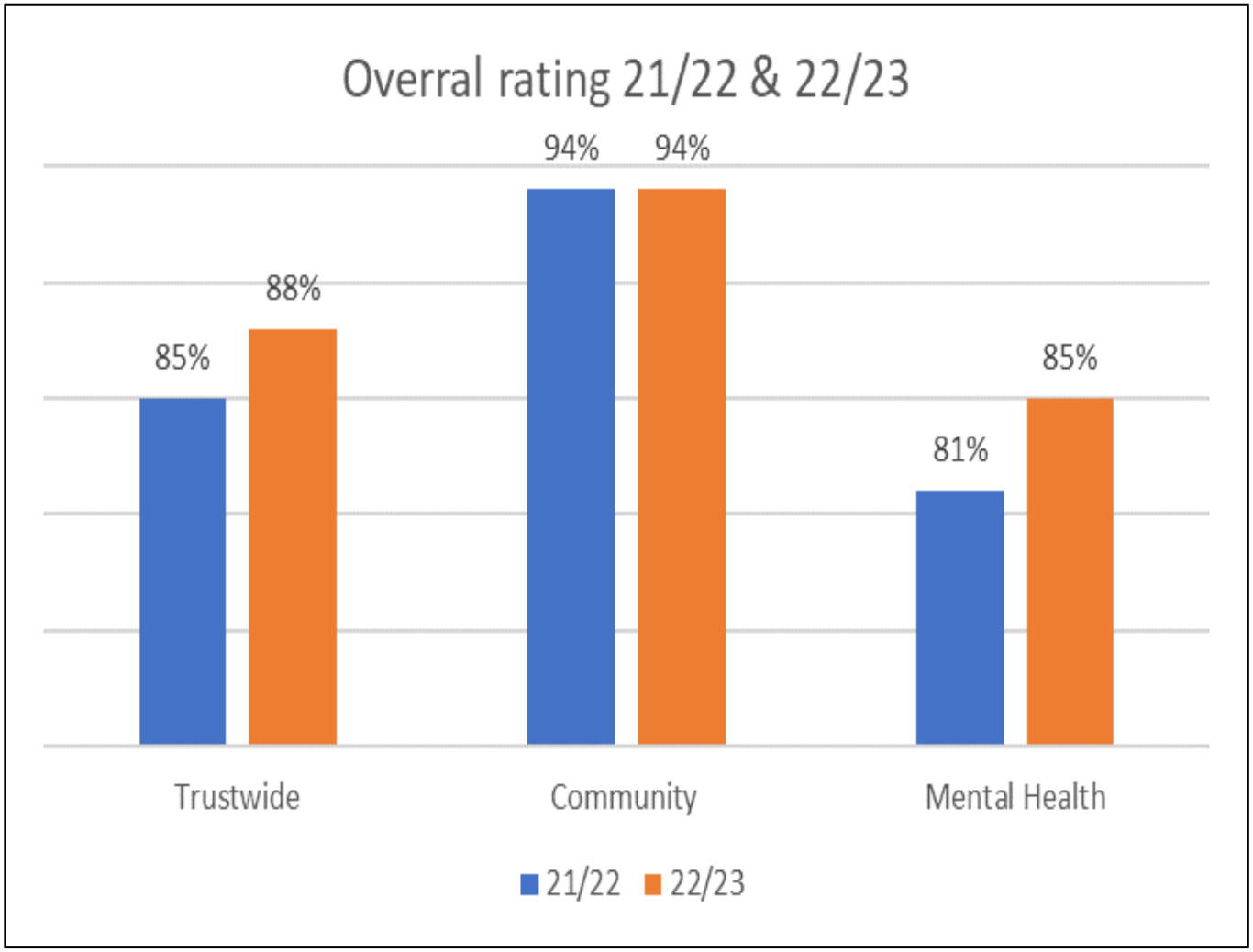
Over 2022/23, Trust-wide we have seen an increase in the number of people that would rate Trust services as ‘very good’ or ‘good’. All service lines, except for mental health services in Barnsley and Attention deficit hyperactivity disorder (ADHD) services met their service lines target. A project group has been formed to look at how to engage service users to design appropriate feedback methods for ADHD services, to try to increase the number of responses received. Currently the number of responses is very low and this impacts on the overall percentage and rating for the service (e.g., there may only be three responses and with two rating the service as good and one rating it as poor and therefore the overall percentage would be 66%).

There was a 16% increase in the amount of feedback received in 2022/23 (n=13,428). Electronic collection methods make up 88% (n= 11,803) of collection methods, of which 62% (n=8,276) were received by text message.

Themes from comments received remains consistent with previous years with staff, communication and access and waiting times, all of which remain in the top three for positive and negative comments. ‘You said, we did’ posters evidence that services are listening to and acting on feedback received by service users, carers, and their families.


Number of returns by service line
Barnsley Community
5238
Calderdale & Kirklees
2935
Barnsley Mental Health
2002
Wakefield
1827
CAMHS
Learning Disabilities (n=261)
ADHD (n=149)

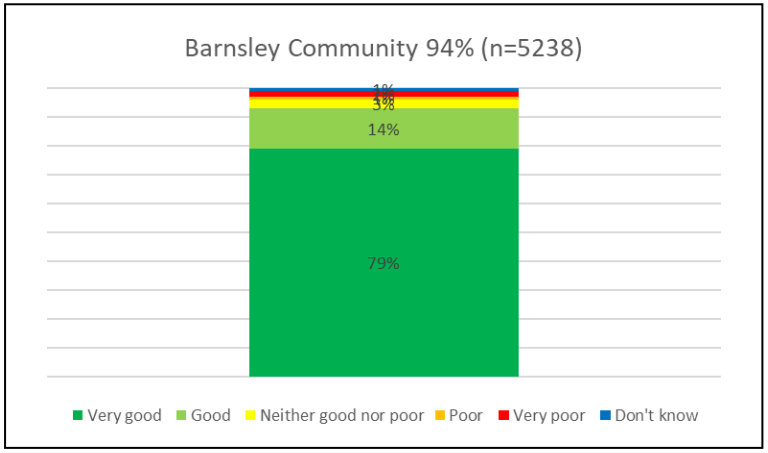

% rated 'very good' or 'good' by service line
Barnsley Community (95%)
94%
Learning Disabilities (85%)
88%
Wakefield (85%)
87%
Calderdale & Kirklees (83%)
85%
CAMHS (75%)
80%
Barnsley Mental Health...
84%
ADHD (85%)
55%

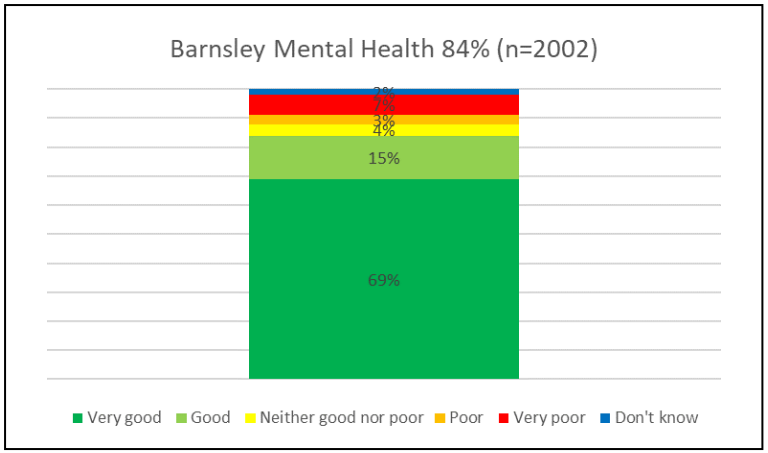

Overral rating 21/22 & 22/23
94%
94%
88%
85%
85%
81%
Trustwide
Community
Mental Health
21/22
22/23

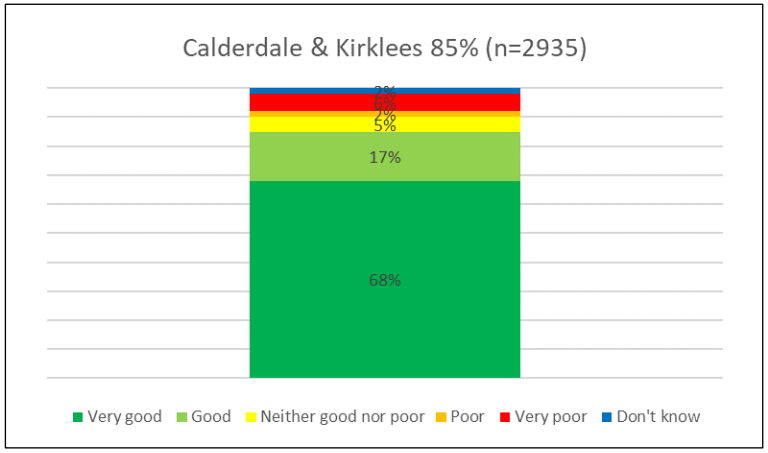
Themes		
Trustwide	1. Staff 2. Communication 3. Access and waiting times	1. Staff 2. Access and waiting times 3. Clinical treatment
Community	1. Staff 2. Communication 3. Access and waiting times	1. Staff 2. Access and waiting times 3. Admission and discharge
Mental Health	1. Staff 2. Communication 3. Patient care	1. Staff 2. Clinical treatment 3. Communication

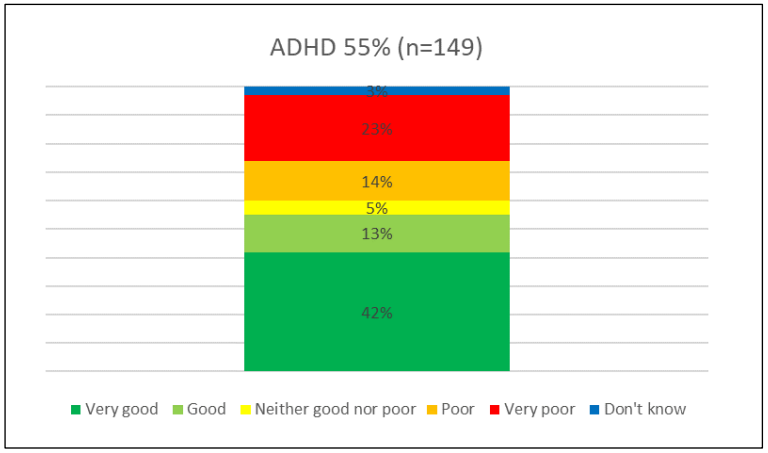
11.1. Service line overview

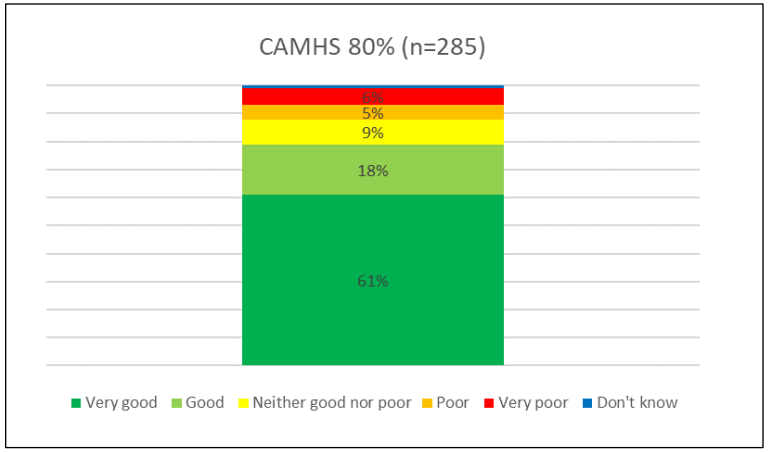
The graphs below demonstrate how individual service lines are rated by feedback from the friends and family test.

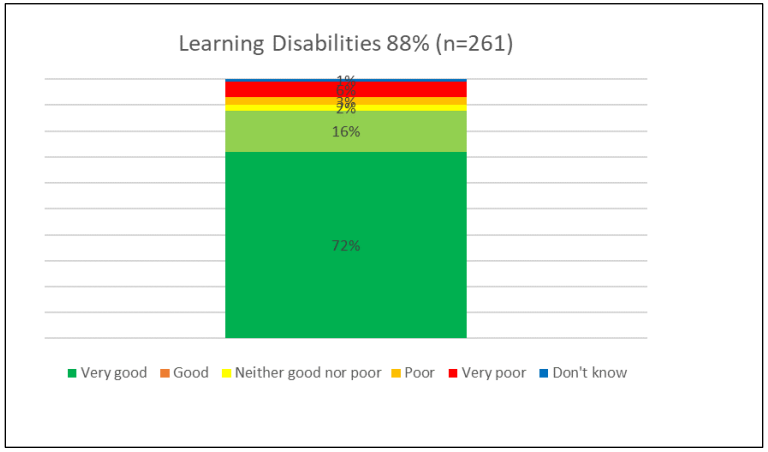


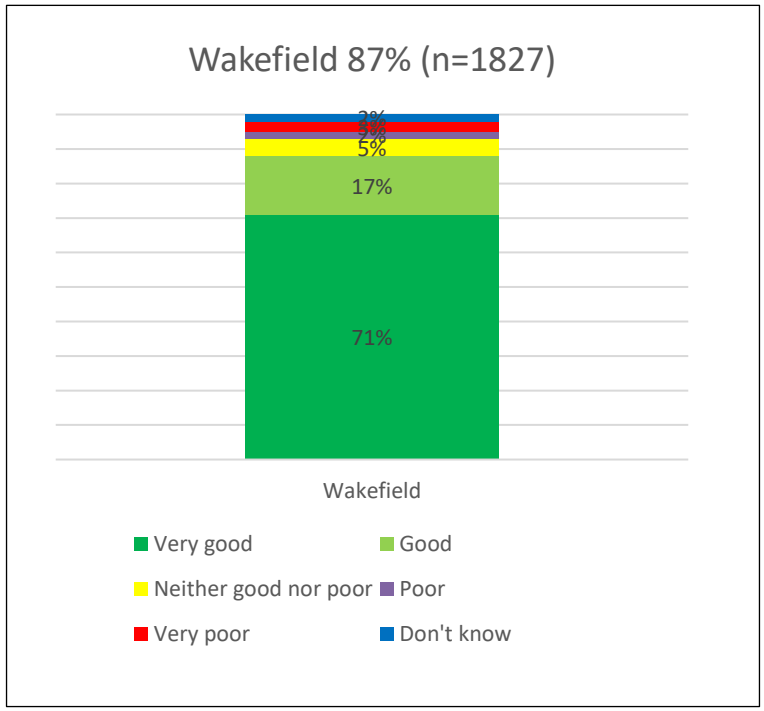




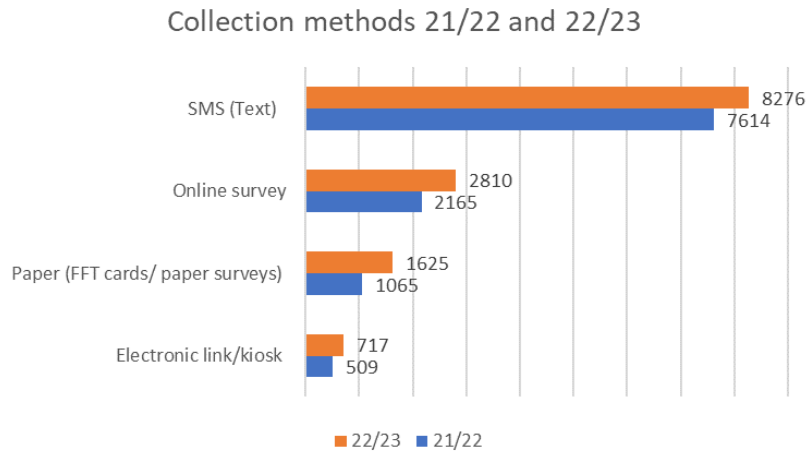



CAMHS 80% (n=285)
6%
5%
9%
18%
61%
Very good
Good
Neither good nor poor
Poor
Very poor
Don't know


Learning Disabilities 88% (n=261)
1%
2%
3%
2%
16%
72%
Very good
Good
Neither good nor poor
Poor
Very poor
Don't know


Wakefield 87% (n=1827)
2%
2%
2%
2%
5%
17%
71%
Wakefield
Very good
Good
Neither good nor poor
Poor
Very poor
Don't know

11.2. Friends and Family Test Feedback – collection methods



Over the last few years, methods used to collect FFT feedback have expanded. The most popular method for providing feedback is via text message. Text messages now contain a link for a person to click on which takes them to the survey. Some communications via social media and the Trust internet are supporting messaging about the safety of this link, as there are concerns around fake links and scams being sent via text message.

11.3. Friends and Family Test Feedback – 'you said, we did'

Team name:

Nostell 5.12.22

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We're listening to your feedback

You've been giving us feedback on your care and treatment. You said:

FOOD & MENUS

"The food is inconsistent, it depends who is serving as to how much you get and there is not much choice."

"Would pre-ordering not work? There would be less wastage and everyone would be able to have an equal chance to have something they like regardless of being at the front or back of the queue."

We're listening and this is what we're doing:

Thank you for your feedback:

- The Catering Team will carry out mealtime observations to look into inconsistencies and food choices.
- Our Catering Team are preparing to introduce an electronic food ordering system. Nostell ward have offered to be one of the first to trial the new system when ready.

Having your say helps to improve care for everyone so please keep putting us to the fast by giving us your feedback each time you use our services.

#allofusimprove and be outstanding

With all of us in mind.

Team name:

Staley Ward 22.5.23

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We're listening to your feedback

You've been giving us feedback on your care and treatment. You said:

FOOD & MENUS

- 'The food isn't good at the moment; it is just slop to me. The vegetables are too soft, and I think its poor quality'.

We're listening and this is what we're doing:

Thank you for your feedback.

Quality monitoring of the meal service, including vegetables, has been scheduled and an action plan will be drawn from this.

Having your say helps to improve care for everyone so please keep putting us to the fast by giving us your feedback each time you use our services.

#allofusimprove and be outstanding

With all of us in mind.

12. Equality and involvement team insight

The following insight is a combination of intelligence and insight received via Trust Governors, Healthwatch colleagues and partners. Some of this intelligence and insight is already going through a resolution process, unless the feedback has been received as a result of involvement activity.

The report provides an overview of the most common themes reported by service users, carers and stakeholders over the last year about our services. The report is split into the service areas that have been referenced during this period. This means that not all Trust services are included in the table below. The data has been taken from the 2022 to 2023 quarterly reports.

12.1. Feedback received

Theme	Narrative
Access to services	Barnsley speech and language therapy - concerns about access. Calderdale – • Currently has no dual diagnosis service. • Some people reported waits for mental health reviews and service access concerns • More support is needed and face to face as well as using Zoom or Microsoft Teams Kirklees - access to crisis services flagged as having long waiting times. Wakefield – • Particularly good collaboration between voluntary and community Sector (VCS) and statutory sectors reported • More information needed on what support is available and would help to signpost between services.
Adult ADHD/ASD service	Barnsley services informed their service users when they complete the assessment templates which was positive.

	Calderdale – • Provided training for social services staff to support service users with ADHD/autism • Reports of long waits for assessments • More information is required and staff need to contact families in a timely manner Wakefield had some individual concerns raised on the reassessment process.
Adult autism services	Kirklees – • Concerns for availability of provision of services • Unclear timescales for assessment, choice for access and follow up
Appointments	Kirklees mental health services - management of some cancelled appointments. Memory Clinic – Follow up letters need to provide clear information.
Baghill house HWB centre	Wakefield had some mixed reviews on quality of treatment.
Bereavement support	Wakefield reports that this is a great service.
CAMHS	Barnsley – • Quality of service which included staff availability and support and waiting times. • Continuity of care, signposting advice, and choice. • Having staff understand and have experience of working with teens would improve the offer • Mental health support in schools, such as workshops and promotion of what support is available and how to access this • Concerns relating to confidentiality in the reception area, so it maintains being a safe space • A suggestion welfare calls could be made to those on the waiting list Calderdale – • Positive online/crisis support • Improvements required for access/communication • Waiting for ADHD assessment and navigating the system were flagged as concerns • Concerns around: ○ some delays or changes in appointments

	○ quality of care issues for inpatient stay ○ discharge and follow up plans ○ E-referrals may not provide a record once submitted and how information is disclosed following MDT meetings ○ General confusion from parents about roles of CAMHS, Open Minds and Northpoint. Kirklees - concerns relate neurodiverse pathway and assessment waiting times. Wakefield – • Support and communication requires improvement particularly support for children with a disability and those who have experienced abuse • Problems with getting through on the support line were reported and management of suicidal thoughts.
Carers	Barnsley - positive feedback on a break for carers and the benefit of having a break with others. Kirklees – • A gap in out of hours (non-crisis) services for mental health and wellbeing support and gender specific services for women. • Positive response and support received from VCS organisations for carers • A general request that consultation with carers be written into procedures to ensure that carers are kept updated of treatment plans Wakefield - during the pandemic carers felt 'individually forgotten about' and mental health needs increased.
Chillypep	Barnsley - positive feedback on the service and the impact staff had with service users.
CMHT	Kirklees - waiting times and support beyond medication was flagged as a gap. Calderdale – • Delays with referrals • Long waiting lists with medication reviews • Follow up calls needed on a more regular basis • Support for complex service users and carers could be improved
Core service	Kirklees - positive feedback about courses provided.

Dales' art therapy	Calderdale - positive experience and support received.
Dementia	Calderdale - delay for dementia assessment.
Discharge	Calderdale crisis support following discharged back to GP requires improvement. Wakefield - no follow up or care after discharge.
Drury lane	Wakefield - longer waits for service, and improvements to communication were needed.
Healthy minds	Calderdale - concerns from service users/volunteers that the service will no longer be funded.
IAPT	Barnsley - waits for counselling and range of therapy could be improved. Calderdale – • Do signpost to support if there are waiting lists • It was felt that a set programme of CBT /mindfulness may not be enough, and that ongoing support or seeing staff face to face would help improve the offer • More support needed for those with complex mental health needs. Kirklees - access to care delayed due to long waiting times.
IBHT	Kirklees - improvement needed for continuity of care and communication.
Laura Mitchell	Calderdale - lack of appointments or telephone support. Would like more signposting to community/peer support.
Live Well	Wakefield - good support offer over the phone but would like more face-to-face offers.
MH services (general)	Barnsley – • Mental health check-ups and waiting times require improvement • More support for people with substance misuse, including signposting would help people who are waiting • Waiting times were seen as long and the range of therapy on offer, limited • Transition from child to adult services requires improvement

North Kirklees enhanced	Kirklees - communication with carers following the move of a service user to core team could have been improved.
Out of area	Calderdale – specific feedback about a service user was moved out of area for 5 weeks, causing a 200-mile trip for family to visit. Concern that placement was in a rehab centre, rather than acute unit and the impact this had on their mental health. Kirklees – specific feedback about a last minute out of area transfer and the impact that had on service user/carers.
Perinatal	Calderdale - positive support given to a new mum on breast feeding and medication.
Priestley unit	• Improvements required for cleanliness of facilities • Staff very caring but activities need to be more inclusive and regular
SPA	Calderdale – • Concerns relate to assessments, delays in treatment and keeping people updated • Need to do more to improve access for people who have a sensory disability and those who are autistic in a crisis Kirklees - difficulty in contacting SPA and some reports of staff attitude.
Transgender services	Barnsley - waiting times and lack of support for those under 16 years old.
Trauma counselling	Barnsley - waiting times.
Treatment team	Kirklees - good quality of care, positive staff attitude and short waiting time.
Turning point	Wakefield - positive experience of care, with quick access to services.

12.2. Themes and 'you told us, we listened'

The Trust responds on a quarterly basis to the common themes which are generated and identified through using this report. This is done using a 'you told us, we listened' format which can be found here on the Trust website: You told us, we listened - South West Yorkshire Partnership NHS Foundation Trust

The following themes were identified and action taken:

- Single point of access
- Inpatient beds – out of area
- Children and adolescent mental health services (CAMHS)
- Adult Autism
- Kirklees community services
- Improving access to psychological therapies
- Intensive home-based treatment
- Kendray Hospital

13. Summary

Feedback from service users, carers and staff is collected in a number of ways across the Trust with one key source being into our customer services team. Feedback is also received through the friends and family test (FFT) and through insight information shared with Trust governors and Healthwatch colleagues and partners. Staff are able to provide feedback in a number of ways and through the freedom to speak up guardians.

This report has rich information captured through customer services, friends and family tests, insight information and from the freedom to speak up guardian.

The numbers of complaints raised through the customer services team has returned to within pre-COVID-19 levels, in line with national reporting on complaints. This has supported the customer services team to address the backlog that had developed. This remains ongoing but is expected to return to zero by the end of July 2023.

An increase in the numbers of responses provided through the friends and

family test is positive and demonstrates that the test is now more easily accessible to a wider population. Overall satisfaction with services is good and work continues to support learning from the feedback provided and to triangulate this with other sources of service user and carer feedback.

Work undertaken following the analysis of insight data has enabled ‘you told us, we listened’ to support improvement work across a number of Trust services.

There are a number of themes that cut across the feedback we receive and these include access to care and treatment, communication and waiting times. Teams who gather this feedback are developing joint ways of working which allow for this rich information to be triangulated and for learning to be shared and embedded across the Trust.

The newly formed patient experience group is aiming to bring together feedback captured through the work teams do every day and enable separate teams to work closely and alongside care groups and services to ensure that, as a Trust, we are using the feedback provided to improve services and deliver outstanding patient care.

13.1. Next steps

The Patient Experience report will be reviewed during 2023-24 and re-designed to ensure that patient experience information from across the Trust is captured and reported on. This will include further work around equality data and protected characteristics and identifying where further action is needed and to provide assurance that providing feedback on Trust services, care and treatment and experience is accessible to all.

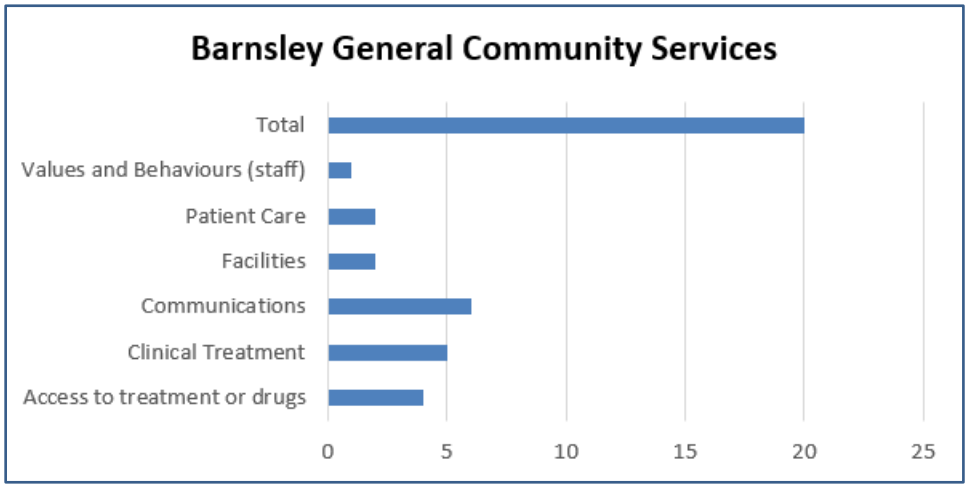
Appendix 1 – Customer services feedback by service

a. Barnsley General Community Services

Top three complaint themes:

1) Communications
2) Clinical Treatment
3) Access to treatment or drugs

During 2022/23 Barnsley General Community Services received 20 complaints and 62 compliments



Compliment examples

"My husband and I really do want to extend to you and your amazing team our gratitude and sincere thanks for the care he has received. It was a horrendous injury to his arm and it is with real diligent care and attention that we can now say he doesn't need any more visits. Please say to all who have been how wonderful they have been."

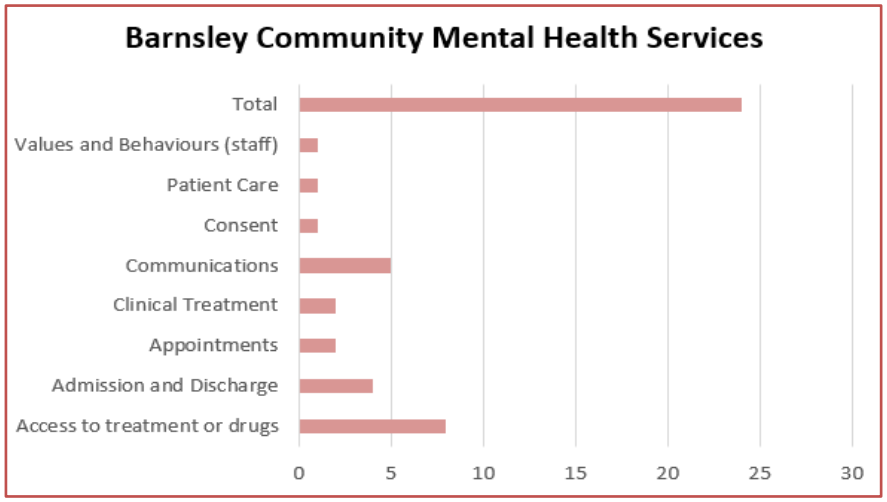
"Thank you for all your hard work with my mum. Our family is so grateful that she is surrounded by a group of caring, friendly and determined people. You're all fantastic!"

Complaint examples

Partner of deceased service user unhappy as phone lines not working prior to service user's death and unable to get through for support. Had been trying for 4 hours.

Complainant unhappy with care and treatment of her father across different NHS Trusts and primary care which led to amputation of leg.

b. Barnsley Community Mental Health Services



During 2022/23 Barnsley Community Mental Health Services received 24 complaints and 13 compliments.

Top three complaint themes:

1) Access to treatment or drugs
2) Communications
3) Admission and Discharge

Complaint examples:

Service user concerned about not being offered any support and being discharged on the basis of a telephone assessment.

Dispute over geographical area and response given by team.

No support from mental health services since discharge from hospital and CPN has failed to make contact, feels medication may need reviewing also.

Compliment examples:

"Thank you for all the help and support you have given me over these last weeks. We both don't know what we would have done without your input."

"I would just like to say a few words about staff member. I have been in therapy for 15 weeks and if I was asked by anyone would it be worth doing, I would tell them to go for it. Cannot believe where I was and how much better I feel. I would like to give the credit to staff member and thank her for everything."

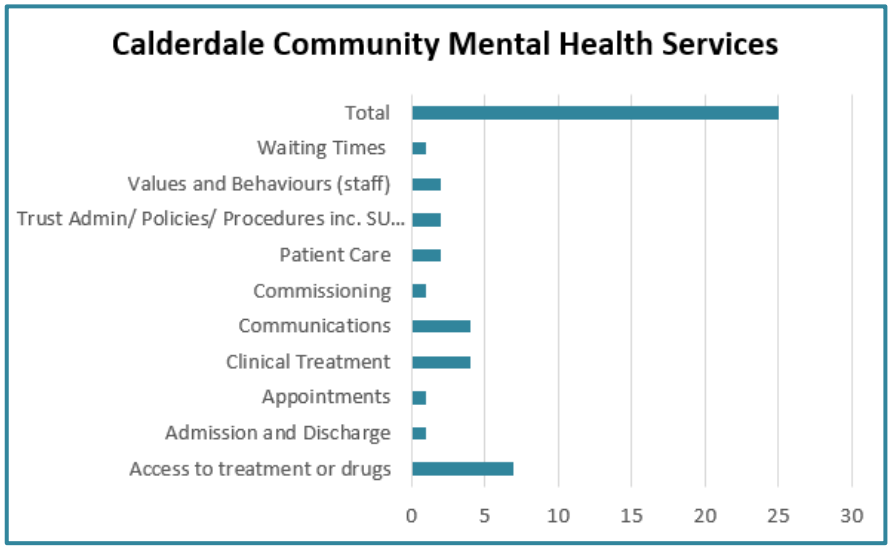
c. Calderdale Community Mental Health Services

Complaint examples:
Service user's sister concerned about decisions taken by services regarding ability to drive and communications with family.
Mother of service user who died from physical causes concerned by the lack of involvement of mental health whilst in a general hospital.
Mother of young adult struggling to obtain support following private diagnosis under shared care arrangements.

Compliment examples:
"I am very grateful for a course that has introduced me to what has been, essentially, a new way of dealing with life. For the first time in a long time I feel hopeful that the resources to live life, as opposed to grinding through it, are available to me. Of course, the hard work starts now!"
"Thank you for getting the help you got for me at the very time I needed it and thank you to the doctor and all involved in my treatment. I just hope I can now stay on path and keep happy. Thank you so much."

Top three complaint themes:
1) Access to treatment or drugs
2) Clinical Treatment
3) Communications

During 2022/23 Calderdale Community Mental Health Services received 25 complaints and 26 compliments

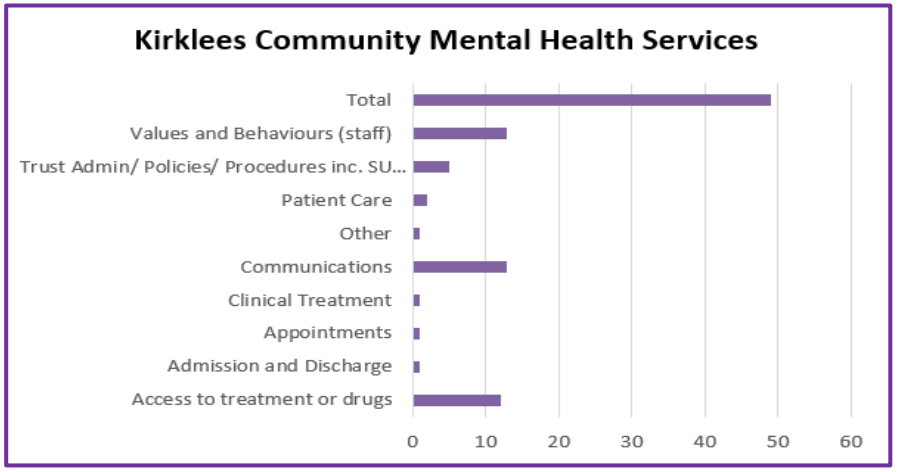


d. Kirklees Community Mental Health Services

During 2022/23 Kirklees Community Mental Health Services received 49 complaints and 7 compliments

Top three complaint themes:

1) Values and behaviours (staff)
2) Communications
3) Access to treatment or drugs



Complaint examples:

Service user upset that repeated referrals have been rejected.

Service user's daughter concerned about the behaviour and attitude of a practitioner during an assessment.

Unhappy with how psychiatry appointment was managed and manner of psychiatrist who has advised without warning that medication will be stopped and care from Trust services will be withdrawn.

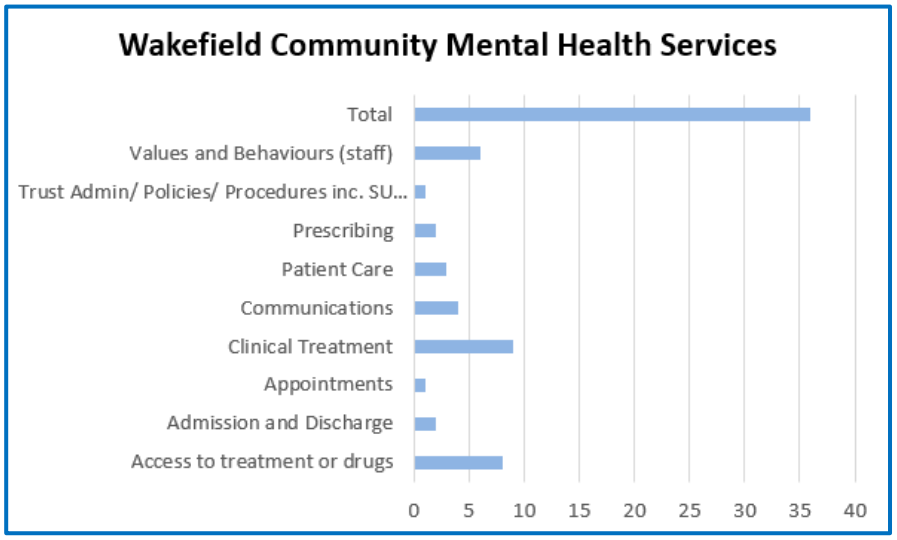
Compliment examples

"I am very happy with her, she does a great job and helps me out a lot."

"My employment specialist has been very helpful, supportive and caring."

"I greatly appreciate the support from the team."

e. Wakefield Community Mental Health Services



During 2022/23 Wakefield Community Mental Health Services received 36 complaints and 24 compliments

Top three complaint themes:

1) Clinical Treatment
2) Access to treatment or drugs
3) Values and Behaviours (staff)

Compliment examples:

"Service user stated that she feels much better in herself and that she is grateful for the support she has received from the team and that if it was not for their input then she would have been admitted to hospital. She wanted to thank every staff member that she has met and that she will never forget the support she received."

"I would love to pass on that the doctor I spoke to was thorough, kind, compassionate and very understanding. We spoke about things at length and she really listened and cared about how I was. I hope she took away just how much she made me feel heard."

Complaint examples:

Complainant has submitted a letter about the quality of care their son received before taking his life.

Complainant not happy with Trust services for her daughter, feels the behaviour of staff is not empathetic and has been hostile.

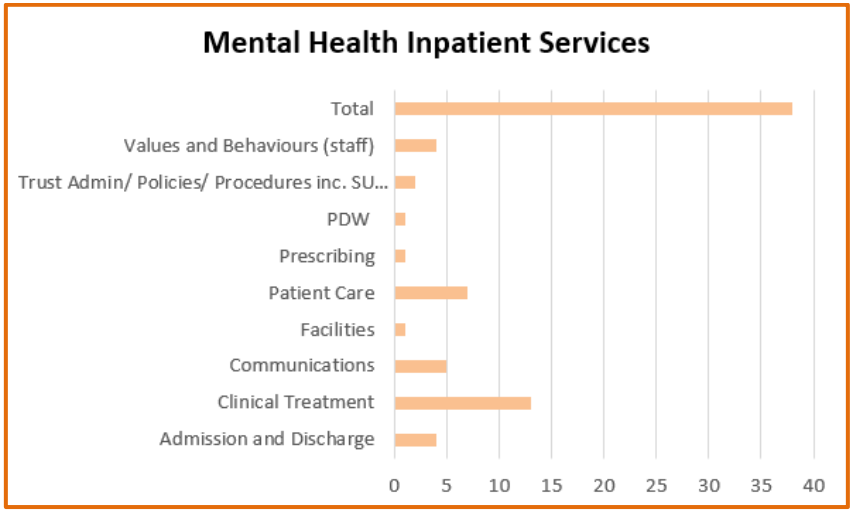
Unhappy with service provided prior to admission.

f. Mental Health Inpatient Services

During 2022/23 there were 38 complaints and 61 compliments

Top three complaint themes:

1) Clinical Treatment
2) Patient Care
3) Communications



Complaint examples:

Mother of service user very unhappy by way in which discharge from hospital was managed and believes this was premature and no consideration of ongoing risks daughter presents with.

Service user unhappy with being detained under the Mental Health Act.

