South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 30 January 2024 at 9.30am
Small Conference Room, Wellbeing and Development Centre, Fieldhead Hospital

AGENDA

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.30	**1. Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
9.31	**2. Declarations of interest**	Chair	**Paper**	1	To receive
9.32	**3. Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal item**	5	To receive
9.37	**4. Minutes from previous Trust Board meeting held on 28 November 2023**	Chair	**Paper**	3	To approve
9.40	**5. Matters arising from previous Trust Board meeting held on 28 November 2023 and board action log**	Chair	**Paper**	5	To receive
9.45	**6. Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
9.55	**7. Chair's remarks**	Chair	**Verbal item**	2	To receive
9:57	**8. Chief Executive's report**	Chief Executive	**Paper**	8	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
10.05	**9. Risk and assurance**				
10.05	9.1 Board Assurance Framework	Director of Finance, Estates and Resources	**Paper**	15	To approve
10.20	9.2 Corporate / organisational risk register	Director of Finance, Estates and Resources	**Paper**	15	To approve
10.35	9.3 Annual planning	Director of Provider Development / Director of Finance, Estates and Resources	**Paper**	5	To receive
10.40	9.4 Safer staffing report	Chief Nurse and Director of quality and professions	**Paper**	5	To receive
10.45	9.5 CQC Inspection reports	Chief Nurse and Director of quality and professions	**Paper**	5	To receive
10.50	9.6 Freedom to speak up annual report six monthly update	Deputy Director of Corporate Governance / Freedom to speak up guardian	**Paper**	10	To receive
11.00	9.7 Equality and Diversity annual report	Director of Strategy and Change	**Paper**	5	To approve

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.05	9.8 Assurance and approved minutes from Trust Board committees - Collaborative Committee 5 December 2023 - Equality Inclusion and Involvement Committee 13 December 2023 - Audit Committee 9 January 2024 - Quality and Safety Committee 9 January 2024 - People and Remuneration Committee 16 January 2024 - Finance, Investment and Performance Committee 22 January 2024	Chairs of Committees	**Paper**	10	To receive
11.15	*Break*			10	
11.25	**10. Performance**				
11.25	10.1 Integrated Performance Report (IPR) month 9 2023/24	Director of Finance, Estates and Resources	**Paper**	20	To receive
11.45	10.2 Care Group Dashboards report	Chief Operating Officer	**Paper**	10	To receive
11.55	**11. Integrated Care Systems and Partnerships**				
11.55	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive / Director of Strategy and Change	**Paper**	5	To receive
12.00	11.2 West Yorkshire Health & Care Partnership (WYHCP)	Director of Provider	**Paper**	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Development			
12.05	11.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive
12.10	**12. Trust Board Work Programme**	Chair	**Paper**	3	To approve
12.13	**13. Date of next meeting** The next Trust Board meeting held in public will be held on 29 March 2024	Chair	**Verbal item**	2	To note
12.15	**14. Any other business**	Chair	**Verbal item**	5	To note
12.20	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 2

Private/Public paper:	**Public**		
Title:	**Trust Board declaration of interests, including fit and proper persons declaration (FPPT)**		
Paper presented by:	**Chair**		
Paper prepared by:	Andy Lister – Head of Corporate Governance		
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the UK Corporate Governance Code, Monitor's (now NHS England / Improvement's) Code of Governance and the Trust's own Constitution in relation to openness and transparency.		
Strategic objectives:	Improve Health		Please tick as appropriate
	Improve Care		
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust compliance with FPPT provides assurance to commissioners and partners that the Trust is Well Led.		
Any background papers / previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality approved by Trust Board in March 2021. Declaration of Interest Paper submitted to Trust Board March 2023 The Standards of Business Conduct Policy (conflict of interest policy) to Trust Board in April 2023. Update to fit and proper persons test to Trust Board September 2023		
Executive summary:	**Declaration of interests** The Trust's Constitution and the Code of Governance for NHS Provider Trusts, the UK Corporate Governance Code and NHS England / Improvement require		

	Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Head of Corporate Governance (Company Secretary) so that the Register can be amended, and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. The Head of Corporate Governance (Company Secretary) is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. Updates to register have been received from Non-Executive Director David Webster. **Risk appetite** The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached update, particularly in terms of any risk presented to the Trust as a result of the declarations made, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024

Updates to the register of interests of the directors (Trust Board)
From 1 April 2023 to 31 March 2024

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by NHSE's Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following updates to the declarations of interest have been made by the Trust Board since the Annual update in March 2023:

Name	**Declaration**
Non- Executive Directors	
David Webster	Chief Financial Officer at Red Embedded Consulting Ltd (trading as Consult Red)

Minutes of Trust Board meeting held on 28 November 2023
Small Conference Room Wellbeing and Development Centre
Fieldhead Hospital

Present:	Marie Burnham (MBu)	Chair
	Mandy Rayner (MR)	Deputy Chair/ Senior Independent Director
	Mike Ford (MF)	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:	Erfana Mahmood (EM)	Non-Executive Director
In attendance:	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
	Julie Williams (JW)	Deputy Director of Corporate Governance
Apologies:	Greg Moores (GM)	Chief People Officer
	Lindsay Jensen (LJ)	Deputy Chief People Officer
Observers:	Paula Gardner	Insight Candidate

TB/23/110 Welcome, introduction and apologies (agenda item 1)

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

MBu 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.

MBu welcomed Paula Gardner, the Trust insight candidate, who is on the GatenbySanderson programme for aspirant non-executive directors.

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

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

TB/23/111 Declarations of interest (agenda item 2)

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

TB/23/112 Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/113 Minutes from previous Trust Board meeting held 31 October 2023 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 31 October 2023 as a true and accurate record.

TB/23/114 Matters arising from previous Trust Board meeting held 31 October 2023 and board action log (agenda item 5)

MBu asked for the following action updates to be noted:

TB/23/40c – updates to the safer staffing report. Darryl Thompson (DT) reported the safer staffing report has been submitted to the quality and safety committee (QSC) and further work had been requested. The report will be updated and submitted to January board. Nat McMillan (NM) reported she supports this proposal as Chair of QSC. It will return to QSC before Board in January 2024.

TB/23103a – Appraisal data in the integrated performance report and reducing restrictive practice and interventions numbers - Mandy Rayner (MR) reported both items were presented to people and remuneration committee (PRC) last week and these matters are being progressed.

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

TB/23/115 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Tim Mellard (TM), lead matron for the Trust and Dean Kenney (DK), the management assistant to the matron team. CH reported TM and DK would share with the Board their story about digital innovation in quality improvement.

TM reported DK was here today as he has been pivotal in this work and added DK is a perfect example of “leading from every seat”.

TM reported today’s story is in relation to digital innovation in inpatient services through a system called “Tendable” which is a clinical audit system. The system is a smart inspection tool, that used to be called “perfect ward”.

The system provides real time data, input by ward teams, regarding clinical audits, which provides assurance not only for issues such as care quality commission (CQC) standards, but also identifies areas for quality improvement which for the Trust, as a learning organisation, is key.

DK reported in terms of implementing the system, the first step was obtaining the equipment required and then rolling out training to leadership teams. Once the matrons were confident

in using the system it was rolled out to ward leadership teams, allowing the matrons to provide support where required. It was then rolled out to the band 6 teams.

DK reported the clinical record keeping audit was then introduced, which was an addition to the audits already undertaken. Pharmacy colleagues were introduced to the system and were interested in how it could support their audits. Pharmacy are now rolling the system out and have moved onto their third locality.

TM reported the system is now fully embedded in the matron team. Matrons undertake a weekly inspection and check the following have been completed each week:

- Staying safe plans
- Quality of care plans
- Mental Health Act rights
- Advocacy referrals
- Quality of risk assessments
- Updating of risk assessments after incidents
- Debriefs with service users.
- Rapid tranquilisation
- Reviewing observation levels
- Risk management plans being in place and a care plan that manages the risks and ensures Datix incidents are followed up.

TM reported the matrons also carry out a monthly inspection which is qualitative. It involves staff interviews, patient interviews, clinic checks and environment checks. It includes some of the points Board members will associate with quality monitoring visits. The system has been beneficial to the matron team. Next steps are for the ward leadership teams to undertake their quality checks which is a slightly different process. There are daily checks and weekly checks.

The daily checks include:

- Clinic checks
- FIRM risk assessments (formulation informed risk management) completed in the correct time frame.
- Completion of observation sheets
- Rapid tranquilisation forms have been completed in line with policy.
- Seclusion records are completed in full.
- Admission/discharge checklists are being followed.
- Post fall protocols are being followed for the older people’s service.

