NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 28 November 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 31 October 2023**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 31 October 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 7 2023/24	Executive Directors	**Paper**	45	To receive
	10.50	9.2 Care Group dashboards (community mental health and mental health inpatients)	Chief Operating Officer	**Paper**	10	To receive
	11.00	*Break*			*10*	
10.	**11.10**	**Risk and Assurance**				
	11.10	10.1 Serious Incidents Quarterly report	Chief Nurse and Director of Quality and Professions	**Paper**	8	To receive
	11.18	10.2 Ligature Annual report	Chief Nurse and Director of Quality and Professions	**Paper**	7	To receive
	11.25	10.3 Medical education annual report	Chief Medical Officer	**Paper**	5	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.30	10.4 Freedom to speak up self-assessment	Deputy Director of Corporate Governance/Freedom to speak up guardian	**Paper**	8	To receive
	11.38	10.5 EPRR compliance report	Director of Finance, Estates and Resources	**Paper**	7	To receive
	11.45	10.6 Assurance and receipt of minutes from Trust Board Committees and Members' Council - Mental Health Act Committee 7 November 2023 - Quality & Safety Committee 14 November 2023 - Members Council 17 November 2023 - Finance, Investment & Performance Committee 20 November 2023 - People and Remuneration Committee 21 November 2023	Chairs of committees/Members' Council	**Paper**	10	To receive
11.	**11.55**	**11. Integrated Care Systems and Partnerships**				
	11.55	11.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive	**Paper**	10	To receive
	12.05	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
	12.15	11.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive
12.	**12.20**	**Governance matters**				
	12.20	12.1 Trust Seal	Director of Finance, Estates and Resources	**Paper**	5	To receive
13.	**12.25**	**Trust Board work programme for 2022/23**	Chair	**Paper**	5	To receive
14.	**12.30**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 30 January 2024	Chair	**Verbal item**	2	To note
15.	**12.32**	**Any other business**	Chair	**Verbal item**	3	To note
	12.35	*Close*				

Minutes of Trust Board meeting held on 31 October 2023
Boardroom, Conference Centre, Kendray Hospital, Barnsley

Present:	Marie Burnham (MBu)	Chair (in attendance via MS Teams)
	Mandy Rayner (MR)	Deputy Chair/ Senior Independent Director (Chair)
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Prof.Subha Thiyagesh (ST)	Chief Medical Officer
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
Apologies:	Nil	
In attendance:	Sue Barton (SB) (item 9.4 only)	Deputy Director of Strategy and Change
	Lindsay Jensen (LJ)	Interim Chief People Officer
	Dawn Lawson (DL)	Director of Strategy and Change
	Rachel Lee (RL)	Associate Non-Executive Director
	Andy Lister (AL)	Company Secretary (author)
	Sean Rayner (SR)	Director of Provider Development
	Tony Wright (TW) (item 9.4 only)	Sustainability Change Manager
Apologies:	Greg Moores (GM)	Chief People Officer
	Julie Williams (JW)	Deputy Director of Corporate Governance
Observers:	Lianne Richards	360 Assurance (Trust internal auditor)
	1 x governor	

TB/23/94 Welcome, introduction and apologies (agenda item 1)

The Acting Chair for the meeting, Mandy Rayner (MR) welcomed everyone to the meeting. Apologies were noted, and the meeting was deemed to be quorate and could proceed.

MR outlined the Board meeting protocols and etiquette and reported this meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting. MR noted that Marie Burnham (MBu) is in attendance via Microsoft Teams.

MR 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.

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

TB/23/95 Declarations of interest (agenda item 2)

The following updates to the Board declarations of interest were noted:

Name	Declaration
Associate Non- Executive Directors	
Rachel Lee – Associate Non-Executive Director	• Director of North Star Psychology Ltd, • Endorses a wellbeing product called Luma, this is a light that guides people through various breathing practices, based on scientific research.
Executive Directors	
Dawn Lawson – Director of Strategy and Change	No interests declared.

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

TB/23/96 Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/97 Minutes from previous Trust Board meeting held 26 September 2023 (agenda item 4)

Darryl Thomspon (DT) noted on page 12 of the minutes **"**MBu noted learning from deaths" should read "MBu noted learning from incidents".

Mike Ford (MF) raised on page 15 of the minutes – "it was confirmed there were national indicators on complaints on turnaround times". MF queried whether there should be an action in place.

Mark Brooks (MBr) reported the Trust needs to first focus internally on reducing its complaints backlog and once we are in a sustainable position, we can look at benchmarking. This might be something we want to revisit through a committee in six to twelve months' time.

Nat McMillan (NM) reported complaints would be monitored through the quality and safety committee (QSC). The minutes need to reflect this action will be monitored through QSC.

Action: Andy Lister

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/23/98 Matters arising from previous Trust Board meeting held 26 September 2023 and Board action log (agenda item 5)

TB/23/26a – It was agreed that the integrated performance report demonstration would take place after strategic Board on 19 December 2023.

TB/23/87b – action to remain open. MF asked to speak to Prof.Subha Thiyagesh further about the checking of the figures in the document. NM agreed she needed further assurance about risks prior to closing the action.

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

TB/23/99 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Jennie Linstead (JL). CH reported she met JL when she visited Lundwood (Trust site in Barnsley) before the pandemic and JL spoke to CH about the use of eye movement, desensitisation and reprocessing (EMDR) and how the Trust utilises this technique to help people live well in their communities.

JL opened by referencing one of the Trust values, being ready for tomorrow. JL has seen the benefits of EMDR for service users and the Trust now need to provide greater equity across services for the availability of this treatment.

JL explained that EMDR is a psychotherapy process that was discovered in America in the late 80s/early 90s. It is a somatic psychotherapy that targets the symptoms of disorder in the body and using a series of eye movements, blinks, clicking of fingers, finger taps and other noises. Trained therapists are able to transform underlying memories underneath the disorder. There are a number of theories as to how this works, one being that it brings forward a natural propensity to promote healing. JL stated it is known to work and therapists are now using EMDR for more and more complex conditions.

JL reported she wanted to share a story with the Board about a service user, who, two years ago, was on a mental health inpatient ward with the Trust. She could not be left alone due to the high level of risk she presented to herself and was very unwell. Today she is living in supported accommodation, has a partner, and a cat, and while she is still engaging in therapy, is living a far more independent life, having spent most of her life in hospital. The reason for this change is that two and a half years ago one of the Trust's EMDR therapists was given some time to spend with patients on the ward to see what help they could provide.

This service user described her position as "stuck" in services despite the efforts of her multi-disciplinary team (MDT). The service user's' mother did not believe her daughter would ever leave hospital.
Two years later after her EMDR therapist transferred her to JL she is now working with JL in therapy, in the enhanced team west in Barnsley, and is making enormous progress.

The service user describes the process as being so somatic; in that she didn't need to have a conscious narrative of what was wrong. At the time when she was involved in risky behaviours towards herself, she did not know why she was doing them. She tried EMDR and it worked.

JL reported EMDR is now being trialled for service users in Barnsley who experience psychosis. We may not know what the underlying trauma is, but this doesn't matter, because it focuses on the physical aspects of the illness and heals the underlying issues. There is no need for the service user to verbalise what the issues are that they have experienced. The other reason we think EMDR has worked so well is because it is a complete psychotherapy. Anyone with the right MDT around them can access it, no matter how complex. There is no other therapy required to go alongside it.

JL reported Tracey Smith had spoken with the Board, and she is helping JL to improve coordination of the treatment offer. We estimate there are 85 practitioners in the Trust. There are six confirmed consultants, most of whom are part time, or are due to retire. The service offer is inconsistent. The inpatient wards in Wakefield have an EMDR therapist, but there isn't one in Barnsley. The intensive home-based treatment team (IHBT) in Calderdale have a therapist, but the IHBT in Barnsley do not.
There are three consultants in Barnsley, but none in Calderdale. Better coordination will improve the provision of EMDR across the Trust to the benefit of many service users. Some trusts have an EMDR coordinator.

MBr thanked JL for her story and asked her how do we decide who receives this type of therapy and how many service users have benefitted from this treatment?

JL reported she was currently collating these numbers. The issue currently is that access to this treatment is not coordinated and so it can be a case of being in the right place at the right time.

MR questioned how the Board can help with the coordination of this therapy?

JL reported time or support to administrate the coordination of the clinicians. All clinicians have to be supervised by a consultant, and at the moment this is done by goodwill.

EM asked if this service is available in community services?

JL reported the majority of practitioners are in community teams, there is less availability on inpatient wards and enhanced teams.

ST reported we need to do more to share information regarding service user numbers. Do we have any benchmarking information to compare us with other trusts?

JL reported the Trust has a much higher capacity for providing this therapy, due to the number of practitioners we have, compared to other trusts.

ST queried if JL had been in touch with the research and development (R&D) team to see how they could help?

JL stated they could use their help to record and capture data.

ST stated she would put JL in touch with the R&D team.

Action: Prof.Subha Thiyagesh

DT reported Tracey Smith is the newly appointed chief psychological professions officer, who will be keen to support this work. DT stated he is sponsoring some work across West Yorkshire for psychology supervision across all providers, and Barnsley will be included in this model. This will look at supervision across all services, especially for specialised services, such as EMDR.

RL noted it was great to hear about EMDR in the Trust and asked how it links to being a trauma informed organisation?

JL noted there is a strong link with trauma informed care, and she has been linking in with the team leading this work, adding consistency of service provision across the Trust is going to be key.

RL asked if there is anything that can be done in relation to succession planning for the consultants who are retiring?

JL reported basic training has now been reduced to one year from eighteen months. You can become an accredited practitioner in five years (supervision by a consultant is required throughout) and become a consultant in around ten to fifteen years. There is a national developmental gap, we need a career structure to help people progress through their accreditation programmes.

Lindsay Jensen reported there are EMDR practitioners and a consultant working in the occupational health team, and they form part of the trauma informed work for the Trust.

EM stated EMDR sounds transformational for the Trust and its service users, but there are a number of points that need to be addressed following this discussion. EM queried if the Board could have an update on the progress they have made at an appropriate time?

CH reported Tracey Smith has just come into role and she will be taking it forward in her new role. DT suggested in 12 months a paper should come to Board to update on progress.

CH suggested that interim reports can be provided to the Quality & Safety Committee (QSC) over the 12-month period through the executive trio report. DT suggested a psychological professions update from Tracey Smith would encompass this work.

Action: Darryl Thompson

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

TB/23/100 Chair's remarks (agenda item 7)

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

- Private risks
- Assurance from Trust Board Committees (private minutes)
- Complex incidents report
- Care group performance report

It was RESOLVED to NOTE the Chair's remarks.

TB/23/101 Chief Executive's report (agenda item 8)

Chief Executive's report

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

- Joint industrial action (consultants and junior doctors) has been well managed by the Trust during October to maintain safe care.
- This is a risk focussed Board and the board assurance framework (BAF) and organisational risk register (ORR) will recognise changes to our operating environment, as well as the consideration of some future risks.
- Our risks include flu and Covid-19, particularly as we move into winter. Flu vaccinations are being provided to staff by the Trust. We are encouraging those that are eligible for Covid-19 vaccinations to receive them. We have reiterated through Trust communications the importance of good hygiene and infection prevention and control practices to Trust staff. Regionally we are seeing rises in Covid-19, and some local trusts have moved back to mask wearing, we are monitoring the position closely.
- The staff survey continues to be promoted across the Trust, and we are providing examples of what has changed in local Trust teams to incentivise people completing the survey.
- This month the integrated performance report (IPR) shows some strong progress on reducing out of area (OOA) bed placements.
- The Care Quality Commission (CQC) has published its annual state of healthcare report and focuses on a number of challenges in mental health. This report is available on the CQC website.
- A number of awareness events have taken place during October, it has been national speaking up month, and it was also world mental health day in early October.
- There are also a number of national initiatives taking place including a survey on how improvements can be made to children and young people's mental health.
- It has also been black history month, which we have been celebrating through October.
- The Provider Selection Regime has been published, subject to parliamentary scrutiny and agreement, which supports what is stated in the health and social care act about focusing more on collaboration than competition. finance, investment and performance committee (FIP) may wish to consider what this could mean for the Trust.

Action: Adrian Snarr

- MBr noted the success of the annual members' meeting and thanked those that had arranged the event and those that had attended.

- A premature mortality report has been released which reported mortality was five times higher for those with a severe mental illness during the covid-19 pandemic – which highlights the importance of retaining our focus on reducing health equalities.
- MBr gave thanks to Sue Barton for acting up into the role of director of strategy and change since Salma Yasmeen left the Trust and her support in Dawn Lawson joining the Trust.

NM noted the provider selection regime, and how it will be interesting to see this develop. NM supported MBr's comments about the annual members' meeting and reported it had been an excellent event. MR agreed.

Kate Quail (KQ) noted industrial action and thanked staff on behalf of the Board for all the work that had gone into managing this. KQ queried if there has been a rise in incidents or any incidents as a result of industrial action?

CH reported there hadn't been a rise in incidents or any incidents as a result of industrial action but there may be longer term impacts that haven't materialised yet, e.g., people that have missed appointments.

MBr reported there may also be some unintended consequences, such as staff having to miss mandatory training or not receiving their appraisal or supervision in order to provide cover.

ST reported silver command meetings have been very effective in managing industrial action. All incidents are closely monitored through the clinical risk panel for any links to industrial action.

EM noted the solving together platform, which relates to hosting a month-long online conversation on children and young people's mental health, seeking views and ideas on how waiting times can be improved, and services being made more accessible. EM queried if the Trust is part of this?

MBr reported the Trust is promoting the platform so staff can participate if they want to, and the Trust is looking at other creative solutions in relation to service provision as demand currently outstrips capacity.

EM asked if is it possible for the Board to look at this again at some point?

Action: Carol Harris

MR queried if 32% is a good for a return at this stage for the Trust staff survey?

LJ reported the Trust is above average in terms of like providers and is slightly above where we were this time last year.

MR acknowledged the progress on out of area beds, and Sue Barton's work as interim director of strategy and change.

MR congratulated David Yockney, who works in Barnsley services, who has been awarded the prestigious title of Queen's Nurse, and the positive comments in relation to children and adolescent mental health services (CAMHS).

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

TB/23/102 Risk and Assurance (agenda item 9)

TB/23/102a Board Assurance Framework (agenda item 9.1)

Adrian Snarr (AS) asked to take the item as read and highlighted the following points:

- The executive management team (EMT) have reviewed the BAF in full..

- Risk 2.4 is a new risk for 23/24 - Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. Today's paper contains a proposed grading. The discussion at EMT identified the Trust is in a much better place in terms of data capture, but we now need time to analyse the data. EMT propose a grading of Amber with an action plan in place to progress to Yellow in the coming months.
- EMT considered external pressures and discussed at length the financial 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. EMT decided this should remain as Amber at this time but will need to carefully consider this risk in the planning process for 24/25 given the deterioration in NHS finances generally.
- Risks regarding recruitment challenges and staff wellbeing were also areas of focus, but no changes to gradings are recommended at this time.

MBr noted these are strategic risks, EMT have considered finance, and staffing and wellbeing in detail. When we look at our staff surveys and metrics, EMT did not feel a need to change gradings at this time but agreed these need to be monitored closely. Finances will be a challenge for next year.

MF noted the number of yellow risks is encouraging. We now need to focus on the risks that are amber to move them to yellow.

AS reported the BAF is a dynamic document and will change every time it is reviewed. These are the Trust's strategic risks, and they are not expected to move quickly because some of them contain engrained challenges, that cannot always be influenced by the Trust. The changes may more likely come incrementally.

MF commented this paper shows objectively we are broadly on trajectory, and that is how it feels at present.

MR agreed. When looking at the BAF we need to take account of the national factors and external factors, and objectively the BAF reflects where the Trust is, noting the external risks across the broader NHS.

The Board agreed the proposals were appropriate for approval.

MF reported he and AS had reviewed a Price Waterhouse Cooper (PWC) paper about risks across the NHS, and 360 Assurance have provided some further insight on BAF development which will be considered at Audit Committee in January, the outcome of which, will be fed back through the 'Triple A' report.

KQ stated she agreed with the grading of risk 2.4 at this time and queried assurance number 78 which relates to the international recruitment processes, suggesting further clarity may be required given the nature of the risk. The assurance should be about international recruits feeling valued and included, rather than the success of the recruitment itself. Assurance 33 also needs to be broken down more by protected characteristics and by service.

MR questioned whether this was included in the international recruitment action plan?

KQ agreed she did not want major new research being undertaken but it would be helpful to receive further assurance regarding the points she has raised, and highlighting where any hotspots may be.

Action: Lindsay Jensen

LJ reported the focus on recruiting international nurses has now moved to how they are working in our teams. We have some dedicated resource in the operations team to look at how embedded international staff are, in our teams and services. Working groups are in place looking at the preceptorship of international recruits and these will be fed back into the People and Remuneration Committee (PRC).

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

TB/23/102b Board Assurance Framework grading process review (Agenda item 9.2)

AS introduced the item and highlighted the following points:

- Benchmarking work has taken place and we have consulted with 360 Assurance for best practice.
- The review identified that three level grading systems are not always effective.
- Consideration was given to the 5 x 5 matrix used with the Trust organisational risk register (ORR), but it was deemed it was important to differentiate between the BAF and the ORR.
- The proposal includes four levels of assurance and five levels of risk and has been brought to Board today for approval.
- If supported, we will look to integrate this into a new Board Assurance Framework

EM queried if this means more actuated differences between gradings, and will this mean that our gradings will get better or worse?

MF reported his understanding is that each risk under this proposal will have two ratings, one for assurance, and one for how likely the risk is to happen. MF queried if the combined total of both ratings provides the risk score.

AS reported the Trust is trying to avoid this type of matrix as it is too close to the ORR grading system.

MF queried where the consequence is going to be referenced?

CH reported the consequence, at this level, is the Trust won't achieve its strategic objectives.

MF reported he would like to see the new grading system, to determine if this is the right step to take.

MR reported the Board is here to take assurance on risks and the new grading system includes this.

MF questioned if this grading proposal should have come to Audit Committee first.

AS noted, the Audit Committee in January will run parallel to the January risk Board, and the BAF, including the new grading system, could be presented to Audit Committee in January, for scrutiny prior to Board.

MBr stated the risk scoring seems appropriate now, but questioned how often the criteria by which risks are determined is fully considered by the Board. The proposed system would be more thorough in assessing risks.

MBr agreed this should go to Audit Committee in January for detailed discussion. It feels the right time to review the grading system, but the Board need to be comfortable with the change.

The Board agreed the BAF including the new grading system will go to Audit Committee in January and then follow into January Board.

Action: Adrian Snarr

It was RESOLVED to NOTE the new Board Assurance Framework grading process, and AGREE for implementation in January 2024, through Audit Committee and then Trust Board.

TB/23/102c Corporate/Organisational Risk Register (agenda item 9.3)

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

- There is an emerging new risk regarding the culture in terms of speaking up, following papers received at board about broader challenges in the NHS.
- Similarly, there is an emerging new risk about individuals feeling safe from sexual harm, this also emanates from broader NHS context.
- There is a good level of detail in the paper which demonstrates this is a good example of the process executive leads go through to review their risks on a regular basis.

MBr stated risk changes should have been through Board committees for detailed discussion and committee chairs will have agreed scores and so we should now be able to take any queries by exception.

NM highlighted that risk 1530 was discussed in detail at QSC, this is also referenced in the committee's Triple A report this month. There is work taking place in respect of quality and demand, and the committee received assurance to this effect from CH. Committees can scrutinise the detail of risks and provide assurance to Board.

DW noted the new risks and asked if they will be presented to Board committees before January Board.

AS confirmed, this will be the normal process.

MF queried the new freedom to speak up risk.

MBr stated there is a need to go through the process to see what controls and assurances are in place. If we have strong controls the risk score should be low, but we need follow this process to provide appropriate assurance.

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 the reduction in risk score for risk 1151, 905, 1568, 1368, 1758.**
- **AGREE to the change in description for risk 1530, 1368, 1689, 1159, 1217.**
- **AGREE to an increase in risk score for risk 275, 1585, 1840, 1432.**
- **AGREE that risk 1757 retains a score of 12 and be further reviewed in Q3.**

TB/23/102d Sustainability annual report (agenda item 9.4)

Dawn Lawson (DL) introduced the item and introduced Sue Barton (SB) and Tony Wright (TW) who highlighted the following points:

- DL asked the Board to note the level of staff interest and engagement in this strategy.
- SB reported this is the first time a combined sustainability and green plan annual report has been presented to the Board.
- We are proud of our progress whilst noting there is a still a lot more to do.

- The report documents key achievements to date and identified next steps.
- We have spent a lot of time on metrics to measure progress, but some of the sustainability agenda is quite hard to measure.
- As part of the sustainability agenda 500 trees have been planted across the Trust at Fieldhead and Kendray.
- SB reported another 1,200 trees are coming. Estates and facilities have been working hard to establish where they should be planted.
- Medicines optimisation work through Kate Dewhirst and her team is starting to take shape around sustainability within medicines.
- An example is the “green bag” scheme, where people bring their medication with them to inpatient wards and then take it back home once discharged.
- There has been the first ever use of the sustainability impact assessment through the West Yorkshire older people’s services transformation work.
- E-bikes have been purchased and are coming to the Trust next week.
- TW reported “the green team” idea has been well supported by the communications team. Over 200 staff have asked to be involved, and the whole idea is for people to take ownership of sustainability within the Trust.
- We want people to start thinking about their role, their team, and their service. The green team will provide a great network of people who will be able to share ideas.
- Details of progress within the Trust will be included in further reports to Trust Board and the Equality, Inclusion and Involvement Committee.
- TW reported there is a desire to engage with patients, carers and families and we need to think about how we are going to do this, and any ideas are welcome.
- At the beginning of next week an e-mail will be circulated about next steps for the green team. There is a broad range of staff wanting to be involved both geographically and also by service and roles within the Trust.
- TW asked that all members of the Board volunteer to join the green team.

Action: Andy Lister

- Start of next week we will be sending out comms around next steps.

NM noted it is good to see metrics in the report so that we know how we are going to measure the impact of this strategy. NM also supported the range of metrics that have been identified.

MBu noted the Trust being one of the first to complete a sustainability impact assessment in the service transformation planning process. MBu sits in a number of national and regional Chairs’ meetings and suggested there may be scope for the Trust being an exemplar for sustainability, showcasing our work.

MBr reported Rob Webster (Chief Executive of the West Yorkshire Integrated Care System) has agreed to feature the Trust in the ICS weekly publication, which is a good first step.

TW reported the West Yorkshire integrated care board (ICB) sustainability impact assessment has been a useful learning process.

MBr gave thanks to Sue and Tony for all the work they have done and noted it is a good report with the right amount of detail.

Sean Rayner (SR) followed on from MBu’s comments and noted paragraph 3.10 of the report. The strategy has substantial depth, commenting that the breadth of the strategy through the partnerships we are involved in, is substantial. One the issues raised is about anchor organisations and how difficult it is to evidence being an anchor organisation. This report provides sufficient evidence for the Trust to justify that it is an anchor organisation.

EM complimented the pace and quality of work that has taken place so far.

KQ agreed and noted reducing health inequalities, building communities, and tackling social determinants is often hard to explain but this shows how we are doing it through the metrics included in the report.

STh noted that sustainability will be included in the public consultation regarding the older people's transformation process, and this in turn will engage with service users, carers, and families as per TW's earlier query.

MR thanked SB and TW on behalf of the Board for the progress made and the good report presented.

It was RESOLVED to NOTE the content of this report.

TB/23/102e Patient safety incident response framework (PSIRF) (agenda item 9.5)

Darryl Thompson (DT) introduced the item and highlighted the following points:

- Updates have been reported to Board as part of quarterly papers, and it has been reviewed in detail at QSC.
- A background paper is presented to Board today and the organisational plan that requires approval to commence from 1 December 2023
- As part of core requirements, it has been agreed as a plan by both West and South Yorkshire integrated care boards.
- Our data analysis and learning from previous incidents has helped us to identify three areas that require investment of resource to aid our learning about the system and subsequent improvements needed:
    - Suicide prevention
    - Clinical risk assessment (Formulation Informed Risk Assessment (FIRM))
    - Pressure ulcer clinical documentation

  We will do this through thematic patient safety incident investigation (PSII) projects.
- We will also undertake other types of learning response for incidents (individual incident or thematic) where we want to identify new learning for improvement.
- The PSIRF policy has been written and is being approved through normal Trust processes.
- We now have recruited three patient safety partners, who are all very experienced.

MR noted the balance between learning and responding, and queried the start date?

DT reported not all aspects will be in place by 1 December 2023, but we will have the core components in place ready to go live.

MF queried if this plan needs an equality impact assessment?

Action: Darryl Thompson

MF noted the list of provider collaboratives, includes the phase 1 provider collaboratives but not phase 2.

DT reported it is a live plan and so items will be added and removed as the work in the organisations develops.

MF noted on page 12 of the plan, there is a list of patient safety issues, but care plans aren't on there?

DT confirmed in thematic patients' safety investigations, the headline is risk assessment,which includes care planning and family views.

It was RESOLVED to RECEIVE the update paper, note the continued progress with these patient safety developments, and APPROVE the plan.

TB/23/102f Workforce equality standards report scores (item 9.5)

Lindsay Jensen (LJ) asked for the paper to be taken as read and highlighted the following points:

- The Trust has been completing both the workforce race equality standards (WRES) and workforce disability standards (WDES) reports for a number of years and they have been through equality inclusion and involvement committee (EIIC) and people and remuneration committee (PRC) prior to being presented to Board today.
- Trust data was input onto the NHSE system in May and these reports now look at what that data is telling us.
- This is the first year we have had a dedicated diversity, inclusion and belonging lead on this work.
- WDES – 9% of the workforce are declared disabled, and we are reducing the "unknown" figure year on year.
- Our disabled colleagues have a poorer experience in terms of bullying and harassment.
- There have been some improvements in terms of adequate adjustments.
- We have a new "people experience team" which are working with staff to identify where more support is needed in terms of equality.
- Action plan – we have focused on the "so what". There are longer term cultural changes included that will take some time to embed.
- The Touchstone partnership has received awards for our working across the collaborative, in relation to employing people from diverse backgrounds.
- The renewed bullying and harassment policy is in development, and we are looking to embed some different principles to be more proactive and identify issues before lengthy investigations are required. A new work plan in relation to talent management and succession planning will be coming to PRC in the next few months.
- Race equality data, metrics and action plan. Our BAME colleagues are less likely to be appointed into posts than white colleagues and are also more likely to be bullied and harassed.
- Race forward, as a group, has shifted its focus to looking at the work we need to complete to change people's experiences. Equity guardians have been a key component of this work.
- There is an extended EMT this week where Monique Carayol is presenting to the group about inclusive leadership.

DT reported the "all of you race forward group" has created a resource around micro aggression, and how to respond. This has been co-produced, and a general manager has been involved in this work to help communicate this message.

NM noted this item was discussed at PRC – we need to be more specific about metrics, we need to be better than "ongoing", and have real timescales. Having strong metrics and timelines will help show us what impact we are having, or not. This will also demonstrate the Trust's level of ambition. The Trust does a lot of good work, and the metrics need to reflect this.

MR reported she has discussed the same issues with LJ.

LJ reported some of these metrics are national metrics and some require review to think about what we measure. We also need to look at the benchmarking reports from these submissions and invite the national scrutiny group to support this work.

EM reported a lot of effort has gone into this work, but we haven't progressed as far as we should have. We have focussed on metrics a little too much and we need to recognise the world outside isn't the same as it was five years ago. We need to pick what we can drive forward, especially in relation to bullying and harassment.

LJ agreed and stated we have taken too broad a view and we need to identify some key points of focus to make identifiable changes.

The race forward work needs to come to fruition. Metrics should be discussed and selected in EIIC and PRC and then we can closely monitor progression over the next couple of years.

DL reported we need to ask staff which metrics would represent what they feel? This would give staff some ownership of what is being monitored.

MBr noted this has been a good discussion and we need to really clear on our scale of ambition. The Board and EMT need to reflect on this. We need to enable real change. Bullying and harassment has improved over the last two years but not to the extent we would like.

MBr reported from those staff he has spoken to, people with protected characteristics regularly find it harder to progress within the Trust. We need to think about how we are going to change these perspectives and the work that Monique is going to carry out this week as a wider leadership team is vital to get our leaders into the right frame of mind. We need to ensure we are doing enough to facilitate real change.

KQ mentioned the reciprocal mentorship programme and whether this could be reinvigorated.

MR stated that PRC and EIIC need to have conversations about how we take this work forward.

Action: Lindsay Jensen

It was RESOLVED to SUPPORT and AGREE the contents of the reports for them to be published in accordance with NHS England requirements.

TB/23/102g Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9.7)

Collaborative Committee 3 October 2023
MF reported on the following:

- Discussions are to take place about the role of the committee when it comes to the approval of some items.

Audit Committee (AC) 10 October 2023
MF reported on the following:

- The accessible information standards audit had a limited assurance finding, this will also be picked up at EIIC.
- There is a slight drift in staff being made available to support internal audit work.
- The triangulation report has identified a slightly larger gap (6 out of 35) between the BAF, ORR and IPR, this is generally because of their operational nature. MF will write to committee chairs to confirm the risk isn't being reported through the IPR.
- MBr also noted there has been a slight drift in the timeliness of completing internal audit actions.

Quality & Safety Committee (QSC) 17 October 2023
Nat McMillan (NM) reported the following:

- NM highlighted that the issue of inequity of access for attention deficit and hyperactivity disorder (ADHD) services for people with a learning disability is being monitored by the committee.
- The committee received an input from the long Covid service which was very positive.
- Received a deep dive report from Laura Hallas, a nurse consultant in tissue viability, who presented on pressure ulcers, which provided a great deal of assurance.
- The restraint and restrictive practice and interventions (RRPI) annual report was the subject of significant discussion about practices and prone restraint. NM opened up to DT and ST to comment.
- DT reported there has been an increase in restraint and prone restraint year on year. ST, DT and CH have met with RRPI leads and operational service and quality leads on 18 October 2023 to conduct a review. We aim to use the least restrictive practice across all of our service areas. The RRPI team's primary aim is to prevent the laying of handson service users. Whenever prone restraint is used it is reviewed by the RRPI team to identify any learning. There is confidence that staff are reporting prone restraint in line with guidance and when required. What we are exploring is how we record prone restraint and how we report it as an organisation, along with the influence this may have on benchmarking. There is a meeting being arranged with RRPI network leads to establish peer organisation thresholds.
- ST reported we are confident we are restraining people only when it is required, and staff use it as a last resort. We can improve on being more open about how we share this information across the Trust. Every Datix involving restraint is reviewed by the RRPI team.
- NM reported a further update will come back into committee on 14 November 2023.

Finance, Investment and Performance Committee 23 October 2023

DW highlighted the following:

- Out of area bed use (OOA) as already discussed is coming down.
- Agency spend has increased very slightly, which will be looked at in further detail at the next meeting.
- The committee has started to look at cost improvement programmes for future years given their importance to financial stability going forward.

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

TB/23/103 Performance (agenda item 10)

TB/23/103a Integrated Performance Report (IPR) Month 6 2023/24 (agenda item 10.1)

AS introduced the item and highlighted the following:

- There is a new inpatient section within the care group section of the report, which shows a number of indicators at ward level.
- Clinical supervision is a challenge in some wards, and there is also some good performance.
- Clinically ready for discharge – we ae getting better at reporting, and understanding the data, but looking at the detail there is variability in performance across wards.
- Equality impact assessment for polices now shows good improvement.
- OOA beds, we have improved, but we are being cautious, it is not yet a trend, but we are hopeful this will be the case.
- Pediatric audiology – we are still seeing staffing challenges. There has been improvement but not to the level we had hoped. There is more work to do before we get back to target.

MR noted improvement in the front sheet and the detail on inpatient services is good but shows some high areas of absence.

RL noted the supervision metric is low, and queried if this is a reporting issue?

CH stated it is not just a reporting issue. CH is going to review the metric with her leadership team, because there is variance in the way timings are being recorded, which could be affecting the output.

DW noted appraisals have started to decline again after some improvement in the summer.

AS responded that we have growing evidence we are under reporting the level of appraisals and the only way we can fix that at the moment is a manual adjustment in the IPR. We want to focus on fixing the system. We continue to push hard to get to the matter resolved.

MR stated the Board needs some assurance that we are progressing towards the 90% threshold.

AS reported, there are two key areas of focus, one is around data input because the system isn't working as we had hoped. There isn't an automatic link between Workpal and ESR. In addition we need to ensure teams are completing appraisals in line with expectations.

LJ noted we are now reporting to teams how many completed appraisals are dropping off after 12 months, and how many new appraisals we are completing to determine the trajectory.

EM queried when there might be sustained improvement.

AS reported part of the solution is whether we need a new system. If we do, this may take time, but we might be able to fix the system and processes we currently have.

MR queried if the detail can be reviewed outside of the Board. MBr suggested PRC should look at this on behalf of the Board and report back. NM suggested as part of this, a review of the business partner role, to establish if it is making the difference that would be expected, should take place.

Action: Adrian Snarr/Lindsay Jensen

KQ noted the RRPI numbers. The RRPI annual report was received in committee, and we heard the number of restraints and seclusions has increased, yet in the IPR it reads as though they have been stable since 2018. These numbers need reconciling. We are also higher than average on comparison against NHS benchmarking data.

AS reported, we have just received a refreshed benchmarking report which we need to analyse.

MR noted there is a need to keep RRPI as a focus. QSC will review this and report back to Board as to clarity the data.

Action: Adrian Snarr/Darryl Thompson

MBu reported the IPR still requires interpretation and analysis rather than taking a holistic overview. The data is good, but it needs interpretation.

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

TB/23/104 Integrated Care Systems and Partnerships (agenda item 11)

TB/23/104a 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 most recent integrated care board meeting was a development session looking at the approach to improvement across South Yorkshire and recognising the financial challenge.
- For the mental health learning disability and autism (MHLDA) collaborative an area of focus was parity of esteem for people with mental illness, and how we can work with partners, particularly those in the acute sector.
- In Barnsley there was a good presentation on eating disorders, and we reviewed the local housing strategy.
- The Barnsley alliance with Barnsley Healthcare Federation have been making sure our objectives are aligned to the joint forward plan and reviewed continuing progress on physical health checks for people with a learning disability and severe mental illness.

It was RESOLVED to NOTE the SYB ICS update.

TB/23/104b 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)

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

- Kirklees and Wakefield integrated care board committees both recently had development sessions which covered the contribution of the voluntary, community and social enterprise sector (VCSE), and reflecting the challenges in relation to reduced grant funding in particular from local authorities and sustainability. Actions have come out of both meetings to be progressed.

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/23/104c Provider Collaboratives and Alliances (agenda item 11.3)

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

- West Yorkshire have demonstrated good progress on the forensic community pathway and have launched the forensic women's pathway. They had an event earlier in the month that was well attended by all partners.
- Using collaborative networks across the country it appears clear that we are probably one of the first to place focus on the women's pathway.

MBr noted the CAMHS provider collaborative in DSouth Yorkshire and increases in exceptional packages of care, this is a risk we need to be aware of, as costs can be high.

MBu queried if this risk appears in the Trust's risk register?

AS reported it is only a risk in West Yorkshire, as there is currently no risk share agreement in South Yorkshire. It is included in the risk register but is also picked up through financial reporting.

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/23/105 Governance matters (agenda item 12)

TB/23/105a Constitution review (agenda item 12.1)

AS introduced the item and highlighted the following points:

- A full review has taken place and the proposal is to extend the constituency of "social care workers in integrated teams" to "social workers" with a view to appointing a governor into this constituency in the next round of governor elections.
- Governors have been consulted over a two-week period and no objections to the proposal have been received.

It was RESOLVED to RECEIVE the update and SUPPORT the recommendation to the Members Council to APPROVE the change of staff governor constituency for social workers in integrated teams to social workers.

TB/23/106 Strategies and Policies (agenda item 13)

TB/23/106a Progress against the Digital Strategy update (agenda item 13.1)

AS introduced the item and highlighted the following points:

- This is the last update on the current strategy.
- We are on track and are delivering on target.
- Digital dictation is to move on from the procurement stage to the implementation stage.
- Sustainability planning – there has been lots of debate about food wastage at EMT. We have rolled out tablets so that service users order food from the wards, and this is reducing food wastage.
- The new digital strategy is being developed and will be brought to board for approval in due course. Engagement with staff is in progress at the moment.

MR noted the challenge given the tightening financial position and moving towards paper light. The report has a lot of detail and is well presented, we are doing some really good work.

AS agreed, finances will be a challenge, but we need to make sure as well as an appropriate strategy we have an appropriate delivery plan, which can be flexible around workforce.

MBr reported there was a good executive time out session last week, and a conversation considering whether we need refresh our overall Trust strategy, we have a clinical strategy in development. We might want to ensure the sequencing of strategy development is logical and therefore to have an updated digital strategy for July might be more appropriate. We just need to consider the sequencing of strategies.

MR supported this.

NM commented if we are developing an updated digital strategy, the Board needs to consider what we really mean by being "digital".

AS reported, we have an excellent starting point with SystmOne, and having a single clinical platform across the organisation that we can incrementally build on, means we can be ambitious and safe at the same time.

MR noted we might need a strategic board/development meeting where we can consider this.

Action: Adrian Snarr

MR asked to thank Paul Foster as author of the report.

A discussion took place in relation to capital expenditure requirements. AS acknowledged the risk of spending our budget within years and also the general availability of capital in the NHS.

It was RESOLVED to NOTE the achievements made to date in respect of the 2023/24 milestones.

TB/23/107 Trust Board work programme 2023/24 (agenda item 14)

It was RESOLVED to NOTE the work programme.

TB/23/108 Date of next meeting (agenda item 15)

The next Trust Board meeting in public will be held on 28 November 2023 at Fieldhead Hospital, Wakefield.

TB/23/109 Any other business (agenda item 16)

Signature:

Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 31 October 2023 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 31 October 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/97	Darryl Thomspon (DT) noted on page 12 of the minutes **"**MBu noted learning from deaths" should read "MBu noted learning from incidents". Mike Ford (MF) raised on page 15 of the minutes – "it was confirmed there were national indicators on complaints on turnaround times". MF queried whether there should be an action in place. Nat McMillan (NM) reported complaints would be monitored through the quality and safety committee (QSC). The minutes need to reflect this action will be monitored through QSC.	Andy Lister	November 2023	Minutes updated as requested.
TB/23/99	ST stated she would put Jennie Linstead in touch with the R&D team to help her record and capture data in relation to EMDR treatment.	Prof.Subha Thiyagesh	November 2023	STh has spoken to R and D and they are going to speak to Jennie about how they can support her.
TB/23/99	CH reported Tracey Smith has just come into role and she will be taking it forward in her new role. DT suggested in 12 months a paper should come to Board to update on progress. CH suggested that interim reports can be provided to the Quality & Safety Committee (QSC) over the 12-month period through the executive trio report. DT suggested a psychological professions update from Tracey Smith would encompass this work.	Darryl Thompson	November 2024 (dated to 12-month update report)	

TB/23/101	The Provider Selection Regime has been published, subject to parliamentary scrutiny and agreement, which supports what is stated in the health and social care act about focusing more on collaboration than competition. finance, investment and performance committee (FIP) may wish to consider what this could mean for the Trust.	Adrian Snarr	January 2024	
TB/23/101	EM noted the solving together platform, which relates to hosting a month-long online conversation on children and young people's mental health, seeking views and ideas on how waiting times can be improved, and services being made more accessible. EM queried if the Trust is part of this? MBr reported the Trust is promoting the platform so staff can participate if they want to, and the Trust is looking at other creative solutions in relation to service provision as demand currently outstrips capacity. EM asked if is it possible for the Board to look at this again at some point?	Carol Harris	January 2024	
TB/23/102a	KQ stated queried assurance number 78 in the BAF which relates to the international recruitment processes, suggesting further clarity may be required given the nature of the risk. The assurance should be about international recruits feeling valued and included, rather than the success of the recruitment itself. Assurance 33 also needs to be broken down more by protected characteristics and by service. KQ agreed she did not want major new research being undertaken but it would be helpful to receive further assurance regarding the points she has raised, and highlighting where any hotspots may be.	Lindsay Jensen	January 2024	

TB/23/102b	The Board agreed the BAF including the new grading system will go to Audit Committee in January and then follow into January Board.	Adrian Snarr	January 2024	
TB/23/102d	Tony Wright asked that all members of the Board volunteer to join the green team.	Andy Lister	November 2023	All board member e-mail addresses sent to Tony Wright to be included in green team circulations.
TB/23/102e	MF queried if the PSIRF plan required an equality impact assessment?	Darryl Thompson	November 2023	The Patient safety incident response policy is the vehicle through which the Trust will deliver the PSIRF plan, as discussed at Board on 31 October 2023. The policy was subject to an equality impact assessment, and this was signed off and in place in August 2023.
TB/23/102f	Workforce equality standards were discussed, and it was noted that the race forward work needs to come to fruition. Metrics should be discussed and selected in EIIC and PRC and then they can be closely monitored over the next couple of years. DL reported we need to ask staff which metrics would represent what they feel? This would give staff some ownership of what is being monitored. MBr noted need to really clear on our scale of our ambition. The Board and EMT need to reflect on this. We need to enable real change. Bullying and harassment has improved over the last two years but not to the extent we would like.	Lindsay Jensen	January 2024	

TB/23/103a	Appraisal data in the IPR was discussed. AS reported part of the solution is whether we need a new system. If we do, this may take time, but we might be able to fix the system and processes we currently have. MBr suggested PRC should look at this on behalf of the Board and report back. NM suggested as part of this, a review of the business partner role, to establish if it is making the difference that would be expected, should take place.	Lindsay Jensen/Adrian Snarr	January 2024	
TB/23/103a	KQ noted the RRPI numbers. The RRPI annual report was received in committee, and we heard the number of restraints and seclusions has increased, yet in the IPR it reads as though they have been stable since 2018. These numbers need reconciling. We are also higher than average on comparison against NHS benchmarking data. AS reported, we have just received a refreshed benchmarking report which we need to analyse. MR noted there is a need to keep RRPI as a focus. QSC will review this and report back to Board as to clarity the data.	Adrian Snarr/Darryl Thompson	January 2024	
TB/23/106a	AS reported, we have an excellent starting point with SystmOne, and having a single clinical platform across the organisation that we can incrementally build on, means we can be ambitious and safe at the same time. MR noted we might need a strategic board/development meeting where we can consider this.	Adrian Snarr	January 2024	

Actions from 26 September 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/85	Nat McMillan (NM) noted the national suicide prevention strategy referenced in the CEO paper, and asked for Naomi Sutcliffe to the present this to QSC, following her presentation of the regional strategy in July.	Darryl Thompson	November 2023	This has been added to the committee workplan for January 2024.
TB/23/86a	CH to update if achievement of 99% compliance in relation to paediatric audiology was achieved in October 2023 to provide assurance to the Board.	Carol Harris	November 2023	Referrals into the service have increased by 100% since October 2022. Referrals are now made more routinely by other professionals and services, rather than when a specific hearing concern is identified. The service has had long term sickness and a vacancy, which has impacted capacity. This has now been addressed and the team will be fully recruited to by early December. A comprehensive service review is being undertaken encompassing demand and capacity, the management of clinics and appointments, service staffing structure, referral pathways, discharge, onward referrals, cancellations. The service level agreement in place with Barnsley Hospital is also under review. A trajectory for achievement of the target is currently being prepared and will be informed by the outcomes of the service review.
TB/23/86a	EM requested the need for some more focus on single point of access (SPA) numbers and the current situation. MBu asked for CH to provide EM with a more detailed update in relation to SPA outside of the meeting and CH agreed to take a deeper dive to FIP.	Carol Harris/Adrian Snarr	November 2023	A paper was presented to the Finance, Investment and Performance Committee on 20 November 2023.

TB/23/87b	Medical appraisal and revalidation item - NM queried the risk around the voluntary status of appraisers if it allocated with their job plan. ST agreed to share the detail with NM outside of the meeting. MF asked for the numbers to be checked as to how many appraisals have been completed as there is differentiation in different parts of the report. ST agreed to share detail, and agreed the narrative of the report needs to be improved.	Prof.Subha Thiyagesh	November 2023	October update: Clarification shared with NM and will be taken into account for the next board report. The numbers have been checked and remain accurate. Differences are due to numbers connected to the trust and their appraisal periods that fall outside of the connection period. The narrative will be further enhanced to be clearer in future. November update: STh has provided additional information to NM and MF and the action can now be closed.
TB/23/87c	KQ agreed the triangulation of the information at care group level from patients and carers complaints and feedback, beyond the friends and family test feedback is limited. In the Lucy Letby case families were reporting things as well as staff and were not being listened to. This is something that could be included in the IPR to help Board monitor issues at this level.	Adrian Snarr	November 2023	This is to be included in discussion about the IPR development with the quality directorate.
TB/23/87e	NM reported the improvement work in complaints is being monitored by QSC, and we need to see the trend continue to be fully assured. The report is an improvement from last year and we can now build on this improvement. The report needs qualitative data as well as quantitative data to confirm we are listening to carers, service users and families.	Darryl Thompson	November 2023	A full review of the patient experience annual report is planned for February 2024, to ensure that the experience of patients and carers is reflected in it for 2023/24. This will be held and developed 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 EMT and Quality and Safety Committee in March 2024.

TB/23/90	MBu queried if the metrics in the equality impact assessment (EIA) for the Customer Services Policy need to appear in IPR as equality metrics. CH agreed but would need to look at how this would work practically. MBr suggested we should assess what we have in the IPR already and look to identify any gaps.	Carol Harris/Adrian Snarr	November 2023	The equality metrics that are recommended by NHSE/I for addressing inequality are Ethnicity and Deprivation. This would align with our dashboard and improvement approach. In addition, further guidance on the delivery of the Patient Carer Race Equality Framework published this month also identifies a requirement for monitoring complaints and patient experience by ethnicity. This information will be shared with the Nursing, Quality and Professions Directorate to progress.
TB/23/92	MF noted there are updates in the IPR on priority programmes, but they don't have any rating as to their progress, is this something we could do?	Adrian Snarr/Dawn Lawson	November 2023	Historically the programs had been rated with regard to their progress against delivery plan, though it was felt to be unhelpful because of the confusion that it was a reflection of progress against delivery of the strategic priority. In most cases the metrics demonstrating progress against strategic programs will be elsewhere in the IPR so there was a concern about duplication. It is a legitimate question to ask, but given the forthcoming strategy refresh, it is suggested that we hold the question and address as we think out our strategic priorities and programs.

Actions from 25 April 2023

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 (next scheduled Board meeting)	A new escalation process was put in place, together with reaffirmed expectations of content after the last safer staffing report. These did not have the full impact required, and so a fundamental review of how we approach the safer staffing reports going forward is now underway. The current safer staffing report is being reviewed and updated to ensure compliance with assurance expectations. The proposal is that this will be presented to Board in January.
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 (next scheduled Board meeting)	A new escalation process was put in place, together with reaffirmed expectations of content after the last safer staffing report. These did not have the full impact required, and so a fundamental review of how we approach the safer staffing reports going forward is now underway. The current safer staffing report is being reviewed and updated to ensure compliance with assurance expectations. The proposal is that this will be presented to Board in January.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 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:	**The financial impact of industrial action has been recognised and will result in £800m of existing NHS England (NHSE) and Department of Health & Social Care (DHSC) budgets being reallocated to support systems and individual providers**. There are also changes to the elective recovery financial targets which will potentially result in a further £200m being available to provider trusts. All systems have been required to update their forecasts for the full year with an expectation the additional funding available will support a position in line with original targets. From a Trust perspective our full year forecast will continue to show us planning to achieve a break-even position. The focus of the Board meeting this month is on performance and monitoring. **It has been pleasing to see a continuation in the reduction in the use of out of area bed placements during October**. Whilst only used when other options have been exhausted, there can be a real impact on services users, families, friends, and carers alike, with potential access challenges, as well as a financial cost. Given issues with leadership capacity in the people directorate, a plan has been established to focus on improvement with key issues such as appraisals, length of time to recruit, and assurance over data quality. **NHS England has launched its national anti-racism framework (patient & carers' race equity framework**). This framework has been co-designed to support mental health provider trusts to improve the experiences of care in mental health services for ethnically and culturally diverse communities. Trusts are encouraged to use their data in a transparent way to inform and improve services for culturally diverse communities. We welcome the introduction of this framework given the known inequalities that exist within		

	mental health provision. Further detail in terms of what the framework provides and how we can use it in the Trust to enhance our own services will be taken through the Equality, Inclusion, and Involvement Committee. A stark example of this is provided in report by the NHS Race and Health Observatory which has been published. A study of ten years of anonymised patient data found that people from Black and minoritised ethnic backgrounds have experienced poorer access to, and outcomes from, NHS talking therapies. Over this time, compared to White British groups, they are less likely to access services, and tend to wait longer for assessment and to access treatments. **NHS Providers has produced a new guide on how to tackle racial discrimination in disciplinary procedures and create a more inclusive and equitable work environment.** The guide includes some practical interventions that have been used successfully in the to narrow the disciplinary gap and improve the workplace experience for everyone. We are reviewing this guide to determine where it can be used to improve our own processes. Building on previous work with our Trust Board, **over seventy leaders in the Trust attended an extended executive management team session facilitated by Monique Carayol which focused on inclusive leadership**. Ensuring we raise awareness and have a consistent approach to inclusivity is vital to us improving experience of service users and staff alike. **Whilst our Trust financial performance is broadly in line with plan and we are forecasting to achieve our targeted break-even position for the full year, this position is being supported by non-recurrent means.** Deficits have been recorded in several months this year and as we approach the planning process for 2024/25 and beyond, there needs to be a tangible shift to focus on waste reduction and productivity to deliver cash releasing savings. This is also subject of great focus in each of our places and integrated care systems, in which we are fully engaged. We continue to promote completion of the annual staff survey. At the time of writing this report (November 20th) 49% (2,378) staff have completed the survey and the deadline for completion is November 24th. Last year 50% of staff completed the survey. Similarly, we are promoting take up of the annual flu vaccination and as at November 17th 44% of front-line staff and 43% of all staff have received their vaccination. The final report by Baroness Hollins which covers people with a learning disability and/or autistic people who are detained in mental health and specialist learning disability hospitals has been published. The report concludes that the use of solitary confinement should be severely curtailed, but not by increasing the use of other restrictive interventions. There are thirteen recommendations which include staff skills and development, along with treating solitary confinement as a never event and reportable to the CQC.

	NHS Providers has published the results of its annual state of the provider sector survey. This provides helpful insight for Board members regarding the general feeling of NHS leaders currently. Key headlines from the survey are • 80% of leaders say this winter will be tougher than last year (66% said last year was the most challenging they had ever seen) • 95% are concerned about the impact of winter pressures. • 78% are concerned about having enough capacity to meet demand over the next 12 months. • Over 80% are concerned about the current level of burnout and morale in the workforce. • 89% are worried that not enough national investment is being made in social care in their local area. **In a cabinet reshuffle Victoria Atkins MP has replaced Steve Barclay MP as Secretary of State for Health and Social Care**. Victoria Atkins was previously Financial Secretary to the Treasury. Prior to that she was Minister of State at the Ministry of Justice and Minister for Afghan Resettlement. Other previous roles include Minister for Women and Minister for Safeguarding. The public hearings for module 2 of the Covid-19 Inquiry began in October and will conclude mid-December. Module 2 covers core political and administrative governance and decision-making. Its scope includes the initial response, central government decision making, and political and civil service performance. A summary of the issues covered will be provided to Board members upon completion of the module 2 public hearings. **The Trust was successful in this year's Building Better Health Care Awards as we won the Patient's Choice special award for the caring garden at Fieldhead.** This is for the entry deemed to have the greatest impact on patient experience and outcomes and was chosen by patient representatives. **Working in partnership with service users and staff many of our inpatient wards have benefited from the creation of some eye-catching murals in recent weeks.** These have been created by artists and have made a real difference to our ward environments.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
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NHS Foundation Trust

The Brief

2 November 2023

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

With **all of us** in mind.

Our mission and values

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

The infection prevention and control (IPC) team took it back to basics for IPC week. They kicked off with a celebration event where staff and teams were invited to celebrate their work. The team also held drop in stalls across our Trust where they invited staff to come and find out about the simple things that can make a big difference, keeping us all safe and well.

With **all of us** in mind.

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 use of resources: We have launched an I-Hub challenge where all staff are invited to suggest ideas on how we can save money and work more efficiently. We need to think differently to help us provide better services, and better care and wellbeing for all.

Golden threads: We have launched our 'Green Team' who will help us to move forward our ambitious aims on social responsibility and sustainability. If you have ideas to help or want to support our Trust to improve contact Tony Wright, our sustainability change manager.

Improving care: improving quality is at the heart of everything we do. Take a look on the intranet for a snapshot of how we are doing on our quality priorities (all on one handy page).

Older people's inpatient mental health service transformation

How we create separate wards to care for people with dementia and functional mental health needs in Calderdale, Kirklees and Wakefield

NHS South West Yorkshire Partnership NHS Foundation Trust

We've held workshops and engagement from 2022 with staff, partners, and the voluntary and community sector to gather views on how we create specialist wards for people living with dementia, and dedicated wards for those with a functional mental health need.

Following these the OPS programme team been working on what the proposed options could be.

The OPS programme is reaching an important milestone…

We are now taking the business case through governance, including NHS England, a joint ICB committee, a joint overview and scrutiny committee and Trust Board for approval to be able to start a public consultation in early 2024.

A public consultation is an important phase where we will be asking people for their views on options for how we could create specialist inpatient wards for dementia and functional needs.

If you have any questions about the OPS transformation, email the team at: **opstransform@swyt.nhs.uk**

What is a public consultation?

- All public organisations who are looking to make a significant change to the way they deliver services must ask people for their views before deciding what to do.
- We must give people enough time to consider what our proposals are.
- By law we can't pre-determine an outcome ahead of consultation.
- We can't make a decision until after we have considered and understood the impact of our proposals on our staff and the public.
- All staff impacted (along with members of the public, service users, carers and families) will be encouraged to respond to the consultation. We will let people know how they can give their views.

No decisions can be made until after consultation closes. We will listen to feedback from the consultation and use that to help us make a decision.

With **all of us** in mind.

The national, regional and local context

NHS
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NHS Foundation Trust

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

The West Yorkshire 'Together We Can' campaign will run for the third year this winter and is set to launch on 6 November. The campaign helps people access health and care services at the right time and place and encourages people to choose well and to opt for convenient self-care, where safe to do so.

The West Yorkshire Critical Incident Staff Support Pathway (CrISSP) is a voluntary, free and confidential service for all staff and volunteers. It offers support following potentially traumatic or critical incidents. This compliments the support offered to staff through our own occupational health team.

NHS South Yorkshire officially launched their 'Five Year Joint Forward Plan' at their AGM. The plan is a response to the South Yorkshire Health and Care Strategy and is a forward look at what is most important for keeping people healthy and making sure everyone has equity of access to healthcare.

The new national suicide prevention strategy for England: 2023 to 2028 was published in September. The strategy sets out the government's ambitions to reduce suicide rates; improve support for people who have self-harmed; and improve support for people bereaved by suicide. The national strategy is in line with what we are working to as a Trust and actions within our own suicide prevention strategy. We are confident that we have work already in place to address the priority areas which have been set out in the new strategy.

During 2024 **NHS 111** will become a universal point of access for people experiencing mental health crisis. 111 will be an addition to our mental health support line, so people will be able to continue to use the services they're familiar with and trust.

Smokefree Sheffield held an official launch event in the city centre, providing advice to shoppers and booking appointments for smokefree support. Since their new service offer went live they have increased referrals by over 45%.

Improving Health
Our performance in September

South West Yorkshire Partnership NHS Foundation Trust

- **51.6%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.3%** within 6 weeks.
- **88.5%** of MH service users followed up within 72 hours of discharge from inpatient care
- **87.5%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **91.8%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **90.6%** of people died in a place of their choosing
- **80%** in CAMHS services waiting less than 18 weeks for treatment

We want to ensure that our Trust is inclusive of everyone so that people of all backgrounds, including those we work alongside, care for and visit, are known, valued, and understood.

Microaggressions are defined as the everyday, subtle, intentional — and oftentimes unintentional — interactions or behaviours that communicate some sort of bias.

Our new guide provides information on microaggressions and advice on managing them in the workplace.

Book onto enhanced equality, diversity and inclusion health inequalities essential to job role (EJR) training for supervisors.

We have agreed new dates for when our Trust will be going back to being **smokefree** for our service users in inpatient services. From **Monday 27 November 2023** in our adult inpatients, learning disability services, the NRU and SRU. From **Monday 15 January** 2024 in our older adult services and adult MH rehabilitation services. Our forensic wards are already smokefree.
These new dates will give us time to make sure we have the right products in place and are able to fully meet the needs of all our service users. If you have any questions about our smokefree Trust contact Becky Smith or Karen Batty.

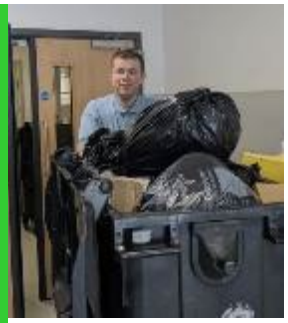
Improving Care
Our performance in September

South West Yorkshire Partnership NHS Foundation Trust

- **187** inappropriate out of area bed days
- **2** children and younger people under 18 in adult inpatient wards
- **82.7%** waiting for referral to assessment within 2 weeks
- **5.7%** of service users clinically ready to discharge
- **87.5%** of service users on CPA offered a copy of their care plan
- **96.6%** of our service users have their ethnicity equality data recorded, **45.4%** their disability status, **44.6%** their sexual orientation, and **99.8%** deprivation (postcode)

96% of respondents in the friends and family test rated our general community services either good or very good; **95%** in our mental health services, 70% CAMHS, **100%** for learning disability services, **75%** for ADHD and **100%** for forensic services.

A new recruitment scheme set up by the Trust is helping people to secure employment with the facilities team. The Trust's facilities operative recruitment programme supports candidates in their application process and offers flexibility to people over a 12 month training programme. At the end of the 12 months, they are offered a substantive role.



Since going live in our Trust at the end of July 2023, Patients Know Best (PKB) has had nearly 6,000 patient registrations. If your team or service wants to know more about how to get started with the new personal health record system for our service users, take a look at how you can access training and get signed up on the intranet or email patientsknowbest@swyt.nhs.uk

There is a national supply shortage of the medication prescribed to help manage ADHD symptoms.
We have worked with our ICS colleagues to produce information to help patients, carers and their families understand the shortage and how it may impact them. The information has been circulated to families and is on our website.

Improving Care
Incidents in September

South West Yorkshire Partnership NHS Foundation Trust

In September we reported:

- **1,094** incidents – **743** rated green (no/low harm)
- **273 were rated yellow and 67 rated amber**
- **11** rated as red (incident severity is reviewed and may be downgraded)
- **96%** of incidents resulted in no or low **actual** harm, or were external to our care
- **27** patient safety incidents that resulted in moderate or severe harm or patient safety related death.

We had **92** restraint interventions in September, a significant decrease by 54 from August. **90%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **34** falls in September, one more than in August. See the falls prevention intranet pages for steps you can take to prevent falls. as the previous month.

We had 32 pressure ulcers in September. No lapses in care have been identified.

The **new patient safety incident response framework (PSIRF)** will go live from 1 December 2023. We would encourage you to watch a 4 minute video here on what PSIRF means. You can book on to an awareness session where managers can find out more, and we will also be sharing more information to help you understand what the transition to PSIRF means for you. There is also a helpful overview and updates on the PSIRF intranet pages.

There were **8 confidentiality breaches** in September. All of us can reduce the number of patient data or sensitive information breaches. See the intranet for our new IG campaign.

Think. Check. Share.

Improving Care
Trust Clinical Strategy

Strategy development is an essential step towards improving care and patient experience within available resources. The clinical strategy will be a core product of the Trust's wider strategy, guided by our vision and strategic objectives. Planned publication is by April 2024.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

How will the clinical strategy help us?

Prioritising our future provision of care within the context of complex challenges in the healthcare landscape including addressing health inequalities

Delivery of care in the context of our integrated systems and partners

Enable Trust in the delivery of its ambition of being an anchor institution and supporting teaching and training

Ensure the delivery of high quality, innovative and evidence-based services for our communities in keeping with our values and mission

Oversight, governance and engagement

Joint SROs: SubhaThiyagesh and Darryl Thompson
Lead: Katie Puplett

Steering group representation from:

- Medicine
- Nursing (mental and physical healthcare)
- Psychology
- Pharmacy
- AHPs
- Communication, involvement, equality and inclusion

We will be looking to engage with internal and external stakeholders.

Please look out for more information on this soon. We are looking forward to hearing your views and value your critical input in the development of this important strategy

Improving health
Vaccination update

NHS
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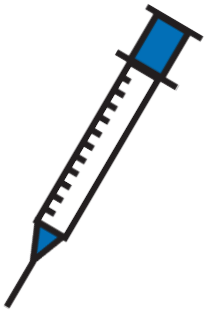
NHS Foundation Trust

You can now book your **flu vaccination**. It is the best defence to against contracting flu, which can have a devastating impact on your health, and that of your friends, family and colleagues. It can also affect our ability to provide care. Details on how to book or attend a drop in clinic can be found on the intranet.

Find out why others in our Trust had their jab through our campaign:

We are seeing an increase in COVID infections across the Trust and in the community. Protect yourself and those you are in contact with by taking up the offer of the **COVID booster vaccine**. NHS front line staff are eligible. Vaccine information can be found on the intranet.



Remember to do everything you can to keep yourself and others safe. This includes good hygiene practices, ventilation and ensuring if you are feeling ill you speak to your line manager about what to do next. Guidance and advice can be found in the COVID section of the intranet.

With **all of us** in mind.

Tea to Improve Quality
What happened in our digital special

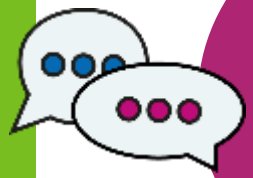
NHS South West Yorkshire Partnership NHS Foundation Trust

Use of digital has been a frequent theme in our past Tea to Improve Quality sessions, so we held a digital special. Here's a summary of what you told us and what we are doing.

You told us…	We are…
We need to update record keeping training	This is being picked up by the Care Plan and Risk Assessment Improvement Group and the Clinical Safety Design Group.
Lots about how we use SystmOne, including: • Consent to share • Challenges with GP practices not using SystmOne • It needs to be easier to get the latest updates. • Getting the ICE system integrated with SystmOne	A dedicated task and finish group is being set up through the Clinical Safety Design Group to look at consent to share and how we address challenges with GP practices who do not use SystmOne. We will be looking at how we create more one-minute guides, and 'how to' guides for using SystmOne, and how we make these easier for staff to find. Integration between SystmOne and ICE is being tested. Further information will be shared once it is it ready to go live.
You would like more information on digital inclusion	The digital team and the involvement team will be looking at this.

Join us in person for the last Tea to Improve Quality of 2023, it goes back where we first began, at the Mental Health Museum:

Thursday 23 November, 10-12 midday, Mental Health Museum, Fieldhead Hospital



Search for Tea to Improve Quality on the intranet or email ndadmin@swyt.nhs.uk

With **all of us** in mind.

Managing risk

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

Key areas of risk identified in the risk register are:

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

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

IG breaches have been increasing. Help to prevent information governance breaches by checking you have the right people To correctly identify a person, check their address, email address and date of birth. These are simple checks you can do to make sure you have the right person. View the poster.

As an employee of the Trust, it is important that you understand the risks of **fraud** within the NHS and how this is being addressed.

This video provides a short animated presentation highlighting the risks of NHS fraud and explains what you should do if you suspect fraud.

If you have any concerns in relation to fraud, bribery and corruption please contact Claire Croft

Improving resources
Our finances in September

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£1.1m	£0m
Agency Spend	£5.4m	£10.1m
Financial sustainability and efficiencies	£4.3m	£12m
Cash	£79.19	£76.9m
Capital	£1.2m	£8.8m
Better Payment Practice Code	97%	

A deficit of £59k been reported in September 2023 which means that the year-to-date surplus is now £1.1m. This is £0.2m behind plan.

The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in September is £0.9m which is higher than the two previous months and remains above the plan trajectory. The year-to-date position is 18% above plan.

The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely. This target remains challenging due to the increasing profile and the need to identify new opportunities.

The Trust cash position remains strong at £78.9m.

Year to date capital expenditure is £1.2m. Expenditure is forecast to significantly increase in the next quarter and the full allocation to be utilised in year.

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

A great place to work

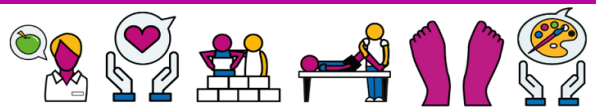
Our performance in September

- 4.9% sickness rate for the month.
- The rolling 12 months sickness rate is 5.3%
- In August we had new **63** starters to the Trust, and **34** leavers
- We currently have **4,358** substantive members of staff
- 72.5% of staff have a completed annual appraisal

Black history month was marked by staff across our Trust. Dr Mohinder Kapoor shared how we can use the opportunity to raise awareness and act on mental health inequalities. **Kirklees** teams held their annual event with the theme of 'saluting our sisters', highlighting the role black women have played in shaping our history and inspiring change. The **REaCH network** also held their celebration event which was a chance to meet colleagues and celebrate the achievements of the network.



On 14 October we celebrated our AHP workforce. We have over 350 AHPs and 125 AHP support staff at our Trust. We shared thoughts and experiences of what a 'day in the life' of an AHP involves, and our chief AHP Katie Puplett wrote about how each AHP has a vital role to play in her blog.



This month forensics held their first 'meet and greet' event which welcomed 24 international nurses to their teams. The event was a fantastic opportunity for the care group to share information, better understand the personal experiences of each new staff member and help support people in their new roles.

We marked **Speak Up Month** with a series of events and awareness raising activities. Our guardians visited teams to talk about barriers to speaking up and what can be done to break them down, we publicised a Trust film where colleagues talked about the importance of speaking up, and throughout the month staff wore green on Wednesdays to highlight their support.


Make sure you have an up-to-date appraisal by checking your WorkPAL account. For appraisal support, guidance and training visit the intranet.

A great place to work
NHS Staff Survey 2023

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Trust is committed to improving staff experience. The NHS Staff Survey is key to this work, it helps us understand what is working well and where we need to improve.
So far over 2,000 have completed the survey and provided valuable feedback.

The survey was sent by email invitation with the subject header: **NHS Staff Survey 2023 Invitation: [South West Yorkshire Partnership NHS FT]**. Depending on different mail software settings this may appear to come from 'Survey' or the e-mail address nhsstaffsurvey@iqvia.com. It should arrive in your 'focussed' email folder, please also check the 'other' and 'junk' folders. What you say is kept confidential and anonymous, all results are handled by an external, nationally approved, survey contractor.

The feedback from the 2022 survey prompted several key actions:

- increased investment in our wellbeing support offer
- further promotion of learning and development opportunities
- enabled targeted support to services and teams
- each service developed their action plan to improve staff experience
- to develop our equality, diversity and inclusion action plans

Make your voice count and take 10/15 minutes to have your say no later than 24 November. It is more important than ever that we support our colleagues and improve staff experience and wellbeing. Give your views and enter our prize draw to win an iPAD.

With **all of us** in mind.

Connecting People

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

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

Your contribution can be in any way which interests you, and you can decide how much involvement you want.

Full training and support will be provided.

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

If you would like to find out more about connecting people please email volunteer@swyt.nhs.uk or call 01924 316426 or 07721 649311. Full details are on the intranet.

Being a 'community connector' means you can...

- Help us shape local services
- Help others have a say in the design and development of health care services
- Support your community to help us make a difference
- Learn more about the NHS
- Take part in training and develop new skills
- Receive out of pocket expenses or funding for your organisation for helping us

You can decide how much time you give us, and how much you want to get involved.

How to get involved

To get involved you will need to commit to three two-hour training sessions. The sessions will provide you with all the information, advice, and support you need. You can do the training in stages. Once you have completed the training you will receive a certificate and will be ready to go.

The course content is:

Session 1:
More about our Trust and how the NHS works

Session 2:
Legal obligations for involvement and equality

Session 3:
Methods and approaches to involvement – becoming a community connector

How can you help?

Some of the opportunities you could support include...

- Reaching people in the local community
- Helping us to deliver a survey
- Gathering feedback in a way that supports people to have a say
- Helping to organise or be part of running an event or activity
- Improving services by working directly with NHS staff
- Being part of any local NHS research
- Being part of or promoting our readers panel
- Bringing skills that support connection or communication
- Being an ambassador and promoting opportunities for involvement

Remember, you choose what you do, how you do it and how much you want to be involved.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Safety always comes first. This winter do everything you can to keep you and those around you safe.

Protect you and those around you by having your flu and COVID vaccines.

Help us achieve our social responsibility and sustainability aims by joining our Green Team.

Think, check, share. Look after other people's information and data as you would want your own to be.

Have your say and help us to improve by taking part in the NHS staff survey.

Read our new guide on microaggressions and advice on managing them in the workplace.

Share your ideas and get involved in our finance and resources i-hub challenge.

Support your personal development. Make sure you have an up to date appraisal.

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 November 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 October 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 October 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 only one national		

indicator which is for ethnicity, the Trust is performing at 96.7% against a target of 90%. For the Trust has set its own targets and as of October 2023 these are performing as follows, disability 46.2%, sexual orientation 45% and postcode 99.8% of service users have had their equality data recorded. Whilst 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. No policy is agreed without an EIA in place and therefore we have investigated why the performance is under 100%.
- Referral to assessment within 2 weeks for mental health single point of access - the overall Trust position increased to 86.8% in October against a target of 75% the highest reported monthly since January 2023. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours. Rapid improvement work in SPA, together with some progress in recruitment has contributed to continued 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 66 days used in October, this is a significant improvement compared to the previous two months (400 in August and 187 in September). Need for use of these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally), increased acuity and capacity issues due to challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 3 people placed in out of area beds at the end of October. 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 waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 74.2% in October from 75.3% reported in September, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The care group escalated a concern regarding

	access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan has been initiated however, improvement in performance to national threshold has not been reached. Issues identified include: ○ It is noted that post pandemic, referrals into the service have also increased from other health professionals. Hearing test outcomes are now requested more routinely by these services, rather than when a specific hearing concern is identified. ○ There has been one hundred percent increase in referrals to the service from October 2022- October 2023 ○ The service has had a long-term sickness issues and this has had a significant impact on the team as it is made up of less than 3 whole time equivalent (qualified and non-qualified) - this is now been addressed and hopefully the vacant post will be appointed to next week. Actions taken: ○ The service has undertaken a demand and capacity and a process mapping exercise. ○ The service is currently undertaking a service review which includes the management of clinics and appointments, service staffing structure, referral pathways, discharge, onward referrals, cancellations, and was not brought SOPs/procedure. ○ The service is reviewing its service level agreement with Barnsley Hospital NHS Foundation Trust. ○ The service is developing regional networking and peer supervision. **Local Quality Indicators** The Trust continues to perform well against the majority of quality indicators; however, the following should be noted: **Care planning and risk assessments** There has been an improved performance with regards to the completion of care plans and risk assessments (inpatient). This focus continues to be driven by the Care Plan and Risk Assessment Improvement Group, particularly on the quality of the completed care plans and risk assessments. The October data for care planning shows continued sustained performance above the 80% threshold since April 23, achieving 87.5% for the month. For risk assessments, the October data shows a slight increase in performance from the previous month within inpatient services (90%). Whilst performance is broadly being maintained, our gap against trajectory will be reviewed for action within the care plan and risk assessment improvement group. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

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 74.7% (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. Slight improvement in performance in October (impacting 21 people) though underperformance against this metric 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

96% of incidents reported in October 2023 resulted in no 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 third consecutive month with 198 incidents reported (92 in September). 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.
- 91.7% of prone restraint incidents were for a duration of three minutes or less, there was two incidents out of twenty-four over the 3-minute threshold and these were complex cases and appropriate measures were taken and support was given to both the service users and staff involved in the incident.
- There were 9 information governance personal data breaches during October 2023 which is one greater than reported in previous months. No hotspot areas were identified as they were across care groups and services. Promotion of safe and effective information governance continues.
- The number of inpatient falls in October was 48 and 71% of these service user falls had a previous falls history. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated, there have been no red or amber Datix incident reported (falls with injury) during the month.

Our People

- Supervision data is now available and included in the report at Trust level and by care group and inpatient ward. As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce, this includes making further changes to the systems and reporting practice.
  The data for October is 62.3% which is a slight improvement from the refreshed performance for September which was 60.7%.
- The Trust had 24 violence and aggression incidents against staff on mental health wards involving race during October - 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 October. The number of people joining the Trust outnumbered leavers in October. Year to date, we have had 408.9 new starters and 300.5 leavers. Focus remains on recruitment and retention.
- Overall turnover rate in October was 12.4% which is slightly higher than last month (12.1%) but remains green as within threshold.
- Sickness absence in October was 5.2% above local threshold, with a rolling 12-month position of 5.2%.
- Rolling appraisal compliance rate for October saw a deterioration, from to 72.5% to 69.7%. 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 reduced marginally from last month 92.1%. Cardiopulmonary Resuscitation (79.7%) and Information Governance (94.5%) are below the Trust target. 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).

Care Groups

In addition to the care group information found within this report, a separate deep dive in to the Adult and Older People and Inpatient care group can be found under item 9.2 on this board agenda.

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 October, and we have also provides a breakdown of the mental health inpatient data split by ward. Areas to note 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 further in October compared to previous months this year. • During October, the overall number of cases that were clinically ready for discharge remain at 5.2%, this has reduced slightly from 5.7% reported last month but remains 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 deficit of £101k been reported in October 2023 which means that the year-to-date surplus is now £1.0m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report. • Spend in October has seen a stepped reduction to £0.6m with a reduced requirement in agency shifts reported. The sustainability of this continues to be assessed. The year-to-date position is 14% above plan. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group.

	• As previously forecast the Trust cash position, whilst remaining strong, has reduced in month by £6.6m. This is due to invoices, which had been chased and date back to April 2023, have been paid. Overall, the Trust cash position is £72.3m. • Out of area placements have continued to reduce in October. This is now £196k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated. • Performance against the Better Payment Practice Code is 98%.
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

October 2023

With **all of us** in mind.

Table of Contents

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for October 2023. The development of the IPR continues, with a ward level breakdown of key metrics within the care group section of the report, added from September 2023.

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

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 of October 2023, disability 46.2%, sexual orientation 45% and postcode 99.8% of service users have had their equality data recorded. Whilst 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. No policy is agreed without an EIA in place and therefore we have investigated why the performance is under 100%.

• Referral to assessment within 2 weeks for mental health single point of access - the overall Trust position increased to 86.8% in October against a target of 75% the highest reported monthly since January 2023. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours. Rapid improvement work in SPA, together with some progress in recruitment has contributed to continued 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 66 days used in October, this is a significant improvement compared to the previous two months (400 in August and 187 in September). Need for use of these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally), increased acuity and capacity issues due to challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 3 people placed in out of area beds at the end of October. 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 waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 74.2% in October from 75.3% reported in September, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The care group escalated a concern regarding access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan has been initiated however, improvement in performance to national threshold has not been reached. Further detail on specific actions can be seen in the care group section of the report.

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

There has been an improved performance with regards to the completion of care plans and risk assessments (inpatient). This focus continues to be driven by the Care Plan and Risk Assessment Improvement Group, particularly on the quality of the completed care plans and risk assessments.

The October data for care planning shows continued sustained performance above the 80% threshold since April 23, achieving 87.5% for the month.

For risk assessments, the October data shows a slight increase in performance from the previous month within inpatient services (90%).

Whilst performance is broadly being maintained, our gap against trajectory will be reviewed for action within the care plan and risk assessment improvement group. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

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 74.7% (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. Slight improvement in performance in October (impacting 21 people) though underperformance against this metric 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

96% of incidents reported in October 2023 resulted in no 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 third consecutive month with 198 incidents reported (92 in September). 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.

• 91.7% of prone restraint incidents were for a duration of three minutes or less, there was two incidents out of twenty four over the 3-minute threshold and these were complex cases and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

• There were 9 information governance personal data breaches during October 2023 which is one greater than reported in previous months. No hotspot areas were identified as they were across care groups and services. Promotion of safe and effective information governance continues.

• The number of inpatient falls in October was 48 and 71% of these service user falls had a previous falls history. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated, there have been no red or amber Datix incident reported (falls with injury) during the month.

Our People

• Supervision data is now available and included in the report at Trust level and by care group and inpatient ward. As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce, this includes making further changes to the systems and reporting practice.

The data for October is 62.3% which is a slight improvement from the refreshed performance for September which was 60.7%.

• The Trust had 24 violence and aggression incidents against staff on mental health wards involving race during October - 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 October. The number of people joining the Trust outnumbered leavers in October. Year to date, we have had 408.9 new starters and 300.5 leavers. Focus remains on recruitment and retention.

• Overall turnover rate in October was 12.4% which is slightly higher than last month (12.1%) but remains green as within threshold.

• Sickness absence in October was 5.2% above local threshold, with a rolling 12-month position of 5.2%.

• Rolling appraisal compliance rate for October saw a deterioration, from to 72.5% to 69.7%. 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 reduced marginally from last month 92.1%. Cardiopulmonary Resuscitation (79.7%) and Information Governance (94.5%) are below the Trust target. 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).

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 October and we have also provides a breakdown of the mental health inpatient data split by ward. Areas to note 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 further in October compared to previous months this year.

• During October, the overall number of cases that were clinically ready for discharge remain at 5.2%, this has reduced slightly from 5.7% reported last month but remains 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 deficit of £101k been reported in October 2023 which means that the year to date surplus is now £1.0m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report.

• Spend in October has seen a stepped reduction to £0.6m with a reduced requirement in agency shifts reported. The sustainability of this continues to be assessed. The year-to-date position is 14% above plan.

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

• As previously forecast the Trust cash position, whilst remaining strong, has reduced in month by £6.6m. This is due to invoices, which had been chased and date back to April 2023, have been paid. Overall, the Trust cash position is £72.3m.

• Out of area placements have continued to reduce in October. This is now £196k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated.

• Performance against the Better Payment Practice Code is 98%.

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	Work continues with each of our partners in place and with both South and West Yorkshire integrated care systems. Health inequalities is a golden thread through all our priorities, and we continue to work on improving the data collection and reporting. Improving the data collection for all of our protected characteristic data links to the NHS England » NHS equality, diversity, and inclusion improvement plan. Focussing initially on the data collection for both disability and sexual orientation will enable us to not only strengthen our individual patient centred care but also improve the quality of our data. This will give us richer data to use as part of service redesign or delivery and will also strengthen our data quality requirements for external submissions e.g. Mental health minimum dataset. This month we have focused on the performance data of percentage of people who have their information recorded in relation to disability and sexual orientation. We have identified the actions we will take to improve this performance.

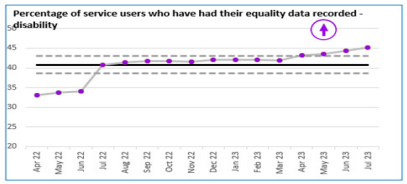


Fig 1.

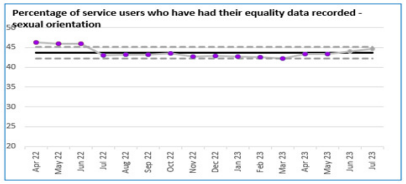


Fig 2.

Target for Improvement

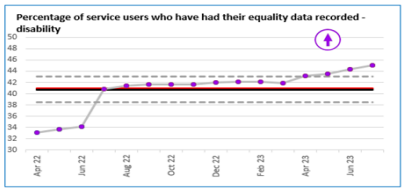


Fig 3.

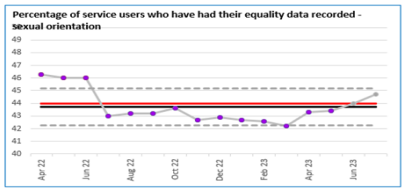


Fig 4.

The Trust is adopting the sigma approach as a target for improvement which helps us to work towards statistical incremented improvements as we work towards our current ultimate target of 90% The red target line indicated on the charts above (Figs 3 & 4), are the individual 'one sigma' data targets which denote the required data change that would indicate meaningful and achievable improvement.

To achieve the sigma target, all the data variation must occur (and be sustained) above the target line i.e., the lower process limit must be above the target line. This would approximately equate to being able to achieve a new mean value of 50 (see Fig 5 below). The process limited would then be further recalculated and a new sigma target applied (see Fig 6). Data variation is normal, however if we continue to do the same thing, then that variation will not change. To achieve a desired target, we need to make changes to the way we work. We want to monitor our progress towards the ultimate target in achievable steps. Sigma is a measure of variation (similar to standard deviations) where the total spread of data between the upper and lower process limits is divided into 6 Sigma. An improvement target of 1 Sigma is considered statistically achievable.