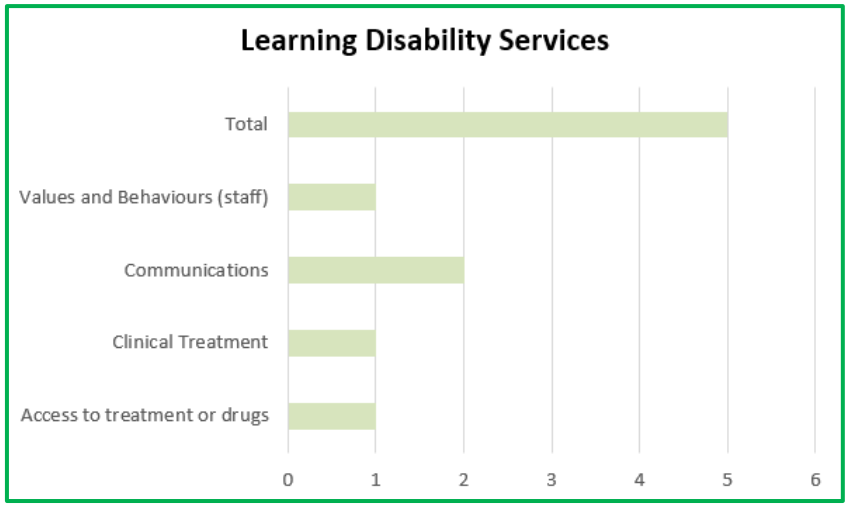
Husband concerned regarding the lack of aftercare proposed once his wife is discharged.

Compliment examples:

"Everyone on the ward was helpful and gave him time and listened. He realises he was poorly but felt all the staff were attentive and supportive."

"Service user stated that the care she received was brilliant, and that she was so grateful to the staff on the ward. She stated that she will miss everyone and was grateful for everything and the staff work tirelessly to meet the needs of all the patients on the ward."

g. Learning Disability Services



During 2022/23 there were 5 complaints and 36 compliments

Due to the small sample size, it is not possible to meaningfully analyse the themes although Communications was the highest category.

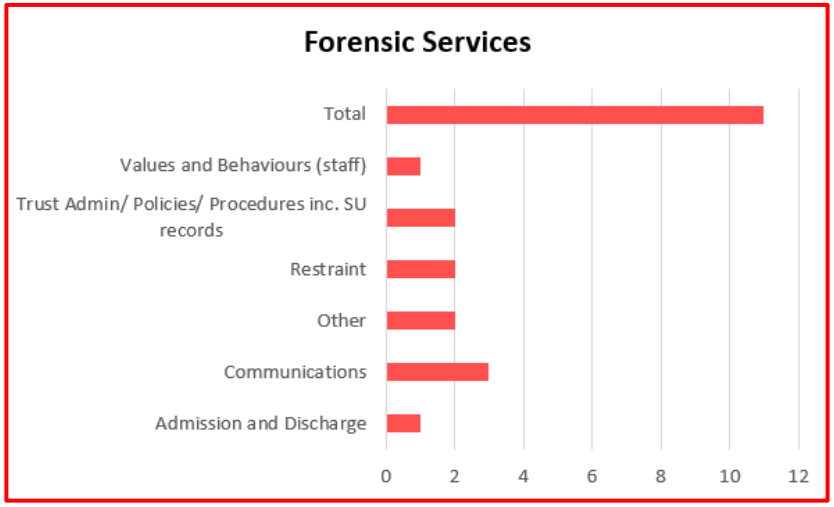
Complaint examples:
Disagrees with sister's assessment report by assistant psychologist.
Complaint by a mother on behalf of her adult son that diagnosis has been removed.
Service user's mother concerned about the conduct of an assessment.

Compliment examples:
"Thank you for all the care and support you have given us as a family."
"Thank you for going the extra mile - really appreciated."
"Just a little thank you to say I appreciate your help and support in making me better and helping me better and helping me along the way. I'm a much better person now, I have my moments but they are few and far between. I have my ups and downs but doesn't everyone? So thank you, I am now in a better place thanks to your patience and support."

h. Forensic Services

During 2022/23 Forensic Services received 11 complaints and 24 compliments

Due to the low number of complaints in each category it is difficult to meaningfully analyse the themes; however, Communications was the top theme.



Compliment examples:

"Thank you for making me feel part of the team. Thank you for your patience and support."

"I would like to express my sincere thanks to the forensic social worker, she has been more than exceptional with her work with me and my sister. I think she's an outstanding member of staff and definitely deserves praise. She has gone above and beyond with us and I really appreciate her help. I also appreciate the unit's staff who I spoke to on my visit."

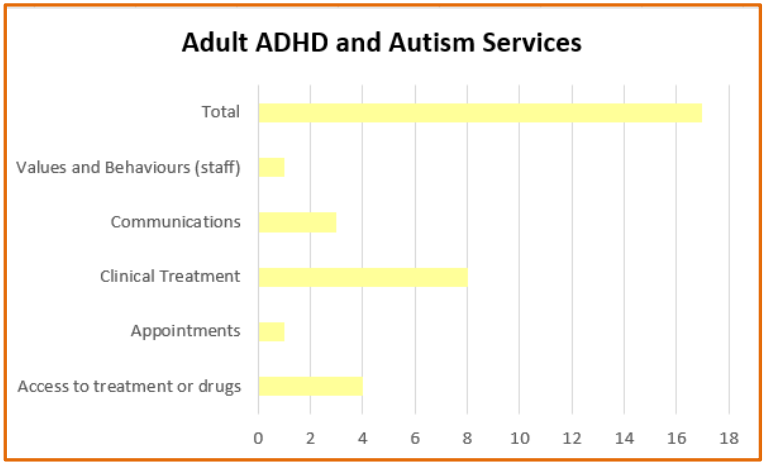
Complaint examples:

Complaint regarding brother's care and treatment as an inpatient and an alleged assault.

Service user's mother concerned about the circumstances that led to her son absconding from care and putting himself at risk.

Service user alleges he was assaulted in his bedroom by 2 members of staff because he wouldn't hand his food over.

i. ADHD and Autism Services



During 2022/23 the Adult ADHD and Autism Services received 17 complaints and 6 compliments

Top three complaint themes:

1) Clinical Treatment
2) Access to treatment or drugs
3) Communications

Compliment examples:

"I cannot sing the staff member's praises enough, she was so lovely and so understanding and gave me the time and space to explain everything- even allowing for a short break. This is the first time in my past experiences of services, that I felt like I was validated and listened to. She made me feel respected and didn't try to invalidate what I was telling her. I feel that I am finally moving forward with my life and I have the closure that I needed."

"We wanted to thank the staff member for his professionalism, knowledge and kindness during this process. He has consistently shown patience and understanding and has spoken to us with a great deal of respect and explained the condition in layman's terms ensuring we fully understand our daughter's diagnosis."

Complaint examples:

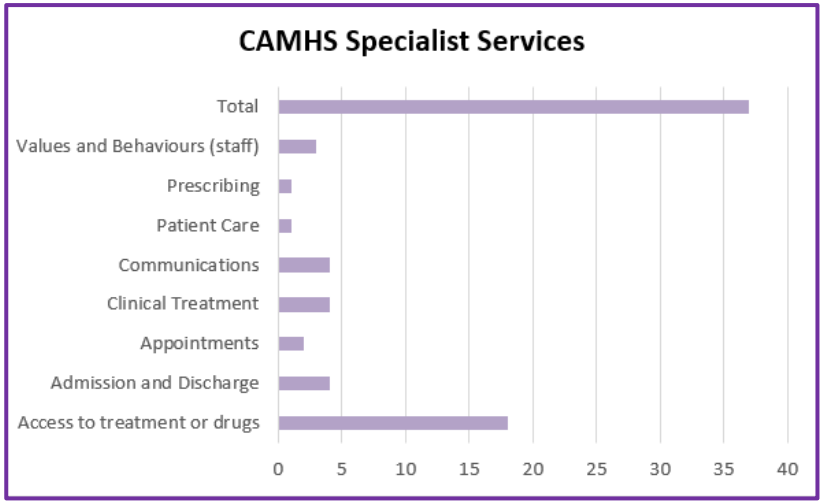
Complainant unhappy with outcome of assessment which did not result in diagnosis.
Unhappy with the diagnosis given and the delivery of it.
Concerns over diagnosis and second opinion assessment.
Unhappy with conduct from practitioner and comments made during assessment.

j. CAMHS Specialist Services

Top three complaint themes:

1) Access to treatment or drugs
2) Admission and Discharge; Communications; Clinical Treatment

During 2022/23 there were 37 complaints and 53 compliments



Complaint examples:

Concerns from mother that several referrals have been rejected for her son.

Mother of service user concerned that service is discharging daughter without adequate step-down support.

Mother very unhappy that CAMHS won't accept private diagnosis obtained for son of ADHD. GP is reluctant to prescribe medication through Shared Care Agreements as specialist medication and asked CAMHS to prescribe.

Compliment examples:

“Thank you for everything! You've helped my life so much! I truly from the bottom of heart appreciate it!”

“I won't write much because it will make me sad but I wanted to thank you for all you've done for me. I'm sad to have to let you go but I guess it is for the best. Without you I doubt I would have made it through the last year, so thank you. Thank you for all the work you've put into helping me. But, most of all, thank you for making me feel less alone.”

k. Trust wide (Corporate support services)

Trust wide (Corporate support services) received 1 complaint in 2022/23 about Trust Admin/Policies/Procedures

Trust wide (Corporate support services) received 17 compliments

Complaint examples:
Complainant unhappy with Customer Services team and all aspects of complaint handling. Feels information she provided was divulged to inpatient unit without her consent and the nature of this information was sensitive and could have been handled better.

Compliment examples:
“Thank you once again for your help and your lovely comments mean a lot. The loss of my daughter has left a very large gap in our lives and her death deserved a full and comprehensive investigation at the time and I appreciate all you have done to try to make sure this has finally happened and I will await the report. Thank you again and I wish you all the very best.”
“Thank you both for all your help! You have been amazingly supportive and patient with me. All the best!”
“I am impressed with the speed and the effectiveness.”

Appendix 2

Ethnicity data comparison Fig 1. Ethnicity Comparison – SWYPFT mental health services. People accessing services, admitted and detained – April 2022 to March 2023

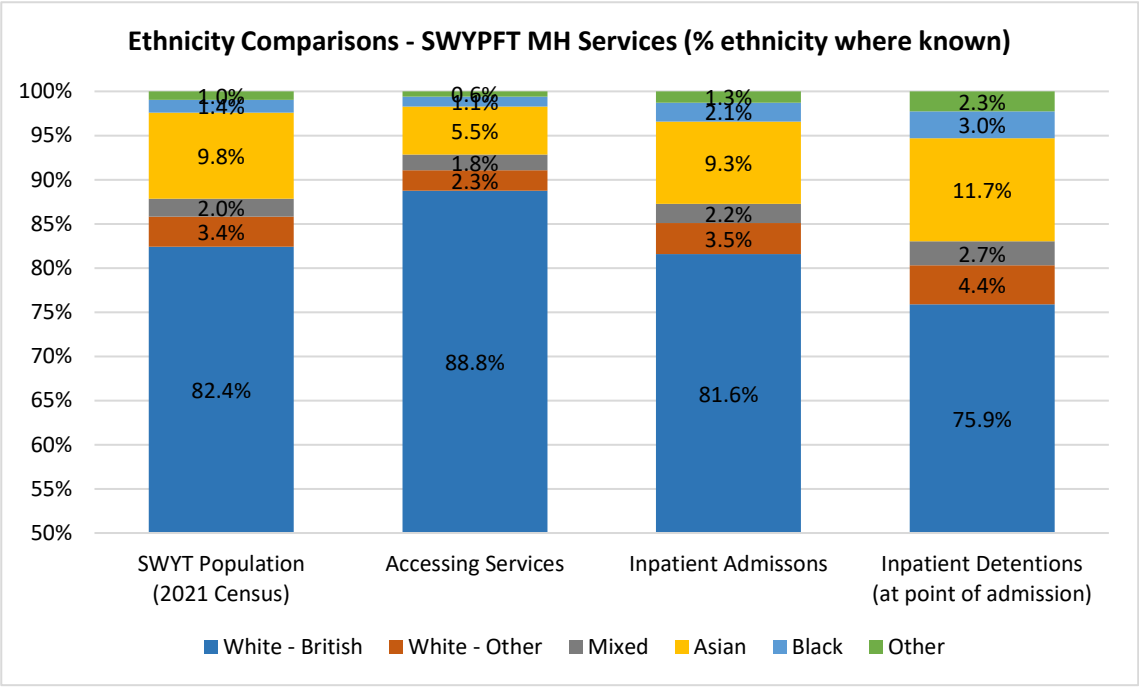
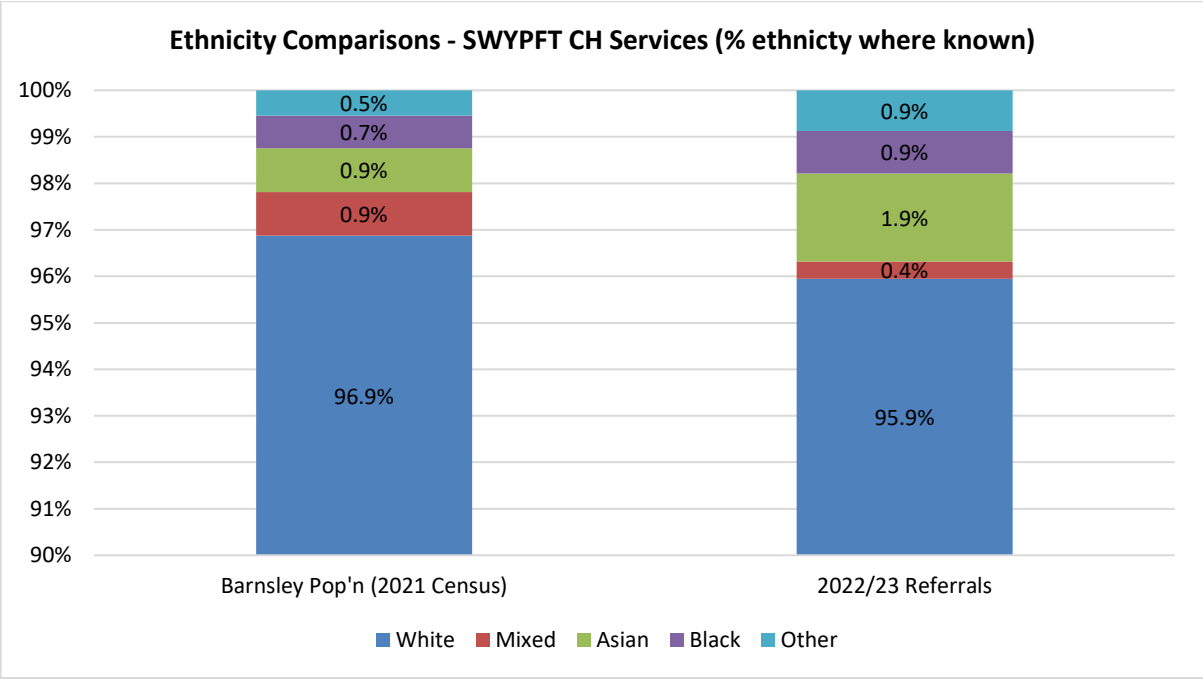


Fig 2. Ethnicity Comparison. Referrals to SWYPFT general community services – April 22 to March 23



Protected Characteristics

Fig 3. Protected Characteristics – SWYPFT mental health services. Referrals - April 2022 to March 2023 by disability and deprivation quintile where recorded. (NOTE – 55% of service users do not have disability status recorded) working groups are currently being set up to improve the data quality and collection.

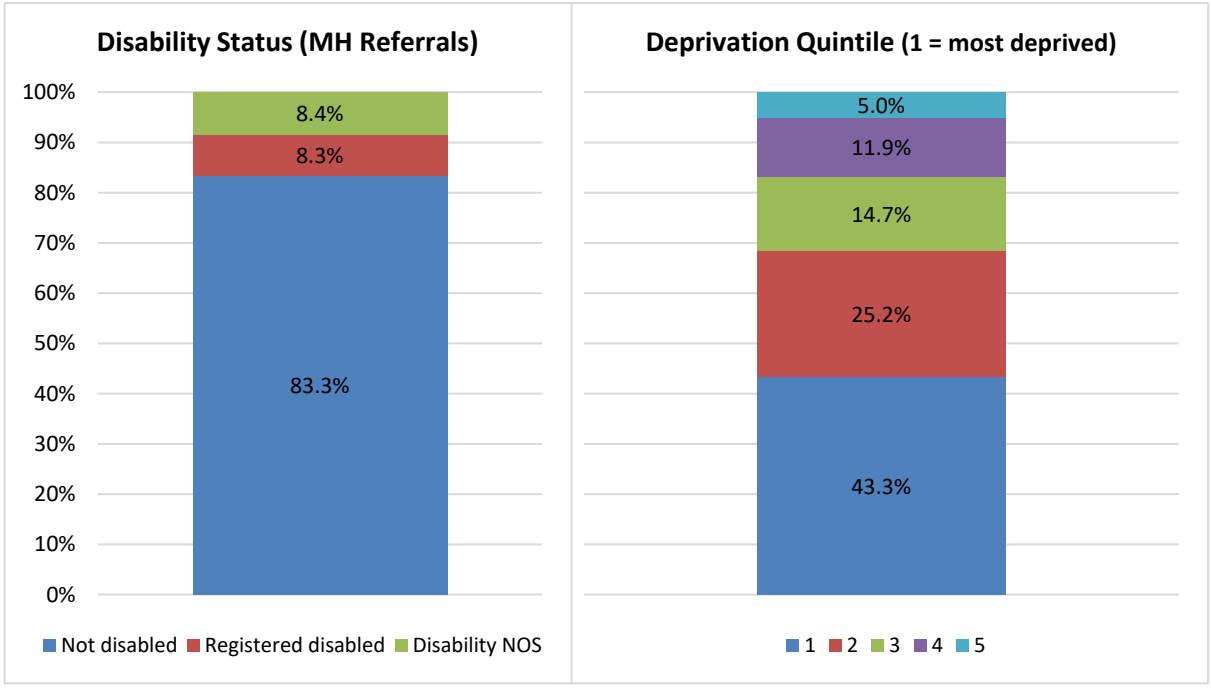
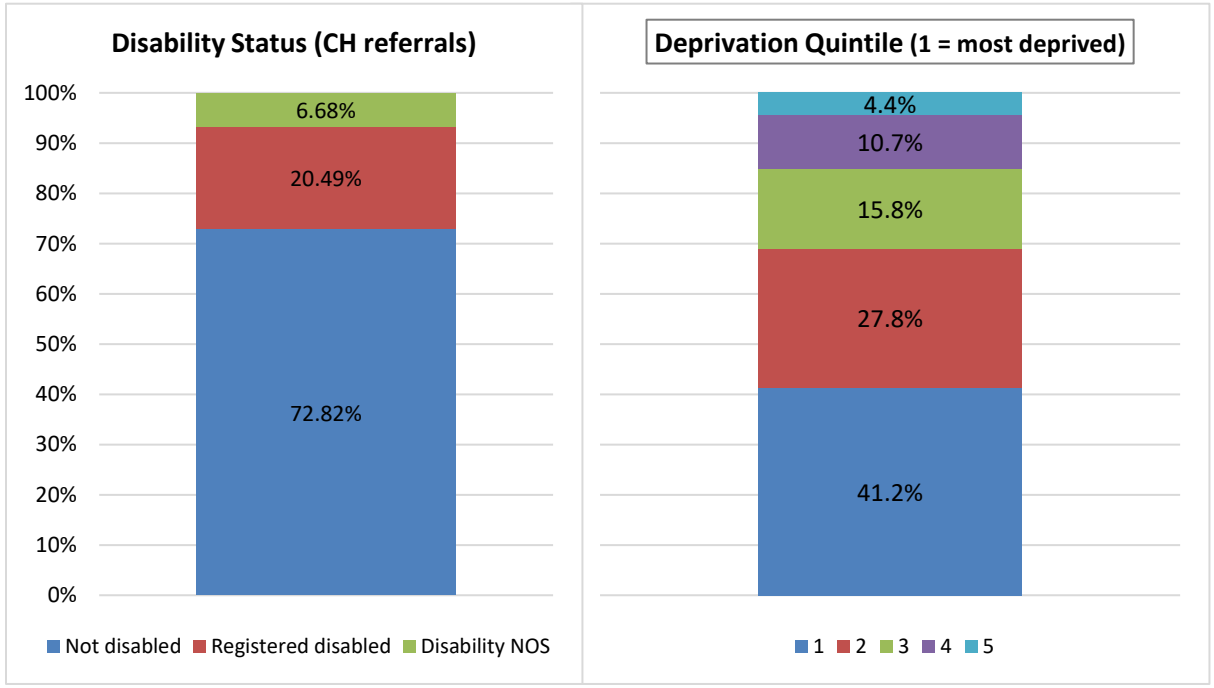


Fig 4. Protected Characteristics – SWYPFT general community services. Referrals - April 22 to March 23 by disability and deprivation quintile where recorded. (NOTE – 46% of service users do not have disability status recorded)



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 September 2023
Agenda item 10.6 – Assurance from Trust Board Committees

Collaborative Committee	
Date	8 August 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	<u>Assure</u>
	The Committee continues to receive reporting across the following areas from both collaboratives:
	• Finance – forecast for year at end of period 3 shows surplus position for WY Adult Secure but small deficit for SY Adult Secure. Opportunities for investment/use of WY surplus being reviewed. SY deficit being assessed in light of ongoing contractual discussions with independent providers
	• Contracting – as noted previously work is ongoing to conclude 22/23 contracts by December 23 and work on 23/24 is underway
	• Quality – significant focus on continued activity from the Commissioning hubs to provide quality assurance through regular monitoring and follow up activity with regard to CQC visits to independent providers
	• Risk – work continues to close a number of risks and to reduce in the scoring of others
	
	<u>Alert</u>
	• Quality monitoring continues to highlight specific areas of concern but positive progress continues to be made
	• Phase II Collaborative not fully integrated into the Collaborative Committee reporting templates
	
	<u>Advise</u>
	• A future committee meeting will review the performance of the adult secure collaboratives against their core purposes as set out in the original business cases
	• SWYFT has submitted an expression of interest for the role of co-ordinating provider for Maternal Mental Health Services
	• 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	Minutes presented to the private board due to being commercial in confidence.

Mental Health Act Committee	
Date	15 August 2023
Presented by	Kate Quail (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	Alert: Strike action may impact on aspects of MHA administration. Advise: Provision of a Second Opinion Appointed Doctor (SOAD). 34 exception reports where the CQC was unable to allocate a doctor within the statutory time limit. The Trust has developed an escalation process, which is working well. (NB the SOAD is required for patients who do not consent to the treatment as prescribed by clinicians. or are unable to consent to the treatment prescribed.) Assure: • Older People's service - working between two legal frameworks (MHA and MCA – Mental Capacity Act) to ensure there is person-centred care, promotion of individual well-being, where capacity is regularly reviewed with the aim of ensuring that detentions are kept to a minimum in duration and number. Inequalities - loneliness and social isolation can lead people to engage in risky behaviours, especially in old age, leading to admission to psychiatric hospital. Work with community teams to access support on discharge. • Annual MHA Performance Report Linked to Inequalities – new report which presented data, prior to further analysis to understand impact and address any service gaps for service users and carers. • Code of Practice oversight group – Group covers the current MH Act, the new /proposed MH Act, and the Liberty Protection Safeguards and supports clinical practice, including on risk assessments, care planning, seclusion, Reducing Restrictive Physical Intervention and segregation. • Performance Monitoring information Q2 – Overall, good assurance of compliance: o Patients' Rights activity for informal and CTO patients extremely positive at 99%. This activity also covers statutory advocacy provision which continues to be positive. • Mandatory Training compliance Training for the MHA. MCA and DoLS is positive and above the 80% target. • 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. • Annual audit of Section 132 (patient rights) - very high levels of compliance:

	○ S132 rights - 99% compliance, 4% increase on last year.. ○ Community Treatment Orders - compliance 99%, 12% increase on last year. • Annual audit of Advocacy Services (independent MHA/MCA and general advocacy) ○ 99% pf patients were informed of their rights to advocacy and about the advocates' roles. ○ There were 1,128 referrals to advocacy over the past 12 months. 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	

Members' Council	
Date	16 August 2023
Presented by	Marie Burnham, Chair (Chair of Committee)
Key items to raise at Trust Board	<u>Key points</u> • Members' Council received the Quality account 2022-23 and external assurance • Members' Council received governor feedback and approved appointments to Members' Council groups • Members' Council received assurance from Members' Council groups and the Nominations Committee • Members' Council reviewed the process of governors observing Board Committees • Members' Council approved to combine the role of deputy chair and senior independent director • Members' Council received an update on the Teaching Trust status • Members' Council received an update to the 2022 NHS staff survey • Members' Council received a presentation on health inequalities and waiting lists • Members' Council received the Quarter 1, 2023-24 Integrated Performance Report (IPR) • Members' Council received the final feedback on the chair's appraisal
Approved Minutes of previous meeting/s for receiving	9 May 2023

Quality and Safety Committee	
Date	12 September 2023
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	<u>Alert:</u>

	Internal Audit Report – 360 Risk Assessment and Care Planning. Committee considered the auditors' findings of 'limited assurance'. The context of the gaps in assurance were that there did not appear to be sufficient evidence that risk assessments were completed to the minimum standard of formulation informed risk management (FIRM), or in a timely manner, care plans did not accurately reflect all relevant service user related risks, and there did not appear to be sufficient evidence that all planned care, documented within a service user's care plan, could be observed in practice. The Trust's response to this is now embedded in the care plan and risk assessment improvement workstream. <u>Advise</u> • The committee received an inspiring presentation from Janet Watson from the Live Well Wakefield service. Janet described the accredited programme delivered by her and the team to promote wellbeing with regards to long-term conditions, people recovering from cancer and a programme for people experiencing mental health problems. • An update on the Care Plans and risk Assessment Improvement Plan was received. <u>Assure</u> • The Patient Experience Annual Report was recommended for approval at Board. • The incident management Q1 report was recommended for approval at Board. Reporting rates remain within normal variation and 96% of all incidents reported resulted in no harm or low harm to patients and staff or were external to the Trust's care. • The Safeguarding Annual Report was received by the committee. • The Quality Monitoring Annual Report was received. • The Medical Appraisal / Revalidation annual report was recommended for approval at Board. Discussed the current Trust-wide corporate / organisational level risks relevant to Committee and were assured that the current risk level, considering Trust risk appetite, given the current environment, is appropriate. New risks identified: No new risks identified.
Approved Minutes of previous meeting/s for receiving	13 June 2023

Equality, Inclusion and Involvement Committee	
Date	13 September 2023
Presented by	Marie Burnham, (Chair of Committee)
Key items to raise at Trust Board	<u>Alert:</u> • The NHS equality, diversity and inclusion improvement plan was published by NHSE in June 2023. The plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The Trust have already mapped current work against

	the actions and these will be embedded in the workforce and 2024/2025 equality action plan. • A recent review by the Race Health Observatory published in July 2023 identifies poorer care and lower life expectancy for ethnic minorities with a learning disability stating that those from Black and South Asian heritage face shorter life expectancy. The average age of death is 34 compared to 62 for white counterparts. • Annual report for Equality, Diversity and Inclusion has been shared in draft for comment. The report looks back on 2022/2023 and highlights progress. The report will be finalised in December 2023 and shared with Trust Board. <u>Advise:</u> • Care Group update: Barnsley Integrated Service Care Group presented by Sophie Hempsall. The highlights included progress on service EIAs and Barnsley community MH have developed pronoun posters collaboratively with TransBarnsley and the Trust EI team. All staff across Liaison and Diversion are trained to complete basic screens for learning disability and autism. There are improvements in the diversity of the workforce and the end-of-life care team has revised care plans for those in the last days of life which promote a person-centred approach to care. • EDS2022: All NHS providers are required to implement the EDS that comprises eleven outcomes spread across three domains, which are: 1) Commissioned or provided services 2) Workforce health and wellbeing 3) Inclusive leadership. Work is being progressed to evidence these outcomes and we continue to work with both South and West Yorkshire ICB towards domain one. The theme for this year will be perinatal mental health, Accessible Information Standard (AIS) and one other service, yet to be confirmed. • A focus on the Disabled staff network achievements and progress was presented by Lindsay Jensen in the absence of Elaine Shelton, chair of the Disabled staff network, who had prepared the presentation. The presentation provided an overview of the achievements of the staff network, which included the news that they had a newly appointed chair, plans to develop an annual comms plan and update the intranet page whilst continuing to recruit new members. • As part of our commitment to carers, the Trust are introducing the Triangle of Care model across all services. The Triangle of Care means including carers at all levels of care and giving them equity in the service user journey. It will help promote safety, support recovery and improve wellbeing. • Community Connectors: The Trust have launched an asset-based approach to involvement called Connecting People. The approach includes recruitment of staff, volunteers, voluntary and community sector colleagues to attend co-designed training which consist of 3 x 2-hour modules and communication materials. We have delivered 2 training sessions and now have over 30 connectors. <u>Assure:</u>

	• The EII exception and highlight report provides assurance that the Trust has delivered on the Trust wide strategy action plans 2023/2024 for both equality and involvement. This month the Committee were asked to approve a recommendation that more work is required to develop the metrics for equality data (not including ethnicity which is already set). • 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. • 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 disabled staff and shows a significant improvement in attracting staff but more work to do to demonstrate we are reflective of our communities. The current baseline for the Trust is 9%, the population average across all 4 places is just over 12%. A case study which used the data framework to review adult and older people mental health services will be used to support the older people transformation and improvements driven by the Mental Health Act Committee. • WRES and WDES reports presented and identified some challenges with the data and more work is identified for the action plans. The People Directorate incorporate actions into existing plans. <u>Risks discussed:</u> Risk register was reviewed, and all updates were approved <u>New risks identified:</u> No new risks identified.
Approved Minutes of previous meeting/s for receiving	12 June 2023

Finance, Investment & Performance Committee	
Date	18 September 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert:</u> • Medium term forecast will require significant cost efficiencies and starting now – this was raised previously at strategic board, but update is this is now beginning and becoming more formalised • Capital slightly behind plan (third party delays), however, options have been sought to mitigate through alternative projects, which are effectively being brought forward from future years, so overall will deliver plan but with different projects. • Proving more difficult than average to recruit against LD roles for MHIS opportunities. <u>Advise:</u> • Agency group ongoing, acceptance that there is likely a small increase going to happen with Out of Area reduction. Once that downward trajectory is maintained, then this will be addressed

	more. Update to be provided in November committee. However, the Agency spend is down vs peak in June. • Year to date, slightly behind financial plan, with non-pay proving a particular challenge. Expect to be able to close the gap by year end, however, it will be non-recurrent savings offsetting recurrent overspend. • NHS England have commended the finance team for prompt payment performance. • People and quality are the next areas to be addressed in the IPR review process. • Benchmarking requests have increased; however, these have been supplied, and expect outputs back in the coming months. • Older people strategy reviewed and will go through more committees before more formal review and approval is sought. <u>Assure:</u> • Out of Area plan presented and trajectories are positive, with the last 5 weeks showing a reduction from 20 beds to 9. Expect to be within target by October without compromising safety. • Updates provided on IPR, demonstrating national metrics, whereby the Board will receive trust wide data, however, the same data can be drilled into at a granular level, ensuring data integrity feeds throughout, and all areas can be reviewed by the relevant areas to ensure success at macro and micro level. • Waiting list data shows no difference in wait by ethnicity, it however, only is relevant from referral to ourselves. It does not provide any assurance on equality in access to gaining a referral before being known to ourselves. However, equality is provided with everything in our control.
Approved Minutes of previous meeting/s for receiving	19 June 2023

People and Remuneration Committee	
Date	11 September 2023
Presented by	Mandy Griffin - Chair
Key items to raise at Trust Board	<u>Alert:</u> • Appraisal compliance is still not met, currently 76.2%. There are challenges around the rate of drop off whilst recognising improvements in some areas The committee has requested additional assurance on this. • Recruitment activity is high bringing significant pressures to the people directorate. • Further impact is expected from ongoing industrial action from Consultants and Junior Doctors who have now agreed dates for a combined strike, alongside other periods of individual strike action, causing further disruption and pressure to service users and staff. • RRPI compliance is still below target at 76.2%. extra physical capacity has now been secured better progress is expected over the next couple of months. **<u>Advise:</u>** • Trust have now received information on Winter planning and Flu and COVID programmes, planning is in progress.

	• The workforce development funding has been reduced across the region by 80%. The impact of this is being reviewed. The committee was advised that CPD funding could cover some of the shortfall. • The government have agreed a VSM pay increase of 5%. This will be backdated to April 2023. A report on this will be received at PRC in November. • Laura Habib one of the trusts well-being champions presented some of the well-being activity including the ongoing recruitment of champions. A discussion was had around ensuring diversity across this group. • The agency scrutiny group AAA report was received one of the key points being that an external review of agency had taken place. The report is being shared with the Scrutiny Group and included in the PRC November report. • The committee received some excellent data around leavers feedback. The data will inform our retention strategy on the back of the NHS Workforce plan. • The new People Directorate structure and workstreams were presented for comment. There are a number of new posts and all posts have now been filled. The structure will take a number of months to embed as new recruits work through their inductions. • The NHS Workforce plan was presented with an overview of the impact on SWYPFT and next steps. • CEO presented Directors objectives for 23/24 • The Consultants Local Excellence Awards (LCEA) process for this year was agreed and will remain the same as last year. • An Interim Deputy CPO has been recruited on a fixed term contract to support the directorate whilst the current deputy acts up. **Assure:** • A discussion around the Lucy Letby case took place. A paper will be presented at BOD 26th September on our approach to the trial and any response required to NHS England. • Onboarding tracking system Genius is progressing with a go-live proposal of October 2023. • The IR35 annual update was received with full compliance being met. • It was good to note that overall workforce staff in post is reasonably stable. Workforce in post has risen by 48.4wte. • The Guardian of safe working quarterly report was presented giving assurance that, despite the challenges all gaps were covered. ERs remain low. • WRES and WDES data for 2023 were submitted and the draft action plans presented to the group. The draft action plans will also be presented at the next EIIC. It was advised the action plans need to include more precise impact, deadlines and leads. There was also a discussion in regard to the results of the Flair Survey and how the results may enhance the action plans. • The GPTW delivery plan was presented progress is good however it was felt that actions and deadlines need to be reviewed. This will be done for the next meeting in November. **Risk Register**: The current risks have not changed since last time and the committee agreed that they are still appropriate. Scoring was agreed with an

	agreement for further discussion at the next meeting. A risk has been raised in Private Board.
Approved Minutes of previous meeting/s for receiving	18 July 2023

West Yorkshire Mental Health Learning Disability and Autism (WYMHLDA) Committee in Common	
Date	26 July 2023
Presented by	Brodie Clark (Chair) (BC) - Chair, Leeds Community Healthcare NHS Trust
Key items to raise at Trust Board	**Alert:** In relation to NHS111 a detailed letter that outlines the concerns and challenges faced is to be cascaded which is to include the lack of clarity and guidance and that this will have a significant and negative impact to the WY population and should be noted on Trust risk registers. **Advise:** • Due to the ICB operating model review there is a high degree of uncertainty for staff • at ICB and Place level, all are to consider this impact on colleagues as part of regular • interactions with place and system colleagues. • The CinC agreed to write to NHSE with a consideration on the development of the • additional Mother & Baby Unit beds. • The NHSE ambition to provide support to individuals with complex needs that • require specific therapy via Maternal Mental Health services has been agreed to • be recurrently funded by all five places within the same timescales and criteria and • over time the CinC would like this service to be overseen by the WY • Commissioning Hub if resourced to do so. • A Neurodiversity summit will take place on the 14th November 2023 that will bring • together clinical and professional experts alongside wider partners in education, • elected members, voice **Assure:** • The collaborative is continuing to strengthen relationships with Primary Care which includes the vice Chair of the MHLDA Partnership Board being from Primary Care. • A sector response to the ICB operating model has been gained by collaborative workshops and we await the ICB response.
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.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Mental Health Act Committee meeting held on Tuesday 16 May 2023 Microsoft Teams meeting

Present:	Kate Quail (KQ) Dr Subha Thiyagesh (STh) Erfana Mahmood (EM) Darryl Thompson (DT)	Non-Executive Director (Chair of the Committee) Chief Medical Officer (Lead Director) Non-Executive Director Chief Nurse / Director of Quality and Professions
Apologies:	Mandy Rayner (MR)	Non-Executive Director
In attendance:	Julie Carr (JC) Nancy Cartwright (NC) Yvonne French (YF) Chris Lennox (CL) Fareena Rasaq (FR) Sue Spencer (SS) Dr Sarah Talari (STa) Carly Thimm (CT) Gordon Walker (GW) Gemma Williamson (GWi) Sarah Millar (SM)	Clinical Legislation Manager Deputy Chair of the Hospital Manager Forum Assistant Director of Legal Services Director of Services Learning Disability Services Manager (Item 2) Governor (observing) Consultant in Learning Disabilities and Clinical Lead (item 2) Mental Health Act/Mental Capacity Act Manager Chair of the Hospital Manager Forum Mental Health Act Officer PA to Chief Medical Officer (author)

MHAC/23/15 Welcome, introduction and apologies (agenda item 1)

The Chair, Kate Quail (KQ) welcomed everyone to the meeting. Apologies were noted as above, and the meeting was deemed to be quorate and could proceed.

KQ outlined the Microsoft Teams meeting protocols and etiquette.

The Committee noted that there were no further Declarations of Interest over and above those made in the annual return to Trust Board in March 2023 or subsequently.

MHAC/23/16 Long Term Segregation and Learning Disability Services (agenda item 2)

Fareena Rasaq (FR) and Sarah Talari (STa) gave a presentation on Long Term Segregation (LTS) in Learning Disability (LD) services including the difference between seclusion and LTS, the current position on Horizon and some assurance around quality and compliance. FR raised that the service had made good progress since the LTS provision was reviewed last year. Service users were helping to improve their own environment and getting involved with activities on the ward such as the recent Eid and Coronation celebrations. There had also been improvements around personalisation, both in bedrooms and with equipment such as projectors to personalise lighting and mood panels, etc.

KQ acknowledged the huge amount of improvement work in a short space of time and Subha Thiyagesh (STh) thanked FR and STa for their commitment and hard work. STh added that the presentation was comprehensive and gave a clear direction of travel for improvement work and assurance to the Committee.

STh referred to benchmarking and how the figure of 50% of service users being in LTS could be misleading when it related to only two people. STh queried where we sit regionally and nationally and STa advised that it is difficult to accurately benchmark as many places do not offer seclusion rooms or LTS. STa added that it is not uncommon to have Forensic service users in LD services in LTS and usually you would expect to see one person per unit in LTS. FR raised that the service had seen an increase in demand post Covid 19 with more people requiring single occupancy and their own space, mainly around their autism and sensory issues.

Darryl Thompson (DT) thanked FR and STa and added that he could sense the leadership in the presentation. DT reported that he had been on Horizon twice in the last month and assured Committee that it felt different now and things have really changed. DT went on to say that whilst LTS use should be minimised, when it is needed on Horizon, it is done as well as it possibly can be. DT referred to the Quality Account and indicated that it would be helpful to pull some parts of the presentation into that in terms of the improvement work.

KQ queried how we know that we are addressing the physical health needs of people in LD services, particularly if they cannot communicate verbally. KQ added that not addressing physical health needs might lead to behavioural challenges, then restraint and LTS. STa advised that a thorough physical health check is part of the clerking in process for anyone being admitted to the ward, in the first 72 hours. Any issues identified are addressed comprehensively and physical health monitoring is carried out regularly throughout the person's stay.

KQ would welcome FR and STa returning to a future MHAC meeting to update further on the ongoing work.

MHAC/23/17 Legal Update (agenda item 3)

MHAC/23/17a Liberty Protection safeguards (agenda item 3.1)

Julie Carr (JC) took the paper as read. It was noted that the government have decided to further delay progressing Liberty Protection Safeguard (LPS) plans to allow them time to deal with social care reforms. JC indicated that 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.