Weekly ward checks include:

- Formulation of risk
- Up to date notice boards are maintained.
- Pre and post leave risk assessments.
- Quality of risk and care plans
- Patient voice

TM reported dashboards are now being developed which allow teams to see trends and themes, not only for individual wards, but also across service lines. This allows teams to build on their quality priority plans, which can then be tracked through the system.

TM reported when the CQC inspections took place earlier in the year, the impact of Tendable was identifiable. An example being when the CQC last inspected the Trust acute services, clinic checks were identified as an issue, and on this occasion, they weren’t, which shows consistent monitoring has been effective.

TM reported the system has allowed improvements in efficiency, matrons are using less paper, which supports the sustainability agenda. Matrons also estimate by using the system to conduct weekly audits, instead of paper, it is saving them approximately two hours per audit.

DK reported alongside the system dashboards there is the administration portal. This allows limited keyholders to add and remove audits as required. These can be added and removed from the system as required.

TM reported the system can be used to support the response to the recent CQC report arrives their audit and assurance processes can be reviewed to check they are in line with what is required.

TM highlighted that service user feedback through the monthly matron inspections, allows the team to look at feedback and trends, and understand what really matters to service users.

TM reported the Tendable system is based on a tablet and can also be used on a laptop. The staff work through a number of questions, and dip sampling can also take place, which is recorded into the system, producing a ward manager report.

TM reported the system has been rolled out across, all working age adult and older people's wards, (15 wards in total). It has now been in place for around two and a half years.

MBu asked what action is being taken as a result of the audits?

TM reported there is a corrective element, where matrons will produce a narrative response to give to the ward leadership teams. Matrons meet with ward leadership teams every six weeks and look at themes and trends and explore any issues that arise. If things don't improve, issues are added to the ward improvement programme.

TM confirmed that matron inspections have been in place for two years, and ward leadership inspections for the last 12-14 months. The matron audits are now fully embedded.

NM noted the importance of the qualitative side of this work and questioned how this information could be used to inform the patient experience report.

Action: Darryl Thompson

TM reported the matron engagement with service users has been so positive that matrons are now attending community service meetings to gain feedback from these services as well.

Kate Quail (KQ) questioned if it would be possible to have service user led audits?

TM responded this is a great idea and something that the team would look into.

MBr noted there will be differing levels of staff digital awareness across the 15 wards, and how to effectively utilise the information the system is providing. Has training for the staff included how to use the tools and interpret what they information they have?

TM reported this is where DK's role has been pivotal. DK has been out to wards and shown people how to use the system. Some have struggled with the technology, but we have a support system where we have paired the ward managers up to support one another.

Prof. Subha Thiyagesh (ST) queried if there is a plan to roll the system out into community services?

TM reported the system has worked well for the matrons because it is something they sought out. It may not be suitable for community services. Forensics don't have the system yet, and we will consider where it can be used effectively elsewhere. It hasn't worked as well as we'd hoped for quality monitoring visits (QMVs) and so there is some work to be done there.

Mike Ford (MF) reported later on this morning the Board will review the IPR. Will the Board know where improvement has been driven by this system?

CH reported improvements are made by the team through the audits they carry out. Tendable is the process by which they conduct their audits. CH noted it would be of value to roll the system out into the forensic service.

DT noted QMVs are being reviewed to help align them to the system.

MR noted that QMVs are quite paper driven, and queried if there may be duplication taking place? Information gained through QMVs may already be available from the Tendable system and MR suggested QMVs could perhaps have an alternative focus to provide a different data set, if this is the case.

TM reported the live inpatient dashboard is being developed and will be viewable at a number of different levels. The biggest challenge now is to continue embedding the system in the inpatient service because of acuity and staffing challenges, it helps get the message across that service improvement remains a priority.

MBu queried if the system would highlight where there are potential leadership challenges?

TM states it would, and it would also identify where strong leadership was in place.

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

TB/23/116 Chair's remarks (agenda item 7)

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

- Complex Incidents report
- Integrated Care System (ICS) updates
- Investment appraisal (six monthly board report)

It was RESOLVED to NOTE the Chair's remarks.

TB/23/117 Chief Executive's report (agenda item 8)

Chief Executive's report

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

- There has been no industrial action since last board meeting.
- £800m has been diverted from national budgets, including digital, to support the financial impact of industrial action, particularly with acute trusts. Total additional funding of £1bn has been made available for systems to cover the costs of industrial action and winter pressures, and all ICSs are expected to present a balanced position for the year.
- The Trust is currently bucking the national trend on out of area beds (OOA), with some improvement in recent months. This is not a trend yet, but the progress is encouraging.

- The patient and carers race equity framework (PCREF) has been published. The Trust has already done a lot of work in this area and will review the document to see if we can enhance our equality, diversity and inclusion plan.
- Hempsons (a legal firm) have issued good guidance on how to counter racial discrimination in disciplinary processes. The author of the report is going to deliver the outcomes to the Trust to see what learning can be taken.
- The Trust staff survey has had at least a 50% return, the final numbers are still to be established with the survey having closed on Friday last week.
- Flu vaccination uptake was strong when it started. This has now plateaued in the last couple of weeks at around 40% uptake and this would appear to reflect the national position. We will continue to promote the offer of the Flu and Covid-19 vaccines to all Trust staff.
- NHS Providers has published the results of its annual state of the provider sector survey. Within this report there is concern about the impact of winter pressures and how this will feed into the new year.
- The integrated performance report will be presented later in today's meeting. In the main we are holding up against most metrics, but there are a couple of areas of focus required.
- The Trust has had some murals developed for some of our inpatient wards, which have been co-designed. They are excellent and well worth a look and demonstrate the added value of engagement with service users, carers, and staff to make ward environments more welcoming.

NM noted the patient and carers race equity framework and queried if this is mandatory?

MBr reported this needed to be checked. There was consultation on the framework some time ago and it was checked against our own equality and inclusion plan. This demonstrated we were largely in line with the framework. We can now reassess and bring the outcome to the equality inclusion and involvement committee for review, and report to Board through the triple A report.

Action: Dawn Lawson

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

TB/23/118 Performance (agenda item 9)

TB/23/118a Integrated performance report Month 7 2023/24 (agenda item 9.1)

AS introduced the summary dashboards and priority programmes:

- There are some areas of positivity in this month's report.
- The finance, investment and performance committee (FIP) agreed to spend more time on performance and is agreeing a programme of deep dives. These will be conducted through intelligence from the IPR, and wider Board feedback.
- At the last FIP meeting there was a focus on out of area placements to try and understand if there was an impact on agency usage.
- A waiting time report was also received from paediatric audiology. This is a challenged area, and we will take further information from Board today about how to develop a deep dive programme.

Strategic objectives and priorities

- We are now trying to embed the capture of our diversity information in order to improve, identifying hotspots and areas where action is required.
- New indicators go through an information gathering phase following which we can look at their impact and the "so what" conversation.

MF raised the metric “number of people who have sustained 26 weeks employment via the Trust individual placement support service”, and questioned what progress there has been in this area?

MBr reported the team have recently presented a Board story, where a service user presented their positive experience of the service. A couple of metrics have been introduced, one of which is the number of people accessing the service. The average is 25 to 35 people a month. In time we expect an increase in service users sustaining longer periods of employment.

MBr reiterated this is a new service and. we have not yet had longevity of service provision to assure ourselves if the service is successful. We know from feedback from service users it is having a positive impact on their lives, what we now need is to establish is the longevity of that impact.

DT reported there is an individual placement support service steering group, and a fidelity assessment against the national standards. The team's performance against these standards is good. DT provided assurance that the team’s approach is in line with national expectations, but he will take MF’s comments on performance against the referenced metric to the steering group for discussion.

Action: Darryl Thompson

Quality including national indicators.
DT gave the following highlights from the report:

National Indicators

- The Trust continues to perform well against the majority of national metrics.
- OOA bed days is over trajectory (for the year), but as already discussed we are seeing good improvement in this area.
- Percentage of service users waiting for an audiology assessment is under trajectory and we are cognisant of conversations about the importance of this metric and our paediatric services are working hard to improve access.