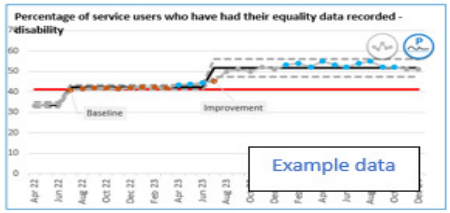


Fig 5.

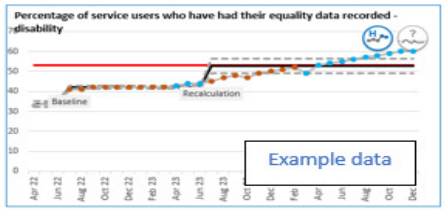


Fig 6.

It is also important to note that while we strive to improve our data collection for these metrics, we must also strive to improve our data quality and ensure that all recorded responses are valid and evidence that a conversation has taken place to capture the data.

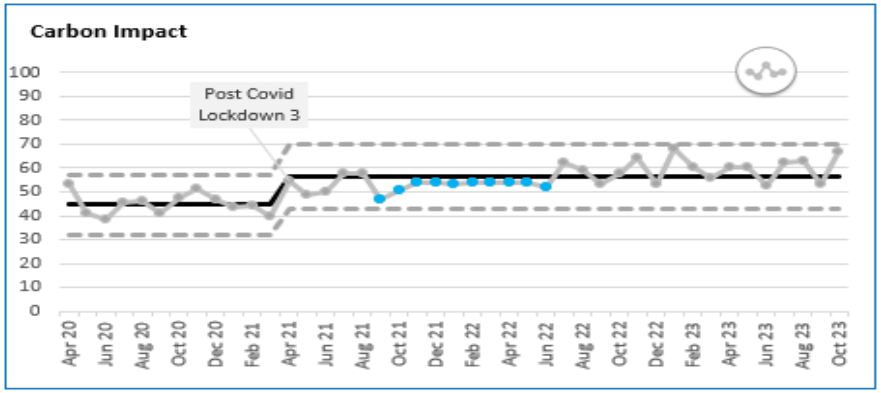
Improving care	Transform our Older People inpatient services	Governance approvals are ongoing: SWYPFT Governance: Quality and Safety Committee – October, Trust Board October – held. NHSE Assurance Approval: awaiting financial clarification before NHSE send approval to proceed letter. Joint Oversight and Scrutiny Committee – scheduled for 27 November. ICB –Joint committee – now likely to be held in early December 2023. Public Consultation planning is ongoing: video completed, Consultation Document revised, consultation summary established, animation storyboard in development, consultation questions established, local assets and advocacy now identified and in place, venues for public meetings identified and provisionally booked as aiming for consultation to commence in January 2024 with public meetings likely to be held mid-late January.
	Improve our mental health services so they are more responsive, inclusive and timely	**1. Inpatient priority programme:** Workstream leads for the four programmes have been identified and work is ongoing to identify key support roles. The Discharge Initiatives (national) are being reviewed and updated by the working group and these will be shared with the wards. The Workforce Group have begun discussions on career progression, completion of the staff survey and International Recruitment. High level KPIs/Metrics have been agreed for the programme and will be reviewed by the weekly performance and oversight meetings. Individual QI metrics will be reported iteratively as projects develop across the workstreams. **2. Care closer to home (OOA):** There has been a sustained reduction in the out of area placements for the month of October/November and the identified baseline key metrics for re-admissions, admits v discharges and occupied bed days will continue to be monitored. A Menti survey has been completed by staff/partner colleagues and we will be using the findings to support the workshop(s) to be held in January. The guidance notes for the Barnsley pilot are being written with an expected PDSA start date to be January 2024. Discussions for a check & challenge peer review with Humber have begun. **3. Improving access to care:** Each project is seeing the benefits of building in the use of waiting list data, waiting list population data, and health inequalities data to inform exploration of areas for improvement. • Community LD services: With SystmOne waiting lists successfully gone live, the focus is on supporting teams to use the SystmOne framework for recording data effectively and supporting locality trios to use the data in reviewing cases waiting for a service from the single community team as well as drilled down information as to what discipline/treatment they are awaiting. • CAMHS neurodevelopmental services: Commissioners have confirmed additional funding to continue the Evolve contract through to March 2024 to provide 150 assessments to support Kirklees CAMHS neurodevelopmental waits. The service has raised concerns at WY ICB level regarding the standards of assessment and screening undertaken by some AQPs does not fit with locally agreed criteria for assessments we can accept. • Core psychology: Using the data available and results of process mapping, work is ongoing with Barnsley team to identify areas for further exploration. Text messaging service has commenced with one round of information sent out. • Single Point of Access Review project group is formed with general manager representation from all localities. Initial data is being collated from all localities including staff and service user views to inform areas for exploring to improve access and reduce impact undertaken in services. **4. Community MH Transformation:** Operational mapping coordinated by task and finish groups exploring how the place-based models have been configured and mapping how SWYPFT aligns into them has commenced in November 2023. A group focused on interoperability and the Severe Mental Illness Physical Health Check (SMI/PHC) has been created with agreed Terms of Reference. The group has representation from SWYPFT/ PCN and ICB colleagues and has aligned into the Trusts Clinical Safety Design Oversight Group Governance. It is currently focused on providing recommendations for standardised practice including templates across SWYPFT and PCN services. The group will be reviewing the NICHE Interim Evaluation for WY Community Mental Health Transformation and working on key areas in regards communications. Items escalated to EMT include: Creative Practitioners business case for continuation of funding April 2024 onwards to support inpatient improvement programme. Currently funded via non recurrent funding. Trauma Informed Programme case for continuation of funding April 2024 onwards to support delivery of national requirements in programmes such as inpatient improvement and CMHT. Currently funded via non recurrent funding.
	Improve safety and quality	**Personalised care (moving on from CPA):** The group have produced a timeline outlining how communications will be delivered and engagement with key stakeholders will commence through the programme. This has been aligned into the Intranet page outlining the high-level communications piece about the Trusts intent on this Programme of work. The group continue to support the Triangle of Care Implementation Group and involving carers in shaping the programme. Work is progressing with defining recommendations for the key worker function and roles and the move from generic care co-ordination to meaningful intervention-based care. The group have aligned with the Care Planning and Risk Assessment Group to focus on the creation of a holistic Care plan, and also scope the development of recommendations for policy changes within the Trust. This group will continue to shape the use of PROMS measures within the Trust as part of the care planning design. The group have joined a Regional and also separate local WY forum focused on Personalised Care and Support to support thinking around this programme.

Improving use of resources	Spend money wisely and increase value	**Value for money:** update was provided last month and is scheduled for next month following FIPC and non-pay review group meetings. Schemes are continuing to be identified as part of the non-pay review group and the corporate services improvement opportunities. Thinking Differently workshops have commenced (2 held to date – 17 staff from across a range of services attended across the two dates). Service specific Thinking Differently workshops are scheduled with Forensics, Strategy and Barnsley services as an output of the annual planning sessions and in support of initiating cost savings.
	Make digital improvements	**Digital Dictation:** Project manager commenced in post 13th November.
Great place to work	Inclusive recruitment	Two projects report to the recently created inclusive recruitment steering group. Scopes and plans on a page established. **1. Time to Hire:** evolved from the current #allofusimprove and value for money activity taking place to improve recruitment processes. Process mapping undertaken for substantive, bank/agency and employability schemes and Improvement action plan developed aiming to speed up process and make the process leaner including reduction of steps involved in recruitment life cycle. (temp/bank staff and substantive processes) Work commenced on working with recruitment team to improve alignment, reduction in duplication and improvements in collaboration and sharing of good practice between bank and substantive recruitment and with other recruitment initiatives identified (e.g. in inpatient, CMHT programmes, and international recruitment). Improvements to aide tracking of candidates through the stages of the process have been identified. Commenced making improvements to the onboarding process and exploring full role out of onboarding digital system. Digital Applicant Tracker System (ATS) solution is being explored. Options paper scheduled for submission to EMT in November. **2. Inclusive localised recruitment:** working group established with care group representation daintified. Work commenced on forming plan aiming to improving access and widening routes into the Trust via social responsibility and employability initiatives in identified care groups. Plan on a page for the programme submitted to EMT.
	Living our values	Work continues to firm up the scope and develop the action plan.

Improving health

Metrics	Threshold	Aug-23	Sep-23	Oct-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.7%	96.6%	96.7%		
Percentage of service users who have had their equality data recorded - disability	To be determined for 23/24	45.5%	45.4%	46.2%		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		44.8%	44.6%	45.0%		
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 completion - 75%	73.5% Service	89.5% Service	82.6% Service		All services have an EIA in place. We have previously agreed with the Equality Inclusion and Involvement Committee that the threshold for service is 75% and have therefore aligned this report to reflect this.
	Policy - 95%	97.4% Policy	96.3% Policy	96.3% Policy		
Completion of equality mandatory training	>=80%	95.9%	96.1%	95.5%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	0	0	0		2023/24 to be used as a baseline once sufficient data is available.
Carbon Impact (tonnes CO2e) - business miles	76	63	53	67		Data showing the carbon impact of staff travel / business miles. In October staff travel contributed 67 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%	66%		Q3 Due Feb 23		Q1 - 65.0% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different service areas.

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 to continue.

Improve Care

Metrics	Threshold	Aug-23	Sep-23	Oct-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	88.0%	87.5%	90.0%		October data shows a slight increase in performance within inpatient services. Risk assessment completion is based upon completion within a set timeframe but does not account for a robust and high quality risk 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. Data validation in progress for community services.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	92.1%	*91.8%*	*Data validation in progress*		
% Service users on CPA offered a copy of their care plan	80%	87.4%	87.5%	87.5%		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	Due November 2023		1057		
Registered substantive staff in neighbourhood teams	Establishment			197		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	16	17	24		Any increases will be monitored by the Patient Safety Team. There was an increase in October in Adults and Older People Mental Health Care Group (Inpatient) this was spread over 11 wards.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	400	187	66		See statistical process chart in National Metrics section for further detail. Please note, this is an in month position and may not reflect the quarterly outturn.
% service users clinically ready for discharge	<=3.5%	5.7%	5.7%	5.2%		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	747	737	610		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. Calderdale - The longest wait for those seen in the month was 764 days, the shortest was 52 days. Number on waiting list at end of October - 169. The longest waiter on the waiting list had waited 844 days. Kirklees - The longest wait for those seen in the month was 664 days, the shortest was 133 days. Number on waiting list at end of October - 1721. The longest waiter on the waiting list had waited 679 days.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	581	588	584		
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	67.9% 38/56	71.9% 41/57	74.7% 62/83		Increase in performance in October (though remains below threshold) 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%	90.7%	88.6%	90.8%		
Community health services two hour urgent response standard	70%	89.5%	88.7%	88.1%		
Referral to assessment within 2 weeks (external referrals)	75%	65.7%	82.7%	86.8%		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.

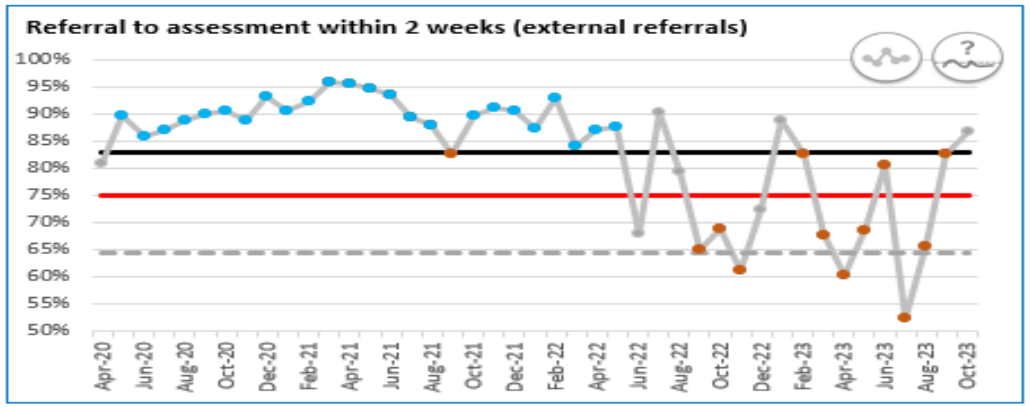
Improve Care

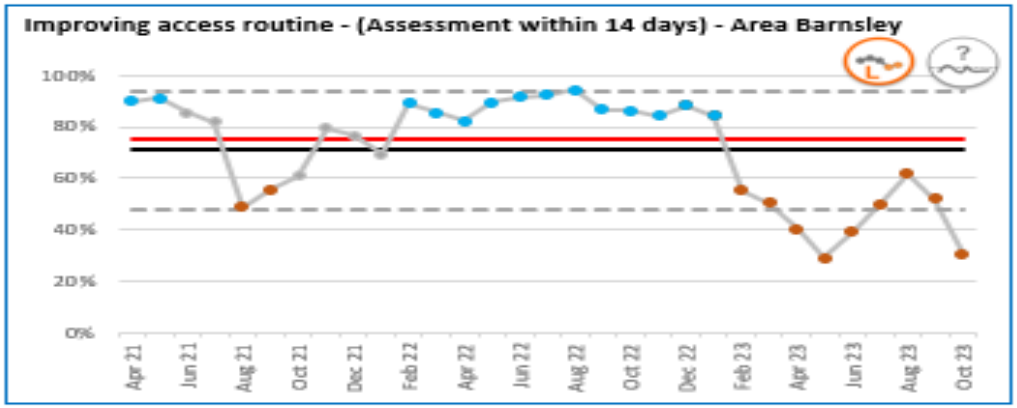
What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

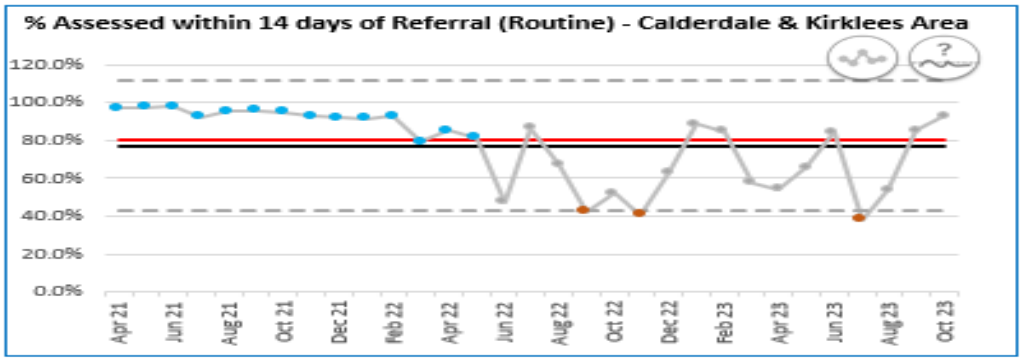
Referral to assessment within 2 weeks (external referrals)

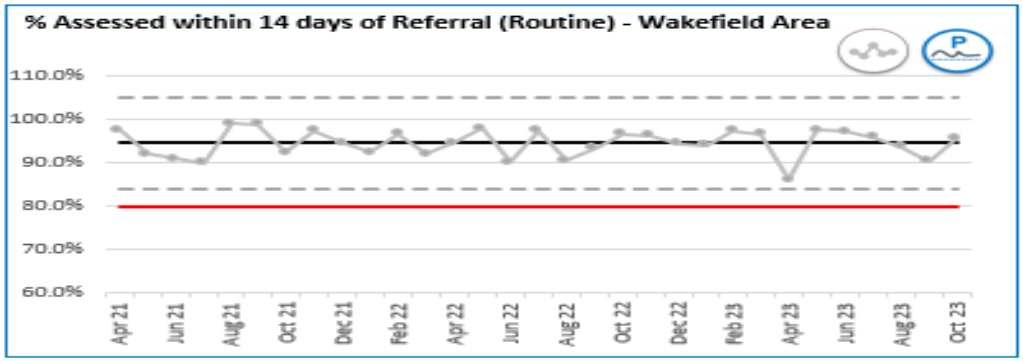
Demand into the Single Point of Access (SPA) and capacity issues have lead to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing with a significant number of vacancies despite active recruitment. SPA is prioritising risk screening 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.

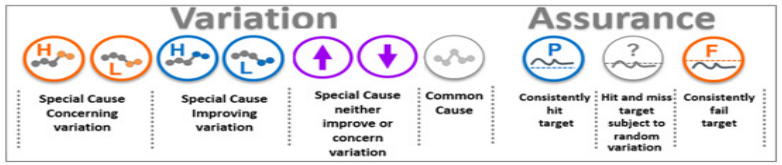
Trust Total











Improve resources

Metrics	Threshold	Aug-23	Sep-23	Oct-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	£446k	(£6k)	(£101k)		A deficit of £101k has been reported in month. This is £6k better than plan. The year to date position is a surplus of £1,012k which is £190k behind plan.
Capital spend against plan (monthly)	£8.8m	(£256k)	(£676k)	(£1,406k)		The year to date position is £2.5m behind plan with spend of £1.4m for the year to date. Work continues to ensure that the full capital allocation is appropriately utilised in year. The funding allocation of IFRS 16 (leases) remains an unknown risk.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£808k	£915k	£636k		Agency spend has reduced in October; primarily within ward / inpatient areas and includes both registered and unregistered nurses. As such this is the first month where spend has been less than planned. Work continues to ensure that this is sustained through continued recruitment and expansion of the Trust bank.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£1,137k	£675k	£130k		The cumulative savings to date are £5.3m and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	3		Due January 2023		All three reported incidents relate to violence and aggression. In all three reports, staff have been supported through their recuperation. There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q2.
Estates Urgent Response Times - Service level agreement (SLA)	95%	96.9%	95.5%	94.2%		Service level agreement 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time. The performance for October has been analysed and understood and are due in part to workload capacity and waiting for parts. The issue is temporary and is expected to be resolved.
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%	100.0%	100.0%	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**	**Aug-23**	**Sep-23**	**Oct-23**	**Variation/ Assurance**	**Notes**
Turnover external (12 month rolling)	>12% - 13%<	13.1%	12.1%	12.4%		Rolling turnover increased by 0.3%
Registered workforce growth	3% (by March 24)	3.3%				
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.2%		Absence rate in month decreased to 5.2%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	>=78%	74.5%	72.5%	69.7%		For the month of October, the percentage rate decreased to 69.7% and continues to remain below threshold.
% staff recommending the Trust as a place to work	65%	N/A				Quarterly Pulse survey. The current national survey closes end of November. Results will be reported once available.
% staff recommending the Trust as a place to receive care and treatment	65%	N/A				
Staff supervision rate	80%	Due October 23	63.4%	62.3%		As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce, this includes making further changes to the systems and reporting practice. The data for September has been refreshed and performance has improved from 60.7%.
Mandatory training - Cardiopulmonary resuscitation	80%	79.9%	80.0%	79.7%		Slight increase in mandatory training in September following seasonal impact noted in August, however this has droppped slightly below threshold in October 23.
Mandatory training - Reducing restrictive practice interventions	80%	82.6%	82.8%	82.9%		Performance has slightly increased September and remains 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%	91.4%	91.2%	91.0%		
Mandatory training - Information governance	95%	95.3%	94.8%	94.5%		Reminders circulated regarding IG training compliance

Quality Headlines

Section	KPI	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	76.0%	81.0%	84.0%	84.0%	81.0%	80.0%	82.4%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	17% 4/23	11% 2/17	16% 3/19	19% 3/16	17.6% (3/17)	10% (1/10)	9% (1/11)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	27% (4/15)	38% (3/8)	17% (2/12)	29% (4/14)	38% (5/14)	38.9% (7/18)	42.9% (9/21)	
Service User Experience	Friends and Family Test - Mental Health	84%	82%	85%	91%	90%	90%	95%	89%	1
	Friends and Family Test - Community	95%	94%	97%	96%	93%	97%	96%	95%	1
Quality	Number of compliments received	N/A	50	66	33	35	22	17	18	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	32	38	27	30	39	21	24	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	1	2	3	3	5	2	1	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	1	1	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	85.0%	85.7%	86.6%	87.5%	87.4%	87.5%	87.5%	1
	Number of Information Governance breaches 3	<12	12	9	14	13	16	8	9	2
	% of inpatients clinically ready for discharge	3.5%	2.4%	2.1%	4.6%	4.8%	5.7%	5.7%	5.2%	3
	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%	90.6%	87.7%	86.7%	87.2%	88.0%	87.5%	90.0%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	92.9%	85.7%	92.9%	92.1%	91.8%	Data validation in progress	2
	Total number of reported incidents	Trend monitor	1197	1327	1257	1154	1201	1150	1256	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	23	34	21	26	33	27	24	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	4	2	5	1	4	1	5	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	5	2	1	3	3	1	2	
	Safer staff fill rates	90%	123.5%	123.5%	123.7%	123.9%	123.8%	124.1%	123.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	94.4%	95.7%	93.1%	93.6%	92.1%	91.4%	91.3%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	29	42	40	36	42	41	21	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	2	1	0	1	1	0	0	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	90%	90.0%	86.6%	89.5%	95.2%	90.0%	90.0%	91.7%	1
	Number of Falls (inpatients)	Trend monitor	34	41	43	33	33	34	48	
	Number of restraint incidents	Trend monitor	192	186	201	145	146	92	198	
	% of staff receiving supervision within policy guidance 15	80%	Reporting to start from Sept 23					63.4%	62.3%	2
	Potential under-reporting of patient safety incidents									
	% people dying in a place of their choosing 14	80%	87.5%	92.1%	87.8%	83.8%	81.8%	90.6%	90.9%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	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.
15 - % of band 5 and above clinical staff who have received supervision in the previous 90 days from the end of September.

Quality Headlines

• Number of restraint incidents - during September there was an increase in number of incidents reported up to 198 which is an increase from 92 reported in September which was the lowest number reported in the last 12 months, however this remains within expected ranges. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less was 91.7% 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.
• The number of people with a risk assessment/staying safe plan in place within timescale had increased slightly at 90% from 87.5% for inpatient services.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased from 5.7% in September but remains above threshold at 5.2%. 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. Further detail is provided in the relevant section of the report.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In October there were 48 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 9 during the month and remains below 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 - The process for complaints continues to be improved, this includes a review of Datix and reporting and developing training for staff. The backlog/waiting list has been eradicated and complaints are now being allocated in real time. This should support closing complaints within the 6 month statutory target over the coming months. Using feedback from complaints meaningfully is being supported by the patient experience group.
• As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, we have been working on our preparations for implementing the Patient Safety Incident Response Framework. This is a 12 month journey 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, with a go live date of the 1st December.

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:

By 30/09/2023 – to have LFPSE compliant software installed on our Datix live system by the end of September 2023. Achieved.

The upgrade to the live system with the enhanced LFPSE functions took place on 24/09/2023. Following the upgrade we are working on the transition to LFPSE - this will be implemented following thorough testing. 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. Level 1 will become mandatory from November 2023. This is currently progressing well at 91% completed. Level 3 training (investigation and oversight) has being delivered for those in specialist or oversight roles. Training on engagement and involvement of those affected by patient safety incidents will be available for Team managers and Quality leads in November, December and January 2024.

Patient Safety Partners
The Patient Safety Team held internal interviews/ discussions on 6th October 2023 and have successfully recruited three patient safety partners (this is a volunteer role)

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).

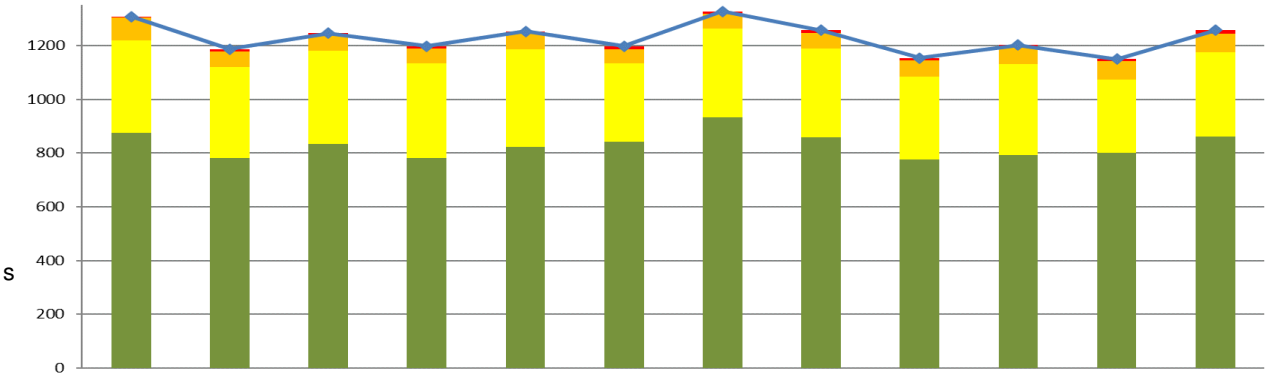
96% of incidents reported in October 2023 resulted in no harm or low harm or were not under the care of SWYPFT. This is based on the degree of actual harm.
Further details about severity and degree of harm can be found in the Incident Reporting and Management Policy.

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.

The 5 severe incidents reported in October were:
4 category 4 pressure ulcer incidents, 1 self harm incident of which following further investigation has been downgraded to moderate (this will be updated in the dashboard next month) the usual root cause and investigation process is beign followed for all these incidents.

The below chart identifies 12 red Incidents in October, at the time of reporting the full review and investigation process may not be completed. The Trust encourages staff to report incidents with an upward bias which enables robust review through clinical risk panel. Tthe 12 reported in October is therefore likely to reduce when data is refreshed next month.



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Red (should not be compared with SIs)	3	8	8	9	9	12	8	11	9	10	9	12
Amber	85	58	59	56	57	51	55	58	62	59	68	70
Yellow	346	339	345	352	364	291	330	330	307	341	273	314
Green	874	781	834	781	823	843	934	858	776	791	800	860
Total	1308	1186	1246	1198	1253	1197	1327	1257	1154	1201	1150	1256

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. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.

No never events reported in October 2023

Safety First cont…

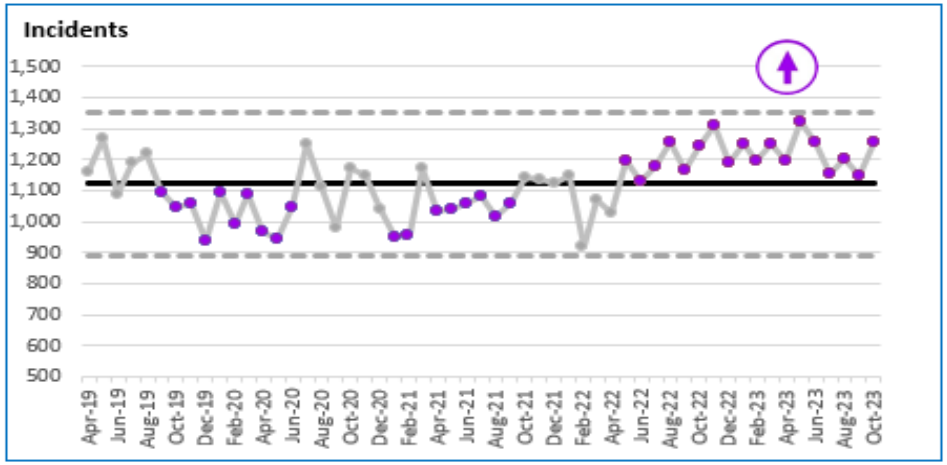
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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

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

Breakdown of incidents in October 2023:
24 moderate harm incidents including 7 pressure ulcer category 3 incidents, 14 self harm incidents,
5 incidents categorised as severe harm, and sadly 2 patient safety related deaths during the month.

Incidents



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

Patient Safety Alerts

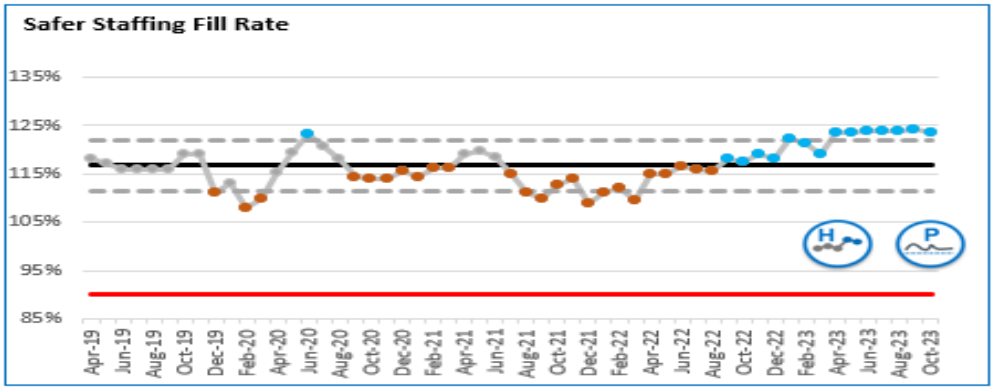
Patient safety alerts issued in October 2023

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.

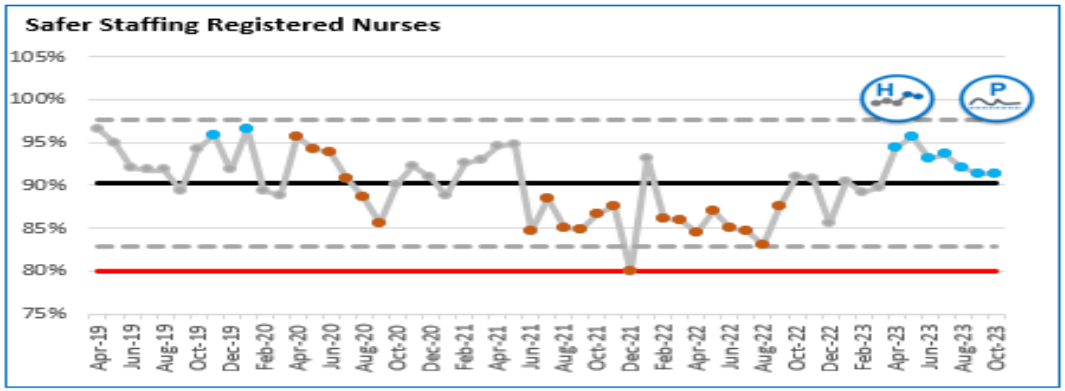
Patient Safety alerts not completed by deadline of October 2023 - None.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
None					

Safer Staffing Inpatients



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

In October there has been a slight decrease in demand of the flexible staffing pool with 31 less shift requests. The number of shifts filled has decreased by 17 shifts to a total of 5,357 and overall fill rates for inpatient areas decreased by 0.6%. The continued high fill rate of requested shifts (90.39%) 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 that have not been filled by wards 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). We continue to monitor staffing related Datix, 20 in November and looking at hotspots and trend analysis of staffing deficits where possible.

Both bespoke adverts and centralised recruitment continues and there were two assessment centres throughout October for band 5 and band 2 substantive, as well as band 5 and band 2 bank, with 25 substantive band 5 offers and 30 substantive band 2 offers. There has been an increased trend of agency colleagues, particularly band 2, applying to join the bank as we decrease engagement with agencies.

Band 5 registered nurse recruitment continues with bespoke adverts and, due to its success, we are reviewing the international recruitment program with a view to introducing a reduced supplementary plan.

Escalation and continuity plans are followed to ensure the delivery of a 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 agency scrutiny group has allowed us to focus on agency spend and reinforce the centralised process for locum engagement. Early results show that this is impacting on our agency with a significant reduction in October.

Although we continue to sustain the overall fill rate, we continue to fall short of the registered nurse fill rate for day shift and will continue to look at ways of improving this. This has meant that 11 wards, a decrease of three on the previous month, have fallen below the 90% registered nurse day fill rate. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams remain under pressure to deliver a high quality of care, as well as being safe, and has impacted on section 17 leave being taken at times as well as other interventions being delayed.

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 October no ward fell below the 90% overall fill rate threshold, this is in line with 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 an increase of two wards on the previous month, there were 25 (80.0%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 25 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 Dales with supportive measures put in place including increased block booking, placing bespoke recruitment adverts, and ensuring that additional resources are placed at their disposal.

Registered Nurses Days: Overall registered day fill rates have increased by 2.9% to 86.4% in October compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have increased by 2.3% in September to 102.2% compared with the previous month.
Overall Registered Rate: 94.3% (increased by 2.9% on the previous month);
Overall Fill Rate: Overall Fill Rate: 123.5% (decreased by 0.6% on the previous month); Health Care Assistants showed a decrease in the day fill rate of 4.1% to 145.7% and the night fill rate decreased by 1.9% to 159.3%.

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 registered nurse 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 17 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 17 to 5,903 (1,272 (+49) RN and 4,631 (-80) HCA) shifts.

Unfilled Shifts						Filled Shifts	
Categories	No. of Shifts		Total Hours	Unfilled Percentage			
Registered	356	(+10)	3816.3	28.1%	(-0.42%)	**916**	**(+39)**
Unregistered	190	(-24)	2116.3	4.6%	(-0.49%)	**4,441**	**(-56)**
Grand Total	**546**	**(-14)**	**5932.5**	**9.4%**	**(+0.28%)**		

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.

In Summary
We are continuing to successfully recruit to band 2 and bank 5 posts for both substantive posts and bank. Our use of agency is under constant scrutiny, with bank being used as opposed to agency as much as possible, including for block bookings, and this is seeing a positive impact on agency spend.

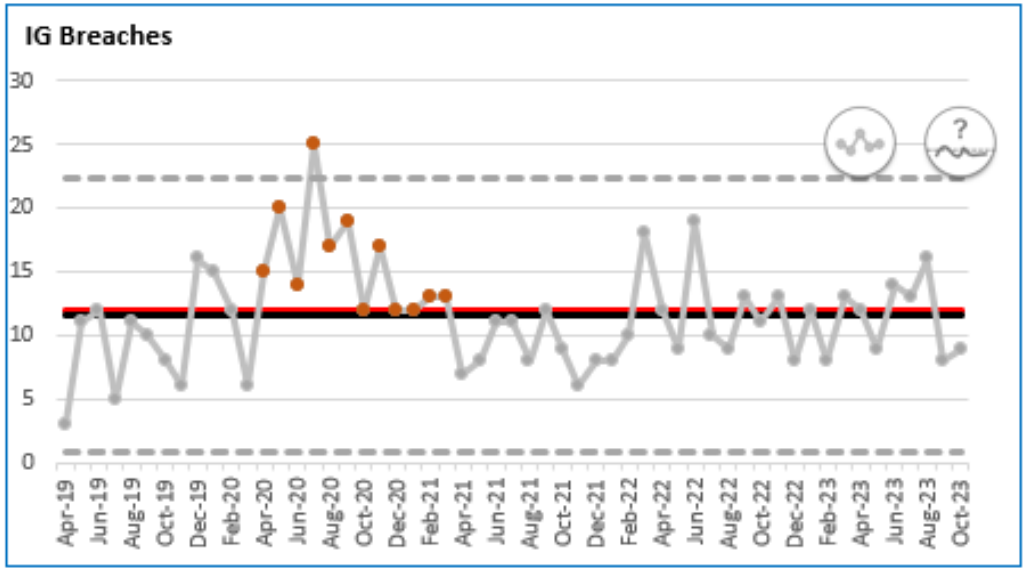
Throughout October there has been slightly less demand on the flexible workforce and although the overall fill rate has been sustained we continue to fall short of the registered nurse day fill rate for the day shift.

This indicates that our acuity remains high, with around half of our inpatient teams regularly requiring at least 20% more staff than their template dictates, and this is broadly across all areas.

Information Governance (IG)

9 personal data breaches were reported during October. 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.

An amber incident was reported when a spreadsheet including personal data about staff was shared with Trust staff who were not authorised to access it. The incident has been reported to the Information Commissioner's Office and a response is awaited.



This SPC chart shows that as at October 2023 we remain in a period of common cause variation. Though we are now under the threshold with 9 breaches.

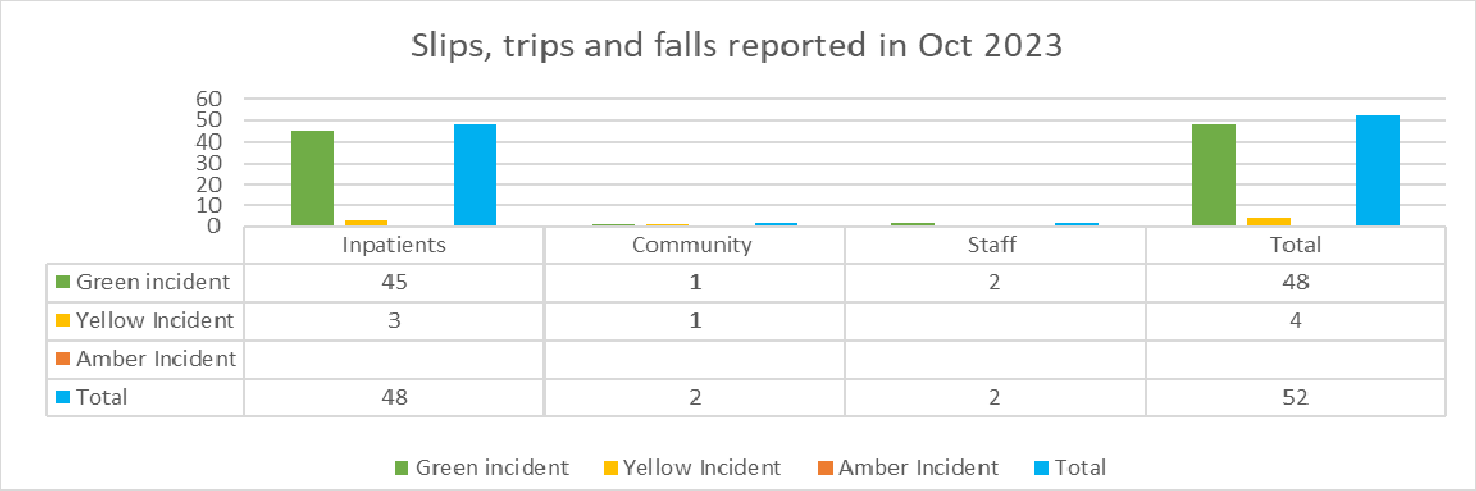
Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are 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 two is due at the end of November. For indicators due this quarter, full achievement is anticipated. Some risk has been associated with full achievement of the following metrics: staff flu vaccinations and outcome monitoring in Adults and Older people and 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 - performance is not assessed for these metrics until quarter 4.

Trustwide Falls

During October 2023 there has been a small increase in falls with a total of 52 slips, trips and falls related Datix reports. Below is a breakdown of falls and if they occurred in the community, inpatients, or staff group. The current average rate for our Trust is approximately 2.81 falls per 1000 bed days. This indicates that we continue to see a downward trend in the total number of monthly falls. The national average is 3-5 falls per 1000 bed days.



	Inpatients	Community	Staff	Total
Green incident	45	1	2	48
Yellow Incident	3	1		4
Amber Incident				
Total	48	2	2	52

Red: There have been no red Datix incident reports following falls with injury
Amber: There have been no amber Datix incident reports following falls with injury
Yellow: A total of four yellow incidents have occurred for service users, three on an inpatient ward and one in community setting. These breakdown as follows:
• One incident was for a younger adult who fell and received a cut above their eye whilst on a ward.
• One incident was for a service user who lost their footing and fell in their bedroom.
• One incident was for a service user had a small graze to their elbow following a fall.
• One incident was for a service user following a fall at home whilst mobilising to the toilet.
Green: The majority of 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.

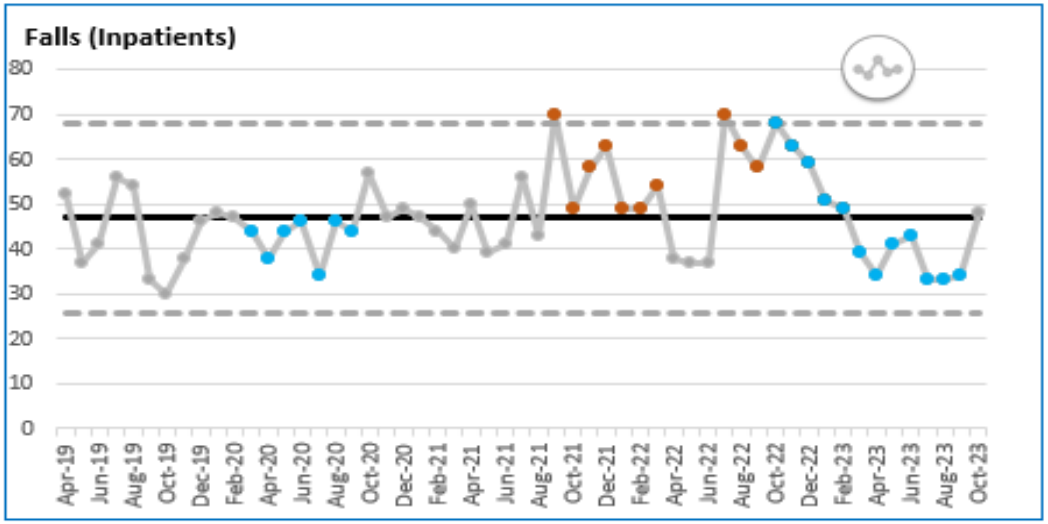
Trustwide Falls cont…

Inpatient related falls: 48 reported slips, trips and falls for service users (34 incidents reported in September)
• 35% of all falls occurred for people under the age of 65 years, this is an increase from the previous month.
• 71% of all falls occurred for service users with no previous history of falls. Generalised falls reported such as sliding from a chair onto the ground, missing the chair when going to sit down, and tripping over sports equipment. There were some reports linked to agitation, low blood pressure and dizziness.
• 55% of all older adults falls had a diagnosis of dementia.
• 21% of falls reported had some agitation or link with poor mental health and frustration.
• 100% of service users received a high-quality physical health intervention, and where appropriate, had a medication review and physiotherapy intervention.
• 100% of service users with a previous fall's history had a multifactorial risk assessment completed.
• 35% of post falls protocols had not been completed following an inpatient fall. It is recognised that the post falls protocol documentation is a legal document that formalises best practice following an inpatient fall. There is a quality improvement project in place to support improvement to 90% by February 2024.

Assurance and actions:
• Datix reports are horizon scanned by the Trustwide falls coordinator for inpatient wards and units, to seek themes and areas of potential improvement. Follow-up has taken place:
• The use of 'as required' medication and clear rational for need and documentation has been reviewed. Staff education and support has been completed by a locality matron.The falls coordinator continues to review medications utilised prior and following an inpatient fall.
• Weekly support and advice given at complex case meetings for a service user on a forensic ward regarding mobility, physical health, and mental health needs.
• Complex case meeting held for a younger person who was trying to harm themselves through falling. Improvements were reported within a 24-hour period.
• The falls coordinator has been working with locality matrons regarding the completion of the post falls protocol document. The falls coordinator has commenced a quality improvement project to improve the completion of the post falls protocol. The aim is to reach 90% completion by February 2024.
• The falls coordinator has been invited to give bespoke falls awareness and documentation education sessions to preceptorship nurses, at staff away days, and for international nurses.
• A meeting is planned to review the current falls and bone health education offered.
• Ward 19 has been successful in a bid for 'Ey Up' charity funding. They are supporting increased physical health activity predischarge, with exercise programmes and visits to sport's centres. This work is to improve mobility, physical activity and reduce falls at home.

Falls (Inpatient)

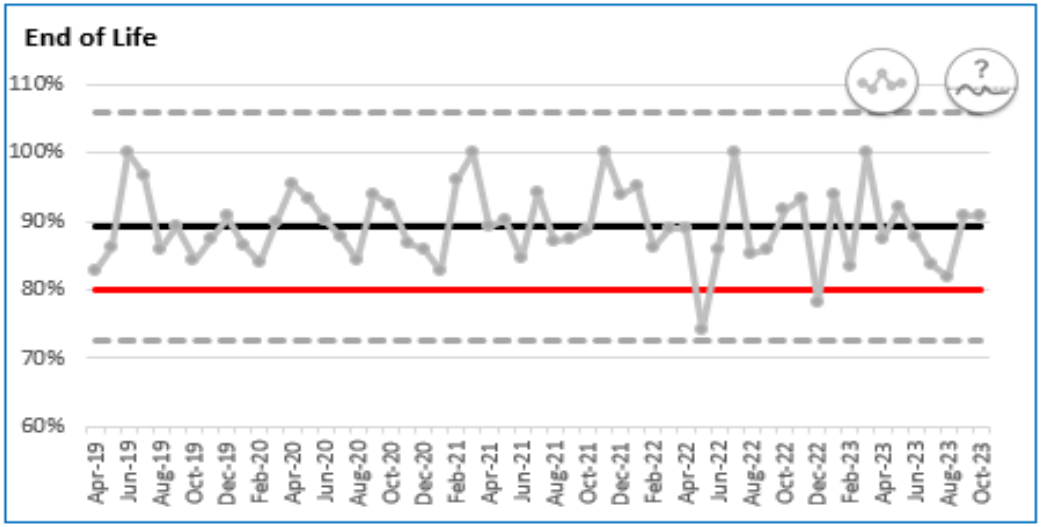
The total number of inpatient falls was 48 in October. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in October 2023 we have entered a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 90.9% in October. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in October 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

- 95% would recommend community services
- 89% would recommend mental health services

	Target	August	September	October
Mental health community	85%	90%	95%	91%
Mental health inpatient	85%	92%	83%	84%
Learning Disabilities	85%	91%	100%	95%
ASD/ ADHD	85%	75%	75%	83%
CAMHS	75%	100%	70%	91%
Forensic	60%	100%	100%	100%
Mental health overall	84%*	**90%**	**95%**	**89%**
Barnsley Gen ops	95%	**97%**	**96%**	**95%**
Trustwide	**85%**	93%	94%	**92%**

** weighted for 2023/24*

- Inpatient and CAMHS satisfaction has increased from the previous month.
- Community mental health and learning disabilities has declined.
- ADHD satisfaction continues to increase and the number of responses returned is also increasing.
- Text messaging service development continues. This is having a positive impact on the number of responses returned (982 responses in October, compared with 488 in September).
- An audit is being undertaken to identify services that have not received friend and family test feedback.

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

Overall, the satisfaction across the Trust has declined (94% in September to 92% in October). However, there has been an increase in the number of FFT returns during October, which may have impacted the overall satisfaction rate.

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

Safeguarding

Safeguarding Adults:
In October 2023, there were 34 Datix categorised as safeguarding adults. Seventeen of these were graded as green, fourteen were graded as yellow, and three were amber. The sub-categories of the safeguarding adults reporting on Datix were mainly emotional/psychological abuse, financial abuse, neglect concerns, physical abuse and domestic abuse.

Of the three amber Datix's (emotional abuse, neglect and self-neglect) appropriate actions were taken, referrals were made to the local authority, a CQC notification was made regarding a care home and capacity assessments were completed.

In addition to the safeguarding adults Datix, there were 25 sexual safety Datix. There was one amber, in relation to staff to staff conduct, there were 14 green, and 10 yellow. In 10 of these Datix, service users were the affected persons, 15 of these had staff who were affected. In all cases reviewed appropriate actions were taken and local authority safeguarding referrals were made where required.

Safeguarding Children:
In October 2023 there were 18 Datix categorised as safeguarding children. 15 of these were graded as green and three were graded as yellow.
The subcategories of the safeguarding children Datix were mainly sexual abuse, neglect and child protection other.

In all of the 18 Datix submitted, Trust safeguarding advice was sought in 11 cases; 10 contacts resulted in a referral to children social care, seven contacts were made to the police and two contacts were made in to the Local Authority Designated Officer (LADO) (involving allegations against non-Trust staff).

Infection Prevention Control (IPC)

Annual plan: progressing well, no areas at risk of non-completion.

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

Mandatory training: figures remain healthy and above Trust 80% threshold:
• Hand Hygiene -Trustwide Total – 95.4%
• Infection Prevention and Control - Trustwide Total – 93.9%

Policies and procedures: a 12-month extension request for policies that are for review in 2023, this is to accommodate implementation of the National IPC Manual, which has a target date of March 2024. The current policies and procedures remain compliance, and there is no risk in the system.

Outbreaks
• 3 Covid-19 outbreaks in October 2023
• 3 Covid-19 clusters, areas monitored

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 –11/11 (100% of formal complaints)
• Number of responses provided within six months of the date a complaint received – 9/21 (42.9%)
• Number of complaints waiting to be allocated to a customer service officer – 0
• 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 –. Complaints are now being allocated in real-time
• There were 11 new formal complaints in October 2023 (increase from 10 in September).
• 18 compliments were received.
• 21 formal complaints were closed in October 2023. This is an increase compared to September where 18 were closed.
• Number of concerns (informal issues) raised and closed in October 2023 – 37
• Number of enquiries responded to in October 2023 - 104 (increase from 92 in September)
• Number of complaints referred to the Parliamentary Health Service Ombudsman and upheld this financial year to date = 1

Reducing Restrictive Physical Intervention (RRPI)

• The figures in this report were sourced from Datix where reporters indicated ‘yes’ to the question “Was restraint used in this incident?"
• There were 198 reported incidents of Reducing Restrictive Physical Interventions (RRPI) used in October 2023 this was an increase of 106 (115 %) incidents from September 2023 which stood at 92 incidents. There was an increase of 73 incidents across three wards (Beamshaw, Newhaven and Poplars) Further breakdown of this data can be found later in the report.
• In October 2023 there were 41 incidents of seclusion use Trust wide, this is an increase of 25 (156%) from September that stood at 16.

Both these figures show large increases from recent months however these figures are in line with and not above the data across a 12-month period, the low numbers in recent months are the exception.

A significant proportion of prone restraints are due to administration of intramuscular injections into the gluteal muscle. A task and finish group are establishing if alternative injection sites could be used.

• Pharmacy colleagues have reviewed licencing of medication and which muscle groups they can be administered
• Reviewing local and national policy and guidance
• RRPI team are reviewing alternative holds to support administration into deltoid muscle and seeking advice from Mersey Care Trust on recovery position technique

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• Reviewing IPC guidance for administration of injection through clothing to support trauma informed care and avoid prone restraint
• Assessing training needs for alternative injection sites
• Reviewing Datix that involve prone to assess if alternative approach and injection site could have been used

To further support prone restraint reduction, the RRPI team are also reviewing seclusion exit strategies. This includes the introduction of a new safety pod to facilitate staff to exit seclusion and networking with other Trust's and restraint reduction network on seclusion exit strategies and techniques. Through a targeted approach these new techniques will be piloted in identified clinical areas and incorporated into RRPI training.

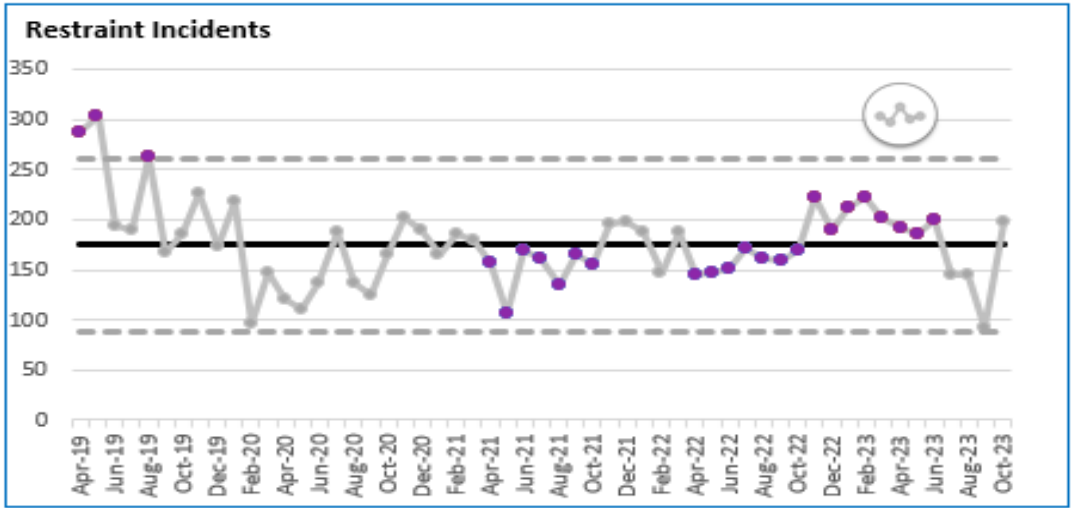
Reducing Restrictive Physical Intervention (RRPI)

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	97	33.2%
Seated	48	16.4%
Safety Pod	40	13.7%
Side	31	10.6%
Supine - held on their back	26	8.9%
Prone - chest down position	25	8.6%
Restricted escort	11	3.8%
Prone then rolled	10	3.4%
Kneeling	4	1.4%
Total	**292**	

Team Using Prone Restraint Oct 2023	Total
Walton PICU, Wakefield	11
Newhaven Forensic Learning Disabilities Unit, Wakefield	4
Horizon Centre, PLD Assessment and Treatment Service, Wakefield	3
Ashdale Ward, The Dales	2
136 Suite Unity Centre, Wakefield	1
Stanley Ward, Wakefield	1
Beamshaw Ward, Barnsley	1
Chippendale Ward, Forensic, Wakefield	1
Total	**24**

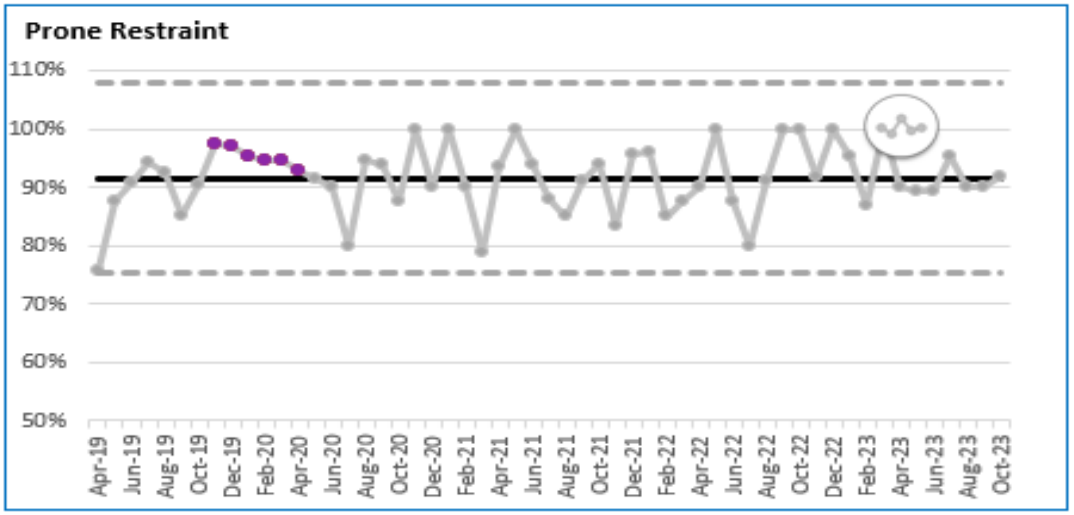
Duration of Prone Restraint	Total
0 - 1 minute	10
1 - 2 minutes	9
2 - 3 minutes	3
3 - 4 minutes	2
Total	**24**

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in October 2023 we remain in a period of common cause variation (no concern).

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



This SPC chart shows that due to the continued variation in prone restraint incidents in October 2023, we remain in a period of common cause variation (no concern).

Guardian of Safe Working - Quarterly report Q2

Distribution of Trainee Doctors within SWYPFT

Recruitment to core training (CT) posts in psychiatry remains good and the Trust is in discussion about accommodating more trainees in the future given the positive news about an increase in training numbers across the region. Things remain uncertain regarding the impact on SWYPFT of the loss of higher training numbers in old age psychiatry across Yorkshire. Changes at short notice for the August rotations left us with gaps particularly affecting Calderdale (2 core trainees (CT), 1 GP vocational training schemes (GPVTS) and 1 foundation year (FY) 2) but also another in Barnsley (GPVTS). The Trust has recruited LAS doctors which have filled the CT gaps and GP gaps, in addition to the International Fellows supporting some of these services. However, not all the newly appointed doctors will be ready to go on the out of hours rotas. The Trust continues to support a number of Less Than Full-Time (LTFT) Trainees and many of the barriers to LTFT training have now been removed. Although we now have 70 training posts, the Whole Time Equivalents (WTE) in post are less than 60 due to a combination of vacancies and LTFT trainees in full-time slots. It is hoped that in the future, more will be placed in “slot-shares”, to reduce the overall impact on WTEs.

Exception Reports (ERs - with regard to working hours)

There have been few exceptions reports completed in the Trust since the introduction of the new contract. There was just one in this quarter, where a trainee in Calderdale stayed late after a busy shift. Time off in leiu was agreed and the doctor was happy with the outcome.

Fines - There have been none within this reporting period.

Work schedule reviews - There were no reviews required.

Rota gaps and cover arrangements

The tables below detail rota gaps by area and how these have been covered. Overall, the numbers of gaps have remained stable with Calderdale and Barnsley having the highest proportion of gaps this quarter. The most common factors included illness, and occupational health recommendations for trainees to come off the rota (42); vacancies (39) and trainees being LTFT (19). The other most significant factor this quarter was the impact of industrial action (29). The costs that were directly attributable to Covid-19, where trainees were Covid-19 positive or self-isolating, are shown separately but the impact remains small currently. The Trust’s Medical Bank has been working well with rota coordinators and the trainees themselves working hard to ensure that nearly all the vacant slots on first tier rotas were filled by the Trust Bank. The increase in the rates for resident rotas and for higher trainees has been agreed and now implemented.

Guardian of Safe Working - Quarterly report Q2

Gaps by Rota July/August/September '23					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	47 (26%)	47 (100%)	0	0	0
Calderdale 1st	68 (37%)	68 (100%)	0	0	0
Kirklees 1st	10 (11%)	10 (100%)	0	0	0
Wakefield 1st	22 (11%)	20 (91%)	0	0	2 (9%)
Total 1st	147 (23%)	145 (98.5%)	0	0	2(1.5%)
Wakefield 2nd	35 (38%)	0	0	35 (100%)	0

Costs of Rota Cover July/August/September '23				
1st On-Call Rotas	Shifts (Hours) Covered by Medical Bank	Cost of Medical Bank Shifts	Cost attributed directly to COVID-19	Agency Hours (Costs)
Barnsley	47 (452)	£17,560	£540	0
Calderdale	68 (716.5)	£32,242.50	£0	0
Kirklees	10 (160)	£5,600	£0	0
Wakefield	20 (87)	£8,865	£0	0
Total	145 (1415.5)	£64,267.50	£540	0

Issues and Actions

Junior Doctors' Forum (JDF) – continues to meet quarterly, offering a forum for trainees to raise concerns about their working lives and to consider options to improve the training experience. The JDF continues to meet mostly by Microsoft Teams. However, we were able to hold our first face-to-face forum since 2020 in September and this was well attended, and we hope to hold more like this in the new year. The face-to-face nature of the meeting really helped with engagement. More of the senior trainees attended and they were able to offer support and advice to their junior colleagues about a range of issues, in particular, what options for rota changes were advisable, given their own experiences. Once again, the importance of using ERs was stressed, especially as evidence if there has been an increase in workload. There were further discussions about the busy Wakefield rota. Time spent travelling to The Poplars continues to create time pressures. The Guardian of Safe Working, the Wakefield College Tutor and the trainee representatives will continue to meet to discuss options. The most concerning topic of discussion was the failure of promised changes to the Barnsley foundation year 1 on-call rota in the acute trust. A trainee reported being given their rota late and being put under pressure to continue the old system, whereby trainees get little opportunity to spend time in their Psychiatry placement. Further discussions are planned with the acute trust and Foundation TPD to try to resolve this. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the Associate Medical Director (AMD) for Postgraduate Medical Education.

Education and support – The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees' experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum. The Medical Directorate Business Manager, the Postgraduate Medical Education Lead, the AMD for Medical Education, the Guardian of Safe Working and the College Tutors continue to meet frequently to coordinate the trust's support of trainees.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Establishment	Improving Resources	Well Led	-	5,157.4	5,174.0	5,193.8	5,196.6	5204.8	5321.0	5323.3
Employed Staff (ESR last day in the month)			-	4,257.0	4,266.2	4,273.6	4,289.5	4,311.6	4358.0	4379.2
Vacancies			-	818.9	822.0	818.4	796.1	772.1	867.8	897.4
Vacancy rate			<10%	15.9%	15.9%	15.8%	15.3%	14.8%	16.3%	16.9%
Turnover external (12 month rolling)			>12% - <13%	13.0%	12.2%	13.1%	13.0%	13.1%	12.1%	12.4%
Starters			-	45.8	54.9	57.5	53.9	64.0	63.3	69.4
Leavers			-	39.4	36.5	41.1	51.3	45.2	35.2	51.8
Number of international nurses recruited			-	Reporting commenced August 23				9	10	10
% Bank Fill Rates - Registered Nurses			-					47.8%	49.6%	51.9%
% Bank Fill Rates - Health Care Assistants			-					69.8%	70.2%	75.9%
Proportion of staff in senior leadership roles who are from BME background (relates to staff in posts band 7 and above, excludes bank staff) *			-					199 (14.7%)	203 (14.9%)	206 (14.9%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-					931 (69.8%)	942 (69.3%)	962 (69.5%)
Sickness absence - Rolling 12 month			<=4.8%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.2%
Sickness absence - Month			<=4.8%	5.0%	4.6%	4.6%	5.1%	4.7%	4.9%	5.2%
Employees with long term sickness over 12 months			-	1	0	0	0	0	2	2
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	74.4%	74.9%	78.5%	76.5%	74.5%	72.5%	69.7%
Employee Relations - Suspensions (over 90 days)			-	0	0	0	3	3	3	4
Mandatory Training - TOTAL	Improving Care		>=80%	90.5%	90.9%	92.0%	92.1%	92.5%	92.1%	92.5%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	76.7%	76.2%	82.6%	82.8%	82.9%
Mandatory Training - Cardiopulmonary Resuscitation				75.5%	79.2%	81.3%	81.0%	79.9%	80.0%	79.7%
Mandatory Training - Clinical Risk				95.6%	95.4%	95.4%	95.2%	94.8%	94.0%	92.6%
Mandatory Training - Display Screen Equipment				96.5%	96.8%	97.0%	97.1%	97.4%	97.4%	97.4%
Mandatory Training - Equality & Diversity				96.0%	96.2%	96.2%	96.0%	95.9%	96.1%	95.4%
Mandatory Training - Fire Safety				90.2%	91.2%	92.8%	92.0%	91.4%	91.2%	91.0%
Mandatory Training - Food Safety				78.0%	83.4%	86.4%	87.8%	89.4%	89.3%	88.1%
Mandatory Training - Freedom To Speak Up (FTSU)				93.2%	93.7%	94.0%	94.3%	94.7%	94.9%	95.0%
Mandatory Training - Infection Control & Hand Hygiene				91.5%	92.4%	94.1%	94.3%	94.3%	95.6%	94.2%
Mandatory Training - Information Governance (Data Security)			>=95%	90.6%	95.9%	96.8%	96.9%	95.3%	94.8%	94.5%
Mandatory Training - Moving & Handling			>=80%	95.5%	94.9%	95.2%	95.1%	95.6%	94.8%	96.5%
Mandatory Training - Nat Early Warning Score 2 (New S2)				92.5%	92.1%	93.8%	94.7%	95.2%	96.2%	96.0%
Mandatory Training - Mental Capacity Act/Dols				91.6%	93.6%	93.7%	93.4%	94.0%	96.7%	99.6%
Mandatory Training - Mental Health Act				91.6%	91.3%	91.2%	91.1%	92.2%	99.8%	91.2%
Mandatory Training - Prevent				95.4%	95.5%	92.1%	94.1%	94.2%	91.7%	93.7%
Mandatory Training - Safeguarding Adults				90.0%	89.7%	89.3%	89.5%	89.7%	93.9%	90.7%
Mandatory Training - Safeguarding Children				90.0%	90.7%	91.1%	91.2%	91.7%	89.7%	95.1%

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.

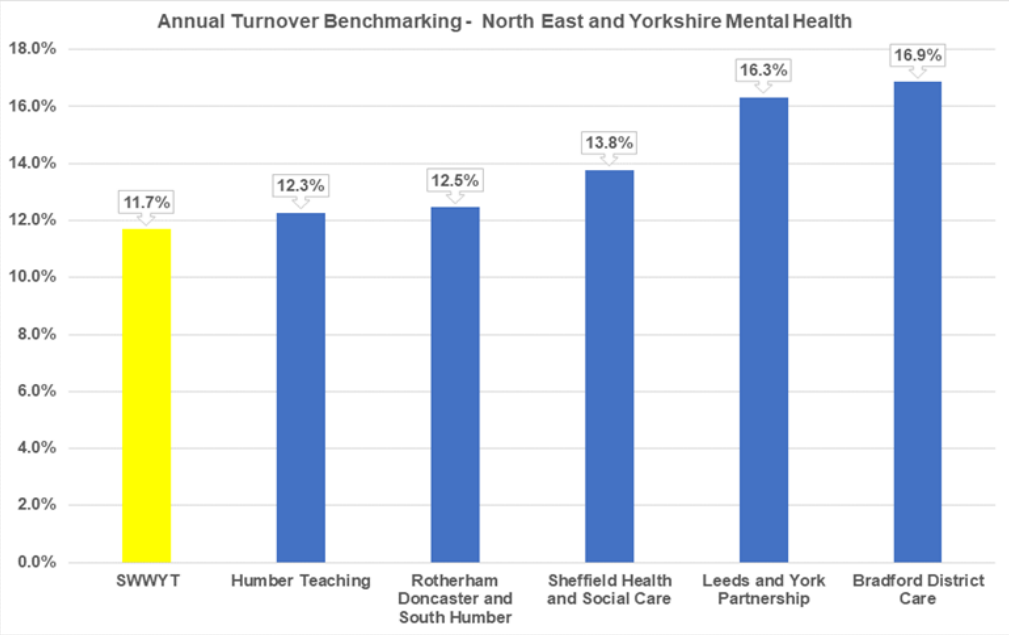
• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.

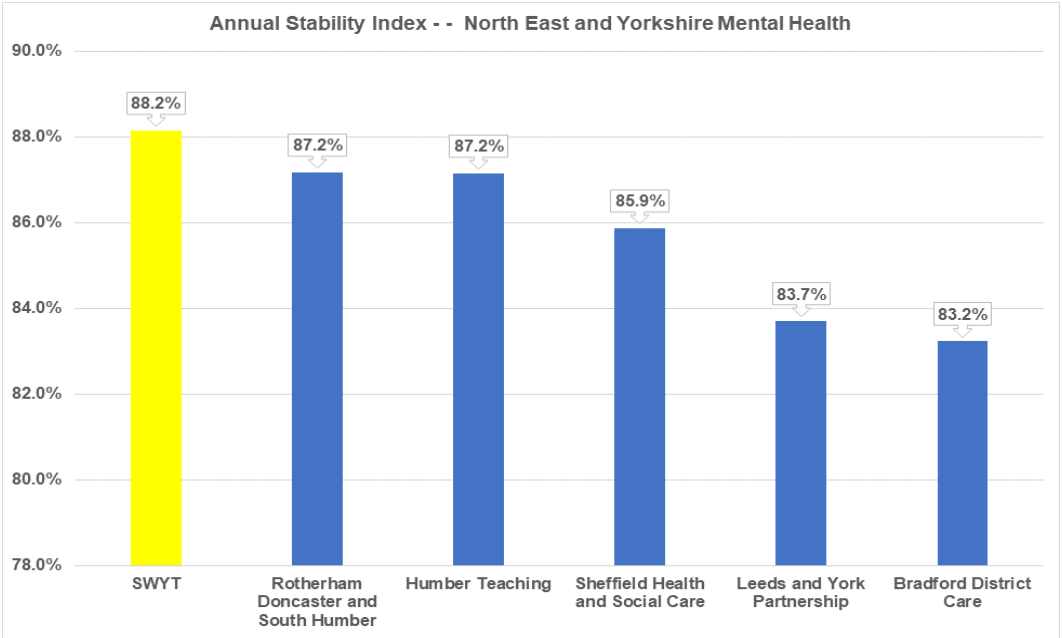
• Sickness absence - from April 23 - the reported figure is rolling over 12 months. For earlier months this was year to date

•.Bank fill rates - We are continuing to successfully recruit to band 2 and bank 5 posts for both substantive posts and bank. Our use of agency is under constant scrutiny, with bank being used as opposed to agency as much as possible, including for block bookings, and this is seeing a positive impact on agency spend.

Stability of the Workforce

- Our 12 month rolling Turnover figure is 12.4% which has increased by 0.03% from last months position.
- Our starters (408.9 whole time equivalents WTE)) continue to outperform our leavers (300.5 WTE) and we have seen more starters than leavers in the last 6 months.
- We continue to onboard our international recruited new starters with a further 10 employees recruited in October

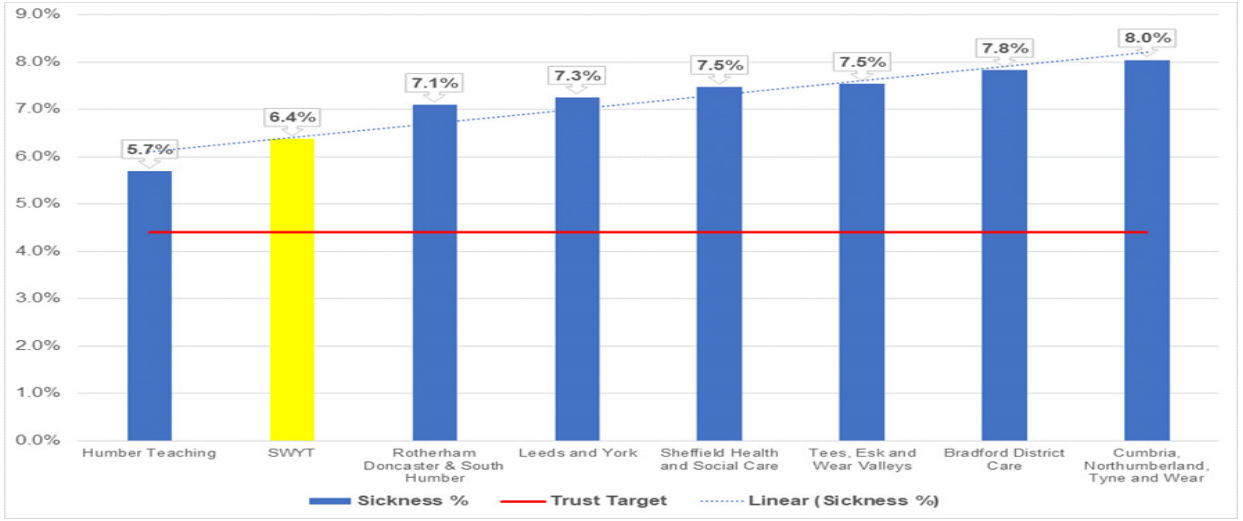




Keep Fit & Well

Absence

• 12 month rolling absence rate has dropped slightly to 5.2%.
• Overall absence (in month) has increased by 0.3% to 5.2%. Most care groups saw a slight increase in the monthly sickness position with the exception of Forensics and Barnsley physical health who both saw an in month reduction from September's position. Forensic services was at 8.4% reduced from 9.4% in September. In Corporate services, the Estates team has the highest level of sickness at 9.36%, with anxiety and musculoskeletal issues being the main reasons for absence. The people team are working with all directorates to ensure the sickness procedure is followed.
• When compared to the Dec 2022 published by NHS England we have the second lowest sickness absence as per the chart. These charts will be updated in line with NHS England publications.



Supportive Teams

Appraisals

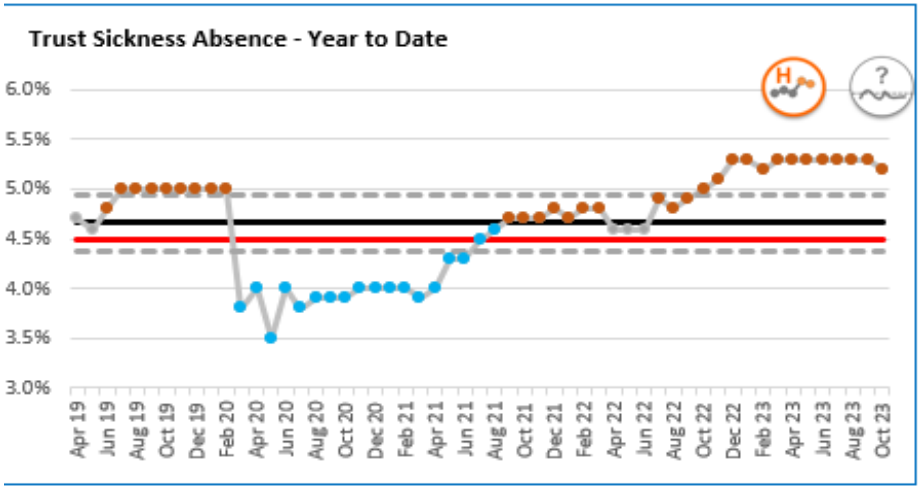
A strong focus on improving appraisals has commenced through a new Appraisal steering Group who are focussing on getting the data right, proactively supporting those areas where appraisal is low, working with the e-appraisal system to ensure that its up to date with staff movements. Two areas of focus identified are Forensics and Estates and Facilities People business partners and learning partners working with care groups to work on improvements. Executive management team also receive appraisal data.

Sickness absence has remained stable over the last quarter at 5.2%. Our rate this time last year was 5.4% and we are predicting this will rise over the coming months as seasonal absence impacts across the Trust.

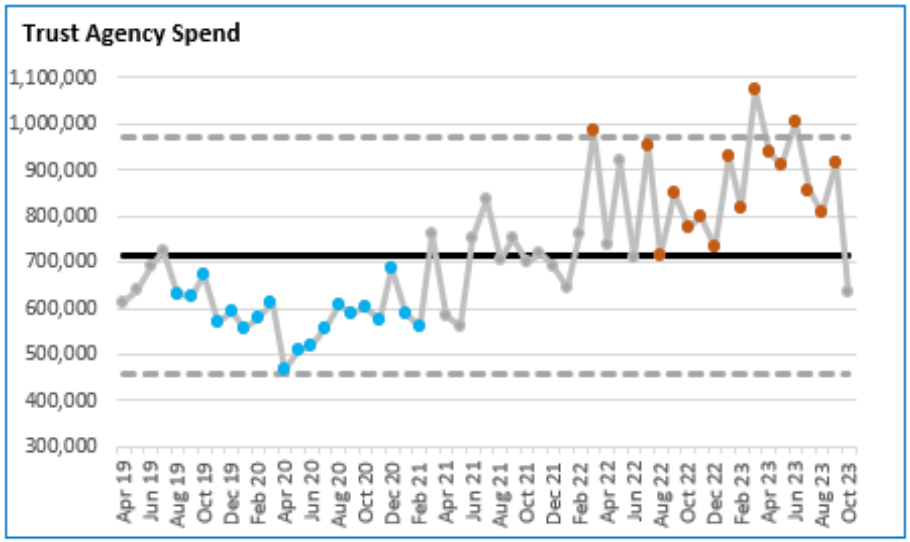
Mandatory Training

• Overall mandatory training reports at 92.5% which remains above Trust target which is positive . Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed
by operational management group. Cardiopulmonary resuscitation mandatory training compliance has seen a decline in October and is below threshold, Information governance training has also further deteriorated in October and remains below threshold at 94.5%

Analysis



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



The SPC chart shows that in October 2023 we have entered a period of common cause variation (no concern) for the first time in over 12 months.

The Trusts Agency Scrutiny Performance Group has been in place for 4 months and this month we have seen a reduction in agency spend. Admin agency usage across the whole Trust is close to zero hours and no further admin agency is being approved as per ICB requirements.
Recruitment activity is high and above last year activity levels and we continue to progress well over 140 active recruitment appointments being processed and have over 40 people attending the monthly welcome events. Recruitment fair activity over the last 3 months and next 3 months is a key focus at national and local level. We have recently attended national clinical and non-clinical events in Leeds, Liverpool and Manchester as well as local University and LGBTQ+ events

MEDICAL APPRAISALS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number expected to be undertaken in period	37	32		
Number undertaken in period	34	29		
Number not undertaken for which the RO accepts postponement is reasonable	2	3		
Percentage of appraisals taken place	92%	91%		
Percentage of appraisals signed off in period as satisfactory	92%	91%		

MEDICAL REVALIDATIONS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of revalidation recommendations due in period	5	6		
Number of positive recommendations	5	6		
Number of deferrals	0	0		
Number of non-engagements	0	0		
Percentage of revalidation recommendations made	100%	100%		

RESPONDING TO CONCERNS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of active cases under Maintaining High Professional Standards procedures	0	0		

National Metrics

Data as of : 24/11/2023 09:36:07

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	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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	F		453	408	451	483	480	434	545	435	589	400	187	66
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		85.4%	85.3%	92.6%	91.4%	74.4%	87.1%	87.8%	88.6%	90.3%	92.9%	72.4%	84.6%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		40.6%	52.4%	57.1%	53.8%	53.8%	52.5%	53.4%	53.1%	50.4%	51.5%	51.6%	52.6%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	89.5%	93.5%	95.1%	95.7%	97.5%	97.9%	99.0%	99.6%	99.0%	99.5%	99.9%	100%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		89.6%	88.9%	87.9%	89.6%	87.2%	92.5%	90.6%	92.6%	87.7%	90.7%	88.6%	90.8%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		10	0	8	30	43	15	11	29	9	18	8	10
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		2	0	1	2	2	3	1	1	1	2	2	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	98.5%	98.5%	97.7%	97.6%	98.1%	97.8%	98.6%	99.2%	99.2%	98.3%	98.3%	99.0%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.9%	99.5%	99.8%	100%	99.8%	99.8%	99.8%	100%	99.8%	99.8%	100%	99.9%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		90%	100%	87.5%	80%	87.5%	50%	80%	100%	70%	66.7%	100%	80%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	79.3%	88.2%	88.6%	100%	95.8%	77.8%	95.8%	100%	92%	91.3%	100%	96.6%
M15	Data Quality Maturity Index		95%	P		99%	99.1%	99.4%	98.2%	98.2%	99.4%	99.2%	99.5%	98.8%	99.3%	99.3%	99.5%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1542	1192	1641	1415	1532	1306	1603	1579	1470	1403	1477	1744
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		97.8%	98.5%	98.1%	99.1%	98.9%	98.9%	98.4%	98.8%	99.2%	99.7%	99.0%	99.0%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	29	36	36	44	30	25	34	26	36	38	34	34
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					66	70	72	51	81	51	67	53	64	60	70	68
M170	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	100%	86.2%	88%	91.6%	79.8%	60.7%	53.3%	82.5%	66.7%	64.1%	75.3%	74.3%

National Metrics

Data as of : 24/11/2023 09:36:07

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
M30	Number of detentions under the Mental Health Act (MHA)					86	90	100	94	86	93	101	93	101	100	97	96
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					20.9%	22.2%	20%	19.1%	22.1%	21.5%	17.8%	12.9%	26.7%	20%	22.7%	24.0%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			96.5%	97.6%	96.3%	95.6%	97.9%	97.5%	97.6%	97.8%	98.3%	98.3%	96.9%	97.4%
M34	% Clients in settled accommodation	⚠	60%			85.8%	85.2%	84.4%	84.4%	84.6%	84.2%	84%	84.3%	83.8%	84.3%	84.3%	84.8%
M35	% Clients in employment	⚠	10%			11.6%	11.4%	11.7%	11.4%	11.2%	11.2%	11.5%	11.7%	12.0%	12.3%	12.6%	12.2%
M41	Completion of a valid NHS number		99%			100%	100%	100%	100%	100%	100%	100.0%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
M42	Completion of ethnicity coding for all service users		90%			99.3%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.4%	99.4%	99.5%	99.4%	99.5%
M43	Community health services two hour urgent response standard		70%			88.4%	84.3%	87.6%	85.0%	83.7%	87.3%	86.6%	86.2%	88.1%	89.5%	88.7%	88.1%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500								1523	1719	2335	1509	1667	1656	1726
M45	The number of incomplete Referral to Treatment (RTT) pathways		2300														2009
			2400											1782	1982	2168	
			2500								1933	1835	1592				
M46	Count of 2-hour urgent community response first care contacts delivered					862	771	796	648	761	826	953	911	936	1019	1003	929
M47	Virtual ward occupancy		80%								82.9%	44.3%	92.9%	51.4%	57.1%	60%	56.3%
M48	Community services waiting list		5430											5024	5170	5048	
			5469														4952
			5652								5420	5298	5131				
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses										3917	3928	3925	3915	3898	3873	3863
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact										10958	11095	11100	11121	10949	11051	11140
M171	% Admissions gate kept by crisis resolution teams		95%			98.7%	100%	98.9%	99%	98.2%	100%	99%	100%	96.6%	100%	99.1%	100%

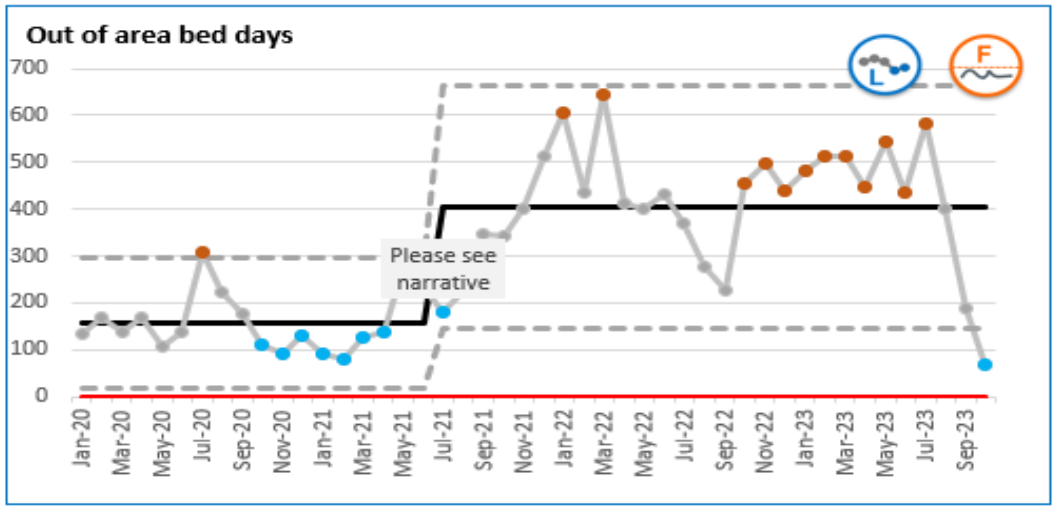
National Metrics

Data as of : 24/11/2023 09:36:07

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 100%
• 72 hour follow up remains above the threshold at 90.8%.
• The percentage of service users waiting for a diagnostic appointment for less than 6 weeks in the paediatric audiology service remains below threshold at 74.2% in October. This has now entered a period of special cause concerning variation (please see SPC chart). The care group escalated a concern regarding access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan was initiated. More recently, the care group reported a concern with reaching the agreed trajectory to full performance by October 2023. This relates to staffing capacity, which is an issue shared across South Yorkshire providers, and to increased numbers of children 'not brought' to assessments where the assessment cannot be rebooked within 6 weeks. Not all appointments are for diagnosis. Overall the average waiting time for an appointment in audiology is 3.5 weeks so if parents need support and advice for their child a general appointment can be arranged.
• 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 have both seen a decrease in performance in October to 80% and 96.6% respectively, though low numbers do significantly impact performance. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.
• During October 2023, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 10 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 52.7% for October. 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 October. 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.