JC referred to the advice from Hill Dickinson solicitors that organisations are encouraged to focus on enhancing their existing policies and practices relating to the Mental Capacity Act (MCA) and Committee were assured that our approach had been appropriate and of benefit.

KQ agreed that the work already done had absolutely not been a waste of time and effort and acknowledged the huge strides forward in terms of improvement.

Next Steps

- Quality Improvement workstreams to continue to support embedding of good practice.
- To share briefings with medical webinar and Clinical Governance Group.
- For oversight of MCA/DoLS and LPA matters to sit with the Code of Practice Group.

It was RESOLVED to RECEIVE the briefing and to SUPPORT the next steps identified.

MHAC/23/18 Feedback from partners (agenda item 4)

MHAC/23/18a Independent Hospital Managers feedback and Draft Forum notes 11 April 2023 (agenda item 4.1)

The Committee received the notes of the Hospital Managers' Forum meeting from 11 April 2023, which were taken as read.

Gordon Walker (GW) referred to recruitment of the four new Hospital Managers, as mentioned at the last meeting, and noted that it had gone very well indeed. Three of them have started to attend panels. KQ noted the good progress with recruitment and that more appointments were expected soon.

MHAC/23/18b Acute hospital feedback (agenda item 4.2)

KQ reported that Carly Thimm (CT) had started a new monthly partnership working group with acute colleagues and had started asking for feedback again as part of those. CT added that they were in the early stages but going well so far.

KQ advised that some operational issues had been identified in Calderdale and CT confirmed that these had all been dealt with and the enhanced engagement had helped with resolving things quickly.

MHAC/23/19 Minutes/Actions (agenda item 5)

MHAC/23/19a Minutes from previous Mental Health Act Committee meeting held 7 March 2023 (agenda item 5.1)

The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Mental Health Act Committee meeting held on 7 March 2023 as a true and accurate record.

MHAC/23/19b Matters arising from previous Mental Health Act Committee meeting held 7 March 2023 and action log (agenda item 5.2)

The action from the meeting on 7 March 2023 was complete and Yvonne French (YF) had shared a paper by way of update.

YF indicated that back in September 2021 Mental Health Act Committee (MHAC) had asked for Forensic services to be involved in a piece of work with our service users about their experience of being detained. This had been done using a Discovery Interview approach and the results were shared with service users in a "you said, we did" format. One of the points raised had been how scary it can be to be admitted into somewhere like Newton Lodge and this led to an animation video being developed telling services users and their families what to expect. The video had been showcased and we have been approached by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) who are interested in developing something similar in their own organisation.

Since then, the Trust's Equality and Involvement Team have commissioned the Yorkshire and Humber Involvement Team to explore the experiences of those from a Black, Asian and Minority Ethnic (BAME) background. The service has also developed an 'Our Voice Counts' project to ensure that the voices of the BAME population at Newton Lodge are heard. This has resulted in an action plan, with some actions already completed and others ongoing.

KQ noted that this work had come from discussions about patient experience, particularly those detained and particularly those in Forensic services. Committee had wanted to find out

more about the BAME experience but then decided to look at all experiences so there could be a comparison. KQ indicated that these issues were not for MHAC to tackle but for the wider system, although it was helpful to see an update.

YF advised that Mike Garnham had presented to Equality, Involvement and Inclusion Committee (EIIC) in relation to their specific action and there were no further actions at this point. Erfana Mahmood (EM) added that Dawn Pearson is the equality lead and will pick up anything relevant in the Equality Strategy or action plans.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for 7 March 2023.

MHAC/23/19c Anything delegated from Trust Board (agenda item 5.3)
There was nothing to note for this item.

MHAC/23/20 Risk (agenda item 6)

MHAC/23/20a Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.1)
The report was taken as read. JC advised that the Organisational Risk Register (ORR) had been reviewed and one new risk that relates to MHAC had been identified. This was in relation to the cumulative impact of staffing shortages and linked to risks 905, 115 and 1614 regarding our ability to deliver on legal and Code of Practice requirements. JC also noted that risk 1368 in relation to access to beds for children and young people had been re-graded since the last meeting from amber to red.

DT referred to discussions in Clinical Governance and Clinical Safety Committee (CGCSC) about risks held in committees that map across to other committees for noting and awareness and raised that these were good examples of that. DT suggested maybe adding a column to the risk document to clearly show who has responsibility for a risk and who is noting it for awareness. KQ acknowledged the progress on cross-committee working over the last few years which could be further built on.

STh raised a potential risk in relation to possible consultant strike action. The ballot to strike is open until the end of June when we will find out if consultants plan to strike or not. STh indicated that this is relevant to MHAC as all inpatient consultants are Responsible Clinicians so Mental Health Act work would be directly impacted. STh highlighted the fantastic response in the Trust to strike action so far, with some great examples of collaborative working but noted that a consultant strike would represent a real governance risk. KQ noted that it was helpful for Committee to be aware of this now although the risk would be dealt with at ORR level.

It was RESOLVED to RECEIVE the update and to NOTE the current Trustwide corporate/organisational level risks relevant to this Committee.

MHAC/23/20b MHA Committee risk register (agenda item 6.2)
Committee noted that there were currently no MHAC risks.

MHAC/23/21 Statistical information use of the MHA 1983 and MCA 2005 (agenda item 7)

MHAC/23/21a Performance report – Monitoring Information Trust Wide January-March 2023 (agenda item 7.1)
The report was noted and Chris Lennox (CL) highlighted the following:

- The Trust remains broadly in line with the national picture in relation to admissions and detentions.
- There had been 5 admissions in Quarter 4 of under 18s and an increase in duration between 7 and 60 days, which was of concern.
- 43% of all new admissions were under the Mental Health Act which represented a slight increase.
- The average length of stay remains stable.
- Forensic services have seen an increase in admission activity under Section 3 with some of these being prison transfers.
- 65% of all uses of Section 5.2 resulted in detention under Section 2 or 3, which was similar to the previous quarter.
- The highest source of internal transfer activity remains attributable to a return to home area.
- There had been an increase in Hospital Manager appeals to 17 although 9 of these were cancelled by the patient or their solicitor prior to the hearing.
- There was also an increase in applications for Tribunals to 138, with 78 hearings. 20 of these hearings were face to face.
- Quarter 4 saw a reduction in Section 49 activity. There were 7 new approaches and the reports are still taking between 12-16 weeks to complete.
- There had been a total of 142 assessments in the 136 suites and 56% of these resulted in admission.
- Whilst BAME service users remain over-represented in terms of detention, this continues to be addressed as part of the equality and inclusion action plans and at service level.
- There had been an increase in use of both Section 2 and 3 in Quarter 4. Of the 38 sections, all were reviewed within 72 hours.
- There were 58 patients subject to a conditional discharge at the close of Quarter 4 with no recall activity.
- There had been an increase in external transfers and access to rehabilitation and other specialist services were the main reasons for that.
- 49 Community Treatment Orders (CTOs) were open at the close of Quarter 4 which is a decrease of 6 active CTOs in the last quarter and consistent with the decreasing trend seen over the last two years. 11 new CTOs have been applied with 17 patients discharged from a CTO.
- There continue to be delays with Second Opinion Appointed Doctor (SOAD) responses and there is an agreed escalation process in place. All patients affected by the delays have an appropriate certificate to authorise ongoing treatment.
- There were 7 new applications for Deprivation of Liberty (DoLS) authorisations. These were all from our physical health wards at Kendray. Two were authorised, none were refused, one is pending an outcome and the others did not progress due to the patient being discharged.
- There were no notifiable deaths in Quarter 4.
- There had been 3 exception reports for civil sections in Quarter 4 which was a decrease on the previous quarter.
- There were 20 Consent to Treatment exception reports to note from Quarter 4 which was also a decrease.
- Three exception reports related to 136 access and all were as a result of the suites being occupied by a service user detained to the suite. CL added that this happened when beds were not immediately available and was closely monitored.
- In relation to Section 17 leave compliance, 675 periods of leave were granted in adult services. There had been a discussion at the last meeting about leave in Forensic and Specialist Services and CL referred to a deep dive into the data and reported that a trajectory for improvement had been set. There had been a small improvement on the last quarter in terms of granted leave taken.
- Three patients had been absent without leave from the Forensic wards and these were reported to the CQC.

- A Quality Improvement (QI) approach had been taken to improving compliance with the Code of Practice following the review presented to MHAC in Quarter 3. The Mental Health Act (MHA) team implemented the new process to address gaps in compliance on 1 April and progress will be reported each quarter with an expectation of improvement by the next meeting.
- There had been 5 Hospital Manager compliments and 8 concerns raised. Five concerns were in relation to the content of reports and the authors had been asked for improved attention to detail. There had been one concern raised about the incorrect pronouns being used for a patient and the professional involved was supported with guidance on identifying the patient in their reports. There was also a concern raised by panel members about the technology available to write decisions and the MHA office is looking at what improvements can be made. The compliments mainly related to quality of evidence, and one for the patient's advocate for being so present and involved in the hearing.
- There had been 3 formal MHA complaints, all of which were going through the usual process.
- The advocacy services had all been active during Quarter 4.
- The compliance rate for patients' rights monitoring for detained patients was 88% which was a reduction from the 99% recorded last time. Informal patients' rights compliance had increased to 95% from 92%. The rate for those on a CTO was 82%. Work continues to improve compliance rates and the MHA office is sending reminders and working with matrons on service improvement plans.
- 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%.

CL referred to a query at the last meeting about the 'other' outcome option for Section 136 referrals. CL had liaised with colleagues and it was determined that the categories for the outcomes were not as precise and relevant as they need to be. It had been noted that practitioners do not always know how to code things, for example if someone was already a service user, they did not want to record them as a new patient for the Intensive Home Based Treatment Team (IHBTT). The categories are being reviewed for more accurate reporting.

KQ referred to the work Mike Garnham had been asked to do on ethnicity and YF advised that two updates would come to the August Committee meeting. One would be on the use of the MHA over the last 2 years from an ethnicity and age point of view and also, if possible, the area the service user is living in. YF advised that Mike is also linking in with Dawn Pearson from an equality perspective. The other piece of work related to the number of people of black ethnicity in Forensic services. Mike had been asked to identify where the individuals were being detained from, such as the community or the criminal justice system and if there are any actions for us as an organisation. KQ indicated that it would be helpful to get some more detail behind why we appear to detain more people from a BAME background. EM agreed and added that Committee had previously heard that people from ethnic, particularly BAME, communities were more likely to be in a Forensic service than a general adult setting. EM suggested that we may need to go back a few years to get a good understanding.

KQ raised that the advocacy service in Calderdale had received 67 referrals but 20 people had not been seen. KQ asked if there was a problem and CT advised that the advocacy services send us a list of why someone was not seen which could be that they refused a meeting, they were too unwell at the time or just due to unforeseen circumstances. CT clarified that there were no issues with the advocacy service facilitating meetings.

KQ referred to a complaint about the care and treatment of a young person in an adult bed and noted that it had been raised as a formal complaint rather than feedback. Consent to investigate was being sought, however KQ asked for any assurance around this. CL did not

think this related to a young person but rather an adult detained in an adult bed. CL will check that but is not aware of any pending complaints in relation to children.

Action: Chris Lennox

KQ would like to understand more about the experience of young people detained in adult beds. It was noted that whilst we do not want to admit to adult beds, we need to assure ourselves on the quality and safety of the care of any young person who is admitted. STh and YF took an action to pick this up with the executive trio.

Action: Exec Trio /Yvonne French

KQ added that it would also be interesting to know how they ended up there and CL advised that the wider system had failed if a young person is admitted to one of our adult wards. STh added that the issues lie with access to Tier 4 beds, input from the Local Authority and other factors that contribute to a situation where a young person is admitted to an adult bed rather than being looked after at home. STh indicated that SWYPFT is already contributing to a lot of work in the system and the remit of the action should only be to understand their experience on the ward.

DT suggested that a pathway failure would be a good way of describing a situation where a young person is admitted. The family would have taken a number of steps before the young person ends up in our care and DT added that it was equally important to capture the carer voice when understanding the experience. DT recommended linking with Gillian Cowell as sometimes the parents have become desperate and might be glad that their child is somewhere safe.

EM noted that whilst we cannot change the pathway ourselves, it might help if we have considered the patient experience when discussing the issue of Tier 4 beds at an Integrated Care System (ICS) level.
It was RESOLVED to RECEIVE and NOTE the monitoring report.

MHAC/23/22 CQC compliance actions (agenda item 8)

MHAC/23/22a MHA/MCA Code of Practice oversight group feedback (agenda item 8.1)
YF took the paper as read and highlighted two elements.

The Place of Safety Standard Operating Procedure (SOP) is under review. It will be shared with MHAC when it is signed off.

It was noted that Section papers are primarily received by a registered nurse and the Code of Practice requires a registered professional or a person who has the necessary competencies to receive papers on behalf of the Hospital Managers. A review of the process has been undertaken following some errors and it was identified that these were mainly due to human factors because of staffing levels and acuity on the wards. As such, it had been agreed that Nurse Associates fulfil the criteria to be able to receive papers, subject to training.

DT raised that this feels helpful in principle and his team were considering where else this needs to be discussed, possibly in the People Directorate if there are changes to roles. YF confirmed this was part of a bigger piece of work from the Nursing Directorate on what roles the Nurse Associates could undertake. DT went on to say that we need to ensure people are working to the limit of their registration, in a positive way, and the correct governance has been followed. STh raised that there is some urgency in confirming arrangements to help with acuity and reduce the chance of errors. It was agreed that training was important and it should be clarified in documentation that the Nurse Associate is competent through training as well

as being registered. DT took an action to check with Margaret Bedford about next steps and the People Directorate on the potential role change.

Action: Darryl Thompson

KQ noted the update on the other workstreams in relation to the MHA and MCA.

It was RESOLVED to RECEIVE and NOTE the update.

MHAC/23/23 Audit and Compliance Reports (agenda item 9)

MHAC/23/23a Thematic review of CQC MHA visits (agenda item 9.1)

JC took the paper as read and referred to the tables that show where the CQC have visited over the last 5 years. JC advised that it is likely we will have around 17 visits over this reporting year and there has already been a significant increase in activity that will be reported on in the next quarter. JC also referred to the tables with actions identified graded as either 'Must do' or 'Should do'.

JC reported that visiting regimes are expected to return to pre-pandemic levels and recommended adding the thematic review of CQC visits to the annual work plan so Committee can see an overview of visits and themes. JC also recommended that the quarterly report on activity and assurance that actions are being responded to in a timely manner should continue to come to these meetings.

It was RESOLVED to RECEIVE the report and APPROVE the recommendations.

MHAC/23/24 Care Quality Commission visits (agenda item 10)

MHAC/23/24a Visits and summary reports Quarter 4 including Care Group actions from previous visits (agenda item 10.1)

JC reported that there had been 4 CQC Mental Health Act visits in Quarter 4, to Nostell, Elmdale, Ashdale and Ryburn wards, with 3 summary reports received.

The action statement received in Quarter 4 gave rise to 33 actions, with 3 being the new standard action for all visits. 7 concerns were reported, 6 arising from service users and one from a carer.

JC advised that we had had a new inspector and there were some issues with actions being duplicated and attributed to incorrect wards. JC added that the reports were long, repetitive and similar for different wards. JC indicated that there were only 5 open actions.

KQ noted the explanation and the plans to complete the outstanding actions in Quarter 1. KQ thanked colleagues for the work to close the actions in addition to everything else they were doing.

STh raised that it was a really helpful report and thanked JC and her team. STh asked if we should wait until the annual thematic report to get an overview or whether we could undertake a gap analysis to understand what the CQC have indicated as the key areas for 23/24. STh went on to suggest that these could then be mapped across to arising themes which might be more helpful for Committee. KQ agreed that more of a 'So what' approach would be helpful and STh gave the example of closed cultures and how further triangulation of what we are doing about that would give assurance to Board.

It was RESOLVED to RECEIVE and NOTE the progress of the actions following CQC visits.

MHAC/23/25 Key Messages to Trust Board and other Committees (agenda item 11)

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 LPS.
- Scoping ethnicity work as YF described.
- Experience of young people on adult wards.
- Closed off Discovery Interview work – 'you said, we did' and the animation.

Assurance

- Code of Practice group and agreement that Nurse Associates can receive Section papers.
- Long Term Segregation in LD and interesting presentation.
- Risk Register reviewed.
- CQC visits and thematic review and how these feed into CGCSC.

MHAC/23/26 Work Programme (agenda item 12)

The Work Programme was noted.

MHAC/23/27 Date and time of next meeting (agenda item 13)

The next meeting will be held on 15 August 2023. 2.00-4.30 pm via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Members' Council meeting held at 09.30 on 9 May 2023

Hybrid meeting
Large Conference Room, Fieldhead Hospital, Wakefield
and Microsoft Teams

Present:	Marie Burnham (MBu)	Chair
	Jacob Agoro (JA)	Staff – Nursing
	Charles Elliott (CE)	Public – Wakefield
	Rumaysah Farooq (RF)	Public – Kirklees
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Claire Den Burger-Green (CDBG)	Public - Kirklees
	Laura Habib (LH)	Staff – Nursing support
	Sara Javid (SJ)	Public - Kirklees
	Adam Jhugroo (AJh)	Public – Calderdale
	Rosie King (RK)	Public – Wakefield
	John Laville (JL)	Public – Kirklees (Lead Governor)
	John Lycett (JL)	Public – Barnsley
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Helen Morgan (HM)	Staff – Allied Health Professionals
	Bob Morse (BM)	Public – Kirklees
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Reini Schühle (RS)	Public – Wakefield
	Phil Shire (PS)	Public – Calderdale
	Susan Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
	Keith Stuart-Clarke (KSC)	Public - Barnsley
In attendance:	Mark Brooks (MBr)	Chief Executive
	Mike Ford (MF)	Senior Independent Director
	Chris Lennox (CL)	Director of Services (Adult and Older Peoples Services)
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NMc)	Non-Executive Director
	Greg Moores (GM)	Chief People Officer
	Kate Quail (KQ)	Non-Executive Director
	Mandy Rayner (MR)	Non-Executive Director/ Deputy Chair
	Adrian Snarr (ASn)	Executive Director of finance, estates and resources
	Darryl Thompson (DT)	Chief Nurse and Director of quality and professions
	David Webster (DW)	Non-Executive Director
	Julie Williams (JW)	Deputy Director of corporate governance, performance and risk

	Asma Sacha (ASa)	Corporate Governance Manager (Author)
	Anthony (Tony) Jackson (AJ)	Corporate Governance Administrator
	Gavin Richardson	Communications Manager
	Chanelle Evans	NHS Graduate Management Training Student (observing)
Apologies:	Members' Council:	
	Cllr Howard Blagbrough (HB)	Appointed – Calderdale Council
	Tanisha Bramwell (TB)	Public – Kirklees
	Bob Clayden (BC)	Public - Wakefield
	Daz Dooler (DD)	Public – Wakefield
	Cllr Brenda Eastwood (BE)	Appointed – Barnsley Council
	Gary Ellis (GE)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Leonie Gleadall (LG)	Staff – non-clinical support
	Daniel Goff (DG)	Public – Barnsley
	Christopher Matejak (CM)	Public - Calderdale
	Fatima Shahzad (FS)	Public – Rest of Yorkshire and Humber
	Elaine Shelton (ES)	Appointed – staff side organisation
	Nik Vlissides (NV)	Staff – psychological support
	Attendees:	
	Carol Harris (CH)	Chief operating officer (sent deputy)
	Sean Rayner (SR)	Director of provider development
	Dr Subha Thiyagesh (ST)	Chief medical officer
	Salma Yasmeen (SY)	Deputy Chief Executive/ Director of strategy and change
	Andy Lister (AL)	Head of Corporate Governance/ Company Secretary

MC/23/13 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). Attendees who were joining virtually were kindly requested to remain on mute, unless speaking.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC/23/14 Declarations of Interests (agenda item 2)

Declarations of interests were received from newly appointed governors who commenced their post from 1 May 2023 and existing governors as an annual process. There are some declarations that are outstanding which will be updated in due course.

It was RESOLVED to NOTE the individual declarations from governors.

MC/23/15 Minutes of the previous Members' Council meeting held on 24 February 2023 (agenda item 3)

Phil Shire (PS) informed that he attended the Members' Council meeting on the 24 February 2023 but was put down as apologies.

Action: Corporate Governance Team to amend

It was RESOLVED to AGREE the minutes of the Members' Council meeting held on 24 February 2023 as a true and accurate record with the noted amendments.

MC/23/16 Matters arising from the previous meeting held on 24 February 2023 and action log (agenda item 4)

MC/23/06a

John Laville (JL) informed that he has been progressing the issues raised by the carers forum. JL said this action was complete but if there are any further issues then this will be discussed during regular meetings.

MC/23/06d

Julie Williams (JW) informed Members' Council that she is currently liaising with the Deputy Director of Finance, Rob Adamson and they are reviewing the process in relation to digital expenses. JW informed she will liaise directly with governors once she has further information.

Action: JW to review and report back to governors

MC/22/63

Mark Brooks (MBr) provided an update to the Members' Council and informed that the Good Governance Institute (GGI) was commissioned to carry out a review of Greater Manchester Mental Health (GMMH) NHS Foundation Trust and their findings were published on the 28 March 2023. It was agreed for this item to be discussed at the Members' Council Quality Group.

Action: Corporate Governance to bring this item to the Members' Council Quality Group.

It was RESOLVED to NOTE the Action log of the Members' Council.

MC/23/17 Chair's report and feedback from Trust Board (agenda item 5)

MBu explained the purpose of her report and the Chair and Non-Executive Director activity.

JL explained there are quite a few abbreviations in the report, and he asked whether this could be rectified for future reports. JL suggested the use of glossary at the end of documents.

Action: Corporate Governance team to action.

It was resolved to NOTE the Chairs' report.

MC/23/18 Chief Executive's Comments on the operating context (agenda item 6)
MBr explained it has been a challenging winter and the Trust has also been directly and indirectly affected by industrial action since 2022. There is positive work that is taking place across the Trust.

MBr stated that the Trust budget is going to be challenging and during the Covid response the Trust were given additional monies to help the Trust to respond to the pandemic, but the Trust has a high demand on services. MBr gave an example of the Child and Adolescent Mental Health Services (CAMHS) stating that the number of people accessing the service has increased to almost 38%. There is high level of demand and patient acuity. Whilst the majority of the care is provided in the community, this has put pressure on the use of out of area beds with the use of 15 to 16 independent sector beds.

MBr said our Integrated Care Boards became live organisations in July 2022 and already they have been informed to make 30% cost saving by 2025 and 20% of that should be delivered in 12 months. The ICSs are producing a 5 year plan/strategy and the Trust is working with our partners in places to contribute to this.

MBr said workforce remains a challenge and vacancies are not always filled in the most demanding areas. This is being continually reviewed.

MBr said the Trust recognises how innovative staff work and the Trust felt its first face to face excellence awards since the pandemic on the 4 May 2023 and there were over 220 nominations. He explained it was an inspiring evening.

MBr explained teams are working on the annual report, quality report and internal auditing.

It was resolved to NOTE the Chief Executives comments on the operating context.

MC/23/19 Members' Council Annual items (agenda item 7)

MC/23/19a Annual report unannounced/ planned visits (item 7.1)
Darryl Thompson (DT) explained the purpose of this paper which provides the Members' Council with oversight and assurance around a recent unannounced inspection by the Care Quality Commission (CQC) to older people's services. The paper also outlines an update on Quality Monitoring Visits (QMVs) for the last 12 months.

He explained the CQC visited two older peoples inpatient units called Poplars in Hemsworth and Ward 19, Priestley Unit in Dewsbury. This report shares the feedback and also the actions and recommendations. He explained within each ward and care group there is an improvement plan. DT explained the report shows positive interactions with staff and how positive the staff were about the culture of working within the Trust and there were some areas for improvement particularly around observations of patients.

DT said the Trust also carry out Quality Monitoring Visits (QMVs) which is an internal review process which is attended by governors and Non-Executive Directors. MBu explained to governors that QMVs are a really good opportunity and gives a good insight. DT explained future planning of QMVs allows for services to prepare themselves for CQC visits and to learn and understand what is looked at during a CQC inspection.

JL asked about the frequency of the QMVs and how many visits had taken place over the last 12 months. JL asked whether the frequency of the QMVs are increasing. DT

explained there was a reduction due to restrictions with Covid. JL explained if there should be a target number of QMVs a month. DT said the Trust is a big organisation and we can't get around everywhere frequently. DT explained the QMVs are full days and they are really detailed and the Trust is looking at quality governance and are working in partnership with our neighbours in the Integrated Care System (ICS). MBu explained that there is not only QMVs but director visits and other activities taking place. MBu asked DT whether it would be useful to bring back a paper to the Members' Council on how we can assure the Members' Council. MBu said we also need to factor in Covid 19 outbreaks and how this has reduced many visits.

Action: DT to report back to a future Members' Council regarding QMVs to provide assurance.

Phil Shire (PS) asked about the inspection of Poplars and asked why the inspection was paused and he noticed nothing serious was highlighted in the action plan. DT explained the CQC found challenges on one of the wards and high level of assurance on another and took a step back and allowed the Trust to start the review of the older peoples mental health services over a two week period. DT said services carried out a review and the CQC were comfortable with the feedback and were assured with the feedback. PS asked about the grading. DT said with this type of inspection, it was not to influence the grading, but it was part of a wider well led review.

Rosie King (RK) said she has participated in unannounced visits with the expert by experience team, she asked whether it was a conflict of interest to be a governor as well as participating in this. MBu said no.

Claire Den Burger Green (CDBG) explained she also took part in unannounced visits through expert by experience. She explained she was concerned about doing QMVs when the concerns are raised rather than just doing the QMVs according to a schedule, but she also understands that the visits are done when they have not been done in a while. She asked who participated in the QMVs. She also asked whether those people participating in the visits have a template to follow and a plan and set of questions.

DT responded that there is a team of people who participate in the QMV which includes a Non-Executive Director, governor, Manager and each member of the panel receives a pack and it highlights concerns, complaints, performance and staff survey. It also includes a plan as to a list of service users and carers who have agreed to participate and a list of questions. The QMV also involves safeguarding colleagues with clinical experience. MBu said staff also meet in a review panel and it is recorded. CDBG asked whether new governors would obtain this support. MBu encouraged new governors to participate.

Andrea McCourt (AMc) asked whether the Trust were aware of concerns before the CQC visits. DT said concerns raised are discussed by the Executive Management Team and they were being discussed in the risk panel.

It was resolved to RECEIVE the annual report unannounced/ planned visits update.

MC/23/19b Care Quality Commission (CQC) action plan (item 7.2)

DT explained this paper provides assurance to the Members' Council of the work undertaken and that remains ongoing around the CQC actions from the Trust's last inspection in 2019. This report contains information from regular reports which are reviewed in detail at Clinical Governance and Clinical Safety Committee and the Executive Management Team. He explained this was a summary of our rating at the time.

He explained particular areas that was flagged was record keeping and clinical risk assessments and care planning compliance and the measure of people receiving a copy of their care plan. DT explained there are regular reports going into the Executive Management Teams and Clinical Governance and Clinical Safety Committee.

Keith Stuart Clarke (KSC) explained he asked about the use of photo IDs for governors participating with QMVs which was an issue as not everyone has a passport. He said he was glad that governors have lanyards and name badges now. MBu encouraged governors to sign up to observe the Clinical Governance and Clinical Safety Committee to gain further insight and assurance.

It was resolved to RECEIVE the CQC action plan.

MC/23/20 Members' Council business items (item 8)

MC/23/20a Associate Non-Executive Director Appointment(s) (item 8.1)
Greg Moores (GM) explained that this paper was to update the Members' Council on the recruitment process for the Associate Non-Executive Director's and agree the recommendations from the Nominations committee to appoint Dr Rachel Lee and Rokaiya Khan as Associate Non-Executive Directors. He explained they were non-voting roles, they won't be chairing Trust committees and the recommendation is to appoint them on a 2 year term.

GM said Dr Rachel Lee was recommended for the clinical post and Rokaiya Khan was recommended for the non-clinical role. Their background was explained in the paper and they were both strong candidates.

JL explained the process was thorough and the Trust used a new recruitment agency. He explained there were high number of applications, and the Trust used stakeholder panels which KSC also attended. JL said he took part as a lead governor and staff governor and the Race, Equality and Cultural Heritage (REACH) network lead, Jacob Agoro (JA) was also on the panel. JL explained it was well run and he was happy with both applicants. No objections were raised to appoint them as Associate Non-Executive Directors.

The Members' Council approved the appointment of Rachel Lee and Rokaiya Khan.

It was resolved to APPROVE the recommendation from the Nominations Committee to appoint Dr Rachel Lee to the role of Associate Non-Executive director (Clinical role) and to appoint Rokaiya Khan to the role of Associate Non-Executive director (Non-Clinical role) with South West Yorkshire Partnership NHS Foundation Trust for a two year term.

MC/23/20b Deputy Lead Governor appointment (to be taken as read and submit questions in advance) (item 8.2)
(Claire Den Burger Green (CDBG) left the meeting).

MBu explained this paper was to consider the recommendation from Nominations Committee to appoint Claire Den Burger-Green as Deputy Lead Governor.

MBu said CDBG was the only nomination, and it is non contested. JL said CDBG will make a good Deputy Lead Governor and it was important for him to speak to someone else in the team to go over ideas and explore new suggestions or improvements to the Members' Council.

Members' Council agreed with the recommendation to appoint CDBG as Deputy Lead Governor.

CDBG re-entered the meeting and the decision was relayed to her. She thanked the Members' Council.

It was resolved to APPROVE the RECOMMENDATION from Nominations Committee to appoint Claire Den Burger-Green as Deputy Lead Governor for three years term of office from 1 May 2023 to 30 April 2026.

MC/23/20c Governor feedback and appointment to Members' Council groups (to be taken as read and submit questions in advance) (item 8.3)

JL said he has spoken to new governors and asked them what they hoped to achieve from being governors and why they put themselves forward. JL said he was delighted with increasing the number of young governors and he was pleased that some of our new governors wanted to talk about why they applied.

Rumaysah Farooq (RF) said she was elected to represent Kirklees. She explained she put herself forward to be more involved in organisations especially because our Trust is predominantly mental health. She explained as a young student in her final year, she found the stress with exams very challenging, and she wants to ensure that the younger demographic is heard. She explained she has many ideas, and she is looking forward to working with everyone and gain understanding of the work of the Trust. MBu said it was really important to represent a younger voice and welcomed her to the Members' Council.

Ian Grace (IG) said he is a Pharmacist representing the medic and pharmacy team. He explained he has worked as a Pharmacist for the Trust for a number of years and has worked in various aspects of healthcare. He said he has also worked in the community as well as the inpatient ward. He spoke about his time on the ward and how he participates in ward rounds. IG said he has looked into the governor role and felt there was a lot he could bring to the role. MBu thanked IG and welcomed him.

Bob Morse (BM) explained he has been involved in a lot of different roles in his career. He said a few years ago he set up a charity called Platform One. He said it centres around men's mental health across Kirklees and Calderdale. He explained he has learned a lot about what works for people experiencing mental health and access to mental health services. He said his constituents have been socially prescribed to his charity. MBu thanked him for his passionate story and welcomed him.

JL explained the purpose of the paper is to support the appointment of governors to the Members' Council groups, Nominations Committee and Trust Board Equality & Inclusion Committee.

JL highlighted that there are four Members' Council groups with vacancies for governors to participate and to become a member, and an invitation was sent to all governors to seek interest and self-nominate.

He explained Phil Shire (PS) has put himself forward for the Nominations Committee, this was the only self-nomination and PS will automatically fill the vacancy.

MBu encouraged governors to apply for the available vacancies. JL said any governor can also sit in on the coordination group and the quality group as a non-member.

Action: Corporate Governance Team.

It was RESOLVED to RECEIVE the governor feedback.

It was resolved to RECEIVE the update and NOTE Phil Shire has filled the public governor vacancy for Nominations Committee from 1 May 2023.

MC/23/20d Assurance from Members' Council groups and Nominations Committee including (to be taken as read and submit questions in advance) (item 8.4)
MBu explained the following paper includes the Members' Council group assurance and asked for comment. Members' Council were happy to receive the notes and annual reports.

CDBG said Item 8.4j, Members' Council Quality Group terms of reference shows that there is a Kirklees governor vacancy and she was the Kirklees governor from 2022/23.

Action: Corporate Governance Team to amend.

It was resolved to RECEIVE the assurance and approved notes/minutes from the Members' Council Co-ordination Group, Members' Council Quality Group and Nominations Committee.

It was resolved to RECEIVE the annual reports for 2022/23 and APPROVE the updated Terms of Reference for the Members' Council Co-ordination Group, Members' Council Quality Group and Nominations Committee subject to any amendments.

MC/23/20e Consultation/ review of Audit Committee terms of reference (to be taken as read and submit questions in advance) (item 8.5)
Mike Ford (MF) explained the purpose of this paper was to consult with the Members' Council on the updates to the Audit Committee's Terms of Reference. The updates were approved by Trust Board on 25 April 2023. He explained the remit of the group has been expanded to cover health and safety and management of safety and emergency response. He said the other change was for at least one non-executive member of the committee to have recent and relevant finance experience. There was also an addition in relation to the appointment of the Chair and work on counter fraud.

Charles Elliott (CE) asked about service delivery and performance and whether this was covered in the Audit Committee. MF explained this was covered in the Finance, Investment and Performance Committee. MBu said all the committees feed into the Audit Committee and they have overall assurance of all the sub committees of the Trust Board.

It was resolved to RECEIVE the updates to the Terms of Reference for the Audit Committee.

MC/23/20f Members' Council elections – outcome (item 8.6)
Julie Williams (JW) updated Members' Council on the outcome of the election process for 2023. She explained that all seats were successfully recruited to except the staff governor seat for social care staff in integrated teams. JW said she will try and do some outreach work in this area for the next election.

JL thanked the corporate governance team for their work to ensure the Trust had a good representation of governors. He explained Daz Dooler (DD) has done some great work with younger people and also there was some good work with the roadshow JL attended with MBu, Asma Sacha (AS), Anthony Jackson (AJ) and Warren Gillibrand (WG) at the University of Huddersfield.

JL said the turn out to vote in the elections was not a high number at only 3.4% and governors and the Trust need to work on engagement with members of the public.

Charles Elliott said his surname was spelt incorrectly on the paper.

Action: Corporate Governance Team to amend.

It was resolved to RECEIVE the election update.

MC/23/21 Integrated Performance Report (item 9)
Kate Quail (KQ) and Adrian Snarr (AS) presented the IPR for Quarter 4 2022/23.

AS explained that these performance figures are used for reports and performance hotspots. He explained there were marked against RAG ratings (red/amber/green).

KQ said despite the pressure on teams the Trust was meeting its targets and making improvements in some areas.

KQ said there is concerns in a few areas, such as the admission of children and young people in inpatient wards. She said there are robust governance arrangements and safeguarding and admission is discussed in the Trust liaison meetings and it is due to unavailability of national beds. KQ said this also has an impact on the Trust bed availability which also leads to out of area placements. Inappropriate out of area day beds is always done as a last resort and this is a national issue across the country, it was not routine.

KQ said in March 2023 the Trust saw a greater demand placed on the flexible staffing resource than in the previous month. This has been for a number of reasons including; ongoing increased acuity on the inpatient areas, substantive staff utilising their annual leave prior to the year end, ongoing sickness and vacancies. There continues to be fluctuations within most wards with an overall decrease in the total fill rate.

KQ explained the performance figures for workforce is that bank and agency spend continue to remain high to support the safer staffing gaps in workforce caused by absence and vacancies in the services. This is primarily in the ward-based service areas.

She explained vacancies remain high across the Trust although decreased slightly from the end of Q3 which was 18.1% compared to 17.6% at the end of Q4. Staff turnover for the year was 13.5%. This is an improvement on previous quarters (Q1 15.4%, Q2 14.8%, Q3 14.2%.

Recruitment activity was up during Q4 2022/23. 193.6 Whole Time Equivalent (WTE) starters joined in the period. 141.7 WTE staff left during the quarter. Sickness absence rates in Q4 2022/23 (including Covid absence) remain at 5.3%, this is the same level at reported at Q3 and remains above the target of 4.5% and the Trust is below the national average.

MBu said there are training sessions on the Integrated Performance Report (IPR) which will inform new governors how it links together and to review the threshold. CDBG explained an in-house governor training session has been scheduled to take place on the 24 May 2023, 10 – 11am, MS teams. Governors agreed that this would be helpful.

KQ said the Trust encourages staff to report incidents and to grade it and to review the incidents, this was very important.

KQ explained there was a slight increase in Covid 19 outbreak on the ward in March 2023. The Infection Prevention and Control requirements continue to be reviewed and updated in line with emerging national guidance and staff feedback.

KQ said despite the pressure there was good feedback from the patient experience – friends and family test (FFT);

95% of respondents in March 2023 would recommend community health services.
83% of respondents in March 2023 would recommend mental health services.
The Trust continues to explore other creative ways of gaining feedback on our services.

GM provided an overall update to workforce and informed governors he will be able to bring another paper to a future Members' Council to discuss the results of the staff survey.

Action: Corporate Governance Team

KQ said the Trust ended the year at a surplus of £3.2m. AS said the Trust delivered this and it was getting financially tighter and we are moving to a breakeven position. He said the Trust key areas are workforce and to achieve this there will need to be a cut in agency spend. He explained there isn't sufficient capital and there maybe difficult decisions as to how we spend money.

Phil Shire (PS) said the IPR comes to the Members' Council Quality Group as a whole document and any new governors interested in attending the group are welcome if they wish to discuss the report further.

PS highlighted the CAMHS referral to treatment was 18 weeks and this was increasing even though there was no threshold (slide 4). MBr explained that children are interpreted another way so 78% are seen within 18 weeks. MBr said we may not be able to maintain this level due to referral rates and how many the Trust is contracted to see. MBu said this was a challenging area and the Trust is reviewing this in terms of third sector support.

CDBG asked whether the waiting lists for CAMHS was reduced because they were contracted out to private agencies. She said she was aware of one case from SWYPFT in relation to a child and Autism services. MBr said this was not the case and explained the Autism and ADHD assessments are being sent to other areas but this was not applicable to CAMHS services.

KQ explained that in addition to assurance about waiting lists, the Trust also give assurance that young people and families are safe whilst they were on the waiting list. KQ said the Trust has a range of mechanisms in place and has put additional services in place.

JL said it was good to see the turnover rate coming down, but the CQC report shows that staff were not getting their appraisals and he has seen information in the Trust communications requesting that staff approach their managers for an appraisal. JL said it is the line managers responsibility to make the appointment for staff appraisal. MBr said the appraisal figures have increased and the areas we have seen a dip in are those areas which are under pressure and he advocates that staff need regular one to ones, feedback and appraisal.

It was resolved to RECEIVE the Integrated Performance Report

MC/23/22 Closing remarks and annual work programme 2023/24 (item 10)
It was resolved to RECEIVE the annual work programme 2023/24.

MC/23/23 Members' Council meetings (item 11)
Hybrid meetings
Wednesday 16 August 2023
Wednesday 27 September 2023 – Annual Members' Meeting (confirmed)
Friday 17 November 2023 (including Joint Trust Board and Members' Council)
Friday 23 February 2024

It was resolved to APPROVE the Members' Council meeting dates.

MC/23/24 Any other business (item 12)

- CE said he would like to bring a paper to the next Members' Council meeting on neurodiversity. MBu said she has responded to his email, and he can take this discussion at the next Members' Council Quality Group meeting. JW said she will be in touch with him to discuss this further.

Action: Corporate Governance Team to arrange a meeting between JW and CE.