Trust Quality Indicators

- Care planning and risk assessments have shown improved performance in inpatient services.
- There has been an increase in restraint incidents, on review the increase has been attributed to the clinical presentation of specific patients.
- 91.7% of prone restraint incidents were for a duration of three minutes or less.
- The Trust has identified that prone restraint incidents often occur at times of medication administration. There is a renewed training programme taking place alongside Leeds & York and Bradford trusts to have a different position to support the person whilst administering medication without using the prone position.
- In addition, new ways of exiting seclusion rooms are also being considered.
- The backlog of complaints awaiting allocation to a complaints advisor has now been reduced and is being continued as business as usual.
- 100% of our complaints have been acknowledged within three working days.
- No complaints have breached the three-month target where we have not had a conversation under an agreed new time frame for completion.
- The number of complaints responded to within six months (national target) has been increasing month on month since June 2023.
- Friends and family test data - the forensics data in this document needs to be refreshed. The actual performance is 100% of people in this service give a positive outcome to the friends and family test. The report has been amended and arrangements have been made for these errors to be rectified and republished.

- All areas in relation to the friends and family test are at 90% or above except autism spectrum disorder (ASD) and attention deficit and hyperactivity disorder (ADHD) which perform at 75%.

MF noted supervision levels of 60% vs the 80% target seems relatively consistent across most areas. Is this an area of concern?

CH confirmed it is an area of concern. Supervision and appraisals are key areas of focus for improvement for all team leaders and managers. There is a practice and a recording issue. All wards with low supervision have a high sickness rate, and this needs to be reviewed, but there isn't a pattern of other metrics failing as a result of low supervision.

David Webster (DW) queried if any benchmarking has taken place against other organisations in respect of restraints. DW had visited a Trust in Bradford and they reported they have no restraints. DW stated it would be useful to understand definitions in this area.

DT reported the reducing restrictive practice and interventions (RRPI) team are well connected across the region to make sure the Trust is in line with emergent best practise.

NM reported RRPI benchmarking against other trusts goes to the quality and safety committee and there are two main focuses at committee, how we are reporting restraint, to understand our approach, and the performance rate, as the number of restraints appears higher than benchmarking data.

KQ asked to reconcile the information in the RRPI annual report with what is in the IPR. We benchmark higher than other trusts. We need to look at the two pictures that have been presented to the Board, in order to understand this.

Action: Darryl Thompson

CH reported individual ward performance data now includes the number of restraints, including prone restraint. The highest user is Walton ward, which is one of our psychiatric intensive care units (PICU), which is expected given the presentations these types of wards deal with

.

People

AS highlighted the following points:

- A continuing trend is that we have had more starters than leavers for every month of this year.
- The vacancy rate has increased. We still attract additional income for the mental health investment standard (MHIS). Board members may start to see a national debate on increasing headcount across the NHS not necessarily matched by an increase in productivity. We have to remember as a mental health trust the MHIS still applies, and we're still being commissioned to provide additional and new services which require our headcount to increase. There are some real positives that we are growing the workforce but there is a challenge that we have to keep pace with new roles through the MHIS. This is a position that is likely to change next year.
- We've looked at some of our peers around vacancy rates and sustainability and we perform well compared to mental health peers in the Yorkshire region.
- There is a continuing challenge in relation to appraisals, detailed discussion has taken place at executive management team (EMT). MBr has asked for some action plans for improvement.
- Appraisals also need to be quality meetings, not just numbers based. We are hopeful we can achieve some sustained improvement.

Mandy Rayner (MR) confirmed the appraisal improvement plan came to PRC last week. There was a good debate around some of the challenges. We are expecting to see some improvement soon and it was noted there had been recent improvement in forensic services and estates & facilities.

MBr asked Board members to note this year we have a phased target, so 80% is only at a point in time, the target has never moved from 95%. The paper that came to committee last week dissected this information and DL is supporting the people directorate with some change management techniques and improvements so that we can have some visible and tangible actions which will come back to EMT.

Care Groups

CH reported:
Barnsley general community

- There is a continued focus on supervision and appraisals.
- The staffing risk has been reduced in the neighbourhood nursing team having recruited to a good number of vacancies.
- Pediatric audiology - we were confident in reaching the target, but unfortunately, we have not managed to achieve this due to demand and staffing capacity. We are reviewing the service and hope to be in a better position to provide a trajectory in January 2024.
- Assurance was provided to quality and safety committee (QSC) that we can still provide paediatric audiology appointments within four weeks. It is the diagnostic appointment that we're struggling with. If parents need support with their child, we can get somebody to see them to provide support in the short term. The maximum wait currently is 12 weeks, and we are doing all we can to address this.

CAMHS

- There is continuing pressure on Tier 4 beds. There are also issues in respect of suitable placements for a child, which might not be an inpatient bed, but the default is often to an inpatient bed because there isn't a better solution.
- There are still some staffing hot spots. The Wakefield team have raised this, as have Wetherby and Adelbeck.
- There have been some good ideas from the service about how to involve children in our recruitment processes.

Adults and older people's services

- There is low use of out of area beds, and patient safety always comes first, if somebody needs a bed, and it out of area, it will be used.
- Calderdale, Kirklees and Wakefield single points of access (SPA) teams continue to be under pressure, but they are managing to see people within 14 days. In this service people with urgent need are prioritised. More routine referrals can be a risk due to the number of urgent referrals being received. There are issues in Barnsley and there is an action plan in place to resolve this.
- Reducing restrictive practice and interventions (RRPI) training - inpatient services, notwithstanding individual hotspots, overall are green and the challenges sit within our community services, who are less likely to utilise restraint, which presents a slightly reduced risk.

Attention deficit and hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) and Learning disability and forensic services.

- The Royal College of Psychiatry invited review, have now returned their final report. There is an action plan in place and the plan is to present this to QSC in January and the Board will be updated through triple A reports.
- There are challenges in finding suitable placements for people who are ready for discharge from Horizon, this is a challenge that is shared with our partners in Bradford. There are collaborative discussions taking place to look at a resolution.
- There are still challenges with learning disability services and completed assessment care packages to commence treatment. 21 referrals out of 71 have not met the assessment to treatment target of three weeks. These referrals are spread throughout Barnsley, Kirklees and Wakefield.
- Forensics are working through a rapid improvement plan in respect of appraisals. We are working on data accuracy plans to improve data and will keep a local record to provide the required evidence.
- Band 5 vacancies have been reduced although the impact of this recruitment has not been seen yet as some staff are working through preceptorship and induction.

Inpatient Wards

- It has been noted that where there is low supervision there is high sickness amongst the staff group.
- There have been some identified dips on Clarke ward in Barnsley in relation to performance and the matrons will be working with the ward to improve performance.
- Ward 19 (female) sickness compared to ward 18 (male) is significant, and all of their workforce performance indicators are currently below target. This is not indicative of a trend, but we need to keep an eye on this. It should be noted there has been a COVID-19 outbreak on this ward.
- Low secure services in the Bretton centre are experiencing high levels of sickness and this is impacting on cardiopulmonary resuscitation (CPR) training compliance.
- Lyndhurst is one of the Trust's rehabilitation wards and is below target on several indicators. There are some new leadership arrangements in place with a service improvement plan and so we are expecting these to change.

MBr noted the Trust is seeing one or two young people placed in adult beds a month, so far there have been 325 young people placed in an adult bed nationally this year.
Learning disability discharge is also a national issue. We need to work with our local authorities and partners to try and improve this position and length of stays.

NM asked CH which areas the Board needs to be aware of as areas of concern?

CH reported Clark ward is a current area of concern, as is Lyndhurst. CH noted she is currently looking at the improvement work that has taken place in Wakefield, Calderdale and Kirklees single point of access (SPA) teams and why this hasn't been effective in Barnsley.
Leadership and how the community teams are brought together is being reviewed so that we continue to learn from each area of the Trust while still understanding the differences in the dynamics of populations. CH also reported she is keeping a close eye on any potential impact as a result of the reduction in out of area beds on other services.

A conversation followed in relation to the “so what” element of the IPR and how the analysis of the data being presented is improving and this is continuing journey as the IPR continues to develop.

Finance and Contracts
AS highlighted the following points:

- There has been a request from NHSE for ICSs to confirm they can deliver their original plan. Our Trust financials are included as part of the West Yorkshire ICS who have submitted a break-even forecast.
- The Trust has not changed its forecast, and this has been fed into the ICB.
-
- We have seen agency spend reduce this month, and this is the first time this year it has been within target.
- There remain some pressures on non-pay, some of these are inflationary pressures, some are activity.
- There is a slight concern the provider collaborative underspend is supporting the underlying Trust position. The risk is that provider collaborative spend can be volatile, a small number of high-cost placements can have a significant impact on this position.
- OOA beds have been discussed and we currently have zero OOA placements for adults and older people services, we have two PICU patients out of area, and both have unique challenges.
- Agency review group reviewed individual roles and looked at what measures we can take. Where we have seen a big improvement, this month is around staff on rotas. Work continues with the operations directorate and the people directorate to understand and maintain the change and identify if there are any unintended consequences.
- Capital is shown as red as we are not spending at the rate we need to. Supply chain and lead in times for some the schemes are difficult.