The SPC chart shows that due to the continued and significant reduction in out of area bed days in October 2023 we have now entered a period of special cause improving variation. We are still not estimated to meet the target of zero bed days though we are closer to this than we have been for over 2 years.

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.

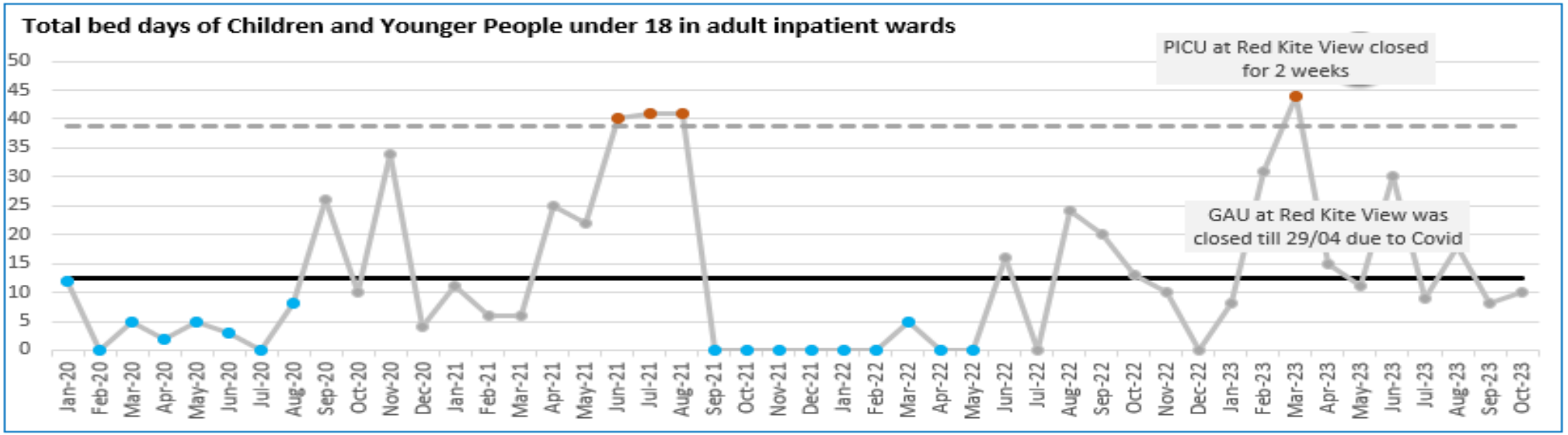
Summary	Actions	Assurance
The Trust has seen a continued reduction in the number of inappropriate out of area bed days and has entered a period of special cause improving variation.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and 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 are now being realised and further improvement and sustainability of the reduced figure is expected.	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 October the following data quality issue has been identified in the reporting:

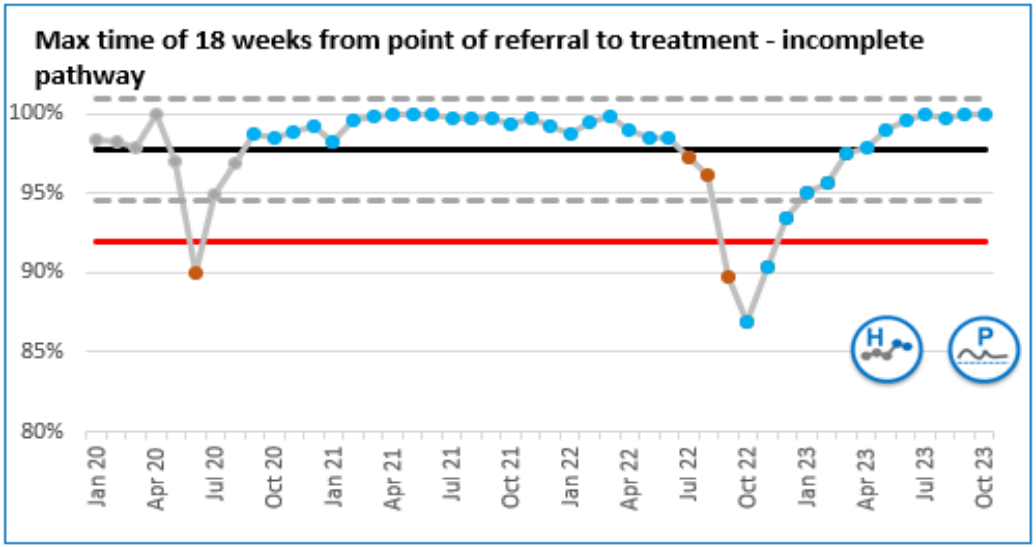
- The reporting for employment and accommodation shows 15.8% of records have missing employment and/or accommodation status with a further 1.10% that have an unknown employment status and 0.95% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

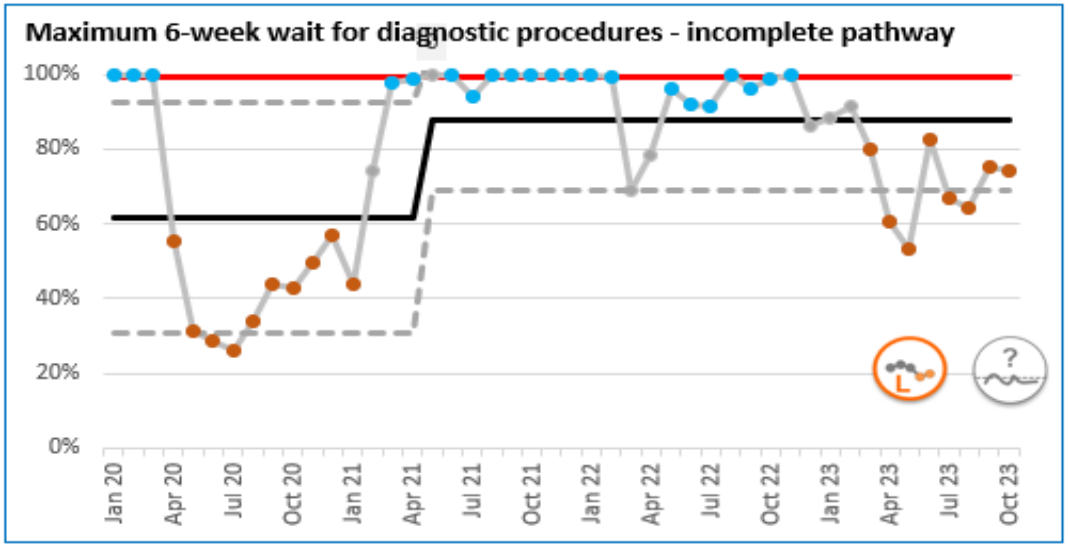
Analysis



The statistical process control chart (SPC) above shows that in October 2023 we remain in a period of common cause variation (no concern) regarding the number of beds days for children and young people in adult wards.

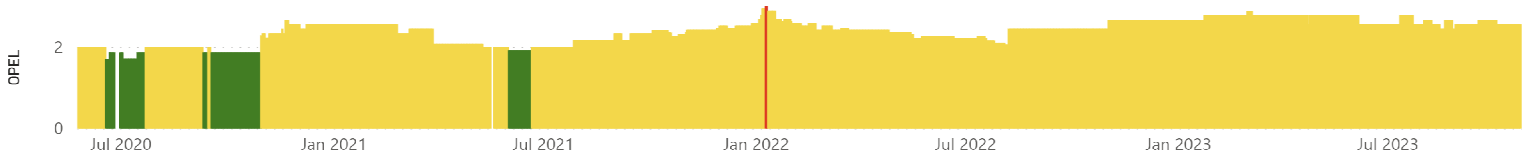
Analysis





The SPC charts above show that for October 2023 we are currently in a period of special cause improving variation for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. For clients waiting for a diagnostic procedure we remain in 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.



Current average OPEL level

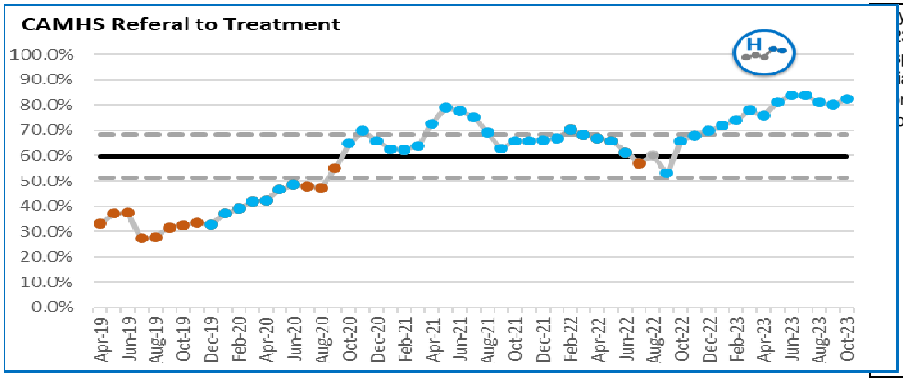
2.56

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

Child and adolescent mental health services (CAMHS)

CAMHS

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	72.4%	72.1%	
% Complaints with staff attitude as an issue	< 20%	0% 0/0	0% 0/3	
% of staff receiving supervision within policy guidance	80%	71.8%	69.5%	
CAMHS - Crisis Response 4 hours	N/A	91.7%	89.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.3%	81.7%	
Eating Disorder - Routine clock stops	95%	100.0%	96.6%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	80.0%	
Information Governance training compliance	>=95%	93.3%	93.9%	
Reducing restrictive practice interventions training compliance	>=80%	65.1%	62.9%	
Sickness rate (Monthly)	4.5%	4.5%	5.2%	
% rosters locked down in 6 weeks				



you can see in October
3, we remain in a period
pecial cause improving
iation. For further
rmation see narrative
ow.

Alert/Action

• Waiting time numbers for Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Kirklees remain problematic. Robust action plans are in place (with transformation programme support) but the shortfall between commissioned capacity and demand remains. Agreement for Evolve contract for a temporary (end March 2024) extension but long-term capacity concerns remain . In Calderdale, Neuro waits have reduced due to the Right to Choose process and less referrals being added to waiting list. Issue now in both Calderdale and Kirklees is that some young people have been seen by another provider but remained on Trust waiting lists. We are looking at processes to ensure that young people are removed from Trust waiting lists if they have been seen by another providers or are on their waiting lists.
• Shortage of specialist residential and tier 4 places due to reduced capacity nationally and ongoing capacity issues locally. In Calderdale and Kirklees there are several young people in the community awaiting a bed, several complex young people on paediatric wards due to acuity. Several young people with Eating Disorders also awaiting a bed.
• 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.

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. Deterioration in reported quatre 2 performance requires further analysis. Some evidence of increasing case acuity/complexity but also some potential for data quality improvement.
• 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 Kirklees Keep in Mind programme will be launched April 2024. New Entry Pathway needs to be developed for all referrals across Kirklees to launch April 24.
• Evident increase in sickness rates – most notable in Barnsley. Small number of long term sickness cases adversely impacting and being proactively managed. Some long term sickness in Kirklees, due to personal issues, being managed by team manager.
• RRPI Mandatory training in red. Limited availability of face to face training offer – but improvement expected in Q3
• Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.
• Management priority being attached to improving appraisal rates across all service, support for this from the people directorate.

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	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	76.1%	72.2%	
% Assessed within 14 days of referral (Routine)	75%	82.7%	86.8%	
% Assessed within 4 hours (Crisis)	90%	97.1%	95.6%	
% Complaints with staff attitude as an issue	< 20%	13% (1/8)	33% (1/3)	
% of staff receiving supervision within policy guidance	80%	65.1%	65.1%	
% service users followed up within 72 hours of discharge from inpatient care	80%	88.6%	90.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.6%	97.5%	
% Treated within 6 weeks of assessment (routine)	70%	97.1%	97.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.1%	79.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	*91.8%*	*Data under review*	
Information Governance training compliance	>=95%	94.4%	*95.1%*	
Reducing restrictive practice interventions training compliance	>=80%	66.8%	66.0%	
Sickness rate (Monthly)	4.5%	4.1%	4.3%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	62.2%	67.4%	
% bed occupancy	85%	86.6%	87.4%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/2)	
% of staff receiving supervision within policy guidance	80%	63.1%	62.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.1%	80.5%	
% of clients clinically ready for discharge	3.5%	7.7%	5.8%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.5%	90.0%	
Inappropriate Out of Area Bed days	92	187	66	
Information Governance training compliance	>=95%	90.9%	*95.1%*	
Physical Violence (Patient on Patient)	Trend Monitor	29	22	
Physical Violence (Patient on Staff)	Trend Monitor	53	55	
Reducing restrictive practice interventions training compliance	>=80%	81.5%	82.8%	
Restraint incidents	Trend Monitor	62	***146***	
Safer staffing	90%	130.4%	126.5%	
Sickness rate (Monthly)	4.5%	4.0%	6.0%	
% rosters locked down in 6 weeks				

Alert/Action

- Acute wards have continued to manage high levels of acuity.
- There are high occupancy levels across wards and capacity to meet demand for beds remains a challenge.
- Rehabilitation services are now commissioned to deliver a flexible bed base offer. Both rehab units still maintain the option of utilising all the beds, however it a fluid resource with the community rehab provision and the use of the beds is required to balance with the community rehab caseload. The aim of the flexible bed base model is to allow for service users to progress in a timely manner from acute services and into the community with rehab input as soon as possible. Kirklees aim to work at a flexible bed base of 16-24, but can accommodate 27 inpatients and 3 social care patients but the community rehab caseload will reduce to accommodate this. Calderdale aim to work at a flexible bed base of 8-10 but can accommodate 14 inpatients with the community rehab caseload requiring a reduction to accommodate this.
- Workforce challenges have continued with continued 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 monitoring the impact of reduced out of area beds on inpatient wards.
- The care group 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.
- There is increased pressure on the wards from the number of learners that require support, namely student nurses, international recruits and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by 2-3 Registered Nurses, some of whom have recently completed their own preceptorship.
- 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. In October performance data indicates that the routine access for assessment target is being achieved in Calderdale and Kirklees and Wakefield. Performance is below target in Barnsley this month. Barnsley have action plans in place and are undertaking specific improvement work.
- Rapid improvement work in SPAs and implementation of BCP in Calderdale & Kirklees together with some progress in recruitment has contributed to an improved performance this month.
- The Kirklees Talking Therapies recovery rate for October is 54.05% achieving the national standard of 50% which is an improvement on September's position. 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, however the picture has started to improve with some successful recruitment.
- There are higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success. There are action plans in place for certain teams experiencing particular challenges and an overall continuation of proactive and innovative approaches to recruitment and workforce modelling.
- All areas are focussing on continuing to improve performance for FIRM risk assessments. The data is currently under review for community mental health services. Inpatient performance for those admitted who have had a staying-well plan within 24 hours is working towards achieving and sustaining improvement against trajectory.
- For FIRM risk assessments on inpatient wards there has been an issue with inclusion of data that should not be included in the data set and with the timeliness of the extract. The next extract is expected to resolve the issues but operational and performance colleagues will work on a solution if not.

Transfers from acute wards to rehab wards have been treated as such by the receiving ward, and patients transferred already have a risk assessment in place in accordance with inpatient performance requirements. This has however been reflected against performance for new admissions, we will be working with performance colleagues to reflect performance more accurately going forward.

- 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.
- Intensive work is underway to consider how quality and safety is maintained on inpatient wards. In addition there is a focus on improving the well-being of staff and service users and focussing on recruitment and retention.
- The care group is actively expanding creative approaches to enhance service user experience and the general ward environments. Challenges and priorities are being identified and included in 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 provision of robust gatekeeping, trauma informed care and effective intensive home treatment.
- The care group is participating in the Trustwide work on measuring and managing waits in terms of consistent data and performance measurement.
- Work continues in collaboration with our places to implement community mental health transformation.
- The care group recognises the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and there is a commitment for acute inpatient wards to achieve the target of all appraisals being completed.
- For all inpatient wards there has been a review of internal processes to ensure we are capturing all exclusions for supervision stats (there are some staff who are captured in these figures that should have been excluded due to long-term sickness for example). Admin staff will be supporting ward managers to ensure all exclusions are recorded on a monthly basis.
- There is a focus on performance with respect to Friends and Family Tests both in content of responses and numbers completed. Action plans for improvement are in place with all areas now above threshold other than Barnsley where significant improvement has taken place.
- All team managers have been contacted where compliance rates are below expected thresholds for mandatory training (this includes Reducing Restrictive Practice/ Cardio-Pulmonary Resuscitation and Information Governance). Inpatient General Managers have also discussed how the service manager might support with monitoring this moving forward.
- Work continues towards meeting 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.
- The care group is working closely with specialist advisors and have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

Assure

- IHBT teams are performing well in gatekeeping admissions to our inpatient beds.
- The care group is performing well in 72 hour follow up for all people discharged into the community.
- Out of area placements have reduced following intensive work as part of the care closer to home workstream

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

LD, ADHD & ASD

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	70.6%	68.1%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	75.7%	74.6%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	82.3%	
% of clients clinically ready for discharge	3.5%	65.8%	75.0%	
Information Governance training compliance	>=95%	91.9%	95.2%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	71.9%	74.1%	

LD, ADHD & ASD

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	16	12	
Reducing restrictive practice interventions training compliance	>=80%	70.9%	70.3%	
Safer staffing	90%	145.4%	143.4%	
Sickness rate (Monthly)	4.5%	2.6%	3.2%	
Restraint incidents	Trend Monitor	9	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 4300 people waiting for an ADHD assessment. This is a national challenge.
- Referral rates for Autism - Referral rates 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). For Calderdale which adopted an AQP model, for ASD the waiting time has increased to over 2 years.
- Friend & Family Test – Friends and family test results are 67%↓ which represents a small decrease. Work to capture the service user voice is ongoing.
- West Yorkshire ICB Neurodiversity Project – the service continues to contribute to this project.
- South Yorkshire ICB Neurodiversity Project- the service continues to contribute to this project.

Advise

- Workforce: 5.83 of 45.47 posts are vacant, 4.50 of these have been offered and recruitment checks are underway, time taken to recruit places pressure on capacity.
- A Business Case Proposal has been submitted to support Barnsley Community Paediatrics 16-18. The 17+ Pathway and funding has been approved and the service has started mobilisation.
- Business cases have been approved for ADHD Triage in Wakefield and Kirklees and Referral Completion Step for Autism in Kirklees. Mobilisation is underway.
- The collaboration with Bradford District Care Foundation Trust is also going well. Service Users are screened via a face-to-face appointment within 4 weeks of referral date. Further collaboration in relation to ADHD is being scoped via commissioner led workshops.

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

Appraisal

- Appraisal performance in Horizon Assessment and Treatment Unit was a concern but is improving. Due to the turnover of clinical staff, line managers have now been reallocated and appraisals are progressing.
- Meetings have been restructured to include increased oversight and management of performance.
- Work is underway to ensure that reporting and recording issues are addressed.

Community Services

- Resource requirements identified to support the ADHD pathway for people with a learning disability and a business case for funding is currently being drafted.

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.
- We continue to progress on improvement actions and the service is now assessing itself against QNLD standards (Quality Network for Inpatient Learning Disability standards) internally and are sharing with the Bradford ward seeking support from national peers.

Advise

Greenlight Toolkit
• Recently presented to extended EMT and is a key priority , analysis of feedback is being undertaken.
• Local teams are now linking in with Learning Disability champions; this work is ongoing.

Community & ATU (Assessment & Treatment Unit)
• Challenges continue with the recruitment of specialist in Speech and Language and Occupational Therapy.
• Wakefield Local Authority have commissioned a review of Learning Disability services on behalf of the Wakefield Alliance.
• Significant improvement in medical recruitment- All 4 communities and the inpatient unit now have substantive consultants in post.

ATU (Assessment & Treatment Unit)
• Vacancies in nursing continues to reduce but inexperience of staff continues to require resources to support.
• Improvement work continues to be embedded into the service.

Assure

• Oliver McGowan training completed by 183 staff members to date.
• Improvement of waiting lists through optimisation of SystmOne which allows service users have earlier access to the whole multidisciplinary team, where appropriate, whilst awaiting a specific intervention. All service users on waiting lists receive regular welfare check reviews.
• Increase in uptake of Annual health checkups evidenced following input from strategic health facilitators.
• Optimisation of physical health through increased liaison with primary care, Primary care Mental Health NMP's (non-medical prescribers), acute hospital liaison, STOMP (stopping over medication for people with a learning disability).
• Autism pathways firmly embedded and more multi disciplinary team members contributing to cut down rising waiting lists.
• Development of locality trio leadership structures-producing locality newsletters, addressing team challenges.
• Positive culture change in the inpatient settings with higher rates of recruitment in all disciplines.

Barnsley General Community Services

Barnsley General Community Services

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	77.9%	71.0%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/1)	
% people dying in a place of their choosing	80%	90.6%	90.9%	
% of staff receiving supervision within policy guidance	80%	47.7%	46.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.4%	81.6%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	94.3%	94.1%	

Barnsley General Community Services

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.9%	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	75.30%	74.27%	
Reducing restrictive practice interventions training compliance	>=80%	100.0%	83.3%	
Safer staffing (inpatient)	90%	106.7%	106.5%	
Sickness rate (Monthly)	4.5%	5.0%	4.8%	
% rosters locked down in 6 weeks				

Alert/Action

• The Band 7 Nurse Prescriber left the service in November 2022, leaving only one Nurse Prescriber. We are currently working with Pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary. One additional team member is also being trained.

Advise

• Band 6 post in Urban House is out to advertisement on a permanent basis
• Podiatry – Diabetic Foot Clinic staff have raised concerns around workloads and increasing pressures within the service. Meeting arranged with BHNFT and contracting to discuss highlighting issues raised.
• 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.
• Our Paediatric Epilepsy Nursing Service continues to face staffing pressures due to ongoing secondments and a breakdown of planned backfill for these. It is hoped that this will be resolved soon.
• Our Paediatric Audiology Service has recommenced school hearing screening for the first time since pre-Covid-19 and this will improve the contracted activity figures for the service. However, the service is still struggling to meet the 6-week diagnostic waiting time target for referrals in. Work is being done to understand how this target can be achieved as soon as possible. Issues identified :
  • It is noted that post pandemic, referrals into the service have also increased from other health professionals. Hearing test outcomes are now requested more routinely by these services, rather than when a specific hearing concern is identified.
  • There has been a doubling of referrals into service from October 2022- October 2023
  • The services has had a long term sickness and this has had a massive impact on the team as it is made up of less than 3whole time equivalent (qualified and non qualified) - this is now been addressed and hopefully the vacant post will be appointed to next week.

Actions taken:
  • The service has undertaken a Demand and Capacity and a process mapping exercise. This information is currently with the Assistant Director- Contracting and Business Development for review
  • The service is currently undertaking a service review which includes the management of clinics and appointments, service staffing structure, referral pathways, discharge, onward referrals, cancellations, and was not brought SOPs/procedure
  • The service is reviewing its service level agreement with Barnsley Hospital NHS Foundation Trust.
  • The service has recently undertaken and submitted a NHS England Audit
  • The service is developing regional networking and peer supervision

Assure

• Neighbourhood Nursing Service position paper updated and finalised and risk (1813) associated with staffing pressures closed due successful recruitment drive and increase in staffing numbers.
• Significant improvement and increase in leg ulcer CQUIN currently reporting at 65%.
• We welcomed our first international recruited staff member to the Goldthorpe District Nursing Team.
• Neighbourhood Rehabilitation Service – proposal paper approved internally to progress with implementation of additional senior clinical roles from a skill mix of existing vacancies proving difficult to recruit to.
• Cardiac Rehab Team have successfully secured £50k funding for directed work targeting priority 4 patients to enhance the service provided and to increase service offered.
• Heart Failure Team have successfully secured £10k funding for directed work targeting the provision to release existing Heart Failure Specialist Nurses to develop patient and professional educational resources to enable enhanced clinical management and improved patient self-management.
• The Neurorehabilitation Unit at Kendray have been celebrating being highly commended and coming runners up in the recent Neuro Rehab annual awards ceremony in the category of teamwork. This event was held on the 26th of October 2023.

Forensic Services

Forensic

Metrics	Threshold	Sep-23	Oct-23	Variation/ Assurance
% Appraisal rate	>=90%	59.5%	55.1%	
% Bed occupancy	90%	84.1%	84.2%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	84.7%	85.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	98.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.1%	74.2%	
% 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%	94.3%	94.3%	
Physical Violence (Patient on Patient)	Trend Monitor	2	5	
Physical Violence (Patient on Staff)	Trend Monitor	7	14	
Reducing restrictive practice interventions (RRPI) training compliance	>=80%	82.0%	82.0%	
Restraint incidents	Trend Monitor	17	23	
Safer staffing	90%	111.8%	111.3%	
Sickness rate (Monthly)	5.4%	9.4%	8.4%	
% rosters locked down in 6 weeks				

Alert/Action

• Bed Occupancy – Newton Lodge 86%↑, Bretton 76.3.86%↓, Newhaven 74. %↓. 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/covid 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 –Service continues to focus on recruitment and retention. Number of Band 5 vacancies has reduced although many of these are preceptees or international recruits who are not yet able to undertake their full Band 5 roles therefore the impact on reducing bank and agency is yet to be realised. There is a high vacancy rate in the forensic community services currently, and improvements will be evident once pre-employment checks complete and new staff commence in post. SaLT and Psychiatry remain areas where recruitment is a challenge and adverts have been reviewed and will be readvertised.

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 remains an area of focus in each service line. The hotspots for restrictive physical interventions and cardiopulmonary resuscitation remain evident although improvements are being noted and RRPI compliance which has increased to 82% in October across the service although continues to remain below expected targets.
The above figures represent the overall position for each service. There are hotspots for reducing and targeted action plans are in place
• 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 (55.1) overall and displaying a marked variation across ward areas. This is being monitored closely through the governance structures within the care group to ensure target is reached. We are noting data quality issues and are in addition ensuring all appraisals undertaken are reflecting as recorded.
• 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 (assessment and management of historical clinical risk) being completed within 3 months of admission.
• Friends and family test remains green
• CPA (care programme approach) 100%
• 25 hours of meaningful activity 100%.
• All Equality Impact Assessments across Forensic Services have been completed for 23/24.

Ward Level Headlines

Sickness

Medium Secure: Priestley ward have a number of staff (3/24) on long term sickness with significant health issues. In addition to this there are a number of staff on short / medium term absence with long term health conditions. All processes are in place to support staff with a timely return to work. The People Directorate have in addition assured general managers that all processes are in place.

Low Secure: Currently in low secure there is a high sickness rate across the service. This has been identified by the senior management group and targeted work has been undertaken to understand this. It is understood that this is in the registered nurse group and work has been targeted to support this group of staff along with individuals. There are a number of supported phased returns in place and we are expecting a trajectory of improvements. The People Directorate has been involved and have in addition provided assurance to the general managers that all processes are in place.
Sandal ward has a number of staff on long term sickness (4/28). In addition, there is also a number of short-term absences. Individual plans are in place to support individuals with a return to work and processes are in place to support.
Thornhill ward: 6/28 staff members on long term sickness including a member of staff who has transferred from another care group to support return to work. Robust plans are in place with individuals and a number of return to work plans are now in place to support returns to work.

Mandatory Training

Sandal and Thornhill wards: There have been some challenges in access to the cardiopulmonary resuscitation (CPR) training, but close plans are in place to ensure that all staff are booked onto the training.

Supervision

Thornhill ward: In relation to supervision, re-structures of group and reflective practice have occurred over the review period which have unfortunately impacted on supervision. This was also impacted on by sickness and absence of some of the teams key individual supervisors. Plans are in place to address.

Inpatients - Mental Health - Working Age Adults										
Metrics	**Threshold**	**Beamshaw Suite**	**Clark Suite**	**Melton Suite**	**Nostell**	**Stanley**	**Walton**	**Ashdale**	**Ward 18**	**Elmdale**
Sickness	4.5%	5.5%	5.3%	14.1%	0.0%	9.1%	8.9%	10.9%	5.0%	11.3%
Supervision	80%	85.2%	35.0%	71.4%	78.6%	70.4%	44.4%	24.2%	43.3%	66.7%
Information Governance training compliance	>=95%	88.5%	90.0%	87.0%	88.9%	96.0%	89.5%	90.3%	96.4%	90.9%
Reducing restrictive practice interventions training compliance	>=80%	80.8%	94.7%	87.0%	96.2%	92.0%	81.1%	87.1%	75.0%	86.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	90.0%	73.9%	92.3%	92.0%	59.5%	90.3%	82.1%	77.3%
Bed occupancy	85%	103.9%	91.7%	97.8%	94.3%	99.1%	89.6%	100.7%	98.2%	97.2%
Safer staffing	90%	124.2%	120.9%	171.8%	123.7%	126.6%	137.4%	118.5%	107.2%	101.7%
% of clients clinically ready for discharge	3.5%	9.3%	15.1%	0.0%	14.4%	11.0%	0.0%	1.5%	6.5%	1.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	60.0%	100.0%	100.0%	93.3%	100.0%	93.3%	100.0%	90.9%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0	2	1	1	5	4	3
Physical Violence (Patient on Staff)	Trend Monitor	5	4	2	2	2	3	1	4	2
Restraint incidents	Trend Monitor	25	11	4	14	2	23	8	5	8
Prone Restraint incidents	Trend Monitor	3	1	0	0	1	12	2	1	0

Inpatients - Mental Health - Older People Services

Metrics	Threshold	Crofton	Poplars CUE	Willow	Ward 19 - Female	Ward 19 - Male	Beechdale
Sickness	4.5%	7.1%	6.0%	9.9%	20.3%	1.1%	12.1%
Supervision	80%	34.8%	59.3%	81.0%	58.8%	75.0%	61.5%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%	89.5%	95.5%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	82.6%	84.6%	76.2%	78.9%	81.8%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.3%	80.0%	52.4%	47.4%	81.8%	91.3%
Bed occupancy	85%	91.9%	67.5%	89.0%	87.3%	96.1%	94.4%
Safer staffing	90%	180.4%	216.7%	106.5%	94.9%	108.9%	150.5%
% of clients clinically ready for discharge	3.5%	0.0%	34.1%	0.3%	6.6%	0.0%	9.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	70.0%	N/A	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	4	0	0		1
Physical Violence (Patient on Staff)	Trend Monitor	2	15	5	0		1
Restraint incidents	Trend Monitor	4	35	0	4		0
Prone Restraint incidents	Trend Monitor	0	0	0	0		0

Inpatients - Forensic - Medium Secure

Metrics	Threshold	Appleton	Bronte	Chippendale	Hepworth	Johnson	Priestley	Waterton
Sickness	5.4%	5.0%	7.2%	6.7%	0.4%	5.3%	10.3%	1.0%
Supervision	80%	95.5%	95.5%	100.0%	73.3%	92.6%	83.3%	90.0%
Information Governance training compliance	>=95%	95.5%	100.0%	90.9%	96.6%	93.1%	90.9%	90.9%
Reducing restrictive practice interventions training compliance	>=80%	81.8%	94.7%	100.0%	79.3%	89.7%	81.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	78.9%	86.4%	67.9%	69.0%	71.4%	72.7%
Bed occupancy	90%	66.9%	88.9%	100.0%	85.8%	86.7%	78.2%	91.5%
Safer staffing	90%	92.9%	98.2%	121.6%	97.5%	143.6%	94.8%	118.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	1	0	0	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2	0	2	0	0
Restraint incidents	Trend Monitor	3	0	3	0	0	0	0
Prone Restraint incidents	Trend Monitor	0	0	2	0	0	0	0

Inpatients - Forensic - Low Secure					
Metrics	**Threshold**	**Thornhill**	**Sandal**	**Ryburn**	**Newhaven**
Sickness	5.4%	17.2%	9.5%	19.1%	11.7%
Supervision	80%	23.1%	100.0%	100.0%	92.0%
Information Governance training compliance	>=95%	95.2%	88.5%	100.0%	92.0%
Reducing restrictive practice interventions training compliance	>=80%	85.7%	80.8%	80.0%	84.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	66.7%	61.5%	80.0%	84.0%
Bed occupancy	85%	77.2%	74.8%	77.9%	74.0%
Safer staffing	90%	115.6%	104.2%	100.0%	122.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0	10
Restraint incidents	Trend Monitor	0	0	0	17
Prone Restraint incidents	Trend Monitor	0	0	0	4

Inpatients - Non-Mental Health			
Metrics	**Threshold**	**NRU**	**SRU**
Sickness	4.5%	9.4%	2.7%
Supervision	80%	55.6%	11.7%
Information Governance training compliance	>=95%	93.1%	95.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.1%	75.9%
Bed occupancy	85%	62.1%	89.2%
Safer staffing	90%	104.3%	108.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0
Restraint incidents	Trend Monitor	0	0
Prone Restraint incidents	Trend Monitor	0	0

Inpatients - Mental Health - Rehab			
Metrics	**Threshold**	**Enfield Down**	**Lyndhurst**
Sickness	4.5%	2.8%	5.1%
Supervision	80%	81.3%	55.6%
Information Governance training compliance	>=95%	94.1%	96.2%
Reducing restrictive practice interventions training compliance	>=80%	80.0%	64.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.3%	84.0%
Bed occupancy	85%	44.6%	62.9%
Safer staffing	90%	94.7%	120.8%
% of clients clinically ready for discharge	3.5%	0.0%	9.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	0
Restraint incidents	Trend Monitor	3	0
Prone Restraint incidents	Trend Monitor	0	0

Inpatients - Mental Health - Learning Disability		
Metrics	**Threshold**	**Horizon**
Sickness	4.5%	7.1%
Supervision	80%	62.9%
Information Governance training compliance	>=95%	91.7%
Reducing restrictive practice interventions training compliance	>=80%	76.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.9%
Bed occupancy	N/A	50.0%
Safer staffing	90%	143.4%
% of clients clinically ready for discharge	3.5%	75.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0
Physical Violence (Patient on Staff)	Trend Monitor	12
Restraint incidents	Trend Monitor	12
Prone Restraint incidents	Trend Monitor	3

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£1m	£0m	A deficit of £101k been reported in October 2023 which means that the year to date surplus is now £1.0m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report.
2	Agency Spend	£6.1m	£9.9m	The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in October has seen a stepped reduction to £0.6m with a reduced requirement in agency shifts reported. The sustainability of this continues to be assessed. The year to date position is 14% above plan.
3	Financial sustainability and efficiencies	£5.3m	£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 for the year to date is £420k behind plan. This target remains challenging due to the increasing profile and the need to identify new opportunities.
4	Cash	£72.3m	£76.9m	As previously forecast the Trust cash position, whilst remaining strong, has reduced in month by £6.6m. This is due to invoices, which had been chased and date back to April 2023, have been paid. Overall the Trust cash position is £72.3m.
5	Capital	£1.4m	£8.8m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £1.4m. Expenditure is forecast to significantly increase in the next quarter and the full allocation to be utilised in year.
6	Better Payment Practice Code	98%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

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

System-wide monitoring

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

West Yorkshire Health and Care Partnership -

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

South Yorkshire ICS -

ICB Board meeting and minutes :: South Yorkshire ICB

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

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 7 (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)	£1m	£0m	A deficit of £101k been reported in October 2023 which means that the year to date surplus is now £1.0m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report.
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3	Financial sustainability and efficiencies	£5.3m	£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 for the year to date is £420k behind plan. This target remains challenging due to the increasing profile and the need to identify new opportunities.
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5	Capital	£1.4m	£8.8m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £1.4m. Expenditure is forecast to significantly increase in the next quarter and the full allocation to be utilised in year.
6	Better Payment Practice Code	98%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

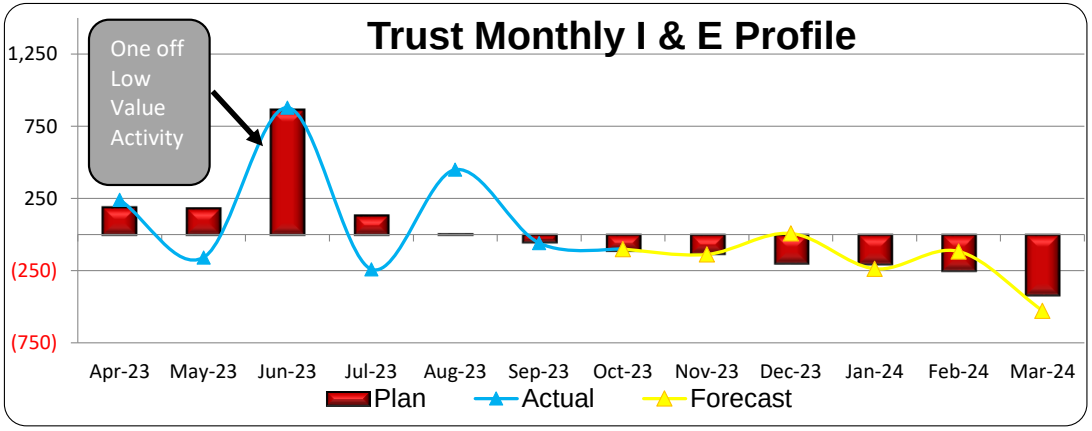
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

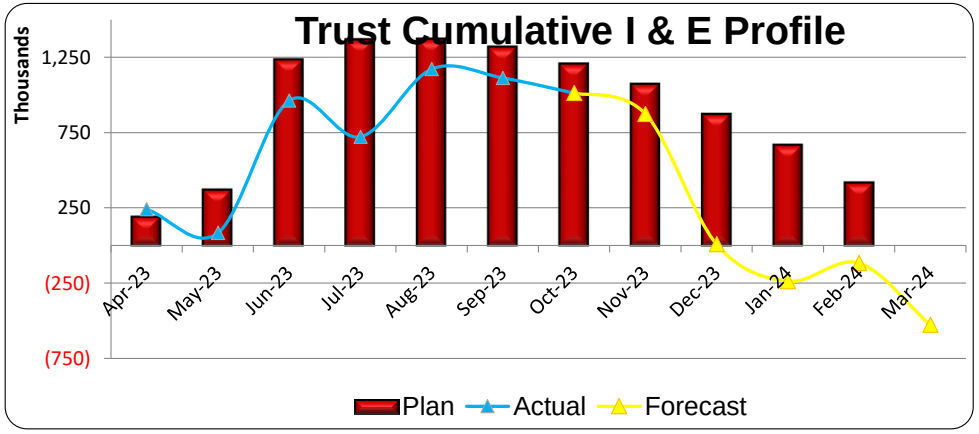
2.0 Income & Expenditure Position 2023 / 24

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					34,239	32,465	(1,774)	230,556	229,211	(1,344)	394,942	391,643	(3,299)
Other Operating Revenue					1,062	1,128	66	7,308	7,772	464	12,663	13,076	413
Total Revenue					**35,301**	**33,592**	**(1,708)**	**237,864**	**236,983**	**(880)**	**407,605**	**404,719**	**(2,887)**
Pay Costs	4,888	4,888	(0)	0.0%	(20,538)	(20,363)	175	(142,348)	(141,643)	705	(245,583)	(244,457)	1,126
Non Pay Costs					(14,480)	(13,051)	1,429	(91,314)	(91,963)	(649)	(156,995)	(156,193)	802
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	**4,888**	**4,888**	**(0)**	**0.0%**	**(35,018)**	**(33,415)**	**1,604**	**(233,662)**	**(233,601)**	**61**	**(402,578)**	**(400,645)**	**1,934**
EBITDA	**4,888**	**4,888**	**(0)**	**0.0%**	**282**	**178**	**(104)**	**4,202**	**3,382**	**(820)**	**5,027**	**4,074**	**(953)**
Depreciation					(482)	(487)	(5)	(3,543)	(3,561)	(18)	(5,949)	(5,994)	(46)
PDC Paid					(179)	(179)	0	(1,253)	(1,253)	0	(2,148)	(2,148)	0
Interest Received					267	387	120	1,796	2,443	647	3,070	4,068	998
Surplus / (Deficit) - ICB performance measure	**4,888**	**4,888**	**(0)**	**0.0%**	**(111)**	**(101)**	**11**	**1,202**	**1,012**	**(190)**	**0**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(135)	(135)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,888**	**4,888**	**(0)**	**0.0%**	**(111)**	**(120)**	**(9)**	**1,202**	**876**	**(326)**	**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	229,211	39,209	691	20,930	168,381
Other Operating Revenue	7,772				7,772
Total Revenue	**236,983**	**39,209**	**691**	**20,930**	**176,153**
Pay Costs	(141,643)	(896)	(66)	(425)	(140,256)
Non Pay Costs	(91,963)	(38,313)	(473)	(20,038)	(33,139)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	**(233,601)**	**(39,209)**	**(540)**	**(20,463)**	**(173,390)**
EBITDA	**3,382**	**0**	**152**	**468**	**2,763**
Depreciation	(3,561)				(3,561)
PDC Paid	(1,253)				(1,253)
Interest Received	2,443				2,443
Surplus / (Deficit) - ICB	**1,012**	**0**	**152**	**468**	**392**
Depn Peppercorn Leases (IFRS16)	(135)				(135)
Revaluation of Assets	0				0
Surplus / (Deficit) - Total	**876**	**0**	**152**	**468**	**257**
Surplus / (Deficit) - Forecast	**(0)**	**0**	**178**	**587**	(765)

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

There is currently no risk / reward arrangement for the Forensic CAMHS and South Yorkshire Adult Secure services and, as such, their financial positions flow directly into the overall financial position.

For 2023 / 24 these are both positive contributions for the year to date and forecast.

West Yorkshire Adult Secure is subject to a risk / reward arrangement alongside services not hosted by the Trust. The overall financial impact of these is modelled within the Trust forecast scenarios.

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					24,283	23,797	(486)	169,579	168,381	(1,199)	290,467	287,781	(2,686)
Other Operating Revenue					1,062	1,128	66	7,308	7,772	464	12,663	13,076	413
Total Revenue					**25,345**	**24,925**	**(420)**	**176,887**	**176,153**	**(735)**	**303,130**	**300,857**	**(2,274)**
Pay Costs	4,866	4,855	(11)	0.2%	(20,378)	(20,199)	179	(141,269)	(140,256)	1,013	(243,781)	(242,095)	1,686
Non Pay Costs					(4,684)	(4,794)	(110)	(31,416)	(33,139)	(1,723)	(54,323)	(55,458)	(1,135)
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	**4,866**	**4,855**	**(11)**	**-0.2%**	**(25,063)**	**(24,993)**	**69**	**(172,685)**	**(173,390)**	**(705)**	**(298,103)**	**(297,548)**	**555**
EBITDA	**4,866**	**4,855**	**(11)**	**-0.2%**	**282**	**(69)**	**(351)**	**4,202**	**2,763**	**(1,439)**	**5,027**	**3,309**	**(1,718)**
Depreciation					(482)	(487)	(5)	(3,543)	(3,561)	(18)	(5,949)	(5,994)	(46)
PDC Paid					(179)	(179)	0	(1,253)	(1,253)	0	(2,148)	(2,148)	0
Interest Received					267	387	120	1,796	2,443	647	3,070	4,068	998
Surplus / (Deficit) - ICB performance measure	**4,866**	**4,855**	**(11)**	**-0.2%**	**(111)**	**(347)**	**(236)**	**1,202**	**392**	**(810)**	**0**	**(765)**	**(765)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(135)	(135)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,866**	**4,855**	**(11)**	**-0.2%**	**(111)**	**(366)**	**(255)**	**1,202**	**257**	**(945)**	**0**	**(997)**	**(997)**

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 various collaborative financial performances are 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	4,888	4,888	(0)	0.0%	(111)	(101)	11	1,202	1,012	(190)	0	(0)	(0)
Provider Collaboratives	22	33	11	50.1%	0	247	247	0	619	619	0	765	765
Total excluding Collaboratives (as shown above)	**4,866**	**4,855**	**(11)**	**-0.2%**	**(111)**	**(347)**	**(236)**	**1,202**	**392**	**(810)**	**0**	**(765)**	**(765)**

Income & Expenditure Position 2022 / 23

October 2023, excluding the financial impact of the provider collaboratives, is a £347k deficit. This is £236k worse 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.

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

Overall pay expenditure remains similar to the previous month. This includes a reduction in agency spend with an increase in substantive staff worked. This had been forecast previously with the impact of recruitment of newly qualified nurses and international recruits being modelled in.

The sustainability of the agency reduction continues to be assessed.

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.

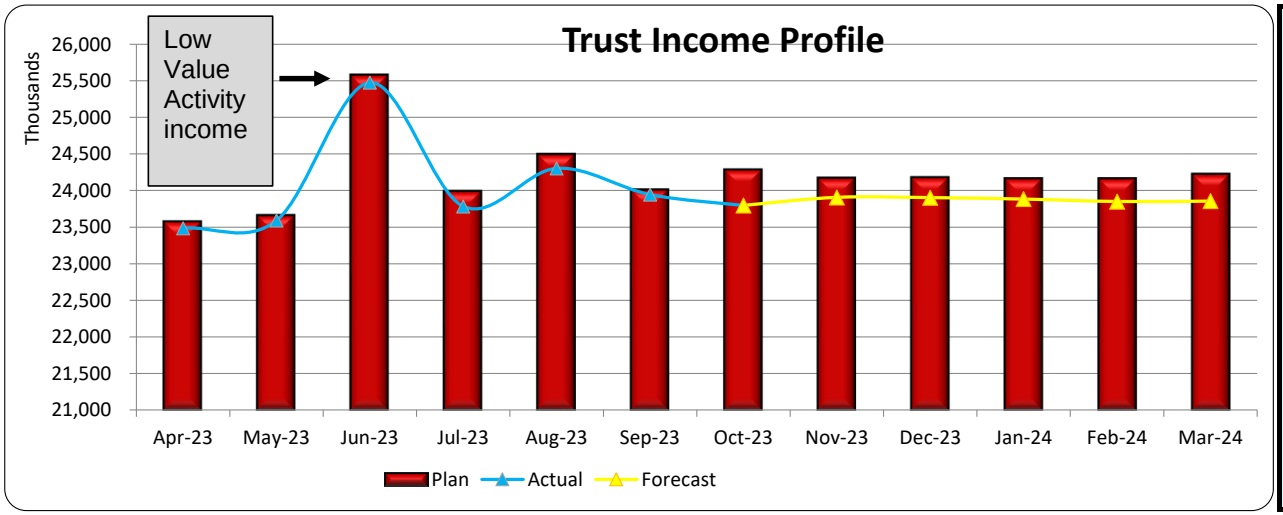
2.1 Income Information

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	20,005	20,009	20,079	20,079	20,057	20,032	20,032	**241,458**	**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	2,741	2,740	2,691	2,689	2,689	2,689	2,689	**32,695**	**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	453	531	503	503	503	503	503	**5,816**	**5,311**
Partnerships	514	584	546	591	472	608	377	501	499	501	493	498	**6,182**	**5,052**
Other Contract Income	197	96	144	102	144	138	140	134	134	134	134	134	**1,629**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,783**	**24,304**	**23,945**	**23,797**	**23,907**	**23,904**	**23,883**	**23,850**	**23,855**	**287,781**	**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 remains in line with last month although the budget expectation has increased for the new additional liaison and diversion service going live. This will be reimbursed on actual costs incurred and mobilisation is ongoing.

This will add to the known shortfalls in income against plan with the largest services being highlighted as:
* Sheffield Stop Smoking (less activity)
* Youth Offender contract (recruitment slippage)
* Additional Roles Reimbursement (ARRS) (recruitment slippage)

These will be, at least partially, offset by underspends on pay and non pay.

2.2 Pay Information

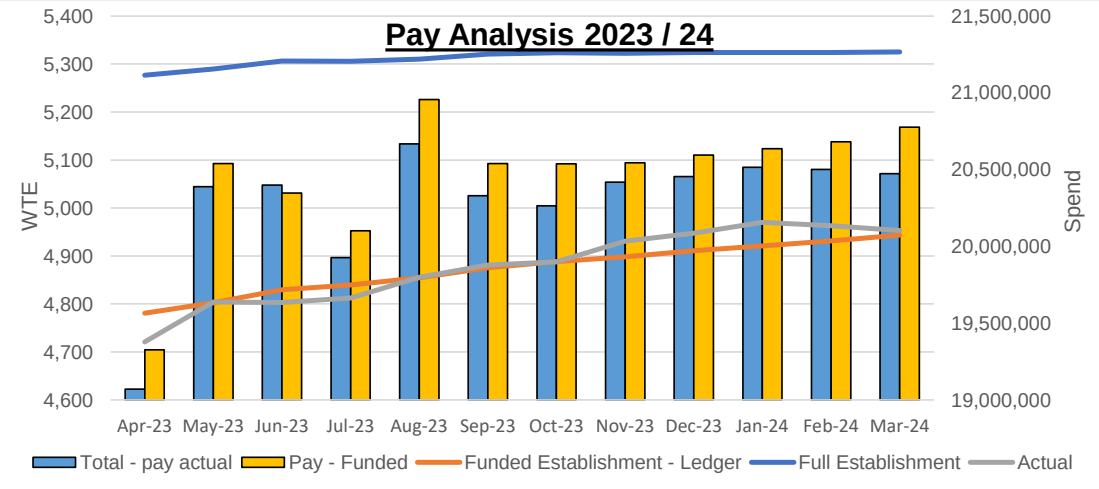
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	17,826	18,128	18,046	18,085	18,132	18,162	18,129	**215,476**
Bank & Locum	849	1,355	1,337	1,360	1,481	1,454	1,436	1,464	1,479	1,510	1,494	1,502	**16,721**
Agency	939	908	1,002	855	810	915	634	804	786	769	741	737	**9,899**
Total	**18,936**	**20,296**	**20,277**	**19,819**	**20,535**	**20,194**	**20,199**	**20,313**	**20,350**	**20,411**	**20,396**	**20,368**	**242,095**
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%	7.2%	7.1%	7.2%	7.3%	7.4%	7.3%	7.4%	6.9%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.5%	3.1%	4.0%	3.9%	3.8%	3.6%	3.6%	4.1%

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	4,367	4,401	4,426	4,437	4,458	4,462	4,451	**4,389**
Bank & Locum	222	314	326	321	356	369	361	367	371	377	372	373	**344**
Agency	157	161	164	163	144	145	126	138	140	135	130	129	**144**
Total	**4,721**	**4,804**	**4,803**	**4,812**	**4,856**	**4,881**	**4,888**	**4,931**	**4,948**	**4,970**	**4,963**	**4,953**	**4,877**
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**



Overall pay expenditure remains in line with run rate with an increase in substantive staff and reduction in agency costs and WTE worked. This had been forecast following the intake of newly qualified nurses and continued international recruitment in September / October.

Worked WTE has increased in October by 7 WTE although substantive WTE increased by 34. This has been offset by a reduction in agency although this continues to be tested to ensure that this is maintained.

The increase in substantive worked WTE has been in adult acute inpatient and in the Barnsley care group.

2.2 Agency Expenditure Focus

Agency spend is £636k in October. This is a large reduction from the previous run rate.

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.

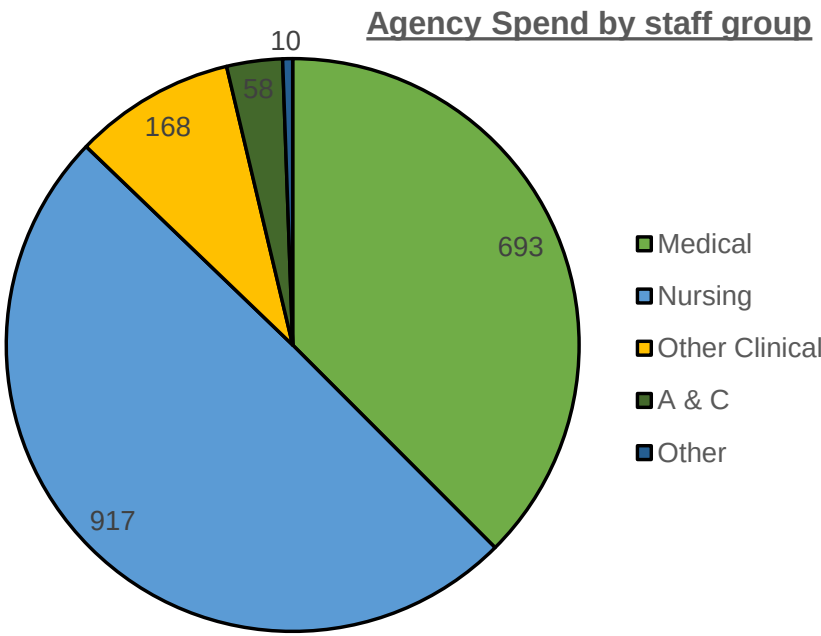
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

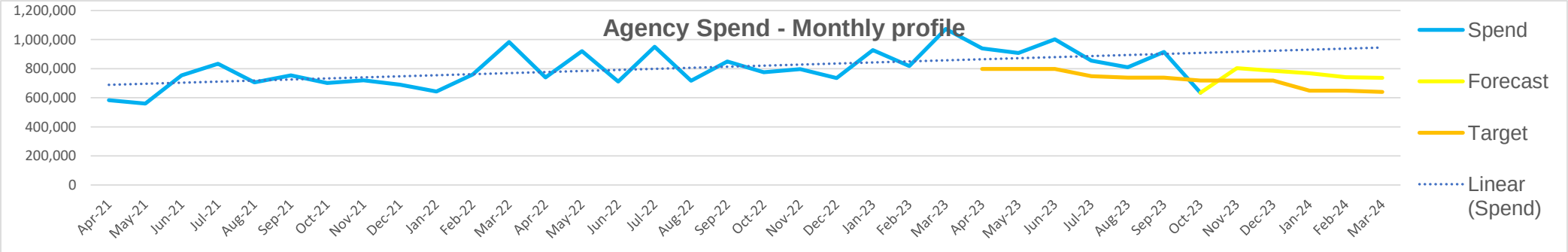
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23 and the target trajectory is outlined in the graph below.

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.

October 2023 spend is £636k which is a significant reduction from the previous run rate. This is due to a reduction in the number of shifts required in month and work continues to assess whether this trend can be sustained. The increase in substantive staff worked would provide some assurance that it can however seasonal sickness absence may impact on future performance.

The main action remains to reduce the demand for agency staff by continued substantive recruitment. This includes reviewing recruitment, onboarding and induction programmes to ensure this is as efficient as possible. The Trust also continues to support the development of a West Yorkshire Collaborative bank to reduce the demand for agency.



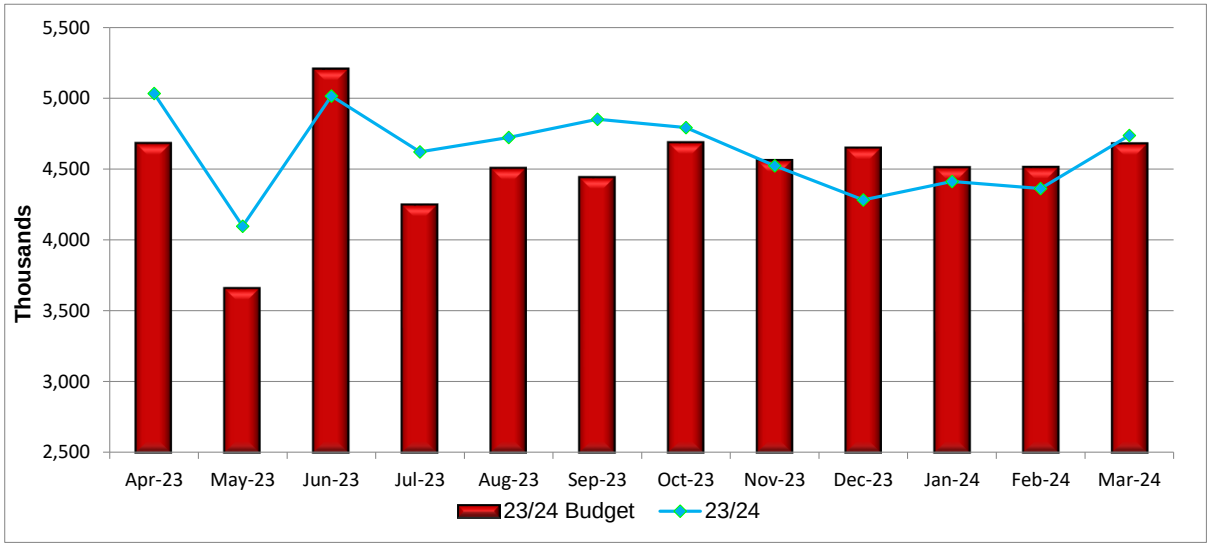


2.3 Non Pay Expenditure

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	4,852	4,794	4,523	4,283	4,413	4,362	4,738	**55,458**
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	2,411	2,295	(117)
Establishment	5,301	5,532	231
Lease & Property Rental	5,083	4,949	(134)
Premises (inc. rates)	3,140	3,331	191
Utilities	1,199	1,282	83
Purchase of Healthcare	5,153	5,527	374
Travel & vehicles	2,961	2,922	(39)
Supplies & Services	3,979	4,299	320
Training & Education	1,118	1,199	81
Clinical Negligence & Insurance	618	621	2
Other non pay	453	1,182	729
Total	**31,416**	**33,139**	**1,723**
Total Excl OOA and Drugs	**23,853**	**25,317**	**1,465**



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. This will help to inform the budgets set for 2024 / 25.

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 as highlighted on the focus page of this report.

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.

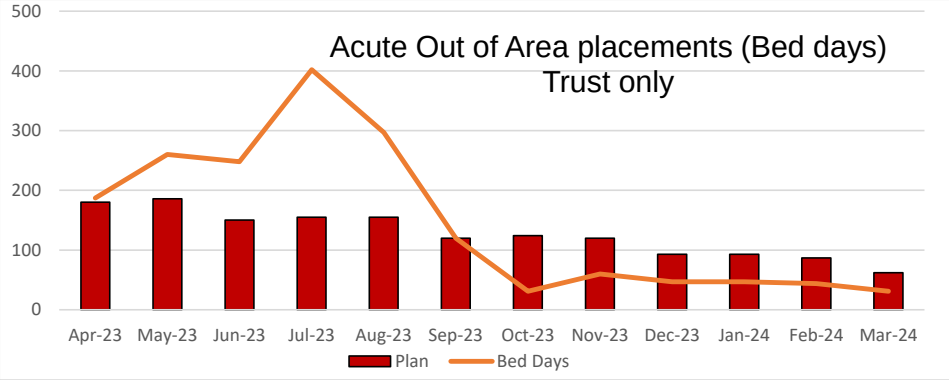
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

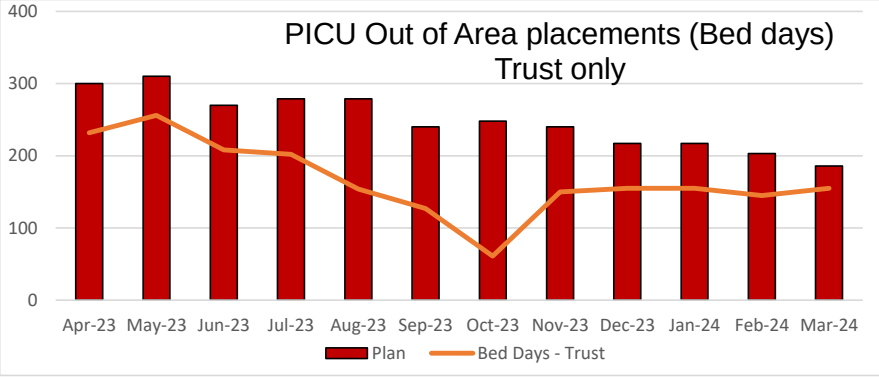
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

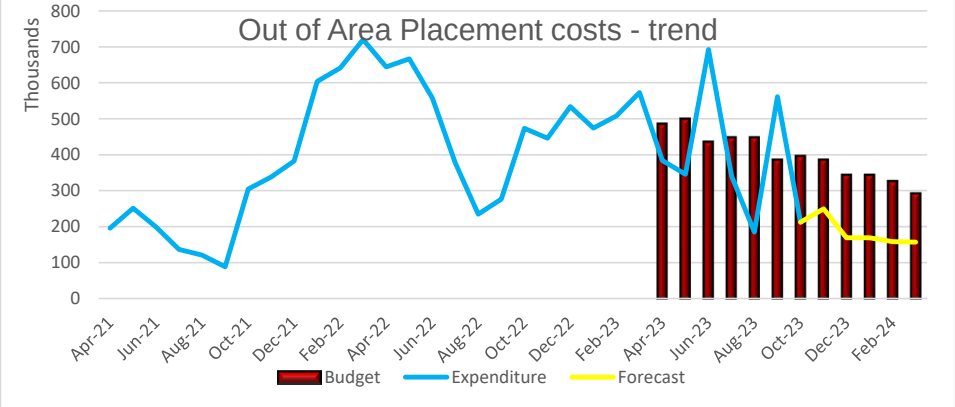
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	815	1,256	441
PICU	2,197	1,398	(799)
Locked Rehab	1,332	1,569	237
Services - NHS	230	304	74
IAPT	103	290	187
Yorkshire Smokefree	46	17	(29)
Other	430	692	262
Total	**5,153**	**5,527**	**374**







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

Positive progress has continued to be demonstrated in the continued reduction in both acute and PICU out of area placements. This is reflected in a revised trajectory for the remainder of the year; assuming an ability to maintain current levels of activity (whilst continuing to strive towards nil usage).

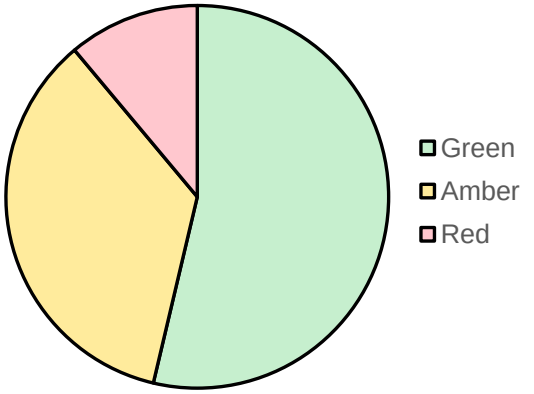
Due to the volatility of this area this forecast assumption remains a risk and this is factored into the Trust forecast scenarios. This is highlighted by the increase in PICU placements in late October.

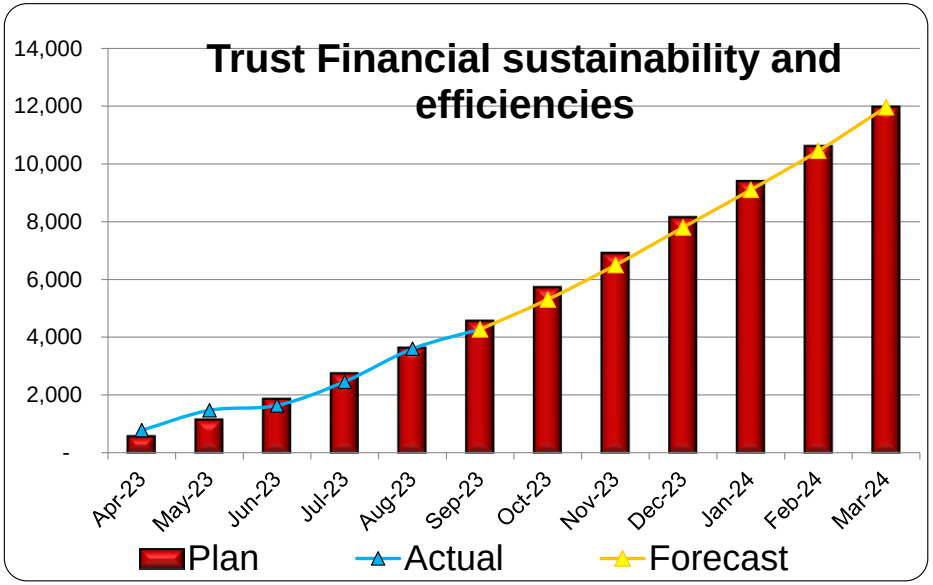
2.4 Value for Money, Financial sustainability and efficiency

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. 12	1,400	1,760		3,197	1,760	2,589	
Agency & Workforce	Pg. 10	1,890	453	705	4,380	785	1,126	
Medicines optimisation		233	172		400	172		
Non Pay Review		488	0		1,048		500	1,327
Income contributions		294	148		500	267		
Interest Receivable	Pg. 4	817	1,464		1,400	2,398		
Provider Collaborative	Pg. 5	606	606		1,044	1,044		
Total		**5,727**	**4,602**	**705**	**11,969**	**6,426**	**4,216**	**1,327**
Recurrent		5,220	4,602		10,943	6,426	4,216	
Non Recurrent		507		705	1,026			1,327





The variance between performance and plan has increased in October and currently the Value for Money programme is £420k behind plan. This is up from £290k in the previous month. This is 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.

These 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 volatility 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	164,527	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,141	
Non NHS Trade Receivables (Debtors)	2,853	2,510	
Prepayments	3,482	4,102	
Accrued Income	9,372	2,205	2
Cash and Cash Equivalents	74,585	72,330	Pg 15
Total Current Assets	**92,097**	**82,520**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(4,147)	3
Capital Payables (Creditors)	(739)	(386)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,267)	4
Accruals	(32,952)	(21,889)	4
Deferred Income	(4,172)	(3,931)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(54,338)	1
Total Current Liabilities	**(104,062)**	**(92,957)**	
Net Current Assets/Liabilities	**(11,965)**	**(10,438)**	
Total Assets less Current Liabilities	**153,210**	**154,090**	
Provisions for Liabilities	(4,319)	(4,322)	
Total Net Assets/(Liabilities)	**148,891**	**149,768**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,657	
Revaluation Reserve	14,026	14,026	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	84,864	
Total Taxpayers' Equity	**148,891**	**149,768**	

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.

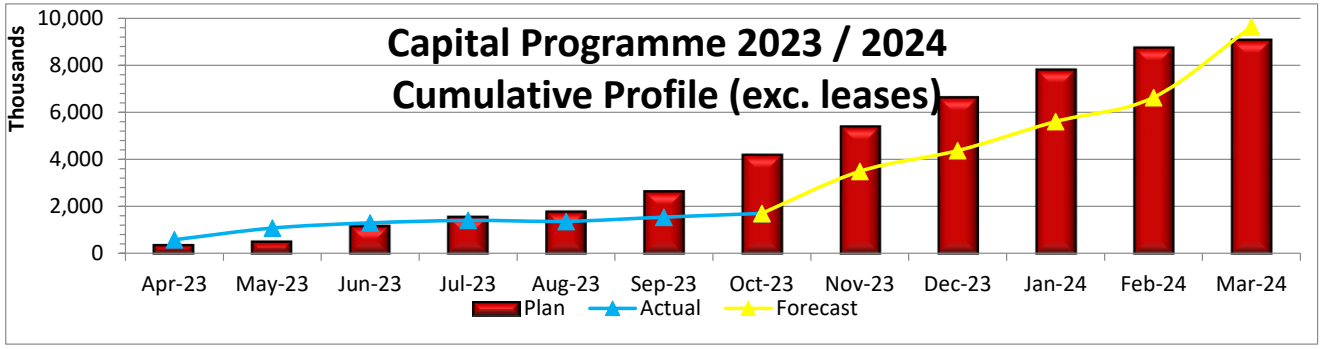
2. Accrued income, and maintaining at a low level, remains a focus in order to reduce risk and maximise cash balances. This has reduced in month but remains a focus to ensure timely raising of invoices.

3. Trade payables have reduced in month as NHS payments have been made in relation to the South Yorkshire Collaborative. This subsequently has a significant impact on the cash position.

4. Accruals remain at a high level but have seen a reduction in month, work is ongoing to ensure that invoices are received and processed.

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	75	37	(38)	575	(900)
Seclusion rooms	750	300	23	(277)	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	185	12	(173)	853	568
Safety inc. ligature & IPC	990	540	432	(108)	2,182	1,192
Compliance	430	430	0	(430)	300	(130)
Backlog maintenance	510	200	34	(166)	158	(352)
Sustainability	300	0	8	8	225	(75)
Plant & Equipment	40	40	27	(13)	53	13
Other	1,223	259	759	500	906	(317)
IM & T						
Digital Infrastructure	1,100	850	39	(811)	1,200	100
Digital Care Records	180	70	6	(64)	70	(110)
Digitally Enabled Workforce	815	579	0	(579)	808	(7)
Digitally Enabling Service Users & Carers	400	250	1	(249)	400	0
IM&T Other	270	120	0	(120)	288	18
TOTALS	**8,768**	**3,898**	**1,378**	**(2,520)**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	6,085	882	6,117	914
New lease	303	293	318	25	875	572
TOTALS	**14,274**	**9,394**	**7,781**	**(1,613)**	**15,760**	**1,486**



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.

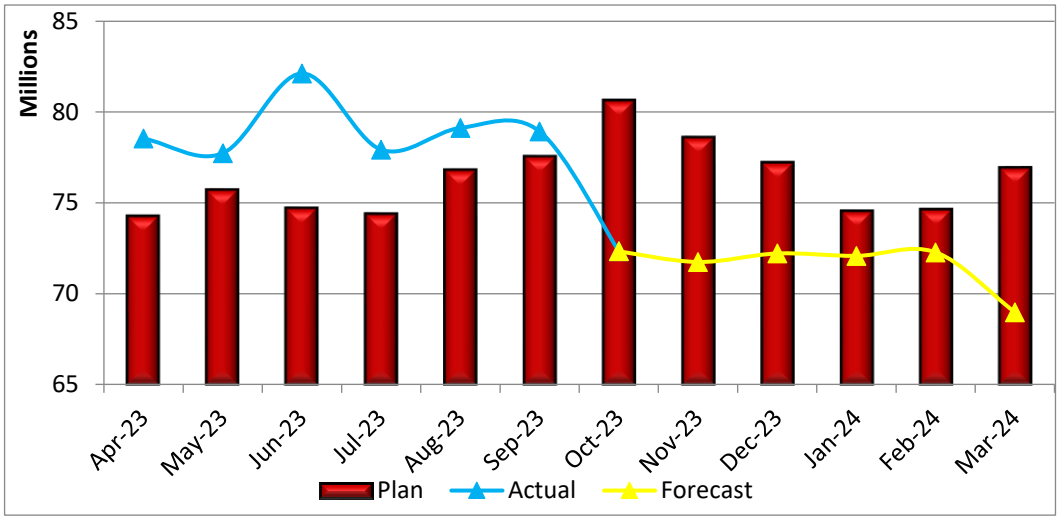
Spend is significantly behind plan to date however work continues to ensure that the full allocation can be utilised in year.

For example a preferred contractor is now in place for the seclusion room schemes and these will be mobilised quickly.

IM & T orders are being placed.

The financial impact of IFRS 16 (leases) remains uncertain. As at October 2023 this remains outside the scope of capital financial monitoring for 2023 / 24 but this could change prior to year end.

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

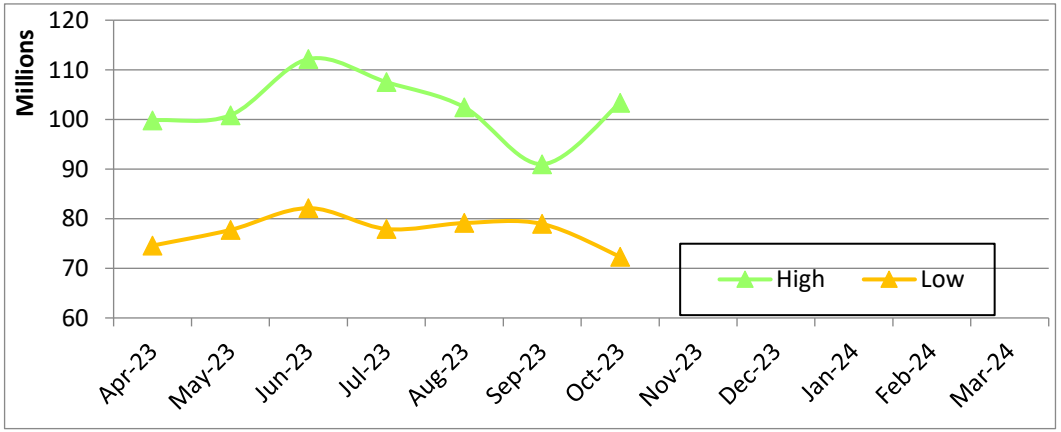


	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	80,638	72,330	(8,308)

The Trust cash position remains positive.

Cash has reduced in month as an extra £7m was paid following receipt of valid invoices. This has led to a reduction in both creditors and accruals.

Actions are currently focused on ensuring that all income is invoiced and received in a timely manner including contract income from commissioners.



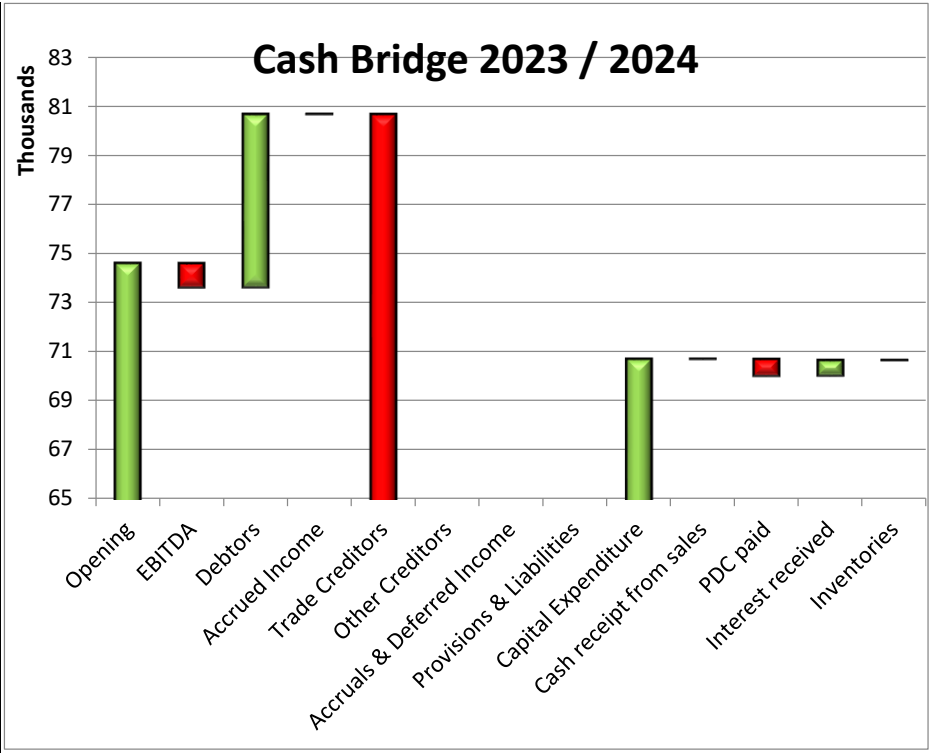
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £103.4m
The lowest balance is: £72.3m

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)	9,431	8,429	(1,002)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(135)	6,935	7,070	
Trade Payables (Creditors)	3,066	(13,401)	(16,467)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	578	(238)	(816)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(8,683)	(1,378)	7,305	
Cash receipts from asset sales	0	5	5	
Leases	0	(4,359)	(4,359)	
PDC Dividends paid	0	(691)	(691)	
PDC Dividends received	0		0	
Interest (paid)/ received	1,796	2,443	647	
Closing Balances	**80,638**	**72,330**	**(8,308)**	



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 £8m lower than plan, £7m of creditors were paid in month, mainly to other NHS bodies and relating to the South Yorkshire Adult Secure Collaborative.

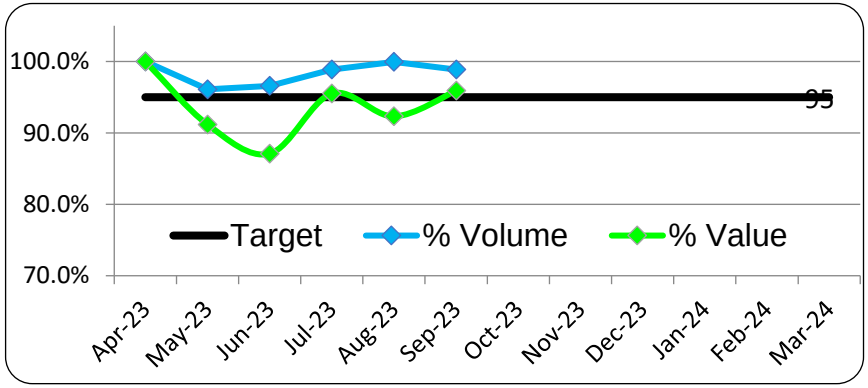
4.0 Better Payment Practice Code

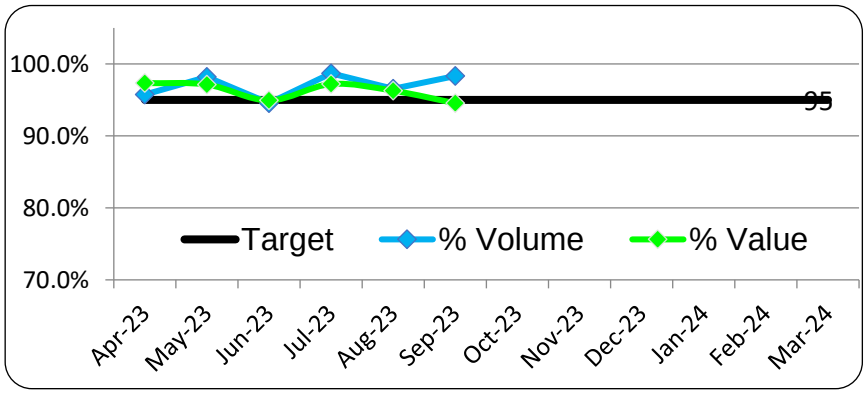
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently. NHS performance continues to be monitored to ensure that recent action to improve performance continues to have a positive effect.