- KSC asked whether nursing staff who worked for the Trust came from around the locality or far away, GM discussed the workforce.
- MF informed governors that alongside observing committees, governors can also attend the Q&A sessions with the executive board. He explained it was a good opportunity for governors to find out the workings of the committee.

Action: Corporate Governance Team to re-circulate the Q&A dates.

Close of Members' Council meeting

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of People and Remuneration Committee meeting held on 23rd May 2023
Microsoft Teams Meeting

Present:	Mandy Rayner (MR) Mark Brooks (MB) Marie Burnham (MBU)	Non-Executive Director (Chair) Chief Executive Chair of the Trust
Apologies:	Natalie McMillan (NM) Julie Williams (JW)	Non-Executive Director Deputy Director of Corporate Governance
In attendance:	Greg Moores (GM) Lindsay Jensen (LJ) Carol Harris (CH) Hazel Murgatroyd (HM) Estelle Myers (EM) Richard Meyers (RM) Richard Marriott (RMA) Richard Butterfield (RB) Chloe Hoyland (CLH)	Chief People Officer Deputy Chief People Officer Chief Operating Officer Interim Head of People Experience Freedom to Speak Up Guardian Learning and Development Lead Consultant Psychiatrist Head of Recruitment and Resourcing PA to Chief People Officer (Author)

PRC/23/175 Welcome, introduction and apologies (agenda item 1)

The Chair, Mandy Rayner (MR) welcomed everyone to the meeting. Apologies were noted and the meeting was deemed to be quorate and could proceed.

Mandy Rayner outlined the Microsoft Teams meeting protocols and etiquette.

Mandy Rayner 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.

PRC/23/176 Declarations of interest (agenda item 2)

There were no declarations over and above those made in the annual return to Trust Board in March 2023.

PRC/23/177 Minutes from previous People and Remuneration Committee meeting held 21st March 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on 21st March 2023 as a true and accurate record.

PRC/23/178 Matters arising from previous People and Remuneration Committee meeting held on 21st March 2023 and action log (agenda item 4)

- PRC/23/142 Guardian of safe working report
  Greg Moores (GM) confirmed renewed rates of bank pay for Doctors and training Junior Doctors has been agreed at the Executive Management Team (EMT) and this has been done in partnership with the British Medical Association (BMA). Action now complete.

- PRC/23/152 Gender Pay Gap audit and Action Plan
  Hazel Murgatroyd (HM) confirmed the action plan has been completed and actions reported next year to the Performance and Remuneration Committee (PRC) with regular updates on progress to the Equality, Inclusion and Involvement Committee (EIIC) as part of overall equality reporting. Action now complete.

- PRC/23/08 Mandatory Training Trust Compliance Targets
  GM confirmed it has been reviewed whether the mandatory training target should be increased. Conversations have been undertaken with the Education and Governance Group, specialist advisors and Operational Management Group (OMG). The outcome from all these conversations was for the training target to remain the same.

- PRC/23/11 Cost of living support for staff
  GM highlighted feedback from staff that the meal deals in the canteen are going down well with staff. We have received data regarding the uptake of wage stream and we have had five thousand streams in the first three months. The mileage rates work has been well received by staff.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for May 2023.

PRC/23/179 Chief People Officer Remarks/Update (agenda item 5)

GM updated the Committee that industrial action remains a challenge and there are a few ballots still outstanding. The BMA have recently commenced a ballot of consultants, due to conclude 22nd June 2023. The Junior Doctors have announced the next strike will be 14th – 16th June 2023, we expect there won't be any derogations. We have been notified informally by UNITE that they will be balloting in our Trust which will be a ballot for full co-ordinated strike action. The RCN are out to ballot for Nurses which closes 23rd June. GM shared how well the industrial action has been managed during the last strikes and thanked all staff involved and who ensured we maintained patient safety throughout. CH commented on the on-going impact of industrial strikes and has raised the message with MP's that this needs to be resolved to ensure the wellbeing of our staff. GM confirmed industrial action is still on the risk register. MR acknowledged the goodwill and hard work of staff during this trying period and thanked all the staff for their continued hard work keeping our service running.

GM updated the Committee on recruitment within the People Directorate we have recruited a Recruitment Team Leader, Head of People Experience and People Planning and Performance Lead. We have recruited another People Business Partner but still require a third post to be filled. We are feeling the impact of not having all of the People Business Partner positions filled. We are still actively recruiting for the third position and will keep the Committee updated in terms of recruitment. GM notified the Committee that the Deputy Chief People Officer Lindsay Jensen will be retiring in the next 12 – 18 months so we will be recruiting for a 1 FTE Deputy and have a short period of double running until Lindsay retires.

GM highlighted to the Committee the Government has ceased the lifetime allowance for pensions and they have increased the annual allowance for pensions which has helped us in terms of retention, particularly senior medics. LJ notified the Committee of the upcoming HPMA awards, we have put in for three awards, these include international recruitment, virtual recruitment, and rising stars.

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

PRC/23/180 Integrated Workforce Report (agenda item 6)

GM informed the Committee that the report covers April's workforce data as agreed as this is the latest data that has been to Board. So, the data will be familiar, however, we have got more opportunity to discuss the trends and talk about the actions we are taking and the impact those actions are having. We have provided care group level data in the IPR to give an extra level of assurance. GM highlighted page 4 of the IPR on sickness data which is currently above our target at 5.3% against a target of 4.4%, however, the latest benchmarking data on NHS digital as of December 2022 shows our sickness is the lowest for Trusts of our type in both our Integrated Care Systems (ICS) and it is the second lowest in the region. GM commented regarding inpatients, adult and older people's mental health inpatient acute do have higher sickness levels than the rest of the Trust as a whole by 0.5% if you review this over the past few months this is reducing. GM highlighted Forensics sickness within the Integrated Performance Report (IPR), sickness in Forensics in the autumn was 9.6% in October, 8.9% in November, as shown in the IPR these levels are reducing which is positive. GM confirmed People Operations are starting to implement the work that has been done on the Sickness Policy. We have recently recruited a band 5 and band 6 into People Operations who are bringing fresh ideas into how we handle the management side of absence.

Hazel Murgatroyd (HM) mentioned the redesigned wellbeing paper that came to the Committee in January 2023 about making our wellbeing offers more accessible to all staff. We have re-launched this now and updated our wellbeing pages on the Intranet and received positive feedback regarding how much easier it is to navigate. We have also aligned this to the communication and engagement plan, so it links on a monthly basis to national initiatives. We can also monitor which pages have been accessed the most, increasingly we are seeing more people accessing each month, for example we have had 129% growth in the search for 'financial health and wellbeing'.

Mark Brooks (MB) highlighted how we have had great success with international recruitment, we may need to consider the optimum number of new recruits each year we can take from international organisations. We need to think about an on-going strategy over the next 12 months of this pipeline of work so it can continue to be managed successfully. Richard Butterfield (RB) agreed with MB confirming we never expected to be in such a good position regarding international recruits and so we do need to manage numbers and resources.

RB confirmed the staff in post figure has increased to 4032 staff from 4194 at the end of March 2023, which is just over 3.6% increase. MB commented that it is positive to see the responses we are getting from exit interviews it would be useful to see any trends that are coming out of the exit interviews. MB commented it was positive to see how we have improved appraisal compliance from around 50% to mid-70% by the end of the year. Now that we are in better position, we need to ensure we keep improving on all these factors and where there are hotspots that we are fully understanding what the barriers are to improvement. MR commented on how we have made positive progress, however, inpatient acute is down at 27% which is a hotspot and will bring the overall average down, it is about focusing and improving in their areas. LJ shared that we have listened and made improvements to the WorkPal appraisal system to make it simpler and easier for users. The feedback has been positive based on these changes. We are however, in the process of looking at whether this system is the right one for

us as it doesn't interface into ESR which is causing significant reporting issues for us. We are now also sharing with managers the appraisal data on a weekly basis on who is due an appraisal which gives us an opportunity to understand any issues and barriers, LJ also commented when the HR Business Partners are in post this will support us in understanding what is happening within those hotspot areas. MR commented how we don't want to lose the quality and opportunity of appraisals that allows managers to spend time and understand the needs of their staff and provide wellbeing support. MR commented it was useful to see the benchmarking data. MR mentioned we are reporting 927 vacancies, is this figure correct, do we need to take any action on this. GM confirmed this is an action in our delivery plan for us to work with Adrian and his team in terms of a workforce plan that reflects budgets.

Richard Meyers (RM) provided assurance to the Committee regarding our RRPI and CPR. With the RRPI it's been around the 70% mark for a while, this is due to some issues in how it has been delivered, we had a back log following Covid, we are in the processing of addressing this. We have done a lot of work to take out heavy components within our RRPI to make it more deployable and accessible. We are working to stress test the opportunity of using external providers to deliver more training. Following these changes, we will hopefully see a spike and a more positive maintenance position. In terms of CPR, we have started to look at how we can approach this differently and have started working closing with specialist advisors group to ensure we can make all the mandatory training groups easily accessible to meet the needs of end users and the Trust. MR commented that these three areas are not moving very quickly therefore cannot remove the challenge. The Committee is looking for assurance and trajectories and expressed concern about Information Governance (IG), by the end of June we should be at 95%, we need to deliver the data protection tool kit, the Committee would like to understand how we are going to achieve this target. GM noted the challenge around RRPI and CPR and wanted the Committee to be sighted on the above, we should start to see an improvement on these over the coming months. GM also highlighted to the Committee as we are doing a lot of recruitment into the areas where RRPI and CPR is required, this results in an increased need for training which affects our ability to catch up. Regarding IG there has been a lot of discussions at EMT we are now just under 91%. Push notifications and emails have also commenced this week to engage staff who require this training.

12-month strategy plan to be implemented around how we successfully manage the pipeline of international recruits.

Action: Greg Moores

Review and understand any trends that are coming out of exit interviews.

Action: Greg Moores

It was RESOLVED to NOTE the update on the Integrated Workforce Report and the comments made.

PRC/23/181: Spotlight on Recruitment and Retention (agenda item 7)

RB shared the presentation with the Committee. He said that recruitment activity is up by 17.5% in the last 12 months with a particular upturn in the last six months. Staff in post is on the increase as discussed in the IPR. We have seen increased activity in our values-based assessment centres resulting in more full day events being scheduled to meet demand and are attended by 50 – 80 applicants, there is a plan over the next 12 months for us to continue with these. The NHS jobs system has been challenging, we have now gone live with our new recruitment micro-site. We have started to implement the applicant tracking and onboarding system. We are receiving up to 1500 bank request monthly, we are constantly improving with 82-85% fill rates. Work is being undertaken in line with our Great Place to Work Strategy which is broken down into three areas 'Our Recruitment Offer' 'Diversity, Inclusion and Belonging' 'Road map to Strong Recruitment'. Within these three areas there are four quadrants of work

which will enable us to deliver on what we aim to achieve. We need to be more innovative when it comes to recruitment and think about the following 'simplify our recruitment process' 'widen routes into the Trust' 'develop communications and marketing' 'expand our referral offer'. Marie Burnham (MBu) thanked RB for the overview and highlighted how great it is to see the positive work that is being undertaken by the recruitment team. LJ commented we are working with the Mental Health, Learning Disabilities and Autism (MHLDA) workforce collaborative which supports with some of the above, whilst we have resources internally, we do work with others to achieve these targets.

It was RESOLVED to NOTE the update on the Spotlight on Recruitment and Retention and the comments made.

PRC/23/182: Staff Survey Results & Action Plan (agenda item 8)

HM highlighted to the Committee we had a great response to the staff survey and the Organisational Development team have been working on the results. Information packs have been created along with templates and shared with managers for them to act. Action plans have been received by the Organisational Development team which have given us an understanding of what the key themes are. These were focussed mainly around the people promise areas of safe and healthy, always learning and we are a team. MBu asked Carol Harris (CH) if she feels staff feel like they are being listened to and if the action plans are relevant to the areas. CH commented that the action plans are going into care groups then the service group meetings to look at the findings within the specific care group or service area and what actions we now need to take.

It was RESOLVED to NOTE the update on Staff Survey Results and Action Plan and the comments made.

PRC/23/184 Holiday Pay Flowers Case 2021/2022 (agenda item 10)

MR confirmed the Committee are here to support and ratify this report. There were some national arrangements that put a settlement in place regarding payment for holiday pay for regular overtime. We paid retrospective back pay and then changes were made to the ESR system so this could be paid in real time. This paper is about ensuring we settle that claim in full. LJ confirmed this has been funded and this has been through EMT and Staff Side. The Committee supported and ratified the Holiday Pay Flowers Case 2021/2022.

It was RESOLVED to RATIFY the Holiday Pay Flowers Case 2021/2022

PRC/23/185 Agency Scrutiny Group – Alert, Advise, Assure Report (agenda item 11)

RB explained there are two groups in position, one is the Agency Scrutiny Management Group which is a strategic group looking at agency contracts and pricing. To support this, we have engaged an external organisation called Liaison Diagnostics who will review and offer recommendations about how we can maximise and make our use of bank and agency more efficiently and they will provide a report at the end of May. We also have an Agency Performance Panel which includes Carol, Greg and senior leads within the service teams. The purpose of this group is to prepare data packs monthly which will go into care groups. The agenda will be structured to identify individual cases of agency spend within the care groups and how we can minimise and mitigate against the continued spend and focus on the long-term solutions for these care groups. We will then create action plans and review how we move forward to meet our agency cap. MBu commented now we have recruitment increasing and vacancies decreasing we

should be seeing agency spend decreasing because of this in the future. MBu also commented we shouldn't be using agency for non-clinical care, RB confirmed looking at non-clinical roles was also part of the brief. MB asked that we ensure we don't over complicate the groups and that the governance is right.

Review of the governance of how the agency scrutiny groups are working and to come to PRC in September.

Action: Greg Moores

It was RESOLVED to NOTE the update on the Agency Scrutiny Group, the terms of reference and the comments made.

PRC/23/187 Guardian of Safe Working Report (agenda item 13)

MR confirmed the report is to be taken as read. RMa highlighted the gaps in rotas have been greater over the past 12 months due to the vacancies and short notice from Health Education England (HEE) about who people have dropped out of the scheme that they are attached to, people on maternity leave or people who are less than full time covering full time slots. This has led to the gaps on rotas resulting in trainees or bank staff covering these gaps. We are in a challenging time with junior Doctors however we have managed things safely over the previous strikes. RMa highlighted how we need to make the Trust as attractive as possible to trainees to ensure we are backfilling posts. RMa mentioned the opportunity to fund our own trainee posts had been mentioned to him but was unsure of where this information had originated from and if any action had been taken. MR thanked RMa for the reports and highlighted how seeing the annual report it is clear there is a lot of good will from staff to cover the gaps and that we appreciate the impact of the industrial action. GM commented an opportunity to fund our own trainee post hasn't come via the People Directorate, but we would be keen to support and explore this.

It was RESOLVED to NOTE the update on the Guardian of Safe Working Report

PRC/23/188 Great Place to Work Strategy – Report on Delivery Plan (agenda item 14)

MR confirmed the paper is to be taken as read and highlighted that it looks as though positive progress has been made to reach May targets. LJ confirmed a lot of items on the Great Place to work Strategy have been met by the deadline. LJ highlighted to the Committee that by April we had hoped the interface between ESR and Occupational Health to be working to allow health passporting, this has been out of our control, but we continue to work through challenges and will provide further updates. We are doing a lot of work around bullying and harassment which has commenced in partnership between People Operations and Staff Side and thinking through different approaches and how we manage potential cases of bullying and harassment along with how we deal with any type of conduct issues. MBu highlighted she was happy with the report. MBu asked if there is any scope for any Governors to support this work in the future. LJ confirmed this is a good point and GM meets with the Governors on a regular basis and we could look to use them on an advisory basis. GM confirmed this is a good point and getting governors who are out in the day-to-day business of the Trust this would be a good opportunity to get them involved. MR thanked LJ for the report and confirmed it is showing good progress.

It was RESOLVED to NOTE the update on Great Place to Work Strategy – Report on Delivery and the comments made.

PRC/23/189 Workforce Equality Monitoring Annual Report (agenda item 15)

HM confirmed this report is part of our public sector equality duty, we are required to publish our data. We look at our total workforce and break it down by protected characteristics, look at different aspects, particularly around recruitment and retention, access to training and pay bands. We have acknowledged we need to work on this report to reduce the size of it but still maintain the quality. Based on the feedback we had on the gender pay gap, the action plan is presented in the same way. MR stated in the report it highlights the BAME network, do we need to include the REACH network. HM noted MR comment and will review. MR highlighted there is a lot of data in the report, in some instances there are no comparisons, however it is noted that this report is work in progress. MBu commented that it is a robust report and it is great to see the increase in staff over 60. MB commented we do need to spend more time on the report which may fall into the Equality, Inclusion and Involvement Committee. There are a. couple of points to focus on, the prospect of being interviewed if you are a BAME candidate is lower than if you are White, we need to understand the why of this. In addition, we can't allow the international recruitment to affect these figures. The average age profile highlights the number of people who will be due to leave the workforce which is something we need to mindful of. MB confirmed overall it is a helpful report and we need to ensure we use the data effectively. RB commented that our retire and return rate has increased to 20% over the past 12 months which is positive. HM commented that the international recruit's data is not included in this data set. MR thanked HM for the report and no further comments were made.

It was RESOLVED to NOTE the update on the Workforce Equality Monitoring Annual Report and the comments made.

PRC/23/190 Freedom to Speak Up (agenda item 16)

MR welcomed Estelle Myers (EM) to the Committee. MR confirmed Freedom to Speak Up is now a standing item at this Committee and EM is standing in for Jules Williams (JW). EM confirmed we have seven open cases and our timescale for closure has improved. We have Freedom to Speak Up training which is mandatory for all staff this is currently at 93. We have 162 concerns to date, in 2021 there was 18, 2021 – 2022 was 39 and 2022 – 2023 we had 53 concerns. This year concerns have come from all care delivery units and staff groups mainly regarding worker safety, most concerns required sign posting rather than coming through the Freedom to Speak Up process. EM confirmed she has been delivering face to face training to volunteers and care certificate staff. The Freedom to Speak Up policy was approved in April and is now live. There is a Board reflection tool which we are in the process of pulling together and an action plan this will then go to EMT for approval. Within the Board reflection tool, I am required to present this to Board twice a year. LJ commented regarding the assessment tool we are assessing where we are in terms of good practice and looking at the areas where we can improve. MBu commented that all the above is linked as part of assurance for the Committee, MBu asked CH if we triangulate the Freedom to Speak Up with high levels of sickness, complaints etc. CH confirmed this does all triangulate together, when the concerns come through to Operations CH speaks with Estelle to confirm they are aware of the concerns and it is being dealt with, it is very rare something comes via Freedom to Speak Up that the Senior Operations team is not aware of.

MR thanked EM for the report and no further comments were made.

It was RESOLVED to NOTE the update on Freedom to Speak Up and comments made.

PRC/23/191 Health Roster Clinical Roll-out Project Plan (agenda item 17)

MR confirmed this paper is still required to go through EMT regarding the funding aspect. The Committee is here to note the update should the funding be made available. RB confirmed the Health Roster plan over the next 18 months will be looking at all clinical areas of the Trust. The benefits of this have been highlighted in the paper. To note there is mandate for all NHS Trusts in the UK that all clinical services must be on a form E-rostering within a certain timescale, and we are following those timescales. Both the Health Roster and Safe Care roll out do need to be reviewed by EMT in terms of funding for the licenses, etc and our ability across the Trust to roll this out across the services. MBu challenged the fact these systems have been around a long time and why this is only being highlighted now. RB commented this should have been progressed sooner and now he is in the role it is a top priority to move forward. RB highlighted in terms of Safe Care this has been extended into the Forensics wards where we are liaising with staff to get their feedback and ensure we roll this out as smoothly as possible.

MR confirmed the Committee have been provided with assurance and will review where we are at the next Committee. The Committee are supportive of the direction of travel for both the Health Roster Clinical and Safe Care roll out.

Update on Health Roster Clinical and Safe Care Roll out to be provided to the Committee.

Action: Greg Moores

It was RESOLVED to NOTE the update on Health Roster Clinical Roll-out Project Plan the Safe Care Roll-out Project Plan and comments made.

PRC/23/192 Safe Care Roll-out Project Plan (agenda item 18)

Agenda item discussed under agenda item 17.

It was RESOLVED to NOTE the update on the Safe Care Roll-out Project Plan

PRC/23/193 Organisational Development Tactical Update (agenda item 19)

MR confirmed this is now a standing item on the Work Plan and will be a paper at future Committees. GM highlighted that this update is to provide the Committee with assurance that we are aligning updates from the Clinical Governance Clinical Safety (CGCS) Committee in terms of organisational development support and aligning this with the organisational development activity that is available. Future updates given to this Committee will provide assurance that we are acting on items brought up in CGCS. HM confirmed there are three elements of work that fall under People Experience, Organisational Development, Diversity, Inclusion and Belonging and Leadership and Management. Under organisational development there are four pillars of works, employee engagement, employee health and wellbeing, change partnerships and organisational health and team effectiveness. We are looking at the process where any of the above are mentioned in platforms such as CGCS to ensure we are noting and acting on feedback and requests. In terms of activity, we have seven programmes running currently where we are actively supporting leaders this includes Wakefield, Barnsley, Calderdale and Kirklees, community mental health teams and forensics. The staff survey data will give us an indication of where else we need to be more present. MBu commented that this is an important part of the Trust's culture to have excellent organisational development as it links in with being a great place to work, recruitment and retention and leadership etc. Overall, we need to think about the Board and the Trusts organisational development to ensure we are focussing on key themes with a tactical approach. MBu requested a conversation outside of the Committee with GM, HM and MB to discuss the Trusts organisational development approach.

Meeting to be arranged with GM, HM, MBu and MB to discuss the Trusts organisational development strategy.

Action: Greg Moores

It was RESOLVED to NOTE the update on the Organisational Development Tactical Update and comments made.

PRC/23/194 Workforce Risk Register (agenda item 20)

GM confirmed we have covered the majority of the risks throughout this Committee meeting. GM highlighted the risk scoring regarding industrial action, it is currently scored at 16 which is one of the Trusts biggest risks, as a Committee do we feel the level of risks remain at this level. MB commented that the industrial action risk will move up and down as we review today it is probably not a 16, however, once we do the derogations for the junior Doctors strike and review what is happening with the RCN and BMA it may raise again so for now suggest leaving it at 16 and be responsive with what is happening. The Committee agreed with MB's comments. The Committee confirmed they are assured that the scoring is appropriate to the current risks.

It was RESOLVED to NOTE the update on the Workforce Risk Register and comments made.

PRC/23/195 Industrial Action (agenda item 21)

This agenda item was covered in the Chief People Officer Remarks/Update agenda item 5.

It was RESOLVED to NOTE the update on Industrial Action.

PRC/23/196 Recruitment of Director of Strategy and Change (agenda item 22)

GM confirmed there is a formal requirement for this Committee to have oversight of Director appointments. GM assured the Committee we are sticking to the timelines that is outlined in the paper and the advert for the role is now live. MB confirmed the timescales for Salma Yasmeen leaving the Trust will be changing and MB has agreed with Sue Barton that she will step up to acting Director of Strategy in the interim. MB will circulate salary proposals for Sue Barton to the People and Renumeration Committee members outside of the Committee for approval.

It was RESOLVED to NOTE the update on Recruitment of Director of Strategy and Change and comments made.

PRC/23/197 Actions from Trust Board (agenda item 23)

Nil

It was RESOLVED to NOTE the update on Actions from Trust Board

PRC/23/198 Matters to report to the Trust Board and other Committees (agenda item 24)

Alert:
1. Appraisal compliance still not met, currently 71.8%. The Committee received data by care group which highlighted some areas below 30% compliance.

2. Challenges around agency spend is still ongoing but actions are in place to mitigate this. Governance around the agency scrutiny group will be reviewed. 3. Industrial action and impact still a risk. With Junior Doctors strike ready to go ahead 14th-16th June 2023. 4. CPR and RRPI compliance are still below target. A new approach was discussed.
Advise:
1. Spotlight on recruitment was a really useful insight into all the on-going activity. The report highlighted the positive work that was being undertaken. 2. Great success with International recruitment, the trust now needs to think about the on-going strategy and how this is managed. 3. 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. 4. Flowers settlement (holiday pay) has now been ratified. 5. Guardian of safe working report provided an insight into the good will and support from staff to plug gaps on the rota. 6. 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. 7. Health Roster and Safe Care roll out plans were presented for consideration. Both plans will be discussed and approved at EMT. 8. The recruitment timeline for the Director of Strategy and Change. Interim arrangements were also shared.
Assure:
1. Discussion around the IPR and KPI's including appraisal compliance. IPR now showing care group level data giving an extra level of assurance. 2. Assurance was provided regarding the staff survey and devolving this into care groups. 3. Workforce Equality report provided excellent data and was a really useful report. 4. The trust had seen an improvement of absence figures in both Forensics and Estates and facilities
Risk Register: reviewed risks. 1. 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.
New risks identified: none

It was RESOLVED to NOTE the update on the Matters to report to the Trust Board and other Committees.

PRC/23/199 Draft Annual Work Programme (agenda item 25)

MR confirmed the additional standing item of Organisational Tactical Update to be added along with the Workforce Equality Report.

Organisational Development Tactical Update and Annual Workforce Equality report to be added to the annual work plan.

Action: Greg Moores

It was RESOLVED to NOTE the update on the Draft Annual Work Programme.

PRC/23/200 Any Other Business (agenda item 26)

Nil

PRC/23/201 Date of Next Meeting (agenda item 27)

The next People and Remuneration Committee meeting will be held on 13th July 2023.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of People and Remuneration Committee meeting held on 13 July 2023
Microsoft Teams Meeting

Present:	Mandy Rayner (MR)	Non-Executive Director (Chair)
	Mark Brooks (MB)	Chief Executive
	Marie Burnham (MBU)	Chair of the Trust
Apologies:	Natalie McMillan (NM)	Non-Executive Director
In attendance:	Lindsay Jensen (LJ)	Deputy Chief People Officer
	Estelle Myers (EM)	Freedom to Speak Up Guardian
	Julie Williams (JW)	Deputy Director of Corporate Governance
	Ellaine Flintoff (EF)	PA to Chief People Officer (Author)

PRC/23/202 Welcome, introduction and apologies (agenda item 1)

MR welcomed everyone to the meeting and explained that the purpose of today's extraordinary meeting was to discuss two urgent items, one which needed Board approval and the other Remuneration Committee approval for the remuneration of the newly appointed Director of Strategy and Change.

PRC/23/203 Performance and Assurance (agenda item 3)

PRC/23/203a Freedom to Speak Up draft annual report (agenda item 3.1)

MR thanked EM for the report and confirmed that everyone had read it. MR asked if EM could pick out the key points and highlight them to the Committee and confirmed that the paper had already been discussed in the Executive Management Team (EMT) meeting earlier in the day with a few slight changes being recommended by EMT. MR confirmed that the Committee's purpose today was to comment on the report and recommend for approval to Trust Board.

EM introduced herself and explained that the report was an overview of the concerns that have been brought to the Freedom to Speak up Guardian from April 2022 to March 2023. EM explained that there was a dip in numbers during Covid, that the main theme was worker safety, this was both psychological and how safe people feel physically. Concerns have come from all care groups, there have been four anonymous concerns and two concerns of detriment. The outcomes of those will be reported into the Freedom to Speak up Steering Group anonymously.

Training figures against a target of 85% are 93.67% for mandatory speak up training. The national FTSU Reflection planning tool is on track to go to November Board. EM asked the group if they had any questions. MR highlighted that the training numbers were in a good place and trying to create the awareness was positive.

MB asked the group to recognise that the report was reviewed at EMT this morning, and the comments made have been put through to the final version.

MB explained that the Trust has recognised that two people have suffered detriment and we need to ensure this doesn't happen in the future. Although it is early it would be helpful to recognise what the benefits of the Steering Group have been. We also need to follow up on some of the outcomes that have been identified in the report. MR asked if these comments were reflected in the amended report. JW confirmed this had already been done. EM reconfirmed that one detriment has been resolved internally and one remains outstanding.

JW informed the group that a complex case section was introduced to the reports on detriment cases ten months ago and this is reflected in the reports. If a case comes through to EM that includes an external body, a meeting is scheduled that includes those leads to discuss the case anonymously and agree the way forward and who will be taking what actions to ensure people are not lost in the system. EM confirmed that a feedback survey is sent out for detriment at 3, 6, and 12 months after the case has closed which asks the person if they feel they have suffered a detriment and gives clarity around that question.

LJ said when we have reviewed the self-assessment tool it has been recognised that we need more awareness for managers and teams to understand what the definition of detriment means. People need to be able to speak up comfortably and we should work out how to do this in the best way. This will be planned over the next 6-12 months.

MR asked MBU if she was happy for the report to go to Board on the 25th July 2023 following the amendments. MBU confirmed that she was. The linking together of complaint trends within care groups is required to be reviewed. MB gave an example of this, being that there is a disproportionally high number of issues raised in Learning Disability Services given the number of staff that are there, it has been noted that there are challenges in that area, Carol Harris is aware and it has been raised in Clinical Governance, there are examples and the data has been triangulated, it would also be overlayed with what we get from FTSU.

MR confirmed that the report was supported by EMT and the Committee were happy for the paper to go to Trust Board on the 25th July.

It was RESOLVED to NOTE and SUPPORT the recommendation for approval by Trust Board on the Freedom to Speak Up Annual Report 2022/23.

EM and JW then left the meeting.

PRC/23/204 Governance (agenda item 5)

PRC/23/204a Appointment of and Remuneration for the Director of Strategy and Change (agenda item 5.1)

MR confirmed that the remaining members of the Committee, (MB,MBU,MR,) supported by LJ were convened to approve the salary for the position of Director of Strategy and Change.
LJ confirmed that MBU was not part of the selection process and therefore is independent of that process. MBU expressed that she felt it was a good appointment and the salary was appropriate given her level of experience and was happy to approve.

MB shared that a key factor in determining the remuneration was that the salary was in the ballpark of other directors at a similar level. MR confirmed that the Committee is happy to approve the salary.

It was RESOLVED to APPROVE the remuneration for the role of the Director of Strategy and Change from the start date.

PRC/23/205 Any Other Business (agenda item 6)

MB asked the group to recognise that the Chief People Officer is on sick leave and has been off for four weeks and at this stage not sure of a return-to-work date. LJ and MB are actively seeking some senior resource to booster the directorate due to annual leave and the level of senior vacancies. LJ has agreed to do an extra day to cover, and the group acknowledged they were appreciative of this. It was also noted that it is the job of the Board to support the directorate.

The next People and Remuneration Committee meeting will be held on 11 September 2023.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee meeting held on Tuesday 13 June 2023 Microsoft Teams meeting

Present:	Nat McMillan (NM) Darryl Thompson (DT) Kate Quail (KQ) Carol Harris (CH)	Non-Executive Director (Chair of the Committee) Chief Nurse / Director of Quality and Professions (Lead Director) Non-Executive Director Chief Operating Officer
Apologies:	Dr Subha Thiyagesh (STh) Marie Burnham (MB) Yvonne French (YF)	Chief Medical Officer Chair of the Trust Assistant Director of Legal Services
In attendance:	Carmain Gibson-Holmes (CGH) Sarah Harrison (SLH) Julie Williams (JW) Manoj Mathen (MM) Kath Hemming (KH)	Deputy Director of Nursing, Quality and Professions PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Corporate Governance & Risk Consultant Psychiatrist (deputising for Dr Thiyagesh) Assistant Director of Nursing (Shadowing)

CG/23/120 Welcome, introduction and apologies (agenda item 1)

The Chair, Nat McMillan (NM) welcomed everyone to the meeting and apologies were noted as above.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed.

NM outlined the Microsoft Teams meeting protocols and etiquette.

NM and Darryl Thompson (DT) would like to put forward a proposal to change the name of the Committee to the Quality and Safety Committee, this will be noted in the AAA report to Board as a recommendation.

CG/23/121 Declarations of interest (agenda item 2)

The Committee noted a declaration of interest from DT who has been appointed to the Council of the National Mental Health and Learning Disabilities Nurse Directors Forum.

The Clinical Governance & Clinical Safety Committee NOTED the declaration.

CG/23/122 Minutes from previous Clinical Governance and Clinical Safety Committee meeting held 16 May 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 16 May 2023 as a true and accurate record.

CG/23/123 Matters arising from previous Clinical Governance and Clinical Safety Committee meeting held 16 May 2023 and action log (agenda item 4)

The action log was reviewed and updated as follows:

- CG/23/113 Apparent Suicide Report.
  It was confirmed that Naomi Sutcliffe will be invited back to the next Committee to discuss the Apparent Suicide Report further.

- CG/23/83 Quality and Regulatory & Oversight Paper.
  NM confirmed that she escalated the TEWV report to Trust Board. Complete.

- CG/23/92 – Dr Mathen informed the Committee that Dr Thiyagesh's medical secretary had now set up the appointments. Complete.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for 16 May 2023.

CG/23/124 Review of Committee related risks including focus on Covid 19 related risks for Committee – update following Board discussion (agenda item 5)

NM noted that as a Committee, we were initially being asked to consider a decrease in score to RISK ID 1568.

DT advised that this suggested decrease was in relation to the availability of a seclusion room. A huge amount of work had been undertaken within forensic services to repair the seclusion rooms and this would reduce the risk from likely to possible. DT informed the Committee that all but one of the seclusion rooms within forensics had been mended and the repairs have been resistant to further damage.

DT went on to note that recently (last week) three seclusion rooms were out of access on mental health inpatient wards due to other types of damage, and therefore due to this the Trio suggested that the risk remain at likely.

The Committee agreed that RISK ID1568, based on current events, should remain at likely.

NM discussed themes from incident reporting and that completion of risk assessments and training are being raised as risks and queried what the risk of harm would be to our patients. CH advised that the risk did feel at the right level and informed that through OMG the three top themes will be escalated to EMT to gain some assurance and challenge.

Julie Williams (JW) suggested a more focussed discussion on the medical devices risk. DT informed that there will be a paper going to EMT next week on medical devices and will bring the paper back to the next Committee.
Action: DT

CG/23/125 Staff / Team Story (agenda item 6)

There was no story available for the Committee this month.

CG/23/126 Chief Nurse - Update Paper (update on verbal items) 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:

- DT noted there had been no change in the Trust's COVID-19 rates since the wearing of masks had been lifted, however advised that processes were in place should an outbreak occur.
- NM stated that she would like to gain further understanding of the complaints responses given the concerns.

It was RESOLVED to RECEIVE the update.

CG/23/127 Quality Accounts Production (agenda item 8)

DT included at item 7.

CG/23/128 Clinical Audit and Service Effectiveness (CASE) Annual Plan (agenda item 9)

Carmain Gibson-Holmes (CGH) gave a brief update to the Committee and highlighted the following:

This plan provided an overview of all planned Clinical Audit and Service Evaluations for 2023-2024. The plan detailed 28 projects which have been prioritised. These 28 projects consist of annual and national audits only. Further audits and service evaluations will take place within teams and services and will be reported though the usual governance structures.

There are 13 national projects included in the CASE plan this year, many of these audits are now continuous data collection on a monthly basis.

NM noted out of area beds and levels of assurance criteria and to possibility include this as part of the clinical audit plan. CGH will take this as an action to include.
Action: CGH

It was RESOLVED to RECEIVE Clinical Audit and Service Effectiveness (CASE) Annual Plan.

CG/23/129 Consideration of External Audit Reports on Trust Quality Accounts (agenda item 10)

Nil.

CG/23/130 Care Group Quality & Safety Report (agenda item 11)

NM noted the report that had been produced by the Trio, and the value it brought to Committee's awareness.

CH gave a brief update to the Committee.

Industrial action

Committee will be kept updated throughout the industrial action which will be taking place between 14-17 June. Clinical and operational leads are working closely together to ensure the wards are staffed and safe. Further ballots have been planned throughout this year and into next which is a concern.

Mechanical restraint
CH advised of a service user in low secure services who requires frequent hospital visits where the team have requested the use of restraints, however as yet there hasn't been a need to use them. The nursing directorate are also producing a piece work with regards to service users who do not want to be physically moved from one place on the site to another but need to be moved in for their safety and / or dignity. This will be informed by the learning from a recent incident and will be shared with the Committee when available.

Neighbourhood nursing services
CH advised that one of the Governors had heard about some staffing issues. CH has responded to the Governor to inform that there is a plan in place which is monitored by OMG and EMT and that the CGCS Committee were notified. The Governor was satisfied that processes were in place.

CH reminded the Committee that the waiting lists data will be going to the Finance, Information and Performance Committee (FIP) next week.

Horizon Centre
CH advised the Committee that the Executive Trio were responding to a further freedom to speak up concern that has been received regarding culture on the ward. The Trio went to visit the ward unannounced and witnessed lovely interactions between the staff and service users. The Manager and Lead Nurse showed the Trio the improvement plan for the ward and informed them of all the work that had been undertaken. The visit was really positive and the Trio were able to see evidence of that. However, concerns are still being raised by some colleagues and these are still being heard.

Subsequently to the visit, three further freedom to speak up concerns had been received relating to the culture on the ward. It was not known whether the concerns could be from the same person who has raised previous concerns or if it was different staff members. The Trio are looking into this and will be keeping EMT fully to up to date.

CH advised that the Peoples Directorate are supporting the Horizon Centre with leadership development work.

NM considered whether there could possibly be a question around the method of the freedom to speak up process given the conflicting issue of what the Trio witnessed, and the concerns received. KQ agreed with NM and echoed the above.

JW advised that she had previously been aware of a task and finish group that would look at the issues above.

CGH informed the Committee that she had a conversation with CH and the Director of Services about some engagement work with the team around a further anonymous way of providing feedback about concerns and improvements.

NM noted the continued focus and noted that updated will continue through the Trio report.

It was RESOLVED to NOTE the report.

CG/23/131 Care Planning & Risk Assessment Improvement Update (agenda item 12)

CGH gave a brief update to the Committee and highlighted:

The paper outlines the progress to date of the care plan and risk assessment improvement group in the completion, co-production and recording of care plans and risk assessments.

- The care planning and risk assessment improvement group has been meeting regularly to develop and define the problem and generate driver diagrams for change, underpinned by a model of quality improvement. The driver diagrams will shape the next stages of the improvement programme.
- Improvements have been noted in the performance reported through the Integrated Performance Report
- Progress to date has been meaningful and there is positive engagement in the improvement work both formally and informally.
- As the problem is further defined and understood, measures are being put in place which will support improved experience of service users, carers, our clinical colleagues and also in our performance.

This work will continue to take a staged approach; the scope of which includes:

- Identify and test improvements to person centred care planning.
- Identify and test improvements to person centred risk assessments.
- Develop and test a metric that accurately reflects coproduction of care planning.
- Develop and test a metric that accurately reflects risk assessments; and
- Embed record keeping as a key part of this work to ensure provision of readily accessible data that supports assurance and improvement against standards.

The Committee continue to note this as an improvement programme and that it was moving in the right direction.

It was RESOLVED to NOTE the report.

CG/23/132 Incident Management Annual Report 23/24 (inc Learning from Healthcare Deaths, LeDeR and Q4 report) (agenda item 13)

CGH advised that she would take the paper as read.

The annual report key headlines:

- The number of incidents reported across the Trust had increased by 12% on the previous year. Analysis of the data showed that harm levels have not overly increased despite the overall increase, and our number of serious incidents has reduced. We have promoted incident reporting through our learning sessions this year which may have increased figures to some extent.
- 97% of all incidents reported resulted in no harm or low harm to service users 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 reporting culture.
- The number of serious incidents reported in the year has reduced compared to last year; this is also reflected in the proportion of serious incidents to all incidents. 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 Patient Safety Incident Response Framework (PSIRF). This year we have seen two cases initially reported as serious incidents but later removed. These were both incidents where we did not identify any care or service delivery issues or learning after review.