MF raised virtual ward occupancy that is highlighted within the national metrics section and noted that performance appears to be under trajectory.

CH reported this is reduced currently but when the team have looked at this, it is believed to be a timing issue, because people on our caseload get added to the virtual ward and then step back down again. We are confident that people are on the right pathway, and this will be reviewed in further detail. CH confirmed she would double check the position and report back to the board.

Action: Carol Harris

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

TB/23/118b Care Group Performance Report (agenda item 9.2)

CH introduced the item and highlighted the following points:

- This report is focused on community mental health and mental health inpatients.
- This is retrospective data from the month prior to the IPR that has just been presented.
- There was an improvement in appraisal rates at the start of the year, but this has started to slow in community services although it has been maintained at 75% in all areas. Further work is underway in all areas to achieve the 95% target.
- In relation to access for people in the community, those in crisis consistently receive an assessment within four hours. Other access measures, such as, 72-hour follow up, and A&E assessments are positive.
- As already mentioned, there are some challenges around single point of access in Barnsley. There is an improvement plan in place to take learning from other areas.
- Learning from incidents and complaints is embedded as part of care group governance processes, and there is further work being undertaken to understand the statistical significance of the data to check that appropriate action is being taken.

- In mental health community services, referrals for white people are marginally overrepresented and Asian people are marginally underrepresented. Equality impact assessments have been carried out along with action plans.
- Looking at our inpatient services there is a reciprocal position. BAME communities are more likely to be referred onto an inpatient ward than white communities and this is a national trend.
- There has been improved performance on sickness and we do focus on staff wellbeing.
- Incidents for this staff group in the main relate to aggression and violence. The race forward group has been looking at racial abuse and how staff can support each other to deal with this issue.
- Turnover runs high for this staff group. Most nurses start their career in inpatient wards before they move onto other areas. We are looking at a career structure to improve retention within inpatient services.
- CH explained safer staffing data is reflective of acuity on wards rather than establishment.

Rachel Lee (RL) noted the referrals by deprivation data and asked what plans were in place to address this.

CH reported this would be reviewed as part of the equality impact assessment action plans.

MBr noted there is a need to work in partnership with public health and commissioners as well so that there is a wider system view on this data.

DT reported he had recently met with the Chairs of care group governance meetings and asked them to consider how assurance can be provided to Board around certain issues.

DT added there is a current initiative through Barnsley recovery college focused on the two post codes of highest deprivation, which is looking at engagement with people from those populations through the recovery college, to address self-care, wellbeing and health promotion.

DL reported the Trust is progressing into a strategy refresh and it is important that it is data informed and action focused. Inequality is a good indicator for the Trust to think about. This will take some time to resolve through work with partners, and the Board may wish to consider what this will look like in the medium- and long-term position.

It was RESOLVED to RECEIVE the report and NOTE comments made.

TB/23/119 Risk and Assurance (agenda item 10)

TB/22/119a Serious Incidents Quarterly report (agenda item 10.1)

DT introduced the item and highlighted the following points:

- There have been almost 3,500 incidents reported in the quarter which remains within expected variation levels.
- 96% of incidents resulted in no, or low harm, or were external to Trust care.
- There has been an upward trend in red incidents in recent months, they continue to be regularly evaluated through our governance process which considers the level of harm caused.
- Physical aggression, threat with no contact made towards staff from service users, is normally the most frequent incident type. Self-harm is the most frequent incident for this quarter. This is reflective of the levels of acuity we are experiencing as highlighted in our board story this morning.
- Learning from experience is included in the report.
- Two serious incidents this quarter and we have had no “never events.”

- The report includes learning from healthcare deaths. There were 98 reported deaths in quarter 2, and 75 of those were in scope for mortality reviews. These numbers include our end-of-life pathway and neighbourhood nursing teams.
- The report has been recommended for approval by Board following presentation to the quality and safety committee (QSC).

MF noted there is a notion that the number of reported red incidents is when reported, then this can reduce on review. Is there a way the table can show the difference between these two totals?

MR pointed out that the narrative includes the differential between reported red incidents and confirmed red incidents after review.

A discussion followed about different date sets in different parts of the report and MBr reported that while the data is important, from an assurance perspective, what we must focus on is the learning that has been taken from these incidents.

DT reported incidents are discussed and reviewed through care group clinical governance meetings, and where learning is identified this is shared into the Trust wide clinical governance group and then fed into QSC.

DT gave an example of a ligature point that hadn't been seen nationally. This was shared throughout the Trust and then shared into national forums for awareness.

NM noted that pressure ulcers had been raised by our governors and we are conducting deep dives at committee in relation to this.

MBu noted the beginning of the report is important from an assurance perspective. MBu asked for future executive summaries to include areas of focus over the quarter and what has changed as a result.

Action: Darryl Thompson

It was RESOLVED to RECEIVE and NOTE the quarterly report.

TB/23/119b Ligature annual report (agenda item 10.2)

DT introduced the item and highlighted the following points in relation to risk assessment:

- The report has been presented to QSC; additional work was requested prior to presentation to Board to provide more assurance.
- This is a fundamental aspect of our safety approach.
- The 2022/23 audit process took place across all our clinical areas to test potential ligature points and 37 separate assessments have been carried out.
- When issues are identified, actions are raised to address these, be it small estates adjustments that are required, or larger schemes such as door replacement.
- The clinical environmental safety group deal with estates changes which feed information into EMT.
- There has been an increase in ligature incidents from last year, but numbers remain significantly lower than 2020/21 when there was a peak.
- The anti-ligature door replacement programme progress is included in the report.
- The Trust ligature audits are in line with national expectations. There have been some delays in sign off process earlier in the year and this was escalated to the clinical environmental safety group.

Mandy Rayner (MR) noted this is a good report and queried if there are any issues that need to be addressed?

DT reported the continuing challenge is new methods of ligature that people continue to create. We are well linked into the national ligature network.

MBr noted one challenge has been as a result of staff turnover and temporary staffing being required. It has been identified through some visits that temporary staff don't always know the ligature points or where the ligature folder is, and this is being dealt with.

NM noted the report has been updated in a timely manner following committee feedback with improved assurance.

RL noticed that 10% of ligature incidents involved transgender patients and this seemed disproportionately high. It was agreed that this would be reviewed through QSC to identify if any further action is required.

Action: Darryl Thompson

It was RESOLVED to RECEIVE the report and confirm it provides the required assurance.

TB/23/119c Medical education annual report (agenda item 10.3)

Prof. Subha Thiyagesh (ST) asked for the paper to be taken as read and highlighted the following points:

- 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) 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 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. This is carried out via annual meetings with each.

MR noted that the people and remuneration committee (PRC) receive the guardian of safe working quarterly report, and this has identified some issues regarding the e-rostering system, which hasn't been as effective as it has been in other areas. The report triangulates well with what is being heard at Committee.

It was RESOLVED RECEIVE the third annual Board update and note the ongoing challenges placed upon the Medical Education Department.

TB/23/119d Freedom to speak up (FTSU) self-assessment (agenda item 10.4)

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

- Estelle Myers, the Trust lead FTSU guardian has unfortunately been called away on a personal matter and has had to give apologies for today's meeting.
- Following publication of the new national freedom to speak up policy, which the Trust has adopted, all trusts have been sent this self-assessment tool to complete.
- Work started on the document at the end of March 2023, and has been completed over several months, with involvement from the people directorate, freedom to speak up guardians, and various staff from across the organisation.
- It took some time to work through the scoring process, following which an action plan was developed, which is the document presented to Board today.

- The document has been through the freedom to speak up steering group, organisational management group (OMG), EMT and people and remuneration (PRC) prior to being recommended to Board for approval, prior to publication (required before the end January 2024)

KQ noted she was thinking back to the letter from NHSE about the Lucy Letby case and there were five things from that letter, in addition to the policy for Trust Boards to action, and KQ asked for some assurance around these. KQ also noted low numbers of cases which can be perceived as an indicator of concern, and questioned how this is being managed.

JW reported a full update paper was presented to Board in relation to the Lucy Letby case and all matters around FTSU include the actions presented in that letter.

Estelle Myers (EM) is key trained for forensics, and visits team during handovers between days and nights. The Trust has recruited more FTSU guardians since the Lucy Letby case and is looking to recruit more.

JW reported through the mechanisms and communication plans in place, we have good systems to reach as many staff as possible.