NHS	Number %	Value %
In Month	98%	99%
Cumulative Year to Date	98%	95%

Non NHS	Number %	Value %
In Month	99%	96%
Cumulative Year to Date	97%	96%





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 (£)
11-Oct-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000057307	2,940,728
17-Oct-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000057431	1,505,372
02-Oct-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5177	800,000
31-Oct-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5188	750,000
11-Oct-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1000295	666,894
18-Oct-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS39	544,330
25-Oct-23	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	203743	519,424
03-Oct-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008367	332,208
18-Oct-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS16	270,000
09-Oct-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 277	245,869
04-Oct-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Nhs Foun	4400000541	230,447
26-Oct-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5184	145,541
03-Oct-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100082721	129,788
03-Oct-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008363	128,035
12-Oct-23	IT Services	Trustwide	Daisy Corporate Services	3I516335	90,250
24-Oct-23	Purchase of Healthcare	Kirklees	Huntercombe Roehampton Hospital Ltd (The)	24309916	84,075
11-Oct-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC017INV	81,804
18-Oct-23	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	324989	77,529
23-Oct-23	Staff Recharge	Forensic	Wakefield Metropolitan District Council	91315254949	65,959
18-Oct-23	Drugs	Trustwide	Lp Hcs Ltd	HCSLP386	65,618
11-Oct-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1000294	64,961
19-Oct-23	Drugs	Trustwide	Lp Hcs Ltd	HCSLP258	63,742
30-Oct-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 Q104 06	62,807
24-Oct-23	Vaccines	Trustwide	Aventis Pharma T/A Sanofi	924478832	57,915
23-Oct-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 11211	56,000
07-Oct-23	Computer Hardware	Trustwide	Dell Corporation Ltd	7402953245	55,860
07-Oct-23	Computer Hardware	Trustwide	Dell Corporation Ltd	7402953517	55,860
11-Oct-23	Training	Trustwide	Business Services Leeds Ltd	BSL08184	50,000
30-Oct-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 Q207 09	47,891
05-Oct-23	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72485990	47,313
04-Oct-23	Drugs	Trustwide	Nhs Business Services Authority	1000077829	46,223

03-Oct-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100082681	45,155
09-Oct-23	Utilities	Trustwide	Edf Energy Customers Ltd	000016797500	42,799
07-Oct-23	Computer Hardware	Trustwide	Dell Corporation Ltd	7402953246	37,985
04-Oct-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001081EPC	36,374
18-Oct-23	NHS Recharge	Trustwide	Bradford District Care Nhs Foundation Trust	203722	35,038
27-Oct-23	Advocacy Services	Forensic	Cloverleaf Advocacy 2000 Ltd	12447	31,397
11-Oct-23	NHS Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6027183	31,204
24-Oct-23	MFD charges	Trustwide	Annodata Ltd	1334189	30,591
24-Oct-23	Purchase of Healthcare	Barnsley	Cygnet Behavioural Health Ltd	APL0308577	29,850
03-Oct-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001373	28,672
06-Oct-23	Purchase of Healthcare	Calderdale	Priory Hospital East Midlands	D560002218	26,955
02-Oct-23	Purchase of Healthcare	Kirklees	Cheadle Royal Hospital	2900023041	26,085
05-Oct-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0312556	25,916
17-Oct-23	Utilities	Trustwide	Edf Energy Customers Ltd	000016760050	25,445

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

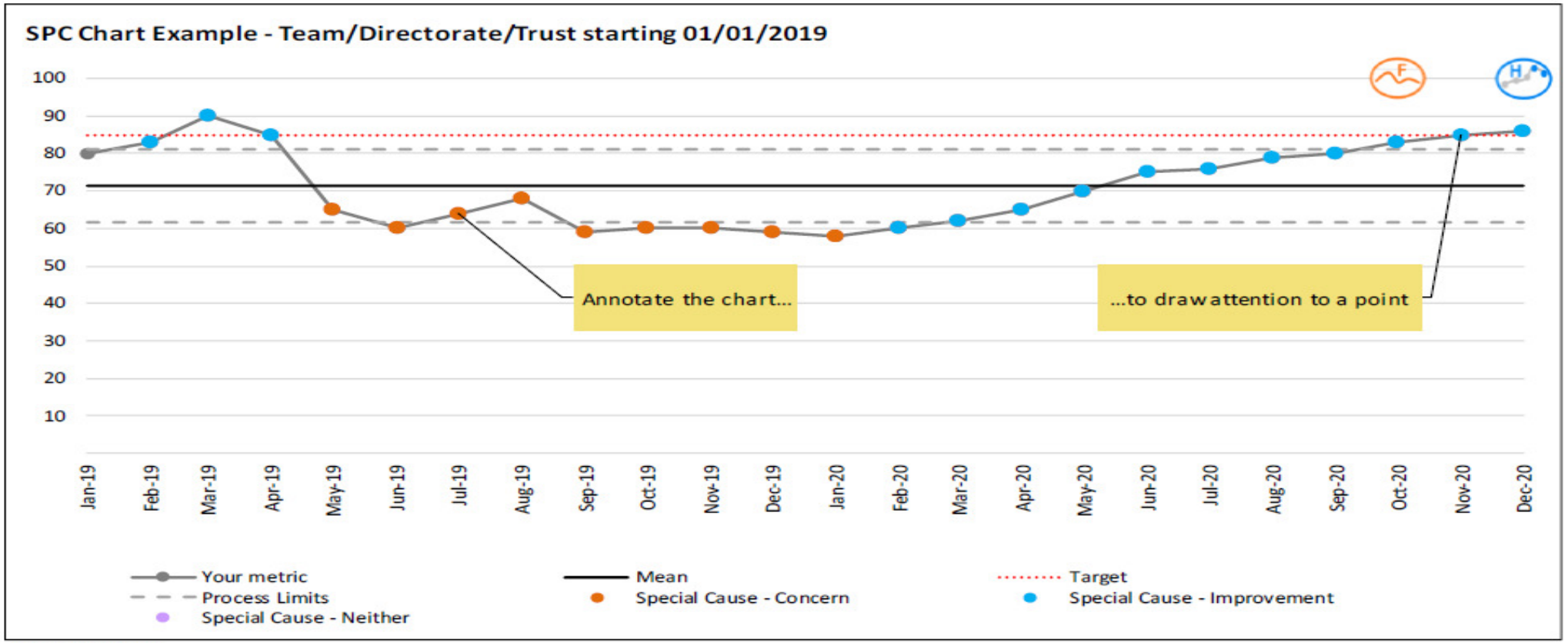
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Care Group Dashboards**		
Paper presented by:	**Carol Harris - Chief Operating Officer**		
Paper prepared by:	Chris Lennox - Director of Services Adults and Older People Mental Health		
Mission/values:	The report focusses on service delivery and as such aligns with the mission and values for the organisation.		
Purpose:	To provide the board with drill down performance information for individual care groups.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	This report provides assurance to Trust Board on compliance with key performance indicators, identifying emerging issues and actions being taken to address the operational contribution to address all strategic risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The report provides further assurance that the Trust has an effective performance management system that contributes to the delivery of the Integrated Care Boards' and Places' strategic priorities and delivery plans.		
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the public Board meetings. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing greater depth on a rolling basis. Care groups worked with the performance and information team to agree the key indicators to be included. Whilst there are common indicators in each report, such as sickness and mandatory training, other indicators are specific to the services provided. Reporting is retrospective to allow time for the report preparation.		

Executive summary:	This month's report provides the performance information for community mental health services and inpatient services for Barnsley, Calderdale, Kirklees, and Wakefield. The key areas to note are: **Community mental health** Although rapid improvement was noted with appraisals at the start of the financial year, progress has slowed, and performance is maintained around 75% in all areas. Further work is planned to reach the 90% target. Actions to resolve data quality and recording issues are also underway. Work is underway to address specific mandatory training hotspots with a specific focus on cardiopulmonary resuscitation, information governance and reducing restrictive physical interventions. Changes to training performance reports led to challenges for managers having a good oversight of all training performance. Work is taking place to resolve this. Further understanding of the turnover measure is essential as community teams are carrying high numbers of vacancies. Communication with teams is maintained alongside a review of exit interview information to ensure appropriate measures are taken to recruit, retain and develop staff. People in crisis consistently receive an assessment within 4 hours. To manage demand and capacity, the single point of access (SPA) prioritise risk screening to ensure that urgent needs are met within 24 hours. This can delay routine assessments within 14 days. Pathway changes in Wakefield have been successful (90.3%) and Calderdale and Kirklees are above target and improving (85.1%). Barnsley is below target at 52.8% and has an improvement plan in place, using learning from other areas. Performance is consistently on target in other access measures as demonstrated in the data for 72 hour follow up, early intervention in psychosis, assessment in accident and emergency and NHS talking therapies. Improvement in the family and friends test has been noted following a focus on this in the teams. A data quality issue has been noted in relation to the FIRM risk assessments, so the data has been withdrawn. This is being reviewed and will be included in future reports and through the integrated performance report. Focus on ensuring people have a formal care programme approach (CPA) review within 12 months will continue to ensure that the performance is maintained.

	Discussion and learning from incidents are embedded as part of the care group governance processes. Work is planned to better understand the statistical significance of the data to ensure appropriate quality improvement actions. Referrals for white people are marginally over-represented and Asian people marginally under-represented against community populations. Equality impact assessments have been prioritised and quality and governance leads are working with team managers to ensure that action plans are meaningful. **Inpatient services** Ward drill down information is available in the integrated performance report. Significant work has been taking place since May 2023 to improve appraisal performance and align local reporting with performance reports. Sickness data demonstrates improved performance. The focus on staff wellbeing has had a positive impact. Mandatory training hotspots include cardiopulmonary resuscitation (CPR) which had reached the target but dropped off in month due to a number of staff needing an update at the same time, and information governance training. Individual action plans are in place for staff members. Most newly qualified nurses and new support workers start their career in inpatient services. Turnover is then impacted as they develop their career and want to move into other specialities. The people directorate business partner is leading on work to develop career pathways to recruit, retain and develop staff to encourage people towards a career in inpatient services. The £311k overspend against budget is impacted by the high use of bank, agency, and overtime to fill vacancies and provide staffing over and above establishment to maintain safe care. Work is taking place to revise the base establishments along with measures to improve recruitment and retention. Bed occupancy is high across all areas with the percentage of people who are clinically ready for discharge also high at almost 8%, due to challenges in finding the right placement for people on discharge. Patient flow forms an important part of the care closer to home improvement work and success is noted in the significant reduction in out of area placements. The care group uses governance structures to ensure learning from incidents. Themes most recurring are violence and aggression and self-harm. Work is underway to promote reductions in restrictive practices and the Race Forward group focus on racially motivated incidents.

	Safer staffing data cannot be relied on as a single measure. The measure is against base establishment rather than immediate need. The data demonstrates the use of additional staff to manage acuity. In keeping with national findings, people from Black, Asian and mixed ethnicity continue to be over-represented against the Trust population. This needs to be further understood and addressed. The service is prioritising the work on actions from equality impact assessments.
Recommendation:	**The Board is asked to RECEIVE the report and COMMENT accordingly.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Care Group Summary

September 2023

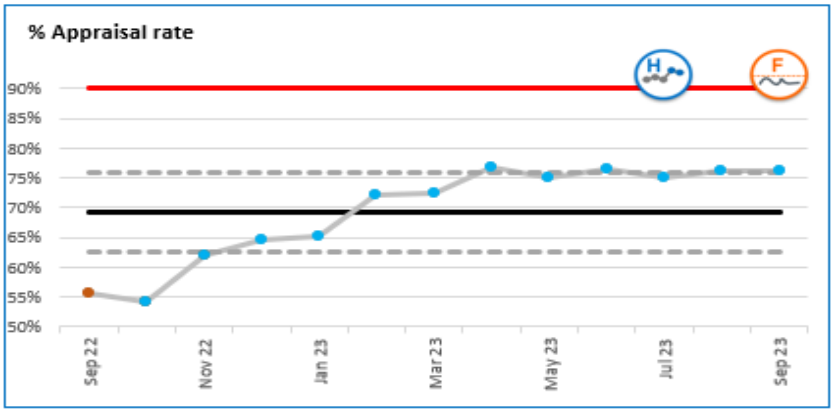
With **all of us** in mind.

Mental Health Community (Including Barnsley Mental Health Services)

Community mental health relates to all community mental health services provided by the Trust in Calderdale, Kirklees, Wakefield and Barnsley. This includes the Enhanced Pathway, Core Pathway, Early Intervention in Psychosis (EIP), Community Rehabilitation, Perinatal service, Single Point of Access, Intensive Home Based Treatment (IHBT), Older people's community mental health teams, Memory pathway, Admiral Nurses, Primary care mental health provision and Talking Therapies in Kirklees and Barnsley. The Care Group challenges reflect those of other mental health services locally and nationally, namely staff recruitment and retention, demand and capacity, access and waiting times for therapy and staff wellbeing. These challenges are reflected in the care group annual plan and the work being undertaken as part of the Trust's priority programmes which include improving access and in particular the SPA review and reducing waits for psychological therapy. In addition to the improving access work a priority area of focus and development in community mental health is community mental health transformation.

Workforce

Appraisals



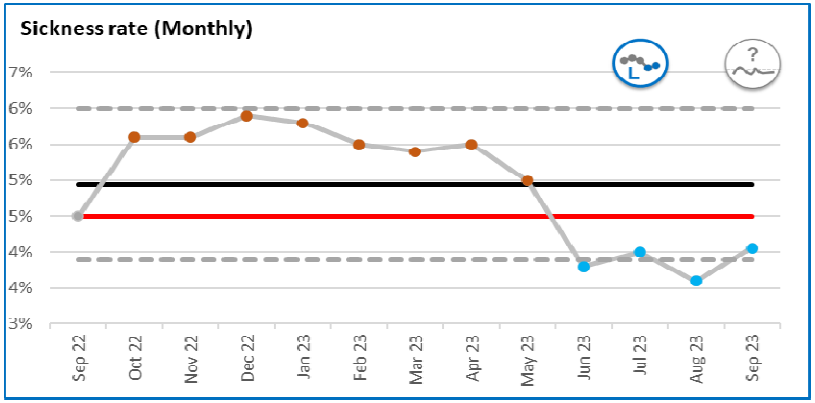
Insights

After strong improvement in appraisal compliance since late 2022 performance has remained at or around 75% since Spring. The care group performance for September 23 is 78.8% for Barnsley, 74.6% for Calderdale & Kirklees and 76.1% for Wakefield

Focussed work is ongoing to improve appraisal completion. Frequent meetings are taking place with all ward managers to focus on improving appraisal completion. A recovery plan was implemented in May 2023 as part of the inpatient workforce group which resulted in a significant improvement . Local data for 4th September 2023 indicated an appraisal rate of 99% (for those eligible and not excluded). There was a large number of new starters at the end of September 2022 who are now due appraisals which has impacted on the current appraisal figures. This remains a focus for the senior leadership team in order to maintain a sustained improvement. There is a renewed trajectory to have all appraisals completed by end of December.

Data cleansing is underway to ensure that WorkPal and Trust performance data reflect actual appraisal activity in service areas. The new pivot reporting will support this work alongside work with the WorkPal system provider to address inaccuracies.

Sickness



Insights

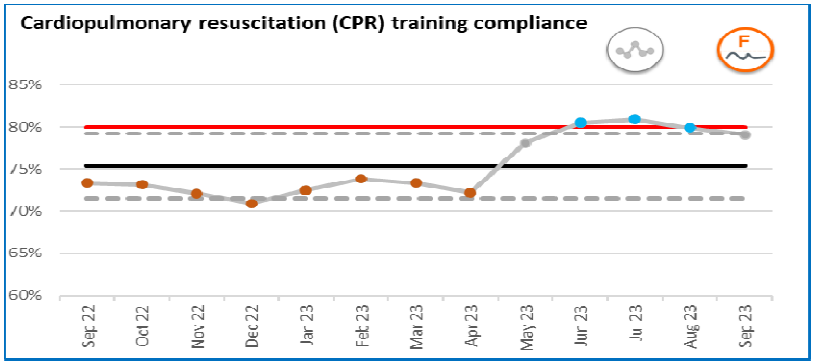
The SPC chart indicates an improved sickness rate over the summer months.

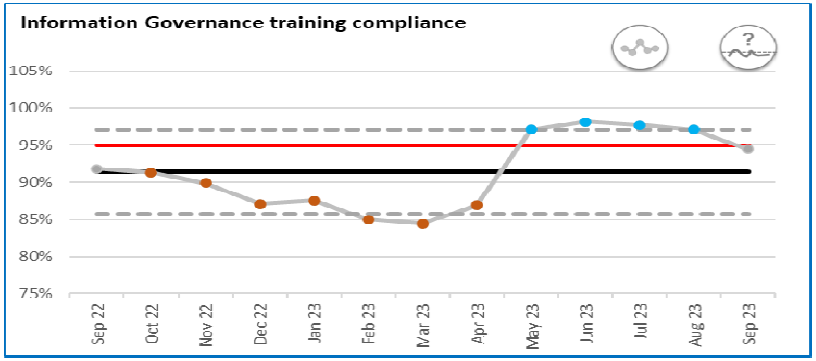
There has been a significant reduction in sickness rate with all areas below Trust target for both monthly and year to date sickness levels. In September 2023 the monthly sickness rate for Barnsley was 4.4%, Calderdale & Kirklees were at 4.2% and Wakefield at 3.4%.

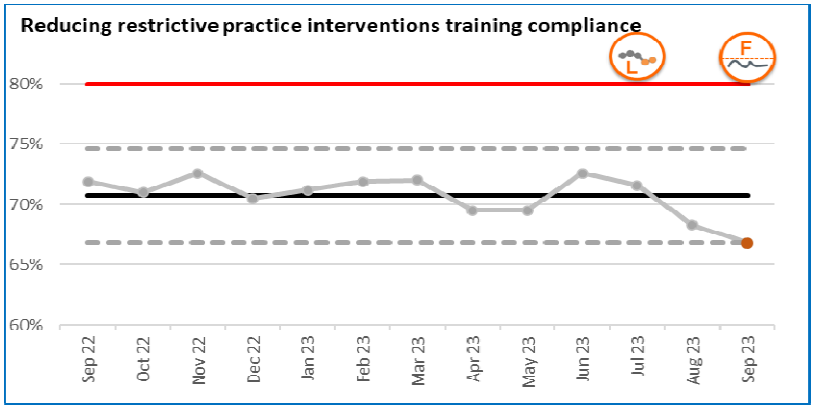
This is the result of team managers implementing the care group's wellbeing plan and looking at local workplace improvements and the benefits of flexible working arrangements across community settings.

Mental Health Community (Including Barnsley Mental Health Services)

Mandatory Training







Insights

Whilst the SPC chart indicates a period of common cause variation (no concern) performance is slightly below the target of 80%.

Calderdale and Kirklees are above target at 81.9%. Barnsley and Wakefield are both under target for cardiopulmonary resuscitation at 76.7% and 76.3% respectively.

There is an issue currently with lack of availability of mandatory training reports at team level, managers currently have to access this information from each individual member of staff's ESR record. This presents significant challenges for leaders to monitor compliance, identify hot spots and undertake focussed improvement work. The People Directorate are working to produce a report that meets operational requirements.

There was a reduction in compliance for Information Governance Training in September 2023 with Calderdale & Kirklees achieving the target at 95.0% and both Barnsley and Wakefield dropping slightly below target at 93.8% and 94.0% respectively.

There is a focus within the care group on ensuring compliance with Data Security Awareness training. The same situation as described above with availability of reports by team is proving challenging.

The SPC chart indicates a period of special cause concerning variation following a further drop in performance in September 2023.

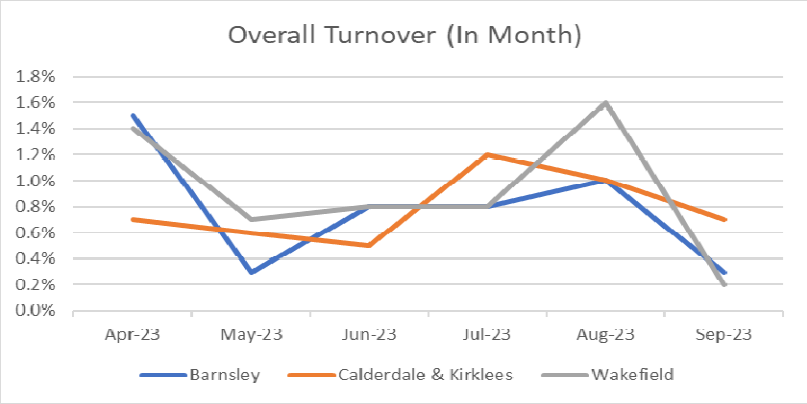
There a downward trend in compliance for RRPI training over the last 3 months with Barnsley at 69.0%, Calderdale & Kirklees at 66.6% and Wakefield at 65.3%.

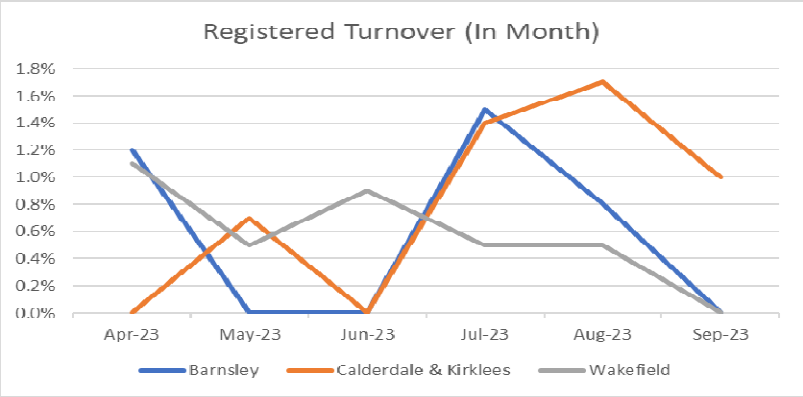
The majority of staff within community Mental Health services are not expected to use physical interventions to restrain people in the same way as mental health ward staff. They are required to understand how to de-escalate and safely exit a situation and get help. Analysis is underway across services to ensure the accurate allocation of the required mandatory training for community roles and a focus to ensure it is then completed.

All areas are under the 80% target for RRPI. This is in part due to the availability of the face to face breakaway training sessions. Capacity for RRPI training is recognised as a Trust wide issue. Additional resource has been approved, but has not been fully successful yet. There have also been unintended consequences from industrial action and issues with sickness in the core delivery team. Colleagues in the RRPI team are considering options to increase availability of

Mental Health Community (Including Barnsley Mental Health Services)

Turnover





Insights

In community mental health services opportunities are being taken to retain skilled and experienced staff through discussing and exploring person-centred options that may encourage staff to stay within the Trust such as flexible working and the transfer scheme.

Further information and analysis is required regarding what is driving the numbers. For example, where staff may be moving to and what qualitative insights and information can be gained from individual exit interviews and statements. Leaders are working with workforce colleagues to analyse data from a range of sources including exit interviews to support future retention.

There are currently higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these vacancies have had limited success.

There are action plans in place for certain teams experiencing particular challenges for example the enhanced pathway in Kirklees has undergone a workforce and service development plan introducing new ways of working and team structures; and in Wakefield Single Point of Access (SPA) undertaking a review of roles and skill mixing to create strengthened leadership and better focus on service user complexity. There has been an overall continuation of proactive and innovative in approaches to recruitment and workforce modelling across the care group.

Mental Health Community (Including Barnsley Mental Health Services)

Finance

Finance

Agency Spend YTD
£582k

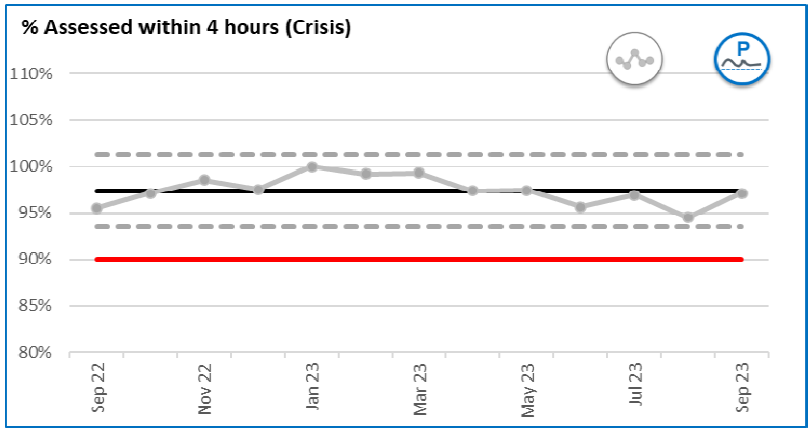
Variance to Budget YTD
£633k Underspent

Insights

The agency spend in the care group community services is for medical staffing. There have been significant issues with recruitment and retention which is a significant contributor to use of agency. Specific plans are in place for each agency post including use of new posts such as international fellows.

Access

% Assessed within 4 hours (Crisis)



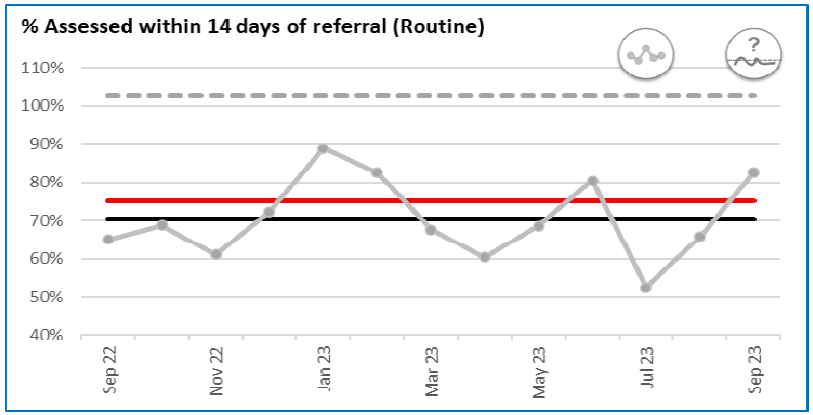
Insights

The SPC chart indicates a period of common cause variation (no concern) and it is estimated that the target of 90% will be met.

All areas are consistently exceeding the target of 90%. In September 2023 Barnsley achieved 93.6% and Calderdale, Kirklees and Wakefield all achieved 100% of crisis referrals assessed within 4 hours.

Mental Health Community (Including Barnsley Mental Health Services)

% Assessed within 14 days of referral (Routine)

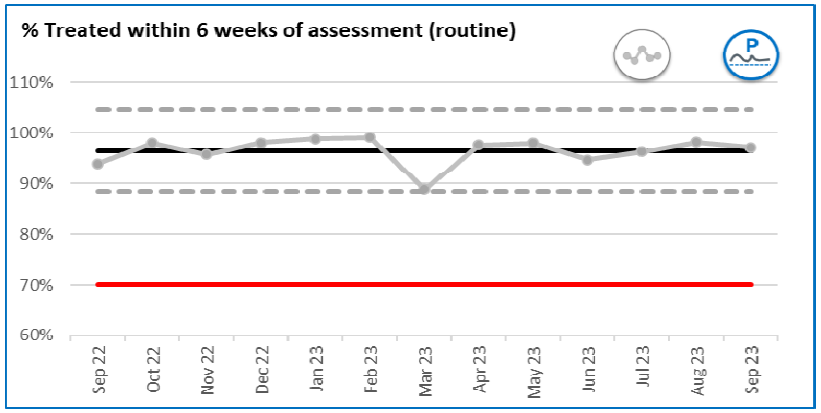


Insights

Demand into the Single Point of Access (SPA) combined with 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 have been at risk of being delayed in all areas. Wakefield have implemented pathway changes to interface more effectively with primary care teams and as a result primary care mental health practitioners have achieved the target in September with 90.3%. Performance has improved in Calderdale and Kirklees and is now above target at 85.1%. Barnsley routine access for assessment is below target at 52.8%. Barnsley have action plans in place and are undertaking specific improvement work such as assertive recruitment campaign and a review of opportunities to undertake assessments across Core and Enhanced pathways.

% Treated within 6 weeks of assessment (routine)



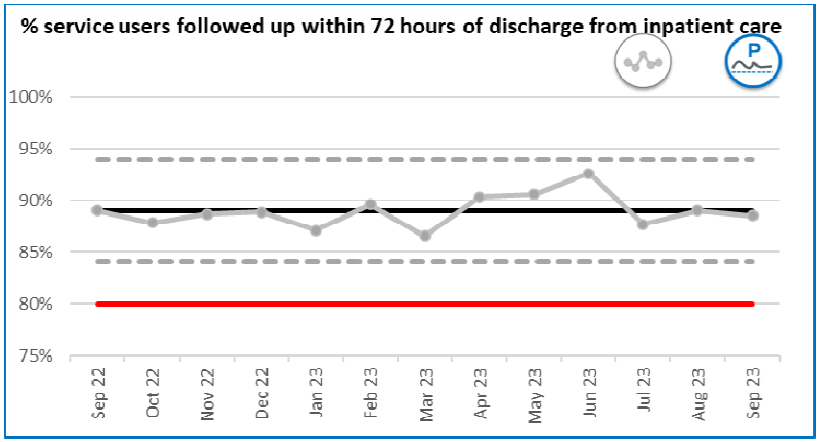
Insights

The SPC chart indicates a period of common cause variation (no concern) and it is estimated that the target of 70% for Barnsley and 95% for Wakefield, Calderdale and Kirklees will be met. Please note that the difference in targets is due to the way that the Trust is commissioned to deliver services in each area.

All areas continue to achieve the routine access for treatment target. In September Barnsley achieved the required 70% target (target set by Barnsley commissioners) at 82.5%, The routine access target for Wakefield, Calderdale and Kirklees of 95% was achieved in September with Calderdale & Kirklees at 99.4% and Wakefield at 98.4%.

Mental Health Community (Including Barnsley Mental Health Services)

% service users followed up within 72 hours of discharge from inpatient care



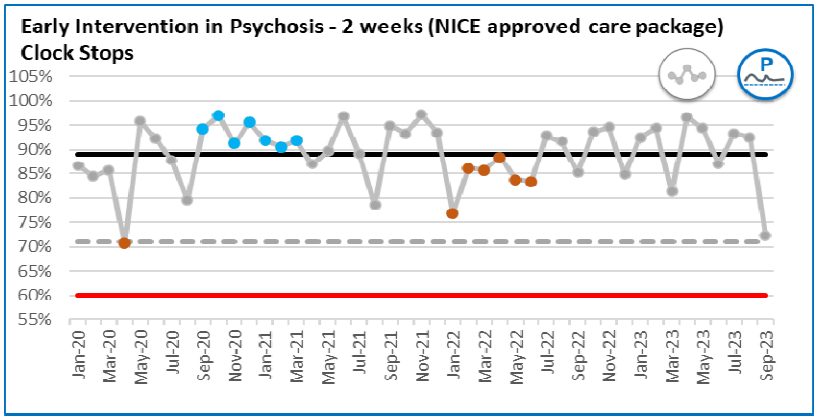
Insights

The target of 80% is regularly achieved and this is expected to continue.

All areas are exceeding the target of 80% of service users discharged from in patient wards followed up within 72 hours of discharge. In September Barnsley achieved 93.9%, Calderdale 89.5%, Kirklees 90.0% and Wakefield 89.2%.

Improvement work is ongoing to ensure accurate recording in order that data collection is an accurate representation of activity.

Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops

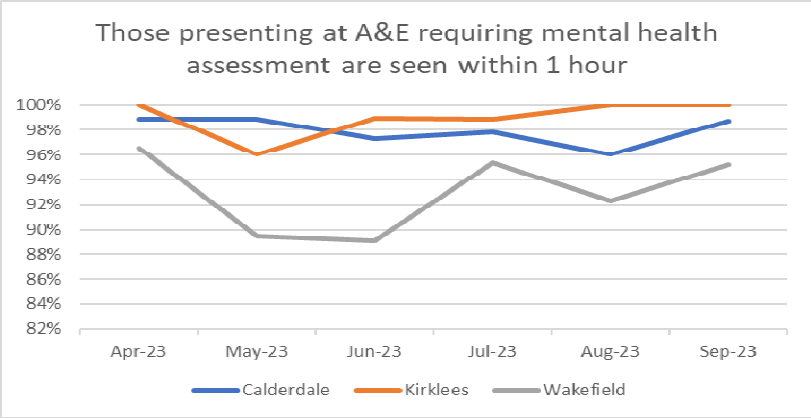


Insights

All areas are significantly exceeding the target of 60% and are performing well. It is expected this will continue. In September Barnsley achieved 100%, Calderdale 83.3%, Kirklees 80.0% and Wakefield 80.0%.

Mental Health Community (Including Barnsley Mental Health Services)

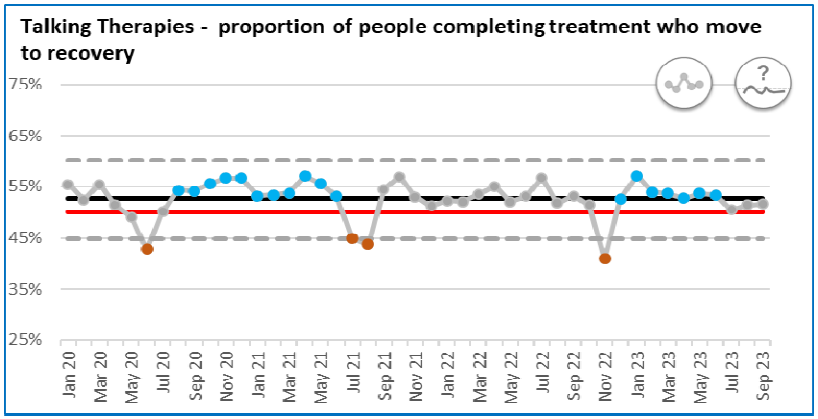
Those presenting at A&E requiring mental health assessment are seen within 1 hour



Insights

All areas are achieving the 90% target for mental health assessments completed in A&E within 1 hour.

NHS Talking Therapies (formerly IAPT) - proportion of people completing treatment who move to recovery



Insights

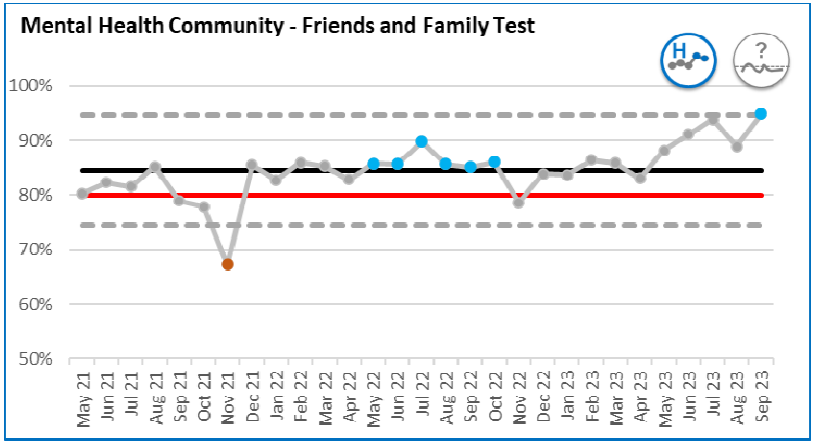
NHS Talking Therapies (TT) service in Calderdale is provided via AQP and only partial service, our Trust does not provide NHS TT service in Wakefield.

The Kirklees Talking Therapies recovery rate for September is 50.05% just achieving the national standard of 50%. This is likely to be a seasonal trend as a similar reduction was noted in 2022-23 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. The Barnsley Talking Therapies recovery rate for September is also above target at 50.3%

Mental Health Community (Including Barnsley Mental Health Services)

Quality and Safety

Friends and Family Test



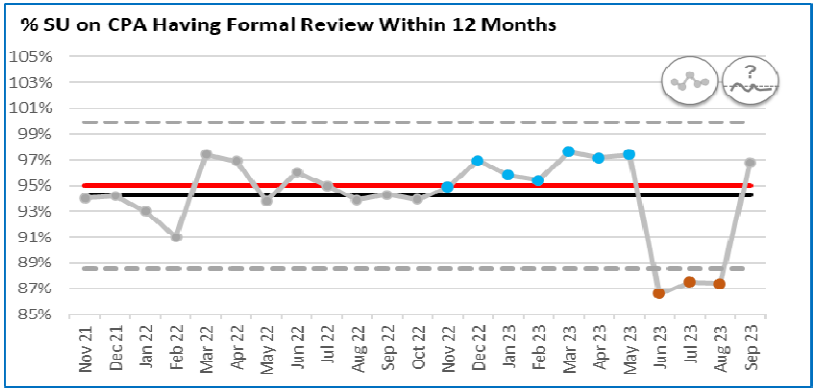
Insights

The SPC chart indicates a period of improving performance.

Focussed work has taken place regarding Friends and Family Tests both in content of responses, numbers completed, and developing actions to improve. All areas have shown significant improvement and are all now above threshold. In September Barnsley was at 91.5% (39/43), Calderdale & Kirklees at 99% (93/94) and Wakefield at 89% (32/36).

The majority of mental health community teams rely on the friends and family test link via text messages to gather feedback. A service line patient experience survey is currently under development for mental health community services which will support the collection of friends and family test feedback as well. Work around how we collate, and demonstrate actions taken as a result of feedback received is also underway.

% Service users on CPA having formal review within 12 months



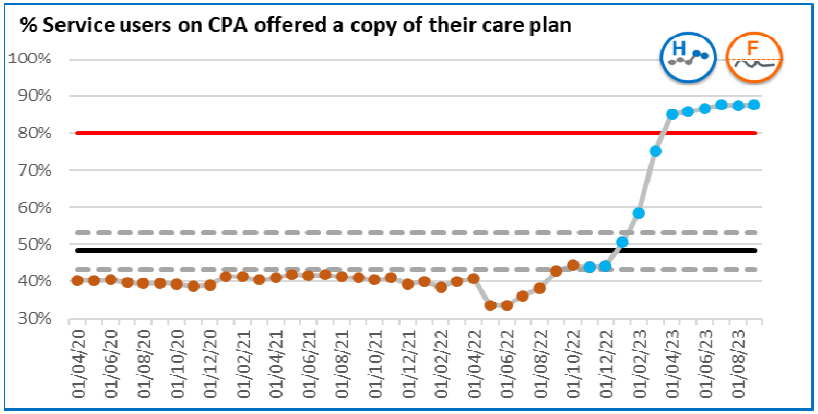
Insights

Care Programme Approach (CPA) review performance is above target in all areas other than Barnsley which was marginally below target. Action plans and support from Quality and Governance leads remain in place. In September 2023 Barnsley achieved 94.8%, Calderdale 96.9%, Kirklees 98.5% and Wakefield 96.6%

Local work continues to take place to ensure this quality standard continues to be achieved.

Mental Health Community (Including Barnsley Mental Health Services)

% Service users on CPA offered a copy of their care plan



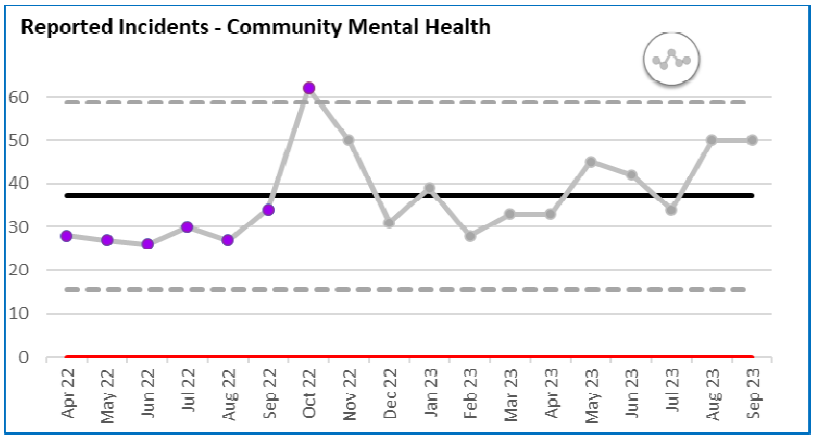
Insights

The SPC chart indicates a period of improving performance.

Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users with all areas achieving the target of 80%. In September Barnsley achieved 91.7%, Calderdale 85.8%, Kirklees 91.2% and Wakefield 88.3%.

Recent changes to how this assurance is given and captured to better reflect clinical practice seems to be supporting the achievement of this metric.

Incidents



Insights

1 Serious Incident reported in September 2023

Community Mental Health services have a positive reporting culture and have embedded discussions regarding incidents and themes within various governance meetings including the care group Quality and Governance meeting.

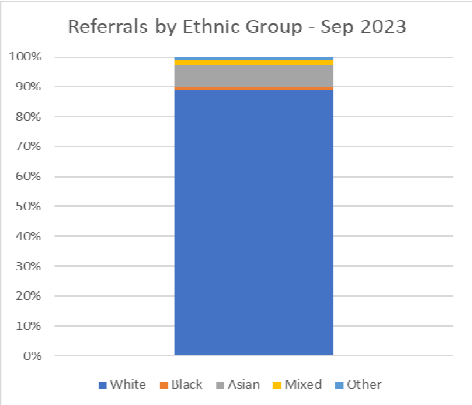
Themes for Q2 of Information Governance (12) and medication issues (31) remain the most reported incidents from a staff related perspective. Self harm (29) and death (22), are the most reported incidents from a service user related perspective. There were 10 incidents of violence and aggression.

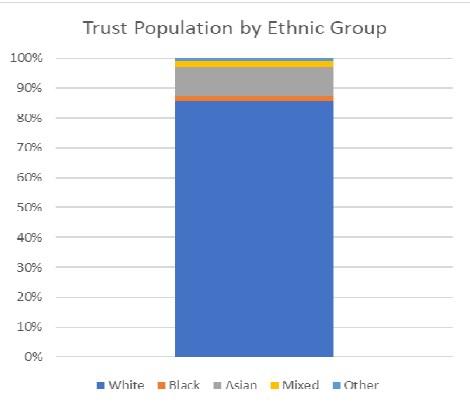
Focused work is being planned to better understand the statistical significance of these figures and to identify quality improvement activity required.

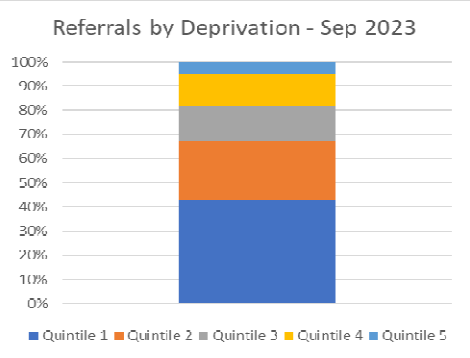
Mental Health Community (Including Barnsley Mental Health Services)

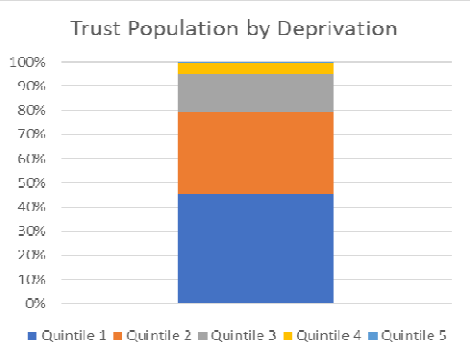
Inequalities

Referrals









Insights

Referrals for people from a white ethnic group are marginally over represented against the Trust's population, and referrals for people from an Asian ethnic group are marginally under represented. More detailed analysis is required to enable better understanding of this data and actions needed to address it.

Community Mental Health services have ensured prioritisation of Equality Impact Assessments over the last 12 months with the Quality and Governance Leads working with team managers to facilitate their completion and to ensure that action plans are meaningful.

A number of care group leaders have also attended the enhanced Equality, Diversity and Inclusion training, further strengthening understanding of the wider equality agenda.

There is marked variation between population and referrals from areas of deprivation / non deprivation. More detailed analysis is required to better understand this data and what needs to be done to address it.

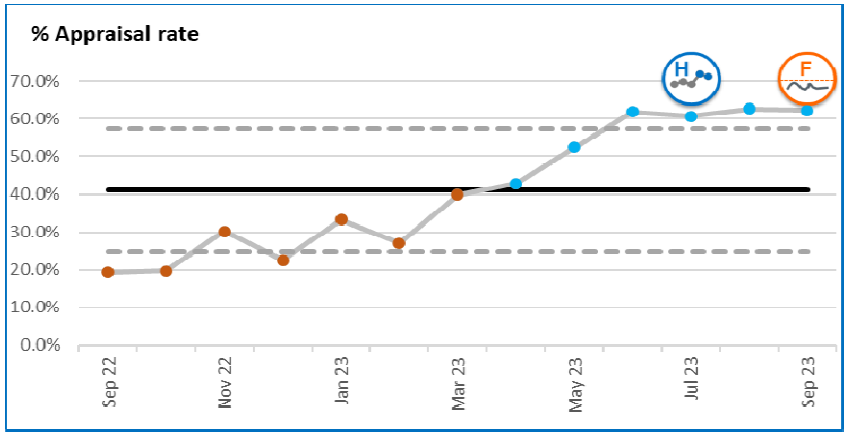
Referrals from Quintiles 4 and 5 (the least deprived parts of the country) are over-represented. A more granular investigation is required to ascertain the reasons for this.

Inpatients

Inpatients relate to inpatient mental health services for adults and older people provided by the Trust in Calderdale, Kirklees, Wakefield and Barnsley. Our inpatient services comprise five older people's wards, Beechdale in Calderdale, Ward 19 in Kirklees, Willow in Barnsley and Crofton and Poplars in Wakefield; Psychiatric Intensive Care Unit provision in Barnsley (Melton) and Wakefield (Walton), seven acute wards, Ashdale and Elmdale in Calderdale, Beamshaw and Clark in Barnsley, Ward 18 in Kirklees and Nostell and Stanley in Wakefield. Inpatient services also include the two rehabilitation units, Enfield Down in Kirklees and Lyndhurst in Calderdale and three Section 136 suites in Calderdale, Wakefield and Barnsley. The challenges for inpatients reflect those of other inpatient services locally and nationally which include staff recruitment and retention, demand for inpatient beds, patient flow and staff wellbeing. These challenges are reflected in the care group annual plan and the work being undertaken as part of the Trust's priority programmes which include the inpatient improvement programme and the care closer to home (CCTH) programme.

Workforce

Appraisals



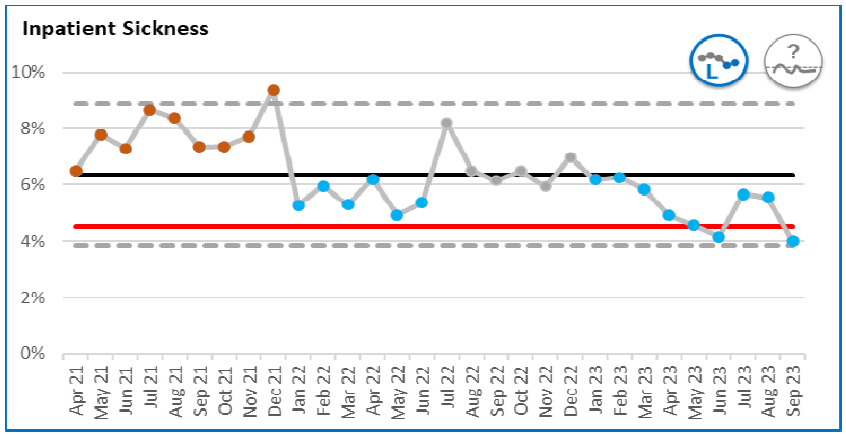
Insights

Data cleansing is underway to ensure that WorkPal and Trust performance data reflect actual appraisal activity in service areas. The new pivot reporting will support this work alongside work with the WorkPal system provider to address inaccuracies.

Frequent meetings are taking place with all ward managers to focus on improving appraisal completion. A recovery plan was implemented in May 2023 as part of the inpatient workforce group which resulted in a significant improvement . Local data for 4th September 2023 indicated an appraisal rate of 99% (for those eligible and not excluded). There was a large number of new starters at the end of September 2022 who are now due appraisals which has impacted on the current appraisal figures. This remains a focus for the senior leadership team in order to maintain a sustained improvement. There is a renewed trajectory to have all appraisals completed by end of December.

Performance is closely monitored via a weekly Inpatient performance meeting chaired by the associate director.

Sickness



Insights

The data indicates an improvement in sickness rates with performance within target for September 2023.

The spike in short term sickness/absence in July and August was due to incidences of infectious diseases (diarrhoea & vomiting and Covid-19) within inpatient wards. These infections have restrictions in relation to specified time periods when staff have to be absent from work impacting on sickness absence rates. These situations will often have a notable impact on inpatient staff sickness rates.

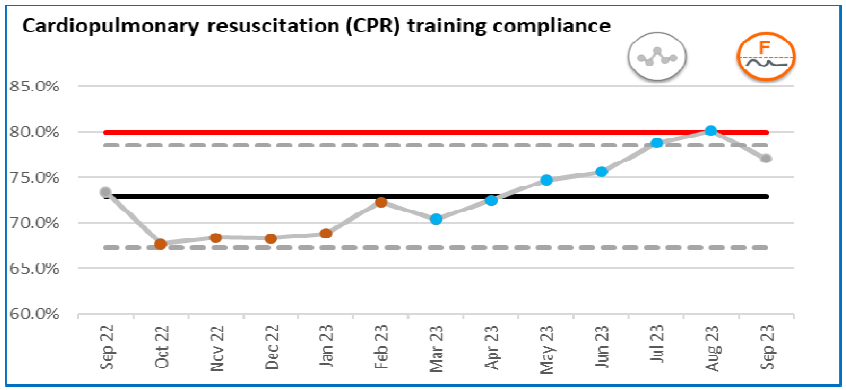
Service managers review themes and trends related to sickness absence and take action to address any issues identified. One potential theme identified and being explored further is a potential link between increased acuity on a ward and increased short term absence rates.

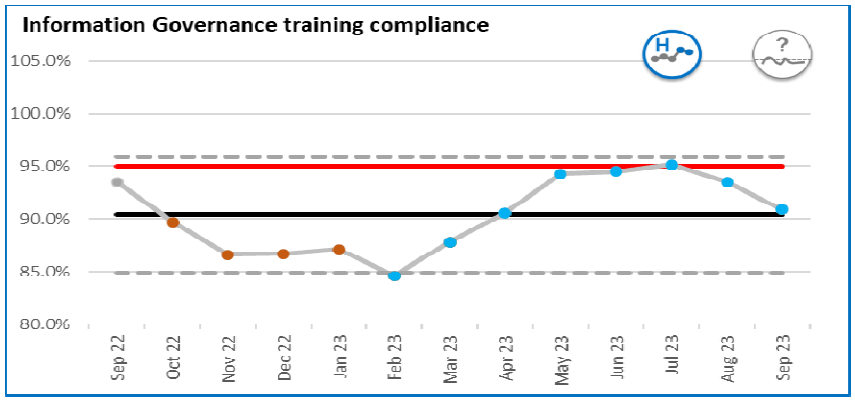
There is a continued focus on staff wellbeing within the care group. There is a planned roll out of staff wellbeing events led by occupational health in January 2024 following the success of the programme at the Priestley Unit.

Through the Inpatient Improvement Programme (IIP), workforce and therapeutic engagement workstreams actions are

Inpatients

Mandatory Training





Insights

There have been improvements over a five month period for cardiopulmonary resuscitation training compliance achieving the target of 80% in August 2023. However the data shows performance dipped in September, impacted by a large number of staff due to renew their training at the same time.

Weekly performance reports had been implemented by the service using Trust data however detailed mandatory training reports are currently not currently available at team level, managers have to access this information from each individual member of staff's ESR record. The People Directorate are working to produce a report that meets operational requirements. The service manager is leading on the close monitoring of mandatory training, meeting with ward managers monthly.

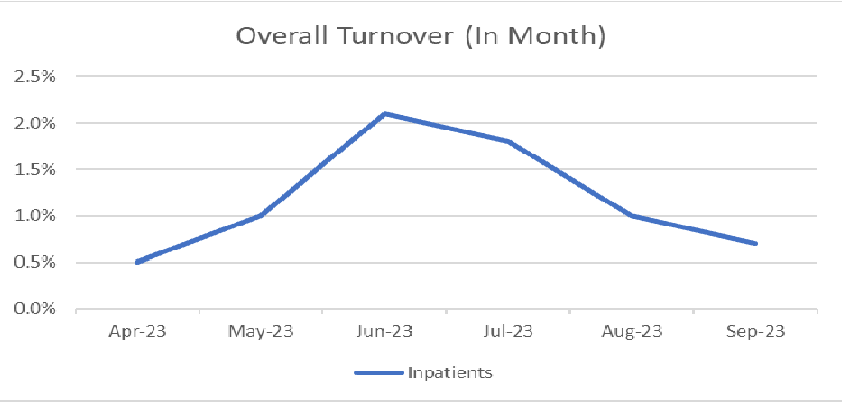
Ward managers conduct regular reviews of staffing to ensure that patient safety needs are met in terms of the cardiopulmonary resuscitation competencies of staff on duty. This is overseen and supported by the service manager.

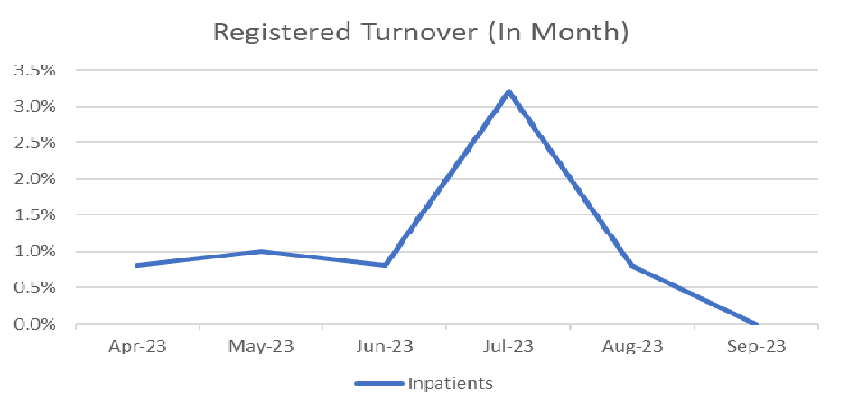
The target for information governance training compliance was achieved in July 2023 following five months of improved performance. However, there has been a fall in performance over the last two months. This is in part due to issues with exempting staff from the training due to long term sickness, career break, maternity leave or unpaid leave. The associate director of operations is liaising with the people directorate to resolve the issue.

There is a focus within the care group on ensuring compliance with data security awareness training. To mitigate the current absence of a centrally generated report the general manager has a detailed summary for each staff member, with actions to improve performance agreed by the ward manager and there is oversight via weekly performance meetings chaired by the associate director. The People Directorate are working to produce a report that meets operational requirements.

Inpatients

Turnover





Insights

The overall turnover for the service has reduced following successful recruitment of staff. Areas of particular challenge for recruitment and retention are the female acute wards.

There is an ongoing challenge of registered nurses leaving to work in higher banded jobs in community settings. The People business partner is leading on workforce developments with inpatient colleagues to establish career pathways within inpatient services.

A matron has been seconded to provide leadership and support to ensure that the internationally recruited nurses are successfully supported and embedded into ward teams.

As part of the care group retention strategy there is a significant focus on staff wellbeing which is a key aspect of the workforce plan. New initiatives include a staff engagement strategy and occupational health site visits for all inpatient units.

As above.

Finance

Agency Spend

Agency Spend YTD
£1,076k

Variance to budget YTD
£311k Overspent

Insights

The significant agency spend is as a result of vacancies across the service line, particularly registered nurse vacancies.

There have been block bookings of agency to fill staffing deficits whilst promoting continuity of care for service users and supporting risk management. A number of new starters joined in September with further recruitment planned for January. Some wards are struggling to recruit health care support workers and nurse associates with particular challenges on female acute wards.

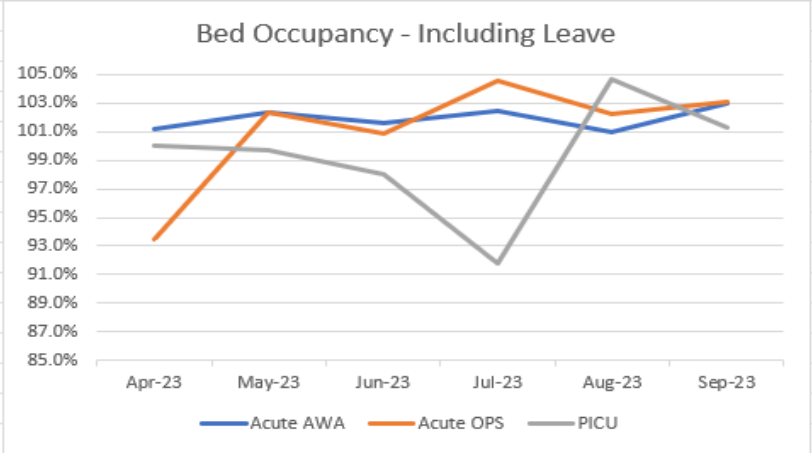
A comprehensive establishment review is nearing completion.

Most wards have at times had to increase staffing above baseline numbers to manage acuity and complexity of the service user group. Health care support workers have been occupying registered nurse shifts when unable to fulfil

Inpatients

Access

Bed Occupancy - Including Leave



Insights

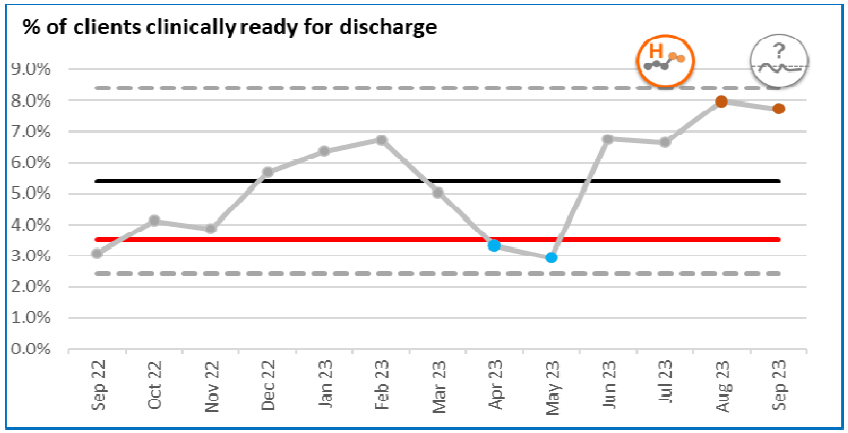
Bed occupancy rates are currently high across working age adult wards, older people wards and PICUs (Psychiatric Intensive Care Units).

Leaders within the care group are currently reviewing systems within patient flow to refine processes and further support flow through the whole system.

Bed occupancy is closely monitored within the weekly performance oversight meeting chaired by the associate director. Any issues identified are addressed collaboratively with leaders and staff in the care group.

Care closer to home improvement work has resulted in a significant reduction in the use of out of area beds. This has resulted in some patients temporarily being placed out of pathway such as informal patients admitted to psychiatric intensive care units (PICUs), older adults admitted to adult wards and the use of non-designated beds which has impacted on bed occupancy. Where this has happened protocols are in place which require service users to be moved within 24 hours of admission to the appropriate pathways.

Clinically Ready for Discharge (CRFD)



Insights

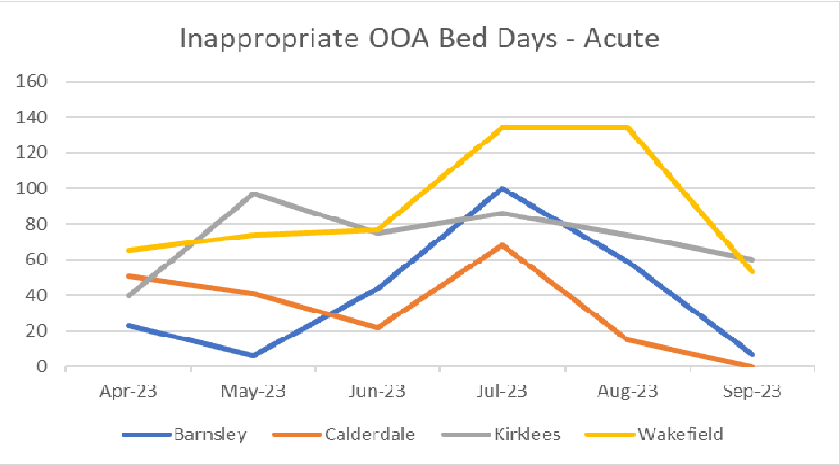
The percentage of patients clinically ready for discharge remains above target at nearly 8%. There are a number of factors impacting on this increase including refreshed application of the NHSE definition of clinically ready for discharge. There are also significant challenges in sourcing appropriate placement provision to meet an individual's needs when they leave hospital. Themes also include waiting for Ministry of Justice (MOJ) decisions, appropriate housing and specialist care home placements.

A dedicated internal workstream has been developed focussing on timely discharge from the wards. Weekly barriers to discharge meetings have been reviewed and there is an increased focus on actions and accountability for progressing discharge packages.

Weekly MADE (Multi Agency Discharge Event) meetings remain in place in each locality. These local partnership meetings are held to discuss barriers to discharge and create opportunities for all agencies to find solutions to best meet people's needs and facilitate their return to community settings.

Inpatients

Inappropriate Out of Area Placements - Acute



Insights

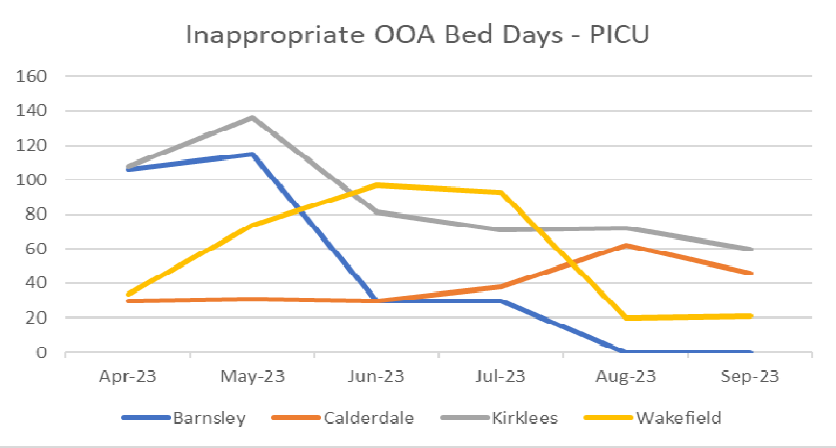
There has been a significant reduction in the number of out of area placements. At the time of this report there were two service users placed out of area for reasons of gender-specific care being required; provision which is not commissioned locally.

The care closer to home improvement work lead by an associate director is having a positive impact on reducing the number and duration of episode of out of area placements, with an increased focus on out of area flow alongside the development of sustainable systems and creative approaches to avoid out of area admissions.

A person-centred safety first principle operates for all requests for admission with a contingency process in place for emergencies. The length of time people are waiting for a bed when all options for community care have been exhausted is being tracked through the electronic patient flow system, and monitored closely and cross-referenced with incidents pertaining to patient safety in community teams.

Providing care closer to home has the potential to impact on acuity and occupancy levels in inpatient areas. This could lead to an increase in the need to use bank and agency staff. The use of agency across the wards is being monitored closely and cross-referenced with incidents of over-occupation.

Inappropriate Out of Area Placements - PICU

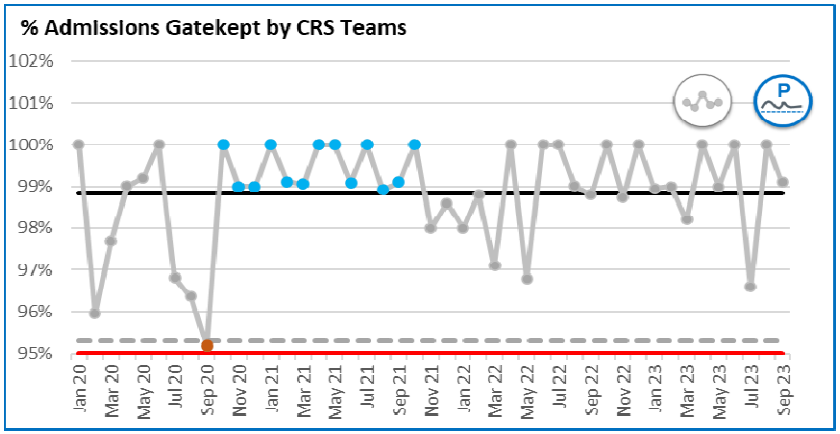


There has been a significant reduction in the number of out of area placements for a Psychiatric Intensive Care Unit (PICU).

The care closer to home improvement work lead by an associate director is having a positive impact on the number and duration of episode of out of area placements. There is an increased focus on out of area flow alongside developing sustainable systems and implementing creative approaches to avoid out of area admissions.

Inpatients

% Admissions gate kept by crisis resolution teams

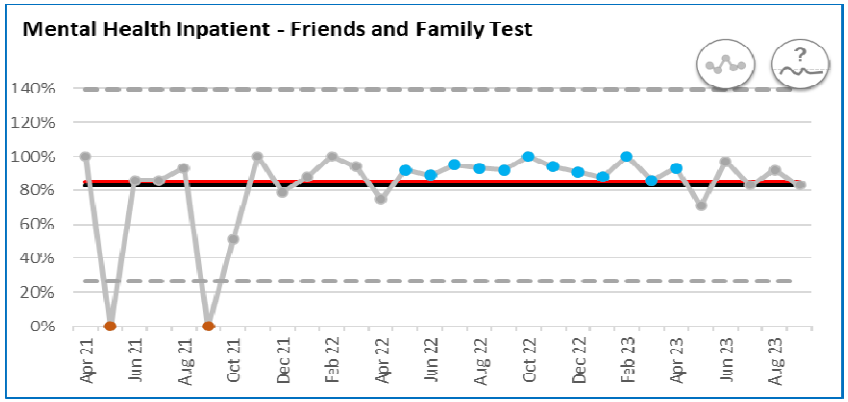


Insights

Intensive Home Based Treatment Teams (Crisis Resolution Services (CRS)) are consistently performing above target for the percentage of gatekept admissions.

Quality and Safety

Friends and Family Test



Insights

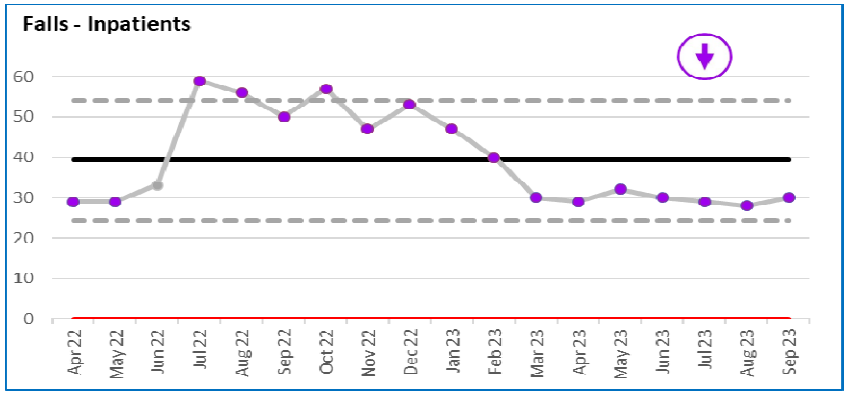
Mental health inpatient wards have a patient experience inpatient survey, which includes the Friends and Family Test question. The survey is available on chat pads which are electronic devices used to collect timely feedback from service users on the wards. Paper versions of the survey including easy read format are also available. Using multiple formats ensures accessibility and encourages completion of the survey. In addition to the survey Friends and Family Test cards are also available in receptions and on wards with feedback boxes. Work focusing on how information is collated and how actions taken as a result of feedback are demonstrated is underway.

There was an increase in quarter two (Q2) responses of 62% as a result of targeted work within the care group. Inpatient feedback for Q2 via the chat pad survey was 90% for the friends and family test element.

All service user feedback is reviewed fortnightly by senior leaders in the service's performance and oversight meeting chaired by the associate director of operations.

Inpatients

Falls



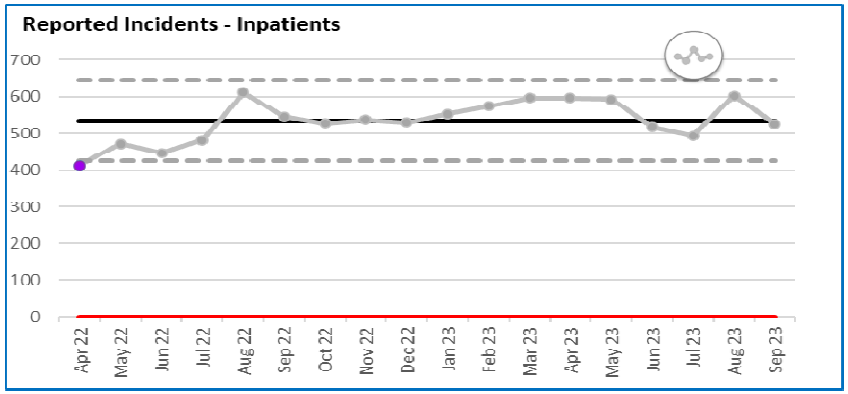
Insights

There has been a significant reduction in the number of falls which is being maintained across the service.
The investment in estates work, particularly at the Priestley unit, is having a positive impact. This work includes installation of handrails in corridors and improved lighting in bedrooms.

Risk assessment processes on the wards are improving with support from the inpatient falls lead. A number of staff have undertaken the two days falls training recently provided by the Trust.

The care group continue to support the most vulnerable and at risk people on our older peoples wards and are currently working with the inpatients falls lead to consider the introduction of new technology on Poplars to enhance safety.

Incidents



Insights

No serious incidents were reported in September 2023.

The service has a positive reporting culture of incidents and has embedded discussions about incidents and themes within various governance meetings including the local acute care forum and the care group Quality and Governance meeting.

Themes of violence and aggression (466) and self-harm (304) remain the most reported incident areas followed by medication incidents and health and safety issues (including fire). There was a spike in false fire alarm activations within Barnsley inpatient areas which were addressed with support from health and safety colleagues.

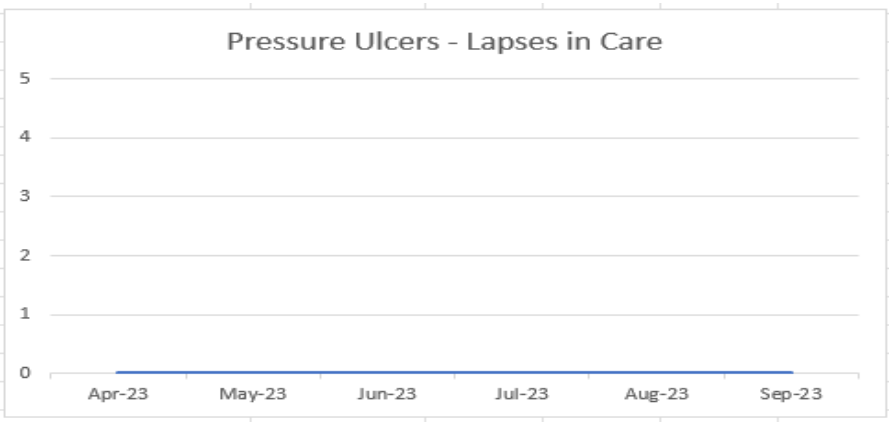
Focused pieces of work are being undertaken promoting reductions in restrictive practices. Quality improvement work has commenced within both psychiatric intensive care units (PICUs) at Barnsley and Wakefield.

The matrons discuss incidents and incident management and share themes for learning at their weekly team meetings.

Inpatients

Quality and Safety

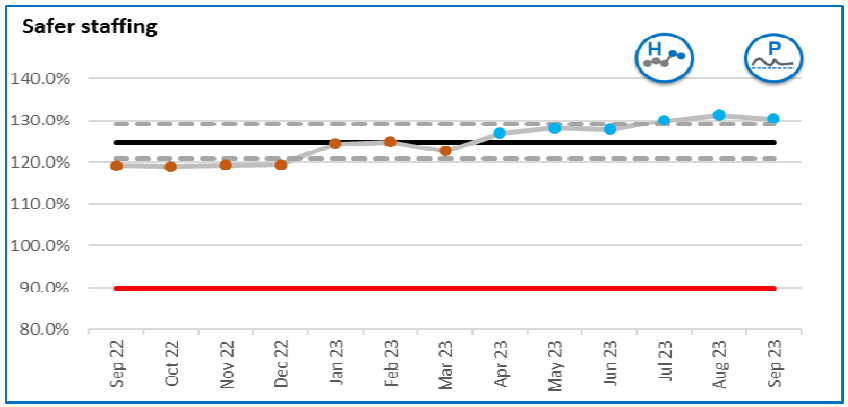
Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care



Insights

No pressure ulcer incidents were reported in September, and there have been none reported since April.

Safer Staffing



Insights

Safer staffing levels are consistently above target as the service has increased staffing numbers to meet patient needs and safety on the wards. Whilst overall fill rates are achieved, registered nurse fill rates do not meet the funded established staffing requirement.

A comprehensive establishment review is in process which includes a focus on providing a broader multidisciplinary team to support service user needs.

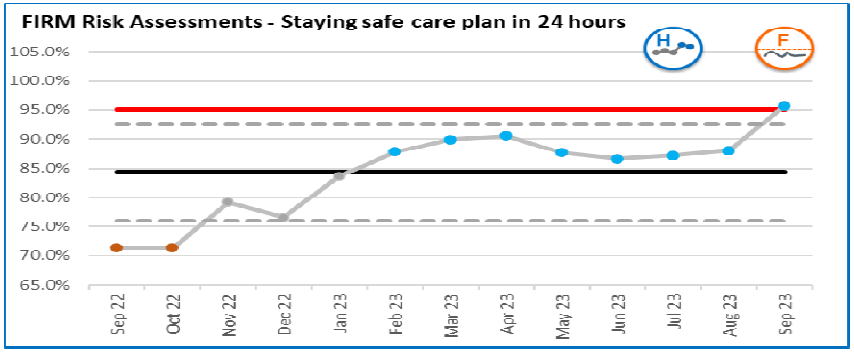
Creative approaches to meet service user need as part of the care closer to home improvement work may have had an impact on the requirement for increased safer staffing resources to manage complex care presentations. This is being carefully monitored and evaluated by the general manager and associate director of operations.

The care group are expecting benefits from the implementation of safe care which enables better alignment of resources to meet demand.

Inpatients

Quality and Safety

Risk Assessments



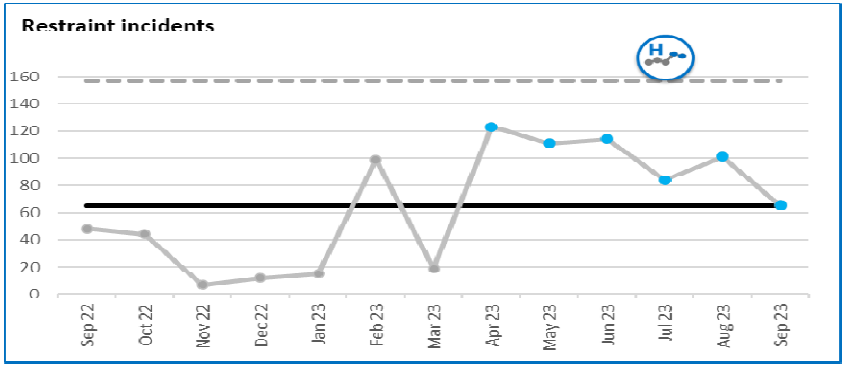
Insights

Risk assessment performance was 86.8% in September 2023 representing 18 out of 136 of assessments not being completed within the 24 hour target. The percentage rates are impacted by the number of admissions per month. On average one risk assessment accounts for around 0.85%. Therefore if more than six risk assessments are completed outside of the 24 hour timeframe the target of 95% would not be achieved. Across all inpatient wards this equates to around 0.35 risk assessments per ward.

The matrons complete a drill down of the reasons for each risk assessment being completed outside of the timeframe. The most common theme is linked to a combination of high acuity and agency staff working as a lone registered nurse during the 24 hour period. At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

The matrons are continuing the roll-out of the inpatient leadership checks via the tendable electronic audit system which

Restraint Incidents/Prone Restraint

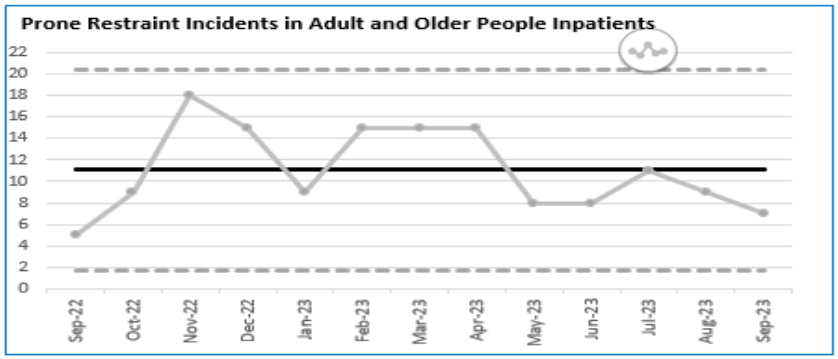


Insights

There is a reduction in restraint incidents noted in September 2023.

Melton and Walton psychiatric intensive care units (PICU) have commenced a reducing restrictive practice quality improvement project supported by the integrated change team. This will be rolled out across all of the inpatient areas in the future.

Additional detailed data at locality level will be made available via the reducing restrictive physical interventions (RRPI) Trustwide meeting.



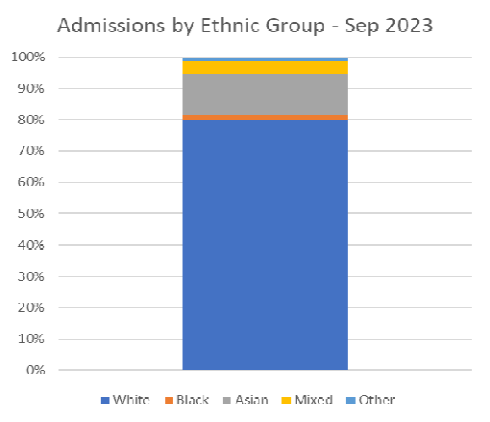
A significant proportion of prone restraints are due to administration of intramuscular (IM) injections in to gluteal muscle. A task and finish group to established if alternative injection sites could be used.

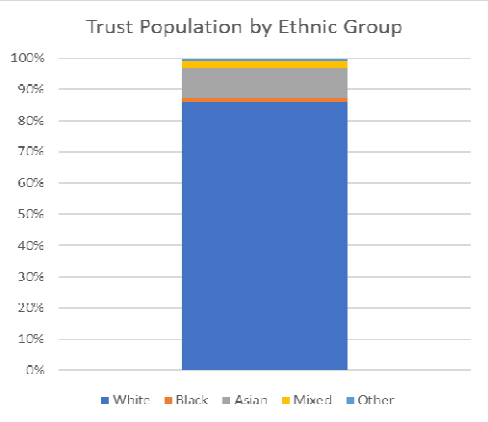
- Pharmacy colleagues have reviewed licencing of medication and which muscle groups they can be administered
- RRPI team are reviewing alternative holds to support administration in to deltoid muscle and seeking advice from Mersey Care Trust on recovery position technique
- Reviewing IPC guidance for administration of injection through clothing to support trauma informed care and avoid prone restraint
- Assessing training needs for alternative injection sites
- Reviewing Datix' that involve prone to assess if alternative approach and IM site could have been used

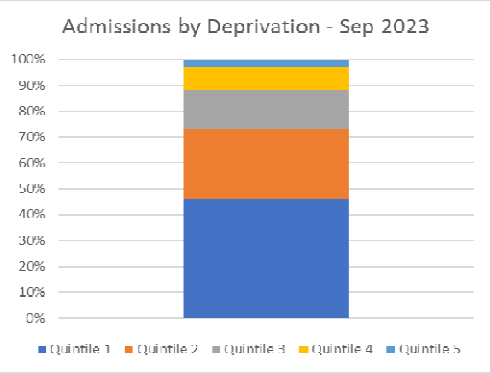
Inpatients

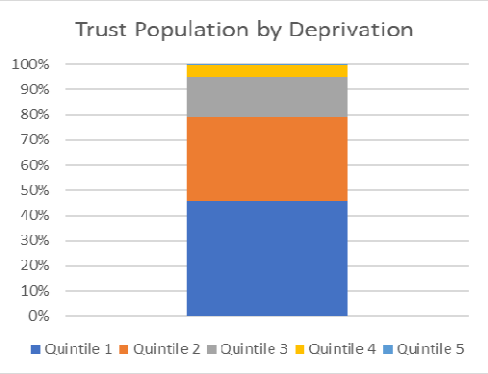
Inequalities

Admissions









Insights

Admissions to acute wards of people from an Asian and Mixed ethnicity background are over-represented in terms of the proportion of people from those backgrounds in the local population. To make the data meaningful, a more detailed breakdown is required. National benchmarking data from 2021-22 indicates that 79% of admissions to inpatients wards nationally are of white British ethnicity with 21% black, Asian, mixed and other ethnicities combined. In comparison September 2023 admission data for the Trust indicates 80% of admissions to inpatients wards are of white British ethnicity and 20% black, Asian, mixed and other ethnicities combined. How this aligns with our local population needs to be better understood.

The service has ensured prioritisation of equality impact assessments (EIAs) over the last 12 months with the matron team taking a lead to facilitate their completion and to ensure that action plans are meaningful. Actions from equality impact assessments (EIAs) have focussed on ensuring that ward information is available in a range of languages including signage on the ward. There has also been a focus on accessibility for carers including technologies to enable virtual attendance at carer meetings.

A number of inpatient leaders have also attended the enhanced Equality, Diversity and Inclusion training, further strengthening understanding of the wider equality agenda.

There is a marked variation between population and admissions from the areas of deprivation/ non-deprivation. More detailed analysis is required to better understand this data and what we need to do to address it.