- We have reviewed the deaths of 253 service users who 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.
- We have incorporated learning from experience into the report. This shares our learning systems and examples of learning in practice.
- 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 Patient Safety Incident Response Framework and Learn from Patient Safety Events.

NM noted that there continues to be violence and aggression towards staff and was concerned about complacency. The real impact on staff is a cause for concern as there is a duty of care to staff as well as service users. DT shared the concern and noted that this was mainly around inpatients, not as much in community and have asked Matrons to ensure that frontline staff were aware of the wellbeing support that can be sought. Clinical risk panel also discuss the wellbeing of staff when it meets each week and the Trio have also discussed.

CGH noted how the trauma informed work could also have a positive impact on both staff and service users as it rolls out further into the organisation.

DT informed the Committee that the RRPI training is a key part of our response and the team are working hard to increase attendance. The team will also go on to the wards to undertake the training.

Pressure ulcers were raised as a risk of harm, with an increase in number noted recently. noted that this had been picked up throughout the year and deep dives have taken place. DT added that around older people this could be around inactivity since COVID-19 and also due to the period of warmer weather, etc and DT will reflect this in his executive summary for Trust Board. NM will include in the AAA to board.

The Committee approved the recommendation to Trust Board.

It was RESOLVED to RECEIVE the report and APPROVE for recommendation to Trust Board.

CG/23/133 Internal Audit Reports (as appropriate) (agenda item 14)

Nil.

CG/23/134 NICE Annual Report (agenda item 15)

The report was taken as read and CGH gave a brief update to the Committee.

- 86% of guidance applicable has been reviewed and assessed for compliance.
- Eight new applicable guidelines have been published, with seven of the eight reviewed and assessed within 6 months of publication date as per the Trust standard.
- Focused improvement work is in progress regarding Decision Making and Mental Capacity, Managing Violence and Aggression and Managing Wellbeing at work.
- The Trust's NICE policy has been reviewed and updated
- Equality Impact Assessment has been completed and rated as achieving.
- An options paper was developed to improve the Trust's review process for NICE guidance during 23/24 and was reviewed by OMG and a way forward was recommended.

Next steps

- To implement and complete actions identified from the Equality Impact Assessment
- To include black and minority ethnic (BAME) representatives, service users and carers in future Improvement work identified through reviewing NICE guideline
- To ensure equality and engagement team has oversight and input in all NICE guideline assessments.
- To triangulate and consolidate data with other services to identify and support areas for improvements.
- To implement the new process for NICE guideline reviews.
- To update the NICE process flow chart to reflect changes in process.
- To review the Trust's NICE database to capture the changes in process.
- To emphasise the need for quality improvement as well as assurance.
- Ensure a clinician or subject matter expert chairs the guidance review meetings with the support of QIAT to guide the discussion and ensure actions are appropriate.
- Ensure relevant identified quality improvement actions have a realistic time scale set and an identified project lead to ensure the actions are met within this time frame. Updates of previous actions will also be part of the quarterly NSOG agenda to ensure everyone is kept up to date.
- Ensure NICE guidance is used as a basis for transformation, quality improvement, and identify gaps with compliance.
- Ensure timely reviews and assessments of all applicable NICE guidance.
- Continue to look for themes and trends across the guidance that we are not meeting and establish improvement groups.
- Continue to update Care Groups on NICE through their monthly Quality Governance meetings. Updates include any upcoming review meetings, risks or actions.

NM agrees with reviewing of the options review in a year's time.

JW queried whether the risk assessment process mentioned followed the Trust's scoring system and CGH will check the rating tool that is used. JW wanted to ensure that the risk assessment was evidence based and DT will discuss in the Clinical Governance Group.

The Committee was happy to approve the annual report.

It was RESOLVED to RECEIVE the report.

CG/23/135 Patient Experience / Customer Services Annual Report (draft) (agenda item 16)

CGH noted that this annual report was still in draft format as further information from other parties was required. Key points were highlighted.

- During 2022/23 the customer services team received and responded to 756 items of feedback in the form of complaints, concerns and comments (excluding compliments). This was a 3% decrease compared to the previous year (2021/22) when 777 items of feedback were received.
- Of these 756 items, 86 of these were formal complaints and this compares with 119 during the previous year. These are complaints where consent has been received from the complainant and the scope of investigation agreed and an investigation started.
- 53 concerns were raised with the freedom to speak up guardian during 2022/23 and this is an increase on the previous 12 months. These were from all disciplines and all services across the Trust.

- The friends and family test had seen an increase in responses over the previous 12 months and an increase in the number of people who rate our services as 'good' or 'very good'.

JW noted the overall good report and suggested adding more information in regard to the ongoing improvement programme and future actions before being sent to board.

DT advised that given the amount of work needed to be done his suggestion would be to take this to the July Trust Board meeting.

KQ and NM will send some comments across to CGH outside of the meeting.
Action: KQ and CGH

DT added that due to the team's challenges with staffing / capacity issues he suggested a possible deferment to September and the Committee were in agreement.

It was RESOLVED to RECEIVE the report and APPROVE for recommendation to Trust Board.

CG/23/136 Infection Prevention & Control Annual Report (agenda item 17)

CGH provided highlights to the Committee of the annual report.

- The Trust has continued to provide assurance to the Trust board through the IPC BAF
- 2022/23 had seen considerable activity and progress regarding IPC and COVID-19 pandemic response within the Trust. Central to the response over the last year has been the reviewing of guidance in light of changes to the management of the pandemic and restoration of services, through the Trust's Moving Forward group.
- 2022/23 had been a challenging and busy year for IPC. The impact of COVID-19 continues to be significant, and the Trust has also seen an increased incidence of influenza, however this was in line with the national surveillance.
- The Trust successfully implemented the IPC Annual Programme 2022/23. The work undertaken demonstrates our open and transparent commitment to exceed expectations in quality of care and shows where there are improvements needed, actions are taken.
- There has been assurance and learning from post infection reviews (PIRs), quality improvement programmes / audits, incidents, etc.
- The Trust made significant achievements and improvement in 2022-23, for example:
    - The introduction of Microsoft Teams allowed quick response and establishment of an incident management team (IMT) for outbreaks.
    - The Trust responded proactively with the changing landscape of COVID-19.
    - Excellent system in place and availability of personal protective equipment (PPE)
    - Increased IPC staffing to improve visibility of the team and improve communication.

Next steps

- Maintain adequate provision of IPC expertise for the organisation, through undertaking specialist training to further develop the knowledge of the IPC team.
- The Trust will continue to support any Infection Prevention and Control initiatives.
- Moving forward, the focus remains on eliminating all avoidable healthcare associated inspections (HCAIs), to sustain improvements in best practice in infection prevention and control and to embrace antimicrobial reduction strategies/action plans.

JW suggested that more information to be added around the moving forward group before submitting to Trust Board.

The Committee were happy to recommend approval to Board.

It was RESOLVED to RECEIVE the report and APPROVE the recommendations

CG/23/137 Customer Services Policy (agenda item 18)

DT noted that this was on the workplan for approval however was still going through the sign off process and is due at EMT next month.

CG/23/138 Reports from Formal Sub-Committees (agenda item 19)

CG/23/138a Drug & Therapeutic TAG (agenda item 19.1)
There was no update for this item.

CG/23/138b Infection, Prevention and Control (agenda item 19.2)
Included at item 17.

CG/23/138c Joint Safeguarding (agenda item 19.3)
There was no update for this item.

CG/23/138d Reducing Restrictive Physical Interventions (agenda item 19.4)
There was no update for this item.

CG/23/138e Improving Clinical Information Governance Group (agenda item 19.5)
The updated was received and noted.

CG/23/138f Clinical Governance Group (agenda item 19.6)
There was no update for this item.

CG/23/138g Clinical Ethics Advisory Group (agenda item 19.7)
There was no update for this item.

CG/23/138h QUIT (agenda item 19.8)
The updated was received and noted.

CG/23/138i Safer Staffing (agenda item 19.9)
This was included at item 12.

CG/23/138j Physical Health (agenda item 19.10)
There was no update for this item.

CG/23/138k NMET (agenda item 19.11)
Taken as read.

CG/23/139 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 20)

NM will share the AAA update with CGCSC members should anyone wants to comment before it goes to Board however NM will provide a verbal update to Board as follows:

- CQC visits and next steps around assurance – broader governance for the next Committee.
- CQC report.
- Trio report.

- Horizon Centre.
- Change of the name Committee to - Quality and Safety Committee
- Extend meeting to 2 hours 15 minutes.

CG/23/140 Risk Register review (agenda item 21)
There were no further updates for this item.

CG/23/141 Work Programme (agenda item 22)
The updated Work Programme was noted.

CG/23/142 Date of next meeting (agenda item 23)
The next meeting will be held on 11 July 2023.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of Equality, Inclusion & Involvement Committee meeting held on 12 June 2023
Via Microsoft Teams

Present:	Salma Yasmeen (SY) Mike Ford (MF) Erfana Mahmood (EM) Mark Brooks (MB) Greg Moores (GM)	Director of Strategy (Lead Director)/Deputy Chief Executive Non-Executive Director Non-Executive Director Chief Executive Chief People Officer
Apologies:	Marie Burnham (MBu) David Webster (DW) Paul Brown (PB) Claire Hartland (CH) Carmain Gibson-Holmes (CGH) Jacob Agoro (JA) Nasheen Oya (NO) Raquel Murray (RM) Zahida Mallard (ZM)	Chair of the Trust (Chair of Committee) Non-Executive Director HR Business Partner HR Business Manager Deputy Director of Nursing, Quality and Professions Matron/REaCH Network Lead Serious Incident Investigator/REaCH Network Specialist Dietician/REaCH Network Equality & Engagement Manager
In attendance:	Rachel Irwin (RI) Dawn Pearson (DP) Sue Threadgold (ST) Aboobaker Bhana (AB) Chris Lennox (CL) Gillian Cowell (GC) Donna Somers (DS) Paul Cartwright (PC) Iffath Hussain (IH) Catherine Musagedi (CM) Tony Wright (TW) Sue Barton (SB) - observing Hazel Murgatroyd (HM) Heather McKnight (HMc) Gemma Hinchcliffe (GH)	PA to Director of Strategy/Deputy Chief Executive (author) Associate Director Communication, Involvement, Equality and Inclusion Deputy Director Equality & Involvement Manager Deputy Director of Operations Carers staff network Chair/Carer Support Worker LGBT+ staff network Chair/Ward Manager Head of Marketing and Communication Diversity Inclusion & Belonging Lead Staff Side Lead for Equalities Sustainability Change Manager Deputy Director Strategy & Change Interim Head of People Experience Equality & Involvement Manager Assistant Director of Nursing, Quality and Professions

Section 1 – Standing Opening Items

EIC/23/28 Welcome, introductions and apologies (agenda item 1)

In the absence of the Chair, Marie Burnham (MBu), Erfana Mahmood (EM) agreed to chair the meeting. EM welcomed everyone to the meeting and all introduced themselves. Apologies were noted as above and the meeting was deemed to be quorate and could proceed.

EIC/23/29 Declarations of interest (agenda item 2)

None.

EIC/23/30 Minutes of previous meeting held on 14 March 2023 (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 March 2023.

EIC/23/31 Matters arising from previous meeting and action log (agenda item 4)

All the outstanding actions had been updated and closed off.

EIC/23/32 Actions from Trust Board (agenda item 5)

No specific actions raised at Trust Board.

EIC/23/33 Review of Committee related risks and any exception reports as required (agenda item 6)

Salma Yasmeen (SY) advised that the 3 risks had been fully reviewed and updated to reflect the ongoing work.

Mark Brooks (MB) mentioned that in terms of the diverse workforce, they had agreed to look at the number of people who are in a Band 7 and above role over the next 12 months for each protected characteristic as have recognised this is something they need to focus on and also there has been a recent EDI improvement plan published by NHS England. The plan looks to be in line with what we are doing or intend to do but likely to be gaps. This paper went to EMT in June and was prepared initially by Dawn Pearson.

Mike Ford (MF) mentioned the recently published plan and Board level members having quality objectives established for 2024. MB advised that the Executives already had those objectives planned but they would also need be incorporated in those set by MBu for the NEDs so that they aligned.

The Committee NOTED the current Trust-wide corporate/organisational level risks.

EIC/23/34 Context report – National, ICS and Trust level (agenda item 7)

DP thanked her team and in particular Zahida Mallard (ZM) for their work in producing this report.

Highlights included: -

- Focus on accessible information for RNIB – launching a campaign, My Info My Way.
- Value of unpaid carers.
- Focus on discrimination, particularly around ageism.
- Guidance around supporting gypsy and traveller communities.
- Document on mental health and wellbeing plan which was previously going to be a separate suicide prevention strategy – now will be a major conditions strategy.
- CQC – quite a lot around monitoring around the Mental Health Act – mental health services are still struggling to recover from the pressures put on them during the pandemic.
- Workforce – staffing levels for mental health, although increasing and more patients being treated, there are still a lot of people not being able to access services.
- LGBTQ+ - Queer Futures 2, focusing on mental health support for young people.
- King's Fund – Need to do more to make sure that our services are inclusive.
- Continued focus on race, particularly one key document around racism, one of the biggest causes of inequalities.
- Charity@Rethink are pushing for more work to be done around the over representation of black people in mental health inpatient facilities.

- Digital - how this can create inequality and disadvantage. Couple of articles around how groups of people experience barriers to accessing healthcare.
- Health and digital literacy survey – some stark findings around the impact of health literacy as a barrier.

DP confirmed this information would be fed into the research library on the intranet, key documents would be shared with particular services and would look at this against the action plan to ensure we have our priorities right.

MF mentioned that at the last meeting, there had been a request from MBu to have a cover sheet with this report to pull out the highlights for members of the Committee which hadn't been carried forward to the matters arising. MF asked if DP could pick this up and provide for the next meeting.

Action: Dawn Pearson

MF asked if there was anything she should pull out to say we are working on it but not where we should or need to be. DP mentioned digital and literacy and this is one of the targets for the dashboard (to look at how we collect that digital information i.e., do people have access to a device and data). DP confirmed that we were pretty much on track with everything else or had an action around it. MF asked how we would pick up the points around digital literacy. DP advised that it was already on SystmOne but still needed to collect data and insight on digital preferences to understand the impact of people not having digital devices or data on our service offer.

MB thanked DP for her report. He was aware she did a gap analysis of all the various updates to ensure they were aligned with our plan, however, there is so much information and so many documents published that one of the challenges is to work out what the largest priorities are for the Trust and how we can make an impact. There are always going to be areas to focus and improve upon.

The Committee NOTED the contents of the context report.

Section 2 – Insight, feedback, and programme updates

EIC/23/35 Staff network update (agenda item 8)

Iffath Hussain (IH) advised that she was new into role and was going to be meeting up with all the Chairs of the networks together. Will very much operate an open-door policy to maintain good relationships with all three networks.

A staff carers event will be taking place shortly and IH will be meeting with Gillian Cowell (GC) to find out how this went.

The presentation today was from the REaCH network – unfortunately no members present at the meeting therefore IH presented on their behalf.

REaCH Network Presentation

IH advised that Noma has now left the Trust and there are vacancies available which have been recently advertised. Nasheen Oya is no longer the Co-Chair and now just a steering group member. The vacancies available are Co Chair and Co Vice Chair and an option to just be a steering group member. Had a couple of people put their names forward and have put the due process in place i.e., application form, voting and election. The number of members has increased from 187 to 207, which might be due to the new international nurses.

The steering group is committed to:-

- Maintaining visibility on social media to maintain presence and engage network members.
- Continuing with the QI sessions.
- Continuing to plan and host South Asian Heritage Month & Black History Month.
- All of You: Race Forward – the network will maintain and continue its support of the workstreams and objective of the Race Forward network.

The differences the network is making:-

- Supporting staff, providing motivation.
- Providing a safe space to share.
- Connecting/networking.
- Improving inclusion/representation in the Trust.
- Providing opportunities.
- Innovating and inspiring staff to speak up about issues that concerns them the most.

We have had the FLAIR survey and will be linking in and working with the networks to understand the information coming out of this and any action plans which may need developing.

What the members want us to do:-

- Representation at every Board/management level across the Trust and for them to be part of the network.
- Stronger voice, more influential, increased membership (people opt out rather than opt in).
- Protected time for meetings and connection.
- Network values to be embedded within the fabric of the Trust rather than the network being seen as 'other.'

What the members want:-

- To be valued and have their voices heard and understood – captured in the staff survey and FLAIR survey (3 year rolling progamme). The People Directorate are committed to working with them to ensure we are working on all the objectives and any concerns or needs are met.
- Equality with securing permanent positions.
- More opportunities.
- Not having to work twice as hard to be appreciated.

The ask from the network is for support. Currently going through a transition period from the old steering group to the new one and have a recruitment process ongoing. Allyship is very powerful and all can pledge their support.

Catherine Musegedi (CM) thought it was very positive that there were more network members but in terms of attending network meetings, attendance had dropped and wondered if this was due to staff not being able to be released from their roles and also with regard to the steering group, there had been emails circulated requesting people to put themselves forward but this hadn't had the response it normally would have and less people are coming forward.

IH advised that she had noticed this herself and thought it was the transition from the previous steering group to the new one and people were less engaged and also issue with capacity. The People Directorate are offering support to engage with this network. Greg Moores (GM) advised that he had had a useful meeting with the LGBTQ+ staff network who had raised similar concerns about people struggling to attend. The action agreed from that meeting was for GM to draft a letter for people to show to their line managers stressing the importance on behalf of the Board of attending network meetings whilst also recognising clinical and operational pressures.

MF asked whether it was possible to get an understanding of the numbers across all of the networks and also numbers in proportion to the number of people who have declared a particular protected characteristic to see where we have any challenges/need to encourage more attendance. IH confirmed she would action.

Action: Iffath Hussain

MF also mentioned the funding being applied for to have an overnight carer retreat and whether we could use charitable funds. GC advised that the funding had already been sourced for the first year via EyUp! but would like to be able to offer this on a yearly basis so funding would need to be sought elsewhere.

SY advised that networks fluctuate in terms of membership and during periods of transition. The key thing is to ensure they are supported through this transition and she was happy that IH was able to do this. SY felt it was important to give steering group members who take on formal roles recognised time to do these roles like other Trusts have. IH advised that they were currently reviewing some policies and guidance and one of these was time allowance to attend networks.

EM felt that the same issues were being continually raised i.e., for values to be incorporated, voices to be heard and more opportunities to realise talents. IH said that often they ask network members to escalate their voice and perhaps there was something about inviting ourselves into their space. MF felt we needed to be mindful that this is a private space where people can speak openly and we need to balance this whilst trying to generate more participation and enthusiasm.

Aboobaker Bhana (AB) mentioned the time off for network Chairs and steering group members and that it had been agreed when first setting up the networks that staff would be allowed to have protected time off and it was part of being a Chair (up to 7 hours per week) and Paul Brown (PB) had devised a document to this effect. AB also mentioned the carers retreat. The request came from the staff carers network and if it proves successful and people enjoy it, it becomes part of the offer to staff carers as it will to other networks if they are interested.

CM asked if we were still waiting for the results from the FLAIR survey and also about collating data in areas where there is no intersectionality to see what people's experiences are. IH advised that they would be taking this forward in the team and she has a date in her diary to discuss the time allocation for network members. Donna Somers (DS) advised that time gets allocated to be a Chair etc. but staff still struggle with pressures and didn't feel Managers fully understood how to support the network members. SY advised that the networks should have time and space to grow and the steering group members should have protected time and we needed to continue to raise awareness and understanding of those roles to support the networks and try and use our comms channels to articulate this.

The Committee NOTED the staff network update and presentation.

EIC/23/36 Care Group Highlight Report (agenda item 9)

Sue Threadgold (ST) presented a paper – highlights included:-

- Very active equality inclusion and involvement forum across all the services she manages – very well attended.
- Good levels of compliance around training around diversity.
- Increasing service user voice – well established group across Yorkshire & Humber in forensics (medium secure). Less engagement in learning disabilities and have recognised that Covid has affected engagement with carers, particularly in forensics where it has been more difficult to maintain the links we had.

- Developed some guidance for staff experiencing a high level of racially motivated abuse from service users, which has gone through clinical governance and hope it will help staff and guide them on what can be done and how to tackle this.
- Cultural calendar – doing lots of work which is informative, educational and fun and people have embraced this – it has enabled conversations with service users about differences and how we celebrate this.
- Strategic health facilitators in all 4 localities in learning disabilities who are leading the way in enabling learning disability service users to access mainstream primary care services and have seen a real improvement in all services.
- Peer support worker on Horizon to support with environmental developments and engagement and communication including accessible information.
- Improvement work on Horizon, trying to connect with the rest of the Trust and to all staff networks.
- Work in FCAMHS – had a literature review which AB supported with and this is now being worked into a research proposal around the level of mental health difficulties in BAME children and how likely they are to have access and utilise mental health services – have done some cultural awareness training with staff and hope to reduce inequalities in this area.

MB mentioned the guidance document in response to hate crime and asked who produced it. ST confirmed that this had been a long-standing piece of work, starting as a care plan, and she had picked it up when she chaired Race Forward but had moved it forward and engaged with a large proportion of BAME staff including bank and agency. MB asked if there was any feedback around how this is being used and if we are offering the right level of support to staff. ST advised it was early days and planned to evaluate later on in the year but in general people had been fairly positive. DP advised that the guidance produced through forensics has been pulled through into the All of You: Race Forward group to look at this and see if we can use for anyone. DP thanked ST for her report and noted that the EIAs were exemplary with 1 excelling (first team to achieve this), which was very encouraging.

ST confirmed that the first recommendation noted in the paper for Committee was an old one from September and apologised for leaving this on. With regard to the EIAs, ST wanted to include more data around temporary staffing as using a lot in forensics and Horizon but wasn't sure how to do this (there is a greater proportion of BAME staff in these areas). ST also asked if Committee wanted the linked charities as a separate paper as she had not included this. SY advised that the temporary staffing matter should be picked up by OMG and wasn't for this Committee. EM didn't feel this Committee needed any more papers and that she should just embed the linked charities information into the existing report. MF asked about reporting on the other care groups. SY confirmed it was a standing item and we had a schedule of care groups to report into EI&I Committee each quarter.

The Committee NOTED the contents of the Care Group highlight report.

EIC/23/37 Patient/Public Story/Campaign (agenda item 10)

DP presented a film on young carers in our community.

DP confirmed the lunchbox sessions continue to run and usually the creator of the film is present to speak to staff, hoping to bring equality to life and consider diversity within our population.

MB mentioned that trust kept coming up on the video and wondered if there was anything they could do about building the relationships with the clinicians (not sure about them seeing the same person every time but would like to try to keep continuity). DP advised that they would continue to work with the young carers groups as they bring a wealth of experience.

The Committee NOTED the film.

EIC/23/38 Sustainability reporting (agenda item 11)

At the meeting in December, Tony Wright (TM) had provided a presentation on the initial planning around the social responsibility and sustainability strategy, the Committee had approved the action plan and driver diagram and agreed to receive bi-annual reporting.

Update:-

- Quarterly report provided – had some excellent input and support from Vicky Humble and involvement from 5 learning initiative leads. Feel the measures reflect the aims of the strategy and Trust values and will be able to take a quality improvement approach to bring positive change.
- Will be reporting to OMG and EMT on anything of particular importance.
- Now coming to the end of phase 1 - feel we have a good understanding of what our priorities are, have evidence of where progress has been made and how to take this forward.
- Have improved levels of communication with staff to enable a deeper understanding of what we are trying to achieve around social responsibility and sustainability.
- Inaugural SRS steering group meeting to be held later today – to agree the Terms of Reference and the role of the group, which will be to provide governance and oversight. The group will consist of people from the 5 headlines initiative areas of work - other members can be co-opted if any specific focus is needed.
- SWYPFT green team – to provide an opportunity for anyone to think about what they can do to push forward the aims of the strategy – changing hearts, minds and behaviours. TM will be providing support together with the quality and improvement team.

MF felt the measures were great and a good framework to build on and that we needed to start to work on targets and plans. TW confirmed they had looked at measures which were both meaningful and challenging. EM questioned capacity to deliver but TM mentioned we all needed to take a greener and smarter approach.

MF asked how much influence we had on procurement as we might not have as much on sustainability or social responsibility for particular suppliers if tied to a central contract. TW advised that the Government recently increased the rating for social value procurement from 5% to 10% and would keep pushing at ICB and national level to increase.

The Committee NOTED the update.

Section 3 – Strategy and Policy

EIC/23/39 Strategy and Policy (agenda item 12)

MF suggested picking up the sustainability internal audit report at this point in the meeting given the links with the above item.

SY advised we have had significant assurance around the development of the strategy itself and some of the priorities and that the paper was just for noting.

MF mentioned the recommendation around the working group, which had already been implemented, and TW confirmed the other recommendation was to get a plan of action around the green plan, which was now in hand.

Section 4 – Performance Reports

EIC/23/40 Equality dashboard (agenda item 13)

SY advised that the dashboard continues to develop and evolve and thanked the business intelligence team for supporting this work. There has been a significant amount of work around

waiting lists, particularly by depravation and ethnicity. MB has shared with ICB colleagues in West Yorkshire at a recent Partnership Board meeting and Rob Webster would like other Trusts to get to the same level we are at, which was very positive. SY also mentioned that South Yorkshire had asked DP and the team to present the dashboard and approach at their inequalities workshop on 22nd June.

Workforce population
BAME Average: 14.8%
By place: Barnsley 3.6%, Calderdale – 14.2%, Kirklees – 27.5%, Wakefield 7.7%
BAME SWYPFT workforce total: 11.2%

Recruitment
Recruitment likelihood of BAME – 1.08 – more detail can be found in the WRES paper.
Recruitment by pay band 1-4: 31%
Recruitment by pay band 5-7: 16%
Recruitment by pay band 8+: 8%
Medical/dental: 76%

POST MEETING NOTE – These figures were contained in the dashboard but weren't accurate and would be amended.

This is one of our three risks (recruitment by pay bands above 8a) – workforce diversity isn't a huge cause for concern from an ethnicity point of view but we are concerned about diversity across all protected characteristics and particularly around BAME.

Disciplinary
14% of BAME staff entering a formal disciplinary process over the last 12 months which is higher than our workforce as a whole and will keep an eye on this but having fewer disciplinaries now (75% reduction due to having put other processes in place).

Training
Non mandatory training (all) **17%**
Non mandatory training (excluding medics) **16%**
Higher than workforce as a whole but not a cause for concern as more training being delivered in the clinical workforce.

EM mentioned that we are still recruiting at Band 1-7 and less at Band 8. GM advised that this would be covered in HM's presentation in terms of what actions are being taken to address this. EM also mentioned racial abuse/harassment of staff and didn't know if 76 incidents was high or low. GM felt that the way we presented this needed to be looked at as this figure in isolation isn't very meaningful.

DP advised that the information comes from the clinical team and there has been a steady decrease in incidents reported through Datix – low figure for this quarter as it has been over 100 previously but most are race related. EM asked if a graph could be produced to show the trend over the last few months to give an indication. SY confirmed that the All of You: Race Forward group could provide a report for a future meeting so we had a deep dive.

CM asked if GM had identified any specific areas where this is more prominent and a more targeted approach is needed. GM advised that they had seen more in clinical areas which wasn't unusual as the workforce is more diverse. GM has recently introduced a change of approach which has reduced the number of formal disciplinaries. GM didn't want to get into case by case specifics. SY was sure we had the data and could identify hotspot areas and thought it was wise to discuss at this Committee to see if the interventions we are making are having an impact. GM advised that we

needed to be careful that we didn't identify ward specific data. MB suggested the subcommittee do an analysis and bring some conclusions to Committee.

Action: Greg Moores/Lindsay Jensen

EM felt the depravation statistics were very good. MB felt it was important to consider the wider determinants of housing and employment and make sure we can influence and tackle wherever possible. DP advised that we collected data on housing and had been looking at this to see how we could use it to translate the data of people using our services in relation to housing and we can add in some data collection to show this through the inequality slide. DP had added case studies as sometimes we lose sight of the work teams are doing at grassroots level to address health inequalities – good picture of the work ongoing and the service improvements. MF asked if the case studies could be further refined in future to link in with the data presented in the dashboard – DP advised that she would look into how best this could be done.

Action: Dawn Pearson

DP advised that there had been a lot of work undertaken around waiting times for learning disability services and Mike Garnham had also used an inequality metric - have since created a data strength framework and are doing a bit of work with the learning disability service to test theirs.

The Committee NOTED the development of the dashboard.

EIC/23/41 Equality, Involvement, Communication and Membership strategy implementation action plan highlight report (agenda item 14)

DP provided some highlights:-

- EIA status – 53.33% - working hard to ensure we have up to date EIAs in service settings. No service is without one so need to be mindful everyone does have an EIA.
- Continue to have good attendance for equality and diversity mandatory training – no issues.
- Now have a full report from FLAIR survey – this will be shared with EMT with some suggested recommendations and actions.
- All of You Race Forward work is progressing – work plan in place and aligning existing work streams. Now have All of You website page and within that All of You Race Forward and All of You LGBTQ+ - starting to collect information to support this agenda.
- Lots of work with team looking at trans and there was an international day of trans on 31st March – lots of staff attendance and good insight and have now been able to create a short film to support the trans gender policy and also create some posters.
- Great event for carers organised by GC and team which increased the visibility of our offer for carers and the ongoing work and progress made.
- Census data still outstanding – has been in the action plan for a while but information is not coming through as quickly as we would like.

MB felt the paper was helpful and there was a lot of work taking place. Very assured by the approach we were taking around EIAs. Asked what changes we make to policy, strategy or service delivery as a consequence of carrying out an EIA. DP advised that the team have been developing a dashboard and working with Sharepoint (to be launched in September) - have the toolbar and data now in a way we can start to draw something meaningful from it. Doing a soft launch initially as staff need to transfer EIAs to an online platform from a paper one. MB felt it would be useful to get a couple of examples.

EM asked about the service EIAs and noted that Barnsley had more than others. DP advised they had a mental health tool but didn't yet have a community one so they are having to look up the insight. Plans are in place to look at this and also to support them to improve their EIAs in a way

that it is easier to do. Heather McKnight (HMc) is working closely with them to come up with some solutions.

DP asked Committee to note the action plan extension for census data (to be moved to September 2023).

The Committee NOTED the report.

Staff Survey
GM updated the meeting due to HM having technical issues. Previously had presented the results of the staff survey and now got into the action planning around this. A paper went to EMT and PRC last month and will be going to Board later this month.

Inclusive Leadership & Development Programme
EM asked if this could be carried forward to the next meeting due to HM being unable to present. MB mentioned that the presentation could be circulated immediately after the meeting and if there are any questions or comments, this could be discussed at subcommittee and then brought back to Committee.

Action: Hazel Murgatroyd

EIC/23/42 Equality Standard update (WRES & WDES) (agenda item 15)
IH updated:-

- Now submitted the data for WRES and WDES.
- International recruitment – still ongoing – accounts for 40% of our employment for nursing in Band 5.
- Work ongoing to attract more diversity into our organsiation – thinking about our wording, recruitment and adverts.
- Some ongoing work with DFN project search, supporting people with learning disabilities.
- Harassment and bullying – Diane Taylor is facilitating a workshop - new policy is based upon a restorative practice approach.
- Bystander training has also been sourced and work is being undertaken to embed this in the Trust.
- Disability training – working with Elaine Shelton to get this signed off.

EM mentioned that not all the time scales were included and asked if they could be incorporated in future. IH advised that these would be updated on the next paper for Committee.

Action: Iffath Hussain

The Committee NOTED the update.

EIC/23/43 Internal Audit Reports - sustainability (agenda item 16)
Discussed already in Section 3 – Strategy & Policy.

Section 5 – Annual Items
EIC/23/44 Annual Items (agenda item 17)
Nil.

Section 6 – Governance
EIC/23/45 Governance (agenda item 18)
Nil.

Section 7 – Standard Closing Items

EIC/23/46 Review of risks (agenda item 19)

No further risks identified.

EIC/23/47 Work Programme (agenda item 20)

The work programme was approved.

EIC/23/48 Items to bring to the attention of Trust Board or other Committees (agenda item 21)

EM detailed items to be included in the assurance form: -

- Risks – good progress being made.
- Context report received – any specific exceptions to be noted i.e., national guidance.
- Staff network update to include governance, members and new Chairs.
- REaCH network presentation highlights plus transition.
- Care group highlight report – highlights.
- Equality dashboard – making good progress and note ICB's interest in the work around inequalities and data collection.
- Sustainability reporting – positive internal audit report and Committee approving the measures.
- Staff survey results – action plan going to Board this month. Inclusive leadership and development programme presentation to be circulated to subcommittee for comment.
- WRES and WDES – making progress.

EIC/23/49 Any Other Business (agenda item 22)

MB thanked EM for chairing the meeting.

MB also mentioned that it was SY's last meeting and thanked her for the fantastic work she has done as executive lead for EDI over the last couple of years. EM said SY had made some amazing inroads and the Trust is an exemplar in terms of where we are and recognised in the system in terms of EI&I. SY would be greatly missed.

EIC/23/50 Date of next meeting (agenda item 23)

The next meeting will be 13 September 2023.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 19 June 2023 (Virtual meeting, via Microsoft Teams)

Present:	David Webster Kate Quail Natalie McMillan	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director (Deputy Chair of the Committee)
Apologies	Julie Williams	Deputy Director of Corporate Governance
In attendance:	Adrian Snarr Rob Adamson Carol Harris John Laville Sean Rayner Jane Wilson	Director of Finance, Estates & Resources Deputy Director of Finance Chief Operating Officer Lead Governor (observing) Director of Provider Development (item 12) Note taker

FIP/23/17 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting, he extended his welcome to John Laville, Lead Governor who was observing the meeting today. 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/23/18 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/23/19 Minutes from the meeting held on 17th April 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 17th April 2023

AS remarked that whilst he appreciated the minutes had been circulated late he wanted to make the committee aware that a lot of time has been spent between meetings to ensure the minutes did not disclose commercially confidential information into the public domain.

FIP/23/20 Matters arising and action log from the meeting held on the 17th April 2023 (item 4)

AS provided the update:-

Action 147 – Vacancy factor

AS confirmed there was an action around the workforce plan for himself, CH, and GM to embed this into our ways of working, and this is captured in all of the financial work that is currently being done. There was a clear action from EMT for a refreshed workforce plan, which includes key milestone dates in 2023/24.

DW remarked that it sounds like the action is going to be more linked with People Remuneration Committee (PRC) when it comes to the longer-term planning.

AS replied that it is going to require overview of both committees as this will be a significant part of the 2024/25 planning, which will also go through Board as it will be key to our medium-term plan.

Action 150 - Agency

AS confirmed this action relates to the Agency Scrutiny Group and that Julie Williams (JW) was checking this from a governance perspective. It has been agreed that this will go through the People Remuneration Committee (PRC) as Greg Moores (GM) is the executive lead. AS confirmed that FIP will continue to pick up the financial implications through the finance report and that it was good that Natalie McMillan (NM) will get to see the financial progress as well as the actual detail that sits behind this.
DW agreed that this action could be now closed.

Action 151 – CIPs
AS confirmed there is a paper being presented today on the efficiency programme. He confirmed that the primary vehicle for oversight is the Organisational Management Group (OMG) which is chaired by Carol Harris (CH) and that we will be looking to put some project management resources into structure that programme. He confirmed Rob Adamson (RA) would provide a further update on this when we get to that section of the agenda.
It was agreed this action could be closed as this item will remain part of the standing cycle.

Action 152 - Benchmarking
AS confirmed there will be a couple of updates later in the meeting around this. He said there had been a couple of challenges around benchmarking and performance over the past couple of weeks, which has resulted in some slippage as to what he intends to bring to this committee. AS stated that he would like to explain this further when we get to that section of the agenda. DW confirmed he was happy with this. It was agreed this action can be closed.

Action 153 - Capital
AS confirmed that a request had gone through to the NEDs for a training session, and the preference that had come back was that they would like this to be at the end of a Board meeting. He stated as Nick Phillips is on leave for the June Board, the plan is to arrange this for the July meeting. AS confirmed that NP is looking into the kitchen issue to see if there is anyway this can be built into the plan. DW commented that from his point of view the kitchen was just an example that he gave, and it was more about understanding how the capital is working. He felt that now that the NEDs training around capital is in hand this item can be closed.

FIP/23/09 Benchmarking Update
CH confirmed that the referrals were broadly correct, but she felt there was more work required in relation to demand. It was agreed to close this action and that an update on the broader demand work would be provided to the committee later in the year.

FIP/23/13 Artificial Intelligence ADHD Commercialisation
AS confirmed there were quite a number of actions from the previous meeting relating to this.
He confirmed that there had been good feedback from committee members last time and since then a separate conversation has taken place with Kate Quail (KQ) between the public and private board sessions last month, with all of these actions having been recorded through the working group. He confirmed there had been lots of ongoing discussions with the Trust specialist legal team and the University of Huddersfield and Investors with no firm commitment yet being made as we work through all the comments and everything else we need to do. AS confirmed that he planned to bring a paper back through this committee once they are ready for the next steps. He advised that Subha Thiyagesh (ST) Medical Director had confirmed last Friday that the Journal papers had been published which he said is a big step to allow us to move forward.
AS confirmed that a progress update would be provided at the July meeting.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the updates in relation to the action log.

FIP/23/21 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 5)

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 Capital

AS confirmed the Capital position remains really tight across the NHS, across our system and for this Trust. He confirmed we have a plan for this year, but we will have some challenges around some of our strategic options, particularly what come out of the Estates Strategy. AS confirmed we have work that we need to do to support the older people's strategy, he explained that there is a need to plan for the capital, but we should not attempt to prejudge the outcome of a public consultation He said for planning purposes we have a multi-year plan in place as to how we will deliver that scheme.

AS confirmed there is going to be a broader conversation across the system about how, or if we can carve out some strategic capital from the overall resources and that for now the risk remains as it is, but that it will definitely require continual review.

Risk 1585 - Revenue

AS confirmed this risk remains as is, and that when RA presents the finance report the committee will see a highlighting of the financial trend, and some of the things that he has been flagging for a little while. He stated this does not pose a risk to the delivery of this year's plan, but it is something we need to be mindful of when we look into future years. AS confirmed he was comfortable with the risk level as it is at this point in time.

DW remarked that his only comment on these would be, have we got a date of completion, and he envisages they may never be complete, and certainly not by the end of July.

AS confirmed that the executive team review all of their risks every month and in that summary of risk actions where the key dates are, we check whether the actions are still current, still ongoing, or complete, as some do complete but many are continuous,

DW asked if these ones will remain continual. AS replied yes and the version presented here will get refreshed in time for the next Board meeting.

NM commented that when she looks at the risk scores, for her it does not correlate with some of the conversations that have taken place at Board around how we feel that finance is going to be a significant risk and our biggest challenge within the next financial year.

AS replied that he completely agreed with NM in that it does currently feels like a monthly balancing act, as he is trying to ensure that the profile of the financial risk is kept sufficiently high. He felt that as a risk for this financial year likelihood of possible seems okay, but if we start to take a longer-term view on this risk he would agree that the risk score may increase next year.

DW asked is it that we need to split these out into immediate future and longer-term risks. AS replied that from a finance risk point of view, because of the high level of vacancies we have, we can control the financial risk, and if it looks like we are going to tip into an overspend position, we can put a stop on recruitment and that would manage the financial risk. He explained it would make many other risks on the risk register increase, but we could make decisions at both executive and board level that says we are not prepared to increase our level of financial exposure by continuing to recruit to roles that we cannot afford, so again there is that challenge of balance across the entire trust.