JW stated the numbers of cases is accurate, staff tend to raise concerns that can be dealt with elsewhere and are these are often resolved through signposting. Examples of this are concerns that are raised that can be dealt with through line management routes, staff side or the people directorate. The FTSU steering group feel that staff know it is safe to come forward and be listened to.
There will always be areas and staff groups that are harder to reach, and the Trust has to make sure the effort is made to reach those areas.

JW reported a thematic review has been requested, but due to low numbers, themes are hard to identify. Therefore, the scope of this work has been broadened and following a conversation with NM, we are working with the deputy director of nursing, quality and professions and looking at intelligence monitoring, quality monitoring visits(QMV) outputs, outcomes of serious incident investigations, and reports into the people directorate, The care groups are very committed to FTSU and it is a regular item at OMG and fed back through the matrons.

MBr raised two issues. This is a self-assessment, and this report states that we have good processes in place, and we have identified there are points for learning, at the same time we can't lose the focus on what is needed to build on what we have and improve through the action plan.

RL noted the report presents a lot of positive actions taking place and explains how FTSU guardians are looking to break down barriers and to improve diversity of the guardians.

MF raised the notion of staff going elsewhere to report issues.

MR reported staff are utilising other routes, such a line management, rather than "going elsewhere", this terminology can be slightly misleading.

A discussion followed about methods for reporting incidents and identifying issues.

KQ noted the staff survey would be a useful way in which to assess the effectiveness of FTSU. It would also be useful to look at equality data for reporting to see what the breakdown is. There is a suggestion that staff from BAME backgrounds may be less likely to utilise this process.

It was RESOLVED to APPROVE the FTSU Reflection and Planning Tool for publication.

TB/23/119e Emergency Preparedness, Resilience and Response (EPRR) compliance report (agenda item 10.5)

AS introduced the item and highlighted the following points:

- The assurance process is new and is a trial.
- There had been a significant deterioration in scores across the region because of the many new requirements from the new process.
- We have arranged to meet NHSE and discuss the new process.
- There are some specific challenges in the scoring.
- AS wants to challenge the proportionality of the scoring system.
- The evidence base that has been used, is the same evidence base we have used previously.
- NHSE have raised the bar significantly in terms of requirements.
- We fundamentally disagree with a number of points made by NHSE and we are going to work through this.
- There is a significant gap between where we feel we are as a Trust and where NHSE deem us to be.
- We have to sign this off today as presented, and then work this through with NHSE.
- We have been able to demonstrate effective EPRR functions, for example we have done it this year, through industrial action and in recent years with the pandemic. We also have a significant assurance internal audit.

MBr asked that an accompanying letter should be sent with the submission to document where the gaps are.

Action: Adrian Snarr

AS reported the Trust needs to move towards full compliance and there are some elements we will struggle with. For example, a decant plan to evacuate a full site is currently not possible. We need to get back to partial compliance and there are a number of challenges to this.

AS reported at sign off today we are 26% compliant.

MF reported the audit committee signed this off at 79% prior to submission.

AS reported, we still don't understand the detail of NHSE interpretation of the requirements. This an issue for all providers.

MF requested the Board approve the report on the basis it needs to return to the audit committee to look at the detail.

Action: Adrian Snarr

MR noted this is about emergency planning, do we have now have a risk, and if so, what action is needed to mitigate this risk.

AS noted, a risk should be considered for the ORR. We have an internal audit report that has given significant assurance around our EPRR.

Action: Adrian Snarr

MBr noted the EPPR process has managed the pandemic well, industrial action, and in the last few years a ward fire.

It was RESOLVED to APPROVE the submission of the core standards compliance position, with a covering letter to NHSE and the action plan to go to Audit Committee for detailed oversight.

TB/23/119f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10.6)

Mental Health Act Committee 7 November 2023
KQ asked to take the report as read and highlighted the following:

- Right care right person input was interesting and clinical risks will be considered.

- The community treatment order (CTO) annual report. Nationally CTO use is eleven times higher on black people than it is on white people. The Trust completely bucks this trend with only 45% of black people on a CTO from a BAME background and we are going to look at why we differ from the national picture.

Quality & Safety Committee 14 November 2023
Nat McMillan (NM) reported the following:

- New and emerging risks were discussed at PRC as well as QSC and we are looking at the joint ownership of those risks to avoid duplication.
- Quality improvement assessments were discussed.

Members' Council 17 November 2023
MBu asked to take the paper as read noting it had been a positive meeting with good engagement from the governors.

Finance, Investment & Performance Committee 20 November 2023
DW highlighted the following from the November meeting:

- There will be a greater performance focus, in addition to finance as documented in the report.

People and Remuneration Committee 21 November 2023
MR highlighted the following:

- There was a good discussion about the score `for the risk for industrial action which demonstrated well the comprehensive way in which risks are managed within the Trust.
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It was RESOLVED to RECEIVE the assurance from the committees and Members' Council and RECEIVE the minutes as indicated.

TB/23/120 Integrated Care Systems and Partnerships (agenda item 11)

TB/22/120a 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:

- There was a powerful video shown from a young person with an eating disorder in Barnsley.
- Diversity and inclusion group has been established – Dawn Lawson (DL) is now a member of this group.
- Industrial action and the current financial position were key focuses of the meeting.

Mental Health Learning Disability and Autism (MHLDA) collaborative

There will be an updated national mental health strategy.

- A major conditions strategy is being developed which incorporates mental health and DL will be the Trust's representative.

- We are discussing the relationship between the MHLDA collaborative and the specialist provider collaboratives including adult secure, eating disorders and CAMHS in South Yorkshire and what the role of commissioning is.

Dawn Lawson (DL) reported the Trust is working closely with the alliance to develop a provider collaborative approach including the Barnsley hospital NHS foundation trust.

It was RESOLVED to NOTE the SYB ICS update.

TB/23/120b 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 for the paper to be taken as read, highlighting the following points:

- Wakefield health and wellbeing board had an item of focus on tobacco control, led by the public health team and West Yorkshire trading standards.
- Our smoking cessation service in Wakefield was highly commended, being noted to be high performing and flexible in its working.
- The data presented did highlight the significant progress being made on smoking reduction, however, it also identified significant inequalities in terms of low income and mental health conditions being disproportionately affected by tobacco.
- In terms of inequalities, smoking remains the biggest killer in Wakefield.
- SR is going to take this issue into the mental health alliance in Wakefield to see what more can be done to reduce smoking rates through work with partners.

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/23/120c Provider Collaboratives and Alliances (agenda item 11.3)

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

- The West Yorkshire collaborative for adult secure services is currently focused on the community pathway and female pathway.
- The community pathway work is to ensure consistency across the region, which means wherever you are in the region, your discharge opportunities are equal.
- The women's pathway work is emerging. It is becoming clear we are one of the first collaboratives to start looking in detail at a women's pathway.
- In South Yorkshire good progress has been made in resolving the one long term outstanding contract from 22-23.
- South Yorkshire are also looking at developing their community pathway.

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/23/121 Governance (agenda item 12)

TB/23/121c Trust Seal (agenda item 12.3)

It was RESOLVED to NOTE the Trust Seal has not been used since the last report in September 2023.

TB/23/122 Trust Board work programme 2022/23 (agenda item 13)

MF queried the timeline for the five-year plan. MBu reported this would be scheduled after the strategic meeting in December.

It was RESOLVED to NOTE the work programme.

TB/23/123 Date of next meeting (agenda item 14)

The next Trust Board meeting in public will be held on 30 January 2024

TB/23/124 Any other business (agenda item 15)

Nil.