Referrals from Quintiles 4 and 5 (the least deprived parts of the country) are over-represented with quantile 2 being under-represented. A more granular investigation would be required to ascertain the reasons for this.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	Trust-wide Incident Management Report - Quarter 2 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 Specialist		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre, • We are always improving		
Purpose:	This report provides information in relation to incidents recorded in Quarter 2 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.		
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	The Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing, and investigating healthcare deaths. This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6		

	The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed.
Any background papers / previously considered by:	This paper was discussed in detail at Quality and Safety Committee on 14 November 2023 where it was recommended for approval at Trust Board. Previous quarterly reports have been submitted to Quality and Safety Committee (previously Clinical Governance and Clinical Safety Committee) and Trust Board, along with annual incident reports. Quality and Safety Committee has also received papers in relation to Learning from Healthcare Deaths Policy requirements.
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 include: **Incident Management Trust-wide report** • The number of incidents reported in Q2 2023/2024 was 3,442. 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. • The report shows that there has been an upwards trend in red incidents in recent months. This is expected, as 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. This will be monitored going forward. **Learning from experience** We continue to incorporate learning from experience into the report (section 3). This shares the learning from incidents in Q2 2023/24 and examples of learning in practice. Previously this was provided annually and has been changed to enable provision of more current information. **Serious Incidents** • There were 2 serious incidents reported in Q2 2023/24. • Serious incidents account for 0.6% 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 Q2 2023/24 there were no 'Never Events'. **Learn from Healthcare Deaths**

	• 98 deaths were reported in Q2 2023/24. • 75 of the 98 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 Trust's internet page.
Recommendation:	**Trust Board is asked to APPROVE the quarterly report on incident management.**

South West Yorkshire Partnership NHS Foundation Trust

Trust-wide Incident Management Report

Quarter 2 2023/24

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

Report prepared by Patient Safety Support Team

October 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 2 2023/24 (01/07/2023 to 30/09/2023) 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.

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 develop our reporting. Where we were able to in this report, we have included SPC charts. This will be developed further.

2. Incident Reporting Analysis

This report has overall figures for incident reporting. In Quarter 2 2023/24 there were 3,442 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 2 2023/2024 Headlines

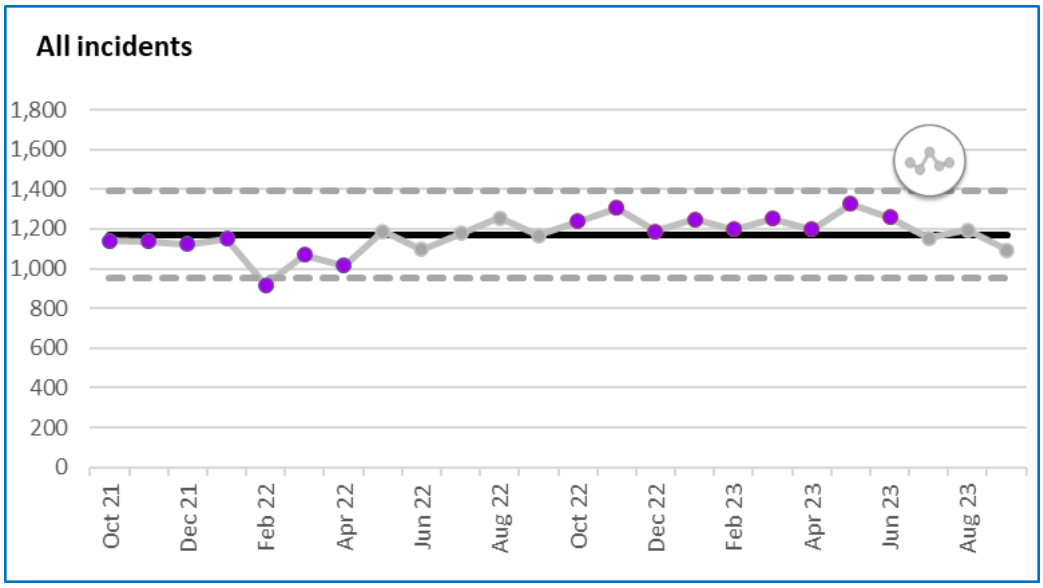
- **3,442** incidents reported
- **Reporting rates remain within normal variation**
- **96%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no / low harm is indicative of a positive safety culture

Figure 1 below shows the pattern and number of incidents reported between 0110/2021 to 30/09/2023 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.

[1] NaPSIR NHS England 2022

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 01/10/2021 to 30/9/2023



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 01/10/2022 – 30/09/2023 by severity and financial quarter.

	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
Green	2475	2439	2630	2298
Yellow	1022	1061	954	921
Amber	219	171	164	189
Red	17	26	34	34
Total	**3733**	**3697**	**3782**	**3442**

In Figure 2, Quarter 2 has seen a decrease in the number of yellow and green 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 2 the figure was 27% yellow and 5% 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 2. The number of red incidents reported in Quarter 2 remains at the same as in Quarter 1 and is due to the number of deaths that have been reported (26). The highest category of death was Death -

cause of death unknown/ unexplained/ awaiting confirmation (14) within the quarter. As described above, severity relates to potential risk and actual harm. These incidents may be re-graded once more information is known about the cause of death.

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 01/10/2021 – 30/09/2023 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, the Patient Safety Support Team will review the red incidents reported in Quarter 1 and Quarter 2 as more information may be available in relation to the deaths where the cause of death was unknown. Refreshed data will be available in Quarter 3 2023/24 report.

Figure 3 shows the severity breakdown for Quarter 2 by Care Group.

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 01/07/2023 – 30/09/2023 by severity and care group.

Care Group	Green	Yellow	Amber	Red	Total
Adults and Older People Mental Health Care Group (Inpatient)	995	558	48	2	1603
Barnsley Integrated Care Group	552	88	75	13	728
Forensic Services Care Group	396	149	40	0	585
Adults and Older People Mental Health Care Group (Community)	184	61	15	17	277
Learning Disability and ASD/ADHD Care Group	115	32	7	0	154
CAMHS and Childrens Care Group	41	14	3	2	60
Trust wide (Corporate support services)	15	18	1	0	34
Provider Collaboratives	0	1	0	0	1
Total	**2298**	**921**	**189**	**34**	**3442**

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.

Figure 4 Type of incident reported in Quarter 2 by Care Group.

Care Group	Adults and Older People Mental Health Care Group (Inpatient)	Adults and Older People Mental Health Care Group (Community)	Barnsley Integrated Care Group	Forensic Services Care Group	Learning Disability and ASD/ADHD Care Group	CAMHS and Childrens Care Group	Trust wide (Corporate support services)	Provider Collaboratives	**Total**
Violence and Aggression	461	19	19	220	82	6	1	0	**808**
Care Pathway, Clinical and Pressure Ulcer Incidents	76	17	435	10	1	7	0	0	**546**
Self Harm	302	25	37	24	2	5	0	0	**395**
Medication	136	54	56	48	4	0	7	0	**305**
Health and Safety (including fire)	112	19	32	59	6	1	12	0	**241**
All Other Incidents	125	9	20	50	8	3	0	0	**215**
Legislation and Policy	98	2	8	32	9	1	0	0	**150**
Security Breaches	44	12	10	75	3	5	1	0	**150**
Slips, Trips and Falls	93	4	16	8	2	0	1	1	**125**
Safeguarding Adults	26	21	42	17	11	0	0	0	**117**
Missing/absent service users	77	2	0	12	0	0	0	0	**91**
Death (including suspected suicide)	1	58	12	1	11	2	0	0	**85**
Information Governance Incidents	8	19	10	1	9	10	7	0	**64**
Safeguarding Children	4	10	15	1	0	18	0	0	**48**
Sexual Safety incident	22	1	1	22	0	0	0	0	**46**
IT Related Issues	8	3	9	4	6	1	5	0	**36**
Infection Prevention/Control	10	2	6	1	0	1	0	0	**20**
Total	**1603**	**277**	**728**	**585**	**154**	**60**	**34**	**1**	**3442**

Figure 5 Trust-wide Top 10 most frequently reported incident categories (01/10/2022 – 30/09/2023)

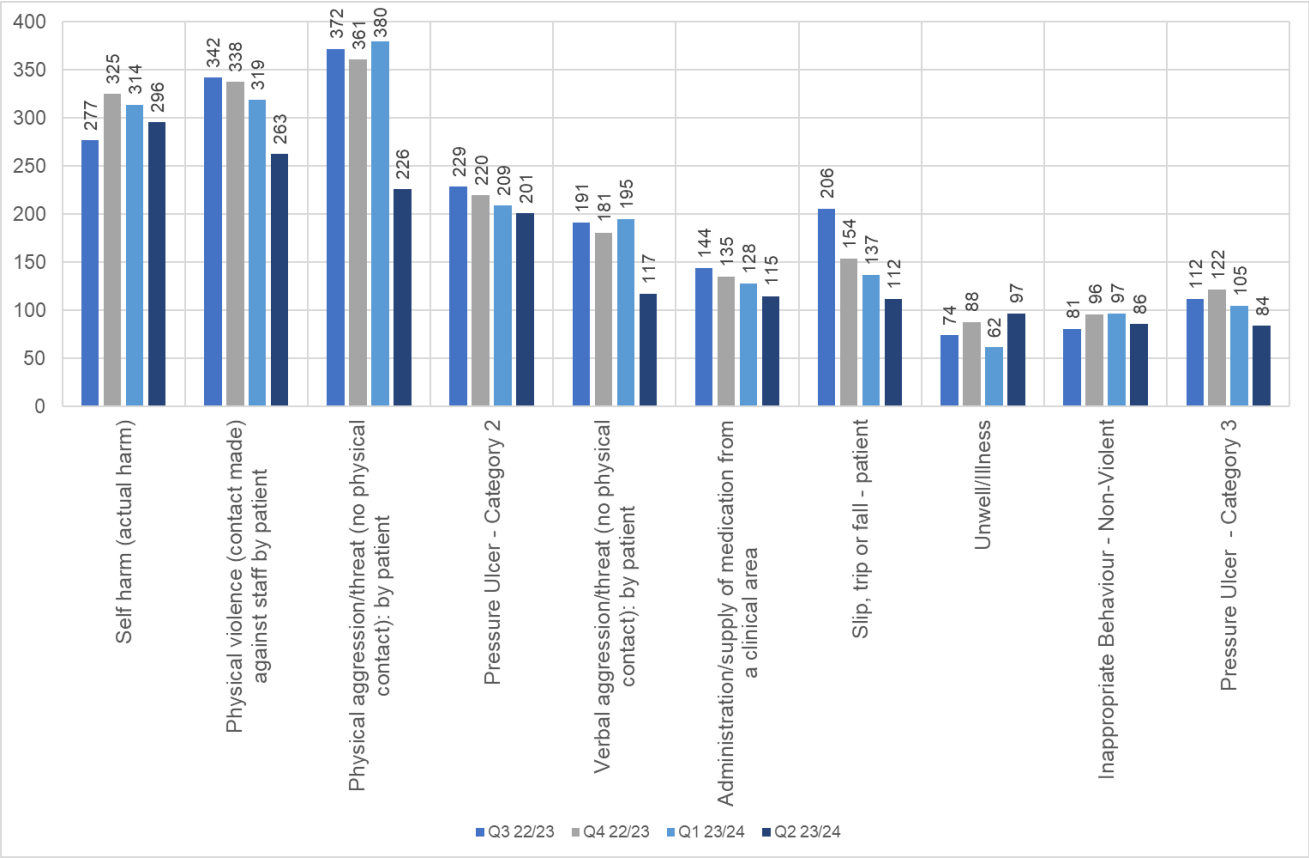


Figure 5 shows that in Quarter 2 2023/24, 'self-harm (actual harm)' was the highest reported category of incidents. This is a change to previous reporting where physical aggression/threat (no physical contact) by patient was the highest reported category of incident. The majority (75%) of the self-harm (actual harm) incidents reported in Q2 were spread across 4 inpatient wards. 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.

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

The third highest category of incident is 'physical aggression/threat (no physical contact) by patient'. 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. There has been a significant reduction overall in Q2. However, this varies across teams, with some seeing increases (often due to individual patient presentation) and other areas have reduced.

Category 2 Pressure ulcers remain in the top 10 reported incidents, and analysis of these incidents shows that 62 of the 201 incidents developed under the care of the Trust (31%). Of the remaining 139 incidents, 134 incidents developed under other providers' care (care home/acute hospital) or in the patient's own home. Five 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. This is similar with Category 3 pressure ulcers; of the 84 incidents, 37 developed under the care of the Trust (44%), and 45 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 has continued to reduce in the last three 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[2] (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 have LFPSE compliant software installed on our Datix live system by the end of September 2023.

The upgrade to the live system with the enhanced LFPSE functions took place on 24/09/2023. Following the upgrade we are working on the transition to LFPSE - this will be implemented following thorough testing. Information for staff is being prepared.

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[2] 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.

In Quarter 2, 1840 incidents were reported to the National Reporting and Learning System compared to 2124 in Quarter 1 2023/24.

3. Learning from incidents

This section of the report provides links to our summary of learning examples in Quarter 2 2023/2024. This is a recent 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 2 2023/2024. The full set of slides are available here. Previous reports are also available on this page.

SIRAN

Royal College of Psychiatrists carried out recent peer reviews and have announced that South West Yorkshire Partnership NHS Foundation Trust have been referenced in the aggregated report due to be published in late September 23 for demonstrating good practice.

The examples of good practice included in the report are below:

Section	Example
Incident review processes	The Trust ensures all reviews are undertaken by trained medical reviewers who have an allocated weekly session dedicated to undertaking SI reviews. The Trust can also access trained bank reviewers to ensure extra capacity when needed.
Involvement of clinical staff	There is a very positive attitude around staff involvement in review processes. Staff are included in and kept informed of the progress of SI reviews. In particular, the three stages of meetings (set up meetings, post incident meetings and the learning events, in addition to individual staff interviews) appeared to be very helpful to staff.

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

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." [4]

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*[5].

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

National Update

The NHS Patient Safety Strategy[6] 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**)

[3] 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).

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

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

[6] 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 91% 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.

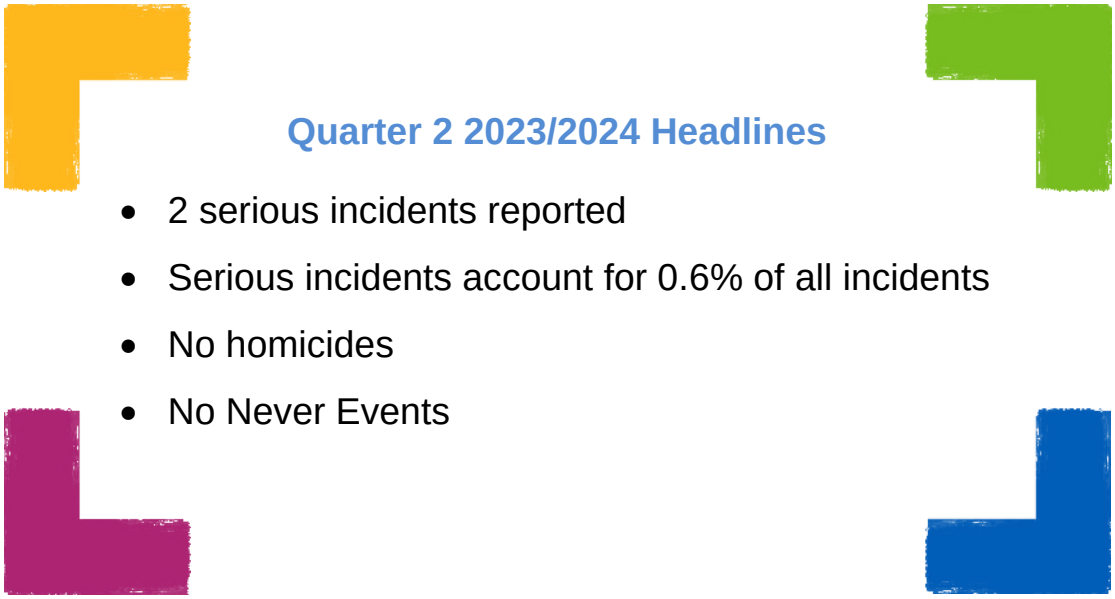
Investigations

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 2 2023/2024

Headlines

During Quarter 2 2023/24, there were **two 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.



Never Events[7] 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.

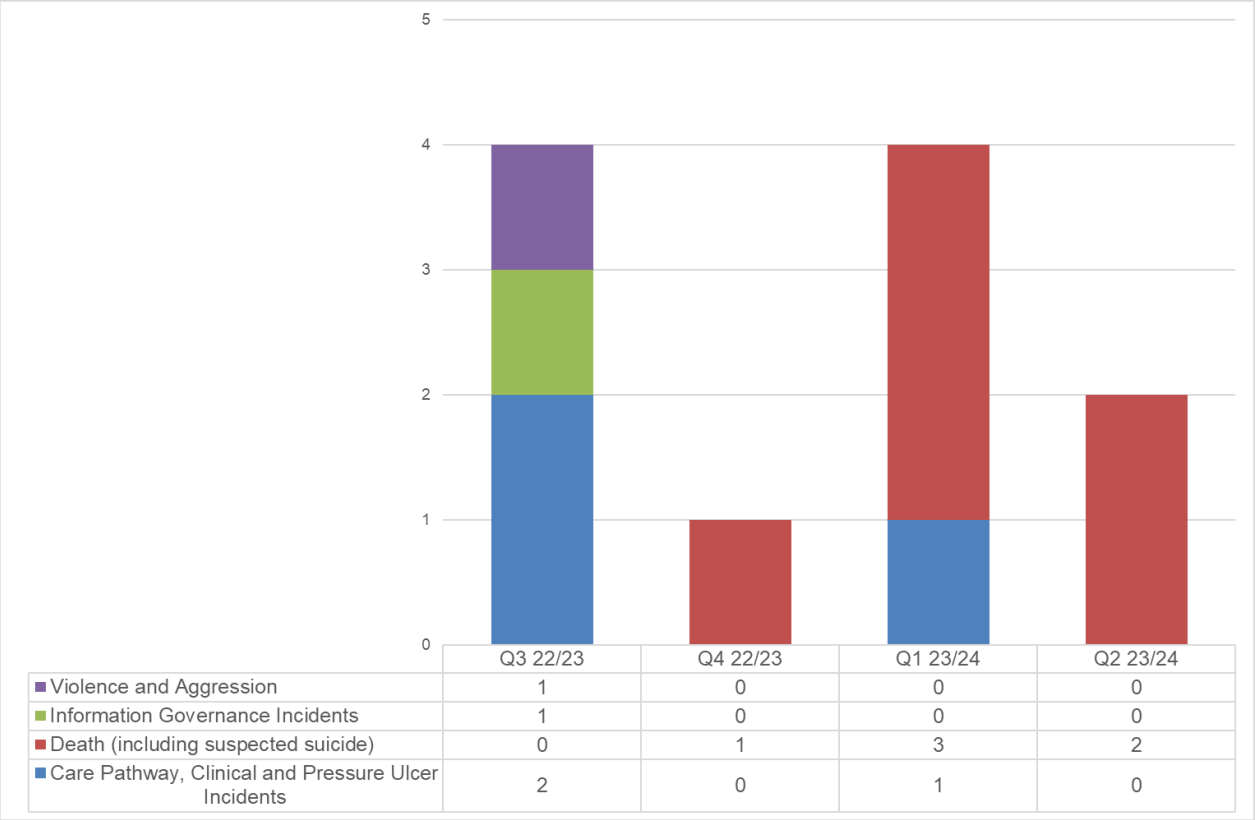
Figure 6 Serious incidents (StEIS) reported to commissioners by financial year and quarter up to 30/06/2023 (2019/20 – 2023/2024)

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	2
Quarter 3	8	8	8	4	
Quarter 4	15	6	1	1	
Total	47	32	22	15	6

Figure 7 shows a breakdown of the 11 serious incidents in a rolling 12-month period (01/10/2022 to 30/09/2023) 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.

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

Figure 7 Types of All Serious incidents reported on STEIS in the 12-month period (01/10/2022 – 30/09/2023)



	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
Violence and Aggression	1	0	0	0
Information Governance Incidents	1	0	0	0
Death (including suspected suicide)	0	1	3	2
Care Pathway, Clinical and Pressure Ulcer Incidents	2	0	1	0

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 Q2 2023/2024

	Barnsley Integrated Care Group	Forensic Services Care Group	Total
Johnson Ward Rehab (Newton Lodge)	0	1	1
Enhanced Team East - Lundwood, Barnsley	1	0	1
Total	1	1	2

Figure 9 Serious incidents reported by category and care group during Q2 2023/2024

	Barnsley Integrated Care Group	Forensic Services Care Group	Total
Death - confirmed from physical/natural causes	0	1	1
Suicide (incl apparent) - community team care - current episode	1	0	1
Total	**1**	**1**	**2**

Serious Incident Investigations completed during Quarter 2 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 2 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
- **6** SI investigations closed by the commissioners
- **8** SI investigations remained under investigation (as at 04/10/2023)
- From the completed investigations, the top action themes were:
  1 Staff education, training & supervision
  2 Record keeping

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 8 investigations that are underway (as at 04/10/2023), these are at different stages of progress. This is reported weekly into Clinical Risk Panel and progress is monitored at the weekly investigator meeting. One of the 8 cases under investigation remain within the 60 working day timeframe. The other seven 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 2 2023/24, five investigations were completed and sent to commissioners. There were 16 separate actions made to improve the system or process to prevent recurrence. There was one investigation sent to commissioners with no action plan, this is currently outstanding (at the time of writing this report) with the Care Group. Four of the investigations took longer than the 60 working days to complete and one was completed within the 60 working days.

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.

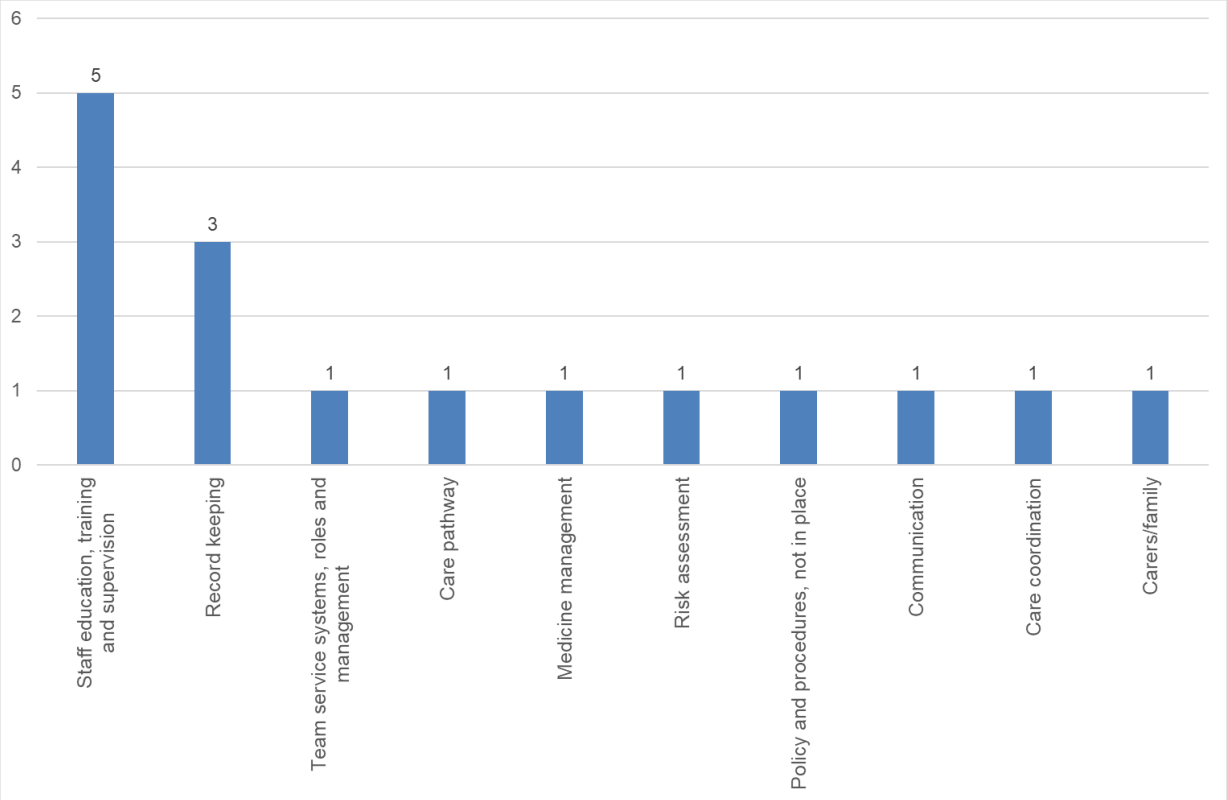
Categorisation of recommendations/actions

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.

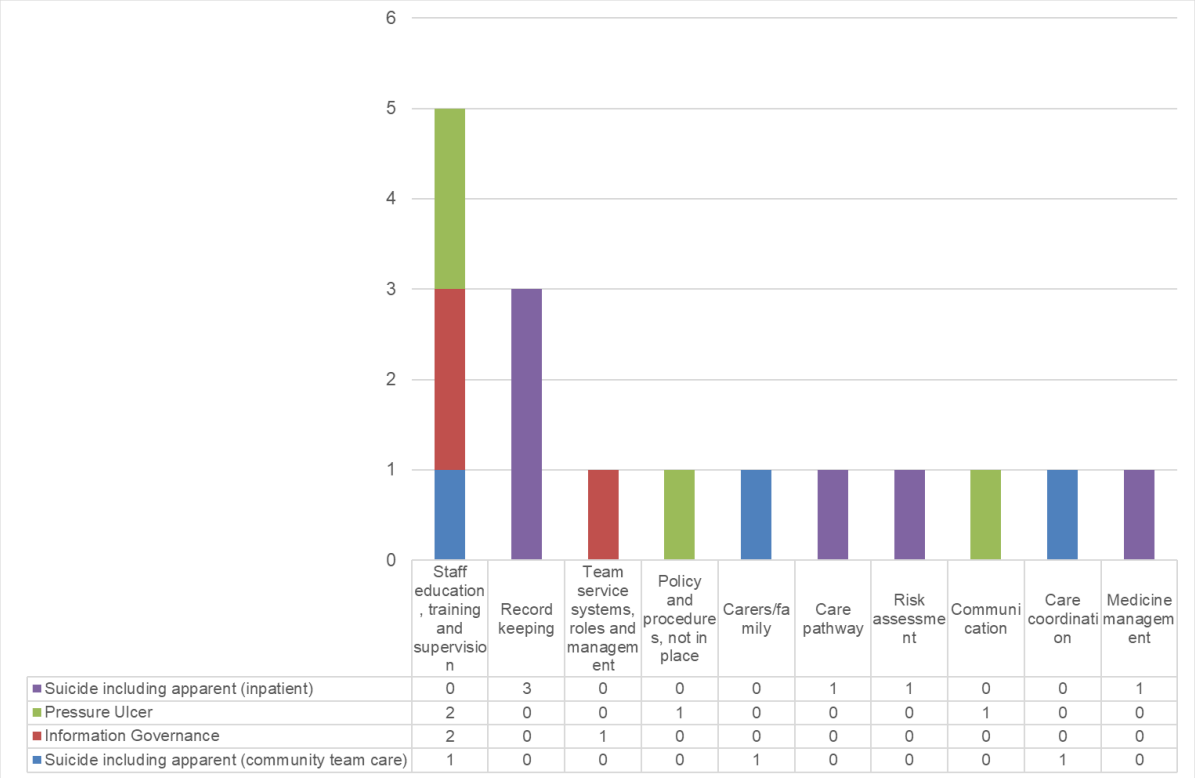
Figure 10 shows the action themes arising from the four of the five serious incidents completed and sent to commissioners during Quarter 2 2023/2024.

Figure 10 Quarter 2 2023/2024 completed Serious Incident investigations, by action theme.



As shown in Figure 11, 9 of the actions came from investigations into apparent suicides (two cases). The themes from these are shown in the graph.

Figure 11 Comparison of action themes from completed Serious Incident investigations in Quarter 2 2023/2024, by action theme and serious incident type.



	Staff education, training and supervision	Record keeping	Team service systems, roles and management	Policy and procedures, not in place	Carers/family	Care pathway	Risk assessment	Communication	Care coordination	Medicine management
Suicide including apparent (inpatient)	0	3	0	0	0	1	1	0	0	1
Pressure Ulcer	2	0	0	1	0	0	0	1	0	0
Information Governance	2	0	1	0	0	0	0	0	0	0
Suicide including apparent (community team care)	1	0	0	0	1	0	0	0	1	0

Top themes this quarter:
An overview of recommendations from serious incident investigations completed in Q2, are detailed below by action theme:

Staff education, training, and supervision	
Tissue Viability and Associated Practices	To be reinforced at Neighbourhood Nursing team meetings, Integrated team meetings and via ongoing training An audit tool to be developed to enable targeted audits of compliance with the Wound Care Policy
	Initial training to be provided to new starters within the Care Group Regular training to be provided to Neighbourhood Nursing teams, tailored to their needs, by the Tissue Viability Team link nurse Periodic training events in various aspects of wound care offered by the Tissue Viability team
Induction	To ensure that the local induction reflects the need for staff on placement or working within the service, to disclose any prior knowledge of a service user to the ward manager. To reduce the risk of staff being on placement where there is a risk of personal connections between themselves, and service users and alternative provisions can be made in a timely manner once risk is identified.
Information Governance	Staff to be trained to recognise an IG breach that needs to be reported. To reduce the risk of IG breaches being missed, and the appropriate actions being taken to mitigate harm from them in a timely manner. This would also ensure that the Trust adherence to statutory responsibilities continued.
Safeguarding	It is recommended that when safeguarding concerns are raised in an inpatient setting that these are communicated with the community team so that assurances can be made that the safeguarding issues have been resolved and/or give the community team the scope to explore any outstanding actions.

Record keeping	
NEWS chart	The service to ensure that staff are aware of the appropriate completion of contemporaneous paper NEWS charts and that the monitoring of these charts is included within a schedule of monitoring and assurance checks.
	The service to continue to work with system developers to expedite the trial of electronic NEWS recording and reduce duplication of work.
Clinical Record Keeping - The System	The service should ensure that all staff are aware of the minimum standards for patient identifiable information when completing clinical records.

Team service systems, roles and management	
Other	To ensure that contact details are in place for both daily operational management and to support operational human resources and holding this information would allow for PIPOT referrals where appropriate.

Care pathway	
Care pathway	The Trust should ensure that in-patients who trigger for COVID-19 treatment should be assessed and considered for treatment or escalated to appropriate other services for treatment

Medicine management	
Other	Staff should be reminded that consideration for alternative medication formats should be made consistently when it is observed that a patient is having difficulties swallowing and/or having difficulties taking their prescribed medications.

Risk assessment	
Risk Assessment and Management	Staff should be reminded that choking risk assessments should be completed for patients when they initially present with swallowing difficulties.

Policy and procedures, not in place	
Standard operating procedures	Discussion with the Care Group Senior Leadership and Management Team to determine the feasibility of developing a standard operating procedure to define when a non-registered staff member can perform an initial visit and how soon/how often this should be followed up by the District Nursing Sister or a registered member of the team.

Communication	
Inadequate handover between practitioners	To be discussed at Integrated Team meetings

Care coordination	
Allocation of care co-ordinator	It is recommended that the enhanced community team review the process in place for when staffing pressures impact on allocation to care co-ordination at the point of inpatient discharge planning – consideration should be given to the role of the Team Duty worker and early rotational attendance at the inpatient MDT meetings – any changes to the management of staffing pressure within community teams that help create improvements in practice should be shared across the Trust.

Carers/family	
Engagement of family/carers	It is recommended that family and carers are proactively engaged at key points throughout the journey with mental health service, in order that the Trust Charter and family engagement work is visible and championed across team discussion and decision making.

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 Autumn, 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 in late 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 – 30/9/2023)

5.1 Background context

5.1.1. Introduction

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 are held quarterly. This meeting facilitates the dissemination of good practice around learning from deaths with sharing of processes that other trusts have in place to review deaths and improve care.

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[8] 2023/2024 covering the period 1/4/2023 – 30/9/2023

Figure 12 Summary of 2023/2024 Annual Death reporting by financial quarter to 30/9/2023

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[9]	2918	539	471			1010
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	379	94	98			192
3	Total Number of deaths which were in scope	253	71	75			146
4	Total Number of deaths reported on Datix that were not in the Trust's scope	126	23	23			46

As shown in Figure 1, row 2 shows that 98 deaths were reported on Datix during Q2 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 a Statistical Process Control chart of all reported deaths (by reported date) between 1/4/2021-30/9/2023. Reporting rates have been checked and remain within the normal variation, within an SPC chart. This demonstrates there has been no increase outside of the anticipated parameters. There are no areas of special cause variation that require further exploration at this time.

[8] 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 – 30/9/23 by date reported.

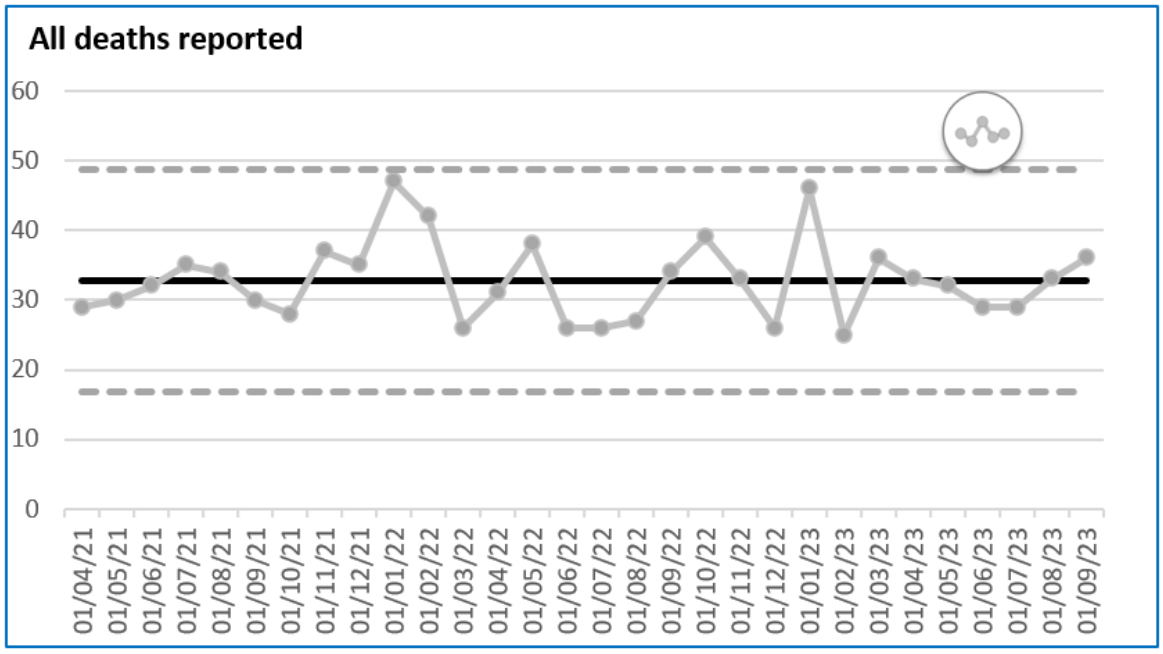


Figure 14 Breakdown of the total number of in scope deaths reviewed in 2023/2024 by care group by financial quarter.

Financial quarter - date reported	Barnsley Integrated Care Group	Adults and Older People Mental Health Care Group (community)	Adults and Older People Mental Health Care Group (inpatients)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	CAMHS and Children services	Total
2023/2024 Q1	19	40	3	8	1	0	**71**
2023/2024 Q2	9	53	2	10	0	1	**75**
2023/2024 Q3							
2023/2024 Q4							
Total	**28**	**93**	**5**	**18**	**1**	**1**	**146**

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 reported	Level 1: Certified	Level 2: Case note review			Level 3: Investigation		Total
	Death certified	Manager's 48-hour review	Structured Judgment Review	Case Note review (PSST)	Serious Incident Investigation	Learning Disability Death process (LeDeR[3])	
2023/2024 Q1	25	27	8	0	3	8	71
2023/2024 Q2	24	34	4	2	1	10	75
2023/2024 Q3							
2023/2024 Q4							
Total	**49**	**61**	**12***	**2**	**4**	**18***	**146**

*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 Q2 (n=75). 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

As of 2021 LeDeR stands for Learning from Life and Death Reviews. The programme was previously known as the Learning Disabilities Mortality Review. The LeDeR work originated from the Confidential Inquiry into the Premature deaths of people with Learning Disabilities (CIPOLD). Information available here: https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

The death of any patient with a Learning Disability has to be reported to LeDeR. It should be noted that the figures may not tally with the figures above by care group. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for. Figure 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)	Reported on LEDER by another organisation	Total
2023/2024 Q1	9	0	9
2023/2024 Q2	9	1	10
2023/2024 Q3			
2023/2024 Q4			
Total	**18**	**1**	**19**

Of the 10 Learning Disability deaths which were reported to LeDeR during Quarter 2, all had the Manager's 48-hour review completed.

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 to the end of Quarter 2 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	Case Note Review	Serious Incident Investigation	Total
2023/2024 Q1	25	27	7	0	3	**62**
2023/2024 Q2	24	34	4	2	1	**65**
2023/2024 Q3						
2023/2024 Q4						
Total	**48**	**61**	**11**	**2**	**4**	**127**

Inpatient deaths

Figure 7 below shows that over the year 2023/24 to the end of Quarter 2, there were seven 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.

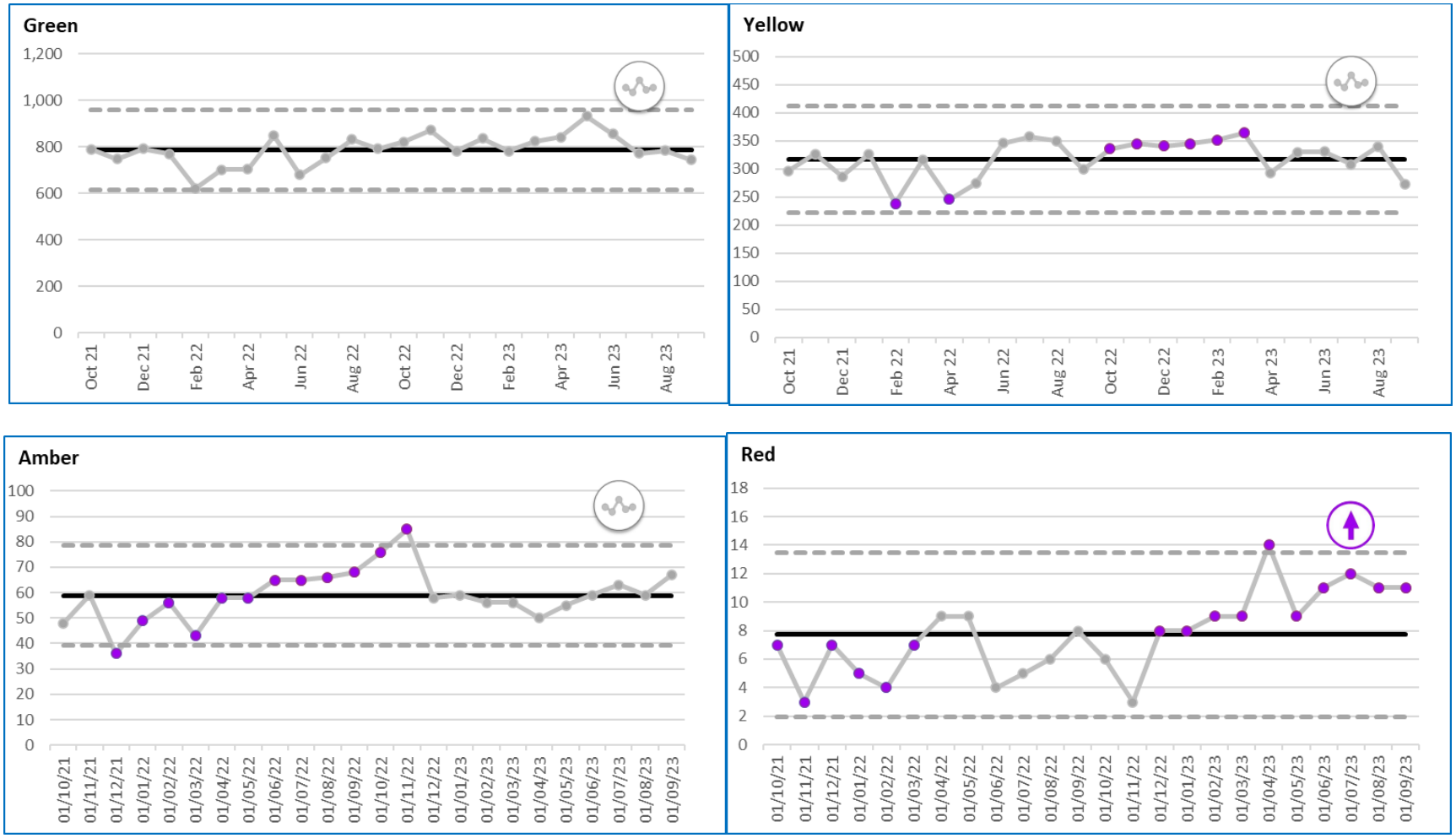
Care Group	Ward	Financial quarter - date reported				Total
		2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	
Adults and Older People Mental Health Care Group (Inpatient)	Beechdale Ward, The Dales Unit	1	1			**2**
	Ward 19 (OPS)	1	0			**1**
	Ashdale Ward	1	0			**1**
	Poplars Unit	0	1			**1**
Forensic Services Care Group	Johnson Ward	1	0			**1**
Barnsley Integrated Care Services Group	Stroke Unit	1	0			**1**
Total		**5**	**2**			**7**

5.3 Next Steps

Our 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 are reviewing our Learning from Deaths policy to reflect the upcoming implementation of the Patient Safety Incident Response Framework.
- We have re-established the Mortality Review Group from 23 October 2023, which will meet quarterly.

Appendix 1 – Statistical Process Control charts for all incidents reported Trust wide between 01/10/2021 – 30/09/2023 by severity



Graph 4 (red incidents) shows that there has been an upwards trend 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.

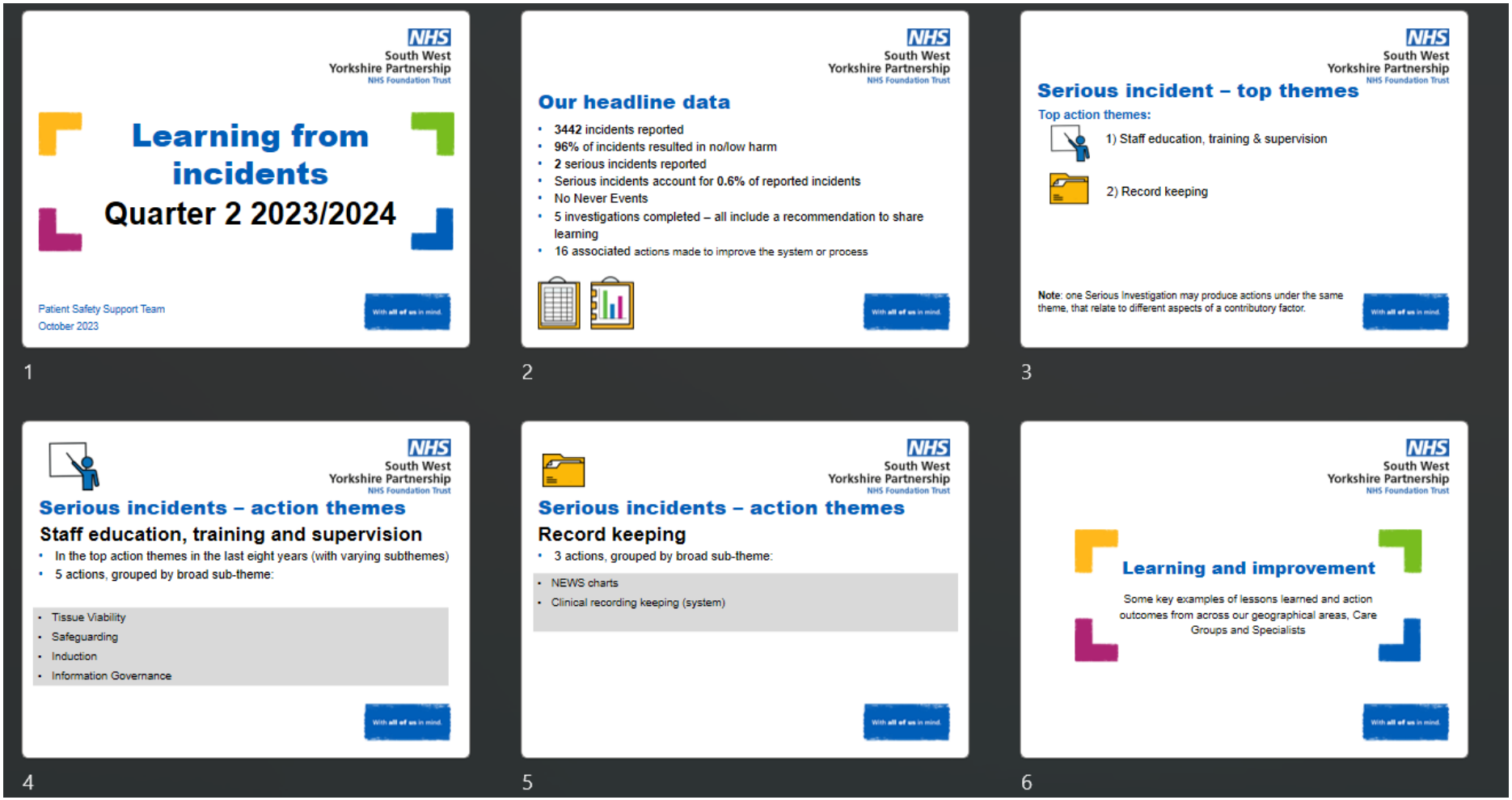
Appendix 2 – Learning Library summaries Quarter 2 2023/2024

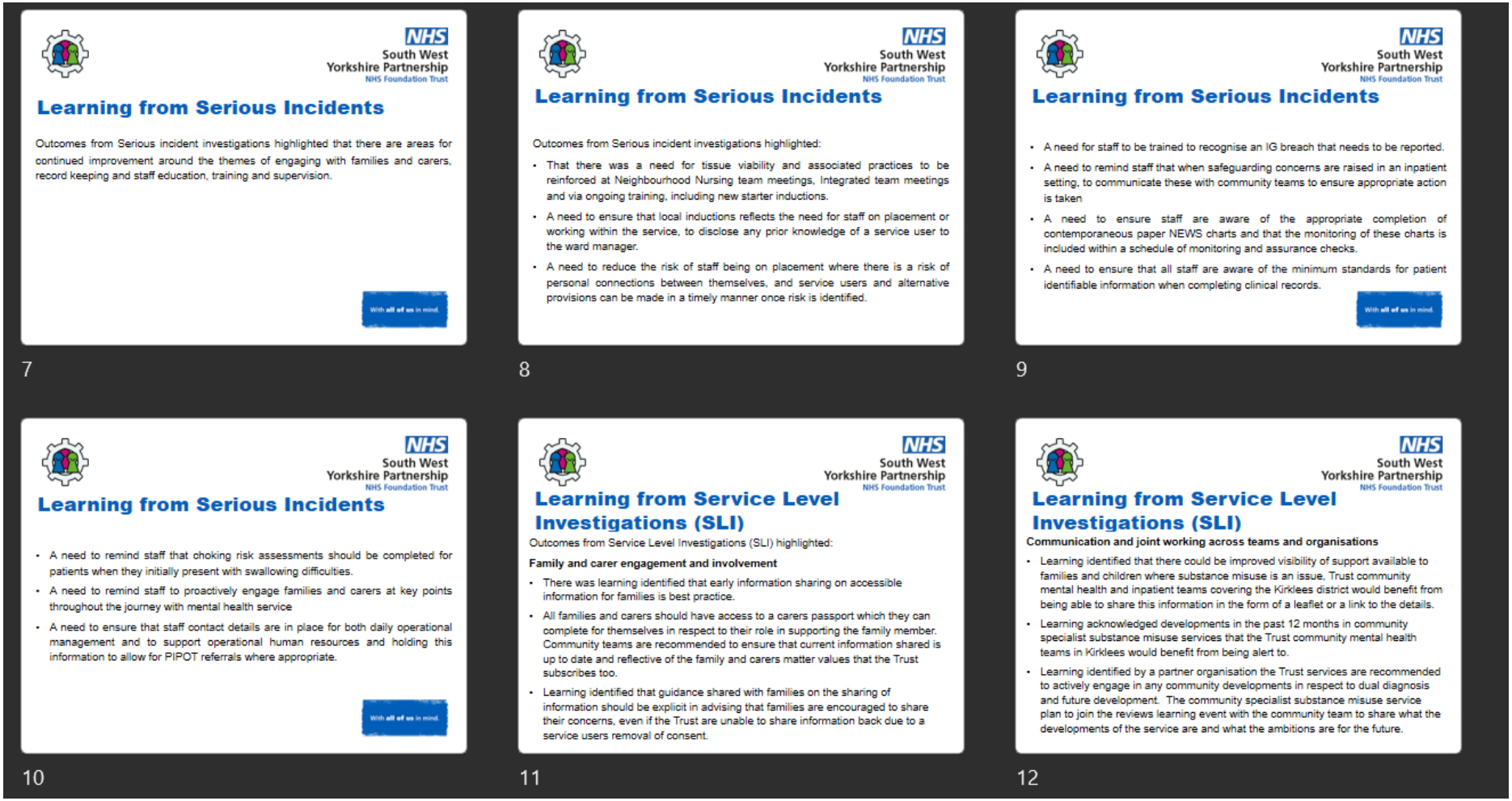
Title	Summary
SBAR Older People as victims of domestic abuse	The Trust Safeguarding Team have seen a year on year increase in incidents involving domestic abuse and have recently been involved in a domestic homicide review involving older people. An initial learning from the review supports the research where professionals did not demonstrate professional curiosity and tended to believe that domestic abuse does not occur amongst older people.
SBAR Inpatient leave and physical health and mobility review	A service user has been granted leave from a ward with a staff member escort. This was part of the service user pre-discharge support plan. It was assessed that the service user had differing mobility needs when on the inpatient ward and off the ward. Section 17 leave has been assessed and granted regarding mental health needs. The differing mobility needs were not fully appreciated, and the service user has fallen and fractured their elbow.
SBAR Incident related to pressure area care	A serious incident investigation highlighted learning for nursing teams caring for individuals with pressure related damage. Patient discharged to neighbourhood nursing service with new pressure damage to sacrum. Both areas referred as category 2. No evidence or documentation regarding equipment provision from the acute trust. No documentation to evidence that pressure areas checked at each visit. Wounds deteriorated to category 3 whilst under the care of neighbourhood nursing. Good practice observed by staff in terms of prompt and appropriate action relating to skin deterioration and clinical condition of individual.
SBAR AWOL incidents from inpatient courtyard/garden areas	There have been three recent incidents of service users going AWOL from both acute Working Age Adult and Older People Service inpatient courtyard areas. This communication is to share the key findings identified in the reviews of these incidents and to highlight the recommendations for improvement.
SBAR When falls become a safeguarding concern	A fall can be a safeguarding adult issue when there are concerns that it was caused by abuse, neglect (including self-neglect) or omission, or there are concerns that there was abuse, neglect or omission following the fall. Not all falls will require a safeguarding adult referral, staff will need to consider whether the person is an adult at risk and whether there was abuse/neglect linked to the fall. An adult at risk is defined in The Care Act (2014) as an adult who: • Has needs for care and support (whether or not the local authority is meeting any of those needs) • Is experiencing, or at risk of, abuse or neglect

	• As a result of the care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect
See it, say it, report it, Poster	We've all got a role to play in keeping work environments safe. You can report incidents and activity to: • Your ward manager • Your supervisor • Security • Your local estates and facilities department Remember to complete a Datix

Appendix 3 – Learning from incidents slides

Below is an illustration of our Learning presentation that brings together some of the learning from Quarter 2 2023/2024. The full set of slides are available here along with previous years learning.




NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
Outcomes from Serious incident investigations highlighted that there are areas for continued improvement around the themes of engaging with families and carers, record keeping and staff education, training and supervision.
With all of us in mind
7
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
Outcomes from Serious incident investigations highlighted:
• That there was a need for tissue viability and associated practices to be reinforced at Neighbourhood Nursing team meetings, Integrated team meetings and via ongoing training, including new starter inductions.
• A need to ensure that local inductions reflects the need for staff on placement or working within the service, to disclose any prior knowledge of a service user to the ward manager.
• A need to reduce the risk of staff being on placement where there is a risk of personal connections between themselves, and service users and alternative provisions can be made in a timely manner once risk is identified.
8
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
• A need for staff to be trained to recognise an IG breach that needs to be reported.
• A need to remind staff that when safeguarding concerns are raised in an inpatient setting, to communicate these with community teams to ensure appropriate action is taken
• A need to ensure staff are aware of the appropriate completion of contemporaneous paper NEWS charts and that the monitoring of these charts is included within a schedule of monitoring and assurance checks.
• A need to ensure that all staff are aware of the minimum standards for patient identifiable information when completing clinical records.
With all of us in mind
9
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
• A need to remind staff that choking risk assessments should be completed for patients when they initially present with swallowing difficulties.
• A need to remind staff to proactively engage families and carers at key points throughout the journey with mental health service
• A need to ensure that staff contact details are in place for both daily operational management and to support operational human resources and holding this information to allow for PIPOT referrals where appropriate.
With all of us in mind
10
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Service Level Investigations (SLI)
Outcomes from Service Level Investigations (SLI) highlighted:
Family and carer engagement and involvement
• There was learning identified that early information sharing on accessible information for families is best practice.
• All families and carers should have access to a carers passport which they can complete for themselves in respect to their role in supporting the family member. Community teams are recommended to ensure that current information shared is up to date and reflective of the family and carers matter values that the Trust subscribes too.
• Learning identified that guidance shared with families on the sharing of information should be explicit in advising that families are encouraged to share their concerns, even if the Trust are unable to share information back due to a service users removal of consent.
11
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Service Level Investigations (SLI)
Communication and joint working across teams and organisations
• Learning identified that there could be improved visibility of support available to families and children where substance misuse is an issue. Trust community mental health and inpatient teams covering the Kirklees district would benefit from being able to share this information in the form of a leaflet or a link to the details.
• Learning acknowledged developments in the past 12 months in community specialist substance misuse services that the Trust community mental health teams in Kirklees would benefit from being alert to.
• Learning identified by a partner organisation the Trust services are recommended to actively engage in any community developments in respect to dual diagnosis and future development. The community specialist substance misuse service plan to join the reviews learning event with the community team to share what the developments of the service are and what the ambitions are for the future.
12

Learning from Service Level Investigations (SLI)

Communication and joint working across teams and organisations

- There was learning identified that the Enhanced team assure themselves that collaboration with partner agencies for specialist substance misuse service is inclusive of the Kirklees dual diagnosis service that the Trust provides and that information sharing on developments is disseminated across community teams in Kirklees.
- Learning identified the need to remind staff that a handover needs to be given to all staff regardless of the time they attend to cover the ward or attend for duty.

13

Learning from Service Level Investigations (SLI)

Organisational Learning

- There was learning apparent for all our teams in considering the active review of service users' needs through the Kirklees specialist Psychiatrist and Dual diagnosis specialist and requesting the early opinion and support in care planning pre- discharge from hospital admissions.
- There was identified learning for community teams and community rehab team representation at discharge MDT meetings. A lack of community representation resulted in gaps in information regarding the suitability of a service users property upon discharge.

14

Learning from Service Level Investigations (SLI)

Documentation

- There was identified learning for staff in the CORE team to ensure that all sections of MDT questionnaires are completed, including the section for discharge planning and MDT, as opposed to recording this within progress notes.
- There was identified learning for the Intensive Home Based Treatment Team to ensure 72 hour follows up were documented in line with Trust policy.

Training

- There was learning identified that staff had not received training around completion of observations on Ward 19 and therefore the current observation policy is being reviewed to support staff and provide further guidance.

15

Learning Library

Below is a summary of learning that has been shared through our Learning Library in Quarter 2:

- AWOL incidents from inpatient courtyard areas
- When falls become a safeguarding concern
- See it say it report it poster
- Pressure area care
- Inpatient leave and physical mobility needs review
- Domestic abuse in older people

16

Learning Network

Below is a summary of learning that has been shared at our Learning Network forum: (3rd May)

- Service user enable to sleep on a safety pod in seclusion
- AWOL incident
- Medication error in the community

17

Bluelight alerts

- Servicing of medical devices
- Potential to create an anchor point for a fixed ligature within door frame using a vape lanyard
- Ligature risk from curtains
- Fruit in stones
- Risk of tampering with "lithium type" chargeable battery from service user property

18

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.2

Private/Public paper:	**Public**		
Title:	Environmental and Ligature Risk Assessments Annual Report		
Paper presented by:	Darryl Thompson, Chief Nurse/ Director of Quality and Professions		
Paper prepared by:	Emma Cox, Associate Director of Nursing, Quality & Professions Nick Phillips, Associate Director of Estates & Facilities Supported by Tracey Kitchen, Portfolio Manager Roland Webb, Health & Safety Manager		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre, • We are always improving		
Purpose:	To provide assurance to Board with regards to the Trust's overview and management of ligature risk assessments, and the subsequent action plans developed by Care Groups in response to ligature risk assessments conducted in 2022/23. An update on 2021/22 plans is also provided.		
Strategic objectives:	Improve Health	✓	Please remove as appropriate
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2- Failure to create a learning environment leading to lack of innovation and to repeat incidents Risk 4.3- Failure to support the wellbeing of staff		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	This report is part of the Trust's internal governance structure.		
Any background papers / previously considered by:	An earlier draft of this paper was presented to Quality and Safety Committee on 14 November 2023. It has subsequently been developed with a view to providing greater clarity with regards to the level of assurance provided by the report.		

Executive summary:	The annual environmental suicide and ligature risk assessment and management process is a fundamental element of patient safety operating in the centre of all good health care. A systematic approach to risk assessment and risk management is followed. The 2022/23 audit process was undertaken for 37 separate visit assessments, commencing in June 2022. These included: • 30 visits to 29 mental health inpatient wards (Gaskill ward was visited twice) as a pre 'move-in' visit was requested in March 2022 by Clinical Lead for Forensic Security due to the ward planning to be used to hold service users from low secure as part of refurbishment plans and also visited again in December with the other forensic wards). • Two visits to Section 136 suites (Wakefield 136 suite was included in Walton Ward's assessment) • Two visits to non-mental health wards (neuro rehab and stroke rehab) • Two visits to occupational therapy (OT) areas • One visit to a non-ward area (café area, upper hospital street, corridors and the gym within the Oakwell Centre) We have continued to hold Clinical Environment Safety Group (CESG) meetings, where we maintain oversight of environmental ligature point risk assessments and action plans. The meeting is attended by Care Group representatives, estates colleagues, health & safety officer and directorate of nursing, quality and professions staff. The CESG monitors and evaluates process of assessing, prioritising and mitigating ligature risks across the Trust. The report describes the escalation processes with regards to ligature risks. There has been an increase in reported ligature incidents in comparison to 2021/22, but fewer are reported than 2020/21. The reported increase is associated with a small number of service users predominantly within our female acute inpatient wards. Of note, not all reported ligature incidents result in a person applying a ligature. They can also include reported thoughts of using a ligature, or where a colleague has found equipment that objectively looks like it is present to facilitate a ligature. In addition, the report provides an overview of the Trust's progress with regards to the anti-ligature door replacement programme, the number expected to be installed by the end of this financial year and the work planned for the next financial year. The Trust's ligature risk assessment processes are in line with national expectations. Delays in the ward ligature risk audit process were noted and escalated as required. Of note, going forward improvements have been made to the Trust's oversight of ligature risk assessment and local ligature risk awareness, but this work falls outside of the timescale of this report.

	Risk Appetite Risk identified – the Trust continues to have a systematic and measured approach to ensuring environmental safety. This meets the risk appetite – low and the risk target 1-6. The clinical risk – risk to service user/public safety which is again low risk appetite and a risk target of 1-6.
Recommendation:	**Trust Board is asked to RECEIVE the report and confirm it provides the required assurance.**

South West Yorkshire Partnership NHS Foundation Trust

2022/23
Environmental and Ligature Risk Assessments Annual Report

November 2023

Emma Cox, Associate Director of Nursing, Quality & Professions
Nick Phillips, Deputy Director: Estates & Facilities

Supported by
Tracey Kitchen, Portfolio manager
Roland Webb, Health & Safety Manager

Background

The purpose of the report is to provide assurance to the Board with regards to the Trust's overview and management of ligature risk assessments, and the subsequent actions taken within the Care Groups in response to the conducted ligature risk assessment. The annual ligature and suicide risk assessment and management process is a fundamental element of safety operating in the centre of all good health care. A systematic approach to risk assessment and risk management is followed.

The environmental risk assessment for suicide and self-harm is a component part of comprehensive clinical risk assessment, which includes service user risk assessment, formulation, and care planning. The appropriate use of observation and engagement, including positive risk-taking and environmental risk assessment, support the management of identified risks. The Health and Safety Executive (2004) directed Trusts and directorates responsible for caring for patients and service users who exhibit self-harm behaviour in reducing possible risks associated with potential ligatures and anchor points.

The work is required by the Health and Safety Act (1974) to maintain a safe environment and the Management of Health and Safety at work Regulations 1992 (amended 1998) to carry out risk assessments. The Trust approach is to undertake clinically led inpatient environmental risk assessments with a clinical lead, Health & Safety representative, Estate's representative, a Quality Improvement and Assurance project manager and a third-party clinician from another area (where possible) to act as an objective and fresh pair of eyes.

Assessments take account of the clinical risk assessment of service users and include the buildings and fittings, the items the person has access to, and their ability to form a ligature with such items. There is no way of creating a completely risk and ligature free environment that does not also adversely impact on other key principles of providing mental health care, including privacy and dignity, recovery, least restrictive practice and positive risk taking. Therefore, actions to mitigate risk are based on a balance of clinical, environmental, procedural, and relational safety measures.

Our approach to managing the environment is proportionate and the Trust has a risk-based approach to non-mental health / learning disability ward areas and community facilities. In line with best practice guidance[1], annual environmental suicide and ligature point risk assessments are also completed in out-patient waiting areas where mental health and / or learning disability service users attend.

Process

Ward/unit managers of bed-based services and other units or areas identified for assessment by the Chief Operating Officer or Clinical Environment Safety Group (CESG) are responsible for ensuring that:

[1] *NHS Confederation and NPSA (2011). Preventing suicide: A toolkit for community mental health services.*

- An annual environmental suicide and ligature point risk assessment is undertaken for their area of responsibility and returned to the service/general manager for sign off within the Care Group process.
- Following the assessment, the estates and facilities department is contacted immediately about any issues of immediate concern. The Clinical Environment Safety Group oversees responses to requests for estates support, ensures that these concerns are addressed in a timely manner, and that interim controls are actioned to manage the identified risk.

The Estates Trust Action Group (TAG) receive and review information from the Clinical Environment Safety Group (CESG), Care Group Directors (via the Care Group Director representative) following the annual environmental suicide and ligature point risk assessment and develop a prioritised programme of work for ligature point removal based on a clinical risk assessment. The Chief Nurse / Director of Quality and Professions or their Deputy, are responsible for reviewing and updating the ligature risk policy with advice and support from the patient safety support team and portfolio managers, if any aspects of the policy require changing prior to the review date.

In addition, the CESG monitor progress in completing assessments, achieving remedial actions and considering any related issues. The group will also advise on actions where an estates solution is not possible or desirable and mitigation is required.

The 2022/23 audit process was undertaken for 37 separate visit assessments, commencing in June 2022. These included:

- 30 visits to 29 mental health inpatient wards (Gaskill ward was visited twice) as a pre ‘move in’ visit was requested in March 2022 by the Clinical Lead for Forensic Security due to the ward planning to be used to hold service users from Low Secure as part of refurbishment plans, and it was also visited again in December with the other forensic wards).
- Two visits to Section 136 suites (Wakefield 136 suite was included in Walton Ward’s assessment)
- Two visits to non-mental health wards (neuro rehab and stroke rehab)
- Two visits to occupational therapy (OT) areas (Priestley OT room was not visited, due to the area only covering one room where service users are constantly supervised and the area being assessed as very low risk)
- One visit to a non-ward area (café area, upper hospital street, corridors and the gym within the Oakwell Centre)

Any areas of ligature risk identified were referred to estates, and appropriate and local risk mitigations were put in place where required. Occasionally, where there was a ligature risk caused by damage the product was replaced immediately during the audit, and where estates were present on the unit at the time of the audit the risk was removed or fixed with immediate effect.

Update on the next steps that were identified in the 2021/22 report:

Action	Progress
Review Clinical Environment Safety Group (CESG), to continue to ensure regular and reliable updates are provided to Executive Management Team (EMT) and Quality and Safety Committee (QSC) (formerly Clinical Governance Clinical Safety Committee) throughout the year.	These have taken the form of a progress updates to EMT and QSC, with regular updates planned to continue to both EMT and QSC.
Exception reports will be provided, and ligature risk action plan spreadsheet updated ahead of CESG meetings	Complete
Continue to monitor all large-scale remedial work	Complete for 2022/2023 and ongoing
Care Group environmental suicide and ligature risk assessment leads to ensure their managers continue to monitor action plans and outstanding work throughout the year, escalate concerns and risks as required and mitigate in the interim	Complete
Complete 2021 annual environmental suicide and ligature risk assessment by 31st December 2022	Complete, albeit the process overran, and five mental health wards were assessed during January and February 2023
Submit annual report for Quality and Safety Committee November 2023	Complete
Complete the 2021 review of out-patient ligature risk assessment by 31st December 2022	The community assessment process overran and due to staff sickness in the QIA team some teams are yet to be assessed. This was escalated to CESG. A quality improvement project was initiated, where the action plan will be incorporated in to the 2022/2023 report
Collaborate with partners and suppliers to seek solutions to high level risks where none currently exist	Complete
Align work of CESG with the Trust suicide prevention plan including updated workplace health and safety risk assessment for self-harm and suicide.	Complete
Review environmental suicide and ligature risk assessment policy and update by 31st December 2022.	Complete but later than planned. The original review was completed within timeframe however a further review was required to include debriefs and further detail. The policy was submitted to and approved by EMT in November 2023.
Ensure that we maintain a centralised function of oversight of ligature assessment and management.	Complete
To be an active member of the Royal College of Psychiatry / National Collaborating Centre for Mental Health.	Complete

Work undertaken in 2022/23

Support for staff:
We know that when a member of staff is supporting a person who ligates it impacts both them and the broader team significantly. The Trust recognises that staff can be physiologically and emotionally affected by suicide and self-harm, both in work and outside of the workplace. Debriefs and initial support are a routine offer for affected teams. The Trust intranet pages have also been refreshed and updated to provide information about:

- support for people who have been affected by suicide, including our staff
- how our Trust is working to reduce the loss of life by suicide - our suicide prevention strategy
- training opportunities in suicide prevention strategies
- details about our suicide prevention champions for additional support
- resources and information

In addition, our Occupational Health (OH) service is also available to affected colleagues to offer support.

In 2022/23 the Trust's Health and Safety Manager has led two awareness session with the inpatient matrons covering ligature audits and the Trust process. These were well received, and two additional sessions are being arranged for ward managers and the Acute Care Forum members in Q4 2023/24.

Trust Policy
A bank investigator with substantial clinical and managerial experience was appointed to work collaboratively with front line clinicians and health and safety colleagues to review the environmental suicide and ligature risk assessment policy. The policy includes the updated audit tool that was introduced following the Care Quality Commission (CQC) feedback to partners nationally. This is with regard to ligature risks rated as 'low' in high-risk areas where service users are not regularly observed such as bedrooms and bathrooms, and the concern that these were de-prioritised solely based on the height of the ligature point. In April 2021, the Clinical Environment Safety Group discussed these concerns and decided the same score (3) is to be given to lower height ligature points as the higher ligature points in unobserved areas. The group also agreed to increasing the room scoring for bedrooms/ensuites/unaccompanied bathrooms and toilets on wards to 5 (from 3).

The Trust also includes an additional overall 5% risk weighting score for higher risk wards that experience significantly more ligature incidents, typically female inpatient wards. The policy is due to be presented to the executive management team in November 2023. An extension was agreed to ensure all learning from the CQC inspections in May 2023 could be incorporated into the policy. This audit tool has been used for the 2022-23 programme of visits.

Clinical Environment Safety Group

The Trust has continued to hold the Clinical Environment Safety Group (CESG) meetings. It is acknowledged that it has proactive attendance from clinicians and health and safety representatives (with support from estates) to support an effective collaborative approach throughout the Trust. Environmental suicide and ligature point risk assessments and action plans are considered in the CESG, which meets approximately every six weeks and is chaired by the Deputy Director of Nursing, Quality and Professions and attended by Care Group representatives, Estates staff, Health & Safety Officer and Quality and Professions staff. The CESG monitors and evaluates the process of assessing, prioritising, and mitigating ligature risks across the Trust. The schedule of meetings have continued vis MS Teams.

The CESG developed an updated audit tool following the national Care Quality Commission (CQC) concerns (highlighted previously).

- Ligature risks continue to be rated on the type of ward (acute, rehab), room designation (bedroom, day room), height of ligature (please note earlier comment about the vigilance for low height ligature points) and compensatory factors (factors that decrease risk, e.g., staff observations).
- The original tool was introduced into the Trust in 2017 and is just one element of our overall approach to assessing and managing environmental risks that includes an annual review of ligature incidents reported on DATIX (see below), personalised clinical risk assessment and formulation, and environmental, procedural, and relational safety measures. If there is a ligature point risk, then action is always taken as per policy to either:
    - Remove
    - Protect
    - Locally manage, that is
        i. The ligature point is of a nature that the audit team, supported by the service manager, believe it is unnecessary to remove it, OR
        ii. There is no technical solution to the problem, e.g., some door hinges, bedroom doors, OR
        iii. There is a need to acknowledge and retain the risk because the risk of another potential injury is greater, if it is removed, than that associated with a ligature risk e.g., grab rails within an older person's toilet.
        iv. Where a risk is to be locally managed, consideration should be given to placing this on the local risk register.

The updated audit tool continues to reflect higher risk wards and specific areas noted for higher risk of ligature incidents, specifically female wards, bedrooms, en-suites, or other private areas and makes it even more clear where remedial action or staff awareness should have specific focus. Bedrooms, en-suites or other private areas score a "5" on the tool and wards deemed as higher risk also have an overall 5% uplift in scores as previously described in the report. Please see below for a recent breakdown of ligature incidents recorded in 2022/23 (N.B. not all using an environmental ligature point). This highlights the greater prevalence of ligature events on our female wards (Clark, Elmdale and Nostell). Non-environmental self-strangulation is being reviewed within the 2023/24 Patient Safety Incident Response Framework (PSIRF) suicide prevention quality improvement workstream.

	Hanging - self injury	Self-strangulation - self injury	Total
Elmdale Ward	21	122	143
Ward 18, Priestley Unit	12	92	104
Nostell Ward, Wakefield	15	74	89
Ashdale Ward	4	45	49
Clark Ward - Barnsley	5	32	37
Newhaven Forensic Learning Disabilities Unit	2	15	17
Stanley Ward, Wakefield	1	12	13
Melton PICU, Barnsley	3	9	12
Hepworth Ward, Newton Lodge, Forensic	0	8	8
Horizon Centre Assessment and Treatment Service	0	6	6
Beamshaw Ward - Barnsley	0	6	6
Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale	3	3	6
Enfield Down Residential Service, Honley	0	5	5
Live Well Wakefield	4	0	4
Sandal Ward (Bretton Centre)	1	3	4
136 Suite - Calderdale	0	3	3
Poplars Unit, Wakefield	0	2	2
Bronte Ward, Newton Lodge, Forensic	2	0	2
Chippendale, Forensic	0	2	2
Intensive Home Based Treatment Team (IHBTT) - Barnsley	1	1	2
Calderdale Community Learning Disability Team	1	0	1
Psychiatric Liaison Service, Wakefield	0	1	1
Police Liaison Team (Wakefield)	0	1	1
CAMHS (Barnsley)	1	0	1
Mental Health Liaison Team (RAID) - Calderdale and Kirklees	0	1	1
Core Team South - Kirklees	1	0	1
136 Suite - Unity Centre, Wakefield	0	1	1
Legal Services Team	1	0	1
Forensic Outreach Liaison service (FOLS)	0	1	1
Crofton Ward (OPS), Wakefield	0	1	1
CAMHS - Calderdale	0	1	1
CAMHS ReACH Team (Crisis Team), Wakefield	0	1	1
Talking Therapies (High Intensity) Kirklees	1	0	1
Thornhill Ward (The Bretton Centre)	0	1	1
Willow Ward - Barnsley	0	1	1
Enhanced Outreach Team	0	1	1
136 Suite - Barnsley	0	1	1
Enhanced Team South 1 - Kirklees	0	1	1
Total	**79**	**453**	**532**

Of note, the data includes all reported incidents (self-harm by self-strangulation, suspended ligature or reported concerns of unconfirmed and threatened use of a ligature) reported on Datix. For example, the incident reported by the legal team involved identifying a potential ligature attached to a tree in the hospital grounds, and teams report incidents where a service user may inform a practitioner that they had thoughts of using a ligature but these may be not actually undertaken.

Out-patient areas and hubs

Some of the environmental suicide and ligature point risk assessment reviews in 2022/23 were impacted due to COVID-19 outbreaks. The Trust continues to apply a robust risk-based approach to non-ward areas and managing community environment settings continues to take place. Originally, premises scores were typically around “18”, based on the Manchester Audit tool, reflecting the relatively low risk of service users accessing these areas.

The Manchester audit focuses on five dimensions: room designation, patient profile, ligature point rating, type of ligature point and compensating factors. A score of 18 would be considered to be a relatively low risk due to staff being in the area, the skill mix and the patient profile.

Summary from ward assessments completed in 2022/23

The 2022/23 ligature assessments have taken place across all ward areas, except the Priestley OT room. Oversight and management of the action plans remain with the Care Group operational managers and are reviewed at the local Care Group governance group and the Trust Clinical Environment Safety Group (CESG). Additionally, the audits are shared with both regular and bank/agency ward staff. Care Group governance group sign off was obtained for all 29 mental health wards and all three 136 suites. However, it has been noted that the process overran the time frame requested of 31 December 2022. Twelve of the visits were not conducted until quarter 3, although no significant risk areas were impacted from the overrun. This was noted in the CESG and is being followed up with a revised process to ensure timely completion going forward and the process and role responsibilities will be added into the new training programme (described later in the report). Progress against ligature assessments and against the action plan was presented to EMT in September 2023.

Summary of the door replacement programme

The Clinical Environment Safety Group also maintains oversight of the door replacement programme. In 2017 two doors were considered as part of a trial at the Oakwell Centre. As part of the 2018/19 capital programme, it was approved by the Operational Management Group (OMG) and the Executive Management Team (EMT), to roll out the preferred option of door thus providing staff on all inpatient wards with the same model of door, which increases safety as staff work across the Trust. In addition, the increased strength, enhanced anti-barricade function and ligature detection system substantially improve service user safety. To date the Trust have replaced all the doors at the Oakwell Centre and continued work is taking place to replace the doors at Fieldhead Hospital in both forensic services and adult working age mental health inpatient wards.

The background to this programme of work is that it was identified that different types and standards of door were in use throughout the Trust. These doors were a combination of ages and some were constructed in accordance with earlier standards, had had various

modifications done to them or were reaching end of life due to use, damage etc. Technology around doors had improved to the extent that they could link to our call systems and register if weight was put on the door indicating an attempt to ligate. The latest advances include the ability to distinguish how this was happening to help rule out false alarms. Of note, these sensors were not intended to replace staff observations. Staff remain vigilant despite the latest technology and observations and risk assessments remain in place as part of usual practice.

The project continued with some delays during the pandemic and is still being undertaken at present. During 2022/23 doors were replaced in forensic services and on the Unity Centre in Wakefield. The Unity Centre development was brought forward from 2023/24 which will shorten the overall programme. In 2023/24, the remaining bedroom doors in forensic services and older people's services will be completed and following a further discussion with the clinical environment safety group consideration to the type of doors to fit to the rehabilitation units will be made. The phased rollout has been adopted in order to tie in with the availability of the specialist doors within the supply chain, as they are being widely retrofitted within the mental health sector as well as being specified in new developments. Wherever possible we have brought our programme forward, working with the supplier and the wards to ensure we do not unduly disrupt wards by having too much work at any one time.

Replacement of bedroom doors was the priority of the initially approved plan. However, as works have proceeded, services have started to identify another tranche of doors which may need anti-ligature door sets. How the organisation moves forward with these doors will follow the same route as before.

Training on the use of the doors

The new doors, whilst operating normally as doors, do require training to be used correctly. This training is provided in the first instance by the installing company. This training is carried out on a team basis. The responsibility for ongoing training lies with the ward managers and includes ongoing registration of training along with logging testing of the doors and the anti-ligature systems associated with them. Forensic services, working with the capital planning lead have developed documentation which can be used throughout the Trust to demonstrate training and testing. In order to improve training a video has been produced as a training aid available on the intranet (August 2023).

Replacement Programme

To date we have replaced all the doors at the Oakwell Centre and we are currently replacing doors at Fieldhead in both forensic services and adult working age wards, as well as at the Dales unit working age adult wards. At the time of writing the outstanding works in this year's programme are as follows:

- Priestley Unit – 18 doors were completed before Christmas 2022
- Horizon Centre – All doors were completed by the end of financial year 2022/23.
- Unity Centre - 56 doors were completed by the end of 2022/23 (brought forward from 2023/24)
- Dales Unit doors were purchased and were installed on a rolling basis by the PFI contractor with all doors installed by the end of the 2022/23.

The programme for financial year 2023/24 is forensic Services (87 doors) and older people's services (7 doors). Once we have placed orders for the doors a more detailed programme of works will be obtained. This will leave the rehabilitation units at Enfield Down and Lyndhurst to be considered for financial year 2024/25. As stated earlier, the programme only covers bedroom doors as this was agreed as the priority. If other high priority rooms are to be added, then a new programme and potentially a different door will be agreed.

Review of ligature incidents recorded on DATIX

During 2022/23 there were 532 incidents involving ligatures (self-harm by self-strangulation or suspended ligature or reported concerns of unconfirmed and threatened use of a ligature) reported on Datix. These incidents have been analysed and identified. The data in the report provides summary information rather than a full breakdown. Please note, these incidents are not all because of environmental risk – some self-strangulation occurs without use of any environmental resource:

- 532 incidents involving ligatures in 2022/23. This compares with 394 in 2021/22 and 814 in 2020/21. The increase in numbers from 2021/22 is associated with a small number of service users predominantly within our female acute inpatient wards (Clark Ward, Ward 18, Nostell Ward and Elmdale Ward). Ward-based matrons maintain oversight of person centred clinical risk assessment and care planning for this population.
- 99% of the 532 incidents in 2022/23 had a specific location of the incident recorded (525)
- Of these, 436 incidents (82%) occurred in bedroom/ensuite or bathroom.
    - 70% Bedroom
    - 12% ensuite/bathroom
- Female wards are the highest reporters of ligatures, with 269 reported incidents (51%) the majority in acute mental health inpatient areas. There are some incidents in other areas such as mixed wards. The acute mental health wards with the highest numbers are:

Ward / area	Number of incidents 2022/23	%
Elmdale Ward, Halifax (female)	143	27%
Ward 18, Dewsbury	104	20%
Nostell Ward, Wakefield (female)	89	17%
Ashdale Ward, Halifax	49	9%
Clark Ward, Barnsley (female)	37	7%
Newhaven Ward, Wakefield	17	3%

Also of note:

- One ligature has occurred in an outpatient clinic.
- Ligature incidents occurred in the Trust's older people's wards (Crofton, Poplars and Willow ward).
- 52 (9.7%) incidents involved a transgender patient.
- Six ligature incidents occurred in a Section 136 suite.
- 35 ligature incidents occurred in forensic services.
- No in-patient deaths occurred involving a ligature during 2022/23.

- The 532 ligature incidents involved 122 unique service users.
- One service user had 48 ligature incidents (9%) (Ward 18), another service user had 47 ligature incidents (8.8%) (42 of these incidents occurred whilst the patient was on Ashdale Ward, whilst the other 5 occurred whilst the patient was at Enfield Down).
- Most common ligatures used appears to be clothing items (19%), followed by bedding (2%), electrical wire/cable (1.3%) and towel (1.1%). A large proportion of incidents do not detail the item used (71%). This will be explored within CESG to determine the reason for not including the ligature, and then be included in the PSIRF suicide prevention quality improvement work.
- Where there was a ligature point involved and/or recorded, the most frequently used ligature point was doors/doorframes (5 incidents, 1%)

*Percentages totals may differ due to rounding.