AS remarked that what makes us slightly different from other organisations is that we are trying to recruit to get our spend levels up, and many organisations that surround us are trying to do the opposite, in that they already have a level of staff they cannot afford, and they are trying to figure out how to reduce this.

KQ remarked that she wanted to add weight to the comments NM has just made around can this risk level be right. She said that whilst she appreciated the explanation AS had given around this, is it more about the longer-term risk, she felt it was very important to clock this now as a committee, as part of their role here is to provide some assurance to the Board. For her she said it is more about ensuring we have got all the risks in here and she questioned if agency was adequately enough reflected.

AS replied that if members were happy he was quite willing to take away an action to have a further discussion via EMT, and also reflect on the BAF which should capture the strategic risk, rather than the risk register which captures the immediate risk. DW agreed this idea made sense.

ACTION: Adrian Snarr

DW remarked that this also links heavily to the workforce action, and once we have this in place if this is a longer-term workforce strategy it will indicate when financial challenges are most likely.

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/23/22 Annual Accounts update (agenda item 6)

RA commented that this continues to feel like a drawn-out process, as traditionally this process concludes before the end of May, and this year we are running nearer towards the end of June. He stated good progress had been made, and that an audit pre close meeting had taken place with himself AS and Deloitte. Deloitte were preparing their close reports.
RA explained that a couple of things were raised last week, and Deloitte have started to introduce some further testing, and are asking questions that have not been asked before. He confirmed finance are still working to the wire in terms of trying to get this year's audit complete and there has been nothing unusual highlighted.
RA informed the committee that one of the things that will specifically be on the IS0260 will be the West Yorkshire adult secured deferred Income which we knew about, it has proved tricky to get this definitively resolved with Audit and all appropriate conversations have now taken place with them.
RA stated that another point to flag is where we have estimates that are slightly different to the actual invoice, he explained that some of the Deloitte samplings picked up utilities this year where we make an estimate of outstanding invoices, and because they are here longer, they now get to test when the invoice comes in, he confirmed this is an estimate and the numbers are never exactly the same, but by the time Deloitte extrapolate this the number becomes larger than we would like.

RA confirmed we are still working through this process but are fully expecting everything to be fully complete in time for the scheduled Audit Committee meeting on 26th June.

AS confirmed that all audit firms across the NHS are still looking for prudence in everyone's accounts, hence the sort of sampling the RA has mentioned. He stated we have received verbal feedback from Deloitte to say that they did not think we were being overly prudent, which is positive.

DW thanked RA and AS for the update.

It was RESOLVED to NOTE the Annual Accounts update.

FIP/23/23 Month 2 Finance Report (agenda item 7)

RA presented the update stating it feels strange still talking about the old year when we are now in month 3 of the new year.

Key headlines:-

- There was not a committee meeting for Month 1, the headline there was that everything remained okay, with a positive run rate coming out of last year, month 1 run rate was also positive. Some pressure seen coming out in Month 2.
- In terms of the main KPIs, this is a green picture which is pretty much consistent with last year's messaging.
- Agency still remains as red. RA to check colour coding on this as it is 13% above plan, which would technically be amber, it is still flagging as high risk in terms of the overall position.

ACTION: Rob Adamson

- This year, and partly linked to a question from Audit, and also to provide clarity, is the overall income and expenditure position that has always been presented, there is now a supplementary tab which shows the core trust business which now excludes the provider collaborative. RA stated the intention is to provide a clearer picture for the Board and committee members as we try to differentiate between the Trust performance and the Collaboratives. RA remarked he would welcome any comments on the presentation from the committee.
- Overall, I&E position – key numbers to pick out this month are, after a positive start in M1, we have shown an in-month deficit for M2, the main driver of this is the fact that we are now reflecting the agenda for change pay award at the 5% which is what has been agreed nationally, rather than the 2% that we agreed as part of the planning assumptions.
  RA stated that as we explain each time we have a pay award coming through, these are never fully funded. We have had to increase our expenditure, also our income, which then creates a pressure. For M2 we are forecasting a £2.5m unplanned pressure, which equates to about £417k for the first two months of the year.
- Year to date £44k surplus overall.

AS remarked that for clarification, the £2.5m cost pressure that RA referred to is the pay award and therefore it is recurrent, and we have non-recurrent flex available to cover that this year, but that only works for this year. He explained that as part of the modelling we are doing for the medium-term financial plan this is where we start to see the stretch coming through in 2024/25 because we have built in a fairly significant cost pressure.
AS remarked that this is where the workforce plan becomes ever more critical because this is the recruitment plan we need to be working to now that the pay levels have been reset at 5% higher.

DW remarked, could we check on forecast figure as a budget for pay costs, as that it not showing £2.5m greater, and is that what we should have expected to see.
RA replied no it is still an unidentified CIP, so we as a Trust are still challenged to break even, which was our plan, and this is what is modelled in the forecast, that we will deliver, albeit non recurrently this year.

AS explained that he is comfortable with the forecast for this year and that we still have some non-recurrent headroom to cover that off, but it is when we start to do the medium financial plan that it all starts to crystalise. The West Yorkshire system is now starting to do some work collectively on

medium term plans so we will feed that underlying position into this as we have been doing for a month or two now already.

- Forecast is showing break-even, month 3 is key milestone.
- Income – nothing major to report, usual reporting, no real risks coming out of this. Working with commissioners re CQINS for this year, already received confirmation from two of them that they are not applying penalties, so we are working to mitigate risks on these, along with working through the contract agreements.
- Pay - 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.
- 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.
- Non-Pay pressures. Some due to timing (establishment), some due to increased usage above rebased planning assumptions (travel) and some due to inflationary cost increases (supplies & services)
    - Acute & PICU out of area beds remains a pressure. Bed days similar to plan but less costs for additional nursing, travel and average bed day rate is less than plan. Report includes breakdown of purchase of healthcare non-pay category which is wider than this.
    - Re starting non-pay review group which will pick up some of these areas.
- Out of area beds. RA confirmed this page in the report still remains draft at present and they are working towards getting this complete for Board next week. The action outstanding is confirming the number of bed days in May, and this is being picked up jointly with P&I. Overall, the costs of acute and picu are still under budget, usage seems to be roughly in line with the plan, the reduction appears to be because we have less additional nursing, less travel costs, and we are paying less as an average bed day rate.
- RA confirmed they have also reincluded the Value for Money (VFM), Financial Sustainability and efficiency page. The schemes have been summarised into a number of headings and categories showing that actually for the year to date we are ahead of plan. RA stated the table shows that out of area placements 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.

  DW asked does this target need increasing now given the extra £2.5m gap in pay. RA replied yes recurrently definitely, there is a question mark as to whether it is non-recurrent, and this is all still currently evolving.

  AS remarked it is a good question, and one of the challenges is we cannot change the plan once it has been signed off and submitted. He stated every organisation deals with some variation in year, but this is a rather big variation early in year. He stated we will have to find a way to ensure that it is clear and visible through finance board papers, as it might be rather tricky to change the overarching £12m CIP target from plan. AS stated that RA and himself will take away an action to figure out the best way to report this through to board. DW remarked that it is important we track this and show that we are dealing with this.

  ACTION: Adrian Snarr/Rob Adamson

  :

- Cash Balance sheet - 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. RA confirmed there is a specific member of the finance team who focuses on this area.
- Capital - 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. Changes implemented under IFRS16 (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.
  The Trust is still forecasting we will deliver the £8.8m in total.
- Cash remains healthy and is expected to remain around the £80m value. The Trust is looking at investment options to maximise interest received.
- 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.

NM commented that as a Non-executive Director she sits in committees and gets to hear some of the conversations about the complexities, one of which AS has just shared around IFRS16, there are others around non funded pay. She felt as a committee we need to think about how we report this into board.

NM explained that the Clinical Governance & Safety Committee (CG&CSC) have moved complex incidents into the private part of the committee, and this is then shared in the private board, obviously for reasons around confidentiality those service users. She felt there was something here about the sensitivity on a political level, around what gets shared around the pressures we feel are in the system and AS has articulated this really well previously at board and here, how we balance that tension.
AS stated that it is a continual challenge to get the balance right, he said RA attended OMG last week and gave a fairly full and frank assessment of what we have just been through. He said previously we have had a softer approach, but we are now starting to provide them with evidence, and this is where we might want to take the Board. He remarked this month's performance should not cause alarm, but you can start to see the trends, we knew the pay award would be short funded, within the next month we can quantify this and say this is what it does to our underlying pay bill, and pay is fundamental to everything we do.
AS stated he was happy to take this through board and provide some of this context in the private session. He did not feel there was anything that they needed to take action on at this point in time, it was more a case of keeping them informed of the context.

RA remarked that we are developing the medium-term financial plan which he thought would be appropriate for private board, also some updates on the adherence to SFIs, and providing reports and information on those care groups that are overspending, and what is being done about this.
RA commented that during Covid the grip and control stuff was not as tight as it was prior to this as the focus had been more on operational, he stated it is now a case of getting back into that rigour, and this was the conversation that had taken place in OMG last week.

AS stated this is a really good point RA has made, he said both of them need to think about taking a medium-term financial plan through the board that does not cause them undue alarm but does start to flag the medium-term stretch within the finances.

NM commented that just thinking and learning from previous boards it is more around the grip and us questioning and making sure we are getting the governance right, also flagging early any issues and making them aware of what we forecasted was going to happen is starting to happen, so the board do not feel any surprises. NM felt it was a good habit and discipline to be asking ourselves here.

DW suggested that it might be that we add an extra 5 minutes standing item on the private agenda for any financial updates that need to be made. He asked AS & RA to take away an action from today's meeting around speaking with the rest of the executives at EMT and figuring out how best to keep everybody up to date.

ACTION: Adrian Snarr/Rob Adamson

AS replied that was fine, and something else he would like to do in this committee is once the system starts to share the financial positions of other provider organisations he would like to share that here for context. AS gave an example of 2 acute trusts in our patch that are delivering cost improvement programmes in excess of 6%, and ours is 3.4%, he said whilst it might sound tough and a big challenge for us, this is what other organisations are already doing. He said hopefully they can provide us with some evidence that they are delivering, and we can learn from them.

It was RESOLVED to NOTE the Finance Month 2 update.

FIP23/24 Financial forecast (agenda item 8)

RA clarified that himself and AS were working on some key numbers with a view to reintroducing this report in Month 3.

It was RESOLVED to RECEIVE the update on the financial forecast.

FIP/23/25 Financial sustainability (agenda item 9)

RA confirmed there was a paper within the pack that was originally shared and discussed with OMG on 14th June 2023. This has been updated to reflect those discussions and provide an update for FIP on the current status and progress, and it provides additional narrative and context to the VFM overview included within the main finance board report.

RA explained that OMG have oversight of sustainability and there are currently lots of individual workstreams already happening, not necessarily finance focussed, but they have a finance element within those, and it will be up to those workstreams to report into OMG and then escalate to EMT as appropriate.

RA stated that he has changed the terminology slightly so that it aligned with the board report itself, in terms of green, amber, and red indicators. He explained we have flagged that there is a level of CIPs that are green that are delivering and that do not present any risk for this financial year. He stated he has also tried to describe the schemes that he believes are amber at the moment, so we are saving money currently, but there is no guarantee we will continue to save money going forward. He remarked there are a whole raft of schemes that he is flagging as red at the moment, that have been identified as areas where we are going to push and explore. He stated as it stands he has not seen any evidence or information that confirms we have made a

saving or not, these have definitely happened, we are just not seeing the financial impact of these yet. RA felt we would definitely see an improvement in Month 3.

AS stated that part of getting that grip and making sure these schemes are properly documented also includes an equality impact assessment for each one of these, and it is making sure this discipline is put back in place before we sign off any finance efficiency programmes.
RA commented that this is the reason we wanted to keep the oversight within OMG because everyone around that table is involved, which enables us to get a rounded view of things.

CH commented that we did not do a quality impact assessment on the short-term incentive payment because it was only ever designed as a short-term incentive payment, and this has just stopped.
RA remarked that in theory once the work goes through we will do one on the overall pay savings /pay premiums scheme as a whole.
CH replied she did not identify this one as a scheme and this was something that should have stopped earlier, and it was stopped mid-summer.

NM stated are we saying we will continue to see that detail here at FIP.
RA replied yes, there will be regular updates on this to supplement the page that will remain in the public board paper, his intention is to feedback on progress, risks, and new schemes as we get them.

KQ asked RA if there was an inpatients versus non inpatient split within this document, as she felt that some service lines are more overspent than others, yet it is going to be the inpatient services where we are more overspent and where it is going to be tougher to make those savings. She asked do we need to clarify between inpatient and non-inpatient.

CH replied it is always inpatients, and prior to us moving into the care groups, this sometimes got a little bit lost in the overall rounding, and because of the difficulties in recruiting to the area and then the high use of temporary staff along with the acuity, that is where the overspend has always been against the budget. CH stated this is not something we accept, and we work really hard to try and get the establishment and environment right, but it is something we have been struggling with for years pre Covid.

KQ remarked that it is obvious this is going to be our costliest bit and where we are going to struggle most, and therefore the need for the QIA is vital.

AS stated that we do have financial pressures in inpatients as CH has described but that does not necessarily mean we then disproportionately try to take funding back out of inpatients. He explained we have not set a financial plan that says we need a 3% CIP, so it is 3% off every budget line, what we have said is we need a 3% CIP, and how can we deliver that, and you can see there are some differentials in there. He remarked that those differentials are particularly taken into account at OMG, as there are some things we may need to manage at care group level, rather than at cost centre level, or budget holder level.

KQ thanked AS for the update which explained clearly that the main focus is to genuinely look and maintain quality and safety, whilst also trying to make those savings.

CH commented that when we have vacancies or gaps in inpatients we have to cover them because of safer staffing and we have to keep the environment safe, and we do not do the same in the community, so we would run with vacancies in a community team, which is how we end up overspending. She stated we do try hard to monitor the impact in the community but again this may be something we need to cover more in CG&CSC.

NM remarked that although it is worth us considering, she did not want to get into a great amount of detail here, as it raises the issue about safer staffing and how we do that in the community, which we have as a regular conversation at Board. She said she is not dismissing it and it might be a good prompt for 'are we really pushing around this enough'.

KQ stated this is a really helpful paper, she asked if there was a broader sustainability piece which is about productivity that uses our internal/external benchmarking.

AS replied yes and this is it, but we are not there yet, He explained that in this financial year we have gone from zero to 50% and we need to get back up to 100%, and all of these things will have been considered previously pre covid. He stated the way funds have been distributed over the last 3 years, service lines have changed, and we now need to review them all.

It was RESOLVED to RECEIVE the update on the Financial Sustainability

FIP/23/26 West & South Yorkshire Collaborative Financial Updates (agenda item 10)

RA stated this is a regular standing item, he apologised for the paper being incomplete at the time of finalising is. He stated he is now in a position to share with the Committee accordingly the information on CAMHs and the Adult Eating Disorders.

RA stated that the West Yorkshire Adult Secure Collaborative financially is fine and is forecast to deliver a surplus this year, which will then flow out into the risk reward share.
He stated the other ones however look like they are going to be financially challenging this year, so CAMHs and Eating Disorders both have deficits for the year to date and are forecasting continued deficits throughout the course of the year, driven by activity, exceptional packages of care and basically being able to deliver the services that they are trying to deliver. He stated there are lots of operational/staffing issues, closures of beds, in cases linked to all of this and these will remain challenging and will become more explicit as we go through the year.

RA stated that South Yorkshire Collaborative is showing as a surplus as at year to date, but following further review it should have shown a bigger surplus, but it is actually forecasting to be a deficit. RA remarked there are pressures in the system, and we just need to keep validating the numbers.

AS stated that on the South Yorkshire collaborative, there is quite a bit of variability, and to provide some assurance, they do have an investment reserve for the community pathway, which may result in them having to scale back their aspirations if we cannot get it to balance.

It was RESOLVED to RECEIVE the update on the West & South Yorkshire Collaborative Financial Updates

FIP/23/27 Costing Update (agenda item 11)

RA stated that normally by this time of year we would be getting ready to take an update to Audit Committee on where we are with the National Cost Collection. Currently as it stands we do not have definitive plans, timescales, information for the 2022/23 cost collection, neither do we have a final result for the 2021/22 cost collection. He said we would normally be submitting late summer, this year it may be nearer Christmas, which will then roll us into another year.

RA remarked there has been no noise nationally that they are going to cancel it, but it does feel like it is a significant challenge. He confirmed the team are involved in all the national forums and checking on progress and he will keep the committee updated.

DW commented that other than just delays are there any other real impact on us. RA replied that the problem for us is that we have not got the outputs from 2021/22 to be able to start to compare,

and the versions that have been shared have had such considerable swings it is not useable information as it stands.

AS confirmed there are two impacts, one is on the costing team, as mentioned before we have a big project underway on Patient Level Costing (PLICS) and this uncertainty on national guidelines is impacting on that. The other area is, understandably all our Place based leads are interested in our costing information, and that is probably going to be most relevant in Barnsley, as it sits outside the West Yorkshire ICB and has a financial challenge, and it wants us to reconfirm that the funding they give us is expended in Barnsley. He stated it is not causing a huge problem at the minute, as they are being patient, but some robust costing submissions would help with this, failing that, we will share the internal work we have been preparing for them.

DW thanked RA for all of his updates.

I**t was RESOLVED to RECEIVE the Costing update.**

FIP/23/28 Commercial decision on Calderdale Talking Therapies (agenda item 12)

A detailed conversation was had relating to the financial and service elements of this potential tender submission.

I**t was RESOLVED to RECEIVE the update on the Commercial decision on Calderdale Talking Therapies, and the Committees RECOMMENDATION to support further investigation to bring to Board.**

FIP/23/29 Monthly Performance Review (agenda item 13)

AS provided the update stating the Committee may recall that when we set out the plan for the IPR development we had a particular challenge around workforce data, in as much as it did not flow through the data warehouse within the organisation, and it was dealt with exclusively within the People Directorate. As part of that transition, it was agreed we would start to feed information into the data warehouse and start to look at the standard operating procedures.

AS stated that following further work with GMs team it was also identified that we had a single point of failure, whereby nearly all of the workforce information extraction was being done by one individual. He explained that we were putting plans in place to improve resilience but this identified some immediate challenges so we have spent the last couple of weeks reacting to ensure all necessary submissions could be made.

AS stated that we had 6 benchmarking reports in the pipeline, a couple of NHS England survey reports around staffing, and our monthly NHS England workforce stats. As an organisation we are really committed to benchmarking so we did not want to miss any, but when some of those benchmarking reviews close, they close, and therefore you cannot participate if you have not sent your data through.

AS explained that in support of GMs team we have taken the work into the P&I team on a reactive basis, which we have successfully managed to submit all the benchmarking reports that were due, we had a few challenges around validating and quality assuring, but we got them all to a good standard for the deadlines. This has started to impact on the day-to-day work of the P&I team, so it has put them off plan slightly, we now just need a couple of weeks stabilisation, mainly because we need to do the IPR for the Board which has a huge amount of workforce data in it. He said once we get this out of the way Mel Wood and her team are going to come up with a sustainability plan for the next 6-9 months, which will involve the transition to the data warehouse, and a clear sign off process with GM and the People team as to what the key milestones are.

AS remarked that he has also asked MW to assess whether there is any impact on the IPR development work, there has not been to date but there could be in the next month or so, so we may need to get some resources to get this back on track.

AS remarked we are a bit on the back foot with some of this at the minute, but we have an improving situation, he felt it was important to flag it here because we have a key role in performance and benchmarking, and he is aware we have been very finance heavy with the agenda today. We have also had to look at the risk and business continuity associated with this, and although we have stabilised it now, it has been a tricky couple of weeks for the P&I team. AS commented that we are due to move to the new IPR for national indicators, which will still to flow through to the Board this time, but we also need to make sure that the next phase has not been knocked back because of this.

AS remarked that he partly wanted to apologise for today because we were due to give a more substantive update on benchmarking, and hopefully for the committee to support us to stabilise and then build again. He said what it should mean as part of this recovery plan is that we just have to re-sequence, because transferring this workforce data was always part of the plan, we have just had to do it slightly quicker than we intended to.

DW commented that single points of failure are always tricky, but it does create that forced challenge and change at times.

AS commented that the good news is because we got the benchmark returns in, once the Benchmarking Network process them we can put them in the annual plan, he said we will add this to the workplan for next month.

ACTION: Adrian Snarr

AS commented that on the monthly performance review, the committee will see in the actions that himself, CH and MW have a scheduled catch up so they can agree what we want to deep dive on, we will bring a proposition back on this next month also.

I**t was RESOLVED to RECEIVE the update on the Monthly Performance Review**

FIP/23/30 Waiting List Report (agenda item 32)

CH provided the update stating that this is the report that CG&CSC used to see and was recommended to bring to this committee. She stated we need to work on the timescales as this is the April data report, as the team had planned them out around CG&CSC meetings, so it was due to go to the last committee. CH confirmed this is the latest version that we have, and that the team publish it alternative months now.

CS explained that the quality impact will still go through to CG&CSC and there is some work ongoing in the Clinical Governance Group around how we support people that are waiting so that we can bring some assurance back through CG&CSC.

CH stated in relation to this report work is still ongoing around the following improvements:-

- Still reviewing the numerator and denominators for each of the waits
- Working on better analysis in each of the services which will then support a better narrative that starts to come through to committee. Started to use the AAA style within the report but there is still more work required.
- Recently included deprivation data alongside ethnicity monitoring, and we need to understand more about the disproportionate impact on people that are waiting, we also need some improved assurance around what we do when people are waiting.

CH stated the specific areas to note in this report from the services are:-

- Adult ADHD continue to see a higher rate of referrals than commissioning cases, much higher than the rate NICE have estimated would need to be commissioned for.

  Where 2 waiting lists are noted, it is a risk prioritisation, which has been agreed with commissioners. Although there seems to be no disproportionate impact for people who wait, deprivation data shows that there is a slightly lower representation of individuals from the most deprived areas being referred for assessment. This may indicate that there is a greater level of awareness of ADHD in less deprived areas. The service will give this further consideration.
- Improvement has been maintained in Barnsley CAMHS and most children are seen within 3 months. CH stated she would like to caveat this by saying we would like to see them sooner, but in terms of improvement they have been sustained.
- Calderdale and Kirklees core CAMHs are each seeing a large proportion of children within 3 months and most children within 6 months.
- Wakefield has seen a sudden increase in the number of children waiting and although they see the majority of children within 6 months. Staff absence due to sickness has stabilised recently and this will help to address waits.
- Both the total number of individual children waiting and the average length of wait for the CAMHS neurodevelopmental pathway in Kirklees are increasing. Demand and capacity modelling is taking place as part of the improvement work to ensure that the pathway from referral to a completed assessment is efficient and effective as possible. CH stated that board members will be aware that we have some support from an external provider to help us to address these waits.
- The measure for learning disability is that service users have been assessed, have a completed care package, and commenced treatment within 18 weeks. Performance for the assessment is generally very good with the assessment being completed within 2 weeks for almost everyone. Staffing capacity then impacts the care package being delivered. Improvement work alongside recruitment is underway to improve this position. Welfare checks are made to ensure that people are supported as they wait.
- All patients on the core psychology waiting list have already received the 6 weeks psychology induction / assessment and exceptionally long waiters are waiting for a specific, longer term treatment modality (for example eye movement desensitisation and reprocessing - EMDR).
- Patients awaiting psychology remain on the core team caseload and have access as appropriate to support in a crisis and mental health outpatient care. A digital appointment may have been offered but patients may prefer face to face therapy.
  Support from a private provider has been secured to address waits for secondary care psychology.
- The integrated performance report has reported pressures on waits for paediatric audiology. This has recently been included in the waiting list report and further work is taking place on the reported data and the narrative. The service has confirmed that a plan is in place to address the waits by October 2023.

NM thanked CH for the update, she asked in relation to the ongoing work around the referrals around deprivation, when can we expect that to come back and where.

CH replied this is a really good question and it is something we need to look at wider, she said she was happy to have a think about a date and then report back to the committee.

ACTION: Carol Harris

CH stated she was confident that the Adults ADHD team will be able to put some narrative in next

month, but this is a bigger issue we have probably not considered.

NM commented that for context, the development of this report has been to CG&CSC before it has been brought here, and it is great that we are now managing to monitor around ethnicity and deprivation and this is a step in the right direction, if we are going to measure it then we need to be clear what our learning is. She said it is likely that if we manage to find some learning around referral rates and deprivation that we will be able to learn this on a broader footprint, so this makes sure we capture it, and it does not get lost.

KQ stated this work is really important and she wondered what the role of Equality, Inclusion & Involvement (EI&I) committee has in this, and as their role is so big there is always a danger of things slipping, so for her it was about the links with other committees.

CH commented that she agreed with KQ in that we do not want to lose this and although she does not attend that EI&I committee they do look at the overall dashboard. She wondered if we start with either the waits or the demand information, so for each stream look at the referral demand so we make sure we can clearly break this down by the inequalities data. CH asked if that data was brought back to the committee do they think that would help, and further discussion could take place.

KQ replied yes this would be helpful.

KQ remarked that in relation to deprivation CH had mentioned that this data shows a less take up from certain individuals in the 20% most deprived, yet there is another table that shows there is a higher representation from people in the 20% most deprived. CH said she would check this.

ACTION: Carol Harris

NM remarked that as this report is getting more developed, the executive summary left her asking more questions, it talks about it as a risk prioritisation around the Adult ADHD, and what does that mean, in terms of what we could expect to happen as a result of that. She said there are a few comments like this that are there as reassurance rather than assurance about what we are doing, she said she appreciates this is a report that is still being developed.

NM commented there was also another example around conversations with stakeholders and discussions around referrals, and again what does that mean then for us as a committee, is there anything happening as a result of this. She said it is that extra layer of what exactly does that mean and what is happening that will really help strengthen the executive summary of the report. NM remarked that she hopes her comments have been helpful.

CH thanked NM for her comments, she said she will think about this and try and balance it better next time.

DW commented that the only thing from his point of view is the increase in waiting lists and is this picked up on a risk register. CH replied that it is.

DW asked does this require FIP oversight of this.

NM stated that there is an action at CG&CSC, which is with Marie Burnham (MB), Chair, as there was a lengthy discussion at the May meeting around risks and where do they sit, and is it across more than one committee, and it led to a broader view for MB to take that discussion to Board.

NM says there is an action around how do we get a bit smarter about being able to see the risks and where do we align them specifically to different committees.

DW stated it is worth keeping as an action, and although there is nothing specific for this committee it is more for awareness.

DW stated this was a very helpful report and he thanked CH for sharing this.

I**t was RESOLVED to RECEIVE the Waiting List Report update.**

FIP/23/31 Workplan (agenda item 33)

DW commented that the only thing he would ask is that AS & CH build the waiting lists update into the work plan on a recurring basis.

ACTION: Adrian Snarr/Carol Harris

FIP/23/32 Any other business (agenda item 34)

NM commented that she had sent DW an email around appraisals that she wanted to raise at the meeting today. She said she appreciated DW had probably not got round to looking at this yet due to annual leave. There had been a discussion at CG&CSC around appraisals and there was a specific action for her to pick up with DW at FIP around appraisal data.

NM stated this is around finding out that there were 2 wards that had 0% appraisal compliance and the question is, how has that happened from a data reporting point of view. She said it is not to talk about at length here but more to ask can we have more scrutiny around how we report appraisals, as when it has been aggregated it has been missed, so there is something around learning here, and how did we not know through our reporting systems that we had 2 wards that had 0% appraisal completion.

AS commented that there have been several conversations about this and the data does exist, it is how do we draw it out to people's attention that can take some actions on it. He said we did stray into a slightly broader conversation of aggregation of targets. Appraisals was central to this because of the CQC data request but there could be other areas where if we over aggregate we might look like we are okay, but we are masking pockets of challenge. AS confirmed there is work ongoing with CH and the care groups, and we need to figure out how best to flag this.

DW asked if it was worth bringing this back as an action to this committee in a couple of months time to understand how we are going to manage this and get visibility in the right way.

ACTION: Carol Harris

Significant issues to report to the Board of Directors

Alert

Pay award agreed nationally was in excess of what we had put in budget which has created £2.5m cost pressure. Will need to find savings which is likely to come from nonrecurrent items this year.

Assure

- Review financial risk rating, yes, it is low and feels strange, this is because it is looking at the shorter term where we are okay this year. There is certainly a longer-term potential challenge. There is an action as to how we keep the Board alert of future challenges.

Revise

- Capital training to be conducted at the end of the July Board meeting.
- Agency working group oversight being reported into PRC.
- Mostly on track with CIP programme, and all items are receiving equality impact assessments.

- Delays on national costing collections
- Waiting list brought to committee for first time.

Action

- How we manage the risk scores in terms of short/long term etc
- How are we going to report that £2.5m cost pressure without changing forecast.
- How are we going to keep board aware of the risks and issues in the private session.
- Inequalities analysis on the waiting list report
- Any actions that cross over
- Data drill downs

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 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** **Dawn Lawson – Director of Strategy & Change**		
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):	• 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 • 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. • 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. • 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 26 September 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 6th September 2023 Key items discussed included: • Story Telling: Workforce. This focused on international recruitment. • Chair's report. • Chief Executive report. Key updates included: o The NHS South Yorkshire Joint Forward Plan was submitted to NHS England on 1 July 2023. A final version of the plan will be published at the time of the ICB Annual General meeting in September 2023. o An independent inquiry has been announced by the Department of Health and Social Care into the events at the Countess of Chester Hospital. o Industrial action continues to take place in South Yorkshire for staff not covered by the Agenda for Change contract. o The NHS Long Term Workforce Plan was published at the end of June. o The process for winter planning, and flu and Covid-19 vaccinations has commenced. o In March NHS England announced that the running cost allowance for ICBs will be reduced by 30% by the beginning of 2025/6. The ICB will be consulting formally on the new organisation design with staff in September and October. This will then be followed by an organisational change process to introduce these new arrangements.

	• Questions from the public.
	• Place reports.
	  o Sheffield
	  o Barnsley
	  o Doncaster
	  o Rotherham
	• 2023/24 NHS South Yorkshire Financial Plan.
	• South Yorkshire ICS Equality Diversity and Inclusion update.
	• Integrated Performance Report (IPR)- an update was provided on key performance risks and mitigation plans.
	• Assurance Committee minutes.

Date of next meeting	Next meeting in public is scheduled for 1st November 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 13th September 2023
	
	Key items discussed included:
	
	• Lived experience story.
	• Managing Director report. Key updates included:
	  o Mental Health Strategy which will follow the existing Long Term Plan.
	  o NHS Confederation Report "The state of integrated care systems 2022/23: Riding the storm".
	  o Major Conditions Strategy.
	  o Perinatal mental health- there was an opportunity to host six more perinatal beds in the Yorkshire & Humber region. Following NHSE's formal review process the decision was to support the proposal from Leeds and York Partnership NHS Foundation Trust (LYPFT) to site the six additional mother and baby unit (MBU) beds in Leeds as an expansion to the existing MBU service at the Mount Hospital, co-located alongside other specialist Mental Health inpatients wards. Implications for the South Yorkshire population are being considered and partner representatives will be part of the governance structure that is being developed.
	• Deliverables for the four objectives
	  o Neurodiversity
	  o Health based place of safety

	○ Learning Disabilities – community of practice and stopping over-medication of people with a learning disability, autism, or both (STOMP) • SY Provider Collaborative Operating Model. • Future commissioning role for the provider collaborative ○ Co-commissioning approach to eating disorders. ○ Commissioning Hub arrangement. ○ Longer term development of commissioning. • ICB Feedback. • Parity of Esteem. • Updates by exception.
Date of next meeting	Next meeting scheduled for 8th November 2023.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	Update from meeting on 31st August 2023 Key items discussed included: • Questions from the public. • Place Director update and Place achievements. ○ This is the second year that Barnsley have supported national Creativity & Wellbeing Week, led by the Culture Health & Wellbeing Alliance. ○ From 31st August Barnsley will be launching a pilot of family hubs. ○ £2.4 million investment has been announced for Barnsley Hospital as part of the national NHS urgent and emergency care recovery plan ○ Anna Hartley will be joining Barnsley Council later this year as the new Executive Director of Public Health and Communities • Primary Care Branch Surgery Closure Report - Barnsley Place ICB have received two applications for branch closures, both from practices requesting to close their branch sited at The Roundhouse Medical Centre, Wakefield Road, Barnsley, S71 1TH. The Primary Care team have been completing due diligence in respect of the applications to consider potential commissioning implications and working closely with key stakeholders including patients and other practices and services in the locality who may be impacted. • Committee minutes and assurance reports. • Updates and escalations from partners.
Date of next meeting	Next meeting scheduled for 28th September 2023.
Minutes	Papers and draft minutes when available Barnsley place public board meetings :: South Yorkshire ICB

Barnsley Place Partnership Delivery Group

Member	Interim Director of Strategy and Change

Items discussed	Update from meeting on 12th September 2023
	
	Key items discussed included:
	
	• Programme update/Highlight Report. This included:
	  o Update on place plan actions.
	  o Focus on respiratory and cardiology.
	  o Mental health out of area placements- psychiatric intensive care unit (PICU) and locked rehab – a task and finish group has been established.
	  o Impact of neighbourhood nursing – impact of developments are being considered, for example on hospital admissions.
	  o Involvement and equality, diversity, inclusion work.
	• System risk and quality issues.
	• Barnsley Strategic Estate Plan- the current position regarding the strategic estate planning for the NHS and partner health and care estate in Barnsley was shared.
	• Neighbourhood update.
	• Place Partnership Delivery Group Terms of Reference annual review- refreshed terms of reference were shared for agreement.
	• Draft agenda for Barnsley quarterly review meeting on 2 October 2023.
	• Escalations from other subgroups.
	• Escalations for Partnership Board.

Date of next meeting	Next meeting scheduled for 10th October 2023.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair and Interim Director of Strategy and Change

Items discussed	Update from meeting on 30th August 2023
	
	Agenda items included:
	
	• NHS Joint Forward Plan for South Yorkshire.
	• LD Health Checks.
	• SMI Health Checks.
	• Frailty & Dementia.
	• Partnership Working with Social Care:
	  o Urgent Response Integrated Service Offer.
	  o Cudworth Co-location Project.
	• Alliance OD – Stage One Report.
	• Key Messages for Place Based Delivery Group.

Date of next meeting	Next meeting scheduled for 27th September 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
26 September 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:	**Mark Brooks- 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 where 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):	• 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. • 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. • 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 • 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 the former clinical commissioning groups and leads the integration of health and care services across West Yorkshire. The partnership continues to develop the governance arrangements, which will be reviewed and adapted as they bed in. Formal reviews 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.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:** • **West Yorkshire Health and Care Partnership;** • **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** **and RECIEVE the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 September 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 where the Trust provides services (Calderdale, Wakefield, Kirklees).

From 1 July 2022, NHS West Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of the former clinical commissioning groups and leads the integration of health and care services across West Yorkshire.

The partnership continues to develop the governance arrangements, which will be reviewed and adapted as they bed in. Formal reviews 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 19th September 2023 Agenda items included: • People at the heart of Integrated Care Board (ICB) decision-making one year review. An update on progress in ensuring that people and communities of West Yorkshire are central to the ICB's decision making. • Focus on the Mental Health, Learning Disabilities and Autism Sector in West Yorkshire. A paper for this item can be found in the meeting papers. • Chair's report. • Chief Executive's report. • System performance. • Winter planning 2023/24. • Committee 'AAA' reports. • Governance. ○ West Yorkshire ICB Transformation Committee / Bradford District and Craven ICB Place Committee Terms of Reference. ○ Governance approach for older people's mental health in-patient reconfiguration across Calderdale, Kirklees & Wakefield Places.
Date of next meeting	Next meeting scheduled for 21st November 2023.
Further information:	NHS West Yorkshire ICB Board Meeting - 19 September 2023 :: West Yorkshire Health & Care Partnership

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 5th September Agenda items included: • Update from the Partnership Chief Executive Lead. Key updates included: ○ The government has ordered an independent inquiry into the circumstances behind the events at the Countess of Chester Hospital. An open letter to staff employed by the NHS West Yorkshire ICB has been issued to reinforce the fundamentals of the freedom to speak up. ○ Industrial action has continued throughout the summer. Doctors in training, consultants and the

	Society of Radiographers have all taken strike action on a number of periods in June, July and August 2023. A significant amount of work has continued across the whole system to mitigate the impact of strike action and keep people safe, including the running of urgent and emergency care. ○ Winter planning. • Partnership Agreement between the West Yorkshire Combined Authority and the NHS West Yorkshire Integrated Care Board- members of the Partnership Board were asked to note the final, signed version of the Partnership Agreement • Patient and public voice. • West Yorkshire People Board Update. • Partnership ambitions.
Date of next meeting	Next meeting scheduled for 5th December 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-5-september-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 12th September 2023 Agenda items included: • Chair's update- it was advised that the West Yorkshire ICB Board meeting taking place on Tuesday 19th September will have a focus on the mental health, learning disability and autism sector. • Adult mental health- NHS 111 for mental health crisis- a presentation was given providing a summary of progress in West Yorkshire with the implementation of 111 for mental health crisis. NHS England have confirmed that local crisis numbers can continue to be advertised in addition to NHS111. • Maternal Mental Health- it was confirmed that SWYPFT will be the Co-ordinating Provider and work is progressing to develop job descriptions and to recruit to the recurrent service.

	• Perinatal Mental Health (PMH). Leeds and York Partnership NHS Foundation Trust (LYPFT) has been confirmed by NHSE as co-ordinating provider for PMH across Yorkshire & Humber. 6 additional Mother and Baby Unit (MBU) beds will be built at The Mount in Leeds taking total capacity to 14 – there will be a need to focus on equity of access across the full geographical footprint. • Mental Health and Wellbeing Hub. The Annual Report was shared. Bradford District Care NHS Foundation Trust have been confirmed as 'host' for the Hub, but are waiting for flow of funds and contract from West Yorkshire ICB to be confident of taking forward co-ordinating provider status. • Workforce- updates were shared on the expanded role out of cultural competency and humility training, positive reflections from the Peer Support Worker Conference and lived experience videos for people to share with staff. • Secondary Care Pathway. • Transforming Care Programme. A report into the supported living accommodation needs of people with learning disability and/or autism and people with severe mental health issues was shared. A session is planned in October for places and local authority planning and housing colleagues to come together to understand the need summarised in the report. • Planning and performance. • Escalations from other workstreams.
Date of next meeting	Next meeting scheduled for 10th October 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	Update from meeting on 7th September 2023 Key items discussed included: • Report of the Place Lead. Key updates included: o Launch of the integrated care strategy and joint forward plan- the Five-year Integrated Care Strategy and NHS Joint Forward Plan are now available to view on the Partnership's website https://www.wypartnership.co.uk/publications. o NHS West Yorkshire Integrated Care Board – Freedom to Speak Up. Following the recent

	Lucy Letby case, Freedom to Speak Up has been highlighted as a way that staff will be heard as part of a culture of positive reporting of incidents and issues. ○ Anna Hartley, Director of Public Health is due to leave in the autumn to take up a new role. Steve Turnbull has been appointed Interim Director of Public Health for Wakefield District. ○ The Big Conversation report has now been published. ○ The Proud to Be You campaign has been developed by the People Alliance's Belonging Group as a toolkit to help all partner organisations explain to colleagues why they should update their equalities information on their HR systems and what this data is used for. ○ Wakefield District Health and Care Partnership People Plan has been launched. ○ Wakefield District Safeguarding Adults Board (WDSAB) Annual Report for 2022-23 was shared. • Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative). ○ The TDC will oversee the delivery of the 3-year Transformation Delivery Plan on behalf of the Wakefield District Health and Care Partnership Committee. ○ A number of Alliances and Programmes have volunteered to test out a new maturity matrix which has been co-designed to support all types and sizes of partnership groups to accelerate the benefits they can deliver for their populations. ○ The latest quarterly figures on maternal smoking released at the end of July show that for this quarter it has fallen to 12.1 per cent. • High risk adult update ○ High-risk adult (HRA) patients are those with a previous hospital admission in the last three years that exceeded 14 days. ○ There is an opportunity to use data to try and identify the precursors and shift the intervention model further to the left. • Mental Health Inpatient Service – Calderdale Kirklees and Wakefield Joint Committee. The committee endorsed the recommendation to establish a Joint Committee of Calderdale, Kirklees & Wakefield, by the WYICB Board as a decision specific WYICB Board sub-committee. • Winter Resilience 2023- Four priority areas selected for winter for Wakefield District are frailty, inpatient flow and length of stay (LOS), intermediate care demand and capacity and single point of access.