Signature: Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 30 January 2024 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 28 November 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/115	NM queried how the matrons monthly inspections qualitative discussions can be used to inform the patient experience annual report.	Darryl Thompson	March 2024	
TB/23/117	NM noted the patient and carers race equity framework and queried if this is mandatory? MBr reported there was consultation on the framework, and it was checked against our own equality and inclusion plan. We can now reassess and bring the outcome to the equality inclusion and involvement committee for review, and report to Board through the triple A report.	Dawn Lawson	March 2024	
TB/23/118a	DT reported there is an individual placement support service steering group, and a fidelity assessment against the national standards. The team's performance against these standards is good. DT provided assurance that the team's approach is in line with national expectations, but he will take MF's comments on performance against the referenced metric to the steering group for discussion.	Darryl Thompson	March 2024	

TB/23/118a	KQ asked to reconcile the information in the RRPI annual report with what is in the IPR. We benchmark higher than other trusts. We need to look at the two pictures that have been presented to the Board, in order to understand this.	Darryl Thompson	March 2024	
TB/23/118a	MF raised virtual ward occupancy that is highlighted within the national metrics section and noted that performance appears to be under trajectory. CH reported this is reduced currently but when the team have looked at this, it is believed to be a timing issue, because people on our caseload get added to the virtual ward and then step back down again. CH confirmed she would double check the position and report back to the board.	Carol Harris	January 2024	• As this is delivered in partnership, there was a lag with getting all staff able to update on the system. • Gaps in the workforce will be resolved by the end of March 2024 • SWYPFT are providing in reach to the hospital to help with pathway challenges and support the safe onboarding of patients who will benefit from the virtual ward.
TB/23/119a	MBu noted the beginning of the serious incidents quarterly report is important from an assurance perspective. MBu asked for future executive summaries to include areas of focus over the quarter, and what has changed as a result.	Darryl Thompson	March 2024	
TB/23/119b	RL noticed that 10% of ligature incidents involved transgender patients and this seemed disproportionately high. It was agreed that this would be reviewed through QSC to identify if any further action is required.	Darryl Thompson	January 2024	This has been added to the QSC workplan and Board will be updated via the triple A report.
TB/23/119e	AS to submit a covering letter with the Trust EPRR submission.	Adrian Snarr	January 2024	Complete, joint letter sent from 3 MH trusts SROs in West Yorkshire
TB/23/119e	AS to take the detail of the EPRR report back to the Audit Committee for further discussion	Adrian Snarr	April 2024	
TB/23/119e	Consideration to be given to the necessity for an organisational risk for the Trusts EPRR position	Adrian Snarr	January 2024	To be picked up in next Risk register review although at this stage no new risk is identified but evidence on existing controls is to be enhanced.

Actions from 31 October 2023

Min reference	Action	Lead	Timescale	Progress
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	A high-level overview has been provided to FIP. Now the PSR is live some case studies will be considered and fed into FIP as part of the business opportunity paper.
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	March 2024	January update: CH will discuss this with the CAMHS teams and bring an update in March 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	This has been reviewed and 2 new gaps in assurance have been developed to reflect these points regarding international recruits in the BAF at Risk 2.4.
TB/23/102b	The Board agreed the new BAF grading system will go to Audit Committee in January and then follow into January Board.	Adrian Snarr	January 2024	The Audit Committee reviewed and approved the new grading system to be implemented from Q1 2024/25.
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	Work is progressing with the Race Forward Group to determine appropriate metrics to measure performance. These will be shared at EIIC. We also use our staff survey results to monitor and measure staff engagement and these are shared at a team level for actions to be identified and delivered. A second Flair survey will be carried out in Q2 of 2024 and following feedback and recommendations arising out of your voice counts inclusive sessions. Engagement with staff will also take place as part of the Trust Strategy Refresh. Committees will report on progress through the Triple A reports.

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	The new reporting system now live. This is still based on existing appraisal package. The in depth appraisal report was presented to PRC on 16 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	This has been added to the QSC workplan to look at the reconciliation of the figures and Board will be updated via the triple A report.
TB/23/106a	In relation to the digital strategy 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	The digital strategy is to be considered in the February development/strategy board for alignment with Trust strategy.

Actions from 26 September 2023

Min reference	Action	Lead	Timescale	Progress
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	March 2024	November 2023 update: 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. January 2024 update: Update to be presented in March 2024, so that the Trust can work through the plan and join up with the systems as well.

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	January 2024	November 2023 update: 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. January update: The IPR has now been updated following review at Finance, Investment and Performance committee.

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	January 2024	November 2023 - 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. On the January Board agenda.

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	January 2024	November 2023 - 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. On the January Board agenda.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
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:	**Further industrial action has been experienced during both December and January.** This action has been taken by junior doctors and consisted of three days in December and a further six days in January. This obviously came at a particularly busy time for the NHS. The Trust has spent considerable time and resource in planning and responding to this action, and our thanks are once again given to all of those who have provided cover to ensure access to safe services is maintained. We continue to monitor the impact on both the junior doctors professional training and the impact on service users through regular debriefs after every period of action. In total the Trust has experienced and managed 38 days of industrial action during 2023 and the initial weeks of 2024. **Both within the Trust and across the wider system winter pressures are being experienced.** Demand for services has been high and the prevalence of respiratory illness, including covid and flu has increased. Occupancy on our inpatient wards has been high with many regularly at 100%. Despite this focus on minimising the number out of area bed placements continues and at the time of writing this report 4 people are placed in an out of area bed, which compares very favourably with many other similar providers, both locally and nationally. **There is a separate brief Board report regarding the planning guidance for 2024/25.** Publication of this did not take place in 2023. NHS England continues to engage with the government regarding 2024/25 priorities and funding. Trust Board will be kept up to date with the development of operational planning guidance with key priorities not expected to change significantly, although there is increased focus on productivity. As things currently stand, we have been asked to assume a requirement for an initial plan submission by the end of February.		

The Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) report for 2022/23 has recently been published. This report will be taken through both the Quality & Safety Committee and Trust Board. The report recognises the constant drive and focus to improve the lives of people with a learning disability and autistic people and notes the introduction of the Oliver McGowan training programme and importance of physical health checks. There are some key points it is helpful to make Board members aware of now.

- Whilst the median age at death for people with a learning disability in 2022 increased to 62.9 years compared to 61.8 years in 2018 it remains far lower than for the general population, 82.6 for males and 86.1 for females.
- 42 per cent of deaths were deemed "avoidable" for people with a learning disability. This is a reduction from 2021 (50%) however it remains significantly higher compared to 22% for the general population.
- Concerns with care were expressed in 25% of deaths in 2022, compared to 39% of deaths in 2021.

Whilst it is pleasing to see improvements there remains a great deal of work to be done to reduce inequality for people with a learning disability and we will continue to strive to make improvements both in our own Trust and across the places in which we work.

Work has commenced to refresh the Trust's strategy. This was a key topic of conversation at the Trust Board Strategy meeting which took place in December 2023. The discussion was very helpful in shaping our approach to the strategy refresh. The refresh presents an excellent opportunity to consider the current and future health and care landscape and provide clear focus to our own future in it. Engagement on its development will commence in February and run until the end of March. Further detail on this process will be provided to all members of the Trust Board before it is launched. We have agreed that we will refresh the Trust strategy in line with our values and will do this by focusing on having a good quality conversation with our colleagues, patients, service users and their families & carers, as well as with our partners. We will be as inclusive as possible by offering a range of different ways and opportunities to engage with us.

The publication of the reports following the Care Quality Commission's (CQC) inspection of our adult mental health, learning disability, and adult secure inpatient wards took place in December. There is a separate paper on this topic in the main agenda. We are always pleased to learn from external reviews of our services and will ensure we place appropriate focus on those areas where improvements can be made. We also recognise the many positive comments about our services that are made in the reports. Staff are thanked for their openness and honesty with the CQC. Updates on actions being taken given the recommendations in the report will be provided regularly.

The CQC has also published a report regarding the provision of inpatient adult secure services at Cheswold Park in South Yorkshire. The report has rated the service as inadequate and placed the organisation is special measures.

There is continued scrutiny on system and individual organisation finances. Both the South and West Yorkshire systems have submitted updated forecasts for 2023/24 which include a level of risk. Our Trust forecast position for this year remains unaltered at break-even. Financial planning for 2024/25 is taking place and will be very challenging.

This Trust Board is focused on business and risk and includes our latest Board Assurance Framework and Organisational Risk Register. There is considerable risk in the wider health & care system currently and this is reflected in our risk management papers. There are some recommended improvements to risk scores this quarter based on work that has taken place. It is likely the impact of financial constraint across public sector finances will lead to higher levels of risk in 2024/25.

Operationally the Trust has had to contend with the usual winter demand pressures and industrial action in recent weeks, along with an increase in respiratory illness including both covid and flu. Despite these pressures it is pleasing to see out of area bed placements typically remain low and our services have worked hard to support system pressures. In Barnsley in the lead up the Christmas there was a significant increase in discharges from the hospital, who have been supported by our community services. Our flu vaccination rate for staff is 53% at the time of preparing this report. This is lower than recent years and reflects a position being seen nationally. Thought will be given to how we approach this next year so we can improve the uptake, given the safety benefits to our staff, service users, families, and carers.

We have received notification that following NHS England's review the Trust remain in segment two of the NHS Oversight Framework. As a reminder there are four segments and segment two is the default position unless there is a specific rationale that warrants a change.