The findings from the review of ligature incidents continue to strongly suggest our focus should be on bedrooms, bathrooms, and en-suite areas where service users are unobserved, and acute mental health wards for females or mixed wards are the highest risk.

Blue-light alerts:

We continue to use our well-established blue-light alert system to quickly notify staff and services of any ligature risks shared from within or external to the Trust. Since the last report there have been eight further alerts relating to ligature risks and environmental safety. These are all available on the Trust's intranet page.

Learning points

To ensure that learning occurs following an incident the Clinical Environment Safety Group receives a report from Datix identifying all incidents involving a ligature. Themes are discussed and learning is shared in the Trust quarterly learning forum, through the Ward Manager forum and Matrons meeting, at the suicide prevention forum and through the production of learning materials such as the production of an SBAR communication tool (situation, background, assessment, recommendation).

Examples of learning points:

- CESG is reviewing the expansion of the door programme beyond bedroom doors following learning from the installation.
- The importance of training staff in the use of the doors before deploying the door top alarm sensors.
- The Trust is linked into the work of the National Mental Health and Learning Disability Nurse Directors' Forum who have been working with NHS England, the Care Quality Commission and nurse academics to co-produce some best practice guidance for managing ligature risks within inpatient environments, therapeutic observations and suicide prevention workshops.

Remedial work

In 2021/22 approved budget and anti-ligature schemes came to £915k:

- Windows Kendray Hospital, £75k

- Windows Fieldhead Hospital, £140k
- Windows Priestley Unit, £250k
- Doors Priestley Unit, £300k
- Harm audit funding budget, £200k
- Unity Centre anti-climb measures, £50k

In 2022/23 approved budgets and schemes totalling £1.66m as follows:

- Door replacement programme - the full list of works undertaken and planned reflects a spend of approximately £1.35m in year with the bring forward of Unity and Horizon
- Window replacement programme - £312k. With further windows on forensics and on the Horizon Centre being renewed
- A revenue allowance of £200k was allowed for works arising from the harm audits as in previous years

Capital Programme 2023/24

- Door replacement scheme on Crofton, Ryburn and Willow wards total £300k (these are complete)
- Window replacements at The Dales £360k
- Anti-ligature reserve funding £100k

In addition, due to changes in the capital programme the doors at the Bretton Centre are being added at a projected cost of £600k and the window programme at the Dales is receiving an additional £200k in funding. With these changes anti ligature spending in 2023/24 will be approximately £1.56 million

Taking the above into account means that the bedroom door programme should complete in the financial year 2024/25. All ligature points rated with a risk score of 81 and 54 that are not completed yet either have a plan in place or would require additional capital or equivalent funding where a solution is available. In particular, the reference to additional capital would include expanding the door replacement programme beyond the originally planned bedroom doors, as described elsewhere in this report. Care Groups place any remaining high-risk ligatures on local risk registers, with actions and mitigations as required. Unavoidable delays in remedial work will inevitably pose a risk that will continue be managed within the care groups.

Despite all efforts, due to human ingenuity to find new ways of securing a ligature and limitations of technical solutions, it is not always possible to eliminate all ligature points in ward areas or prevent all ligature point incidents. Work has been progressed and is ongoing to minimise the risk from ligature points in ward areas and action plans are progressing well. The use of non-ligature points, typically clothing and/or other means remains a consistent risk and is managed through assessed observation levels.

Remedial work can be disruptive and takes time and wherever possible, care groups and estates colleagues will speed up the process where it is safe to do so and mitigating action will be taken by ward teams in the interim.

Smaller scale remedial work

Within the Clinical Environment Safety Group (CESG), the agreement remains that smaller tasks to address environmental safety issues that are identified during any ligature audit can be requested directly from Estates colleagues, without needing to be approved by CESG. A report at each CESG meeting is received from Estates colleagues to give an overview of any outstanding tasks that still require a response.

Changes, Improvements, and achievements

Audit Process

The central coordination of the ligature audits continues to remain in the Quality Improvement and Assurance Team (QIAT) under the Directorate of Nursing, Quality and Professions. This has continued to enable oversight and management of the arrangements and communications regarding ligature audits. It has also supported the timeliness of ligature audits being undertaken, and the awareness of when and where these are delayed.

A member of QIAT accompanies the visiting team on ligature audit assessments when undertaking ward visits. This function also updates the previous year's audit tool and keep a log of the visit to reduce the number of potential queries going back to the visiting team.

The mental health ward ligature audits during 2022/23 were not completed by the deadline of 31 October 2022. This was due to a vacancy within the Health and Safety team (five months). The audit process continues to be tightened for 2023/24.

Next steps 2023/24

- The Clinical Environment Safety Group (CESG), to continue to ensure regular updates are provided to the executive management team (EMT) and Quality & Safety Committee throughout the year.
- The process status updates to the Clinical Environment Safety Group to be reviewed to include a highlight report, identify time taken at each stage and reasons for any stage not being completed by the deadline given.
- Continue to monitor all large-scale remedial work
- Care Group environmental suicide and ligature risk assessment leads to ensure their managers continue to monitor action plans and outstanding work throughout the year, escalate concerns and risks as required, and mitigate in the interim
- Complete 2022 annual environmental suicide and ligature risk assessment by 31st December 2023.
- Submit annual report for Quality & Safety Committee November 2024
- Complete 2022 review of out-patient ligature risk assessment by 31st December 2023.
- Collaborate with partners and suppliers to seek solutions to high level risks where none currently exist
- Align work of CESG with the Trust suicide prevention plan including updated workplace health and safety risk assessment for self-harm and suicide
- To share learning from incidents at the Trust suicide prevention forum, the Trust quarterly learning forum, at the ward managers' forum, the matrons forum and through the production of learning material.
- To establish a provider forum to share risks, learning and ligature audit toolkits and training with other providers.
- To establish a quality improvement group to review the ligature audit process

- To establish a task and finish group to review the clinical environment risk factors
- Review environmental suicide and ligature risk assessment policy and update by 31st December 2023.
- Ensure that we maintain a centralised function of oversight of ligature assessment and management.
- To be an active member of the Royal College of Psychiatry / National Collaborating Centre for Mental Health.
- For the Reducing Restrictive Physical Intervention Team to review the use of ligature knives and review the product and availability.
- For the Reducing Restrictive Physical Intervention Team to review the use of anti-ligature clothing and review the product and availability.

Overall summary

The Trust has robust systems of oversight of in-patient and community venue ligature risk audit and ligature risk actions within the clinical environment safety group (CESG). Learning is reviewed and responded to within CESG, with escalations as required to the Operational Management Group, Clinical Governance Group, Executive Management Team and Quality and Safety Committee.

The quality improvement and assurance team continue to co-ordinate the inpatient and community ligature risk audit programme and report through to CESG and now EMT. Completion of the 2023/24 programme of ward audits is the current priority. Following the completion of these, the lead for the ward audits will focus on the remainder of the community venue ligature risk audit programme.

The Trust has a clear process in place to quickly address minor estates concerns that are identified in any ligature risk audit. More complex estates responses, e.g. door replacement, is reviewed within CESG with recommendations through to EMT.

There has been an increase in reported ligature incidents in comparison to 2021/22, but fewer are reported than 2020/21. The reported increase is associated with a small number of service users predominantly within our female acute inpatient wards. Of note, not all reported ligature incidents result in a person applying a ligature. They can also include reported thoughts of using a ligature, or where a colleague has found equipment that objectively looks like it is present to facilitate a ligature.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.3

Private/Public paper:	**Public paper**		
Title:	**Medical Education Annual Board Report 2022-23**		
Paper presented by:	Chief Medical Officer / Director of Medical Education		
Paper prepared by:	Medical Directorate Business Manager		
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving compliance and continuously improving all aspects of medical education within the Trust, in order to fulfil our contractual obligations and educational duties as a Trust to all levels of doctors in training and students.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 3.3 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives Risk 4.3 – Failure to support the wellbeing of staff		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	This report demonstrates the Trust's progress in achieving compliance and continuously improving all aspects of medical education within the Trust, in order to fulfil our contractual obligations and educational duties as a Trust to all levels of doctors in training and students.		
Any background papers / previously considered by:	The 2 previous Medical Education Board Reports for April 2020-March 2021, and April 2021-March 2022.		
Executive summary:	The Medical Education Department aims to ensure that the Trust is fulfilling its contractual obligations to NHS England Workforce, Education and Training Directorate (formerly Health Education England as of 1st April 2023) and the Universities in which it holds contracts, to ensure that a high-quality training experience is being provided in line with the relevant frameworks, as set out by the General Medical Council. This report forms part of the annual assurance process to demonstrate the department is achieving its obligations and future-proofing its services as well as ensuring that Executive Management Team have oversight of any		

	challenges that the department is expecting to experience, or areas of particular focus for the next 12 months. The Medical Education Department, on behalf of the Trust, provides assurance to NHS England (formerly Health Education England) and to the relevant universities. For NHS England, this is done through annual meetings with their Quality Team and for universities, this is done through annual meetings with respective universities, analysing broadly similar areas as NHS England.
Recommendation:	**Trust Board is asked to RECEIVE the third annual Board update and NOTE the ongoing challenges placed upon the Medical Education Department.**

South West Yorkshire Partnership NHS Foundation Trust

Medical Education Board Update April 2022 to March 2023

1. Introduction

South West Yorkshire Partnership NHS Foundation Trust is a Mental Health and Learning Disabilities Trust, working across four main localities: Barnsley, Wakefield, Calderdale and Kirklees. The Trust provides a variety of services, including inpatient mental health services for older people, working age adults, learning disabilities, medium and low secure forensics and outpatient services including liaison services, community mental health teams covering older people and working age adults, learning disabilities and child and adolescent services.

The Medical Education Department is responsible for a variety of students across the Trust, including medical students from two universities and student Physician Associates (PAs), as well as students on elective placements. The Medical Education team are also responsible for doctors in training across the Trust, which include Foundation Doctors, Core Psychiatry Trainees, Higher Specialty Trainees and GP trainees, as well as being responsible for the professional development of Consultants, SAS and non-training grade doctors such as International Fellows

The purpose of this report is to provide an annual update on activity, achievements and challenges to EMT (Executive Management Team) and the Trust Board in relation to the Medical Education Department. This report provides assurance the Trust is achieving the requirements as stipulated by the medical schools that provide medical students on placement and the requirements of Health Education England Yorkshire and the Humber (HEEYH) in relation to the doctors in training placed at the Trust.

1. Background

The Medical Education Department aims to ensure that the Trust is fulfilling its contractual obligations to NHS England Workforce, Education and Training Directorate (formerly Health Education England as of 1st April 2023) and the Universities in which it holds contracts, to ensure that a high-quality training experience is being provided in line with the relevant frameworks, as set out by the General Medical Council.

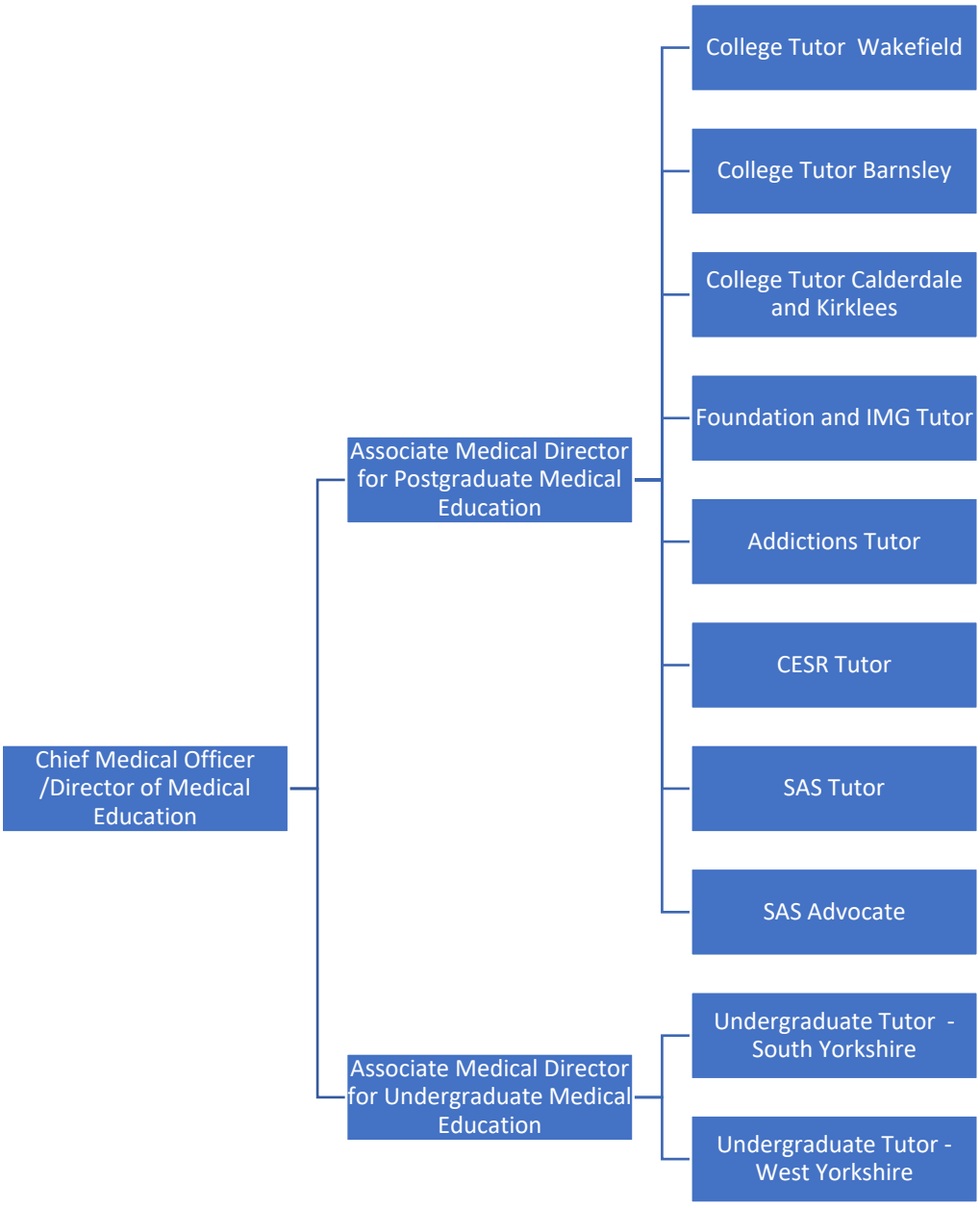
This report forms part of the annual assurance process to demonstrate the department is achieving its obligations and future-proofing its services as well as ensuring that the Trust has oversight of any challenges that the department is expecting to experience, or areas of particular focus for the next 12 months.

2. Medical Education Structure

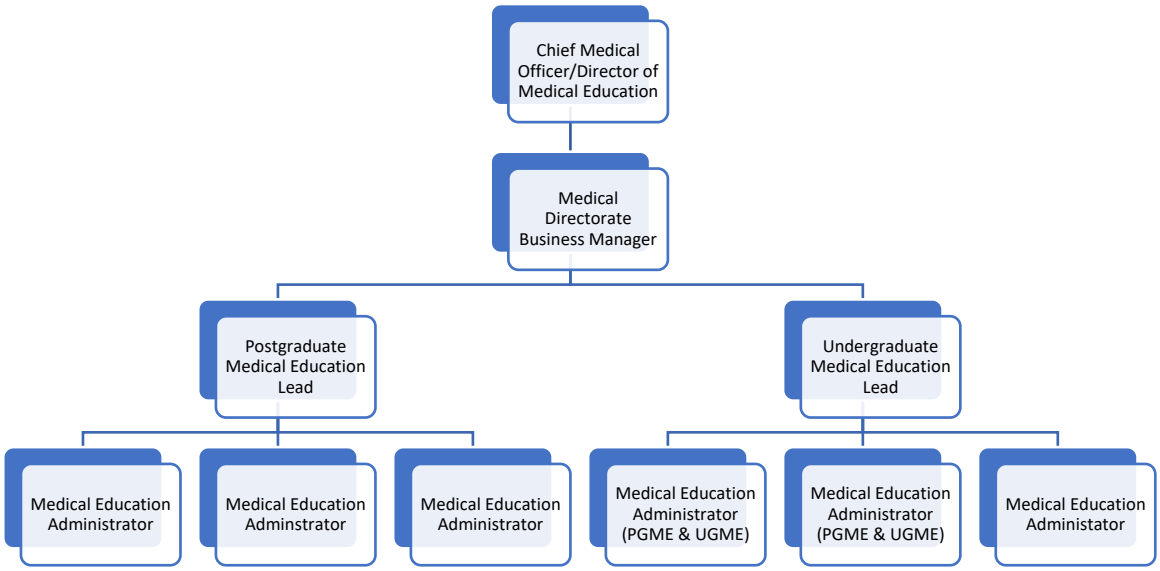
The Medical Education Department structure is continually being monitored to ensure it is fit for purpose and to account for increasing numbers of trainees, students and

medical leaders that the team of administrators support. The Medical Education Department is keen to ensure that the Trust can provide a great place for students and junior doctors to train and work. Clinical support is available through various tutor roles such as the Foundation Training/International Medical Graduates Tutor, two Undergraduate Tutors, a Certificate of Eligibility for Specialist Registration (CESR) Tutor and a Specialty Doctor and Specialist Grade (SAS) Tutor to support and develop SAS doctors that wish to become a Consultant. The Trust has a specialised Addictions Tutor to proactively ensure core trainees are able to fulfil the recently implemented curriculum changes, and a appointed a SAS Advocate role this year to bolster the support in the Trust for our expanding group of SAS doctors and International Fellows.

Clinical



Non-Clinical



The medical education administrative support team is continuing to manage an increase in workload and some vacancies in the team over the course of 2022-23. There are discussions underway about the flexibility of appointing to posts within the team and whether further restructuring is appropriate to maintain effectiveness, improve workload burden and retain valuable staff with a suitable career pathway in place, focusing on staff morale and work/life balance as a priority.

3. Assurance

The Medical Education Department, on behalf of the Trust, provides assurance to NHS England (formerly Health Education England) and to the relevant universities. For NHSE, this is done through annual meetings with their Quality Team and for universities, this is done through annual meetings with respective universities, analysing broadly similar areas as NHSE.

We are clearly meeting the requirements to achieve our contractual obligations to NHSE and universities and continue to receive positive feedback from quality visits and through the GMC National Training Survey (NTS) and the NHSE National Education and Training Survey (NETS).

4. Role of NHS England

4.1 Monitoring the Learning Environment / Senior Leaders Engagement Visit

Historically, there have been annual Monitoring the Learning Environment events held between the Trust and Health Education England Yorkshire and Humber (now merged into NHSE) and the last one took place on the 13 October 2022. As preparation for these events, all available regional and national trainer and trainee surveys for the Trust are reviewed, and in some cases, meetings are held with

trainees prior to the event. During the October 2022 event, the Trust received positive feedback including acknowledgement of the Trust ranking of 6th across all domains of the NETS 2021 survey and HEE (now NHSE) commended the Trust on a remarkably consistent performance. In addition Less than full time training (LTFT) was discussed, and the Trust highlighted that 25% of Postgraduate Doctors in Training are LTFT and welcomed HEE's support and offer of further discussions and support with this increasing number. It was also acknowledged that the Trust has an excellent partnership with the Creative Minds Charity which provides support to people in recovery, and this is enhancing the quality of mental health student placements. Finally, it was acknowledged that the open requirement in relation to bullying and unprofessional behaviour was being investigated appropriately by the Trust, with the expectation that this would be resolved successfully and an outcome communicated in due course.

4.2 Multi Professional Education and Training

There is an annual undergraduate meeting with the University of Leeds, where feedback is reviewed from students, both medical and physician associates, as well as providing assurance on the finance relating to the finance associated with undergraduate medical education. In both the July 2022, and the most recent meeting in July 2023, the University was extremely pleased with the Trusts' continued dedication to ensuring students have a positive experience and ensuring that funds are spent appropriately. Specifically in relation to the July 2022 quality visit, acknowledgement was shared of the excellent work, feedback and innovative approach despite the ongoing COVID challenges. The majority of the feedback was over 80%, with students enjoying seeing a wide variety of service users, high standards of teaching, structured timetables and students appreciated an individually assigned consultant. There were a couple of areas of feedback discussed to include suggestions of informal feedback sessions at the end of each placement to work with students in particular around community placements which may not always feel as rich an experience as acute placements. We found that some students felt that there were not enough structured activities, and there were still areas where students felt they had limited exposure, primarily in community placements. The feedback will be considered and measures put in place to look at these aspects for the forthcoming academic year. There has been no formal quality visits from university of Sheffield and one is planned for the next academic year.

4.3 National Training Surveys

As mentioned above, there is an annual national training survey undertaken by the General Medical Council, which surveys all doctors in training and trainers. The survey results provide an average of the experience across the Trust, but can also be analysed by training programme. In larger organisations, they can also be analysed by site. The overall training experience has remained very positive, and all scores have improved from the previous year, with a specific note to state that no patient safety concerns or undermining feedback from trainees was received during the latest GMC NTS Survey.

There is also an NHS England National Education and Training Survey, which again has shown very positive results for the Trust, which is further assurance that the

Medical Education Department is meeting and indeed exceeding in the provision of training and education to doctors and students.

4.3.1 The postgraduate team continues to work to and update the action plans, which are embedded within the Medical Education working Strategy, finalised and implemented in February 2023.

5 Governance and Process

5.1 Complaints and Concerns process

There is an established pathway and flowchart for trainees to raise concerns or complaints. From induction onwards trainees are encouraged to speak up about their experiences and are informed of the various ways to do this, including speaking to their supervisor, College Tutor, the AMD for Postgraduate Medical Education, a member of the medical education administrative team or the Freedom to Speak Up guardian. The FTSU Guardian speaks at induction, the Junior Doctor Forum and attends medical directorate meetings periodically to encourage all doctors to speak up.

Each complaint or concern is dealt with on an individual basis, dependent upon the nature of the issue, Medical Staffing/People Directorate colleagues may be involved with the initial meeting with the trainee to establish the nature of the complaint and the initial facts. The College Tutors who have been trained to undertake fact findings, would then undertake a fact find before reporting back to the AMD for PGME, for a plan of next steps, which is shared with the Director of Medical Education/ Chief Medical Officer and, if necessary, NHSE (formerly HEEYH).

The trainee is offered support at every stage, including specialist occupational health support.

5.2 Medical Education Trust Action Group

This is a quarterly medical education governance meeting, chaired by the AMD for PGME or AMD for UGME.

The aim of the meeting is to provide assurance that medical education meets its medical professional, educational, training and developmental needs, in compliance with professional bodies and other national regulation, standards and guidance, within the Trust's governance framework. The meeting brings together representation from all undergraduate and postgraduate medical education, including trainee representatives for each area, SAS doctors, college tutors, Guardian of Safe Working and Flexible Training, SAS Tutor plus the Health, Safety and Security Managers for the Trust, to ensure that there is a cohesive approach across the Trust, allowing each team to have an awareness of the challenges and priorities of each other.

This meeting is also where the annual survey results from the universities, GMC and NHSE respectively and any associated actions plans are agreed and monitored.

Minutes are taken at this meeting and actions followed up on. There are Terms of Reference for this meeting, which were last reviewed in May 2022 and remain accurate.

5.3 Medical Education Catch-up meetings (formerly Bronze calls during COVID-19)

Following step-down of COVID-19 protocols, it was felt that the continue monthly Medical Education catch-up meetings were beneficial and should continue for appropriate representatives to attend to update colleagues and raise any key issues.

5.4 Guardian of Safe Working Hours

The Trust has an experienced Guardian of Safe Working Hours, who prepares a quarterly report and an annual board report. The Trust receives a low number of exception reports, but the Guardian reviews each exception report and provides a session at induction, to promote a culture that encourages trainees to report.

5.5 Junior Doctors' Forum

The purpose of the forum is to provide junior doctors across the Trust an opportunity to raise any issues and to provide feedback to the organisation. The forum was created as part of the National 2016 changes to the junior doctor contract and is led by the Guardian of Safe Working Hours and attended by the Trusts BMA representative, as well as Medical Staffing, AMD for Postgraduate Medical Education, Medical Education key personnel, in addition to all junior doctors across the Trust being invited.
The quarterly junior doctors' forum continues to take place online and is better attended due to this. The meeting highlights suggestions for change, and an opportunity for collaborative discussions around decisions affecting junior doctors, including purchasing of new equipment and items through the training recovery funding and other such funding available from NHSE from time to time.

6 Educational Governance Structure

The medical education governance structure has several levels, as depicted below.

<table>
<tr><td colspan="2">Board level representation, Quarterly reports, Annual Reports</td></tr>
<tr><td>Responding to Concerns Action Group, Appraisal and Revalidation meetings</td><td>Director of Medical Education (DME) / Head of School (HoS) regional calls with appropriate Trust representation from DME, Associate Medical Director of Postgraduate Medical Education and/or Medical Directorate Business Manager
Guardian of Safe Working Hours
Freedom to Speak Up Guardian</td></tr>
<tr><td>METAG with Trainee representation

DME, Associate Medical Director(s) & Business Manager – Senior Education Trio meetings</td><td></td></tr>
</table>

AMD supervision	
Local – Medical Education team meetings, Junior Doctors' Forum, Supervision	

7 Achievements

In the past 12 months medical education has numerous achievements, including:

Education and training

- Academic programme has continued to be delivered successfully in the aftermath of COVID and is some elements are gradually returning to face to face; however the flexible approach maintains to achieve balance.
- The Trust has continued to engage in the West Yorkshire Trainee Engagement Forum to ensure the Trust is a great place to work and train.
- The Trust currently holds an Associate Teaching Trust status with Leeds University
- Health Toolbox (formerly Dr Toolbox), an app designed to enable doctors to be able to access induction information, as well as other useful information, such as contacts and maps has been rolled out to undergraduate medical students. Access is given to the app in advance of eligible individuals joining the Trust.
- Clinical and multi-professional collaboration throughout the junior doctor strike action.
- Consultant Forensic Psychiatrist within the trust has been nominated for Trainer of the Year.
- There has been a year-on-year expansion of training posts.
- Two Higher Trainees were sponsored through the Royal College of Psychiatrists Leadership & Management scheme. One project looked at wellbeing of doctors in the Trust and one focussed on a multimedia project for induction.
- There was clear communication and engagement with junior doctors throughout the periods of industrial action, which enabled a smooth process to be put in place to collate accurate records of participation.
- Medical Leaders' Advisory Group (MLAG) and medical education trust action group (METAG) development days are taking place face to face, and these are expected to continue on an annual basis.
- The trust is a General Medical Council (GMC) sponsor for international fellows.
- The trust continues to build on work with foundation and international doctors and there is a specific tutor for foundation and international medical graduates, and a tutor for the Certificate of Eligibility for Specialist Registration (CESR) route.
- The undergraduate tutors have been involved with the expansion of the medical students and physician associates (PAs) placements. The teaching programme has also been expanded and received very positive feedback.
- The Undergraduate team was nominated for a Trust Excellence award in 2023, for partnership working.
- Two individual members of the Medical Education team were nominated for Trust Excellence awards, Unsung Hero and Leader of the Year.

- A successful annual MPET meeting in July 2022 led to renewal of the Associated Teaching Trust agreement between our Trust and Leeds University for a further 5 years.
- 28 members of staff in the Trust have received commendation letters from Leeds medical school (via green card system where students can submit green card to highlight specific, excellent, learning experience on placement).
- Article “Improving placement experience for Undergraduate medical students at SWYPFT” has been published in the Royal College Northern and Yorkshire Division, (page 16-18). December 22. This was led by a Higher Trainee working within the Trust.
- The educational programme for undergraduate students receives excellent feedback consistently. This has been expanded with sessions on “Introduction to choose psychiatry” and motivational interviewing.
- In 2022, the trust created 3 educational films on the subject of mental state examination. This was undertaken with a professional film company and simulated patient actors. From September 2023, these will be incorporated into the regular teaching programme. These teaching sessions have also received excellent feedback.
- Within the student teaching programme each cohort of Leeds medical students have the opportunity to present a case to the student case conference. This is an optional element of the programme to present a case to a senior psychiatrist, with best presentation each cohort receiving a small prize, and all presenters being recognised via the University Green card system as well as being issued a written letter of thanks and feedback for their portfolio
- Continuous improvements to induction programme to address any feedback; however feedback is consistently positive for both postgraduate and undergraduate programmes.
- The Trust received a letter of thanks on behalf of Leeds School of Medicine Secondary Placement Management Team, for supporting a large cohort of Year 4 medical students and for all the preparatory work undertaken to accommodate a very large Year 4 cohort in 2023-24.

Wellbeing

- All junior doctors receive a risk assessment that is reviewed regularly (and at the start of each placement). This was implemented during Covid and will continue.
- All junior doctors and medical students continue to have access to a laptop and VPN, meaning that when clinically appropriate they can work from home to ensure continued flexibility for hybrid working where suitable.
- The Chief Medical Officer continues to hold monthly webinars to update all medical staff and provide a forum for all doctors to ask questions and raise concerns. The webinars continue to have good attendance and strong engagement from trainees and have been well-received with positive feedback.
- The Trust has employed a Diversity, Inclusion and Belonging lead, whose key functions are supporting staff networks, carers and LGBT+, their aim is to ensure a diverse workforce which is meaningful and appropriate for service users.

8 Challenges

There are continuing challenges that can be difficult to address, alongside new and unexpected challenges that can sometimes be unforeseen. Please see below examples of challenges the Medical Education team are facing currently:

- Trainee vacancies, including an increasing number of requests for less than full time working, along with other reasons such as trainees withdrawing from a training programme, trainees being successful in obtaining Out of Programme Experiences, sickness and parental leave. Some of these decisions can become apparent at short notice and cannot therefore be forward planned for, which often means challenges with out of hours rotas and service provision.
- There is acknowledgement of challenges regarding the unstable structure of Rota Coordinator posts within the Trust. This can adversely impact a trainee's experience with regard to their on-call rota. Rota coordinator posts are not currently managed within the Medical Directorate and therefore places some burden on members of the Medical Education team to step in to cover elements of the role, and support new postholders due to their unique knowledge in relation to trainees. This is a continued concern and steps are being taken to look at options in relation to this matter through joint working with operational colleagues.
- There have been a number of periods of industrial action which are placing a strain on all colleagues in the Trust. Specifically to Medical Education, this is affecting medical student timetables, junior doctor induction programmes in some cases, supervision arrangements and has an impact on capacity within the administration team.

The team continues to work hard to address challenges and any concerns raised because of them, and continually monitor progress through feedback and communication to resolve issues and improve upon difficult situations where possible.

9 Objectives and Plans for 2023/2024

There are a series of objectives linked to the Trust-wide objectives for medical education to deliver, which have been incorporated within the postgraduate and undergraduate plans respectively:

1) **Actively promote psychiatry as a career** *(Improving health/Improving care)*
   Actions:

   - Promoting psychiatry to medical and physician associate students, foundation doctors and LAS and international fellows. Choose Psychiatry teaching sessions are held during the undergraduate programme in order to collate information and feedback. These sessions are well received and will continue.
   - Providing taster sessions for all grades of doctor, via linking with our local partner Trusts.
   - Providing mentorship to trainees, especially Core and Higher trainees and specifically focussing on international medical graduates.
   - Promoting shortage specialties, such as CAMHS and Learning Disability.

2) **Ensure that medical education is an outstanding service, promoting participation and inclusion.** (Improving health/improving care)
Actions:

- Analysing all survey data, local and national to create an action plan using #allofusimprove methodology to focus on specific projects, such as the foundation doctor experience and international medical graduates.
- Celebrate success, both for individuals and teams, including recognising areas of exceptional feedback or highly rated placements and supervisors.
- Promote participation of student and trainees in trust wide committees and projects in areas such as research and development and leadership.
- Encourage participation from senior medical colleagues to host medical and physician associate students, to consider hosting additional trainees, apply to be a clinical or education supervisor, and be actively involved in the teaching sessions.
- Monitor, adapt and improve new starter inductions, utilising feedback and external resources to continually enhance induction experience for trainees.
- Work with all Staff networks including Race, Equality and Cultural Heritage (REaCH) network, disability network, LGBTQ+ network and Carers network to understand and tackle any barriers to training.
- Work with Freedom to Speak Up Guardians in the Trust in order to fully support and encourage doctors and students to speak up and raise any concerns, in particular if they do not feel able to discuss with their clinical supervisor.

3) **Health and wellbeing matters** (*Make this a great place to work*)
Actions;

- Improving the peer and pastoral support and mentoring offer in the Trust, including particular focus on international medical graduates
- Conversations about health and wellbeing as part of regular supervision, including promoting the health and wellbeing continue, and we continue to promote health and wellbeing and signposting support resources where appropriate. This forms part of induction for postgraduate and undergraduates, and trainee representatives are supported to raise awareness at local and trust wide committees.
- Regular checks and reviews of the facilities and equipment that doctors and students have access to, to ensure they are fit for purpose, in collaboration with universities and based on feedback from individuals.
- Introduction of multimedia project, which will provide information in advance regarding out of hours on calls to help reduce stress and anxiety for doctors participating in an out of hours rota, sometimes for the first time.

4) **We promote sustainability and are financially responsible.** *(Improve Resources)*
Actions;

- Working with finance and the wider Trust to centralise funding for trainees. This will provide flexibility and a streamlined process for increasing the number of trainees in the Trust.
- Work with the wider trust to ensure medical education is financially responsible, spending money to enhance trainee provision.

- Actively work with the trust sustainability agenda, being responsible with resources.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.4

Private/Public paper:	**Public**		
Title:	**Freedom to Speak up Reflection and Planning Tool 2023**		
Paper presented by:	Estelle Myers, Freedom to speak up guardian		
Paper prepared by:	Estelle Myers - Freedom to speak up guardian Julie Williams – Deputy director of corporate governance		
Mission/values:	We put the person first and in the centre We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow		
Purpose:	NHSE has produced an updated Freedom to Speak Up reflection and planning tool, which all NHS Trusts are required to complete and submit to their boards by January 2024.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust has a robust system and structure for Freedom to Speak Up (FTSU) which is crucial to ensure the needs and concerns of patients and staff are identified, listened to, and acted on.		
Any background papers / previously considered by:	July 2023 - Annual report for FTSU presented to PRC and Trust Board		
Executive summary:	The attached self-assessment tool is designed to provide a benchmark for the Trust on its current status in respect of FTSU and is required to be published on the Trust website by the 31 January 2024.		

	An action plan for improvement will be monitored via the Freedom to Speak Up steering group, with progress reported into the people remuneration committee and Trust Board. The development and completion of this self-assessment has taken place over several months in partnership with the Non-Executive Director Lead, Chief Nurse and Director of Quality and Professions, Interim Chief People Officer, Associate Director of Communication, Involvement, Equality and Inclusion and the Deputy Director of Corporate Governance. The document has been reviewed and commented on by members of the Freedom to Speak up steering group, operational managers group (OMG) and the executive management team (EMT). <u>Principle 1: Value Speaking up.</u> We continue to review FTSU arrangements and receive feedback and act and learn from this. Our improvement actions for this principle are to continue to develop training needs and to continue to increase awareness and promote the role of the non-executive lead for FTSU across the Trust. <u>Principle 2: Role-model speaking up and set a healthy Freedom to speak up Culture.</u> The full time FTSU Guardian is supported internally by three further part-time FTSU Guardians and externally through a FTSU supervisor. <u>Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.</u> Trust policy has been updated in line with the national policy update in 2022. A plan is in place to develop a staff survey question around knowledge on the policy. A three key question survey is also being developed to be used when FTSU guardians are visiting Trust sites. Work is underway to promote and share positive stories and this will be included in the annual communications plan, which addressed ways in which the Trust encourages and supports open culture and hearing what the workforce tell us. <u>Principle 4: When someone speaks up, thank them, listen and follow up.</u> A review of the local induction programme is to be completed to ensure FTSU is included. FTSU guardian to continue to meet with managers across the Trust to raise awareness of the benefits of staff speaking up. FTSU Guardian has a follow up survey 3-, 6- and 12-months after the closure of a case to ascertain if any detriment has been suffered as a result of raising a concern. <u>Principle 5: Use speaking up as an opportunity to learn and improve.</u>

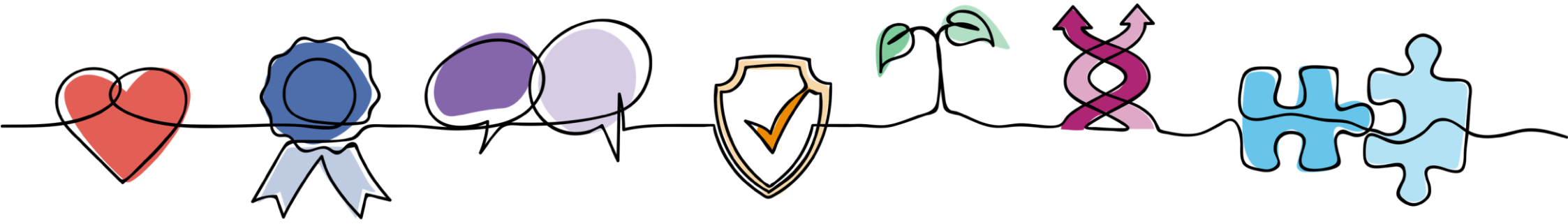
	Consideration of equality data and any patterns of impact will be monitored by the people and remuneration committee (PRC)_ to identify any Trust-wide issues that need to be addressed. An annual review of FTSU data against other sources of Trust data to identify any specific improvement areas and incorporate into a FTSU action plan. The Quality Improvement and Assurance team will support delivery of the improvement plan which will include, triangulation of data from complaints, incidents and FTSU to identify themes and areas in need of support. <u>Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.</u> The full time FTSU Guardian is supported internally by three further part-time FTSU Guardians and externally through a FTSU supervisor A review of the effectiveness of civility and respect champions will be undertaken, including relevant signposting within the organisation. The FTSU steering group is in place to help improve learning from cases and is to include representation from all care groups. <u>Principle 7: Identify and tackle barriers to speaking up</u>. EMT have reviewed cases of detriment to understand areas of learning. An annual communications plan is to be produced to help improve awareness of FTSU and civility and respect champions. Following October's speak up month an evaluation of barriers to speaking up is in progress. <u>Principle 8: Continually improve our speaking up culture.</u> Further work is planned to look at Workforce Race Equality Standards and the Workforce Disability Equality Standard. A key part of this is promoting psychological safety, which in turn strengthens and promotes an improvement in speaking up culture. An improvement approach will be utilised to review anonymous case studies and share the learning with the quality assurance and improvement team. In addition to the above, the self-assessment tool contains a table of all actions (areas of development for the Trust) over the next 12 months, which is included in the main body of the report. In summary, the Trust continues to focus on raising awareness of the freedom to speak up process and educate managers and staff of the important role it plays in safe and high-quality care.
Recommendation:	**Trust Board is asked to APPROVE the FTSU Reflection and Planning Tool for publication.**

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

Achievements:

Named Freedom to speak up (FTSU) Senior Lead is the Chief Nurse and Director of Quality and Professions.

A review of where the role sits has been completed, and the day-to-day oversight is now delegated to the Corporate Governance Team reporting into the Deputy Director of Corporate Governance, who provides regular supervision and access to role development.

Speaking up arrangements are reviewed every 2 years.

The lead Freedom to Speak Up Guardian was recruited via internal advert on NHS jobs and through a selection process.

It is a funded whole time equivalent post.

The Freedom to Speak Up Guardian has regular meetings with Chief Executive, Chief Nurse and Director of Nursing Quality and Professions, Chief Medical Officer and Chief Operating Officer.

6 weekly meetings with the Senior Independent Director for FTSU, Deputy Chief People Officer and senior lead responsibility on cases, themes, action plan and learning FTSU steering group now set up and meets bi-monthly, which adds an additional layer of governance and opportunity for shared learning.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Continue to review FTSU arrangements on an annual basis and utilise feedback from those who have used the service as part of the annual reporting service to People and Remuneration Committee and Trust Board. Act upon the results of the review and learn from the review.
2 To recruit additional guardians to ensure cover across our services and geography.

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	4
I am confident that the board displays behaviours that help, rather than hinder, speaking up	4
I effectively monitor progress in board-level engagement with the speaking-up agenda	3
I challenge the board to develop and improve its speaking-up arrangements	3
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4
I am involved in overseeing investigations that relate to the board	N/A to date
I provide effective support to our guardian(s)	4
Enter summarised evidence to support your score.	

- Six weekly meetings with Chief Nurse and Director of Quality and Professions with Deputy Chief People Officer and Deputy Director Corporate Governance also in attendance at meetings
- Annual and 6 monthly report to People & Remuneration Committee (PRC) and Trust Board
- Guardian has access to non-executive lead for guidance and support
- Non-Executive Director (NED) is involved with communication planning for part of FTSU month each year.
- FTSU is a standing agenda item at PRC.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 To undertake an annual review of training needs and explore further opportunities for Board engagement

2 Continue to take part in raising awareness of NED role and promoting their role as Lead Non-Executive Director for Freedom to speak up

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	Yes
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3
We regular discuss speaking-up matters in detail	yes

Enter summarised evidence to support your score.
Score of 3 is about how we have evidenced the whole leadership team including all our managers and not just our Trust Board.

Achievements:
A session with board and governors about FTSU has taken place (22/03/23).
Commitment seen by board and governors to FTSU.
FTSU Guardian attends Operational Management Group (OMG) quarterly
Executive management team (EMT) have completed speak up training and have a plan in place to complete Listen up and Follow Up.
Intranet section visible to staff, posters are visible around the Trust and also laminated on the back of staff toilet doors.
Visibility of Guardian across the Trust, who managed to visit all 30 wards over October 2022 and visits to community teams in October 2023.
FTSU strategy in place for 2022-24
Senior leadership and Operational Management Group members are supportive and have bought into FTSU, with regular attendance at the Trust steering group and participation in events.

Training has been provided to the Operational Managers Group (OMG) on listen up (October 2022) and follow up (November 2022)
Reports go into EMT with quarterly updates
Presentation and reports go to Board twice a year
Reports go into People Remuneration Committee (PRC).
Mandatory training at 93% compliance
Guardian attends Trust welcome event
Guardian attends care certificate training
Posters, video and blogs screen saver
Steering group for FTSU to oversee lessons learnt.
We have 6 weekly meetings with Senior Independent Director, lead for FTSU and FTSU Guardian.

Areas for improvement:

Staff survey results 2022/23 benchmarking against our peers

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)
1 Review the staff survey results for 2022/23 and benchmark against our peers.
2 Review senior leader engagement plans annually.

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up Guardian process) in our wider culture improvement plans	3
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3

Enter summarised evidence to support your score.
Achievements:

FTSU included as part of our Great Place to Work strategy which is aligned to the people promise and just culture work in the organisation. FTSU guardian links with all staff networks. “Getting the support you need” leaflet in place to reference support available for staff to create a safe space for individuals. Good examples include the patient safety incident response framework (PSIRF), improvement network, ihub, preventing Bullying and Harassment Policy, pre disciplinary process. Aiming to triangulate data with staff survey,Datix incident reports, and exit interviews highlighted in reports to board. Equity Guardians are in place across the Trust to support staff with issues of racism. All of you: Race forwards group in place to raise awareness and help improve Trust culture with the workplace and reduce incidents of racism. Values based appraisal system in place, which includes an assessment of staff performance against Trust values, including an assessment of being open and transparent. The Trust is developing a restorative just and learning culture and in the process of becoming a trauma informed organisation to improve psychological safety within the organisation. The Co-Senior Responsible Officer for this is the Chief People Officer, to ensure vigilance and oversight of any Trust processes that might invite experience of trauma including speaking up.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To continue ensure that the FTSU strategy aligns and informs the great place to work delivery plan
2

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes

Enter summarised evidence to support your score.

Achievements:

The lead FTSU guardian is full time in the role. Universal job description used. FTSU guardians attend regional network and national events, Lead FTSU guardian is co-chair of the Regional Network for FTSU guardians.

The Freedom to Speak Up Guardian is supported with continuous professional development and other development opportunities e.g. Just and Learning Culture training

Funding available to promote the role and other promotional materials have been provided as requested.

Job aligned with other organisations in agenda for change banding.

Sustainable offer for FTSU cover for lead FTSU guardian when on annual leave was explored though expressions of interest to matrons, quality governance leads, civility and respect champions, equity guardians, and through staff networks. There are now 3 part time FTSU guardians who are trained and in place to support the full time FTSU guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	4

Enter summarised evidence to support your score.

Achievements:
Trust policy has been reviewed and strengthened to meet the new Guardians Office policy (approved April 2023). Therefore, the Trust policy met NHS England's expectations following the Lucy Letby trial outcome. Policy is available via the intranet and a link on the FTSU page.
Contained within the speak up training it references finding the policy and providing feedback to FTSU Guardian about this.
Feedback to the FTSU guardian about the policy is that it can be found.
Posters are laminated on staff toilet doors.
Freedom to Speak Up Guardian attends the Trust Welcome event for new starters every month
Freedom to Speak Up Guardian attended 30 inpatient wards in October 2022 (speak up month) and during October 2023 community team visits have been undertaken.
Freedom to Speak Up Guardian is key trained to be able to access secure services to ensure visibility and accessibility
Screensaver have been introduced to further enhance awareness
Delivery of FTSU training to care certificate new starters.
"Getting the support you need" leaflet signposts to all sources of support including FTSUG, there are posters in service / workforce areas and dedicated intranet pages with links to the FTSU page.

Areas for improvement:
Intranet content requires a review and search functionality to make it as easy as possible to navigate.
Stories to be publicised through the Trust communications route

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To explore inclusion of a question on FTSU policy awareness in the 2024 staff survey
2 Consideration to be given to a stand-alone FTSU survey or asking 3 key questions when FTSUG visiting sites using tablet.

Statements about how speaking up is promoted	**Score 1–5 or yes/no**
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3
Enter summarised evidence to support your score. **Achievements:** Comms plan in place, screensaver, ward visits, questions are asked as part of national survey and exit questionnaires, speaking up publicised through the Brief, headlines and welcome events. Staff networks are an example of how we encourage people to speak up and share with Trust Board members	

The View is utilised to help share publicity of freedom to speak up **Areas for improvement:** A plan is in place to share stories of staff experience of speaking up and building this into our improvement processes A plan to review the effectiveness of our comms strategy through staff survey, Comms can also show data for publicity, reads and hits.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Review all communication and engagement plan for FTSU to ensure it takes account of all the activities that are taking place.
2 Mapping all the ways in which the Trust encourages and support this open culture and listens to the workforce
3 Consideration to be given to a stand-alone FTSU survey or asking 3 key questions when FTSU Guardian visiting services using tablet.
4 To explore how managers can communicate improvements at a service level in team brief and meetings

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	3
Our HR and OD teams measure the impact of speaking-up training	3

Enter summarised evidence to support your score.

Achievements:

The Trust has speak up training as a mandatory subject and is at 93% against a target of 85%.
Listen up and follow up training in place as required.
Freedom to Speak Up Guardian present at Welcome event (the corporate induction) and has a stand at the event
The Freedom to Speak Up Guardian collects feedback on the service received by staff and also has access to exit interview data
Freedom to speak up feedback survey part 1 has been introduced to ascertain demographics of those coming forward

Areas for improvement:

FTSU has been requested to be included in local induction documents and a review of local induction is to be completed by 31st January 2024

To continue to raise awareness of the benefits of staff speaking up with managers across the Trust

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Equality monitor training impact and identify any specific groups that may need targeted trust communications to encourage the use of FTSU Guardian. Work in confidence with these groups to understand what happens when a concern is raised. Look if these individuals are from particular groups of staff.

2 To undertake a review of local induction with the People directorate to ensure FTSU included

3 To continue to meet with managers across the Trust to raise awareness of the benefits of staff speaking up

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	4
We have enabled managers to respond to speaking-up matters in a timely way	2
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

Achievements:

The Trust has speak up training as a mandatory subject and is at 93% against a target of 85% (September 2023)
Managers are offered listen up training available via Electronic Staff Record (ESR) as required
Evaluation and learning with manager following closure of a case, process and checks are in place to monitor timescales and escalate as appropriate.

Areas for improvement:

Increased awareness of Listen up and Follow up training required, together with clear direction as to where to access it given current low uptake of this training.
The regional network has identified that barriers still exist for people coming forwards and this (and solutions) have been explored in the Trust with teams during October 2023 speak up month. The results of this will be taken through the FTSU steering group in January 2024 and a (myth busting) communications plan developed.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Follow up survey 3, 6 and 12 months following closure of case to ascertain if any detriment suffered as a result of raising a concern.

2 Increase awareness of Listen up and Follow up and training uptake

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	3

Enter summarised evidence to support your score.

Achievements:
FTSU guardian able to have control of own diary and visit wards and service areas and is key trained for Forensics to facilitate access.
FTSU guardian triangulates data from various sources to help identify areas in need of improvement. Staff survey, exit survey feedback, staff side and trade unions could be used wider.
Quality Monitoring Visits, learning from incidents reports Datix, clinical risk panel, Operational Management Group, Quality and Safety committee, Patient Experience Group and the Insight report all assist with data triangulation of areas needing support.
Steering group now in place as a forum for sharing learning across the organisation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Consideration of equality data and any patterns of impact to be picked up through People and Remuneration Committee to identify any Trust-wide approaches to address.
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	3

Enter summarised evidence to support your score.

Achievements:

A gap analysis is carried out after each case review and action plan in place

Good practice shared at FTSU guardian regional meetings

Any incidents reported on Datix relating to bullying and harassment are shared with equity guardians and FTSU guardian.

Areas for improvement:

Follow up sharing internally from learning externally needs to be improved the steering group can be a vehicle for this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Annual review of FTSU insight against other sources of data to identify any specific improvement areas, look at staff survey data, Datix, exit interviews, and incorporate into FTSU action plan.
2 To work with the Quality Improvement and Assurance team to help support delivery of the improvement plan, working on triangulation of data, complaints, incidents and FTSU data to identify areas in need of support.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	yes
Our guardian(s) has been trained and registered with the National Guardian Office	yes
Enter summarised evidence to support your score. **Achievements:** As above through a transparent recruitment process Training has been completed by FTSU Guardian in line with National Guardian Office (NGO) recommendations. Any future Freedom to Speak Up guardians must complete the training before they can join the team, 3 part time Freedom to Speak Up guardians have been trained, registered and are in place.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	4
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

Achievements:

Annual appraisal and objectives in place
One to one meetings with lead director and other directors (see above).
Psychological supervision is in place external to the organisation.
Clinical supervision in place with other Freedom to Speak Up guardians.
Lead for FTSU Guardian to cover FTSU Guardian absence out of office in place for periods of annual leave.
Quarterly data submitted to NGO by Freedom to speak guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Increase the diversity of the FTSU guardians in line with workforce, expressions of interest have gone out to equity guardians and civility and respect champions. To ask for further expressions of interest from matrons and quality and governance leads, and through staff networks. 3 further Freedom to Speak Up guardians have been recruited trained and are in place.
2

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	3
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2

Enter summarised evidence to support your score.

Achievements:

New Freedom to speak up policy approved in April 2023.
Managers template in place to provide timescales for closure of cases
Freedom to Speak Up guardian has quarterly input into the Operational Management Group
Confidentiality with people coming forwards via the Freedom to speak up process is maintained where possible in line with legal requirements.
Speaking up cases have varying timescales (due to levels of complexity) for completion when taken fully through the process.
Freedom to speak up steering group in place to improve learning from cases

Area for improvements:

Need to enhance Trust awareness of any positive experience of speaking up, given the feedback survey has poor returns.
A brief procedure to support the policy to be pulled together to provide clarity to staff on what happens on receipt of a concern.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Review effectiveness of civility and respect champions and signposting within the organisation
2 FTSU steering group in place to help improve learning from cases to maintain the steering group and increase the effectiveness of the steering group including representation from all care groups.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	3
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

Achievements:

Exit surveys and exit interviews are carried out at individual request.
Staff survey results look at the culture within the organisation
FTSU guardian collects information about the role of the person speaking up unless the person is anonymous.
We have civility and respect champions which are a blend between FTSU champions and bullying and harassment advisors in the organisation which require further embedding and promotion through Communications (Comms) plan

Promotion of the role through Comms – Posters, screensaver, care certificate training, attending wards and team meetings, welcome event, use of social media, sports bottles, business cards, speak up month in October. When barriers are identified then steps to address these are implemented eg attending meetings to promote the role, new templates to speed up the process and governance group to help oversee the processes in place. Equality monitoring data collected via FTSU feedback survey. The Equality impact assessment for the policy identifies generic barriers with a clear action plan Lead FTSU guardian lead recruited from Racial Equality and Cultural Heritage (REACH) staff network, and champions recruited to reflect the diversity of the workforce. Lead FTSU guardian attends medics learning events. Lead FTSU guardian is key trained for Forensics and so can visit forensic inpatient wards independently and without escort, including as part of FTSU month. Visits to community teams have taken place during October 2023 speak up month.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Annual communications plan to be produced to help improve awareness of Freedom to speak up and civility and respect champions
2 To undertake an evaluation of barriers to speaking up and solutions to this following October 2023 speak up month events.

Statements about detriment	**Score 1–5 or yes/no**
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director champion for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes

Enter summarised evidence to support your score.

Achievements:

We ask on the feedback survey about detriment, and where it is self-reported where historically we have identified a case of detriment the Trust has addressed this. Each case is individual, and patterns are looked for.

Any claims of detriment are investigated independently and overseen by the Non-Executive Director (NED), once identified then organisation will act.

Where staff have been moved, we have maintained and protected unsociable hours pay.

Just and restorative practice and improving working relationships starting to be developed and embedded.

Freedom to Speak Up guardian has links with staff networks who flag any issues of people who do not feel supported through issues.

Freedom to Speak Up guardian links in with Human Resources and partnership meetings to improve joint working.

Areas of improvement:

To ensure our managers fully and consistently understand what detriment is and how to prevent it.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To raise awareness of what detriment is, how to identify it and how to prevent it occurring
2 To follow up on determent cases.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	4
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
Our improvement plan is up to date and on track	4

Enter summarised evidence to support your score.

Achievements:

Freedom to speak up strategy 2021-24 in place since November 2021.
Freedom to speak up audit action plan completed in 2021/22
Freedom to speak up reports are sent to Trust Board via People and Remuneration Committee and are published.
We use insight data collected from staff feedback surveys and are gathering more feedback and insight from staff on race and diversity to help inform/improve our culture.

Areas for improvement:

There is more work to do on our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) plans to promote psychological safety which in turn strengthens and promotes an improvement in the speaking up culture

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Further work planned on our response to the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Part of this is promoting psychological safety, which in turn strengthens and promotes an improvement in the speaking up culture.
2

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	3
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	No
Our speaking-up arrangements have been evaluated within the last two years	Yes

Enter summarised evidence to support your score.

Achievements:

We have continued to evaluate our speaking up arrangements there is one full time guardian in place and 3 part time Freedom to speak up guardians in place.

Audit on FTSU process and improvement plan completed in 2021/22.

Regular meetings are held with the non-executive director and executive director lead, which include discussion of the effectiveness of the Freedom to Speak Up guardian process, how this can be maximised, and the themes coming through from people who are speaking up.

Areas for improvement:

Implementation of a 'plan, do, study, act approach to improvement in the plan.

Staff survey results look at organisational culture and we need to develop further mechanisms to measure improvement and confidence to speak up

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Exploring how we can improve psychological safety within teams.
2 To use a Plan Do Study Act approach and anonymous case studies to share the learning and work alongside with Quality Assurance and improvement team.

Statements about assurance	**Score 1–5 or yes/no**
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	3
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3
Enter summarised evidence to support your score.	

Achievements:
Report has been updated following audit and meets NGO requirements and those of the Trust Board
Report provided directly to People Remuneration Committee twice a year, report has been delivered to Board previously by the executive sponsor for FTSU, the FTSUG now presents directly to Board.
Learnt lessons are recorded in the report
Numbers of Datix and near misses also reflected in patient safety report - positive reporting culture within the Trust.
Senior lead for FTSU (the Deputy Director of Corporate Governance) now attends Quality and Safety Committee

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

The plan will be reviewed in line with reporting into people renumeration committee dates of July and January

Actions are presented in order of principles.

Development areas to address in the next 6–12 months	Target date	Action owner
1 Continue to review FTSU arrangements on an annual basis and utilise feedback from those who have used the service as part of the annual reporting to People and Remuneration committee (PRC) and Trust Board. Act upon the results of the review and learn from the review to inform next year's improvement plan.	31 July 24	FTSUG/Deputy Director Corporate Governance
2 To undertake an annual review of training needs and explore further opportunities for board engagement, to ensure the board continues to meet their obligations.	31 July 24	Non-Executive Director Lead/Interim Chief People Officer
3 Continue to take part in raising awareness of the role and promoting the role as Lead Non-Executive Director for Freedom to speak up. Continuing to promote the role of Lead Non-Executive director.	31 July 24	Chair/Non-Executive Director Lead
4 Review the staff survey results for 2022/23 and 2023/24 and benchmark against our peers, to identify best practice and areas for improvement.	30 April 24	FTSUG/Interim Chief People Officer
5 Ensure FTSU strategy aligns and informs the great place to work delivery plan, to continue improve the speaking up culture within the organisation.	30 April 24	FTSUG/Interim Chief People Officer

6 To explore inclusion of a question on FTSU policy awareness in 2023/24 staff survey to ascertain if staff are aware.	30 April 24	FTSUG/Interim Chief People Officer
7 Develop a 3 key questions survey awareness questionnaire for be used during visits to teams and wards. To be able to receive real time feedback.	30 April 24	FTSUG/Deputy Director Corporate Governance
8. A robust communications plan to be produced annually to take account of reviews that have taken place, using staff survey data, Datix, exit interviews, civility and respect champions and FTSU steering group. To include improvements at a service level in team brief and meetings.	31 July 24	FTSUG/Deputy Director Corporate Governance
9 Follow up survey 3, 6, and 12 months following closure of case to ascertain and assure if any detriment suffered as a result of raising a concern, and report on actions taken as a result. Review data after in place after 12months.	31 March 24	FTSUG/Deputy Director Corporate Governance
10 Mapping all the ways in which the Trust encourages and supports this open culture and listens to the workforce, this forms part of the annual communications plan.	31 August 24	FTSUG/Deputy Director Corporate Governance
11 To undertake a review of local induction with the People directorate to ensure that new starters are informed about the FTSU process within the Trust.	31 January 24	FTSUG/Deputy Director Corporate Governance
12 Increase the diversity of the representation of FTSUG in line with workforce. To recruit 2 more guardians. Ensure that new guardians are supported in the role and access support from National guardians' office as well as internal support. Lead guardian with other supporting FTSUGs with an inclusive sustainable model.	31 October 24	FTSUG/Deputy Director Corporate Governance

13 To review the barriers to speaking up and the solutions following October 2023 speak up month, share this via the FTSU steering group and by developing a communications plan.	31 July 2023	FTSUG/Deputy Director Corporate Governance
14 Raising awareness of what detriment is and how to prevent it occurring and learning from events. Restorative conversations within teams. EMT paper presented.	30 September 2023	FTSUG/Deputy Director Corporate Governance

Development areas to address in the next 12–24 months	Target date	Action owner
1 Introduce the Plan Do Study Act approach and anonymous case studies to share the learning and work with Quality Assurance and improvement team to facilitate this, sharing learning via the FTSU steering group.	31 Dec 2024	FTSUG/Deputy Director Corporate Governance
2 continue to raise awareness of Listen up and Follow up training uptake, via promotion in Operational Management Group and the communications plan.	31 Dec 2024	FTSUG/Deputy Director Corporate Governance
3 continue the development and use of equality data and any patterns of impact to be picked up through performance and remuneration committee to identify any Trust wide approaches to address and monitor this via the FTSU steering group.	31 Dec 2024	FTSUG/Deputy Director Corporate Governance
4 continue the use of equality monitor training data to ensure specific groups that may need targeted trust communications to encourage the use of FTSUG are identified and supported.	31 Dec 2024	FTSUG/ Associate Director Communication, Involvement, Equality & Inclusion

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
The Trust has a communications plan that will continue to promote the areas of strength below. The FTSUG will also ensure these are shared as appropriate externally for example as part of the regional network:	31 March 2024	Estelle Myers
1 Recruitment of FTSUG via fair and transparent process from REACH network	31 March 2024	Estelle Myers
2 Clear process for addressing detriment, all cases are independently investigated and overseen by lead NED	31 March 2024	Estelle Myers
3 Feedback on ease of finding policy has been received by FTSUG	31 March 2024	Estelle Myers
4 Speak up training is mandatory	31 March 2024	Estelle Myers
5 Emotional support in place for FTSUG	31 March 2024	Estelle Myers
6 New policy contains process for speaking up	31 March 2024	Estelle Myers

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.5

Private/Public paper:	**Public**		
Title:	**Emergency Preparedness, Resilience and Response [EPRR] Compliance**		
Paper presented by:	**Adrian Snarr - Director of Finance & Resources (Accountable Emergency Officer)**		
Paper prepared by:	Emma Hilton - Emergency Planning Advisor		
Purpose:	The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) clearly set out the EPRR standards which NHS Organisations and providers of NHS-funded care must meet.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	This report shows the Trusts compliance with the core standards for EPRR as introduced by NHS England, to outline a framework for providers to follow; to meet their obligations under the Civil Contingences Act 2004, the NHS Act 2006 and the Health & Social Care Act 2022.		
Any background papers / previously considered by:	Executive Management Team – weekly updates via Deputy Director of Estates and Facilities. Operational Management Group - weekly updates via Deputy Director of Estates and Facilities. Annual Board reports		
Executive summary:	The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) clearly set out the EPRR standards which NHS organisations and providers of NHS-funded care must meet. The new standards were published on 25 May 2023 with a request for compliance status by the end of October 2023. A self-assessment toolkit was provided (attached appendix 1) which formulates an action plan for the following 12 months; this along with the self-assessment is to be submitted to NHS England.		

In early June 2023, a new self-assessment template was provided, followed by new guidance and assessment criteria on 20 June 2023.

A request was provided with the new guidance for completion of assessment and provision of evidence to be submitted to NHS England by 28 September 2023.

A new assessment process ensued through September and October resulting in a final submission of assurance and subsequent action plan being processed on Friday 17 November 2023. This action plan will form the core work streams for the 2023/24 action plan for EPRR and as such supersedes any previous EPRR work programmes.

The core standards include a review on Chemical, Biological, radiation & Nuclear (CBRN)/ Hazardous Materials (HAZMAT) standards, which now places additional duties on Mental Health and Community providers in comparison to previous years.

SWYPFT as a Healthcare provider of Mental Health and Community services is mandated to provide assurances against 58 standards. These standards enable providers of health care to share a common purpose and to co-ordinate EPRR activities. In addition to this the Trust must also provide assurance against 10 “Deep Dive” standards; however, these do not form part of the final position of the Trust. This year the Deep Dive seeks assurance regarding EPRR Training.

It is now evident following the self-assessment that NHS England expectations in regard to evidence have increased significantly hence the significant mismatch between the Trusts self-assessment and NHSE’s assessment.

An evidence submission and declaration process followed, with compliance levels being reported as below:

	Number of Standards			
	Trust Initial Declaration	NHSE Initial Assessment	NHSE secondary Assessment	Trust final declaration
Fully Compliant (Green)	46	4	5	15
Partial Compliant (Amber)	9	46	45	31

Non-Compliant (Red)	0	8	8	3

These works relate to the review of governance arrangements along with updates to plans, policy and procedures to meet new expectations; the implementation of a new Training Needs Analysis and subsequent training packages and implementation of an EPRR risk register. Works to progress all standards are underway locally and on a regional footprint.

Last year the Trust declared substantial compliance; this year the Trust will be declaring non-compliance. It is a point of note that the reduction in compliance rating was expected due to the changes from the national review and the implementation of new assessment criteria across the footprint. The Trust is aware that this is challenge for other mental health and community Trusts. The Trust has agreed to meet with NHSE and the West Yorkshire integrated care board (ICB) to establish a way forward.

Recommendation:	**Trust Board is asked to APPROVE the submission of the core standards compliance position and note the action plan.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
SWYPFT Core Standard Update Report

Background

NHS England introduced the Core Standards for EPRR, in order to outline a framework for providers to follow; to meet their obligations under the Civil Contingences Act 2004, the NHS Act 2006 and the Health & Social Care Act 2022. The standards have expanded historically to include additional standards. This is as a result of responses to major incidents and identification of gaps in assurance across the NHS. In order to ensure that the standards continue to remain current and also be fit for purpose, they are reviewed at a national level every 3 years.

A recent self-assessment process was undertaken by all provider organisations, which in turn enabled them to provide a snapshot picture in time, of each providers compliance level against the Core Standards. Compliance levels were previously measured as follows:

- Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
- Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
- Green (fully compliant) = Fully compliant with core standard.

In 2022, NHSE conducted a pilot in the Midlands, to test a new method of assessment against the Core Standards, by way of provision of evidence to NHSE. The reason behind these changes was due to the outcomes of national incidents, including Grenfell tower and the Manchester Arena Bombing.

The outcomes revealed a significant reduction in compliance against the core standards, however it was agreed by NHSE that this would be moved forward into 2023, with Yorkshire and Humber being the next areas to take part in the new trial process; it is a point of note that the extension to the trial was unknown to providers and rolled out 3 months prior to compliance deadlines. It is expected by NHSE that this new process will roll out nationally in autumn 2024.

As part of this new process, compliance levels are rated as follows:

- Green/Compliant – the evidence contains all required components.
- Amber/Partial - evidence is missing one or more required components of the assessment criteria.
- Red/Non-compliant - evidence does not meet the required components.

Assurance Stages

Following an internal initial assessment of the standards and new assessment guidance criteria, the Trust submitted a self-declaration of 79% compliance, along with relevant evidence, which equated to Partial Compliance. This was submitted on Friday 29th September. NHSE then assessed the evidence provide in line with their assessment criteria, returning an initial feedback response by the end of October. The initial feedback advised that SWYPFT were not at 79% compliance, but at 5% compliance which equates to non-compliance.

The Trust were given the opportunity to challenge this rating within 5 working days, which was undertaken, however response was further received noting a 7% compliance rate, which was as a result of NHSE accepting a challenge against 1 core standard relating to Mass Casualties.

The new process allows for organisations to challenge recommendations based on analysis of feedback and understanding of what is in place within their Trust, therefore following discussions with the Director of Finance and Resources (Accountable Emergency Officer (AEO) for EPRR), and the Deputy Director of Estates (Deputy AEO), a final submission of 26% will be submitted.

Whilst this still equates to non-compliance this this is a position that the EPRR team and AEO consider better reflects the Trusts position against the new standards based on NHSEs enhanced evidential requirements and external auditing review process.

NHSE have stated that the compliance ratings reflect that organisations have not provided sufficient evidence to meet standard criteria and does not mean that organisations are not carrying out their work effectively.

A total of 11 amber rated standards have been changed to green and 3 from amber to red by the EPRR Adviser and AEO from the following domains:

- Governance – Amber to Green x 2 - the trust has an effective EPRR policy in place. Whilst the policy does not reflect the EPRR framework, this can be updated accordingly. The Trust also have an AEO in place with appropriate documentation noting their position within the Executive Director Team.
- Duty to Maintain Plans – Countermeasures – amber to green - the Trust has suitable response arrangements in place to respond in the event of the requirement to vaccinate patients and staff. The standard recommendations refer to responding to nerve agent antidote and mass prophylaxis. The Trust would respond in line with guidance provided at the time from ICB's and NHSE, with primary response being in the wider network.
- Duty to Maintain Plans – Evacuation and Shelter - amber to red (changed from initial assessment due to being unable to achieve within 12 months) – the ability to produce while site evacuation and shelter plans for our inpatient settings cannot be achieved within 12 months. This is a regional risk and workstream given the complexities and pressures within Mental Health settings.
- Duty to Maintain plans – Excess Fatalities – amber to green - the Trust would not have an Excess Fatalities plan, however, would provide Psychosocial support to those affected in events leading to excess fatalities. This again would be a multi-agency response, with primary response being within Primary care and Mental Health trusts as secondary care, therefore access to services would be through already established pathways. We will document a process for evidentiary purposes next year.
- Duty to Maintain plans – On Call Mechanism – amber to green - whilst NHSE marked the Trust down based on the results of the latest on call test, we argue that the Trust has an effective on call process in place and any actions from the latest test will be captured and managed accordingly.
- Training and Exercising – Staff Awareness and Training – Amber to red – training as a whole is suspended at the moment due to national and regional works being undertaken by NHSE and the ICB's to identify training packages, trainer requirements and training availability. Until this is achieved at national and regional level all providers are unable to achieve this standard.
- Business Continuity x 3 standards – amber to green – the Trusts business continuity arrangements work effectively, however will need further review. The need to review does not mean that the processes do not work, hence the challenge to green.

- Business Continuity – BC Audit – amber to green – NHSE challenged governance processes around the audit process, even though this is confirmed in the audit report and EPRR policy. Background works will be undertaken to strengthen evidence; however, it is believed the Trust have effective arrangements in place for auditing EPRR.

Conclusion

Whilst the trust is effectively acknowledging a 50% reduction from their initial self-assessment, against the former processes; the acceptance is due to changes in new evidence requirements that were introduced one month after the initial core standards release. In addition to this, providers are still awaiting a number of frameworks, plans, procedures, and training packages from NHSE to enable achievement against numerous standards, again in line with the new assessment criteria.

The Trust can consider the effectiveness of EPRR arrangements following confirmation of Significant assurance following a 360 Assurance audit in September 2023. Works are to progress to effectively evidence all required arrangements in line with NHSE's new requirements.

Emma Hilton
EPRR Adviser

Adrian Snarr
Director of Finance & Accountable Emergency Officer

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description						
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.					
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.					
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan						
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group					
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations						
Domain 2 - Duty to risk assess											
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather						
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document						
Domain 3 - Duty to maintain Plans											
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded						

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.						
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/						
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.						
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.						

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16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						
Domain 4 - Command and control											
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners						
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.						
Domain 5 - Training and exercising											
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff						
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning						

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff						
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board						
Domain 6 - Response											
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.					
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies						
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes						
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records						
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template						
Domain 7 - Warning and informing											
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.						
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).						

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35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements					
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response					
Domain 8 - Cooperation											
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.					
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system					
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate					
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004					
Domain 9 - Business Continuity											
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning					
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation					

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.					
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices					
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans					
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved					
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers					
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme					

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents					
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers					
Domain 10 - CBRN											
56	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation					
57	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services					
58	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient					
59	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident					

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
61	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.					
62	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53					
64	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment					
65	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records					
66	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS					
67	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning					

Ref	Domain	Standard	Deep Dive question	Further information	Mental Health Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - EPRR Training											
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders							
DD2	EPRR Training	Minimum Occupational Standards	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios							
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff							
DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.							
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered							
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records							
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.							
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website							
DD9	EPRR Training	Continuous Improvement process	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements.							
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.							

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 10.6 – Assurance from Trust Board Committees

Mental Health Act Committee

Date	7 November 2023
Presented by	Kate Quail (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • 'Right Person Right Care' - risks and mitigations – agreed to go through the risk process to determine whether our controls, assurances and actions are sufficient to mitigate any risks, noting some risks will be Mental Health Act related. • Ethnicity - continued picture of underrepresentation of preventative, least restrictive services and over representation of detained patients from certain minority groups. This is an ongoing concern and area of focus for MHAC and is part of the equalities work across care groups. **Advise:** • Briefing – 'Mental Health Act or Deprivation of Liberty Safeguards (DoLS). Case law confirms that people who lack capacity and are clinically fit for discharge but have no community placement to be discharged to, can still be detained under the Mental Health Act, not the Mental Capacity Act (MCA). Legal briefings for governance groups, staff and Hospital Managers' Forum, and update on Trust MCA intranet page. **Assure:** • Performance Monitoring information Q2 - Overall, good assurance of compliance: • Section 17 leave compliance, positive position of leave being granted and taken. Exploring different ways of measuring pre-planned leave in Adults' and Older people's mental health services, in line with Forensics. Forensics and Specialist services had an improvement plan and exceeded the 90% plan, with 92% of granted leave being taken. • Mental health advocacy - positive position, good partnership working and relationships between Advocacy services and Trust staff. Service users and carers supported appropriately. • Section 132 Patients' Rights, positive position - compliance for detained patients 99% held from quarter one. 93% for informal patients. Community 84%. • Mandatory Training compliance MHA and MCA/DoLS have some of the highest compliance rates of all mandatory training across the Trust - Compliance (standard 80%) Trust-wide for clinical staff 91. 74%; non clinical 100%. Assurance gained that any service /team 'hotspots' of non-compliance are identified and addressed promptly. • Code of Practice Oversight Group – assurance on ongoing activity relating to the implementation of the current Code of Practice and

	the development and preparatory work related to pending legislation. • Care Quality Commission MHA visits – Assurance that actions and recurring themes have an action plan or quality improvement workstream taking place. All actions are managed through the nursing quality and professions directorate or though the MHA team. Visit activity has increased with the number exceeding previous years. • Community Treatment Order (CTO) Annual Report - Assurance on the use of CTOs, patient rights, and access to advocacy services for those subject to a CTO. Of note, nationally, CTO use on Black people are over 11 times that of White people. (CQC national reports on longstanding inequalities state "urgent action is needed to tackle the over-representation of Black people on Community Treatment Orders & that progress too slow"). However, in this Trust, only 45% of people on a CTO are from a Black Asian Minority Ethnic background. The MHA Team is working with Performance Monitoring & Informatics team to build a report on the use of CTOs by the Trust. • Independent Hospital Managers' Annual Review – All managers have had their personal reviews. Rolling programme of recruitment ongoing, with a focus on increasing diversity. MHAC acknowledged and thanked Gordon Walker in his last meeting as Chair of the Hospital Managers' Forum for his hard work and dedication. Committee also fondly remembered Lorraine Jeffrey who sadly died in September. Lorraine worked tirelessly for patients and families and will be hugely missed by all. Committee also thanked June Stokes who is standing down after many years dedication and service to the Trust and to patients and families.
Approved Minutes of previous meeting/s for receiving	Minutes of 15 August 2023

Quality and Safety Committee

Date	14 November 2023
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert** • The committee deferred the Safer Staffing report as it required additional work to provide analysis for the committee and to enable assurance to the board. • The committee discussed the two new and emerging risks (still to be allocated a reference number) on the risk of staff not being able to speak up and the risk of fear of sexual harm. The committee recommended that the first risk on speaking up should be primarily assigned to the People and Remuneration Committee with issues around quality continuing to be escalated and reported to the QSC. The committee agreed that the risk of sexual harm for our service users and patients was an emerging risk and should be assigned to this committee with a dual role into People and Remuneration in respect to the risk for staff. • Reducing Restrictive Practice Interventions (RRPI) remains a focus of the committee and the board. There is ongoing work around this given the key issues escalated to the board in October specifically around the use of prone restraint in the way that we report and alternatives to injection in the buttocks. These are not resolved

	hence the alert to board with assurance that work is happening to address this. • the committee heard about international nurses reporting a poor experience including issues raised around racism. The Trio have acted quickly to meet with them to understand their experience and an external review has been commissioned. **Advise** • The committee received the Patient Safety Update • The committee acknowledged the broadening of the Patient Experience report through the update provided and welcome this to ensure we hear the voices of our service users. • The committee acknowledged the positive discussions at a system level and in place around LeDER (Learning from Deaths Report) and the profile this is being given. • The committee were advised in October of an issue with access to ADHD assessments for people with learning disabilities and were advised at this meeting that this information has been shared with commissioners in order to start negotiations on this. • The committee noted the Advancing Clinical Practitioner (ACP) report and welcomed the update. It was recommended that this should report into the People and Remuneration Committee as part of the wider workforce planning and development. **Assure** • The committee requested that the Quality Improvement Assessments (QIA) overview be reported through committee so the board can be assured that these are taking place for the larger scale improvement programmes as currently it shows as zero as it relates to local Cost Improvement programmes (CIP). • The committee were assured that the presence of NEDs on Quality Monitoring Visits (QMV) is not optional and that this has been communicated across the team. There are still issues around the scheduling and the team are aware of this now and will be addressing. • The committee noted the reduction in the use of Out of Area beds and acknowledged this positive position and the work that had led to this. The next steps are to develop assurance around the impact of this reduction in terms of the wider system. • The committee recommended approval at board of the Trust Incident Report for Q2. • Learning from incidents remains a focus and the committee were advised of such learning and action being taken as a result of a serious incident to look at restricting access to plastic bags and confidence in searching and lock down procedures. • The committee received the Annual Ligature report and advised some amendments ahead of recommending approval to board. • The committee received the Medical Education Annual report and noted the ongoing pressures around the rota coordinator team, the impact of industrial action and trainee vacancies.
Approved Minutes of previous meeting/s for receiving	Minutes of 10 October 2023

Members' Council

Date	17 November 2023
Presented by	Marie Burnham, Chair (Chair of Committee)
Key items to raise at Trust Board	**Key points** • 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 approved the Constitution review • Members' Council received the Patient Experience annual report • Members' Council received the Incident Management annual report • Members' Council approved the Chair remuneration • Members' Council received an update on the Members' Council election process in 2024 • Members' Council received the Integrated Performance Report (IPR) • Members' Council received a presentation on how to make governor contribution to the Members' Council easier
Approved Minutes of previous meeting/s for receiving	Minutes of 15 August 2023

Finance, Investment & Performance Committee

Date	20 November 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Capital in year remains on track, but an emerging risk, given property related activity is somewhat dependent on external factors. • ASD & ADHD referrals continue significantly in excess of expectations, but diagnosis levels remain in line with expectation. Referrals are self-referral via GPs, and therefore for various societal reasons, this has resulted in circa 10x increases in referrals vs expectation, resulted in long wait times. To address this, something wider than addressing wait times appears to be required, and wider than SWYPFT in isolation. **Advise:** • Short term financial sustainability remains ok, however, as we move into Q4, it is expected that this risk will increase • Reassured that Cost Improvement Programmes are in progress, full assurance will be provided with a detailed update in January committee. • Agency reduced significantly in October, mainly in inpatient settings, further evidence is required to understand if this will be sustained or a one-off • Single point of access update provided demonstrating where we are, and what actions are next to further improve experiences. **Assure:** • Cost Improvement Programme is being worked on with other Trusts in the same system being consulted to ensure fair and collective targets. • Reforecast was submitted, presenting the Trust as break even, as we are expected to see upsides offset by risks.

	• Out of Area has now demonstrated a consistent decline. Work ongoing to ensure all are clear why this is a focus for the Trust, so it can be sustained after the emphasis on it has been reduced. Work also ongoing in Kirklees where some out of area remains, due to under commissioned beds.
Approved Minutes of previous meeting/s for receiving	Minutes of 23 October 2023

People and Remuneration Committee

Date	21 November 2023
Presented by	Mandy Rayner (Non-Executive Director) (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Appraisal compliance was discussed in detail as part of the IPR. The committee also received an appraisal improvement plan. The compliance had dropped to 69% this month. The plan described an ambition to initially target 80% compliance with a further ambition to achieve 95%. The committee continue to seek assurance on the effectiveness of the plans in place to improve the take up of appraisals so as to meet our targets. • The committee received a verbal update on the Organisational Development plan which was encouraging but not where we need it to be little progress has been made. A paper will be presented to the committee in January. • The IPR was subjected to challenge more focus on hot spots has been requested. The Directorate has been asked to provide metrics across care groups. **Advise:** • The interim CPO presented a report on current activities taking place across the people directorate, this included onboarding system issues, feedback from international nurses and nurses from across the trust, OD priorities and a staff side working in partnership discussion. • Uptake of the flu vaccine is low at 45%. This is the trend nationally. • The freedom to speak up numbers were shared and challenged. Incidents are low it seems staff are using other methods to speak up. The committee also received the FTSU reflection tool a self-assessment that scores the trust against some key standards. The tool will be received by the BOD in November. • The great place to work activity plan is making good progress. The plan has now been consolidated and prioritised. • The committee ratified the Clinical excellence awards. • The Very Senior Manager pay award was supported and approved. **Assure:** • The trust is currently showing a 50% response rate to the staff survey. This equals last year and may still increase over the final week. • The committee received a presentation on e-rostering and the safe care tool. Good progress is being made, however there are some challenges around optimisation and driving the efficiencies the solution can bring. • Agency spend has seen a reduction last month. There was some discussion around what data the committee needs to see and how

	they could add value to the management and control of agency spend. • The committee received the mandatory training annual report. Overall, the trust is in a good place reporting compliance of over 90%. The report was very detailed and did describe areas requiring improvement such as RRPI and CPR. **Risk Register: reviewed risks.** • Two new risks were presented to the committee around FTSU and Sexual Harm. Both will be discussed at EMT. The committee did except that both should be assigned to PRC. The Sexual Harm risk will also be assigned to Quality and Safety committee • The risk around industrial action was discussed it was decided the score should stay the same as the impact has had a broader impact. • All other risks associated with the committee remain the same. **New risks identified:** See above still to be approved
Approved Minutes of previous meeting/s for receiving	Minutes of 19 September 2023

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Mental Health Act Committee Meeting held on Tuesday 15 August 2023 Microsoft Teams Meeting

Present:	Kate Quail (KQ) Dr Subha Thiyagesh (STh) Erfana Mahmood (EM) Mandy Rayner (MR) Carmain Gibson-Holmes (CGH)	Non-Executive Director (Chair of the Committee) Chief Medical Officer (Lead Director) Non-Executive Director Non-Executive Director Deputy Director of Nursing, Quality and Professions
Apologies:	Darryl Thompson (DT)	Chief Nurse / Director of Quality and Professions
In attendance:	Julie Carr (JC) Yvonne French (YF) Chris Lennox (CL) Rajarshi Das (RD) Carly Thimm (CT) Gordon Walker (GW) Gemma Williamson (GWi) Sarah Burns (SB)	Clinical Legislation Manager Assistant Director of Legal Services Director of Services OPS Consultant (Item 3) Mental Health Act/MCA Manager Chair of the Hospital Manager Forum Mental Health Act Officer PA to Chief Medical Officer (Author)

MHAC/23/28 - Welcome, introduction and apologies (agenda item 1)

The Chair, Kate Quail (KQ) welcomed everyone to the meeting.
Apologies were noted as above.
The meeting was deemed not to be quorate. Yvonne French (YF) advised KQ that she had taken advice from the Head of Corporate Governance (Company Secretary) who advised that there were two agenda items where a Committee decision was needed:

- Item 4 - Ratification of the draft Minutes of the 16th May Mental Health Act Committee meeting –, these could be agreed by Committee but must be reviewed by DT prior to Minutes going to Trust Board.
- Item 8.2 - Mental Health Act (MHA) risk register. any additions to this could be agreed in the Committee meeting but would also need to be agreed post-meeting with DT on his return.