	• Summary of 2022/23 quarter 1 quality, safety and experience report. • Performance exception report- Autism Spectrum Disorder (ASD) waiting times continue to remain high. • Finance update. • Wakefield Place risk register.
Date of next meeting	Next meeting scheduled for 2nd November 2023.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk) https://www.wakefielddistricthcp.co.uk/wp-content/uploads/2023/08/WDHCP-Committee-7-Sep-23-Meeting-Pack-1.pdf

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	General Manager, Wakefield Community Services
Items discussed	Update from meeting on 15th August 2023 Key items discussed included: • Escalations from alliances/programmes. • Children's Observation Hubs business case. • Outcomes framework update. • Transformation Delivery Plan –highlight report template. • Overview of performance report. • Housing and health action plan. • Update on the development of integrated neighbourhood teams. • Items for escalation to Wakefield District Health & Care Partnership Committee.
Date of next meeting	Next meeting scheduled for 26th September 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	The planned agenda for the meeting on 20th September 2023 is as follows:
	
	• Mental Health Alliance Dashboard.
	• Standing item updates.
	  ○ Mental Health Emergency Dept Strategy Group.
	  ○ Older People and Dementia Group.
	  ○ Community Mental Health Transformation.

	○ NHS 111 roll out. • Mental Health Alliance stakeholder meeting update. • Partner updates ○ Nottingham Community Housing Association - update on the WY crisis line ○ Deep dive into Health Checks for people with severe mental illness. • Review of Mental Health Alliance Terms of Reference • West Yorkshire Supported Accommodation Assessment • Mental Health Alliance next phase • MHA Maturity Matrix • Partner updates. • Wakefield Transformation and Delivery Collaborative feedback. • Wakefield District Health and Care Partnership Committee feedback. • West Yorkshire MHLDA Partnership Board feedback. • Alliance Forward Plan.
Date of next meeting	Next meeting scheduled for 18th October 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting on 12th September 2023 Key items discussed included: • Reducing Health Inequalities. ○ CORE20PLUS5 update. ○ The Rosalie Ryrie Foundation. • Domestic Abuse ○ Breakthrough presentation. ○ Health impact on children. ○ 0-19 Service. ○ Focused discussion with partners. • Pharmaceutical Needs Assessment. • Wakefield Corporate Plan. • Wakefield District Adult Safeguarding Board. • Annual Report 2022-2023. • Strategy 2023-2026. • Overview and Scrutiny Committee papers.
Date of next meeting	Next meeting scheduled for 23rd November 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 Development Session on 20th July 2023 Agenda items included: • Public questions • Health inequalities in Calderdale- a reality. Several stories were presented. Key themes arising from these were challenges navigating the system; need for personalisation, holistic approach and flexibility; need for alignment between different parts of the system; essential role of VCSE. • Transformation delivery plan- the Board was asked to review and comment on the Calderdale Transformation Delivery Plan (Forward Plan). Nine priority areas were agreed (Delivering Fuller, Primary Care and Community Services, Hospital Reconfiguration, Urgent and Emergency Care, Transfer of Care/Discharge, Elective Care, Mental Health, Learning Disabilities, Cancer, and Maternity Care Transformation). • Place lead report. • Risk register. • Place Quality & Safety report. • Place finance report. • Place Performance report. • Work plan.
Date of next meeting	Next meeting scheduled for 28th September 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	Interim Director Strategy and Change
Items discussed	Update from meeting on 14th September 2023 • Golden Threads – A 'follow up' intervention for high-risk public locations in Calderdale. Work is underway to ensure any person who presents at a public place in Calderdale in a state of distress is supported to have their needs met. Next steps include developing the service specification for Golden Threads service, ongoing discussions around professionals who could deliver elements of the services and commissioning/contracting arrangements. • Gateway to Care.

	• Health and Wellbeing Board Report.
	• Non-recurrent funding 23/24.
	• Discharge to assess business case.
	• 3CPB Workshops update:
	  ○ Entity Development Subgroup
	  ○ Neighbourhood Development Subgroup
	  ○ Estates
	  ○ Workforce

Date of next meeting	Next meeting is scheduled for 12th October 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	Update from meeting of 24th August 2023 Items discussed included: • Health and Wellbeing Board - Membership August 2023. • Health and Wellbeing Strategy - Developing Well. The Director, Children and Young People provided an update on the Health and Wellbeing Strategy, Developing Well and gave a presentation which outlined the Calderdale Hopes and Aspirations following a feedback workshop from the Ideas Alliance. • Better Care Fund Calderdale Narrative- the Better Care Fund narrative plan template 2023–25 was endorsed. • Buying Our Care - Integrated Action Plan- Improving Cultural Health. This was endorsed. • Inequalities in Health and Adult Social Care. • Neighbourhood Partnerships. • Health and Care priorities update.
Date of next meeting	Next meeting is scheduled for 13th October 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 has a signed Collaborative Agreement.

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 13th September 2023.
	
	Items discussed included:
	
	• People story- this focused on men's mental health.
	• Kirklees Community Services – assessment process outcome and next steps. The recommendation to directly award contract/s, in line with the outcome of the assessment process, to the West Yorkshire ICB Finance, Investment and Performance Committee was agreed subject to a number of actions including agreement performance metrics and improvement plans. The request for a tender waiver to support the direct award of contract/s was agreed.
	Home First Discharge- an update was provided on how the model will support more people to go home first alongside providing an optimal temporary community bed base for those in need of further recovery time prior to going home. The Committee supported the repurposing of the existing funding for implementation of the 2023-24 Home First Discharge model.
	• Governance approach for Older People's Mental Health In-Patient Reconfiguration across Calderdale, Kirklees and Wakefield Places. The Committee endorsed the recommendation to establish a Joint Committee of Calderdale, Kirklees and Wakefield, by the WYICB Board as a decision specific WYICB Board sub-committee.
	• Accountable Officer's Report- this focused on a number of areas including:
	  ○ Integrated Care Board Operating Model and Running Cost Allowance
	  ○ Cataract Referral Management Scheme
	• Kirklees Place Quality Report.
	• Finance update.
	• Performance Report against Key Performance Indicators for 2022/23.
	• High Level Risk Report.
	• Items for the Attention of the ICB Board.
	• Committee Work Plan.
	• Receipt of Minutes.

Date of next meeting	Next meeting scheduled for 8th November 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 7th September 2023 Items discussed included: • People stories. • Kirklees Health and Care Plan- an update was given on the development of the life course approach and implementation. • Director of Public Health Report – Poverty Matters. A summary of the report was received. • Work plan.
Date of next meeting	Next meeting scheduled for 5th October 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development

Items discussed	The July meeting of the Health and Wellbeing Board was cancelled.
	
	Update from meeting of 29th June 2023
	
	Key agenda items included:
	
	• Director of Public Health Report- this was presented. The report captures lived experience and insights gathered in winter 22/23. Key themes include challenges with household bills, food costs, travel costs, mental health, housing, social isolation, support from other and work opportunities, protecting family, but also a key theme of hope things would get better. Examples of recommendations were shared e.g. promoting uptake of support/financial assistance, considering how to embed support with rising costs into clinical pathways, and Poverty Aware Practice training.
	• Kirklees Health and Wellbeing Strategy update- an update on progress was shared.
	• Connected Care update- a system- wide event has been held focusing on discharge planning. Ongoing work has been taking place around the community services contract.
	• Healthy places priority- progress updates were shared. These included:
	  ○ Examples of groups in the community.
	  ○ Local partner updates to develop range of spaces and activities to promote physical activity and emotional wellbeing.
	  ○ An example of an affordable food initiative.
	  ○ Safe and active travel.
	• Health and Care Plan Update- the approach to the plan development was outlined via a system planning group.

	Starting well, living well, aging well are the three strategic themes to the Plan, with mental wellbeing and dying well crosscutting all. • West Yorkshire ICB Forward Plan update- the Forward Plan will be launched in July 2023. • West Yorkshire Climate Change Strategy. • Local Declaration on Tobacco Control- Kirklees Council have signed up to the Local Declaration on Tobacco Control.
Date of next meeting	Next meeting scheduled for 28th September 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 4th September 2023 Key agenda items included: • KDC Proposed Workplan. • Provider Selection Regime Commissioning Process. • Starting Well Programme Update. • Services in the Community.
Date of next meeting	Next meeting scheduled for 2nd October 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 18th September 2023 Agenda items included: • Patient story • Deep Dive – Crisis Transformation • Programme highlight reports (by exception) • CLEAR Working Better Together updates and annual report. • New ICB Operating Model. • Key points for the next meeting. • Future plans.
Date of next meeting	Next meeting scheduled for 30th October 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
26 September 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**		
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):	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 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 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. 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. The Adult Secure Provider Collaborative Board has continued to meet, and the collaborative have progressed among a range of items: • Development of a performance matrix for forensic community services, to support oversight and monitoring. • Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned. • Development and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway has been a key focus and the Women's Pathway work has commenced. Planning has commenced with Research and Development to understand how the collaborative develop an evidence base for change undertaken through our workstreams. • The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Work with the West Yorkshire Complex Rehabilitation Programme to explore opportunities for joint working. • Work to understand variance between PICU (psychiatric intensive care) and adult secure pathways. • Work to improve the interface with prisons, improving assessment and transition processes. • Involvement in national work to revise the secure service specifications. • A project to consider how patient reported experience measures are captured across the collaborative, working with the Yorkshire and Humber Involvement Network. • A training and development project focussing on how West Yorkshire adult secure providers can collaborate to develop a secure care training programme – developing clinical skills, shared cultures and approaches to care. For the 5 months to August 2023 the collaborative operated with a financial surplus. The Adult Eating Disorders Provider Collaborative reported a deficit at month 5. A year end deficit position is forecast.

	The Children and Young People's collaborative reported a deficit position at month 5, largely due to an extraordinary, high cost and complex package of care. A year end deficit position is forecast. **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. This has been reviewed by the Commissioning Hub and discussions with NHSE/I remain ongoing. The Partnership Agreement has been updated and will be shared with partners for signature once the Lead Provider contract has been agreed. The Hosting Agreement for the SYB Commissioning Hub has been signed by the Trust. A year-to-date deficit is reported. **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. Expressions of interest were invited from West Yorkshire Trusts wishing to be Coordinating Provider for the Maternal Mental Health (MMH) service. The Trust put forward an expression of interest and have been confirmed as Coordinating Provider. Initially the MMH service will be commissioned by the WY ICB, with a plan to transfer to Coordinating Provider arrangements with the Trust from April 2024. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECIEVE and NOTE the Specialised NHS-Led Provider Collaboratives update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 September 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'. The revised process has been approved.

- Further development of Standard Operating Procedures (SOPs) for all West Yorkshire Provider Collaboratives.

- 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.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet, and the collaborative have progressed among a range of items:

- Development of a performance matrix for forensic community services, to support oversight and monitoring.
- Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned.
- Development and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway has been a key focus and the Women's Pathway work has commenced. Planning has commenced with Research and Development to understand how the collaborative develop an evidence base for change undertaken through our workstreams.
- The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Work with the West Yorkshire Complex Rehabilitation Programme to explore opportunities for joint working.
- Work to understand variance between PICU (psychiatric intensive care) and adult secure pathways.
- Work to improve the interface with prisons, improving assessment and transition processes.
- Involvement in national work to revise the secure service specifications.
- A project to consider how patient reported experience measures are captured across the collaborative, working with the Yorkshire and Humber Involvement Network.
- A training and development project focussing on how West Yorkshire adult secure providers can collaborate to develop a secure care training programme – developing clinical skills, shared cultures and approaches to care.

SWYPFT, in its role as Lead Provider, 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 took place in July 2023 in order to share learning from these visits, and to discuss future plans for the collaborative.

For the 5 months to August 2023 the collaborative operated with a financial surplus of £1,014k. A surplus position of £2,312k is forecast and this will be subject to the collaborative risk/reward share arrangement. However, there are risks to this position associated with independent sector price increases.

Review of the 2023/24 Lead Provider Contract Variation is complete, and feedback has been provided to NHS England in order that the CV can be prepared for signature. 2022/23 contract variations with in-area partners are being progressed to signature as a priority, and 2023/24 contract variations have been prepared.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 8th August 2023, with a further meeting planned for 3rd October 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 were developed. Primary care partners will host the physical health monitoring. A task and finish group continue to meet to progress implementation and funding opportunities.

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 5, a deficit position of £199k 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. An Inpatient and Referral Oversight Group has been established to manage patient and referral flow. In this reporting period there has been no increase in out of area admissions. There is currently 1 person placed out of area at an IS provider in the Humber & North Yorkshire PC area.

The forecast position for the 2023/24 financial year is a £352k deficit. The collaborative will investigate ways to increase crossflows income and continue to reduce OOA placements.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

A year-to-date deficit of £1,145k is reported for the 2023/24 financial year to August 2023 against a balanced plan. High-cost exceptional packages of care are primarily driving the collaboratives deficit position. There is one ongoing EPC which is forecast to continue throughout the 2023/24 financial year.

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 Lead 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 has been updated, and will be shared with partners for signature once the Lead Provider contract has been agreed. The Hosting Agreement for the SYB Commissioning Hub has been signed by the Trust.
- Risk share discussions continue between providers.

A year to date deficit of £170k is reported, with forecast deficit of £503k.

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 commissioning oversight will be managed going forward has been developed and has been discussed at the September meeting of the Provider Collaborative Patient Safety and Quality Group, and will be discussed at the October meeting of the 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.

5.3 Maternal Mental Health

Individual Districts in West Yorkshire were allocated a commissioning resource for the development of a Maternal Mental Health (MMH) service. However, this resource was too small to realistically commission a viable MMH service in each district, so the decision was taken to 'pool' the district allocations to facilitate the commissioning of a viable WY-wide service.

Expressions of interest were invited from West Yorkshire Trusts wishing to be Coordinating Provider for the MMH service. The Trust put forward an expression of interest and have been confirmed as Coordinating Provider.

Initially the MMH service will be commissioned by the WY ICB, with a plan to transfer to Coordinating Provider arrangements with the Trust from April 2024.

Initial focus will be on implementation of the new service. As the service is currently ICB commissioned, reporting will be in line with other Trust service lines. Work will take place within the West Yorkshire partnership to clarify commissioning arrangements from April 2024, and to ensure appropriate governance is in place in advance of this date.

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
26 September 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Fit & Proper Persons Test (FPPT) framework revised standards**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates & Resources**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Purpose:	To provide the Trust Board with an overview of the changes to the FPPT, which come into force on the 30 September 2023. The full FPPT revised guidance is available in the reading room on diligent.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust compliance with FPPT provides assurance to commissioners and partners that the Trust is Well Led.		
Any background papers / previously considered by:	• The Trust annual report for 2021/22, (including annual governance statement) 18 October 2022 (to note 2023/24 will be presented at the Annual members meeting on the 27 September 2023. • Statutory update to Trust constitution, 31 January 2023 • Annual director declarations of interest, 28 March 2023 • Trust Board self-certification compliance with NHS provider licence conditions, 25 April 2023 • Corporate Governance Statement, 27 June 2023 • Self-assessment against NHS Constitution, 25 July 2023.		
Executive summary:	**Introduction** The revised framework is effective from 30 September 2023 and NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going		

	forward from that date. It should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework. The Framework will introduce a requirement for and means of retaining certain information relating to testing the requirements of the FPPT for board members, a set of core elements for the FPPT assessment of all board members, and a new way of completing references. **Purpose** The purpose of the new Framework is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. It is a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations. **Applicability** The Framework applies to executive and non-executive directors of integrated care boards (ICBs), NHS trusts and foundation trusts, NHS England and the CQC, interim as well as permanent appointments where greater than six weeks and those who are called "directors" within Regulation 5. If they wish, trusts can extend the framework to cover other senior managerial positions for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only. **What's new?** • Updates in the NHS Electronic Staff Record (ESR) to record the testing of relevant information about board members' qualifications and career history. • A new standard board member reference template for references for all new appointments. For board members who leave their position, organisations must complete and retain locally the new board member reference, whether or not a reference has been requested by a prospective employer. • An NHS Leadership Competency Framework will provide guidance for the competence categories against which a board member should be appointed, developed and appraised. • The annual assessment needs to be in line with the FPPT checklist which is set out at appendix 7 of the framework (attached) so organisations should ensure they are familiar with this document. • The duty to store information relevant to the annual assessment (as set out in the checklist) will apply to existing directors (as they will have to comply with the assessment each year) and not only new appointees/promotions.

Trust current process

Fit and Proper Persons requirement for Board members

Any new appointments to the Board are assessed under the fit and proper persons requirements prior to appointment. In March each year, all members of the Board make a declaration in relation to their interests, fit and proper person requirement and where applicable their declaration of independence. The Trust is in the process of reviewing the new fit and proper persons guidance disseminated by NHSE and will be presenting a paper to Board in September 2023 documenting key changes to process.

At the time of writing the following processes are in place:

Fit and proper person requirement

Although the requirement is in relation to new director appointments, Trust Board took the decision to ask existing directors to make a declaration as part of the annual declaration of interest's exercise. All directors sign a declaration stating they meet the fit and proper person requirements. In addition, the corporate governance team oversee the following checks:

- Registers
  - Bankruptcy and Insolvency Registers
  - Disqualified Directors Register

- Google searches – the websites searched are www.google.com, www.bing.com, www.theconsultanthub.com,www.linkedin.com,www.facebook.com, www.twitter.com, using the following:
  - "name" plus the word "complaint"
  - "name" plus the word "scandal"
  - "name" plus the word "fraud"
  - "name" plus the word "suspended"
  - "name" plus the word "healthcare"

- Professional registration – note, this is only required if a specific qualification was needed for the role
- Good Conduct and Character Reference – including checks for disciplinary/grievance/whistleblowing processes
- Date and outcome of current DBS check
- The annual Trust Board fit and proper test, declaration of interest, and declaration of independence self-declaration forms
- The last annual appraisal – date of completion

In order to ensure full implementation of the revised FPPT framework the corporate governance team will work with the people directorate to ensure

	that points 1-5 are incorporated into systems and process for all new and existing Board members from 30th September 2023.
Recommendation:	**Trust Board is asked to RECEIVE the revised Fit and Proper Persons Test (FPPT) revised standards.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 September 2023
Agenda item 12.2

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 June 2023.
Recommendation:	**Trust Board is asked to NOTE the update to the Trust Seal since the last report in June 2023.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 September 2023
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Customer Services Policy - supporting the management of complaints, concerns, comments and compliments**		
Paper presented by:	**Darryl Thompson, Chief Nurse, Director of Nursing and Professions**		
Paper prepared by:	Sarah Whiterod, Associate Director of Nursing, Quality and Professions		
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.		
Purpose:	To enable Trust Board to approve the Customer Services Policy, a core policy for the Trust and reserved for Trust Board consideration and approval.		
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	Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust. The Customer Services policy, based on the NHS Complaint Standards, aligns with policies which support the management of complaints, concerns and compliments in a consistent manner. This policy provides a consistent process for the handling of complaints which includes the Trust engagement with system partners.		
Any background papers / previously considered by:	The policy was last approved at Trust Board in May 2021. Members of the Customer Services Team have been involved in the review of this policy. Care Groups have been consulted regarding their processes for the management of complaints and feedback. Members of Clinical Policy Review and Ratification Group were consulted in the review of the policy. The group membership includes Care Group representatives, staff side, equality and inclusion leads and corporate services.		

	The new and updated version has been approved by the Executive Management Team on 21 September 2023.
Executive summary:	The purpose and scope of the policy is: • To set out a framework for the management of complaints and feedback received into the Trust. • To define roles and responsibilities. • To outline the processes which are followed when feedback is received. • To incorporate obligations set out in the NHS Constitution and the Health and Social Care Act. • To align with the NHS Complaint Standards (December 2022), which align with the legal requirements arising from NHS Complaint Regulations and other regulations which relate to complaint handling. Following an extensive review, the following changes have been made: • A new introduction and updated purpose and scope of the policy, based on updated NHS Complaint Standards (updated December 2022). • References to Business Delivery Units (BDUs) changed to Care Groups. • Aligning definitions with NHS Complaint Standards and Parliamentary and Health Service Ombudsman (PHSO) definitions. • Principles updated to align with the updated NHS Complaint Standards • Update to detail about who can make a complaint, informal and formal complaints and timescales for making a complaint. • Section 4.4.6 and appendix B have undergone a substantial review. This relates to the management of unreasonable and persistent behaviour in relation to the making of complaints and providing feedback to the Trust. Appendix B outlines the process which should be followed when someone is identified as being persistent in their contact. This new process sets out roles and responsibilities, how contact will be managed through a two-step process and how contact will be monitored and reported. • Duties, section 5, have been updated to reflect Care Group processes. • Section 6 – reporting feedback has been updated based on updates received from Care Groups and internal and external reporting of feedback and complaints. • Section 7 – learning as a result of feedback has been updated. • The flowchart in appendix A has been updated. • Appendix B on managing unreasonable and persistent contact has been completely reviewed.
Recommendation:	**Trust Board is asked to APPROVE the updates to the policy.**

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and internet
Issue date:	TBC
Next review:	September 2026
Approved by:	Executive Management Group on 21 September 2023
Developed by:	Reviewed by Associate Director of Nursing, Quality and Professions
Director leads:	Chief Nurse and Director of Quality and Professions
Contact for advice:	Customer Services

With **all of us** in mind.

Contents

1. Introduction

The Trust is committed to the provision of high-quality care. To enable delivery of high-quality care it is essential to receive feedback and where necessary use this to make positive changes.

On occasion service users carers, families and/or their representatives may have concerns about the service, care or treatment they receive. The customer services function operates as a single gateway for raising issues and enquiries.

The Customer Services policy provides a framework for how complaints, compliments and feedback received are handled, processed and responded to.

2. Purpose and scope of the policy

People who use Trust services have a right to have their views heard and acted upon.
The Trust has made a commitment through its mission and values to put the person first and in the centre and to be honest, open and transparent. This policy sets out a framework for the management of complaints and feedback received into the Trust. It defines roles and responsibilities and the processes which are followed when feedback is received.

The Customer Services policy incorporates the obligations set out in the NHS Constitution and the Health and Social Care Act. The NHS Complaint Standards (December 2022) align with all the legal requirements arising from the NHS Complaint Regulations and other regulations which relate to complaint handling. This includes:

- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – A toolkit for commissioners (updated September 2018)
- The NHS Constitution (updated January 2021)
- Patients Association, Good Practice Standards for NHS Complaints Handling (2013)
- NHS Resolution Risk Management Standards (2020)
- Report of the Mid Staffordshire NHS Foundation Trust public inquiry (2013)
- Parliamentary and Health Service Ombudsman guidance
- Healthwatch
- Independent Advocacy Services
- Human Rights Act (1998)
- Being open when things go wrong (duty of candour) policy (updated February 2022)
- Care Quality Commission – Complaints Matter (updated 2022)

3. Definitions

For the purposes of this policy, feedback is defined across four categories, compliments, comments, concerns and complaints. These are based on definitions outlined in the NHS Complaint Standards:

3.1. **Feedback:** an opinion, whether invited or spontaneous, that can be positive, negative or neutral.

3.2. Compliment: Positive feedback received regarding care, generally from service users, their relatives and/or carers. Compliments are also sometimes received from other health care professionals, services or external partners.

3.3. Comments (service issues): A comment is a matter that is not about an individual's care and treatment. It is something that is a cause for concern to the complainant, e.g., they may be unhappy with parking arrangements at the service, or someone is leaving lights on when a building is empty. The relevant service provides information to the customer services team on a monitoring form to allow for feedback to be provided.

3.4. Concerns: A concern is a matter which an individual wishes to be considered on an informal basis. This can be done by the complainant directly with the service and should be resolved to the individual's satisfaction within two working days. All staff are expected, on a routine and daily basis, to deal with patient concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational/clinical areas, allowing for timely and informal resolution of the concern.

3.5. Complaints: An expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action or activity by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

3.6. Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, friends and family test, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Care Quality Commission. These are not considered as part of this policy.

4. Principles

The NHS Complaint Standards (December 2022) outline that an effective complaint handling system promotes a learning culture across organisations. The Trust welcomes complaints positively and acts thoroughly and fairly when complaints are investigated. The responses we provide aim to be fair, accountable and offer apology.
The Trust adopts the following principles in the management of concerns and complaints:

- Identifies complaints as an opportunity to learn and improve services
- Approaches complaints in an open and non-defensive manner
- Shares learning from complaints and helps people to understand how this learning has been used to improve services
- Supports and trains colleagues to deliver best practice in handling complaints
- Provides a timely response, considering the complexity of the issues

- Ensure that service users and colleagues are able to have their say and are kept up to date
- Sets out what happened and whether mistakes were made or standards met in responses and fairly reflects the experiences of those involved
- Outlines organisational accountability
- Take action to make sure learning is identified and used to improve services

Failure to deal with complaints appropriately presents a risk to the organisation – a missed opportunity to improve services because of feedback and could have an adverse effect on the Trust's public reputation as well as to future service user and carer experience.

NHS complaints legislation requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person-centred approach which ensures that issues are dealt with in a way that empowers people and allows them to make choices about how their concerns are dealt with. This approach has been further strengthened through the adoption of the framework which sets out best practice in five steps which are reflected in this policy:

- Considering a complaint – ensuring people are given information about how to complain, understand that they will be supported to raise a concern and that care will not be compromised.
- Making a complaint – ensuring all staff understand the process and are able to help people who wish to raise a concern. The process for making a complaint is easy and convenient.
- Staying informed – keeping people up to date and making sure that the response is personal.
- Receiving outcomes – resolving complaints and achieving the appropriate outcome.
- Reflecting on the experience – ensuring complaints are handled fairly and consistently and people understand how their feedback has helped to improve services.

4.1. Who can give feedback?

Any individual can give feedback to any Trust employee, including the customer services team. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carer, relative, member of parliament, councillors, independent advocates and Healthwatch.
A customer service information leaflet is available on the Trust internet and intranet page, this includes an easy read version. This leaflet can be provided to support people to give feedback on the services they have received.

4.2. Receiving feedback

The Trust encourages and expects staff to seek feedback and to know how to signpost to the customer services team if required. Customer service leaflets and posters are displayed in all service areas.

The customer services team can be contacted by telephone, email, via web link, text, in writing or by referral from a member of staff. Corporate social media accounts and external websites (NHS Choices, Patient Opinion, Healthwatch) are also monitored to ensure feedback is captured and responded to if possible. Details of which can be found on our website/in our leaflets and displayed within ward and service environments.

4.3. Acting on feedback

A key objective of the Trust is to listen, learn, change and improve in response to concerns and complaints. The lessons learnt and trends identified as a result of concerns and complaints play a key role in continuously improving the quality of care received by service users and remains a priority for the Trust.
Feedback is received through everyday conversations with the people who use our services. This can be to raise an issue, make a request, ask a questions or highlight a worry. In many instances staff can help to deal with feedback immediately. This policy supports and encourages staff to:

- Feel empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible
- Encourage people to discuss any issues they have as they may be able to sort out the issue to their satisfaction quickly and without the need for them to make a formal complaint

4.4. Concerns and Complaints

a. Informal concerns

Responses to concerns should be immediate wherever possible and a monitoring form should be completed and shared with the customer services team to ensure these are logged to support any future contacts from the service user or their representative.

If it is not possible to resolve the concern straight away, assistance should be sought from the service line management team. If the concern is raised verbally, and can be resolved within two working days, the response does not need to be in writing or managed under the complaint regulations. The issue should be recorded using the monitoring form along with details of the feedback provided).

b. Formal complaints

It is recognised that issues cannot always be resolved as they arise and that sometimes people will want to make a formal complaint. A complaint can be about:

- an act, omission or decision we have made
- the standard of service we have provided.

If it is considered that a complaint (or any part) does not fall under this policy, the reasons for this will be explained. This will be done in writing and any relevant information, including signposting will be provided.

Complaints are received in the following ways:

- in person
- by telephone
- in writing
- by email
- through accessing the Trust internet site

All accessibility and reasonable adjustments will be made for anyone who wishes to make a complaint in an alternative way. This will be documented.

Concerns and complaints received in writing, by email or via telephone that cannot be resolved quickly by the service (within two working days) will be managed in accordance with complaint

regulations. Complaints are reviewed by the customer services manager and allocated to a named case handler.

The allocated case handler will always contact the complainant to understand the specific concerns/issues they want the Trust to investigate and respond to. The complainant will receive an action letter for their records in line with complaint regulations.

Complaints will be acknowledged within three working days of receipt and recorded on DATIX (incident management reporting system), with a complaint reference number allocated.

Formal complaints will always require a formal investigation and written response. The complainant will receive a written response from the Responsible Officer for Complaints Management (the Trust's Chief Executive).

The target response time for formal complaints is within six months from the date of receipt. This is a statutory timeframe as outlines in NHS complaint regulations. This is monitored on a monthly basis and reported through the integrated performance report.
The procedure for complaints handling is detailed in appendix a.

Guidance for managing persistent and unreasonable contact is detailed in appendix b.

4.4.1. Who can make a complaint

In line with the NHS Complaint Standards (2009) the following apply:

- A person who is in receipt of, or who has received, services from the Trust
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity, or lack of mental capacity (Mental Capacity Act 2005), or has been requested to act as a service user's representative
- Complaints can also be made by a person acting on a patient's behalf for any services connected with the Trust, as long as consent is provided by the service user or the person has the legal authority to do so

All complainants will be informed about the right to access independent complaints advocacy. This is done verbally and in writing during the initial acknowledgement.

All complainants have the option to apply to the Parliamentary and Health Service Ombudsman, to ask for independent review of their complaint, should they remain dissatisfied following receipt of the Trust's formal response to their complaint or the Trust's handling of their complaint. This response completes stage one of the complaint process (local resolution).

4.4.2. Timescale for making a complaint

Complaints must be made within 12 months of the date of the incident being complained about occurred or the date the person raising the complaint found out about the incident, whichever is the later date.

If a complaint is made after that 12-month time limit, it will be considered if:

- It is believed there are good reasons for not making the complaint earlier, and
- It is still possible to properly consider the complaint

If a good reason is not identified, or it is thought it is not possible to properly consider the complaint (or any part of it), the complainant will be notified in writing.

4.4.3. What is not covered within this policy

In line with the NHS complaint regulations, the following are **not** covered by this policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure)
- Requests for a change to care plan or medication (refer to clinical team)
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair)
- Complaints made by a member of staff about their employment or about another member of staff(refer to HR policies)
- Complaints made about volunteer activity (refer to Equality & Engagement team)
- Complaints about involvement activity (refer to Equality & Engagement Team)
- Commissioning decisions (refer to appropriate Integrated Care Board (ICB))
- Complaints about services delivered by an independent provider, on behalf of the Trust, are not covered by the NHS complaints regulations. However, the Trust must satisfy itself about the quality of service and that the independent provider has its own robust complaints procedure
- Complaints about superannuation (refer to payroll/HR department)
- Staff who wish to voice concerns or grievances should be raised through appropriate line management processes in line with Human Resources policy, or through the Freedom to Speak up Guardians where appropriate
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman)

4.4.4. Complaints involving multiple organisations

If the Trust receives a complaint that involves other organisations (including cases that cover health and social care issues) the complaint will be investigated in collaboration with the other organisations. It will be agreed who will be the ‘lead’ organisation, responsible for overseeing and coordinating the complaint.

Handling of the complaint, such as making sure the complainant is kept involved and updated throughout and ensuring the individual receives a single, joint response will be delivered by the lead organisation.

4.4.5. Complaints to other bodies, including the Care Quality Commission (CQC)

People who are, or who have been, detained under the Mental Health Act have the right to complain to the Care Quality Commission (CQC) about use of the Mental Health Act. The CQC will usually ask that the complaint is initially submitted to the hospital managers.

The Mental Health Act Code of Practice (2015) requires that information on how to complain to the CQC is readily available on all wards that are registered to support people detained under the Act. The Trust has a duty to ensure this information is available and displayed on its wards, with consideration given to the accessible information standard in how this information is shared.

4.4.6. Management of unreasonable and persistent behaviour

The Trust is committed to dealing with all concerns and complaints fairly and impartially and to providing a high-quality service. As part of this approach the Trust would rarely limit people from making contact.

There are a small number of people where the frequency of their contact with the Trust, or their individual behaviour, hinders consideration of their own and/or other people's complaints. Examples of unreasonable and persistent behaviours are detailed in appendix B.

The Trust recognises the need to distinguish between people who make a number of genuine complaints and those whose persistence goes far beyond what is reasonable and/or which may have significant resource implications for the Trust.

The Trust will ensure it meets the requirements of the Equality Act 2010 and the Public Sector Duty Act and ensure we consider reasonable adjustments for disabled individuals. Some individuals may have difficulty expressing themselves or communicating clearly or appropriately. Where there is indication that this is the case, the needs and circumstances of the individual will be considered, including applying any reasonable adjustments. This does not mean that we will tolerate abusive language, shouting or unacceptable behaviour/actions.

When a person's behaviour is considered to be unacceptable, or they are being unreasonably persistent in their requests, they will be advised of the need to address this. This will be determined through a review of the person's contact, frequency and supported utilising the examples in appendix B. Communication of behaviour which is considered unacceptable will initially be shared verbally and will then be followed up in writing should there be no changes to the contact. During this verbal communication with the complainant, it will be explored if there are barriers to the communication and if the person needs support with the complaints process. The person will be reminded of advocacy support that is available to them. If this is unsuccessful, action may be taken to limit their contact with the Trust.

Any decision to limit access or place restrictions on contact with the Trust will be taken by the deputy director of nursing, quality and professions, in liaison with the relevant service director and clinical lead. Limiting access will follow a decision-making process, utilising available evidence and details of this will be held on the Datix system alongside the restrictions in place. Any restrictions imposed will be appropriate and proportionate with a regular timeframe for review. Options for consideration are detailed in Appendix B, alongside the timescale for review of any restrictions.

Where behaviour becomes so extreme that it threatens the immediate safety and welfare of others additional options will be considered. These will include reporting the matter to the police or taking legal action. In such cases a complainant may not be given prior warning of that action.

Appendix B outlines the procedure which identifies situations where a complainant may be considered habitual/unreasonably persistent and possible courses of action.

4.4.7. Learning from feedback

Themes from complaints and feedback are gathered by the customer services team and reported annually through reporting to Quality and Safety Committee (formally clinical governance and clinical safety committee).

Care Group quality and governance groups are responsible for aligning themes and learning from complaints within their own quality improvement and service improvement programmes. This learning should be triangulated with other forms of feedback on care and service delivery so that improvements are made to services.

Themes and learning from complaints are shared through the Patient Experience group, where other forms of patient experience are reviewed and triangulated. This is then shared through clinical governance group.

4.5. Data and complaints information

All records relating to complaints investigation are confidential and must be kept by the Trust in a secure environment for 10 years. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.

4.6. Compliments

Compliments can be provided to any member of staff by any member of the public, other members of staff or partner organisations. If a compliment is provided in writing to the relevant ward/department, the manager will respond to acknowledge the compliment.

Each Care Group is responsible for ensuring all compliments are logged with the customer services team so timely feedback can be given to the staff or team being complimented and compliment numbers per service can be monitored.

Compliment numbers and themes are shared within the Patient Experience annual report and used to demonstrate the positive work of staff and services.

5. Duties

The customer services process is supported by: -

5.1. The Chief Executive

The Chief Executive (or nominated deputy), as the nominated responsible person, has overall responsibility for ensuring the Trust Customer Service Policy meets statutory requirements as set out in the NHS Complaints Regulations (2009). The Chief Executive will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

5.2. The Trust Board

Trust Board is responsible for approval of this policy. Quality and Safety Committee (formally clinical governance and clinical safety committee) will receive quarterly reports from the Customer Service Team and be responsible for receipt of the patient experience annual report.

5.3. The Executive Management Team (EMT)

The Executive Management Team will monitor key performance indicators (KPIs) in relation to complaints through monthly business intelligence dashboard reporting. The Executive Management Team will also review any action plans arising from complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

5.4. Executive Directors

The Chief Nurse and Director of Quality and Professions is the director with overall responsibility for the customer services team, including the management of complaints. Alongside the Chief Operating Officer and Chief Medical Officer (the executive trio) they have the following responsibilities:

- To ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery
- To ensure that, through agreed processes, customer services information is reported appropriately to Care Groups; reported into integrated performance reports (IPR) and through quarterly and annual reporting to Quality and Safety Committee
- To review all final responses to complainants, having received assurances from the customer services team that the response addresses all points raised in the complaint management plan

5.5. Service Directors and Clinical Leads

The Service Directors and Clinical leads will ensure appropriate systems are in place within Care Groups and services to:

- Respond to feedback, investigate concerns and complaints
- Ensure that staff who deal with complaints are properly supported and trained
- Make sure that people who use Trust services know how to complain and where to get support
- Have oversight of open complaints being investigated within their own Care Group
- Review complaint responses to:
    - Ensure the response addresses the concerns raised
    - Have oversight of the quality and tone of the response
    - Ensure that any learning has been identified and is detailed within the response, as appropriate
- Monitor delivery of complaint action plans through Care Group governance processes
- Provide updates to the customer services team to support reporting into Board and Quality and Safety Committee.

5.6. Customer Services Manager

The customer services manager is responsible for managing delivery against this policy and related procedures and for overseeing the handling and considerations of any complaints and feedback received into the Trust.

5.7. The Customer Services Team

The customer services team will ensure processes that support effective complaints investigation and resolution, for example the complaint toolkit, remain fit for purpose, support staff to resolve issues, and support service users in receiving effective complaint resolution.

The role of the customer services team is as follows:

- On receipt of a formal complaint, acknowledge receipt of the complaint verbally with written formal acknowledgement which explains the process and discusses the handling of the complaint and the need to receive consent from the service user to be able to proceed. The written acknowledgement is sent within three working days, in line with the statutory target
- Share informal concerns with the relevant service to facilitate a quick resolution/discussion with the complainant where possible within two working days as set out in the complaints regulations
- Ensure the complainant is at the centre of the process and that a complaint management plan is developed
- A named complaint handler is allocated to agree the scope of a formal complaint with the complainant, including expectations for resolutions and a timescale for the investigation and response. The complainant will receive an action letter which provides a written copy of the agreed scope of their complaint in line with the complaint regulations. The complainant must agree the scope of their complaint before a complaint investigation can proceed
- To liaise with the relevant general manager to facilitate the allocation of a lead investigator from within the Care Group/service to formally investigate the complaint and provide their written findings by returning the toolkit which details the agreed concerns from the action letter
- Provide advice, support and guidance to the lead investigator and receive timely updates on the progress of the investigation so these can be communicated to the complainant to manage their expectations about how their complaint is progressing.
- On receipt of the completed toolkit from the lead investigator, customer services will draft a written response to the complaint which then enters the Trust's internal quality assurance process with senior managers before final sign off from the Chief Executive

The customer services team are also responsible for alerting service directors to any concerns or complaints which highlight that quality of care may be compromised, where there is a safeguarding concern or immediate scoping/intervention may be required.