In terms of national developments for our sector the following are worthy of Board note:

- The potential of introducing a new mental health commissioner role for England is being explored.
- From 15 January, a two-month national advertising campaign will seek to increase the uptake of NHS Talking Therapies services, with a focus on reaching people aged 30-50, people from Black and South Asian communities, and those aged 65 and above.
- The Department of Health and Social Care has published a new framework identifying the wide range of factors that can interact to influence the mental health of babies, children and young people, as well as what opportunities there are throughout the life-course of a young person to positively shape and re-direct the development of their mental health.
- The Diana Award in partnership with Centre for Mental Health and UK Youth is planning to recruit twelve young 'changemakers' to re-imagine mental health services for black and black-mixed heritage youth communities.
- We are very aware that people with severe mental illness and those with learning disabilities face some of the most significant gaps in

	life expectancy. NHS England has published new guidance and case studies on addressing the physical health needs of these groups. This is aimed particularly at integrated care systems. - NHS England has also published guidance on meeting the needs of autistic people in mental health services. When national guidance is received the Trust has a process for disseminating the information appropriately so it can be considered in our service development and provision. **I am delighted to share the news that Carmain Gibson-Holmes has been appointed to the role of Director of Services (Children and Families).** Carmain has been our deputy director of nursing for the past couple of years and it is positive we are able to continue to support Carmain in developing her career with the Trust. **Recently, our Wakefield and Calderdale Individual Placement and Support (IPS) services have both been awarded the highest possible rating by IPS Grow** following fidelity reviews carried out in September and October 2023. Out of a possible 125 points, Wakefield scored 118, and Calderdale scored 120 – we believe this is the highest score in the country. This is a great credit to the team who are striving to make a real difference to people's lives. **Following a recent Care & Treatment Review at the Horizon Centre (our assessment & treatment unit for people with a learning disability) the team there has received some positive feedback**. 'I can see over the last 12 months improvements in the service they are providing, from a person-centred approach to standards of record keeping. I can see in my visits over the 12 months how the team have developed. It feels the team work as one and have the same goal for the patients. The MDT appears balanced and knowledgeable and willing to hear ideas and suggestions and have a willingness to work with external professionals'. Over the Christmas and new year period events were organised for our international recruits to enable them to meet with each other and enjoy some of the festivities.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

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The Brief

21 December 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 always important for us to 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

Service users and staff now have the opportunity to spend time with our canine befrienders in a comfortable and safe environment as our new purpose-built lodge which has opened in Fieldhead. Find out more online.

With **all of us** in mind.

Our priorities for 2023-24

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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 care: The Oliver McGowan mandatory training on learning disability and autism aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The Trust is taking a phased approach to rolling out the training, which is mandatory for all staff. The training is available via ESR.

Golden threads: We now have over 40 members of staff, volunteers and community members who have signed up and completed the Connecting People training. If you would like to find out more about the Connecting People programme and how to get involved visit the intranet or our website.

The national, regional and local context

South West Yorkshire Partnership NHS Foundation Trust

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

NHS Calderdale Talking Therapies will move to a new provider from 1 April 2024. Following a procurement process NHS West Yorkshire Integrated Care Board (ICB) have confirmed that Vita Health Group will be the only provider of NHS Talking Therapies in Calderdale. More information is on the intranet.

The West Yorkshire Staff Mental Health and Wellbeing Hub will have limited capacity from 21 December to the 3 January due to staff shortages over Christmas. This means that new referrals to the therapy service will not be processed before 4 January, and the Hub will not be able to respond to calls to the message taking service during this period. See the intranet to find out about other support available.

Barnsley integrated services care group general operational management team were awarded a Covid remembrance token for collaborative working. The team were presented with their award on Tuesday 5 December by Susan Burgan from Barnsley Hospital.

NHS South Yorkshire are supporting health and care staff across the region to put a stop to aggressive and abusive behaviour from patients and members of the public under a new zero tolerance approach and public campaign backed by South Yorkshire Police called #NotInADaysWork.

Improving care
Our 2023 CQC inspection

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NHS Foundation Trust

In May 2023 the Care Quality Commission (CQC) visited our Trust to carry out unannounced inspections of our adult acute mental health inpatient wards, psychiatric intensive care wards, and forensic inpatient wards.

Thank you to all staff for everything you did to accommodate the inspection and for your quick responses to subsequent data requests.

The CQC also highlighted many positives. They noted that our staff treat people with compassion and kindness, understand the individual needs of people, and support our patients to understand and manage their care, treatment or condition. They also saw evidence that our Trust has successfully created a culture on our wards where patients and staff felt supported and were able to express their views.

What did the inspection say and what are we doing?

- The CQC acknowledged the significant pressures we are facing around staffing.
- We continue to put in place measures to help us address the national and regional staffing challenges in mental health and forensic services, which along with the increase in demand for mental health services can impact on the care we provide.
- Since we received the initial inspection report we have continued work that was already in motion to improve, including:
  - providing Oliver McGowan learning disability and autism training for our staff,
  - improvements in how we manage restrictive practises,
  - targeted work to improve staff appraisal rates, and
  - our care planning improvement programme which is already achieving positive results.

We were disappointed that the two services inspected were rated as ‘requires improvement’, though the Trust retained its rating of ‘Good’ overall. We welcome the feedback from the CQC and are already using this as part of our improvement work. We know that there are things we can do better.

Older people's mental health inpatient services transformation

South West Yorkshire Partnership NHS Foundation Trust

In January 2024 we will launch a public consultation on improving mental health care for older people on inpatient wards across Calderdale, Kirklees and Wakefield. The consultation will ask people about our proposals to invest into and create a specialist inpatient service for older people with dementia, and dedicated wards for older people living with functional mental health needs.

Your views are really important. Once the consultation closes we will use what staff, patients, families carers and the public tell us to inform our decision.

Thank you for all the feedback you have already given us to help us get to this stage.

Save the dates for our consultation events. Drop into the events anytime between 2-7pm, there is no need to book in advance:

- Tuesday 16 January, Halifax Town Hall
- Wednesday 17 January, Brian Jackson House, Huddersfield
- Thursday 18 January, Balne Lane Community Centre, Wakefield
- Tuesday 23 January, Hemsworth Community Centre
- Wednesday 24 January, Hebden Bridge Town Hall
- Thursday 25 January, Dewsbury Town Hall

There will also be online meetings

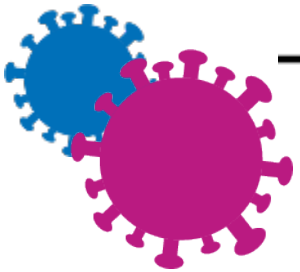
- Wednesday 31 January, 10 – 11.30am
- Tuesday 6 February, 10.30am – 12pm
- Saturday 10 February, 10.30am – 12pm.

We will share further information in early January 2024, including:

- detailed information about the proposals
- how you can give your views
- how you can share information with patients, carers and loved ones
- where you can pick up information.

With **all of us** in mind.

Improving health
Flu vaccinations



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The flu vaccine provides the best protection available against a virus that can cause severe illness. It's a highly infectious disease with symptoms that come on very quickly.

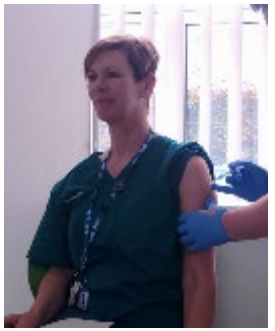
Isn't it too late to get my flu vaccination?
You can catch and spread flu all year round, it's just more common in winter, so it's well worth getting protected. We also still have drop in and bookable clinics running.

I'm worried about side effects?
Most people won't experience any side effects after their flu vaccination but If you do these should be mild and should clear up after a day or so.

Do I have to get the flu vaccine?
Getting your flu vaccine is entirely your choice, however we would strongly encourage you to take up the offer to keep yourself, your loved ones, your colleagues, and service users safer this winter.

I've already had my vaccination?
Please remember to update your vaccination status either by logging into **VaccinationTrack** or by emailing the **occupational health team's flu account**.

Chief pharmacist Kate Dewhirst had her vaccination and said: "I've had my flu jab because The side effects are mild and short term compared to the illness. It protects me, my family and colleagues and helps us keep services going."



Visit the intranet to join 52% of your colleagues and find a flu clinic date that works for you.

The NHS winter flu and Covid-19 vaccination programme continues to provide vital protection. You can now book a Covid-19 vaccination directly with a local NHS vaccination service, such as a pharmacy, or visit a walk-in site. Details of pharmacies and walk-in sites can be found online.

A great place to work

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

On Tuesday, 5 December we marked International Volunteer Day. To say thank you to our volunteers, we created a **short video** to recognise the contributions they make to the care we provide.