With these assurances it was agreed to proceed with the meeting.

KQ outlined the Microsoft Teams meeting protocols and etiquette. Meeting would be recorded for transcription purpose and would be deleted once minutes had been agreed.

MHAC/23/29 - Declarations of Interest (agenda item 2)

The Committee noted that there were no further Declarations of Interest over and above those made in the annual return to Trust Board in July 2023 or subsequently.

MHAC/23/30 - Challenges and opportunities in Older People's Mental Health (agenda item 3)

Dr Rajarshi Das gave a presentation on the Mental Health Act (MHA) in Practice, within the older people's speciality which focused on the clinical application of the MHA on an older people's mental health ward and its interface with the MCA. The presentation addressed the least restrictive option, and the therapeutic benefit for the patient and also considered the person holistically as an individual. Currently the ward has 50/50 patients detained under the MHA and informal. Where possible the aim is to treat patients informally with the emphasis on promoting recovery and discharging back to the community.

Dr Das reported that there have been improvements in compliance with the Trust s.132 policy for patients, with the Mental Health Act Office sending feedback every week and e-mail updates as to whether the rights of the patient has been documented or not. There is an initial capacity assessment by the admitting doctor which is reviewed by the ward consultant to ensure that where possible patients can be treated informally rather than under the MHA. The Crofton ward team are working collaboratively with both patients and their families to formulate care plans and their updates. There is a focus on the staying safe plan for the patient and a regular review of the patient's capacity to consent to the admission and to treatment is documented with each MDT review.

With the support of the MHA office the Approved Clinician (AC) in charge of treatment ensures the capacity assessment to support consent to treatment under s.58 (forms T2 and T3) are recorded in full. Additionally, when receiving a T3 from the SOAD the AC will discuss the outcome of the opinion with the patients and ensure this is recorded.

Dr Das presented three scenarios to demonstrate how the MHA and MCA inform care and treatment for different patients and how this is reflective of their needs.

Deprivation of Liberty Safeguards (DoLS) can be difficult to apply in an acute psychiatric setting. The application needs to justify why the MHA is not the appropriate legal framework to detain a person who has a mental illness to a psychiatric ward. There are also difficulties such as when a person who lacks capacity to consent to the admission is not objecting to the admission or the care and treatment it is not appropriate to seek an urgent authorisation, which provides an immediate self-authorisation to deprive the person of their liberty until a standard authorisation can be granted for the on-going detention. Instead, a standard authorisation should be sought, this takes 21 days to complete, and although the Local Authority prioritise hospital applications there can be delays in this process leading to longer waits.

Dr Das described how the service balances the challenges of working between the two legal frameworks so that the overall approach ensures that there is excellent person-centred care, promotion of individual well-being, where capacity is regularly reviewed with the aim of ensuring that detentions are kept to the minimum both in duration and number.

STh asked what challenges are faced such as section 17 leave and staffing issues. Dr Das explained that in terms of section 17 leave there are challenges for the service because staffing is a big problem with inpatient units, so even though patients may be granted escorted leave to the local area, it is not always possible to facilitate this and maintain ward safety and functioning, some patients can get annoyed.

STh stated that the MHAC are developing an annual performance report and some of the areas planned for review are inequalities, gender elements and age etc. STh asked if in Dr Das's opinion, if he is seeing the right numbers of admissions in terms of the ethnic minorities and if he has noted any impact from some other sources such as deprivation, loneliness etc?

Dr Das explained that loneliness is a huge issue as is the associated social isolation that does not fit into the core psychiatric illness, or diagnosis. Unfortunately, because of the loneliness people can engage in risky behaviours. This is especially so in old age which leads to admission to psychiatric hospital. The team then try to work collaboratively with the community teams, to access options such as befriending services for support on discharge. In regard to ethnic minorities, Dr Das had not noted any disparity within Wakefield, however noted that there are different experiences on other wards across the Trust; And to focus more on the culture in the wards, engaging with the person's family and use pastoral services as well to help support the staff, the person and their family.

EM commented on loneliness and what services are available in the community including local charities. Dr Das commented from a psychiatric inpatient perspective, that through the discharge process contact is made through the support networks and befriending services for patients who do not have support from families or friends.

KQ commented that we need to look at how we work with and support community groups, the voluntary and community sector, in terms of prevention.

CGH commented on employing least restrictive practices whilst using legislation, and how this is not always easy and can cause some anxiety within the workforce around how to manage that. CGH asked whether through the adopted QI approach anything around patient and staff experience working within a least restrictive practice had been captured.

Dr Das reported that nothing of this nature has been captured to date though this was something that could be explored, especially focusing on the consent to treatment aspect.

CGH thought it was a good opportunity to capture patient and staff experience to support other wards to take on the practice. CGH will contact Dr Das outside of the meeting.

Action: Carmain Gibson-Holmes

KQ suggested linking in with the Integrated Care Board (ICB), West Yorkshire, who are undertaking work in relation to loneliness. KQ noted that we need to ensure that all our services are linked into those services so we can signpost to the right place.

CGH advised the committee that information is available though we need to revisit this to ensure people know where to access the information. CGH will contact the communications team to circulate a reminder in the trust briefings about available information and resources.

Action: Carmain Gibson-Holmes

STh noted the important point that Dr Das had made about loneliness and risk, and the importance of understanding a lot more about the impact on their mood, well-being and physical health. ST added that further links could be made with the work happening within Integrated Care System (ICS)

KQ thanked Dr Das and commented on the complex legislation that is used within mental health and praised staff's ability to navigate it with skill and sensitivity, always putting service users and families in the centre of what they do.

MHAC/23/31 - Minutes from previous Mental Health Act Committee meeting held 16th May 2023 (agenda item 4)

No amendments or corrections to the minutes from 16th May 2023. Minutes agreed as a true and accurate record by the Committee with the understanding that DT will review and confirm approval outside of the meeting.

MHAC/23/32 - Matters arising from previous Mental Health Act Committee meeting held 16th May 2023 and board action log (agenda item 5)

Agreed that there were no matters arising from the previous meeting, other than those on the Matters Arising action log.

MHAC/23/19b - Matters Arising 1

YF confirmed her discussion with Research and Development (R&D) and also with Dawn Pearson with regard to the previous Discovery Interview service user engagement work that was undertaken on Forensics. YF informed that this links with a new piece of work looking at the journeys of Newton Lodge service users who have come through the criminal justice system. The work will look at the ethnic background of the person and what MHA section they had been admitted into hospital under. The data will be cross referenced with their index offence.

YF met with Wajid Khan in R&D to share this work and agreed to meet again, subject to committee support, to progress this work further. This will also link into other R&D work on equality.

STh stated that we need to be realistic in terms of scale of the challenge, we have to continue to do this work and need to link this with other pieces of work happening in the organisation.

STh explained that a few years ago work was taken to the West Yorkshire ICS which showed research engagement and participation is lower in minority ethnic groups.

EM felt that this could be used to support our application for teaching hospital status. STh confirmed that it would be helpful to continue having wider conversations and it is in keeping with our trust objectives.

KQ was supportive of this work and confirmed that this action was now completed.

Action in relation to linking with Susan Bains regarding accessing Charitable funds for toiletries and access to drop in services such as hairdressers had now been closed.

MHAC/23/21a - Performance report 3

CL confirmed that this pertained to young people in adult beds rather than relating to our provision of care. KQ confirmed this action was now closed.

MHAC/23/21a - Performance report 4

This action was to discuss with the Executive Trio how to better understand the experience of young people admitted to adult beds, acknowledging they are a particularly vulnerable group and need more bespoke patient experience methods rather than those used for adult patients.

CGH explained that following a Task and Finish Group in 2022 it was determined at that point due to low numbers of young people accessing beds, it did not appear to be a meaningful exercise.

However, since these numbers are increasing again and with a greater understanding of the pressures across the system, CGH responded that it would be helpful to revisit and review the impact on the young people around their experience.

KQ would like the outcome of the review to be brought back to the committee and to hear what the experience of young people was whilst on our inpatient wards, this would include both formal and informal patients.

CGH stated that we would need to establish if we wanted to undertake a retrospective piece of work or to capture experience 'live' in time. This could be a challenge as we don't have that many young people on our wards, so we'd need to navigate that as and when that comes up and think about the best person to discharge that and report on that.

CGH further discussed what is it we want to understand and what impact collating this data will have and therefore it might require planning to determine how we take that forward. We need to know that we're asking the right questions that will lead to something meaningful in terms of output.

KQ felt the purpose of this work would be to gain assurance about young people's experience and the quality and safety of their care.

EM asked if the Red Kite team could help with the work.

CGH felt that the Red Kite idea was worth exploring, however when it first opened it was asking very similar questions as would be asked of patients on an adult ward. This piece of work could look at potential gaps if the child /young person was not being cared for in an age-appropriate environment. Our safeguarding team provide wrap around support, our RRPI team, specialist advisors support our clinical teams to ensure that we're meeting those needs that are specific to a child or young person within our wards.

MR commented that for assurance, if any young person is admitted onto an adult ward, we have to make sure their experience is as good as possible. So how do we avoid them being there at all. We know we've got national pressure around tier 4 beds and being able to place patients, which is why the Exec Trio were looking into the operational management around the system and being able to discharge. MR feels that we need check the experience for the patient or service user is as good as it possibly can be though we've got to focus on avoiding them being there in the first place and it's just that assurance around those two areas.

STh explained that this is being addressed through the acute inpatient improvement work, some of this is about patient experience and mapping that across to good practice standards. and to the in-patient work already being done. The focus would be to understand the impact on the young person on the ward, how they feel at the time, leading up to it and short and long term impact.

It was agreed Executive Trio to specifically look at including the experience of young people on adult wards into the wider acute inpatient improvement work and to take updates into MHAC and Quality and Safety Committee. CL and CGH to link in with Carol Harris.

Action: Carmain Gibson-Holmes/Chris Lennox

MHAC/23/22a - MHA/MCA Code of Practice Oversight Group

KQ confirmed that this action was now completed.

MHAC/23/33 - Legal Briefings (agenda item 6)
MHAC/23/33a - Liberty Protection Safeguards (agenda item 6.1)

JC explained that we have now had written confirmation from the government of their intention at some point this year to release an updated Code of Practice which appears to be a combined Code of Practice for the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA.) There will be updates required for various policies and processes.

MHAC/23/34 - Feedback from Local Partners (agenda item 7)
MHAC/23/34a - Local Authority/Acute Trusts (agenda item 7.1)

KQ explained that local authority Approved Mental Health Practitioners (AMHPS) and our Acute Trust colleagues previously attended this meeting, however following a review of Trust committees they now attend the Mental Health Multi-Agency Partnership Group. Key operational issues that they raise at the Multi-Agency group can be brought through to alert committee as and when required.

KQ mentioned previously that CT has commenced 2 sets of monthly meetings with all acute partners, and any escalations of note for MHA committee are provided in the form of Alert, Advise, Assure (AAA) reports.

These meetings discuss the workstreams outlined in the Service Level Agreement (SLA) to support the Acute Trusts.

There is a further meeting held with Acute Trust partners and our CAMHS consultants in relation to our service users who are in the acute hospital but also under the care of Child and Adolescent Mental Health Services (CAMHS).
CT informed that the meeting with the CAMHS consultants has been extended to include Psychiatric Liaison Team (PLT) and also includes Acute Trust safeguarding leads and Matrons for complex needs. Complex scenarios are discussed and best practice shared.

This work with the acute Trusts has led to strong partnership working in relation to service users who require treatment for physical health needs. In some instances, this has developed into MDT working which includes practitioners from the acute trusts.

KQ thanked CT for developing the good practice which shows strong partnership working and can identify potential risks for our patients. Committee takes assurance that there are processes in place to deal with issues as and when they arise.

KQ suggested it would be beneficial for the Mental Health Multi Agency Group to provide a AAA or other highlight report into this committee. CGH as Chair of that group agreed to provide this if the information is appropriate for this committee. YF to discuss with CGH the best way to feedback to MHAC.

Action: Yvonne French

MHAC/23/34b - Independent Hospital Managers feedback (agenda item 7.2)

GW stated that newly appointed Hospital Manager colleagues are starting to contribute to the work and their inputs are greatly appreciated. GW also reported a return to more frequent face

to face reviews and appeals, where at least some of the reviews will be with the patient present.

KQ stated the annual reviews have been completed with most managers, though not yet all, and thanked the Hospital Managers for taking part and MR and EM for supporting the process.

MR explained in going through these reviews there had been some really positive feedback and was surprised at how long some of the managers have been doing the role and wanted to thank them for their commitment and loyalty.

MHAC/23/35 - Risk Registers (agenda item 8)
MHAC/23/35a - Consideration of the items from the organisational risk register (agenda item 8.1)

The organisational risk register (ORR) presented to the Trust Board on the 25th July 2023 has been reviewed in order to provide this report to Committee.

KQ confirmed that all organisational risks are assigned to relevant Trust Board committees though there are none currently assigned to this committee.

There are 2 new organisational risks that may impact on the operation of the MHA, which are: 'Delays of patients clinically ready for discharge', which can impact on bed availability during MHA assessments in the community. Graded as within risk appetite at Amber. The 2nd risk is 'A possible deterioration due to resource provision with the local authorities and other partners'. This could impact on the availability of AMHPS to undertake MHA assessments. Graded as above risk appetite at amber.

There are 3 risks that have previously been reported to MHA committee: risk 1368 and risk 1568 have been regraded from Amber to Red. Risk 1758 has been graded from Red to Amber.

KQ explained that the paper was introduced in order to understand the potential impact of organisational risks on the application of the Mental Health Act.

KQ confirmed that MHAC had been asked to receive the current Trust-wide corporate / organisational level, which it had done.

MHAC/23/35b - MHA Committee risk register (agenda item 8.2)

KQ asked those present to confirm that no risks had been identified for addition to the MHAC Risk Register . This was agreed with the proviso DT to confirm post meeting.

MHAC/23/36 - Statistical information use of the MHA 1983 and MCA 2005 (agenda item 9)
MHAC/23/36a - Performance report – monitoring information April – June 2023 (agenda item 9.1)

CL presented the Performance report for quarter one and thanked JC and colleagues for preparing the reports.

- In terms of the national picture, SWYPFT continues to match the trend in relation to the proportion of admissions under the Mental Health Act, with 44% in adult acute services, though the varies by locality,

- Admissions under the Act show Calderdale are currently seeing a high proportion of detained patients in comparison to Kirklees, Wakefield and Barnsley.

- There were three admissions of patients under the age of 18 compared to five in the previous quarter.

- Ethnicity data used to monitor the use of the MHA shows that there is an under representation of access for certain minority groups and access to services but an over representation of detained patients in hospital.

- The use of parts two and three of the MHA remains steady and has been maintained for some considerable time. There has been a decrease in the use of civil sections but nothing untoward can be taken from this.

- 41% of all admissions were under the MHA in the last quarter which is a small decrease.

- The average length of detention has reduced slightly for Section 2 and Section 3. These figures do not include our Forensic services where service users can remain for a number if years.

- 43% of Section 5(2) holding powers were converted to a Section 2 or Section 3. This is a slight decrease on last quarter.

- 48% of assessments under S136 resulted in an admission to hospital. Of these only 24% required formal admission the remaining 76% were voluntary admissions. CL advised that the service would look into this in respect of care closer to home and how people are being supported in the community.

- Transfer activity in Calderdale being the highest source of activity, and this is attributable to the older people's wards and the admissions onto Ward 19 and then people moving back to Calderdale going back to home area. No appeal hearings were affected by these transfers.

- 41 Community Treatment Orders (CTO) active at the close of quarter 1, there were 5 new applications and 14 discharges from CTO.

- 11 appeals to the Hospital Managers during quarter 1, Five of which resulted in a hearing. There were no discharges ordered by the Hospital Managers. Cancelled hearings were due to RC review and cancellation by the patient’s solicitor.

- There was a 13% decrease in applications to the Mental Health Tribunal, 55 hearings were heard which resulted in 9 discharges.

- The Trust received 10 new approaches for reports under Section 49 of the Mental Capacity Act, 2 resulted in orders for reports. The Trust currently has 26 open cases and 11 dormant awaiting instructions; and the courts advised of response time of 12-16 weeks due to continued pressures in clinical services.

- 8 Deprivation of Liberty applications during quarter 1 which were from the Trust neuro and stroke units. 1 application was refused, 3 are awaiting conclusion and 2 cancelled due to the patients being discharged.

- During quarter 1 there were 2 deaths of detained patients which have been reported to the CQC as part of the statutory notification. An 86-year-old female who was on escort to Pinderfields Hospital who died of physical health causes. A 59-year-old female who was detained under section 37/41, who also died due to physical health issues.

- 4 compliance reports submitted in quarter 1 which relate to documentation completed by medical and nursing staff and 1 section expiry.

- 34 exception reports submitted relating to consent to treatment, 33 exceeded the required CQC standard, all were escalated to the CQC for action. It was noted that one certificate is outstanding since May 2023. This is being managed by MHA office.

- 7 exception reports about 136 suites not being available due to being occupied by a service user detained following an assessment. CL felt that this needs qualification and interpretation due to it increasing; there is a developing common practice for AMHPS to immediately detain a person to the suite rather than wait to know where the identified bed is being made available.

- Section 17 leave is showing good compliance at a rate of 99% within Working age adult, older people services and rehabilitation. The Forensic service have an improvement strategy with a trajectory of 90%, in the last quarter this achieved 88% compliance. 5 patients were reported as Absent without leave during quarter 1 from the Forensic services.

- Recording of Consent to treatment under the MHA is being monitored by the MHA administration team. A Quality Improvement process is being followed to support the work.

- There was 1 compliment and 1 concern raised by the Hospital Managers during quarter1. These were in relation to a service user not being supported to read the reports prior to the hearing. The compliment was in regard to the excellent evidence provided by staff.

- There was 1 formal complaint received relating to the MHA and the Trust decision making regarding care and treatment. This is in the process of being allocated a complaint handler.

- Patient's Rights activity for informal and CTO patients are positive at 99%. This activity also covers statutory advocacy provision which continues to be positive.

- Training for the MHA. MCA and DoLS is positive and above the 80% target.

KQ felt there were many highlights: the mandatory training achievement is excellent and the really high levels of compliance for sections 132 and 132a is fantastic for patients who are informal, detained or on CTO's. KQ thanked colleagues for the achievements.

KQ commented on the 34 exception reports and explained that the Second Opinion Appointed Doctor (SOAD) is for patients who do not consent, or are unable to consent, to the treatment

as prescribed by clinicians, Second Opinion Appointed Doctors are engaged and managed by the CQC and of those 34 cases the CQC were unable to allocate a doctor within the statutory time limit. KQ noted that whilst we have emergency powers to continue treating, they are not meant to be long term.

CL confirmed that there are also certain treatment regimens that also automatically require that second opinion, so it brings in a broader cohort of patients and is rather a long-standing challenge.

The MHA administration team has developed an escalation process for these incidents, which is working well.

KQ confirmed that the MHA Committee was asked to receive and accept the performance and monitoring report, which it had done.

MHAC/23/36b - Annual MHA Performance Report Linked to Inequalities (agenda item 9.2)

YF explained that this is the first iteration of the report and further work will be ongoing during the year to build on the data and to link in with other Committees' work.

EM felt that the report was really good and that it highlighted data we already know about though don't have any empirical knowledge behind. EM also commented on whether the findings could be shared at ICS level?

MR commented that after reading the report the question is "So What" and felt that the next steps included in the Report are a journey towards this; what is the learning, how do these figures help us make better decisions about our service users.

YF had already linked in with Dawn Pearson and Aboobaker Bhana about the report and also with Wajid Khan (R&D), to discuss how to use it more broadly and how to build on it. YF had not yet had an opportunity to discuss the report in detail with STh.

STh thanked YF, JC, Mike Garnham and the team for bringing this together and appreciated colleagues' constructive feedback.

STh felt that a key point is talking about "So What" and linking in with what's happening already and mapping that and looking at potential gaps and in particular in terms of loneliness, social deprivation and length of stay by deprivation.
Whilst it can be affected by a small number of people, it still appears length of stay is a little bit longer for people from more deprived communities. When we talk about inequalities, we focus a lot on minority ethnic populations and there are other health inequality determinants which we also need to look at including deprivation. As an organisation we can do even more, and this committee could commission work.

KQ discussed the area in relation to asylum seekers waiting to be repatriated back to their home country as the trust does have a small number of inpatients who are asylum seekers and work is being carried out with our immigration colleagues to get them resettled.

KQ asked for clarification on the final paragraph which states, "the data shows several clear inequalities in access to services and the use of the MHA". JC advised that the comment is in relation to differences that have been highlighted in the report. These differences need to be explored further to understand any inequalities that may be impacting on access to Trust services.

KQ confirmed that the committee was happy to accept the suggested next steps, taking into consideration comments from Committee colleagues.

MHAC/23/37 - Audit and compliance (agenda item 10)

MHAC/23/37a - s.132 Patients' Rights Assurance Report (agenda item 10.1)

- S132 rights stands at 99% compliance, a 4% increase on the compliance last year.
- Community Treatment Orders compliance shows 99%, a12% increase on last year.
- Recommendation and action from the audit is to hand over the prompting and day to day management to the operational services.

KQ confirmed that the Committee was asked to receive and comment on the progress of the annual s.132 patients' rights assurance report and its actions, which it had done.

MHAC/23/37b - Advocacy Services (Independent MHA/MCA and general advocacy) Compliance Report (agenda item 10.2)

- Advocacy is also looking positive. The audit shows 99% pf patients were informed of the rights to advocacy and what their roles are.
- There were 1,128 referrals to advocacy over the past 12 months.
- Action and Recommendations is to hand over the prompting and day to day management to operational services.

Currently looking at handing back advocacy compliance to clinical services as it falls under S132. Engagement meetings with advocacy are ongoing and will continue to be monitored and will ensure all publications and posters are up to date and accessible to staff and patients.

MR commented that we would probably want to hand back with caution because clearly the work that has been carried out has made a huge impact and wouldn't want to lose that. CT commented, it will take some time to hand it back successfully to avoid negative impact to patients or the compliance rate.

KQ thanked CT for the reports and the fantastic Improvement work that she and colleagues had done.

KQ confirmed that the MHA Committee was asked to receive and comment on the progress of the annual advocacy compliance report and its actions, which it had done.

MHAC/23/38 - Care Quality Commission visits (agenda item 11)
MHAC/23/38a - Visits and summary actions quarter 1 including BDU actions (agenda item 11.1)

At the last MHAC meeting, JC reported that potentially we will have 17 visits over the next 12 months.

- 64 open actions in total over the quarter and of those, 48 have been completed and closed.

- 7 remain open and not due for completion this quarter, 7 are open and overdue however it is expected that these will be completed and closed by the next report.

- 6 actions were found to repeat findings from previous visits. It was noted the CQC are looking at the last virtual review and last in person review, i.e., they are looking at last two visits and assessing to see if we have completed the actions.

- From the 64 actions the 4 most common themes of findings account for almost 40% of all the actions raised. These 4 actions related to: 1. consent to treatment for which there is a trust wide QI project, which has shown a 13% improvement; 2. care planning which is also being addressed through a trust wide improvement group. 3. blanket restrictions for which there is a process in place, 4. respect and dignity issues which have been raised for consideration within the Nursing, Quality and Professions Directorate.

STh explained that following CQC visits to the inpatient wards, the response standard requires all providers to provide evidence such as, how we share the feedback with service users, and what information we received from them. We have service user groups, community groups on the wards. STh shared potential approaches to enhancing engagement and to ask for support to proceed with the piece of work to fully enhance and have more robust service user engagement and feedback following MHA CQC visits.

STh to discuss further with MR on other digital approaches and opportunities for service user involvement.

Action: Subha Thiyagesh

KQ confirmed that the Committee was asked to receive and comment on the progress of the actions following CQC visits, which it had done.

MHAC/23/39 - MHA/MCA Code of Practice oversight group (agenda item 12)

YF explained that this group is divided into three different segments and 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.

YF is meeting with CGH next week to define areas that we need to report to Mental Health Act Committee.

Code of Practice Group, has looked at the MHA CQC visits and shared the learning across the Trust.
Code of Practice Group discussed the low level of appeals and agreed to benchmark to look at our rate of appeals. A large number of renewal hearings as we have a lot of service users that are with us for extended period of time, this may impact on the number of appeals received.

Best practices are being discussed in relation to Section 17 leave and the Section 132 annual report. The three main areas relating to blanket restrictions, are health and safety, which includes fire, violence, and aggression and IPC. IPC is linked to outbreaks within ward areas.

Seclusion and segregation, the work on the electronic seclusion record keeping is progressing. A new task and finish group are reviewing the application and use of segregation.
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KQ confirmed that Committee was asked to accept the paper and note the ongoing activity relating to the implementation of the current Code of Practice and the development and preparatory work relating to the impending legislations, which it had done.

MHAC/23/40 - Key messages to Trust Board and other Committees (agenda item 13)

Alert
Potential 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

- **The act in practice - Older People's service** - working between two legal frameworks 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
- **Annual MHA Performance Report Linked to Inequalities** – presented data, prior to further analysis to understand impact and address any service gaps for service users and carers
- **Code of Practice Oversight Group** – update on progress
- **Risk registers** - reviewed Organizational risks identified as having a potential impact on the application of the MHA. Currently no risks on Mental Health Act Committee risk register.
- **CQC MHA visits** - actions & updates – Assurance that actions and recurring themes have an action plan or improvement workstream with improvement work and action taking place
- **Audit compliance reports** -
    - Annual audit report Section132 (patient rights)
    - Annual audit of Advocacy Services
- **Performance Report** including Mandatory training compliance and patients' rights activity.

MHAC/23/41 - Work Programme (agenda item 14)
The Work Programme was noted. JC will add Annual MHA Performance report (Inequalities).

Date and time of next meeting (agenda item 15)
The next meeting will be held on 7th November 2023 at 14:00 – 16:30 via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Quality & Safety Committee meeting
Tuesday 17 October 2023
9am – 11.15
Hybrid

Present:	Nat McMillan (NM) Carol Harris (CH) Darryl Thompson (DT) Kate Quail (KQ) Dr Subha Thiyagesh (STh) Marie Burnham (MB)	Non-Executive Director (Chair of the Committee) Chief Operating Officer Chief Nurse / Director of Quality and Professions (Lead Director) Non-Executive Director Chief Medical Officer Chair of the Trust (from 10am)
Apologies:	Carmain Gibson-Holmes (CGH) Julie Williams (JW)	Deputy Director of Nursing, Quality and Professions Assistant Director of Corporate Governance & Risk
In attendance:	Sarah Harrison (SLH) Yvonne French (YF) Emma Burton (EB) Tracey Smith (TS) Helen Roberts (HR) Laura Hallas (LH) Ryan Hunter (RH) Matthew Burns (MBurns)	PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Legal Services Long COVID Service (item 6) Chief Psychological Professions Officer Observing Patient Safety Manager - Observing and PSIRF Update (item 15) Tissue Viability Consultant Pressure Ulcers Report (item 13) Change & Innovation Partner (item 17) Quality & Governance Lead (item 17)

QS/23/201 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 there were two colleagues observing the meeting, Tracey Smith and Helen Roberts. NM also acknowledge that Laura Hallas, Ryan Hunter and Matthew Burns will be attending for their respective items.

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.

QS/23/202 Declarations of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those already made.

The Quality & Safety Committee NOTED the declaration.

QS/23/203 Minutes from previous Quality and Safety Committee meeting held 12 September 2023 (agenda item 3)

The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 12 September 2023 as a true and accurate record.

QS/23/204 Matters arising from previous Quality & Safety Committee meeting held 12 September 2023 and action log (agenda item 4)

The action log was reviewed and updated as follows:

- CG/23/145 Quality Regulatory & Oversight Paper.
  NM confirmed that this action could now be closed as she had discussed in the People and Remuneration Committee who would now take forward the issue with appraisals.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates.

QS/23/205 Committee related risks were reviewed in accordance with the terms of reference. Including:

No risks were in need of discussion today.

NM did note that RISK ID1650 was included within the Care Group Report later in the agenda

It was RESOLVED to RECEIVE the update.

QS/23/206 Staff / Team Story (agenda item 6)

Emma Burton (EB) (Occupational Therapist) from the Long COVID Service attended the meeting to elaborate on their service and what they are able to offer staff and patients.

EB shared a presentation on screen with the group relating to the service in Barnsley. EB will be sharing the presentation with the Committee after the meeting which can be further shared with teams in the Trust.
Action: Emma Burton

Kate Quail (KQ) thanked EB for the presentation and all the useful information contained therein and acknowledged how few run the service and asked if the service was available elsewhere in the Trust. EB confirmed that all regions with the UK have a long COVID service and that NHS England provided funding last year for every area. From next year the funding will be provided by the ICB and therefore promotion of the service is required to keep the service in Barnsley going and to hopefully increase the staff therein.

Subha Thiyagesh (SThi) thanked EB for the very succinct presentation and asked what challenges the service had, EM advised that they had no medic or access to psychology and a lot of the patients that present to the service have mental health issues following long COVID and in turn they are having difficulties of where to refer these patients.

EB feels that Barnsley was providing the best service they can but have limited resources and staff and felt a visit from the Trio would benefit the service.
Action: Trio

DT was happy that this was a AHP led service, and also notified EB of the Quality Committee at Place in Barnsley and suggested that this service be highlighted there. He also suggested that Tracey Smith from the Trauma Informed team to get in touch with EB.

NM would like operational and executive colleagues to raise the profile of the service and increase the referrals and would like to keep this at the forefront by the Trio.

The Committee thanked EB for the presentation and attending the meeting.

QS/23/207 Chief Nurse - Update Paper (update on verbal items) inc update of topical & legal risks, escalations, QIA/EIA reviews / Quality Account (agenda item 7)

The paper had been circulated to all members.
Headlines:

- Development of an easy read version of the quality account.
- Flagged in the report are some of the conversations from the different Place Committees and noted that their agendas mirror this agenda. DT also noted a conversation from the Calderdale Place Committee to bring certain papers of interest from QSC to their Committee. It was agreed that this can be added to the "items to bring to the attention of Committees and Trust Board" at the end of the QSC agendas.

NM was glad to read the feedback in the report from Governors and Members being acted upon with regards to the easy read version of the Quality Account.

NM noted Safecare within the report and informed that Colin Hill will be attending the Peoples and Remuneration Committee to discuss this. DT suggested that should a further discussion be needed after Colin attends PRC then he can be invited to attend this Committee to present the functionality of Safecare.

QS/23/208 Quality and Regulatory Oversight Paper (agenda item 8)

The paper had been circulated to all members prior to the meeting.

DT will cover the CQC draft report in the private section of the agenda.

The report highlighted the following information:

- An update on the CQC inspections which took place in May 2023
- Notification of quality monitoring visits undertaken on Clark Ward and Melton Suite
- The quality monitoring visit schedule up to March 2024
- Updated data on the new enquiries received into the Trust from the CQC. This is broken down by Care Group
- Information about the CQC's four stage plan for delivering new ways of working
- Key updates on our Local Authority Assurance and Integrated Care System work
- An overview of the process for mental health act inspections within the Trust, including the receipt of reports and action plans
- An updated on CQC routine medicine management engagement calls

KQ raised a query in relation to the CQC pharmacy interviews and to be mindful of the areas that could be considered, such as rapid tranquilisation.

NM wanted to thank the QIAT team for sharing the quality monitoring visit schedule up to 2024 and confirmed that non-executive directors are key and are booking onto these. The next steps around quality monitoring visits was how to get the assurance on actions taken to ensure that the loop is closed.

NM noted the pressure ulcers information on page three of the report,d the number of complexities which has increased. The service has provided assurance to the CQC on this, and NM would like to know what those assurances are. This will be discussed with Laura Hallas later in the agenda.

Committee thanked individuals for their input into the response to the CQC.

It was RESOLVED to RECEIVE the Quality & Regulatory Oversight Paper.

QS/23/209 Care Quality Commission Inpatient and Community Surveys (agenda item 9)

DT noted that this paper had been deferred from the September meeting and was taken as read.

DT advised that the national service user programme originated in 2009. DT brought a proposal to the Committee to consider stepping away from this survey as it was no longer mandatory and does not provide the quality information needed as we have local processes that provide information that is more meaningful and appropriate.

KQ felt that stepping away from the national model would hinder being able to benchmark and track progress nationally, however she stated that she does understand the request being made and the information that can be sourced locally. NM echoed this.

DT advised that the survey would be blended into the patient experience report but could purposefully report into this Committee and EMT explaining the new model and process for at least the next 12 months to get a sense of assurance before incorporating into the patient experience report.

DT will add the proposal to the next Chief Nurse report for Committee.
Action: DT

It was RESOLVED to RECEIVE the Care Quality Commission Inpatient and Community Surveys paper.

QS/23/210 Quality Strategy Update (agenda item 10)

DT noted that this paper had been deferred from the September meeting and was taken as read.

DT advised the paper was relating to the implementation of the strategy which also outlined the three aims.

The progress against the Quality Strategy highlighted:

- Outline of the three aims
- Publication and dissemination of the strategy
- Progress against the quality strategy aims, including:
    - highlights on key initiatives as outlined in the strategy
    - Updates on embedding quality improvement across the organisation

- Work which is underway on 'making data count'
- Next steps for the strategy
- Risks to delivery of the strategy

NM advised of an NHS England presentation around making data count which was very helpful and interesting.

NM stated that it was hard to navigate the report as a NED, however acknowledged the amount of work around this item and would like key progress areas to be included within the Executive Summary on the front sheet.

Good update report and will advise up to Trust Board in relation to the delivery of the strategy.

It was RESOLVED to RECEIVE the Quality Strategy update.

QS/23/211 Care Group Quality and Safety Report (agenda item 11)

CH advised the Committee of the pressing issues within the report.

Key Issues for October Committee

Neurological rehabilitation unit at Kendray Hospital

The complexity, unpredictability and co-dependencies of the patient cohort often require additional staffing (both trained and untrained) to be requested at short notice. It is becoming increasingly difficult to source the number of additional staff required to cover vacant shifts per week. Decisions have been made to limit capacity (mainly through not using the four spot purchase beds) and carefully manage admissions as people are discharged. Not being able to provide a timely admission impacts the individual patient and their family and the wider healthcare system.

Work is taking place to understand and quantify what uplift in core staffing would reduce the continual need to source additional staff on what is becoming the norm rather than an occasional requirement.

Sharing best practice – posters

Staff are always encouraged to share best practice and positive health messages and posters have proved a successful medium this month.

Supported by Barnsley Speech and Language Therapy Service, 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. Young people who stammer have been supported to design new posters #AboutMyStammer.

The 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 relating to Vocational Rehab and Stroke Support Cafes. One of the Trust's posters won the competition.

Barnsley Speech and Language Therapy Service

Colleagues in this team have also won a national 'Giving Voice' award at the Royal College of Speech and Language Therapists awards, for their 'Hey, it's ok to stammer' campaign. The team used charitable funding to purchase a children's book for every school in Barnsley. The Boy Who Made Everyone Laugh, by Helen Rutter tells the story of a child who stammers and how he faces his fears and finds he is OK with who he is.

Industrial action
The recent period of industrial action involved consultant and trainee doctors taking strike action at the same time. Thanks to the commitment of operational and clinical leaders and staff, care and safety continued to be prioritised. Mass cancellation of clinical activity was not undertaken as decision making remained with the local trios, supported by senior leaders and silver command. Feedback from staff and silver command members has confirmed that this is the most appropriate way of ensuring decisions are person centred and balance risk with demand and capacity.

The longstanding dispute is wearing on staff who want to focus on future developments. Although staff take great care to successfully mitigate the impact on service user safety, any longer-term impact on service users cannot be confirmed.
Feeback from staff has been shared both regionally and nationally in terms of any potential hidden impact not only on physical but also on mental health of service users, which will only become evident in the longer term.

ADHD pathway for people with a learning disability
Work has been underway to understand and address an inequity of access for people with a learning disability in relation to accessing an assessment for ADHD (attention deficit hyperactivity disorder), as the current commissioned provision is for people without a learning disability. Demand is now better understood and business cases for resources are being worked through.

Digital access for staff from older people's community team
The trio were pleased to receive positive feedback from an older people's community team who had raised a concern about timely digital access. The team advised that the action taken, to ensure they had access to a SIM card in each laptop, means they are able to make better use of time, complete assessments and care plans collaboratively with the person in their own home, make contemporaneous records and access other hospital and GP records to support the delivery of safe care and where appropriate, make decisions on prescribing.

This also represents a significant culture shift. Previously staff have reported that opening a computer in someone's home could be a communication barrier. The shift to it enabling conversations about care is positive.

Patient flow
Committee members are already aware of the significant reduction in out of area bed use. Contributory success factors include strong dedicated leadership at associate director level, continued commitment to the improvement plan, clinical lead engagement, critical friend support from Humber NHS Foundation Trust and support from Place based multi-agency discharge meetings (MADE). The improvement group are developing the assurance process in relation to the wider impact of a reduced reliance on out of area placements. This will include assurance of patient safety, i.e., people are not experiencing unsafe waits in the community for a bed and staff safety, including case load size for intensive home-based treatment teams.

Forensic patient flow and occupancy
Medium and low secure services are provided as part of the West Yorkshire Secure Provider Collaborative. The collaborative commissioning hub have highlighted a risk in relation to low occupancy levels in Newton Lodge (medium secure), particularly as people from West Yorkshire are in out of area placements. The wards in Newton Lodge link to care pathways and, due to the needs of service users on the pathways, mixing people on different pathways with different levels of need is not considered safe or effective which is why the occupancy gap cannot be simply filled by repatriating people back into empty beds at Newton Lodge.

Work is underway to review the approach at Newton Lodge and to increase flexibility across the bed base to allow for fluctuations in pathway demand.

Forensic services are reporting zero in relation to people who are clinically ready for discharge. This relates to the complex discharge planning process, engagement with the Ministry of Justice and timing of the agreement that someone is ready for discharge. The team are reviewing this and it is likely that the reported figure for clinically ready for discharge will change.

Risk related to roof access
Committee has oversight of risk 1650: *'inpatient areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury'.* On Saturday 7 October 2023, a person was able to gain access to the roof from the Melton Suite PICU (psychiatric intensive care unit). Police and estates support were provided. No injuries were sustained and the person was safely returned to the ground. Immediate information suggests that the risk score remains appropriate. However, it will be reviewed again in detail once the incident has been fully reviewed.

Risk related to demand
Committee has oversight of risk 1530: '*Risk that demand continues to rise placing further pressure on access to services and waiting lists'.* The executive team received a presentation on the review of demand from Vic Humble, intelligence change partner, that suggested that for the majority of areas demand in terms of numbers of people being referred into the service appears to be stable, with notable exceptions such as ADHD/ASD and CAMHS.

Staff have consistently reported increased demand and pressure on services and it was a surprise that the data did not correlate across all areas. In order to ensure that the right actions are in place to support staff to manage demand, further work is taking place to understand other aspects of the demand. The risk has been reviewed, with actions updated but no change to the scores.

Prone restraint
The Trust has invested in bespoke safety pods as an alternative to prone restraint and will be introducing the use of a safety pod within seclusion suites within reducing restrictive physical interventions (RRPI) training. The RRPI team are also planning on a targeted approach to training in clinical areas that have higher use of prone restraint, such as the Horizon Centre and Newhaven Ward. They will work in collaboration with clinical teams to implement new techniques and person-centred approaches.

The team are also introducing alternative exit strategies from seclusion to reduce the use of prone restraint. These are being developed with a plan to implement them to training in December 2023.

Shortage of medicines for Attention Deficit and Hyperactivity Disorder
There is a national supply shortage of the medication prescribed to help manage ADHD symptoms. The supply disruption of these products is caused by a combination of manufacturing issues and an increased global demand. Our chief pharmacist is working with ICB colleagues and specialists to develop appropriate patient information leaflets and clinical guidance.

Community focused falls prevention work
Working in partnership with Barnsley Council, Age UK Barnsley and the Barnsley Older People Physical Activity Alliance, the Trust attended Barnsley Market for the day on 22 September. Colleagues from across the service ran information stalls and provided falls prevention advice and guidance to over 300 local residents.

KQ thought the report was really helpful and acknowledge the huge amount of work that had taken place throughout the industrial action together with the CQC inspection.

NM would like an update to come back around the inequity issue which was highlighted around ADHD.
Action: CH/ Trio

NM acknowledged the use of the safety pods and asked what they were like which CH explained that they are like a large bean bag. NM also noted the reduction in the use of the out of area beds which was positive.

NM would like an update regarding the risk relating to demand and would like further assurance at a future meeting.
Action: CH/ TRIO

The Quality Care Group and Safety Report was RECEIVED and NOTED.

QS/23/212 Reducing Restrictive Physical Interventions Annual Report (agenda item 12)

DT noted that this paper had been deferred from the September meeting and was taken as read.

This report contained a review of incidents related to violence and aggression reported via Datix. It also includes an overview of RRPI training throughout the year.

Improving education and training
The Trust achieved Restraint Reduction Network (RRN) accreditation in 2021 and have successfully retained the accreditation for the last two years, which provides assurance around our core training. The team have also continued to provide bespoke training for Care Groups to support individual service users. The Trust's compliance for reducing restrictive physical interventions teamwork course is currently just above 80%. This target has been reached due to the restraint reduction network (RRN) granting a once only extension for refresher course to 18 months instead of the usual 12 months. This will reduce once the 6-month extension period has passed. Actions to support maintaining safe training compliance levels:

Improving person-centred approaches
The RRPI specialist advisors have provided advice on reducing restrictive physical interventions for individual service users across Care Groups. They have also supported staff to respond and understand service users' needs and proactively reduce restrictive physical intervention.

Benchmarking
Data is taken from NHS benchmarking network and is based on per 10,000 occupied bed days during 2021/22 reporting period. Data for 2022/23 has not been finalised by NHS Benchmarking Network at the time of this report.

Use of restraint
Within working age adult, older adult, low secure and learning disability inpatient wards the Trust has a higher-than-average use of restraint. The RRPI TAG will review this further through in-depth analysis of themes and trends in the coming year.

Use of prone restraint
Within adult, psychiatric intensive care and learning disability inpatient settings, the Trust is shown to use prone restraint more than the mean. To reduce the frequency of prone restraint, the RRPI team are exploring alternative seclusion exit strategies within training, in conjunction with partnership working with pharmaceutical colleagues to explore alternative injection sites.

Use of seclusion
Within adult acute, psychiatric intensive care and learning disability inpatient wards, the use of seclusion is higher than the mean. The seclusion policy has been reviewed and updated, and this has been strengthened with regards to the information in relation to applying seclusion in a flexible manner for a period of assessment.

Incidents of restrictive interventions and violence and aggression reported through the Trusts Datix reporting system

- Reports of violence and aggression on Datix **decreased** by 329 from 4166 in the financial year 2021/22 to 3837 in the financial year 2022/23, a reduction of 8%
- Physical violence by patient on staff (contact made) **increased** by 308 from 857 in the financial year 2021/22 to 1165 in the financial year 2022/23, an increase of 36%
- Physical violence by patient on patient (contact made) increased by 39 from 199 in the financial year 2021/22 to 238 in the financial year of 2022/23, an **increase** of 20%
- The number of restraints increased by 146 from 2019 in the financial year 2021/22 to 2165 in the financial year of 2022/23, an **increase** of 7%
- The number of prone restraints **increased** by 27 from 228 in the financial year 2021/22 to 255 in the financial year of 2022/23, an **increase** of 12%
- The number of seclusions increased by 44 from 681 in the financial year 2021/22 to 725 in the year 2022/23, an **increase** of 6%

The RRPI team are currently working with the Trust's health and safety team on the violence prevention and reduction standard. This provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence.

There have been three instances of the use of mechanical restraint within 2022/23.

Restraint reduction
The RRPI TAG are establishing a restraint reduction collaboration group to facilitate workforce engagement and develop local quality improvement initiatives to improve quality, safety, experience and outcomes.

KQ had the overall feeling that a boost was needed within the team and the Trust benchmark was quite high for instances of prone restraint and was concerned that numbers are going the wrong way. KQ was also aware that medication could be administered into different parts of the body other than the buttocks. NM agreed with what KQ raised and would like another level of assurance around this issue.

Marie Burnham echoed the above, and made reference to the numbers that are being seen. She stated that she was aware that in the report it mentioned that higher numbers were in relation to better reporting and higher acuity, however more assurance is needed about that.

CH noted that the numbers are not high in all services areas and the Trio have spent some time with the analysts in the Patient Safety Support Team looking at what is being recorded in relation to restraint and what was being recorded in relation to prone restraint. The Trio agreed that the data needs a further breakdown to understand where any problem areas are.

NM noted the concerns together with the Trio about the contents of the annual report which needs some focussed attention and will escalate this to Trust board, and therefore an interim response will be needed.
Action; DT

KQ noted that the heat mapping of restraints which took place on Nostell from 2019 wasn't rolled out and as a learning organisation this should have been done. Also, that the use of pie charts within the report were not useful as the sections were so small she was unable to make sense of the information provided therein.

NM and MB would like a lengthy discussion in the private part of Trust Board.

It was RESOLVED to RECEIVE and NOTED the Reducing Restrictive Physical Interventions Annual Report.

QS/23/213 Pressure Ulcer Deep Dive Report (agenda item 13)

Laura Hallas attended the Committee meeting to present the report which has already been received and taken as read.

Laura advised that the health and wellbeing of the population of Barnsley was on a worrying trajectory in respect of the increasing health needs in comparison to rest of Yorkshire and Humber, and also nationally.
The Census data 2021 showed that:

- One in four people in Barnsley are living with fair to poor health.
- One in three people live with a disability, either physical or mental health, that impacts on their ability to live day to day.

The impact of the cost-of-living crisis is thought to be having a very real impact on patient and carer health and wellbeing locally.

The increase, and potentially increasing prevalence of pressure ulcers can also be viewed in the context of:

- Increased levels of frailty and acuity of patients that contribute to an aetiology of skin related changes and reduced mobility.
- The widening health inequalities and the wider determinants of health linked to social isolation of house bound people and cost of living in relation to food and fuel and poverty, all of which have a direct impact on increased risk and incidences of pressure ulcers.
- Once a pressure ulcer has occurred in individuals with very complex health issues, frailty and reduced mobility, the prognosis of healing is poor, and this cohort of patients are who our neighborhood nursing teams are dealing with daily.
- Increased training and awareness sessions, which in turn leads to increase in

knowledge and then an increase in identification and accurate reporting.

- Poor health and disabilities, whether physical or mental health, place people within an 'at risk' group for developing pressure damage, and this will be significantly impacting the number of reported pressure ulcers purely by the demographics of the population.

Wound care accounts for over a third of District Nursing activity at approximately 1,690 visits per week. From May to October 2022, the number of reported pressure ulcers was 745; 439 of these developed in the patient's own home, 242 developed in a residential care setting and 54 in other provider care / the broader Trust.

Within the Care Group, there are further discussions with regards to appropriate terminology, as a defined lapse in care from the absence of a particular risk assessment might not in itself cause any harm to the patient or have a causal role in the subsequent development of a pressure area. Overall, evidence suggests that the increase in pressure ulcers is due to the wider determinants of health and this report highlights the health inequalities of the population of Barnsley.

The Committee thanked LH for attending to present the information. NM queried table two, incidents and prevalence of pressure ulcers and was surprised by the increase in category two pressure sores and the 300% increase in pressure ulcers of patients in our care. LH informed that this was due to the further and rigorous training that has been given to staff who are now more able to recognise and report the early signs of a pressure sore.

MB was impressed with LH and the team and felt that they are on top of the work that they are carrying out.

KQ stated how important that comms was regarding this issue and that the Trust needs to ensure that it is part of the wider population health work.

LH advised the group of a booklet that is being prepared which will contain all the new and relevant information in one place.

LH also advised of stop the pressure day on the 16th November.

The Committee thanked LH and was happy that assurance had been provided.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/214 Clinical and Strategic Approach to Learning Disability Improvement Report (agenda item 14)

Taken as read for information,

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/215 PSIRF Plan Approval (agenda item 15)

The PSIRF plan requires Trust Board and Integrated Care Board approval. Our ICB colleagues in both West Yorkshire and South Yorkshire have agreed to the content and our proposed start date of 1 December 2023.

The PSIRF policy will proceed separately through the policy approval process.

The Committee received and recommended plan for approval at Trust Board.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/216 Greenlight Toolkit (agenda item 16)

Included at item 14.

QS/23/217 Older Peoples Service Inpatient Transformation (agenda item 17)

This item will be discussed in the Private Section of the agenda.

QS/23/218 Reports from Formal Sub-Committees (agenda item 18)

QS/23/2184a Drug & Therapeutic TAG (agenda item 18.1)
There was no update for this item.

QS/23/218b Infection, Prevention and Control (agenda item 18.2)
The report was taken as read and received.
DT advised that all Covid-19 updates will be included within this report.

CQS/23/218c Joint Safeguarding (agenda item 18.3)
The report was taken as read and received.

QS/23/218d Reducing Restrictive Physical Interventions (agenda item 18.4)
Included at item 12.

QS/23/218e Improving Clinical Information Governance Group (agenda item 18.5)
There was no update for this item.

QS/23/218f Clinical Governance Group (agenda item 18.6)
The report was taken as read and received.

QS/23/218g Clinical Ethics Advisory Group (agenda item 18.7)
There was no update for this item.

QS/23/218h QUIT (agenda item 18.8)
STHi noted a delay with the implementation of the Smoke Free Policy and an options paper will be taken into EMT.

QS/23/218i Safer Staffing (agenda item 18.9)
There was no update for this item.

CG/23/218j Physical Health (agenda item 24.10)
There was no update for this item.

QS/23/219 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 19)

Alert
The Committee was made aware that there is an issue regarding inequity of access for ADHD (attention deficit hyperactivity disorder) for people with a learning disability, this is in relation to accessing an assessment. Further work is being undertaken to understand this and will be reported back to the Committee.

The Committee was advised that forensics are reviewing their discharge reporting process and there is an expectation that the number will increase (currently zero).

Risk 1530: The Committee was made aware that related to this risk a review into demand has shown that the data does not correlate with what we are hearing from staff in terms of increasing demand. This work is ongoing and will report back to the Committee.

The Committee shared their concerns about the findings of the RRPI (Reducing Restrictive Practice Interventions) Annual Survey in terms of the trust being an outlier and subsequent discussion on how we record at SWYPFT. Specific concerns were raised around the use of prone restraint. This risk is being escalated to the Trust board and an update has been requested from the Director of Nursing and Professions and the Medical Director for the next meeting on 31st October.

Advise

The Committee heard from the Long COVID service and noted it was therapy-led. The service is keen to raise the awareness so people can access it and get support.

The Committee agreed to support the move away from the Mental Health Inpatient Service User survey with the condition that we develop our alternatives and continue to do better in hearing from those who use our services and acting on their feedback.

The Committee heard that the trust is investing in bespoke safety pods as an alternative to prone restraint and NEDs asked if they could visit and see these to understand more about their use and effectiveness.

The Committee was advised that the Barnsley Speech and Language Therapy Service have won a national award 'Giving Voice' for their 'Hey, it's ok to stammer campaign'.

The Committee heard about the work being undertaken to prevent falls across the community service attending Barnsley market with other partners to share information and guidance.
The Committee received the update on the Clinical and Strategic Approach to Learning Disability Improvement.

Assure

The Committee received the Older People Service Inpatient Transformation business case. The Committee was assured about the stakeholder engagement process to date and the process around the comprehensive Quality Impact Assessment. However, the Committee asked for clarification when it comes to the Board around consultation process and the difference in engagement and feedback.

The Committee received the Deep Dive report into Pressure Ulcers and was assured by the analysis and work being undertaken by the team to report and prevent. The Committee were assured by the data provided that reporting at the early stages is increasing and having an impact on reducing the prevalence of pressure ulcers in category 3 and 4.

The Committee received the Quality strategy update and were assured of the progress and noted the risks to delivery.

Risk 1650 is being reviewed in line with trust process following an incident whereby a person gained access to the roof from Melton Suite PICU. The Committee has oversight of this risk and will monitor this review and the risk.

Out of Areas beds usage has seen an ongoing reduction (at the meeting we were advised it was down to 2 people).

PSIRF (Patient Safety Incident Response Framework) was recommended for approval at Trust Board.

QS/23/220 Risk Register review (agenda item 20)

NM noted that there was a possible new risk for RRPI to be included relating to the concerns raised.

QS/23/221 Work Programme (agenda item 21)

There were no further updates for this item

QS/23/222 Date of next meeting (agenda item 22)

The next meeting will be held on 14 November 2023 (MS)

Minutes of the Members' Council meeting held on 16 August 2023
10.30 – 14.00

Hybrid meeting
Conference Centre, Board Room (Hybrid meeting), Kendray Hospital, Doncaster road, Barnsley, S70 3RD and Microsoft Teams

Present:	Marie Burnham (MBu)	Chair
	Jacob Agoro (JA)	Staff – Nursing
	Cllr Howard Blagbrough (HB)	Appointed – Calderdale Council
	Bob Clayden (BC)	Public - Wakefield
	Daz Dooler (DD)	Public – Wakefield
	Claire Den Burger-Green (CDBG)	Public – Kirklees (Deputy Lead Governor)
	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Sara Javid (SJ)	Public - Kirklees
	Adam Jhugroo (AJh)	Public – Calderdale
	Rosie King (RK)	Public – Wakefield
	John Laville (JLa)	Public – Kirklees (Lead Governor)
	John Lycett (JLy)	Public – Barnsley
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Bob Morse (BM)	Public – Kirklees
	Phil Shire (PS)	Public – Calderdale
	Nik Vlissides (NV)	Staff – psychological support
In attendance:	Mark Brooks (MBr)	Chief Executive
	Mike Ford (MF)	Senior Independent Director
	Carol Harris (CH)	Chief Operating Officer
	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, Quality and Professions
	Lindsay Jensen (LJ)	Acting Chief People Officer
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Mandy Rayner (MR)	Deputy Chair
	Adrian Snarr (ASn)	Executive Director of finance, estates and resources
	David Webster (DW)	Non-Executive Director
	Andrew Lister (AL)	Company Secretary/ Head of Corporate Governance
	Asma Sacha (AS)	Corporate Governance Manager (author)
	Laura Arnold (LA)	Corporate Governance Administrator
Apologies: Members' Council	Cllr Sue Bellamy (SB)	Appointed – Barnsley Council
	Tanisha Bramwell (TB)	Public – Kirklees
	Keith Stuart-Clarke (KSC)	Public – Barnsley
	Rumaysah Farooq (RF)	Public – Kirklees
	Leonie Gleadall (LG)	Staff – non clinical support
	Daniel Goff (DG)	Public – Barnsley
	Laura Habib (LH)	Staff – Nursing support

	Christopher Matejak (CM)	Public – Calderdale
	Helen Morgan (HM)	Staff – Allied Health Professionals
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Reini Schühle (RS)	Public – Wakefield
	Fatima Shahzad (FS)	Public – Rest of Yorkshire and Humber
	Elaine Shelton (ES)	Appointed – staff side organisation
	Susan Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
Apologies:	Dr Rachel Lee (RL)	Associate Non-Executive Director
Attendees		
	Natalie McMillan (NMc)	Non-Executive Director
	Greg Moores (GM)	Chief People Officer
	Sean Rayner (SR)	Director of provider development
	Darryl Thompson (DT)	Chief Nurse and Director of quality and professions
	Julie Williams (JW)	Deputy Director of corporate governance, performance and risk

MC/23/25 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/23/26 Declarations of interest (agenda item 2)

No further updates. 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/23/27 Minutes of the meeting dated 9 May 2023 (agenda item 3)

Approved.

It was RESOLVED to AGREE the minutes of the Members' Council meeting held on 9 May 2023 as a true and accurate record with the noted amendments.

MC/23/28 Matters arising from the previous meeting held on 9 May 2023 and action log (agenda item 4)

No further updates were received, and any actions shown as closed for May 2023 meeting were approved.

It was RESOLVED to NOTE the action log of the Members' Council.

MC/23/29 Chair's report and feedback from Trust Board (agenda item 5)

MBu provided highlights from her report which she asked to be taken as read. She explained the purpose of the report was to highlight the Chair's and Non-Executive Director's activity since the last meeting.

MBu said it was a privilege to attend the 75th anniversary of the National Health Service on 5 July 2023, it was a proud moment of her career, and she was joined by NHS staff from the Trust.

It was resolved to NOTE the Chairs' report.

MC/23/30 Chief Executive's Comments on the operating context (agenda item 6)

Mark Brooks (MBr) provided a verbal update to the Members' Council and highlighted the following points about the current operating context:

- MBr thanked everyone for coming to the meeting and explained that the Trust appreciates the feedback it receives from governors, and they form an important part of the Trust governance process.
- MBr explained that recent industrial action, which has included strike action from junior doctors and consultants, has been well managed. A lot of planning has taken place to ensure the Trust continues to provide safe services.
- MBr reported there are currently a high number of people in out of area beds, but this is a national issue and Trust partners are also having similar issues.
- MBr reported in June 2023 there were six staff off due to assaults, four of which have resulted in fractures. Staff are being supported through their recovery. MBr explained that the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) is when the Trust has to report to the Health and Safety executive (HSE) where staff have been off work for five days or more due to work related incident.
- MBr reported the NHS workforce plan was published on 30 June 2023 and there are three themes running through which is training, retaining staff, and working in the most effective way.
- MBr noted there are recommendations for changes to the Trusts Section 136 suites The different rules will come into place over the next few weeks and the Trust is working with South and West Yorkshire police to make sure it is as seamless as possible for the service users and staff.
- MBr explained the Trust is working with commissioners to reduce costs of running the Trust and we are under a lot of pressure to contribute to the cost saving.

MBu reported our previous Director of Strategy and Deputy Chief Executive, Salma Yasmeen has left the Trust and secured a Chief Executive role at Sheffield Health and Social Care NHS Foundation Trust. Dawn Lawson, Director of strategy will commence her post on 11 September 2023.

MBu stated that nationally there are pressures on out of area beds and the Trust must ensure people are safe when they come into services. The Trust has started winter planning which includes the covid booster and flu vaccinations.

Cllr Blagborough (HB) stated staff wellbeing concerns him, and asked about the use of lone worker devices for staff to ensure staff are safe and protected.

MBr reported the Trust uses lone worker devices and there are approximately 1600 devices in operation. MBr explained the Trust also has risk assessments and most staff have a mobile phone. MBr said there will be further digital improvements the Trust can make in the future.

John Laville (JLa) noted reducing overheads by 30% in the Integrated Care System is a tough challenge and there are already challenges in local authorities such as Kirklees. He asked about the Kirklees bankruptcy proceedings and whether this will have an impact on joint working.

MBr said the Trust is engaged with all the Local Authorities, and there are ongoing discussions about services and the knock on effect on health services.

Carmain Gibson-Holmes (CGH) explained she has attended strategic meetings with Trust partners to understand the impact of the changes in Section 136 suites, and there is cross referencing and learning taking place to ensure it works for the Trust.

Adam Jhugroo (AJ) reported he was aware that sometimes people are brought into the Section 136 suite by police but left with two members of staff when it is not safe to do so. AJ said people go AWOL from the ward if there are a minimum number of staff on shift.

MBr reported the police are taking a responsible approach on how to maintain safety for everyone.

It was resolved to RECEIVE the update from the Chief Executive on the operating context.

MC/23/31 Quality accounts and external assurance (agenda item 7.1)

Carmain Gibson-Holmes (CGH) presented the Quality Account for 2022/23 and explained this reflected Trust services and the care that is provided over the last year. She explained NHS healthcare organisations are required under the Health Act 2009 and the Health and Social Care Act 2012 to produce Quality Accounts when they deliver services under an NHS standard contract.

She explained the Trust Quality Account is produced annually and published following approval at Trust Board. She said earlier drafts of this Quality Account have been presented to Clinical Governance Clinical Safety Committee (now Quality and Safety Committee) and Trust Board.

CGH stated the Quality Account has been shared widely with internal and external stakeholders, including the Integrated Care Boards (ICB's), Healthwatch and acute Trust partners. She said all stakeholder feedback is included within the report, and no concerns about the report have been identified by the stakeholders. The report was published on the Trust website on 30 June 2023.

CGH said she has received feedback from a governor in relation to the customer services policy and complaints procedure and their comments will be incorporated into the next review which is due at the end of August 2023.

She explained in the NHS survey, in p39 – 40 of the report, there was a question from a governor regarding the scales and scoring, and for clarification the higher the score, the better the result.

She said there was also a request for the glossary to be placed at the beginning of the report and this will be shared with the author of the report for ease of navigation in the future.

Bob Clayden (BC) stated there was a typing error on the customer services policy and he will provide the details. BC said he has visited the Trust website to have a look at the Customer Services Policy and in Appendix A, an informative piece to show how the system works, is not on the website. He asked how long that had been missing. CGH apologised, and she will go back to review this and meet him outside of the meeting.

Action: CGH and BC to meet to discuss the Customer Services Policy.

Phil Shire (PS) said there was some great information in the quality report. He asked about the layout and whether it was a standard format.

MBu confirmed the Trust needs to present the information in the standard format.

CGH said the national quality board are reviewing the report and this may impact the layout for future reports, and she will update governors if she receives any further information.

MBu asked whether the Trust can do this differently. MBr said the abridged version will be presented at the next annual members' meeting on 27 September 2023.

MF asked whether this document is audited. MBr said it is a prescriptive format from NHS England.

JL said the report was very good, but he was not happy with the current national complaints timescales of resolving a complaint by 6 months.

MBr said during covid when resources were deployed elsewhere across the organisation, it was challenging. MBr reported there are around 25 complaints a month and the Trust is looking at reducing the backlog.

MBr said as part of the complaint response, the Trust also reviews how letters are written, whether it is empathetic, thanking people, apologising, or explaining what the Trust is doing about the issues raised. He explained the investigator also has to have clinical experience, and the Trust is satisfied with the progress that is being made.

AJ asked about the complaints format.

MBr said complaints are responded to by letter, verbally (over the telephone) and email.

AJ said he made a complaint some time ago, but he gave up as it took a long time to resolve. MBr said AJ's concern is valid and there is improvement, the team has experienced staff turnover due to the nature of the job, and therefore there are differing contributory factors. MBr said it is one of the Trust's objectives to improve the complaints process .

BC asked whether the Trust could reduce the target from 6 months.

MBr said there had been a shorter target, but it was not achievable. MBr said it depends on the complexity of each complaint, some are resolved within 48 hours, some complaints are very complex with input from legal services, which takes a longer time to resolve.

It was resolved to RECEIVE the Quality account for 2022/23.

MC/23/32 Governor feedback and appointment to Members' Council groups (to be taken as read and submit questions in advance) (agenda item 8.1.)

JLa explained that he had a very interesting conversation with governors at the pre-meeting in particular regarding suicide prevention. He stated HB raised the issue about organisations working in silos and referred to the "Burnt Bridges" report which was a review carried out

following a number of deaths in Calderdale. He asked for reassurance that the Trust is working closely with our partners.

MBr reported Darryl Thompson (DT) leads a group meeting across West Yorkshire which focuses on suicide prevention. This is a system initiative working with our local authorities and other NHS Trusts. MBr explained every suicide is a tragedy and not everyone who completes suicide is known to mental health services it is about how the Trust works together with partners to reduce the risk of suicide. MBr said the Trust has an annual review of ligatures and the Trust also has a robust risk assessment process.

AJ said he read the "Burnt Bridges" report from Calderdale safeguarding board following the death of five men from Calderdale. He said there was a recommendation about tackling the issue of people with mental health difficulties being discharged to homeless accommodation without adequate follow up.

MBr said there are challenges with service users waiting for specialist placements who are also clinically ready to be discharged. AJ said there is a lack of social housing in Calderdale, and it is a whole system issue.

Action: To discuss the Burnt Bridges report in a future Members' Council Quality Group

Daz Dooler (DD) said the public health team work closely with DT to look at how the system can reduce suicide and the risk of suicide. Wakefield has the worst suicide rate in the district.

BC asked if he could have the link to the zero-suicide training.

Action: Corporate governance team to circulate the dates of the zero suicide training to all governors.

JLa said he chairs the Kirklees Mental Health Carers Forum in Kirklees and discharge back to GP's has been a problem when people have been stepped down from the enhanced to the core team. JL reported Paula Scott-Loftus, Quality and Governance Lead had given a presentation about the discharge process and she discussed some of the practicalities and the issues around discharge. JLa said Paula took some actions away from her discussion with carers which was helpful.

JLa said the Trust have got good initiatives and he has read a letter from Penny Woodhead (Chief Quality and Nursing Officer) congratulating the Trust on various achievements There was also a discussion at the carers group about the staff carers passport, but there were staff present who had not heard about the support available. JLs explained it would be helpful for new initiatives to be communicated to all carers when they are introduced, so people who have been carers for a long time do not miss out. It was noted that the carers passport is on the staff wellbeing page and had been communicated on the staff Headlines.

JLs explained governors attended a development session with Amanda Miller from the Single Point of Access and they discussed signposting of people to the third sector but there is also a long waiting list in the third sector as well. He explained Paula received feedback from governors.

Andy Lister (AL) presented the paper on governor appointment to Members' Council groups and Committees. AL explained that the corporate governance team communicated with governors on the 16 May 2023 and again on the 23 May 2023, inviting self-nominations for vacancies on Members' Council groups.

He explained the self-nominations were discussed at the Members' Council Co-ordination Group on 21 June 2023 where members reviewed the statements and made the following recommendation;

Members' Council Co-ordination Group
Bob Morse, public governor - Kirklees (uncontested)

Members' Council Quality Group
Daniel Goff, public governor – Barnsley

Nominations Committee
Laura Habib – staff governor

Members' Council approved the recommendation from the Members' Council Co-ordination Group. It was agreed that all members would have a three year term, unless they stand down from the group or they are not re-elected/ re-appointed as a governor of the Members' Council.

It was resolved to RECEIVE the governor feedback and APPROVE the appointment of governors to Members' Council groups.

MC/23/33 Assurance from Members' Council groups and Nominations Committee including (to be taken as read and submit questions in advance) (agenda item 8.2)

Members' Council confirmed they had read the paper and they had no questions.

It was resolved to RECEIVE the assurance from Members' Council groups and Nominations Committee

MC/23/34 Governors observing committees – review (agenda item 8.3)

Andy Lister (AL) explained that several governors have taken up the opportunity to attend board committee meetings since it was introduced in January 2023. He stated all board committees are chaired by a non-executive director and include other executive and non-executive members. He summarised the Board Committees of the Trust Board that governors can attend;

- Audit Committee
- Engagement, Inclusion & Involvement Committee
- Quality and Safety Committee (previously Clinical Governance and Clinical Safety Committee)
- Finance Investment & Performance Committee
- Mental Health Act Committee
- Charitable Funds Committee
- People and Remuneration Committee

AL reported it had been agreed for one governor to attend one/two of each of the committee's meetings each year. This would be to observe and not participate, and the governor present would be asked to provide feedback to the Members' Council by completing a feedback form.

AL confirmed that from 2 January 2023 until 11 July 2023, eight governors have attended the following committee meetings;

Audit Committee – one governor

Quality and Safety Committee – two governors

People and Remuneration Committee – one governor

Finance Investment & Performance Committee – one governor

Charitable Funds Committee – one governor

Mental Health Act Committee – two governors

Engagement, Inclusion and Involvement Committee – *one governor is a member.*

AL stated that a survey was sent to all governors who had participated in observing committee meetings to provide feedback (governors were referred to item 8.3b). He explained an email was sent by the Chair to all non-executive directors on 5 July 2023 to provide feedback.

AL stated in the Members' Council Co-ordination Group meeting on 21 June 2023, the observation of Board Committees was discussed, and it was agreed that the observations were positive and for governors to continue with this process.

AL said feedback from Non-executive directors also supported the continuation of governors observing committee meetings with the same guidance, including the use of the feedback form.

AL reported Non-executive directors have suggested governors should have access to the meeting agenda beforehand to aid their understanding of the overall flow of the committee meeting.

JLa said he would like to thank MBu and MBr with the progress that has been made and he is delighted with the feedback.

JLa reported he is part of the national lead governors association and in comparison, to other Foundation Trusts, our Trust has made positive progress.

JLa said he had seen first-hand how the Non-executive directors provided challenge in the committee meetings and this was very positive and provides assurance to governors.

It was resolved to RECEIVE the update on governors observing Trust Board Committee meetings.

MC/23/35 Proposal to merge the Deputy Chair / Senior Independent Director (SID) role (agenda item 8.4)

MBu presented the proposal to combine the deputy chair and senior independent role. She explained the NHS England's new Code of Governance for NHS Provider Trusts became effective on 1 April 2023 and it stipulates that the Chair of the Audit Committee should not be a deputy or vice chair or independent senior director.

MBu explained as a result a discussion has taken place and it is proposed Mike Ford (MF) will continue to Chair the Audit Committee, but will step down from his role as Senior Independent Director. MBu said it is proposed that Mandy Rayner (MR) will take up the combined role of Deputy Chair / Senior Independent Director subject to approval from the Members Council.

MBu explained the Nominations Committee met on the 5 July 2023 and agreed the proposal that Mandy Rayner become the Deputy Chair and Senior Independent Director. This change will be implemented on approval by the Members' Council.

BC said within the last year, governors had been advised to split the role.

MBu explained the recommendation has come from the new Code of Governance and asked governors to support the recommendation so that the Trust is aligned to the new guidance.

BC asked about the Deputy Chair taking complaints about themselves.

MBu reported there is a process in place if the Deputy Chair and Senior Independent Director position becomes compromised. MBu thanked MF for his role as Senior Independent Director.

It was resolved to APPROVE the Nominations Committee recommendation of Mandy Rayner to become the Deputy Chair and Senior Independent Director from 17 August 2023.

MC/23/36 Update on Teaching Trust Status (agenda item 8.5)

Prof.Subha Thiyagesh (ST) and Izzy Worswick (IW) presented an update on the Teaching Trust status.

ST explained that in February 2023 she shared with Members' Council the Trust's ambition to be recognised as a Teaching Trust to reflect significant teaching, training and research work with a range of stakeholders including local Universities.

ST said it reflects the Trust commitment to teaching and learning, matching our vision and living by our values, in order to be outstanding. It will also improve the visibility of the Trust as a learning organisation. She explained this will attract a high calibre workforce and strengthen the Trust's bids for research and development projects.

IW spoke about the process and progress so far. She explained the Trust has engaged with NHS England and they have guided the Trust through the process and requirements in how to gain Teaching Trust Status. IW reported a steering group has been established in the Trust with senior management ownership.

ST said they are consulting with the University of Leeds regarding the process and the Trust need to ensure Trust ambitions align with those of the University. The Trust will work over the next 6 months to evidence that it can meet these requirements. A letter will then be sent by the Chair to Members towards the end of the year.

ST explained the Trust is also working with our places and Integrated Care Boards and feedback will be brought to Trust Board in July 2024 and then to Members' Council around August 2024.

ST said there is a lot of work to be done and her team will continue engaging with the University.

HB thanked ST and IW, and fully supports the move towards teaching trust status.

HB asked about Trust staffing and how the teaching status will impact on this. ST said the team is working with the people directorate as to how different groups of students, such as sixth formers can shadow our services. She acknowledges there are vacancies, and staffing is a challenge, but the aim is for people to be attracted to want to work for the Trust.

MF asked whether we could have a different grading status as there are some actions where the Trust is on track but has not delivered them yet and can this be reflected by labelling as blue rather than red. This was agreed by ST and IW.

Action: Izzy Worswick

It was resolved to RECEIVE the update on Teaching Trust Status.

MC/23/37 NHS staff survey 2022 Update (agenda item 8.6)

Lindsay Jensen (LJ) and Ashley Hambling (AH) updated the Members' Council on the 2022 NHS staff survey results and the actions the Trust has taken to respond to the feedback.

AH explained the presentation shows the results were positive with four key theme scores better than average, four themes as average and one theme which was below average. He said there were no significant changes in theme scores since 2021.

AH explained the results compare positively to other providers across West and South Yorkshire, and the region and they have come through the governance and service groups and wider engagement with teams.

AH said there is variation in service level results, noting community service results are more positive and results for mental health inpatient services are below average. He said medical staff results are the most positive and colleagues in clinical support worker roles and estates/ancillary roles are the least positive.

He explained the results for Black, Asian and Minority Ethnic (BAME) colleagues are more positive than the Trust average theme scores, but results are less positive for disabled colleagues.

He explained the results were presented to the People and Remuneration Committee and Trust Board in June 2023. Each service has agreed an action plan and the key themes include workplace wellbeing, access to development, improving teamworking and staff recognition.

LJ said there were different experiences from different staff groups, and below average scores were from inpatient areas. There were different responses from the protected characteristic group as well.

AH said the first slide provided an overview of the survey. The green themes are areas highlighted where the Trust scored a better score than average compared to Trust sector peers. AH said it was overall a better survey.

JL asked to hear the views of staff governors and how it felt for them.

Nik Vlissides (NV) said it was very pressured on the ground.

Ian Grace (IG) said from a medicine and pharmacy perspective the inpatient area was pressurised and resources were limited. He said some staff are heroic in provision of services and he hopes things will get better.

LJ said staff experience was lower in inpatient areas and it was similar with partner organisations, and this will be the Trust area of focus.

AH said people on lower bands had the worst experience and the results for nurses were mixed.

AH explained disabled colleagues had less positive experience than other areas and the Trust will be reviewing this with the staff disability network.

AH said on this survey bank staff were asked for feedback and they reported they had better work life balance but there were some areas of concern, and they were also experiencing more violence and harassment at work from service users. He explained each service was asked to identify high level actions by the 12 May 2023.

LJ said the 2023 survey will be released from October to November 2023.

Phil Shire (PS) said some of the scores are concerning and they do not indicate high morale amongst the workforce. He said this seems to be a problem that the Trust shares with other Trusts and the impact this could possibly have on service delivery.

MBr reported the Trust is working on improving things by setting the right tone and culture in terms of career development opportunities and providing a safe working environment.

AJ asked whether the disability staff group have seen the results so they can feedback. AH said the feedback has been circulated to the Chairs of the networks for wider circulation within the individual staff network groups.

It was discussed about some groups of staff having less flexibility in work with the added pressure of the cost of living and having less chances of flexible working.

Daz Dooler (DD) asked about complex cases and what the Trust meant by this.

Carol Harris (CH) said she doesn't have a clear answer to this but when people are admitted to hospital, they have increased level of distress, this impacts on their behaviour which leads to an increase in violence and aggression. She explained the self-harm is also more extreme and people coming into inpatient wards are more poorly. In terms of numbers, she explained the Trust hasn't seen increase in numbers through the Intensive Home Based Treatment Team (IHBTT) but people need more than one practitioner working with them and that people needs are increasing.

Andrea McCourt (AMc) said from an Acute Trust perspective, the increase in response rate of the staff survey is good as challenges are with people completing them when they are unhappy. She explained staff are also completing the survey in winter when there are winter challenges.

MBu thanked LJ and AH.

It was resolved to RECEIVE the NHS staff survey 2022 update.

MC/23/38 Focus on item – Health inequalities and waiting lists (agenda item 9)

Sue Barton, Acting Director of Strategy and Change introduced herself and explained she will present this item with Mike Garnham, Health Intelligence Analyst and Information Manager and Sara Javid, public governor for Kirklees.

She explained health inequalities work is part of the Trusts priority programmes, to 'address inequalities, involvement and equality in each of the Trust places with partners' and also the golden thread of 'Equality, involvement and addressing inequalities'.

SB explained how the Trust works to meet the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution.

The Trust considers ten protected characteristics, "carer" is not one of the national protected characteristics, but the Trust recognises this as an additional group. SB explained there is a national model called Core20 plus 5 for adults and for children and young people.

Inequalities are driven by insight; she said the Trust has an evidence base using work from the King's Fund. The Trust is also linking with national approaches and looking at inequalities in our four places and across our Integrated Care Systems (ICSs). This is managed via the Equality Involvement and Inclusion Committee (EIIC) and EIIC sub group which is Chaired by MBu.

SB explained the Trust works in partnership with Local Authority colleagues and places to look at a Joint Needs Assessment (JNA), population health data and working in partnership with communities with partners to capture voice and ensure greater involvement.

She said Equality Impact Assessments (EIA) are carried out to ensure Trust services are culturally sensitive, appropriate and relevant, taking action against impacts and co-designing improvements.

She said the Trust also works on capturing and monitoring equality data to inform person centred care by a reflective workforce and capturing patient experience.

SB said the Trust is improving the quality of equality data and ethnicity data has improved and is at 97% across all services. SB provided examples of the Trust addressing health inequalities;

The Life After Stroke programme is a new 6 week rolling programme in partnership with Barnsley integrated community stroke rehabilitation team, Stroke Association and Tesco. The sessions are delivered in a local supermarket's community room making it easily accessible to stroke survivors.

The Kirklees Child and Adolescent Mental Health Services (CAMHS) have delivered some focus groups with children and young people with a focus on areas which have a higher than average Black and Minority Ethnic (BAME) population.

She said the Trust has undertaken parent telephone interviews and developed a service website using data collected from the schools survey on the different languages spoken, and worked with Conscious Girls which is aimed at improving outcomes for black young people in Kirklees.

SB said Sara Javid (SJ) will now present her case study based on lived experience.

SJ introduced herself as public governor to Kirklees.

SJ said she wanted to speak about inequalities, particularly in relation to the following *(she presented the following slide);*

Migrant populations
Ethnic minorities
Long term conditions
Deprivation
Isolation
Religion and beliefs
Cost of living
Culture
Young people

SJ gave an account of her family as Kirklees constituents and their issues with mental health explaining cultural differences and how these had impacted on her family. She addressed issues of isolation, language barrier, physical health conditions and the impact this has on mental health. SJ also spoke about dual diagnosis and early intervention in South Asian

families. She spoke about cultural elements and for services to reach out to those communities who were hard to reach.

SB thanked SJ for her powerful message to the Members' Council. She explained that MG will continue with his presentation before governors can ask SJ any questions.

MG thanked SJ and said The Kings Fund report found health inequalities in England between ethnic minorities and white groups. He explained access to primary care health services was found to be generally equitable for ethnic minority groups, however people from some ethnic minority groups are more likely to report being in poorer health and report poorer experiences of using health services than their white counterparts. MG presented data, see slides 20 and 21. MG explained we are looking at data about making it more accessible and to use it to understand what it says about services the Trust is providing by creating a Health Inequalities Improvement Report and other reports such as the Mental Health Act committee report and Inpatient pivot reports.

MB and MBu thanked SJ for her incredibly brave and powerful story. MBr asked SJ to meet with her outside the meeting to discuss some of the matters she raised. MBr said it was important to hear about lived experiences and how the Trust can learn from them.

Action: MBr and SJ to meet outside the MC meeting.

Cllr Blagborough thanked SJ for sharing her powerful story. He said he couldn't imagine what she has gone though.

Erfana Mahmood (EM) also said she was incredibly moved by SJ's journey, and the journey of her family and she was a hero in managing this. CH thanked SJ and asked whether she would be happy to speak to the Kirklees care group about her journey. SJ agreed.

Action: SJ to meet with Kirklees care group.

PS and AJ thanked Sara for sharing her story. Governors discussed issued such as working in silos, varying health conditions (mental and physical), deprivation, and insight.