5.8. Clinical Leads / General Managers / Quality & Governance Leads

These roles, or people with delegated responsibility have the following responsibilities:

- To receive new toolkits for investigations and allocate a lead investigator, within two working days. Service directors should be included in any initial email correspondence for awareness and oversight
- To ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues personally or by appointing a suitably skilled member of staff to conduct the investigation
- Provide support to the lead investigator and ensure wellbeing is maximised at all times
- To ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit (Appendix D)
- Understand and comply with agreed timescales and key performance indicators (KPIs) in relation to complaints investigation and management (outlined in Appendix C)
- Advise the service director of open complaints within the service or Care Group, and support review of issues and learning through Care Group governance processes

- Ensure any learning for the wider Trust is shared through Care Group governance groups and into Clinical Governance Group or Operational Management Group as appropriate

5.9. Complaint Investigators

Complaint investigators will have completed relevant training, such as root cause analysis training. They will be responsible for coordinating the response and collaborating with relevant colleagues as required. The complaint investigator is responsible for:

- Undertaking a thorough investigation, which includes, where relevant, discussion with the individuals involved in the complaint
- Seeking specialist advice from clinical specialists as required, e.g., medical colleagues, specialist advisors
- Liaising with the customer services team on a weekly basis to provide an update on the progress of the complaint investigation
- Ensuring the response for each element of the investigation is of a high quality and addresses the concerns and questions asked
- Ensuring that the investigation is completed within the expected timeframes (see appendix 2 for KPIs). Any delays should be highlighted to the customer services team as early as possible and shared with their general manager
- Completing the toolkit with detail found during the investigation and including any learning identified. The toolkit should be returned to the customer services team for formulating into a formal response

5.10. All Staff

All staff need to be aware of Trust policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet. Staff have an individual responsibility to seek out this information. All staff will assist and cooperate in the complaints process. Wherever possible they will try to deal with issues of concern before it becomes a formal complaint.

6. Reporting Feedback

The customer services team will provide regular reports to Care Groups, advising of open and closed complaints during the reporting period and provide an update on where open complaints are in the complaints process, i.e. under investigation. The general managers have the responsibility for oversight of complaints open in their respective areas. This includes a breakdown of the complaints and concerns, themes identified and any lessons learnt.

The customer services team review and report on the following information:

Internal:

- Patient experience annual report, in collaboration with patient experience lead, equality and inclusion team and freedom to speak up guardian
- Monthly report analysis, looking at the numbers of complaints closed in the relevant period, how many of these were responded to within the six-month statutory timeframe and identifying delays within the process

- Quarterly report and review of numbers of persistent and unreasonable complaints with restrictions in place
- Monthly data to the IPR including key performance indicator data as outlined in Appendix C
- Quarterly report into the mental health act committee to highlight complaints which relate to the application of the mental health act

External:

- KO41a Hospital and Community Health Services complaints collection annually. This is submitted to NHS Digital and monitors written complaints received by the NHS. The data submitted includes:
    - Organisational detail
    - summary of complaint numbers
    - age or patient
    - status of complaint
    - service area
    - subject area of complaint
- Complaints related to mental health act are reported monthly to the CQC MHA team

The Quality and Safety Committee is responsible for approving Trust policy for complaints handling, for ensuring compliance with national and local targets in relation to complaints, and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved service user experience.

7. Learning and improving as a result of feedback

Many complaints arise from misunderstandings and may be resolved through appropriate explanation and discussion. Other complaints, however, will reveal ways in which Trust services may be improved. The Trust recognises the pledge in the NHS Constitution to learn lessons from complaints and use these lessons to improve its services.

Themes from complaints and other feedback are collated by the customer services team.

Complaints which suggest a performance, conduct or particular concern or where a risk is identified within a service will be reported to the Service Director, clinical lead and the Chief Medical Officer and Chief Nurse and Director of Quality and Professions, as appropriate.

Individual care Groups are responsible for monitoring and identifying areas for learning which arise from complaints. It is expected that each Care Group will have their own system in place for monitoring themes from complaints and for ensuring learning is disseminated into practice.

Analysis of lessons learnt from complaints will be undertaken by the Customer Service team with recommendations for wider improvements in response to identified trends considered by the Clinical Governance Group and Quality and Safety Committee (formerly clinical governance and clinical safety committee).

8. Equality Impact Assessment

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An equality impact has been completed for this policy and this can be found in **Appendix D.**

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through customer services, the availability of information in different formats on request, and promoting access to advocacy and interpreting services. Monitoring of complaints received from people with protected characterises is completed as part of annual reporting. Further work is needed to enable more regular monitoring of access to complaints.

9. Dissemination and implementation arrangements

This policy will be promoted through 'The Headlines' weekly staff bulletin and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Implementation of the policy will be the responsibility of staff at all levels and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are also required to ensure appropriate support is in place for staff impacted by complaints.

General managers within Care Groups are required to ensure staff who undertake complaints investigation are skilled and supported to do so, to develop action plans to address areas for improvement, and to monitor delivery of same through governance processes.

10. Process for monitoring compliance and effectiveness

The Associate Director of Nursing, Quality and Professions is responsible for monitoring compliance with this policy. This will be achieved through:

- Monitoring and reporting on complaints and feedback as outlined above
- Data analysis and reporting to ensure compliance with the principles outlined within this policy
- Supporting Care Groups to ensure staff are aware of this policy and appropriately trained in its use and in what to do when feedback is received
- Monitoring of action plans through Care Group governance as outlined above
- Receiving feedback from Care Groups on the effectiveness and usefulness of this policy
- Gathering feedback from service users and complainants about their experience of being supported through making a complaint
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsman, the CQC, the Information Commissioner and NHSI.

11. Review and revision arrangements

This policy is subjected to a full review every 3 years but may be amended or reviewed sooner to ensure it is in line with statutory requirements for the management of complaints and feedback.

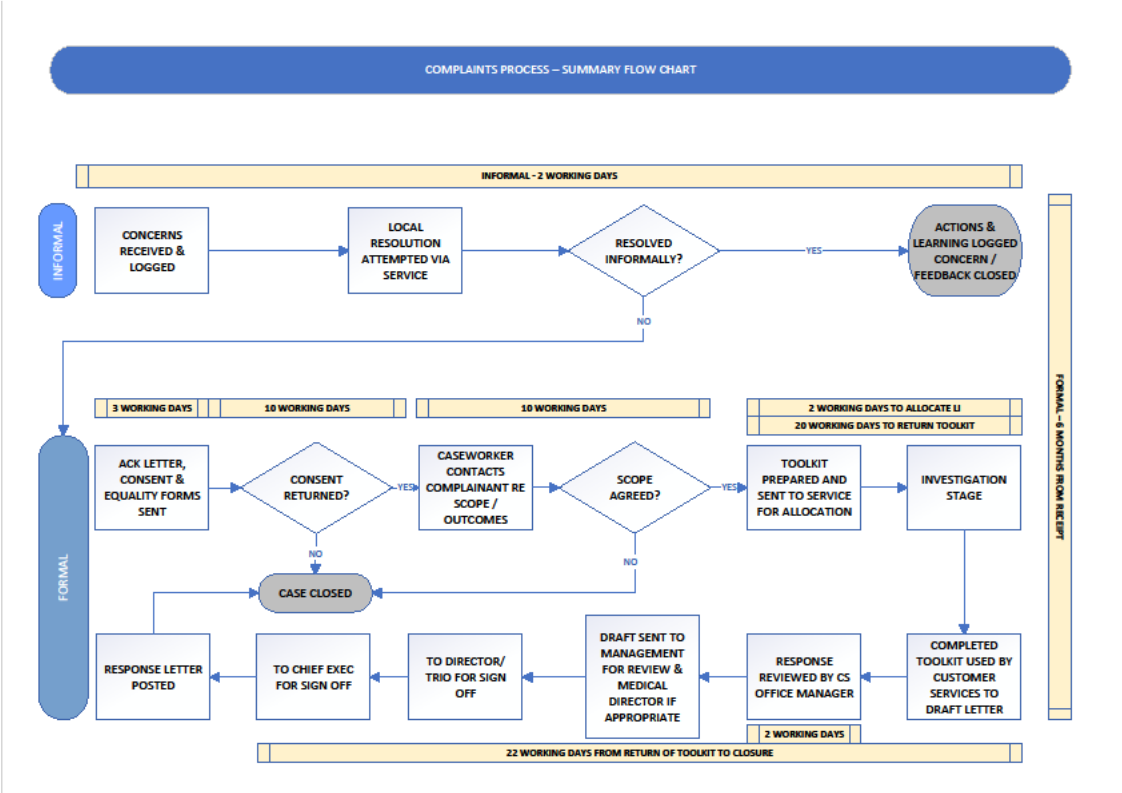
12. Associated documentation

Supporting procedural documents include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures.
- Being Open policy – including duty of candour.
- Claims Management Policy and Procedure.
- Safeguarding Children procedures.
- Safeguarding Adults procedures.
- Health and Safety policies, procedures and processes.
- Human Resources and related policies and procedural and related documents.
- Information Governance (and Caldicott Guardian) related policies and procedural documents.
- Freedom of Information Policy
- Accessible Information Policy
- Communications, Engagement and Involvement Strategy
- Preventing Violence and Aggression Policy

Complaints Procedure (Local Resolution)

All complaint investigations should follow the pathway for complaint management as set out below.



Throughout the complaints process consideration must be given to the following:

- All complaints must be risk screened on receipt. This enables any rated as 'red' to be escalated early and for any other risks to be identified early
- If a complaint involves clinical or patient safety issues that require urgent attention the appropriate Service Director must be informed immediately
- Complaints that may have a learning response underway under the Patient Safety Incident Response Framework must be referred for advice to the patient safety support team and escalated to clinical risk panel
- Where a complainant indicates they intend to take legal action, the matter must also be referred to the Assistant Director of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaint's procedure. This is consistent with national guidance
- Complaints or concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate
- Complaints about members of staff that involve an accusation of misconduct must be referred to the Peoples Directorate. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members through a HR process
- Issues that could potentially attract media attention must be referred to the Communications Team
- Issues relating to child protection or vulnerable adults must be referred to the Trust safeguarding team
- Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police. If the complainant chooses not to report a possible criminal matter the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality
- Investigators should always alert the customer service team at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating by providing support timely to reach a satisfactory resolution

Guidance for dealing with persistent and unreasonable contact

a. Definitions

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or unreasonably persistent where current or previous contact with them shows that they have met at least two of the following criteria listed below. However, once it is clear that a complainant meets any one of the criteria, it would be appropriate to inform them verbally initially and follow up in writing if there is no change in behaviour that they are at risk of being classified as habitual/ unreasonably persistent, allowing them the opportunity to modify their behaviour. They should be advised of what the outcome might be if they continue to behaviour in an unacceptable way. This can include:

- Aggressive/abusive behaviour
- Unacceptable demands
- Unacceptable levels of contact
- Refusal to cooperate

More detailed examples of unacceptable or persistent behaviour are outlined below.

- Insufficient, or no grounds for their complaint and are making it for reasons that they do not admit or make obvious
- Refusal to co-operate with the Trust's established complaint investigation process, whilst still wishing their complaint to be resolved.
- Insists on their complaint being dealt with in ways that are incompatible with NHS complaints regulations or good practice or are disproportionate to the complaint.
- Adopts an excessively 'scattergun' approach, for instance, in pursuing a complaint with multiple organisations, departments or individuals.
- Makes the same complaint repeatedly, perhaps with minor differences, after the complaint has been investigated. This would include where people insist that the minor differences constitute new complaints that require further investigation
- Persists in pursuing a complaint where the Trusts Customer Services policy has been fully and properly implemented
- Seeks to prolong contact by changing the substance of a complaint or by continually raising new issues and/or questions whilst the complaint is being addressed (care must be taken to recognise new issues which have not previously been considered)
- Is unwilling to accept evidence of treatment given as being factual (e.g. clinical records)
- Does not accept that facts can be difficult to verify when a prolonged period of time has elapsed
- Does not identify clearly the precise issues they want investigated, despite reasonable efforts by staff to help them to do so and/or the independent advocacy service
- Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved
- Uses physical violence or threats towards staff or their families/carers at any time. This will in itself cause personal/individual contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented and reported via the Trust DATIX system and to the police after consultation with the appropriate senior management staff
- In the course of pursuing a complaint, has made an excessive number of contacts (or made multiple complaints) with the Trust, placing unreasonable demands on staff and resources.

Such contacts may be in person, by telephone, letter, or electronically. Discretion must be exercised in deciding how many contacts are required to qualify as excessive, using judgement based on each case

- Has harassed or been abusive or verbally aggressive towards staff dealing with their complaint – directly or indirectly. If the nature of the harassment or aggressive behaviour is sufficiently serious, this could in itself be sufficient reason for classifying the complainant's behaviour as unreasonable. It must be recognised that complainants may sometimes act out of character at times of stress, anxiety, bereavement or distress and reasonable allowances should be made for this
- Displays unreasonable demands or expectations and fails to accept that these may be unreasonable after a clear explanation has been provided about what constitutes an unreasonable demand. For example, insisting on responses to complaints or enquiries being provided more urgently than is reasonable or recognised practice

b. Implementation

Where people identified as exhibiting 'habitual or unreasonable' behaviour in accordance with the above criteria this should be raised with the Customer Services Manager in the first instance.

Prior to any action is should first be considered and confirmed that:

- The Customer Services Policy and procedure for the management of complaints has been implemented correctly and if any material element has been overlooked or inadequately addressed
- The stage at which the complainant became or is developing into a persistent complainant. There should be evidence to demonstrate the habitual and persistent nature of the complaint. This will support any restrictions to be as the result of a fair and consistent process

Any action taken must be proportionate and appropriate to the nature and frequency of the complainant contact with the Trust.

Consideration must be given as to whether there are any relevant equality considerations that may be linked to the persistency of the complaints. It is the responsibility of the manager reviewing each individual case to recognise that some complainants (for example, individuals with speech/hearing impairment, learning disability or other permanent or temporary cognitive impairment or service users for whom English is not their first language) may need the Trust to implement relevant adjustments to the process for the handling of their complaint (s) to minimise communication issues and barriers.

The management of perceived unacceptable or persistent behaviour should be undertaken in two stages.

Stage one:
Once a complainant has been identified as being persistent or unreasonable in their contact the customer services manager will review the case and can consider the following:

- Offer a face-to-face meeting or telephone call to attempt to resolve outstanding issues
- The complaints should be informed verbally that their behaviour is unacceptable/persistent. This should be followed up in writing if a verbal request to change behaviour does not support a change in behaviour

- Notify the complainant in writing that the Trust Chief Executive has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant should also be notified that the correspondence is at an end and that further letters received might be acknowledged but not responded to
- Ensure that the complainant is aware of how to contact an advocate to support them in the complaints process if they are having difficulty

Stage two:

Should the above not support the complaint to modify their behaviour then the matter should be escalated to the deputy director of nursing, quality and professions, the relevant service director and clinical lead to consider next steps. The trio will consider all available evidence, review any actions taken to support the complainant through the complaint process and recommendations from the customer services manager.

Below is a list of possible options for consideration. One or more might be chosen and applied if warranted. The list is not exhaustive and often local factors will be relevant in deciding what might be appropriate action.

- Placing time limits on telephone conversations and personal contacts
- Restricting the number of telephone calls that will be taken (for example, one call on one specified morning/afternoon in any week
- Limiting the complainant to one medium of contact (telephone, letter, email etc) and/or requiring the complainant to communicate only with one named member of staff
- Requiring any personal contacts take place in the presence of a witness
- Refusing to register and process further complaints about the same matter. Where a decision on the complaint has been made, providing the complainant with acknowledgements only of letters, faxes, or emails or ultimately, informing the complainant that future correspondence will be read and placed on the file but not actioned. A designated officer should be identified who will read future correspondence
- When a caller has been officially declared a habitual or repetitive caller, it may be decided that no further telephone communication will be accepted.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

c. Notification of the Decision

Once a decision has been made to take action in relation to a service user/complainant under this policy, the relevant Service Director in liaison with the Deputy Director of nursing, Quality and Professions will write to them to explain the following:

- The decision that has been taken
- The reasons why that decision has been taken
- That any restrictions will remain in force until they are notified otherwise and that the restriction will be reviewed at appropriate intervals (to be agreed and defined during the decision to take action)
- How a request can be made to have the decision reviewed and the time limit within which to make a request. The customer services manager will be responsible for ensuring that key staff are aware of the decision and any restrictions in place, including any changes to those decisions/restrictions (see paragraph below)

Should a request for any imposed restrictions to be reviewed be received this will be escalated to the Trust Chief Executive for oversight.

A central record of decisions/restrictions will be held in the customer services team. This will include name of complainant, restrictions imposed, decision made by, date imposed, review date, reason for restrictions. This will also be recorded on the DATIX system.

Where a valid request has been made to review a decision within the appropriate time limit, the review will be carried out by the Customer Services Manager in collaboration with the Associate Director of Nursing, Quality and Professions and a recommendation made to the deputy director of nursing, quality and professions. Any review will consider any relevant documents that informed the original decision, the decision letter and the information provided in the request for a review. The associate director has the discretion to make a recommendation to the deputy director to uphold the original decision/restriction(s), uphold the original decision and amend the restriction(s), or quash the original decision in its entirety. The service user/complainant will be notified of the decision by letter or their preferred method of communication e.g. email.

d. Review of Restrictions

Once a complainant has been deemed as habitual or unreasonably persistent a mechanism to review or withdraw that status (if appropriate) needs to be agreed.

The status should be reviewed by the customer services manager and associate director of nursing, quality and professions every quarter. This will be done through the Complex Complaints Panel, with attendance from the deputy director, service director and clinical lead (or nominated representative). Any recommended changes will be agreed and put into place with written notification sent to the complainant. This can be reviewed earlier if it becomes apparent that the complainant has adopted a more reasonable approach.

Any changes or review to restrictions must be communicated to the complainant in writing.

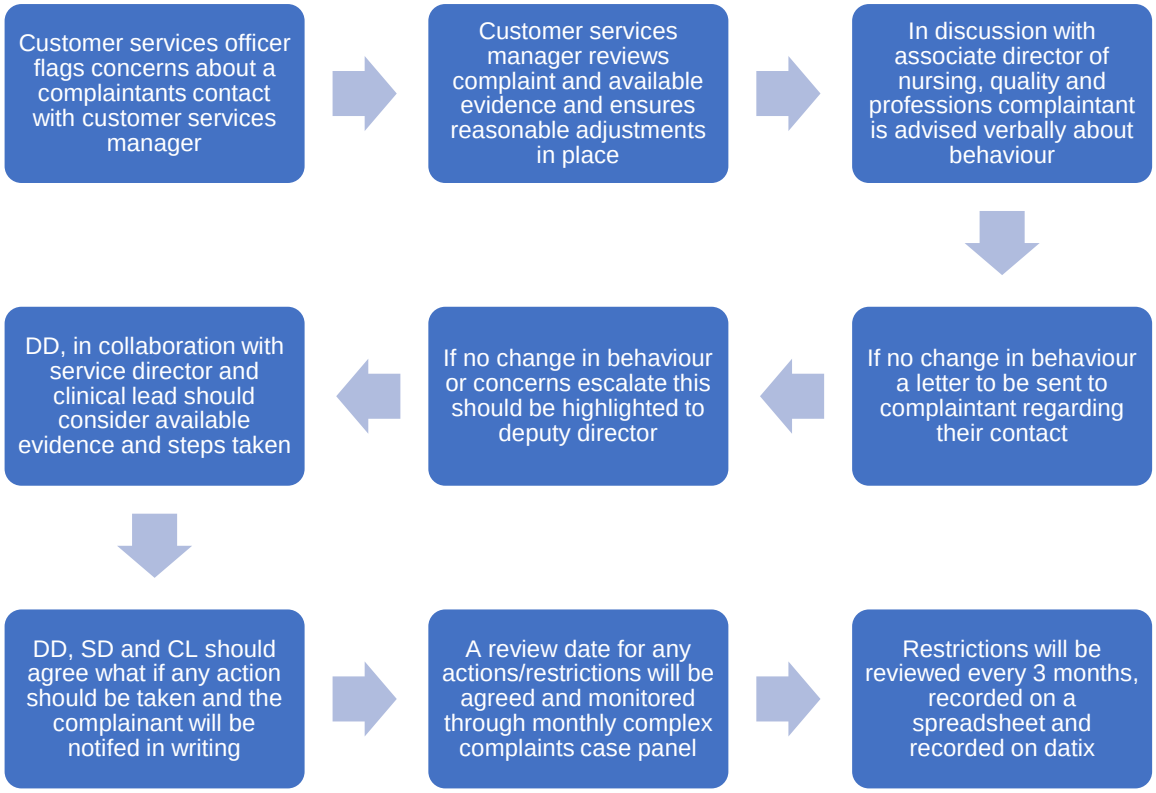
e. New Complaints

The Trust will not operate a blanket policy of refusing to deal with any genuinely new complaints. If a new complaint is received, from a person who has previously been identified as persistent or unreasonable in their contact under this policy, the new complaint will be considered.

f. Failure to Adhere to Restrictions

Should a service user/complainant continue to behave unreasonably and/or fail to comply with restrictions previously imposed under this policy, then the Trust may take further action as it deems reasonable and proportionate, including legal action and reporting the matter to the police where their behaviour may amount to a criminal offence.

Flowchart for the management of unacceptable and persistent behaviour



APPENDIX C

Complaint Investigation Toolkit

Date:

Reference: CS

Case Handler:

Your investigation is due back on:

BDU	
Service/Ward identified in complaint	
Names of staff identified in complaint	
Lead Investigator	TBC
Background	**Complainant –** **Service user –**
What the complainant is requesting as an outcome?	Apology if appropriate Full investigation Service improvement

Issue 1 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

What should have happened? What did happen?	Evidence Provided to support findings
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies
Lessons Learned	**Mandatory field**

Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

Issue 3 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

Issue 4 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

APPENDIX D

Equality Impact Assessment

Date of EIA: **September 2023** **Review Date:** **September 2026**

Completed By: Sandra Montisci

	QUESTIONS	ANSWERS AND ACTIONS
1	**What is being assessed?** Prompt: what is the function of this document (new or revised)	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Description of the document** Prompt: What is the aim of this document	To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff, partner organisations
3	**Lead contact person for the Equality Impact Assessment**	Sarah Whiterod, Associate Director of Nursing, Quality and Professions
4	**Who else is involved in undertaking this Equality Impact Assessment**	Customer Services team
5	**Sources of information used to identify barriers etc** Prompts: service delivery equality data – refer to equality dashboards (BI Reporting - Home (sharepoint.com) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact InvolvingPeople@swyt.nhs.uk for insight **What does your research tell you about the impact your proposal will have on the following equality groups?**	Equalities data – BI equalities reporting Staff Surveys National and local data sets
5a	**Disability Groups:** Prompt: Learning Disabilities or Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such Diabetes, Cancer, Stroke, Heart Disease etc. Accessible information standard	Across all communities the Trust will ensure that services remain fully accessible due to a higher than national average proportion of people whose day to day activities are limited 'a lot' by their disability. We will use the clinical services and Care group data and EIA's to ensure we fully understand the nature of the disability so we can adjust and adapt our services according to need and feedback, remaining person centred throughout. The policy support the provision of accessible information and support to disability groups to effectively submit their complaint and be part of the complaint process. This includes where a complainant might be identified as persistent or habitual and ensuring that all appropriate actions have been taken to support.

Disability groups

	Not Disabled	Disabled
England % av.	47.2	13.2
Kirklees		
% average	82.6	17.4
Barnsley		
% average	78	22
Calderdale		
% average	81.7	18.3
Wakefield		
% average	79.9	20.1

Taken from Census 2021 for each area

Disability	**Total**	**%**
Not Recorded	63032	54.17
Not disabled	37268	32.03
Disability NOS	5670	4.87
Registered disabled	7313	6.29
Disability status not given - patient refused	3067	2.64
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Disability		%
Mental Health Condition	35	28
Does not have a Disability	13	10
Hearing impairment	1	1
Epilepsy	2	2
Prefers not to say	48	39
Aspergers	1	1
Learning Difficulties	8	6
Cognitive Impairment	3	2
Unknown	11	9
Sensory Impairment	1	1
Dyslexic	1	1
	124	**100%**

Customer Service data 2021/2022

	QUESTIONS	**ANSWERS AND ACTIONS**
5b	**Gender:** Prompt: Female & Male issues should be considered	Gender equality is reported as part of our workforce approach and services continue to ensure environments and workplaces remain gender sensitive and appropriate. There is no impact from this policy on gender, although further work is needed to understand data around complaints submitted to the Trust which relate to gender.

	Male	Female
England % av.	49.2	50.8
Kirklees		
% average	49.4	50.6
Barnsley		
% average	49.1	50.9
Calderdale		
% average	48.9	51.1
Wakefield		
% average	49	51

Taken from Census 2021 data

Gender	Total	%
F	63629	54.68
M	52666	45.26
I	39	0.03
U	16	0.01
Total Patients	**116350**	

Trustwide Information 2021/2022 data

Gender		%
Female	87	70
Male	35	28
Prefers not to say	2	2
	124	**100**

Customer Service data 2021/2022

5c **Age:**

Prompt: Older people & Young People issues should be considered

The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that Barnsley represent a higher than average older population and Calderdale a higher than average age range of 0-15 age range. The Trust will ensure that feedback is encouraged across all the age ranges and support to give feedback is provided for those who need it.

The customer services policy outlines how the complaints process should be adapted to support the needs of older individuals where hearing impairment or cognitive impairment (which may arise from dementia) and to ensure they can be supported through the complaint process.

There is further work to do to understand complaints which relate to age.

	4yrs & under	5-9	10-15	16-19	20-24	25-34	35-49	5
Barnsley	13463	14366	16953	9653	12448	32951	44859	5
%	5.5%	5.9%	6.9%	3.9%	5.1%	13.5%	18.3%	2
Calderdale	11317	12803	15877	9038	10125	24920	39471	4
%	5.5%	6.2%	7.7%	4.4%	4.9%	12.1%	19.1%	2
Kirklees	25144	27647	34153	21328	25844	54869	83410	8
%	5.8%	6.4%	7.9%	4.9%	6.0%	12.7%	19.3%	1
Wakefield	20074	20994	24764	13933	18001	48974	67143	7
%	5.7%	5.9%	7.1%	3.9%	5.1%	13.9%	19.0%	2

	50-64	65-74	75-84	85+

Barnsley	52285	26462	15765	5371
%	21.4%	10.8%	6.4%	2.2%
Calderdale	43769	21958	12688	4661
%	21.2%	10.6%	6.1%	2.3%
Kirklees	84012	42461	25146	9208
%	19.4%	9.8%	5.8%	2.1%
Wakefield	72882	36927	22110	7573
%	20.6%	10.4%	6.3%	2.1%

Taken from Census 2021 data

Age Band	Total	%
18-29	20134	17.3
Under 16	19244	16.5
30-39	16393	14.15
50-59	12450	10.7
40-49	12351	10.62
70-79	10512	9.0
80-89	9610	8.26
60-69	8512	7.32
16-17	4873	4.2
90-99	2271	1.95
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Age	%	
18-25	8	6
26-55	88	72
56-64	13	10
65-74	7	6
75 and over	3	2
Unknown	5	4

Customer Service data 2021/2022	**124**	**100**

5d **Sexual Orientation:**

Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category

The Trust will improve on the recording of sexual orientation in line with the 'Sexual Orientation Monitoring standard' so the Trust can ensure that services and workforce adequately represent the population they serve. The 2020/21 census may contain further baseline information which can be used to support the Trust understanding further as this is an area that remains mainly unknown.

There is no impact from the customer services policy on sexual orientation.

	Straight/ Heterosexual	Gay/ Lesbian	Bisexual	Pansexual
Barnsley	182948	2990	1817	290
%	91.6%	1.5%	0.9%	0.1&

Calderdale	149815	2811	1968	395
%	89.9%	1.7%	1.2%	0.2%
Kirklees	311501	4340	3697	504
%	90.0%	1.3%	1.1%	0.2%
Wakefield	261615	4321	2968	504
%	91%	1.5%	1.0%	0.2%

	Asexual	Queer	Other	Not Given
Barnsley	69	14	23	11638
%	0%	0%	0%	6.9%
Calderdale	71	62	22	11488
%	0%	0%	0%	6.9%
Kirklees	147	58	61	25742
%	0%	0%	0%	7.4%
Wakefield	126	29	30	17945
%	0%	0%	0%	6.2%

Taken from Census 2021 data

Sexual orientation	**Total**	**%**
Not Recorded	53576	46.04
Heterosexual	57001	48.99
Sexual orientation unknown	2614	2.24
Sexual orientation not given - patient refused	821	0.71
Bisexual	1082	0.94
Female homosexual	739	0.64
Male homosexual	517	0.44
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Sexual Orientation		**%**
heterosexual	73	59
Prefers not to say	42	34
Bisexual	4	3
Lesbian	4	3
Gay	1	1

Customer Service data 2021/2022

124	**100**

5e	**Religion & Belief:** Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered	Faith and spiritual care and support in an important component of person-centred care provided. The Trust have a spirit in mind service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in service delivery and as such the analysis of complaints which relate to religion and belief are reviewed and shared with Care Groups and services. There is further work to do to ensure this analysis support all people and enables learning from complaints.

There is no impact from the policy on religion or belief.

	Christian	Buddhist	Hindu	Jewish	Sikh	Muslim	Other	No religion
England % av.	71.8	0.3	1	0.5	0.7	10.1	0.2	15.1
Kirklees								
% average	67.2	0.2	0.3	0.1	0.7	10.1	0.2	14
Barnsley								
% average	59.4	0.5	1.5	0.5	0.8	5	0.4	24.7
Calderdale								
% average	60.6	0.3	0.3	0.1	0.2	7.8	0.4	30.2
Wakefield								
% average	66.4	0.16	0.25	0.04	0.12	2.0	0.3	24.4

Taken from 2011 Census data

Religion	Total	%
Not Recorded	38437	33
Not religious	20517	17.6
Church of England, follower of religion	6686	5.7
Religion NOS	7180	6.18
Patient religion unknown	4591	3.9
Christian	15395	13.2
Religion not given - patient refused	3269	2.8
Church of England	1999	1.7
Muslim	3209	2.8
Roman Catholic	1662	1.4
Christian religion	629	0.5
Atheist	669	0.5
Methodist	447	0.4
Agnostic	335	0.3
Religion (Other)	1495	1.3
Declines to disclose religious beliefs	4321	3.7
Religious affiliation	136	0.1
Mormon	114	0.1
Spiritualist	91	0
Protestant	85	0
Pagan	163	0.1
Baptist	36	0
Sikh	120	0.1
Buddhist	101	0

		Hindu	58	0
		Anglican	41	0
		Pentecostalist	25	0
		Catholic: non Roman Catholic	65	0
		Nonconformist	55	0
		Church of Scotland, follower of religion	19	0
		Church Of God	8	0
		Orthodox Christian	12	0
		Rastafarian	13	0
		Quaker	9	0
		Patient religion could not be communicated	12	0
		Wesleyan Methodist	6	0
		Sunni Muslim	15	0
		Church of Ireland, follower of religion	7	0
		Apostolic Pentecostalist	7	0
		Eastern Catholic	10	0
		Seventh Day Adventist	4	0
		Ismaili Muslim	9	0
		Evangelical Christian	7	0
		Coptic Orthodox	3	0
		Presbyterian	8	0
		Russian Orthodox	16	0
		Follower of United Reformed Church	5	0
		Christadelphian	3	0
		Unitarian	2	0
		Orthodox Jew	10	0
		Independent Methodist	3	0
		Greek Orthodox	6	0
		Salvation Army member	4	0
		Greek Catholic	2	0
		Serbian Orthodox	2	0
		Shiite Muslim	2	0
		Old Catholic	1	0
		Heathen		0
		Congregationalist	7	0
		Jain	2	0
		British Israelite		0

		Celtic Christian 2 0 Uniate Catholic 1 0 Christian Spiritualist 2 0 Jewish 20 0 Wiccan 5 0 Church in Wales, follower of religion 2 0 Romanian Orthodox 4 0 Reformed Christian 2 0 Total Patients *Trustwide Information 2021/2022 data* No information available as this is not collected by Customer Services
5f	**Marriage and Civil Partnership** Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category	There is no impact on marriage or civil partnership from this policy. **Married** / **Single** / **In a [registered] civil** / **Divorced** / **Widowed** / **Separated** England % av. 46.6 34.6 0.2 9.0 6.9 2.7 **Kirklees** % average 48.4 32.4 0.2 9.3 6.8 2.8 **Barnsley** % average 46.6 34.6 0.2 9 6.9 2.7 **Calderdale** % average 46.7 32.1 0.3 10.5 7.3 3.0 **Wakefield** % average 48.2 30.9 0.18 10.5 7.5 2.6 Source unknown **Marital Status** / **Total** / **%** Single person 62828 54.0 Married 21158 18.2 Widowed 8063 6.9 Not Recorded 18209 15.6 Divorced 4240 3.6 Separated 1852 1.9 Total Patients **116350** 100%
5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	No information available as this is not collected by the Trust or Customer Services
5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	The customer service policy and agenda for gender re-assignment people will remain a focus and data collection will need to be improved to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data.

Gender reassignment	Total	%
No	116143	99.8
Gender reassignment patient	207	0.2
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

For Customer Service information please see figures included in sexual orientation section.

5l **Carers**

Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered

It is not anticipated there will be any negative impact on service users or their carers from this policy.

A number of people who contact the customer services team are carers/family members for service users and are supported to raise a concern on behalf of a service user who might be unable to do so themselves.

Relationship to service user		%
Parent	37	30
Service User	70	56
Sibling	4	3
Son/Daughter	5	4
Spouse/Partner	6	5
Other	2	2
Customer Service data 2021/2022	**124**	**100**

5j **Race**

Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.)

Work has developed within the customer services team to understand who is in contact with the team and providing feedback/raising concerns/complaints. There is further work to do to examine this data and understand why there is a disproportionate amount of people who are white British providing feedback and how to encourage feedback from other ethnic groups.
The policy supports the sharing of information in different languages and formats and the team are able to access language line for support if needed.

Race equality

	White	Asian	Black	Mixed	Chinese & Other
England % av.	81%	9.6%	4.2%	3%	2.2%
Kirklees					
% average	73.6%	19.4%	2.3%	3.1%	1.5%
Barnsley					
% average	96.9%	0.9%	0.7%	0.9%	0.5%
Calderdale					
% average	86.1%	10.5%	0.7%	1.9%	0.8%
Wakefield					
% average	93%	3.6%	1.3%	1.4%	0.7%

Taken from Census 2021 for each area

Ethnicity	Sum of All Patients	
Any other Asian background	496	0.30%

Any other black background	302	0.26%
Any other Ethnic group	815	0.7%
Any other mixed background	575	0.49%
Any Other White background	2591	2.22%
Bangladeshi	87	0.075%
Black African	554	0.48%
Black Caribbean	426	0.36%
Chinese	82	0.07%
Indian	975	0.58%
Not Recorded	1543	1.32%
Not Stated	2070	1.78%
Pakistani	3513	3.01%
White and Asian	340	0.29%
White and Black African	177	0.15%
White and Black Caribbean	624	0.53%
White British	100730	86.57%
White Irish	450	0.38%
Total Number of Patients	116350	100%

Trustwide Information May 2021/2022 data

Of people who made a complaint to the Trust their Race/Ethnicity is recorded below (124 received in total)

ethnicity		**%**
White British	89	72
Prefers not to say	13	10
Pakistani	4	3
Any other Black	1	1
Any other Ethnicity	1	1
Any other White	3	2
Black African	1	1
Indian	1	1
Unknown	6	5
White & black Caribbean	3	2
White Asian	2	2
Customer Service data 2021/2022	**124**	**100%**

Action Plan

When thinking about actions look at the impacts you have identified and add **1-3 annual actions** that will mitigate against impacts and ensure service improvement.

Potential themes for actions could cover anything from geographical location, built environment, timing access to a service, make up of workforce, stereotypes and assumptions, improved equality monitoring, community relations/cohesion, ward environments and care, or any other specific issues/barriers you would like to address. Complete one action for each form below and RAG rate your progress.

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update	RAG
Age		Further data analysis required to understand complaints which relate to protected characteristic to identify where learning and changes are needed to services.	Ruth Foxcroft	August 2024		
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						
Carers						

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update	RAG
Age		Work to gather feedback from complainants who have a protected characteristic to understand their experience of providing feedback to the Trust	Ruth Foxcroft	August 2024		
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						

Carers						

Who will benefit from this action? (tick all that apply)		**Action 3: This is what we are going to do**	**Lead/s**	**By when**	**Update**	**RAG**
Age						
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						
Carers						

Involvement & insight:

- Have you reviewed existing insight i.e. patient experience, complaints, previous surveys to support EIA completion?
- Have you gathered the views of people to support EIA completion?

If yes, please add any reports or evidence in the box below

The Customer Services team captures data on most protected characteristics to support the development of Trust services for people. This information has been utilised to complete this EIA, however, as outlined in the actions section there is further work to do on this captured information and to understand what impact this policy and the customer services process has on people with protected characteristics.

7 Methods of Monitoring progress on Actions

Progress and completion of the actions will be monitored through the customer services team meetings, through clinical governance group and reported through the Customer Services Annual report where these have also been identified as areas for action over the coming year.

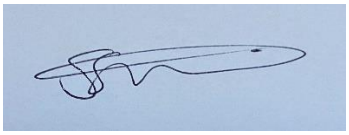
8 Publishing the Equality Impact Assessment

The EIA will be published as part of the customer services policy. The policy is available both internally and publicly on the Trust website.

- This EIA will be shared with InvolvingPeople@swyt.nhs.uk who will publish as they see fit.
- This EIA will be saved within the shared drive of for the team to have access to.
- This EIA will be saved within the Team Managers folder for others to have access to.

The EIA has been graded as **Developing** by Aboo Bhana Equality and Involvement Manager

9 Signing off Equality Impact Assessment:



Sarah Whiterod
Associate Director of Nursing, Quality and Professions

Once approved, you must forward a copy of this Assessment/Action Plan by email to:
InvolvingPeople@swyt.nhs.uk

Appendix E

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is it clear who will be responsible implementation and review of the document?	YES	

APPENDIX F
Version Control Sheet
This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Dec 2013	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with Francis Report, Patient's Association Report on Complaints and the Rt Hon Ann Clwyd review of NHS Complaints Management.
2	Dec 2014	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with the Francis Report, The Government's response, 'Hard Truths' and the Duty of Candour.
3	January 2016	Deputy Director of Corporate Development	Final	Approved by Trust Board Included updates in line with CQC Essential Standards and PHSO report 'My Expectations'
4	January 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes update in line with: • CQC inspection 2016 • CSE Accreditation 2016 • PHSO report 'My Expectations' • NHSE Assurance of Good Complaints Handling • CQC report 'Complaints Matter'
5	June 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes updates in line with CQC action plan to include reference to people's right to complain to the CQC about detention under the Mental Health Act – in line with the Mental Health code of practice.
6	May 2021	Associate Director of Nursing & Quality		
7	August 2023	Associate Director of Nursing, Quality and Professions		Full update of policy and alignment with NHS Complaint regulations. Section on managing persistent and

				unreasonable contact expanded and updated.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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)			✘									

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
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 *(September 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)*