JL said SJ's story amplifies how difficult it is to reach some groups of people, he explained it is services not reaching out rather than them being difficult to reach.

MG said the Child and Adolescent Mental Health Services (CAMHS) are working in schools to talk about mental health and that they can talk about it at an early age.

BC said in the cancer services, they have the same problems with the inability to talk to some groups of people and this having an impact on early diagnosis and consequent treatment. Governors discussed how the NHS systematically treats the symptoms and not the cause. It was discussed that moving forward the NHS is looking at a preventative agenda.

Governors thanked SJ, SB and MG for their presentation on health inequalities.

It was resolved to RECEIVE the presentation on health inequalities and waiting lists.

MC/23/39 Integrated Performance Report (IPR) (to be taken as read and submit questions in advance) (agenda item 10)

David Webster (DW) presented the Integrated Performance Report for Quarter 1 2023/24.

He highlighted key points;

- Percentage of service users who have had their equality data recorded by ethnicity is 96%.

- The timely completion of equality impact assessments (EIAs) in services and for policies, although by service it is a red rating of 67.7%, the completion for policy is currently in green.
- Inappropriate out of area bed placement (days) is 441 (in red).
- The percentage of service users clinically ready for discharge is 4.6% (red) – this is challenging and has been added to the organisational risk register.
- The number of people with a risk assessment/ staying safe plan in place within 7 working days of first contact – community is at 92.3% (green)
- The percentage of ligature jobs completed within timeframe is a challenge.
- Turnover of staff has increased.
- Appraisals are increasing.
- There has been good feedback from family and friends test.
- During June 2023 there was an increase in demand of the flexible staffing pool with a total of 261 more shift requests. The number of shifts filled has increased by 24 shifts to a total of 5,004 and fill rates increased overall for inpatients however two care groups decreased slightly. This continued to be 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.
- 96% of incidents reported in June 2023 resulted in no harm or low harm or were not under the care of SWYPFT.
- Maximum 6 week wait for diagnostic procedures has increased from 79.8% to 82.5%
- 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 our ward-based service areas.
- Vacancies remain high across the Trust although an improved position decreasing from 17.6% at the end of Q4 2022/23 to 15.8% at end of Q1 2023/24.
- Agency spend is high at £10.3m.
- A surplus £19k greater than plan has been recorded in month; overall the surplus was £879k. Pressures in pay and non-pay have been offset by additional income and interest received.
- The monthly run rate of agency spend continues to be higher than plan trajectories. The run rate has increased in month with spend greater than £1m.
- The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
- We have continued to pay suppliers promptly; 96% of all valid invoices within 30 days.
- Capital spends - the year to date position is £105k ahead of plan with spend of £993k. This is due to prior year schemes and a door replacement programme being undertaken earlier than planned.

JL said it was good to see an increase in appraisals, he asked about retention of staff and if the Trust was doing exit interviews and if we are, are there are common themes identified.

LJ said the Trust are doing leavers questionnaires and they are sharing this with CH and her colleagues at operational management group who take it back to their teams, some of the themes include learning and development and some people are leaving for promotion or other jobs. She explained the people directorate are looking at roles and retention.

LJ said the Trust had 100 internal transfers this week which was about supporting staff to move within the organisation rather than leaving but there is a lot more to do.

Adrian Snarr (AS) said governors need to be aware of the system context we operate in and the financial challenges.

It was resolved to RECEIVE the Integrated Performance Report (IPR).

MC/23/40 Annual work programme 2023/24 (agenda item 11)

No changes.

It was resolved to RECEIVE the work programme for 2023/24.

MC/23/41 Members' Council meetings (agenda item 12)

Wednesday 27 September 2023 – Annual Members' Meeting

Friday 17 November 2023 (including Joint Trust Board and Members' Council)

Friday 23 February 2024

It was resolved to RECEIVE the dates of future Members' Council meetings.

MC/23/42 Any Other Business (agenda item 13)

MBu reminded governors that the next Annual Members' meeting will take place on 27 September 2023, Al Hikmah Centre in Batley.

It was resolved to NOTE any other business.

Close of public meeting

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 23 October 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:		
In attendance:	Adrian Snarr Carol Harris Rob Adamson Nick Phillips Julie Williams Jane Wilson	Director of Finance, Estates & Resources Chief Operating Officer Deputy Director of Finance Deputy Director, Estates & Facilities Deputy Director of Corporate Governance Note taker

FIP/23/67 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting.
No apologies were received, 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/23/68 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/23/69 Minutes from the meeting held on 18th September 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 18th September 2023

FIP/23/70 Items delegated from Trust Board held on 26th September 2023 (agenda item 4)

DW confirmed that a review had taken place at the previous meeting around the two areas outstanding, these are Out of Area (OOA) and Agency and it had been agreed that a further update would be brought back to the November meeting.

FIP/23/71 Matters arising and action log from the meeting held on the 18th September 2023 (item 5)

There were no outstanding actions to review this month.

It was RESOLVED to NOTE the updates in relation to the action log.

FIP/23/72 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)

AS presented the review of committee related risks.

<u>Risk 1114 - Revenue</u>

AS confirmed that this risk has been discussed and reviewed in EMT and it had been decided to leave as it is for this financial year but keep it under review as we move into 2024/25 planning.

NM pointed out that in the detail there is an element around staff engagement to develop efficiency ideas around the Cost Improvement Plan (CIP) and as it refers to Q3, which we are currently in, are there any updates around these.
AS responded that when we get to the papers RA is presenting the committee will see where we are currently with the CIP plan, also where the risks are. In terms of engagement, Sue Barton, Deputy Director of Strategy & Change, is currently working on some comms to engage the broader staff within the organisation and this will go out this week. We also want more targeted engagement with budget holders and care group directors, and this is predominantly done through OMG. We were conscious of the fact that the CIP programme for this year was generated centrally, and people were asked to deliver on it, as a result, you can see the bits that are going well, also the bits that are slipping, and we want to try and revert back to how we used to do this when we had financial challenges in the past. This was more bottom up, where people suggested ideas, we worked them up, then we did the Quality Impact Assessment (QIA) and then added them into the plan.

AS confirmed that planning engagement is starting internally and part of this will be how we build up the CIP programme for 2024/25. Most things are on track for 2023/24, non pay savings is one that is slightly off track and that is potentially because we did not get full engagement on every service line.

NM remarked that this risk is currently sitting at 9 and do we feel we are managing this, or do we potentially see this as an increasing risk as we go into next year.
AS responded that this year we will deal with it non recurrently, the challenge is getting the balance right between the recurrent and non recurrent schemes. He was confident the Trust will hit the £12m target for this year, but with more of it being non recurrent this will therefore roll into next year's risk when they do the plan.

NM thanked AS for the helpful update.

<u>Risk 1585 - Capital</u>
AS confirmed that following reviews on this, it was proposed to increase this risk from a 3, possible, to a 4, likely, as we have not got sufficient capital available within the trust to do everything that we want to do as part of our strategy going forward. He explained the trust have already had to curtail the Bretton scheme and we are going to find it very difficult to get the full scheme back within programme. We are also starting to see other pressures coming through, so it definitely feels like this risk is increasing and that is the reason for recommending it was likely rather than possible.

DW remarked as this is an increasing risk do we need to have something more external focussed.
MB pointed out that we already do a huge amount of lobbying ourselves and via membership bodies e.g., NHS Providers, Confed, and that this is a political issue.
DW commented we need to note that we are doing this.

KQ remarked that following the update from AS she was happy to agree to the increase in risk.

It was RESOLVED to NOTE the risks, relevant to this Committee, also to NOTE the RECOMMENDATION to increase risk 1585 in relation to the risk content, risk levels and risk appetite.

FIP/23/73 Month 6 Finance Report (agenda item 7)

RA presented the financial position for month 6.

Key headlines:-

- Current focus is on trying to firm up year-end positions and planning for where we are for future years. Awaiting national planning guidance
- KPIs - agency spend is still red rated for ytd and forecast. Capital ytd is red, as we are behind plan. We are forecasting that we are going to deliver the full allocated spend.
- I & E position – a small deficit was recorded in month of £59k, which means that ytd is £1.1m. This is behind plan; £574k at the Trust level (reducing to £201k overall).
- The provider collaboratives have made a positive contribution; excluding this the core Trust would be a deficit of £228k and be £174k behind plan.
- The forecast, as externally reported, remains at breakeven and in line with plan.
- RA currently undertaking deep dive into income, to ensure all numbers are what we have agreed with Commissioners and internally and that we are receiving the cash for these. There is a little bit more work to do on this as they finalise contract signatures.
- National focus on contracts, ensuring they are all signed.
- Most income remains block which allows us to plan with certainty.
- There is an element of risk around the income and slippage that finance are stilling working through.
- Pay continues to be biggest driver. Workforce growth (substantive and bank) has continued in month although this is less than previously forecast. Worked WTE has increased in September by 25 WTE. This is, however, 37 WTE less than forecast last month which is reflected in the updated forecast. The forecast continues to highlight an additional 53 WTE by March 2024.
- Agency spend saw a reduction in July and August. It has seen an increase in September with a total of £915k in month.
- Non pay – mostly showing as over against budget. To be reviewed within the non pay review group and inform of the Trust planning process for 2024/25.
- OOA placements has been positive in last few months with a continued reduction in both acute and PICU out of area placements.
- Spending more than planned on rehab beds, which is predominantly Barnsley, also on IAPT services.
- Value for money (VFM) and efficiencies, year to date 290k behind plan, gap reduced due to positive movement on interest and out of area placements.
- Balance sheet – Capital showing considerable underspend for the ytd, predominantly IT but also some of the minor capital schemes. Quite a large increase in planned trajectory in Q3. Still forecasting to deliver in total £8.8m.
- Cash remains positive and we continue to pay suppliers as quickly as possible.

NM remarked that OOA had recently been discussed at the recent Quality and Safety Committee (QSC) in terms of the improving performance, and she wondered what has been done differently to help us achieve this, and can we sustain it.

CH replied that they have allocated a senior member of staff at associate director level to work with teams in a very focused way. James Waplington (JW) is working closely with teams and providing them with direct leadership and support, he's showing them what the care plan could look like, and what they need to do with a view to looking after people safely in the community wherever we possibly can.

CH pointed out that with regards to sustaining this going forward, demand has fallen, and it is more about getting people's hearts and minds back into the space they were in prior to Covid and

JW is doing this. They have also been really active in the Multi Agency Discharge Events (MADE) and have really pushed our Places to help us try and find placements, this remains challenging as the Committee will see in some of the delays in discharge. Overall, it has been about having increased focus, increased leadership, whilst getting back to arrangements that were put in place some time ago.

NM remarked that what is interesting from a sustainability perspective is that if we did it before and then we have had to go back in, albeit for good reasons, is there something around taking learning from this, so it does not slip again, and we have to put additional capacity in.
CH responded that we were one of the few Trusts who were managing low numbers in OOA, these really were a set of unusual events that shifted everyone's focus, and it was difficult to get a grip back on this. She confirmed they will also look at keeping a leadership focus on this as it has been extremely effective.

AS commented that this is a slightly different scenario, but the end point is the same in that there has been a focus on OOA placements throughout the provider collaboratives and through that intensive focus at a patient level they have managed to reduce OOA. This is one of reasons why West Yorkshire is in strong financial position, because it has managed to reduce the number of OOA placements.

NM thanked CH and AS for the update.

DW commented that as we are looking at the impact of OOA further at the November meeting could we also bring back further information on agency so the committee can understand the impact of the nursing increase over the last month.
AS remarked that there is currently an intensive focus on agency, but it is not delivering the same results at this point in time, it is proving quite difficult to move the dial on this one. AS agreed to do a deep dive into this with a view to bringing an update to the November meeting.

ACTION: Adrian Snarr/Rob Adamson

DW remarked that in relation to other non pay, adversity in particular seemed to be increasing quite quickly in a negative trend and should we be looking at this in a little more detail.
RA replied that he was quite happy to do a deep dive into this and bring further details back to the committee.
DW commented that from his point of view this is more around giving the committee a greater understanding of what is causing the adversity.

ACTION: Rob Adamson

AS remarked that by way of assurance, this is an area of focus, and it is expected that we have a high degree of scrutiny on non-essential spend in particular to see what we can do to reduce this. There are a series of non pay scrutiny groups, one of which he attends, which looks at all orders over £5k to understand if they are essential and if the committee thinks it would help to see this they could start to bring some of this high level analysis here.

DW responded that this may just be a one off so it at this stage it would be good to receive assurance in the first instance.

NM referred to agency spend and the system controls and scrutiny around this, she was conscious we are now going into November, and do we know what we look like as a system around this, do we look like an outlier, also have we any indication yet what the consequences might be of not hitting the target.

RA responded that originally we were the first trust to say we were going to breach our cap so we were an outlier. As of August, 7 out of 10 Trusts are also saying they are in the same position. AS advised that in terms of consequence there is still no explicit consequence of breaching the cap, he suspected it would be in the round of the West Yorkshire system position, so we are having to enact all those control measures around agency, vacancy control and non pay. If the West Yorkshire plan remains off track he felt that would bring some consequence at a system level and they don't know what this would be, they would just have to keep an eye on that. He did not feel the trust would be exempt from scrutiny even though we are going to break even, He confirmed that if the West Yorkshire plan remains off track he thought it could still bring some national or regional attention.

KQ referred to the risk register in relation to efficiencies, she asked where we are at with the Patient Level Costing (PLICS) work.
AS responded that the sign off process to submit had been agreed with the Audit Committee, it was agreed the outcomes would come back here once available, the national collection window has been put back to January, which is not the first time it has been delayed. He stated the PLICS information is available and although there is still work to do on the income side of it, the cost side of this is pretty robust. Due to the national delays of this we will not be able to compare to peers and it will be quite some time before we get any national benchmarking as part of this exercise.

It was RESOLVED to NOTE the Month 6 Finance update.

FIP/23/74 Financial forecast (agenda item 8)

RA commented that even though the ytd position is slightly off plan, there is real confidence that the trust will be able to deliver a break even or better position overall. . RA has spent a lot of time over the last few weeks sharing trust policies and procedures with the ICB to demonstrate we are doing everything we can to support this process.
RA advised there will be an updated matrix including RAG rating available on Friday to show how we compare with other people.
RA confirmed that the baseline forecast has been updated in month with a positive movement to a surplus. The main movements relate to OOA placements and South Yorkshire Adult Secure collaborative. As in previous years the risks and mitigations will be worked through over the course of the year and included into the baseline forecast as appropriate. Values, and the level of risk, will also be re-assessed each month. A detailed, bottom-up, forecast continues to be updated monthly by teams in conjunction with stakeholders. This reflects current assumptions and actions.
Top down assumptions are overlaid as part of the scenario modelling. These are also reviewed each month and updates are included in the report. These assumptions act as an action list to work through and confirm the likelihood and impact to secure the year end position.
RA confirmed the forecast continues to be reported externally as breakeven and in line with plan.

AS remarked that in relation to opportunities, there is a lack of the certainty on the risks and we think they may be overstated rather than understated. RA agreed that they were prudent, and he felt the important thing for the committee to note is that most of this is non recurrent.

DW thanked RA & AS for the update.

It was RESOLVED to NOTE the Financial Forecast update.

FIP/23/75 West & South Yorkshire Collaborative Financial Updates (agenda item 9)

RA provided the update stating CAHMS and Adult Eating Disorders are both forecasting deficits and pressures, and these are being offset by the West Yorkshire Adult Secure Collaborative. South Yorkshire is reporting a break-even position but there is further work to be carried out yet to ensure both the invoicing in and out is correct.

AS explained that the South Yorkshire specialist collaboratives for adult eating disorder and CAMHS are not in a dissimilar position financially to West Yorkshire ones as he felt they have a bigger pressure on adult eating disorder. He pointed out that the committee will remember he had an action to get a risk share in place with South Yorkshire, and he has not been able to do this because partners have not been willing to sign up to one. If we did enter into a risk share we would have some financial risk pressure resulting from that, and he felt this was still the right thing to do and we will continue to try and facilitate conversations around this.

DW asked if there was a reason why they do not want a risk share. AS responded that there are lots of reasons, one of them is the maturity of the collaboration, we should not underestimate how strong it has been in West Yorkshire for quite some time, when the specialist collaborative was created there was already a high degree of collaboration across the system that is not necessarily there in South Yorkshire.

It was RESOLVED to NOTE the Provider Collaborative update.

FIP/23/76 Monthly Performance Update (agenda item 10)

JW provided the update stating this is a new report that will go to Board for the first time this month, it is a retrospective report, which will allow more time for insight and will take account for two care groups at a time on a rolling programme. It has been brought to the meeting today for the committee to give feedback on the new format and to find out if they think it will help them gain insight into care group and operational activity. This is also a first look at what the data is telling us for two particular care groups, there is still a lot of work to do on this ahead of it being circulated to board members later this week.

KQ felt there was a lot of rich information and analysis in the report which is great. In terms of the format she said it would be helpful and beneficial if JW could pull out what the key points and risks are, this would also help when drawing attention to this at Board. JW responded that she appreciated this feedback and that she would add this to the front sheet.

ACTION: Julie Williams

NM agreed with KQ and that being able to see the key highlights is really important for them.
We also need to be careful around some of the language in relation to the actual insights and analysis. CH responded that this has now been addressed.
NM liked the report overall, and she felt the SPC charts really helped in terms of visuals and she felt there were a lot of interesting conversations for us to have in terms of performance and targets, also how realistic these are.
DW remarked in relation to metrics could we put an action for a future meeting to do a deep dive into this, he was happy for AS and JW to agree on the timing of this outside the meeting.

DW agreed with KQ and NM around the summary and he said his preferred choice of format was key bullet points, so one step below the front sheet and not as much detail.

JW remarked that in terms of the deep dive they would need to look at this ahead of next year, her choice would be to bring something back here early in the new year to look at those targets. She advised that a discussion would firstly need to take place at EMT, and that she would liaise with AS/Jwi outside the meeting around the timing of this.

ACTION: Julie Williams

CH remarked that she would like to pick out some of the key points in terms of the actual data:-

- The RRPI (Reducing Restrictive Practice Interventions) is showing as the hotspot for both CAMHS and Barnsley Community. They are revisiting who should be doing what element of the training and also looking at, are we measuring performance that we do not need to measure, particularly when there is such pressure on the training places.
- Paediatric Audiology is the other hotspot and they are revisiting the narrative because they are looking to provide a trajectory. Previously the Board have been given assurance from the service drill down that this has been done and that they will be back up to full service by October. We have now identified that we have challenges in relation to this and they will be able to provide Board with further details around this at the meeting next week.
- CAMHS Neurological waits, the committee will be aware of this from previous performance reports, and this reports into Board.

DW remarked that it is good to hear that RRPI is being looked at in more detail as this is a hot topic.
NM stated that the RRPI annual report was discussed at the recent QSC meeting, which CH, KQ and herself had attended and she wondered if some of this was coming on the back of those discussions, and for her it was about being able to triangulate this information in Board.

ACTION: Julie Williams

DW commented that one thing he wanted to call out was the different wait times by different areas, and we can't do anything about spending across areas, what is stopping us from moving people across area to balance those wait times out.
CH responded that we are commissioned differently in each of the areas, and we are commissioned for different elements of different pathways.

NM asked if the new HR business partners contribute to the insights and narrative around care groups. CH responded that yes they do.

KQ remarked that whilst she appreciates there is a lot of content in the report, and there is still much do she wondered when this would come back here for a progress update, particularly around the RRPI training, CAMHs and General OPS.
CH responded that she was happy to pick up on specific actions, but that they also needed time to work on this as this is a new report and is new to the care groups. She explained they are currently drawing on the skills of the business analyst who is helping them to triangulate the information better. The RRPI is currently picked up in the IPR so this can be looked at in the care groups section, she agreed that paediatric audiology needs to be picked up here and an update will be brought to the November meeting. CH felt that as they get used to using the reports the committee should start to receive more assurance.

ACTION: Carol Harris

KQ remarked that she was mindful everyone is asking for lots of detailed analysis and do we have the capacity for this.
JW responded that there is currently one full time equivalent sat within the strategy and change directorate, and this is Vic Humble. There are also 2 more people within the performance team, in health intelligence who can analyse this data, and they are just looking at how these 3 people can work together.
CH confirmed they are also doing more on the making data count work through OMG so that as care groups they get better at being able to analyse the information they are being given.
KQ appreciated that these things take time to embed into an organisation.

DW remarked that whilst he appreciated this is still a work in progress this looks good, and he thanked JW for her update.

It was RESOLVED to RECEIVE the monthly Performance Update

FIP/23/77 Capital focussed progress report (agenda item 11)

NP provided the update stating that overall, the capital expenditure has fallen behind plan, but with the new delivery plan in place confidence is high that the plan will deliver in full.
They are continuing with struggles to get contractors and are currently working with the procurement department on a tender which has been approved by EMT, this is now in the standstill position, and will take us forward on one of the seclusion programme major schemes. This will extend fully in year with some expenditure in the following year as it has come in slightly above budget. NP confirmed the other major capital scheme is the Kendray Infrastructure project and they are bringing forward doors and window expenditure from next year.

NP confirmed they have been successful in getting some external funding for digital dictation and there is currently a tender for this
Overall digital is slightly behind schedule but there is a plan to deal with this.
NP remarked that overall, they have had a period where they have not been able to drive things forward as much as they would have liked, but things are now starting to get back on track and they should start to deliver this over this next 6 months.

KQ asked what gives us the confidence that the digital capital plan will be delivered in full.
NP responded that some of this is around contractors and although there are still labour issues generally, some of this is around getting partners in Places working with procurement, and this is taking a little bit longer than anticipated.
AS remarked that on IM&T, the lead in times are shorter than on the estates schemes, so even where we do incur some slippage we still have 6 months to recover that in year and the lead in time should facilitate that for IM&T. In terms of confidence in the overall plan, the conversations taking place have not so much been around the plan, but more the need for us to fully utilise the capital available to us, for the reasons we discussed earlier around the risk on future capital availability. Dynamic purchasing should allow them to flex the plan, so they have increasing confidence they can deliver the expenditure within the plan but also allow more expenditure within the plan.
KQ remarked it is great news about the funding for digital dictation,.
DW remarked that in relation to delivering the figure by the end of the year, would it be possible to see what we are expecting to spend each month to give that extra assurance.
RA pointed out that within the finance report there is a profile that finance work with in conjunction with estates and IT that gives the breakdown of each scheme.
NP remarked that if the committee would find this helpful he would include this information in future narrative.
DW responded this would be helpful and he suggested this be presented in a small table format if possible.

ACTION: Nick Phillips

KQ referred to the OPS business case, previous discussions that had taken place at the QSC meeting around the preferred option issue, and us not saying what that preferred option is, because we are going out to consultation. She said there was a strong view at the meeting that we should have our own preferred option based on all our analysis.

. NP confirmed there are meetings diarised for the forthcoming week to discuss this further.

. She thought it would be helpful in this committee to map out the business case and the different parts of the process.

NP stated that his involvement is only a small part of the business case, and whilst he is aware of the OPS business case he is sat outside of it.

DW remarked that MB has pointed out that this conversation needs to be held with subject matter experts and he thought this was on the Trust Board agenda next week.

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DW remarked that from a governance perspective we agreed this needed to be raised here but as MB has now confirmed this will be picked up at Board.

It was RESOLVED to RECEIVE the Capital focussed progress report.

FIP/23/78 Work plan (agenda item 12)

RA advised they were not sure when the national planning guidance will be out yet in terms of planning.

DW commented that as there are meetings in both November and January AS and himself can discuss this at future agenda setting meetings.

AS remarked he would also like to pick up a review of the work plan with DW at the next agenda setting meeting in November, as it currently feels like we have not got the sequencing of these right in terms of getting the meetings even. He said if we factor in planning and the MHIS we may want to shuffle things around a little bit.

DW confirmed that any changes that were agreed outside the meeting would be brought back for committee approval.

ACTION: Adrian Snarr/David Webster

FIP/23/79 Any other Business (agenda item 13)

DW confirmed there were no further items to discuss.

FIP/23/80 Meeting evaluation & confirmation of:

a) Meeting effectiveness
b) Significant issues to report to the Board of Directors

Advise

- CIP plans for future years, engagement starting throughout Q3
- Agency spend increasing in month, OOA review taking place in November.
- Reviewed forecast with risks and opportunities for year-end position

- Reviewed different wait times across areas.

Alert

- Capital risk in the medium term, have increased the likelihood from possible to likely.
- Agency continues with adverse target.
- Capital is tracking behind budget but expected to catch up by year end. Slight deficit in the month which is slightly behind the plan but expected to recover by year end.

Actions

- Other non pay costs, finance to provide further information with breakdown of key lines.
- Reviewing metrics in new year, particularly where we are continuously under/over performing.
- - Further information to be brought back to November meeting on Paediatric audiology
  - OPS business case action to remain open until after Board.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of People and Remuneration Committee meeting held on 11th September 2023
Microsoft Teams Meeting

Present:	Mandy Rayner (MR) Mark Brooks (MB) Marie Burnham (MBU) Natalie McMillan (NM)	Non-Executive Director (Chair) Chief Executive Chair of the Trust Non-Executive Director
Apologies:	Carol Harris Greg Moores Miriam Heppell	Chief Operating Officer Chief People Officer Interim Deputy Chief People Officer
In attendance:	Lindsay Jensen (LJ) Sue Wing (SW) Naomi Fernandez (NF) Richard Meyers (RM) Richard Butterfield (RB) Gemma Lockwood (GL) Julie Williams (JW) Diane Taylor (DT)	Interim Chief People Officer Director of Services (covering COO) Head of People Experience Learning and Development Lead Head of Recruitment and Resourcing PA to Chief Executive Officer (Author) Deputy Director of Corporate Governance Associate Director – People Operations

PRC/23/206 Welcome, introduction and apologies (agenda item 1)

The Chair Mandy Rayner 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/23/207 Declarations of interest (agenda item 2)

There were no declarations of interest.

PRC/23/208 Minutes from previous People and Remuneration Committee meeting held 23rd May 2023 (Redacted) (agenda item 3.1a)

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on 23rd May 2023 as a true and accurate record.

PRC/23/209 Redacted Minutes from previous People and Remuneration Committee meeting held 30th July 2023 (Extra Ordinary) (agenda item 3.2a)

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on 30th July 2023 as a true and accurate record.

PRC/23/210 Minutes from previous People and Remuneration Committee meeting held 30th July 2023 (Only sent to Committee Members involved in the decision making around the remuneration) held 30th July 2023 (agenda item 3.3a)

Previously approved online. It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on 30th July 2023 as a true and accurate record.

PRC/23/211 Matters arising from previous People and Remuneration Committee meeting held on 21st March 2023 and action log (agenda item 4)

- PRC/23/180 Integrated Workforce Report
  Richard Butterfield (RB) updated that the recruitment and retention strategy is ongoing. RB will produce a paper for the next meeting with a plan.
  Action: Richard Butterfield

- PRC/23/186 International Nurses Reckonable Service (Leeds Teaching Hospitals NHS Trust) (agenda item 12)
  (RB) updated work started, looking at international recruitment as a whole. Couple of individuals who have put in reckonable service requests, paused those to look at everyone at the same time. Update at next meeting.

- PRC/23/192 Safe Care Roll-out Project Plan
  Lindsay Jensen (LJ) updated Extended Management Team (EMT) have approved funding, RB working with e-rostering and Safe Care implementation team on a planned approach to roll out these out further across the organisation. There had been some initial resistance from colleagues on safe care, but this is now progressing, and it is anticipated that wards will see the full potential and benefits. Nat McMillan (NM) updated that she and Marie dropped into to visit the e-rostering team recently, as they have heard a lot about e-rostering and safe care, and that this should come to board. MR requested a formal presentation at the meeting in November by the team on strategic direction rather than operational detail which would then be shared with the Board.
  Action: Richard Butterfield

- PRC/23/148 Workforce Performance Report
  LJ updated we now have full team of People Business Partners and this is one of their objectives to work with the care groups on workforce data and performance, due to staff being new we would be looking at January for the deep dive to take place. Mark Brooks (MB) wanted to make sure that the deep dive was clear and defined. RB updated the performance and planning role is now in place and their core duties are looking at the IPR and this will be worked with colleagues in PB&R. Julie Williams (JW) updated that the Care Group drill down is coming to Trust Board this month, this will tie in to work the People Directorate are doing as well.
  Action: Richard Butterfield

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for May 2023.

Actions from Trust Board
There were no actions from Trust Board

PRC/23/212 Chief People Officer Remarks/Update (agenda item 6)

LJ presented a summary of the report. Firstly, this included an in-depth report on the impact of industrial action by junior doctors and consultants over recent weeks, this had been produced by Carol Harris (CH) and Subha Thiyagesh (ST). This covered the escalation of action by the doctors and more industrial action for Junior Doctors and consultants again in October. The arrangements put in place have ensured that the impact has been kept to a minimum and this is down to all the hard work of clinical leads and operational managers in leading this. Recognition of this and a thank you has been sent to everyone involved.

Silver command meetings are continuing, now looking at implications of both sets of doctors striking together and the wider impact. Subha Thiyagesh (ST) has fed back a sense of weariness amongst doctors. At the recent re-ballot of junior doctors, the majority voted yes to further strike action which demonstrated the depth of commitment and feeling by the juniors.

All Senior Leadership positions within the People Directorate team are now filled.

Pay for senior managers has now been agreed but formal notification has not been received yet, once received it will be taken through this committee for approval.

Response to Lucy Letby trial, people issues will be picked up as they emerge. Fit and proper test for the board, paper will be sent to board regarding the change of guidance.

Onboarding update, dedicated project lead in post to move this forward, plan in place and will be rolled out in phased basis across trust. This will be brought back to this meeting in the new year for update. Collaborative bank, contract has now been signed and looking for go live before Christmas, first meeting with RLDatix our collaborative bank provider taking place soon. Winter Planning, flu programme up and running, covid programme will be picked up at EMT time out this week. Notification from HEE, workforce development funding will be reduced this year by 80% paper sent to EMT, we have CPD funding for other training and development programmes already commissioned which will reduce the impact this year. Currently using learning needs analysis and study leave to prioritise training requests, this has gone through OMG to help with prioritisation.

(NM) asked if we are confident that local decision making from the Trio is embedded at all times and not just strike time, is there wider learning for it to work effectively? Sue Wing (SW) confirmed the local trio working is a good network right across operational delivery. Rather than cancelling mass clinics, decision making was kept local. Decisions are made between the business continuity plans and the local trios and then shared across the care groups. NM asked for assurance that the decision making with the trios is happening at local level and it works effectively. SW explained that systems are in place locally, operational governance meetings and clinical governance and this feeds back to ops management group and then shared across. NM thanked SW for the assurance.

MR questioned how many doctors were on strike and that the percentages seemed low, LJ confirmed that it included doctors on leave and study leave and that certain days had more activity.

JW confirmed that any escalations from OMG would go to EMT. In addition to planning for flu and covid there is also planning for measles and a specific group is headed up by Alison Thomas which looks at data management and how we will manage vaccination status of staff. JW will include update to next committee.

MB responded regarding long term workforce plan, that it is a financial risk not a training/education risk, funding needs reallocating to ensure that training and education is supported and spent effectively.

With regard to industrial action MB expressed that we must not lose sight of the fact whilst we are currently managing this well this is a huge effort by colleagues to ensure we manage it effectively and this is not a sustainable position. Good practice needs to be reiterated in terms of Covid. The points are raised every week in The View/The Brief. It was noted that there are patients with Covid, and we do promote rules and good hygiene. Covid is a standing agenda item at EMT.

MR had noticed that the Genius implementation was slightly behind first original schedule and asked for an update in the new year.

Once formal notification of pay uplift for very senior managers has been agreed to be brought back through this committee.

Action: Lindsay Jensen

Onboarding update, dedicated project lead to move this forward, plan in place and will be rolled out in phased basis across trust. Bring back to this meeting in the new year for update.

Action: Lindsay Jensen

Update on vaccination status of staff required at next meeting.

Action: Lindsay Jensen

It was RESOLVED to NOTE the update on the Chief People Officers Remarks / Update and comments made.

PRC/23/213 Staff Story – Laura Habib (agenda item 7)

Laura Habib (LH) presented the PowerPoint presentation on Health and Wellbeing Champions and explained her role within the trust, who the wellbeing champions are and how many we have and in what areas within the trust. LH updated on some quotes from staff as to how wellbeing champions had helped them. LH explained there is a knowledge gap with regards to the role and explained how you can find out about it, she explained the support available for champions and the expectations of the role. LH informed the committee of the quarterly network for champions that acts as support and resources for the champions.

MB thanked Laura for her time and dedication to the role and recognised the amount of people that we have in the roles who want to help improve the lives of people in the organisations.

RB asked if we have enough male representation for wellbeing champions, LH updated that she is speaking with male colleagues and actively promotes and asks for the male attendees on the call to promote it where they can. MR expressed that the diversity of the champions is also important. NM agreed with MB comments and asked if we have any areas that we are concerned about where we don't have wellbeing champions. LH explained that some areas have identified gaps and she is working with them. SLT members have come forward to be champions and members of resourcing also. A call out through comms has been done for wellbeing champions, LH suggested a specific male request could also be done if this is possible. LJ expressed her thanks to Laura confirmed that this was a positive that had come from the feedback from staff and a really good example of 'You said We did'.

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

PRC/23/214: Review of Off Payroll Appointments and IR 35 – Rob Adamson (agenda item 8.1)

Rob Adamson (RA) explained that the IR35 process implemented assesses if the individual or contract work undertaken should be regarded as work that meets the rules as an employee of the trust and therefore paid thorough our payroll and taxed accordingly or are paid off payroll. The paper documents how we undertake assessments and how we arrive at the outcome. Current position shows twenty-two individuals as of March 23 which is an increase to the prior year. The reason being that the threshold hasn't change but the amount we are paying has due to pay increases. The majority relates to staff supervision in these criteria. MR asked if this paper goes to FIP, RA confirmed it only comes to PRC. MB asked is there a risk on the length of time people have been in roles? RA confirmed that staff are reassessed every 12/18 months and these are done in conjunction with the person/company and this will be reported back. MR asked when from a risk point of view will we see the results. MB confirmed this will be seen by exception. If a risk is identified then, it will be brought back, if not then annually.

It was RESOLVED to NOTE the update on the Review of Off Payroll Appointment and IR 35 and the comments made.

PRC/23/215: Integrated Workforce Performance Report (agenda item 8.2)

LJ confirmed that IPR data is for July. RB updated that general recruitment is outperforming starters against leavers, slight dip over last quarter but still on track for meeting our 3% growth for the end of March we are at 1.14%. Currently seeing a high number of applicants at our value-based recruitment centres, two ran last week one for bank, one substantive, over 250 applicants, focussing on nurses and HCSW.

High number of applicants for Health Care Support Worker (HCSW) who are requiring visa applications. Trust will not support for band 2 recruitment for HCSW as UKVI does not support HCSW at that level. Seeing a lot of activity in terms of recruitment, we are currently looking at 80-100 VRF's every week, some difficulties in processing but we are working through this. Vacancies across the trust remain high 796 WTE, this has reduced by 150 since March.

MR asked if the reduction is due to changing the establishment rather than filling vacancies. RB explained that the establishment has risen in the same period, in line with starters and leavers therefore we are outperforming. MB asked about headcount reconciliation and asked that we don't look at vacancies until we have reviewed establishment. MR confirmed that LJ had also had that discussion. MR asked about recruitment fairs and are Liverpool Birmingham and Glasgow worthwhile in regards time and effort? RB explained we had done one so far, we are looking at feedback and if we are getting benefits from the events. LJ agreed, we should also focus on local jobs for local people as well as the veterans. MBU asked if we had opened our training places for student nurses as this is sometimes a challenge. What is the correlation between opening up the places, has it increased or not and what is the recruitment from that effort, i.e. offering training. RB explained the challenge to increase the placements is to increase the mentorship on the wards. There is conflicting challenge with the nurse recovery programme which is giving pressures and also TNS coming into the ward. Currently working with other universities. MBU requested the data at the next meeting on student placements. SW updated we have operationally linked back in with Sheffield University 3rd year nurses that are about to qualify 6 months in advance. This is more so post covid. Clinical lead in district nursing is now teaching on the course for pre reg nurses.

Diane Taylor (DT) Sickness has some hotspots within forensics and estates and facilities. HR Ops Team working closely with mangers to manage absence and discussions around getting people back to work early and looking at the FIT note. Currently looking at getting staff back to work early to do something rather than be off work.

Stress is the top sickness reason, need to understand the underlying reason, also on a focus on short term absence. MR updated there is an audit review planned for the 4th quarter for sickness within the trust. MR updated long term sickness and stress was discussed at the YOI and this should be looked at in depth.

NM, agreed that the expectation should be set for looking into the trends and what we are to do about them.

Richard Meyers (RM) updated that appraisals have seen the numbers dip slightly this month versus previous and this is through drops offs that were not anticipated. Phil Speight (PS) has reworked the data to go on a weekly rather than monthly basis and this helps to look at the data in a more live way. This has helped to see the errors and this is being corrected in a timelier basis to give a more true reflection of appraisal rates and gives more agile reporting to help understand the drop off rates. This reporting can now be used at OMG. Mandatory Training overall has two areas of concern, local induction and welcome event, figures are high at 90% and work continues for timely registrations. Local induction forms are followed up could be worked with Genius to make things more streamlined. RRPI has dipped over a period and has now stabilised at 76%, the target is 80%, now managed to attain a secondary space for dual delivery of RRPI, used to be able to train 16 people a week, the sports hall is now able to be used to train 32 people.

MBU requested assurance not just data, she asked if appraisal levels can be turned around to a reasonable standard. RM confirmed 80% of target is a reasonable ask, we have been over 75% for a reasonable amount of time. Support has been put in but the drop offs are the issue, more work needs to be put in to anticipate the drop offs and potential to complete appraisals pre-emptively before they occur. It was suggested appraisals are completed 8-12 weeks before they are due. The figure can be maintained once we get there but more work needs to be done in maintaining a more proactive approach in this area.

NM requested trajectories around improvements, it was agreed that 80% is a generous target and we should be achieving this without a problem. People business partners should bring the analysis to the appraisal to target the hotspot areas. RRPI learning is required and assurance is required more explicitly in the cover sheet. MR agreed with the comments NM made. MR updated that CPR is green and has been for two months. This was noted as being really positive. MR asked how we will release extra staff to facilitate the extra training in the sports hall. Securing the sports hall gives some additional assurance.

MB advised that this is a standing agenda at EMT and that the figure has moved from 52% nine months ago to mid 70's but is nowhere near where it needs to be. There should be a staggered target throughout the course of the year that finishes at 95%. Hotspots need to be identified and then we need to understand why they are not completed and help them to complete. Issues have been identified with WorkPal around it not being aligned to ESR therefore internal catch ups have had to be made. Contract expires end of March, new proposal being put forward. Appraisals are included in all Directors objectives. RRPI, offer of recruiting in two members of staff due to injury therefore progress my take a little longer. LJ commented that appraisals are high on the PD agenda, and that they will be concentrating on the quality not just the quantity.

Naomi Fernandez gave assurance that she will be working will the OD and Wellbeing lead and looking at the quality of the staff survey data around appraisals and working with the people partners.

Update required on training places for student nurses at next meeting.

Action: Richard Butterfield

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

PRC/23/216 Organisational Development (agenda item 8.3)

Lindsay Jensen (LJ) updated that Miriam Heppell has joined the trust and one of her objectives is to work with Noami Fernandez on the OD plan. The plan would be to bring a draft plan and to capture the work we are doing in one place later in the year as this is developed and more engagement takes place.

It was RESOLVED to NOTE the update on Organisational Development 2021/2022

PRC/23/217 Wellbeing Annual Review (agenda item 8.4)

MR reminded people that she is the Trust Board wellbeing champion for SWYT, Rachel Lee will be assisting her in the role moving forward.

NF updated report focusses on the ten key priority areas for employee health and wellbeing programme resources and sets out plans for ongoing improvement for seven of the areas. Other programmes included H&W across care groups in Calderdale and Kirklees forensic care group and disabilities setting employee wellbeing groups for Wakefield CAMHS nursing professions, Barnsley integrated care services group and estates and facilities. Currently working with Robertson Cooper, to build some more internal capacity, wellbeing surveys have been sent out to staff identified as in hot spot areas.

Staff are being trained to complete targeted intervention work to target hotspots and this will feed into appraisal work. Work going on with leadership teams and how they can be helped. Currently looking at men's health and how to improve their health. Ashley Hambling working regionally. Ongoing work around financial and crisis management, with subsidised meals continuing. Mental health first aid we currently have 120 mental health first aiders. Joining up with other trusts to support key learning opportunities to support MHFA. Moving towards being a trauma informed care organisation. Phase 1 is complete.

LJ added that Laura and Kirsty work closely with Occupational health to deliver the actions. Trauma informed care is being piloted in Occupational health and this may link into other actions for our absence management policy.

It was RESOLVED to NOTE the Update on Wellbeing Annual Review

PRC/23/219 Agency Scrutiny Group (agenda item 8.6)

RB updated that there are two current groups in place. One is looking from a strategic viewpoint at our agency contracts and whether we are getting value for money and has commissioned Liaison Contingency Workforce (external provider),to assess our agency approach to offer recommendations and improvements in a report.

Results of findings from Liaison will be presented at a face to face with stakeholders in September in terms of next steps. A high level initial feedback report has been received, nothing that has come out of the report is concerning. Some of the things we are already working on particularly around scrutiny. Will await findings to create an action plan for next steps and will bring back to this group for assurance.

The second part, performance panels, are currently meeting and making good progress analysing line by line the agency spend, made initial steps around zero spend on agency admin

and should be able to say we have achieved zero admin by September. At this stage it is likely that we will not meet the target, however actions are being developed and implemented to work towards reducing our spend.

MR asked if the Liaison report will come back to PRC, RB explained it will come back as a Triple A report to the next meeting.

Triple A report with actions from the findings of the feedback reports required for next meeting.
Action: Richard Butterfield

It was RESOLVED to NOTE the update on the Agency Scrutiny Group

PRC/23/221 Update on Guardian on Safe Working Report (agenda item 8.7)

Richard Marriot (RM) updated that the Junior Doctor position is challenging at the moment due to industrial action and everything is being done to support the trainees. A swap over of trainees has happened since the report was written. Overall gaps on rotas remain an issue but bank are working well to cover. Maternity, occupational health issues etc contribute to the gaps. Exception reports in comparison to acute trusts mental health have far fewer. There seems to be reluctance from trainees to complete exception reports but we do offer support to encourage completion. Estelle Myers attends the forums to make sure colleagues are aware to come forward if they do have concerns. MR asked about the pressure of travelling to and from sites for prescribing.

RM couldn't update on how soon a prescriber would be appointed. The best position to be in would be to have those patients on a main hospital site but this is not something that can be decided in this meeting.

It was RESOLVED to NOTE the update on Guardian on Safe Working Report and the comments made.

PRC/23/220 Freedom to Speak Up Steering Group Update (agenda item 8.8)

Julie Williams (JW) updated that there are now three additional guardians in place. There are six open cases. The group are currently looking at detriment, over the last three years there have been three cases of detriment all of which have been remedied. Looking at why they took place and how they can be prevented. Estelle is working with the trauma informed lead on those cases. Freedom to speak up month theme for October is barriers, Paul cartwright helping to pull together a plan.
Themes in terms of FTSU, numbers are small, working with Nursing and Quality Directorate to give an idea of what is happening across the organisation. In response to an enquiry regarding the Lucy Letby case and speaking up we sent a response to South Yorkshire ICB Chief Executive who requested us to respond to the NHSE letter. No response was requested from West Yorkshire ICB so we haven't given one. EMT discussion at timeout, following that there is a board paper which details our response to NHSE coming to public trust board on the 26th September with opportunity in private session for a more detailed discussion following that the presentation of that public paper. There is a new Self-assessment requirement from NHSE and the guardians office regarding FTSU. The self-assessment tool has been completed and an action plan has been generated, this will go to OMG for discussion on the 13 September then will go back to steering group to discuss the outcome, will then go to EMT on the 5th October, it is proposed that it will be on the agenda at PRC on 21st November then to Board on 26th November. Mike Ford will also review the tool kit in between those dates.

MR requested a FTSU report for future meetings.

It was RESOLVED to NOTE the Freedom to Speak Up Steering Group Update

PRC/23/222 WRES Report and Action Plan (agenda item 8.9)

LJ explained that the equality data has been published on the NHSE website and we are now seeing some of the national reporting data coming back. We are required to publish our improvement/action plan based on our data each year. At this stage this is a draft action plan. Our metrics around the first four indicators have seen improvements. Data around BME colleagues have seen improvements but are still not seeing the same experience as white colleagues. Work on the flair survey will also provide more rich data and feedback to inform our actions. The draft action plan has been broken down into the different areas of the WRES reporting. NF explained that we are focussing on the meaningful actions. MR updated that the percentage of BAME staff has gone up and self-reporting has gone up therefore we are seeing improvements in our data.

NM queried the FLAIR survey taking place in April and it now being September. LJ explained that it was discussed at Trust Partnership Forum (TPF) and happy that they will be involved in the flair survey. Greg being off was part of the reason for the delay. Also trying to understand what we had done already regarding our equality actions through Race Forward, staff networks and wider equality plans. This is now back on track and first survey has been shared with plans to engage wider on this through an appreciative enquiry approach and will involve staff networks and staff side then shared. Another survey will take place early next year. We need to ensure we have fed back on the first survey before we start the next one.

NF updated that we recognise that lines of enquiry are going on because one survey isn't enough, and we are using external consultant to further help us on developing our inclusive approaches. Sponsorship and support will be required from all leaders. NF meeting with Sue Barton and Dawn to lead link with broader equality and diversity work.

MR requested that the results are shared to all on the first Flair survey before the second one commences.

It was RESOLVED to NOTE the update on the WRES Report and the draft Action Plan and the comments made.

PRC/23/223 WDES Report and Action Plan (agenda item 8.10)

LJ reported that there has been a big push across the trust in terms of a staff and service user point of view to increase reporting in terms of diversity from a disabled person point of view and we are now getting better reporting. Looking at the metrics it is recognising the difference of experience with our disabled colleagues we need to make sure we have the actions that are going to make a difference. The challenges around the disabled workforce are having a really robust and stable disabled network this is an action to understand and support. Due to the change in leadership the agenda has not moved forward as much as it should have, and this is one of the biggest actions. Future plans around disabled people and more confidence around disabled people disclosing their information. LJ noted the results were suggesting that we are more likely to employ disabled people than non disabled people she wanted to take some time to clarify this. Is this a positive or is this by chance and she would like to build on this. Both the WRES and WDES will be going to the Equality, inclusion and Involvement committee (EIIC) next week and then will go to board with the final action plan in either September or October.

NF added that we need to work with the disabled network more and a paper will be pulled together to go to EMT to standardise the training and infrastructure to be more representative of the workforce.

MR highlighted that less people at senior level are declaring disabilities and we need to continue to monitor that.

It was RESOLVED to NOTE the update on WDES Report and the draft Action Plan and the comments made.

PRC/23/224 Leavers and Feedback Report – Quarter 2 (agenda item 8.11)

Richard Butterfield (RB) updated the feedback from the reports which are shared with the care groups. Career development/progressions is a key feedback area, and this is also linked to pay. We know with agenda for change there is a limit to what we can change on pay bands although we do continue to explore any other options/flexibilities.

Staff groups and roles are another area that is being raised and some protected characteristics groups. The survey monkey report will also be revisited, the retention lead will look at how this links into our wellbeing survey and how we can make this more relevant and key.

NM asked what are we doing next? Career progression, what do we mean by that and what is happening? What are we going to try and how are we going to map. MR commented on how this will link into the NHS workforce plan and the retain, reform, recruit agenda. RB explained that one approach could be to look at career progression for specific groups of staff initially and then broaden this across the trust. We may have hot spots in care groups and we do see that in the feedback but we need to identify across the trust where the barriers are. MR We seem to be putting everything towards the business partners, we need to manage expectations.

RB explained that the retention lead will lead on this and the People BP's will be part of this discussion and bring their local intelligence in to support the action plans, this is done on a quarterly basis. MR asked when the "So What" will come? RB explained that Q2 report will come in Sept and at the end of that report some of the so what should be happening. Some of the action plans should be coming back in the new year.

It was RESOLVED to NOTE the update on Leavers and Feedback Report – Quarter 2 and the comments made.

PRC/23/225 Great Place to Work Strategy (agenda item 9.1)

LJ updated that the focus has been very much internal within the people directorate and getting the right teams in place to deliver the actions. The recruitment team has been working hard to restructure and centralise and this has taken longer than anticipated. September actions have been slower as we have been waiting for new starters to join the teams.
OD actions have relied on Naomi Fernandez and her team to take up post. The team met in June to agree to make the actions smarter and reflected on deadlines. LJ explained that she hasn't been able to make many changes other than focus on specific areas. The great place to work strategy is due for review and refresh next year and this will give an opportunity to prioritise the work and actions and build on the foundations of the work that has been done so far.

NM agreed that smart metrics would be beneficial. We need to be realistic, get the balance right, did we try and do too much. Its more beneficial to complete less things and do them well. MR suggested a RAG rating to make the reading easier. MR asked what support is needed for smarter delivery plans that have the appropriate deadline and measure.

NF proposed that we think about the narrative, why are we doing what we are doing and what is the purpose. That we should consider a five-year plan and incorporate the workforce planning.

It was RESOLVED to NOTE the update on the Great Place to Work Strategy and comments made.

PRC/23/226 People Directorate Structure (agenda item 9.2)

LJ informed the committee that she had already met with MBu around the PD structure and asked for colleagues' thoughts before it went out wider across the Trust.

The employee lifecycle has been presented to EMT and LJ asked if this would be helpful to go out to the organisation or just used within the directorate. MBu gave some feedback on her thoughts and agreed that the description of the directorate structure and responsibilities were helpful. Her view and past experience are that there are benefits to have the Training and Development and OD team together. MBu questioned the positive exit plan referred to on the employee life cycle and how it may not sit correctly with all levels of staff. MBu went on to explain that she thought more was required on digital workforce and more on performance management. MR agreed with MBu's comments on the diagram and the structure.

It was RESOLVED to NOTE the update on the Structure and comments made.

PRC/23/227 NHS Workforce Plan (agenda item 9.3)

LJ updated that a presentation on the plan and the implications for our Trust had been completed and a discussion at the board development event had taken place where we acknowledged the three areas of focus. Further discussion took place about the impact and opportunities for the Trust.

It is acknowledged many areas of focus in the long-term plan are already part of our great place to work strategy and we are already working on. Recruitment is one of the areas, Mental Health, diversity, international nurse and medical fellowship programmes.

Updates continue at TPF on social value and sustainability strategy linked with local employability actions and progress. Learning needs analysis and workforce planning, good apprenticeships offers and other foundations in place, leavers survey, new roles group in place. Values embedded and an improving staff survey.

Future priorities and areas to consider extending our plan to 3-5 years for the great place to work strategy, maximise our opportunities as an anchor institution and continue to work collaborative across the MHLDA to ensure inclusive recruitment. Continue with international recruitment. Student placements and T - Levels.

Challenge around retaining talent, require a good OD plan and talent management and ensure we follow up with staff survey and the "You Said we Did" approach. Learning and development opportunities are maximised.

Digital and how we use new technologies, colleagues currently working on strategies and how we embed them. Good examples are electronic prescribers. Stronger links with universities and the impact with medical degree programmes.

Next steps will be to review the great place to work strategy, how will this be aligned and used alongside other strategies. Governance of the plan and how we can broaden the scope of the new roles groups. Conversation around robust workforce groups and financial planning.
NM asked how this will come back to board? How we make a difference around inequalities? These will be further considered as we review the Strategy next year,

It was RESOLVED to NOTE the update on the NHS Workforce Plan and comments made.

PRC/23/228 Workforce Risk Register (agenda item 10.1)

No new risks to update. Risks come to EMT and LJ reviews risk actions and updates with Corporate Governance regularly.

MR asked does this represent the current risks, it was agreed that it does.
MB confirmed that the risks were reviewed all the time and the challenge was an acceptable one.

It was RESOLVED to NOTE the update on Workforce Risk Register

PRC/23/229 Annual Review of Executive Director's Performance and objective Setting (agenda item 11.1)

MB was happy to accept these as read as was the rest of the committee.

It was RESOLVED to NOTE the update on Annual Review of Executive Director's Performance and objective Setting and comments made.

PRC/23/230 Consultants Clinical Excellence Awards (agenda item 11.2)

LJ summarised that this would take the same process as in the last 2 years and are currently working though the eligibility criteria for this. JLNC support the way forward and will have a paper for the next meeting. MR mentioned that we were going to change the process for this next year and that we hadn't and that we should be mindful of this for next year, we need more narrative for next time.

It was RESOLVED to NOTE the update on Actions from Trust Board

PRC/23/231 Matters to report to the Trust Board and other Committees (agenda item 11.3)

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
To escalate an issue that requires further discussion or action 1. 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. 2. Recruitment activity is high bringing significant pressures to the people directorate. 3. 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. 4. 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.

Advise:

To highlight an issue that may require further monitoring (by the Committee) over a period of time

1. Trust have now received information on Winter planning and Flu and COVID programmes, planning is in progress.
2. 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.
3. 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.
4. 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.
5. 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.
6. The committee received some excellent data around leavers feedback. The data will inform our retention strategy on the back of the NHS Workforce plan.
7. 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.
8. The NHS Workforce plan was presented with an overview of the impact on SWYPFT and next steps.
9. CEO presented Directors objectives for 23/24
10. The Consultants Local Excellence Awards (LCEA) process for this year was agreed and will remain the same as last year.
11. An Interim Deputy CPO has been recruited on a fixed term contract to support the directorate whilst the current deputy acts up.

Assure:

1. 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.
2. Onboarding tracking system Genius is progressing with a go-live proposal of October 2023.
3. The IR35 annual update was received with full compliance being met.
4. It was good to note that overall workforce staff in post is reasonably stable. Workforce in post has risen by 48.4wte.
5. The Guardian of safe working quarterly report was presented giving assurance that, despite the challenges all gaps were covered. ERs remain low.
6. 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.
7. 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: reviewed risks. 1. 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
<u>New risks identified:</u> none

It was RESOLVED to NOTE the update on the Matters to report to the Trust Board and other Committees.

JW,RB,RM,SW, LJ,NF,DT Left the meeting

PRC/23/232 Any Other Business (agenda item 13)

MB, MBu, MR, NM Private Discussion

PRC/23/233 Date of Next Meeting (agenda item 14)

The next Performance and Remuneration Committee meeting will be held on 21 November 2023

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 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):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1- Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2- Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place- based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative.
Executive summary:	From 1 July 2022, NHS South Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and leads the integration of health and care services across South Yorkshire. The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative continues to develop. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the Health and Care Alliance. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board is asked to NOTE the SY ICS and Barnsley Place updates.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 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 1st November 2023 Key items discussed were: • Story telling- this item focused on the experience of children and young people with eating disorders. A video was shared, recorded by a young person in Barnsley with an eating disorder. Key messages included the importance of developing trust with healthcare professionals, and of consistency in professionals involved in care. Issues highlighted included how to manage interfaces between a number of different providers, accessibility, including transport, and non-specialist staff awareness of eating disorders. • Chair's update- the Chair updated that the first meeting of the South Yorkshire Equality, Diversity and Inclusion Group has taken place and highlighted the commitment to this work. • Chief Executive report- key updates included: o NHS South Yorkshire commissioned an independent investigation into the death of Yusuf, and the care and treatment he received. The report has now been published and makes a number of recommendations for organisations involved in his care and treatment to ensure there is learning from this case. o Options regarding Doncaster Royal Infirmary development are being assessed. o Industrial action continues to be managed well, but it is having an impact.

	○ There is a high level of focus on winter planning and vaccination programmes. ○ NHS South Yorkshire's formal staff consultation on the new team structures required to comply with the mandated reduction in ICB running cost allowance has now been completed. Impact on those involved was acknowledged. ○ The second cohort of the Inclusive Cultures Programme has commenced. • Place reports ○ Barnsley –Amanda Pritchard, NHS England Chief Executive, visited the Community Diagnostic Centre and the 'How's Thi Ticker' initiative at the nearby market. There is strong focus locally on early intervention and smoking prevention. ○ Doncaster – key areas of work highlighted included GP improvement work, winter preparation, physical healthcare group workshops facilitated by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), and a recent social and digital inclusion event. ○ Rotherham- key areas of focus included cost of living work, winter planning, and digital inclusion. ○ Sheffield- key areas of focus highlighted were the north-east of the city (funding 4 community groups in neighbourhoods), medicines optimisation, carers' roadshow, positive increases in physical health checks for people with severe mental illness and people with a learning disability. • Child Death Independent Report. • 2023/24 NHS South Yorkshire Financial Plan- the current position and forecast were received. • Emergency Preparedness Resilience and Response (EPRR) Framework. • Primary Care Access Recovery Plan / Action Plan. • Digital, Data and Technology Portfolio update- the importance of digital inclusion was highlighted. An ICS Digital Strategy is being developed. • Sustainability and Net Zero Plan update. • NHS South Yorkshire ICB Staff Survey Progress Report. • Integrated Performance Report (IPR). • Corporate Assurance Report. • Minutes of the ICB Place Committee meetings for the period. • Assurance Committee Minutes.
Date of next meeting	Next meeting in public is scheduled for 3rd January 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 Development of an updated national 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.
	  o Learning Disabilities – community of practice and stopping over-medication of people with a learning disability, autism, or both (STOMP).
	• South Yorkshire (SY) Provider Collaborative Operating Model.
	• Future commissioning role for the provider collaborative:
	  o Co-commissioning approach to eating disorders.
	  o Commissioning Hub arrangement.
	  o Longer term development of commissioning.
	• ICB Feedback.
	• Parity of Esteem.

Date of next meeting	The meeting planned for 8th November 2023 has been rearranged. The next meeting is scheduled for 5th December 2023.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair

Items discussed	Update from meeting on 28th September 2023
	
	Key items discussed included:
	• Story from our communities- eating disorders.
	• Questions from the public.
	• Place Director update and Place achievements.
	  o ICB Running Cost Allowance Programme- the staff consultation has started and aims to conclude by 23rd October 2023.
	  o Maternity Services at Barnsley Hospital were inspected by the CQC recently with the report published in September. The hospital was rated good across the domains of effective, caring, well led and responsive.
	  o All organisations will have concluded their individual estates plans by the end of Quarter 3. Overall utilisation analysis is underway alongside leasing arrangements.
	• Feedback from South Yorkshire Integrated Care Partnership Board.
	• Eating disorders.
	• Homeless Prevention Strategy.
	• Transition of Pharmacy, Optometry and Dentistry.
	• Quality and safety report.
	• Board assurance framework, risk register and issues log.
	• Finance update.
	• Performance dashboard (including SY ICB Performance Report).
	
	A Development Session was held in October, with focus on workforce.

Date of next meeting	Next meeting scheduled for 30th November 2023.
Minutes	Papers and draft minutes when available Barnsley place public board meetings :: South Yorkshire ICB

Barnsley Place Partnership Delivery Group

Member	Deputy Director of Strategy and Change

Items discussed	Update from meeting on 14th November 2023
	
	Key items discussed included:
	
	• Data and Technology update. Key updates included:
	  o A refresh of the South Yorkshire ICB Digital Strategy refresh is due to take place.
	  o The ICB are trying to explore how to align to place base priorities.
	  o Yorkshire and Humber Shared Care Record.

	○ Digitising social care: £800k funding was previously received for care records and innovative technologies e.g. falls sensors in homes. It is hoped to expand this work into domiciliary care, but a funding decision is awaited. • ICS Data and Insights Strategy ○ An insight-led approach to health inequalities and prevention was outlined. ○ Consultation has taken place with partners, and user stories generated. ○ Several initiatives were described including delivery of a South Yorkshire data platform for the system, and creation of an ICS Data and Insight Alliance. • Health inequalities programs- there was a discussion around funding to address health inequalities for Barnsley. • Barnsley Place Plan- assurance reports from each workstream will be received going forward to provide highlights and assurance as a way to manage/monitor progress against the place plan.
Date of next meeting	Next meeting scheduled for 12th December 2023.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy and Change
Items discussed	The Barnsley Community Health and Care Alliance meets bi-monthly. In September, a Development Session was held with focus on neighbourhood working and organisational development. <u>Update from meeting of 25th October 2023</u> Agenda items included: • Frailty and Dementia. • Urgent Response Services out of hours integration. • Connecting Care approach. • Development session update: Ward Alliances and risk management • OD update. • Key messages for Place Based Delivery Group.
Date of next meeting	Next meeting scheduled for 29th November 2023 (Development Session)

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change
Items discussed	Update from meeting on 9th November 2023 Agenda items included: • Barnsley Place Partnership update. • Joint Health Needs Assessment (JNSA). • Cold Weather Plan. • Homelessness update. • Draft Housing Strategy consultation. • Minutes from ICB Barnsley Place Committee and Barnsley Place Partnership Board.
Date of next meeting	The next meeting is scheduled for 15th February 2024
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 28 November 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):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1 Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other partners 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:	West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts. NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the West Yorkshire (WY) population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. All nomination and appointment processes to the Board include a commitment to improve the diversity of the WY Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. The paper summarises key developments from recent ICB and place-based partnership meetings.
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 RECEIVE the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 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 (WY) where the Trust provides services (Calderdale, Wakefield, Kirklees).

West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts.

NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the WY population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board.

All nomination and appointment processes to the Board include a commitment to improve the diversity of the WY Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements.

The paper summarises key developments from recent ICB and place-based partnership 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	Planned agenda for meeting of 21st November 2023. Key agenda items include: • Urgent decision- to approve the updated terms of reference for the Finance, Investment and Performance Committee, Quality Committee, Transformation Committee and Remuneration and Nomination Committee. • Public Questions. • Focus on Primary Care. • Chair's report. • Chief Executive's report. • System performance. • Winter planning 2023/24. • Annual assurance of Emergency Preparedness, Resilience and Response Core Standards. • Committee 'AAA' reports.
Date of next meeting	Next meeting scheduled for 16th January 2024.
Further information:	NHS West Yorkshire ICB Board Meeting - 21 November 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	The planned meeting of 14th November 2023 was cancelled. Update from meeting of 10th October 2023 Agenda items included: • Chair's update ○ Challenges for ICB colleagues currently going through the ICB operating framework staff consultation were acknowledged. ○ Support was confirmed for Bradford District Care NHS Foundation Trust (BDCT) to coordinate work across West Yorkshire to determine the best use of NHSE funding for mental health services for victims of sexual assault. Scoping work is being undertaken this financial year, and it is proposed that a West Yorkshire service commissioned by BDCT on behalf of the WY partnership will be implemented next financial year. ○ The issues being presented for Children and Young People's Gender Dysphoria services were acknowledged, and discussions are taking place between ICB and Collaborative partners. ○ The delay in Strategic Development Funding (SDF) funding becoming 'baselined' was noted,

	and confirmation from NHSE that mental health and learning disability SDF should still be treated as recurrent funding streams that will eventually become baselined.
	• Children and young people's mental health in acute settings - an overview presentation was given, and update on the work relating to training, improvements to resources on wards and the role of Mental Health Champions.
	• Children and young people's mental health:
	  ○ An overview presentation of recent multi-disciplinary crisis events was shared, and reflections on the feedback and learning so far. Two events have been held, with a final event planned for December.
	  ○ A presentation was shared on the My Needs App. It was agreed to continue work to build the basic prototype and test within a couple of areas, before considering learning and whether there is a viable case to proceed further.
	• Community Mental Health Transformation – an update presentation was given.
	• Yorkshire Ambulance Service (YAS) - a presentation was shared which included update on the new YAS 2025-2029 strategy development process.
	• Older people's mental health.
	• Neurodiversity Programme - a presentation was shared. This included a breakdown of NHS provider workforce and the variation between services for children and young people and adults, and considering how new roles might support recruitment to vacancies. Discussions are taking place with primary care regarding how to develop quality assured shared care processes as part of a consistent WY commissioning framework. A summit is planned for 4th December - Working together to improve access, assessment and support for neurodivergent people.
	• Complex rehabilitation - Enhanced Care Reviews are demonstrating that fewer people require locked rehab than initially thought if they can be well supported by CREST and relevant local options, remaining in the community. A workshop is planned for 6th November.
	• Planning and performance.
	• AAA reports - these were received for NHS 111 for mental health, Maternal Mental Health (and funding paper for Place 'sign off'), Perinatal Mental Health, Transforming Care Programme, Children and Young People's Mental Health, and Secondary Care Pathways (mental health).

Date of next meeting	Next meeting scheduled for 12th December 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 2nd November 2023
	
	Key items discussed included:
	
	• Report of the Place Lead. Key updates included:
	  ○ The Wakefield District Health & Care Partnership's Experience of Care Network won the Patient Experience Network National Award for Strengthening the Foundation.
	  ○ The Wakefield System Workforce Team was highly commended at the Healthcare People Management Association (HPMA) Awards.
	  ○ The West Yorkshire response to the Secretary of State around dedicated NHS diversity, equality and inclusion roles was shared.
	  ○ The Better Care Fund 2023-2025 plan has been approved.
	  ○ Wakefield Safeguarding Children Partnership Annual Report 2022/23 has been published.
	• Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative). Key updates included:
	  ○ A key focus has been how the Transformation and Delivery Collaborative can support Urgent and Emergency Care.
	  ○ The collaborative has supported priority pathways to be mapped out and streamlined for the winter months: same day emergency care, X-ray request, mental health support workers and care navigation in the Emergency Department.
	  ○ Work is ongoing to secure accommodation for the Walk In Centre.
	  ○ The NHS Impact Tool (Improving Patient Care Together) has been launched nationally and gives opportunity to use tools and resources to deliver continuous improvement.
	• Public health profile- tobacco control. The UK Government has set out plans for a Smokefree Generation. This means bringing prevalence of smoking down below five per cent. Details of the plan, the implications for Wakefield District, and next steps were outlined.

	• Wakefield carers showcase- a presentation was shared by Carers Wakefield & District who offer a wraparound service for carers and families in Wakefield District.
	• Outcomes framework- the outcomes framework approach was agreed. The Committee agreed that the framework will be tested for at least six months and be reported at alternate meetings, with regular highlights to be reported in the Transformation and Delivery Collaborative (TDC) report.
	• Core20Plus5
	  ○ An evaluation process has sought to understand the impact of the Core20PLUS5 funding made across the system, while the funding allocation for 2024/25 is due to be officially confirmed in November.
	  ○ The overall Core20PLUS5 framework has been implemented locally adopting a partnership approach. The Health Inequalities Steering Group has undertaken a Task and Finish group exercise to support its development, scope and business.
	  ○ Alongside this work a Community of Practice will also be developed.
	• Summary of 2022/23 quarter 2 Quality, Safety and experience report. The Partnership Committee was presented with a summary of the 2023/24 Q2 Quality, Safety and Experience report for Wakefield place which was presented to the Integrated Assurance Committee on 25 October 2023.
	• Finance update- it was reported that the ICB in Wakefield reported £4m adverse variance to its planned surplus of £5.9m in line with the agreed reporting position of the West Yorkshire ICS with NHS England.
	• Wakefield Place risk register.
	• Issues escalated/for escalation.

Date of next meeting	Next meeting scheduled for 9th January 2024.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk) WDHCP-Committee-Meeting-Pack-Public-Session-2-November-2023-1.pdf (wakefielddistricthcp.co.uk)

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group

Items discussed	<u>Planned agenda for meeting of 21st November 2023</u>
	
	<u>Key agenda items include:</u>
	
	• Programme highlight reporting - escalations from alliances/programmes by exception.
	• Highlight reports.
	  ○ Housing and health.
	  ○ Healthcare inequalities.
	  ○ Digital and business intelligence.
	  ○ People Alliance.
	• Investment process updates.
	• Population segmentation presentation.
	• Outcomes and performance.
	• Virtual ward model review.
	• Terms of reference updates.
	• Items for escalation to Wakefield District Health & Care Partnership Committee.

Date of next meeting	Next meeting scheduled for 14th December 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	<u>Update from meeting on 15th November 2023</u>
	
	<u>Key agenda items included:</u>
	
	• Mental Health Alliance performance dashboard.
	• Future Selph- a presentation was shared on the Mental and Emotional Wellbeing Service for 16-25 year-olds, commissioned from the VCSE sector via the Primary Care Networks (PCNs).
	• Reducing Health Inequalities Steering Group.
	• 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.
	• Digital District- project update and request to defer residual grant.
	• Development session.
	• 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 20th December 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Planned agenda for meeting of 23rd November 2023 Key agenda items include: • Public questions. • Tobacco control. • Better Care Fund update. • Overview and Scrutiny Committee papers. • Connecting Care Executive Papers.
Date of next meeting	Next meeting scheduled for 18th January 2024.
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

Calderdale

SWYPFT is a strong partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 28th September 2023 Agenda items included: • Public questions. • Citizen story. • Deep dive on maternity and neo-natal care in Calderdale - an update on maternity services in the Calderdale Place was given highlighting strategic ambitions, how current services are performing, improvement initiatives, challenges, and opportunities for the future. • Talking Therapies Evaluation Report - a report was received following evaluation of the Talking Therapies tender and recommendation to award the contract approved. • Calderdale Delivery Plan Reporting Framework. • Place Lead report. • Quality and safety report. • Place finance report. • Place performance report.

	• Work plan.
Date of next meeting	Next meeting scheduled for 30th November 2023.
Further information	Further information and meeting minutes can be found here: https://www.calderdalecares.co.uk/about-us/meeting-papers/

Calderdale Cares Community Programme Board

Member	Deputy Director Strategy and Change & Associate Director of Operations, Adults and Older People Mental Health Care Group

Items discussed	Update from meeting on 9th November 2023
	
	Agenda items included:
	• Update on Family Hubs.
	• Community health and wellbeing workshop outcomes and direction of focus.
	• Workshops update:
	  ○ Transformation Delivery Group.
	  ○ Neighbourhood Development Subgroup.
	  ○ Estates.
	  ○ Workforce.
	• West Yorkshire Community Healthcare Collaborative- it was reported that this has been established for all major statutory community providers (physical health services) across West Yorkshire.
	• Data sharing agreements.
	• Community Diagnostic Centre.

Date of next meeting	Next meeting is scheduled for 14th December 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 and Director – Provider Development.
Items discussed	Update from meeting of 13th October 2023 Items discussed included: ○ Starting Well - Maternity and Early Years Strategy 2023 to 2027. ○ Preparing for winter. ○ Health and Wellbeing Board Forward Plan for December 2023. Update from Development Session of 3rd November 2023: A session was held to consider the role of the Board and how it operates, drawing on expertise from other areas. Further work will

	take place to consider the forward plan for the Board, and how partners will contribute to this.
Date of next meeting	Next meeting is scheduled for 14th December 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 8th November 2023 Items discussed included: • People story. • Kirklees approach to health equity- a report was shared highlighting the local health inequity challenge and the rational for a strategic approach to tackling the challenge, progress made to date and areas for improvement. Recommendations were approved including implementing a 12 month partnership focus on reducing language and poverty-related barriers to accessing and engaging with healthcare and wider support, and securing sustained investment for a core local VCSE Community Champions offer. • North Kirklees Urgent Care Re-design – approach to contracting Kirklees Walk in Centre- the Committee were asked to support the proposed intent of re-commissioning the Kirklees walk in centre services identified in scope and the direct award of a 12 month contract from April 2024, via tender waiver of services in scope to Mid Yorkshire Teaching Trust, note the procurement considerations, risk and mitigations in relation to the above, and support the recommendation to utilise year one of the contract to scope the transformation required and develop any business cases that may be required. • Urgent Community Response Assessment Process Outcome Report- the Committee were updated on the assessment process and evaluation undertaken in relation to the commissioning of Urgent Community Response (UCR) services for Kirklees. The Committee noted the

	support of the Transformation Sub-Committee of the recommendation of the direct award of contract/s, in line with the outcome of the assessment process and were asked to approve the direct award of contract for a period of 3 years with an option to extend by a further 2 years, from 1 April 2024 and to support the request for tender waiver to support the direct award of contract/s, in line with the outcome of the assessment process, to comply with the West Yorkshire ICB Scheme of Delegation. • Governance Review/Operating Model Recommendations A review has been carried out to assess the effectiveness of the governance mechanisms established at the inception of the ICB in July 2022. Findings and recommendations from this were shared. • Questions from Members of the Public • Accountable Officer's Report. • Kirklees Place Quality Report. • Finance Update. • Contract Report. • Performance Report against Key Performance Indicators for 2022/23. • High Level Risk Report: Cycle 4 2023/24 (September – November 2023). • Items for the attention of the ICB Board. • Committee Work Plan. • Receipt of minutes.
Date of next meeting	Next meeting scheduled for 8th January 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 2nd November 2023 Items discussed included: • People stories. • Update from Workforce Programme. • Update on Palliative Care Partnership work- an update was given on the ongoing work and the establishment of the Dying Well Programme. • Update from Digital Health and Care Board. • Work plan.
Date of next meeting	Next meeting scheduled for 7th December 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development

Items discussed	The July and September meetings of the Health and Wellbeing Board were 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	The next meeting scheduled for 23rd November 2023. This will be a Development Session.
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 6th November 2023 Key agenda items included: • Services in the community- a presentation was shared on Kirklees Community Services- the focus of this was on intermediate community care and discharge recovery. • Health and Care Plan priority- an update on the holistic approach to out of hospital care priority was given including an update on impact of mental health social prescribers. • UCR evaluation outcome and 2024/25 commissioning recommendation- the approach taken was noted by the Delivery Collaborative. A paper will be presented to the November Kirklees ICB Committee with recommendation to note the assessment process that has been undertaken, and support the recommendation of the direct award of contract/s. • Anticoagulation Service redesign. • Starting Well programme overview. • Ageing Well programme overview. • Dying Well programme overview.
Date of next meeting	Next meeting scheduled for 4th December 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 30th October 2023 Agenda items included: • Patient story. • Deep dive- voluntary sector community offer. • Quality for health. • Kirklees Health and Care Plan. • WY Mental Health, Learning Disability and Autism Partnership Board. • Programme highlight reports (by exception). • New Operating Model.
Date of next meeting	Next meeting scheduled for 11th December 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 28 November 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):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1- Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2- Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.
Executive summary:	**West Yorkshire Specialised NHS-Led Provider Collaboratives** In West Yorkshire, the Trust is Co-ordinating Provider of the Adult Secure Provider Collaborative, and a partner in the Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) and Adult Eating Disorder (AED) Provider Collaboratives, for which Leeds and York Partnership NHS Foundation Trust (LYPFT) is the co-ordinating provider. All Phase 1 Provider Collaboratives have received formal communication from NHSE to provide feedback on the Quality Maturity Framework (used to assess how developed a collaborative is) and to request evidence of progress against a number of key areas including fulfilment of Lead Provider roles and responsibilities. Following this, updated business cases will be required to outline Provider Collaborative ambitions for 2024-26 in advance of a new contract being issued for this period. Work is underway to prepare a response. The Adult Secure Provider Collaborative Board has continued to meet, and the collaborative have progressed among a range of items: • Development and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway and the Women's Pathway work continues to be a focus. • Development of a West Yorkshire- wide community model, with work now focused on workforce and finance planning to support the proposal. • 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. • Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network. • Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Improvements in reporting patients 'Clinically Ready for Discharge'. Opportunities are being reviewed for closer working with community colleagues and place-based commissioners to minimise delays in discharge. • 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 to strengthen the voice of service users.
- 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 7 months to October 2023 the collaborative operated with a financial surplus.

The Adult Eating Disorders Provider Collaborative reported a deficit at month 7. A year end deficit position is forecast.

The Children and Young People Mental Health Provider Collaborative reported a deficit position at month 7, 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 surplus 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 Specialised Provider Collaborative Commissioning Hub.

Work has continued by the 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.

An options paper as to how commissioning oversight will be managed going forward has been developed. A workshop was held in November between SWYPFT FCAMHS colleagues and the Commissioning Hub to work through

	future governance arrangements. NHSE have agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023. In November 2022, NHSE/I published the Perinatal Mental Health (PMH) 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. Following a panel process in April 2023, NHS England confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health Collaborative. A 'go live' date has been confirmed for the PMH Provider Collaborative of 1st April 2024. A mobilisation group has been established, and quality due diligence is due to commence October 2023. A Clinical Director for the PMH Provider Collaborative has been appointed, due to start November 2023. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 November 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

All Phase 1 Provider Collaboratives have received formal communication from NHSE to provide feedback on the Quality Maturity Framework (used to assess how developed a collaborative is) and to request evidence of progress against a number of key areas including fulfilment of Lead Provider roles and responsibilities. All West Yorkshire Provider Collaboratives have been rated as Level 2 'Normalising'. Following this review process, updated business cases will be required to outline Provider Collaborative ambitions for 2024-26 in advance of a new contract being issued for this period. Work is underway to prepare a response.

All West Yorkshire Provider Collaboratives continue to further understand 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 and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway and the Women's Pathway work continues to be a focus.
- Development of a West Yorkshire- wide community model, with work now focused on workforce and finance planning to support the proposal.
- 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.
- Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network.
- Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Improvements in reporting patients 'Clinically Ready for Discharge'. Opportunities are being reviewed for closer working with community colleagues and place-based commissioners to minimise delays in discharge.
- 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 to strengthen the voice of service users.
- 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.
- Participation in a national adult secure workforce benchmarking exercise. The collaborative will be attending a national follow up event to this work in December.

For the 7 months to October 2023 the collaborative operated with a financial surplus of £954k. A surplus position of £1404k is forecast and this will be subject to the collaborative risk/reward share arrangement.

Following review of the 2023/24 Lead Provider Contract Variation, feedback was provided to NHS England, and a final version has now been received for signature. A briefing paper was considered by EMT on 9th November 2023 who approved the signing of the 23/24 LP Contract Variation. This will now be progressed to signature.

2023/24 contract variations for in area providers have been prepared so that they are ready for signature once the Lead Provider Contract Variation has been signed. A discussion has taken place with NHSE to agree the most efficient approach regarding contracting for out of area providers for 2022/23 and 2023/24, and contract variation templates prepared and issued to providers.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 3rd October 2023, with a further meeting planned for 5th December 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). It has been agreed that primary care partners will host the physical health monitoring and a Service Level Agreement is being developed.

The original Adult Eating Disorder Provider Collaborative business case assumed a level of income generation from other provider collaboratives placing patients in West Yorkshire. The national ambition for provider collaboratives to place patients close to home has resulted in a reduction of referrals and admissions from out of area, which negatively impacts on income.

At month 7, a deficit position of £277k is reported. This is a deterioration against a break even plan and can be attributed to deficits against the out of area (OOA) budget (£186k) and the cross flows income target (£161k). There are currently 2 people placed out of area.

The forecast position for the 2023/24 financial year is a £539k deficit. The collaborative will investigate ways to increase crossflows income and reduce independent sector placements.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

A year-to-date deficit of £727k is reported for the 2023/24 financial year to September 2023 against a balanced plan. High-cost exceptional packages of care (EPC's) are primarily driving this position. There is one ongoing EPC which is forecast to continue throughout the 2023/24 financial year.

The forecast position for the 2023/24 financial year is a £1,017k deficit. This has improved by £59k in month.

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.
- Work to develop the specialist community services business case and specification is underway.

A year to date surplus of £468k is reported, with forecast surplus of £587k. This is an improvement of the forecast compared to last month. The main risk, as with other collaboratives, relates to unknown activity and exceptional packages of care pressures. For South Yorkshire this is increased due to ongoing contractual discussions.

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

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 has continued 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.

An options paper as to how commissioning oversight will be managed going forward has been developed. A workshop was held in November between SWYPFT FCAMHS colleagues and the Commissioning Hub to work through future governance arrangements. NHSE have agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023.

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 (PMH) services.

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.

West Yorkshire ICB will retain responsibility for commissioning local community specialist PMH services, delivery of access target and joint work to enable a trauma-informed maternity system across WY.

A 'go live' date has been confirmed for the PMH Provider Collaborative of 1st April 2024. A mobilisation group has been established, and quality due diligence is due to commence October 2023.

Recommendation:

Trust Board is asked to:

Receive and note the Specialised NHS-Led Provider Collaboratives update.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 November 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	Andy Lister - Head of Corporate Governance		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Compliance with the Trust's Standing Orders provides assurance to systems and partners of the Trust's adherence to the framework within which the Trust operates and how its officers conduct Trust business.		
Any background papers / previously considered by:	Quarterly reports to Trust Board.		

Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance and Resources of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The Trust Seal has not been used since the last report to Board in September 2023.
Recommendation:	**Trust Board is asked to NOTE the update to the Trust Seal since the last report in September 2023.**

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
Care Group Performance report (private)	✘		✘	✘		✘	✘	✘		✘		✘
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			✘			✘		✘				✘
Internal governance structure review										✘		
Strategies and Policies												

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
Digital strategy (including IMT) **update**							✘					
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 (March 2024)												✘
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 (March 2025)
- 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)*