This year has seen industrial action from both junior doctors and consultants. Further industrial action has been announced by the BMA from Wednesday 20 December for three days and Wednesday 3 January for six days. We value all of you and respect your rights to engage in industrial action. Thank you to all our teams and services for their continued work throughout industrial action. We always welcome feedback from our staff, so please let us know if there is anything we can support with – speak to your line manager, union representative, or come and Talk to the Trio.

A new dashboard has been created which will enable managers to review appraisals for employees with historical data, current compliant status and when the next appraisal is due. It is important that all staff have an up to date appraisal.

Our first ever EyUp! charity fest was a huge hit with over 100 attendees helping to raise over £1200! The afternoon was filled with incredible performances and live music from Studio A, Hands of Industry, Amber Falls, Karl Johnson and Holly Tandy.

Don't forget to nominate your colleagues and teams for an Excellence award. Nominations can be made online throughout December and up to Friday 19 January, with an awards evening planned for May.

"I came away feeling revived and ready to take on challenges" – Read equality, diversity and inclusion lead Zahida Mallard's review of attending the Health and Care Women Leaders Network experience and see the importance of networking, training and personal development.

With **all of us** in mind.

Our achievements 2023

NHS
South West Yorkshire Partnership
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We returned to a smokefree Trust for service users in our inpatient services. And from Monday 15 January 2024 our older adult services and adult MH rehabilitation services will also become smokefree.

Kirklees individual placement and support service (IPS) received a top rating and achieved a IPS Grow Quality Kite Mark with 143 people accessing the service since May 2022.

David Yockney, our Registered Nurse Professional Lead (Adult Nursing) for the Barnsley Integrated Care Group received the Queens Nurse Award. The award is a formal recognition that the individual is part of a professional network of nurses committed to delivering and leading outstanding care in the community.

At the start of 2023, Carmain Gibson-Holmes started drop-in sessions - **tea to improve quality**. Sessions have been held across the Trust and have gone from strength to strength. Thank you to everyone who has taken the time to come and shared their thoughts, experiences and practices to help us learn and improve. You can read about the outcomes from the sessions and put the dates in your diary for further sessions in early 2024 on the intranet.

The Trust's early intervention in psychosis teams have been named as some of the best performing in the country, with two of our teams achieving 'Top performing'.

The Trust was awarded at the 2023 Eventeer Awards for its successful virtual recruitment fair held in collaboration with local NHS partners.

Our achievements 2023

NHS South West Yorkshire Partnership NHS Foundation Trust

The Trust was awarded Future-Focused Finance Towards Excellence Accreditation level 2; and we achieved Level 3 (Leader) Disability Confident status.

Our Trust through our Barnsley children's and adult's speech and language therapy team became the first NHS Trust in the country to use new **vir**tual reality (VR) software to support children and young people who stammer.

The Trust's linked charity Creative Minds was announced as a winner in a Europe-wide 'challenge' focused on different ways to empower communities to improve their health. Later in the year they supported the Trust in winning the national patient's choice award at the Building Better Health awards for our caring garden in Fieldhead.

Patients Know Best (PKB) a personal health record system for our service users went live across our Trust in July 2023. PKB gives our service users access to their health information with the ability to share this securely with any health and care professionals involved in their care, alongside their carers and family members. We are continuing to offer training to teams, as we look at adding more functionality in 2024.

Our Trust became successful in our application to become a member of the Triangle of Care. This means that we are committed to including carers at all levels of care, giving them equity in the service user journey. Find out more on the intranet.

TRIANGLE OF CARE

With **all of us** in mind.

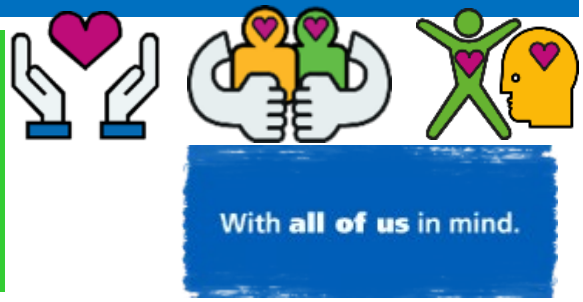
Looking forward

South West Yorkshire Partnership NHS Foundation Trust

Looking forward into the next year we have some important and exciting work either continuing or starting up:

- Launch of a public consultation on improving mental health care for older people on inpatient wards across Calderdale, Kirklees and Wakefield.
- Changes to our care group operational management team structure.
- We will be refreshing our overall Trust 5 year strategy.
- We will be developing a new clinical strategy.
- We will be updating our Trust strategies for:
    - Digital
    - Workforce and organisational development
    - Equality, involvement, communication and membership strategies
- We will be hosting our Excellence awards 2024.
- Investigating opportunities to further develop our Mental Health Museum.
- Continuing to focus on our golden threads – being recovery focused and trauma informed, social responsibility and sustainability, and equality, involvement and addressing inequalities.

We will be working with our staff, patients and partners to develop our strategies together. We are doing this work in line with our values and it is really important that all voices are heard. Please look out for opportunities to engage in the discussions to shape our strategies, there will be lots of different ways for you to input.



Take home messages

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

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Thank you to all of you. Wishing you a merry Christmas and a happy New Year

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Board Assurance Framework (BAF) Quarter 3 – 2023/24**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance Andy Lister - Head of Corporate Governance		
Mission/values:	The BAF is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	For Trust Board to be assured that a system of control is in place with appropriate mechanisms to identify potential risks to the delivery of its strategic objectives.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Board Assurance Framework allows Trust Board to monitor risks against the Trust's strategic objectives and in doing so enables them to assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships and Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	Reviewed quarterly by Executive Management Team. Reported quarterly to Trust Board.		
Executive summary:	The Board Assurance Framework (BAF) provides the Trust Board with a simple but comprehensive method for effective and focused management of the risks to meeting the Trust's strategic objectives. The BAF is used by Trust Board to generate the agenda for meetings, provide assurance on the management of strategic risks, and provide assurance against the delivery of the Trust's strategic objectives. The Chief Executive also uses this document to support his mid and full year review meetings with directors to ensure they are delivering against agreed objectives, and action plans are in place to address any areas of identified risk. The BAF is also used in the formulation of the Annual Governance Statement.		

In line with the Corporate / Organisational Risk Register (ORR), the BAF is aligned to the Trust's strategic objectives:

Our four strategic objectives	
Improving health	Improving care
Improving resources	Make this a great place to work

As part of the head of internal audit opinion process, the Trust BAF is reviewed by the Trust's internal auditors, 360 Assurance. Their review includes recommendations relating to the clarity of control and assurance statements. The quarter three recommendations have been updated in the attached version of the BAF.

On 11 January 2024, the Executive Management Team (EMT) fully reviewed the updated BAF for 2023/24 to consider current circumstances and the grading of strategic risks.

EMT were also provided with an update in relation to the proposed changes to the BAF grading system, following submission to the Audit committee in January 2024.

Audit Committee agreed with the proposed changes, requested some grading colour alterations, and noted that following consultation with internal audit, the grading system change should be implemented in Q1 2024/25, reporting in July 2024. EMT agreed with the above recommendations.

EMT discussions in respect of strategic risks considered the external environment in which the Trust operates, including factors such as continued high levels of acuity and complexity in presentation, winter pressures, improvement in the use of out of area bed placements (OOA), 2024/25 financial planning arrangements, continuing industrial action in some sectors, recruitment and retention, and the ongoing need to support staff wellbeing.

As agreed at April Board the Trust has 14 strategic risks for 2023/24 against the Trust strategic objectives:

Improving health – 4

Improving care – 4

Improving resources – 3

Make this a great place to work – 3

The table below shows the risk rating and no changes to grading between Q2and Q3:

(*2.4

Strategic Risk Ratings	Q1 2023/24	Q2	Q3
Red	0	0	0
Amber	5	6*	5
Yellow	8	8	9
Green	0	0	0
Ungraded	1	0	0

grading was approved by Trust Board in October 2023)

EMT has given careful consideration to all strategic risks with a particular focus on the below:

Risk 1.4 - Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. EMT discussion noted that there has been a significant improvement in the amount of equality data being obtained by the Trust, but further work is required to analyse this data and make further meaningful change to access before any change in grading can be properly considered. EMT therefore propose retaining a grade of Amber at this time.

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.

In October 2023, EMT proposed an initial grading of Amber along with a high-level action plan to be developed to reduce the risk, with an update on progress to be presented to the January 2024 Board.

In January 2024, EMT discussion noted that actions are being progressed but as an example a recent meeting between the executive trio and international nurses highlighted that further work is required to improve experience for staff with protected characteristics before consideration can be given to a change in grading.

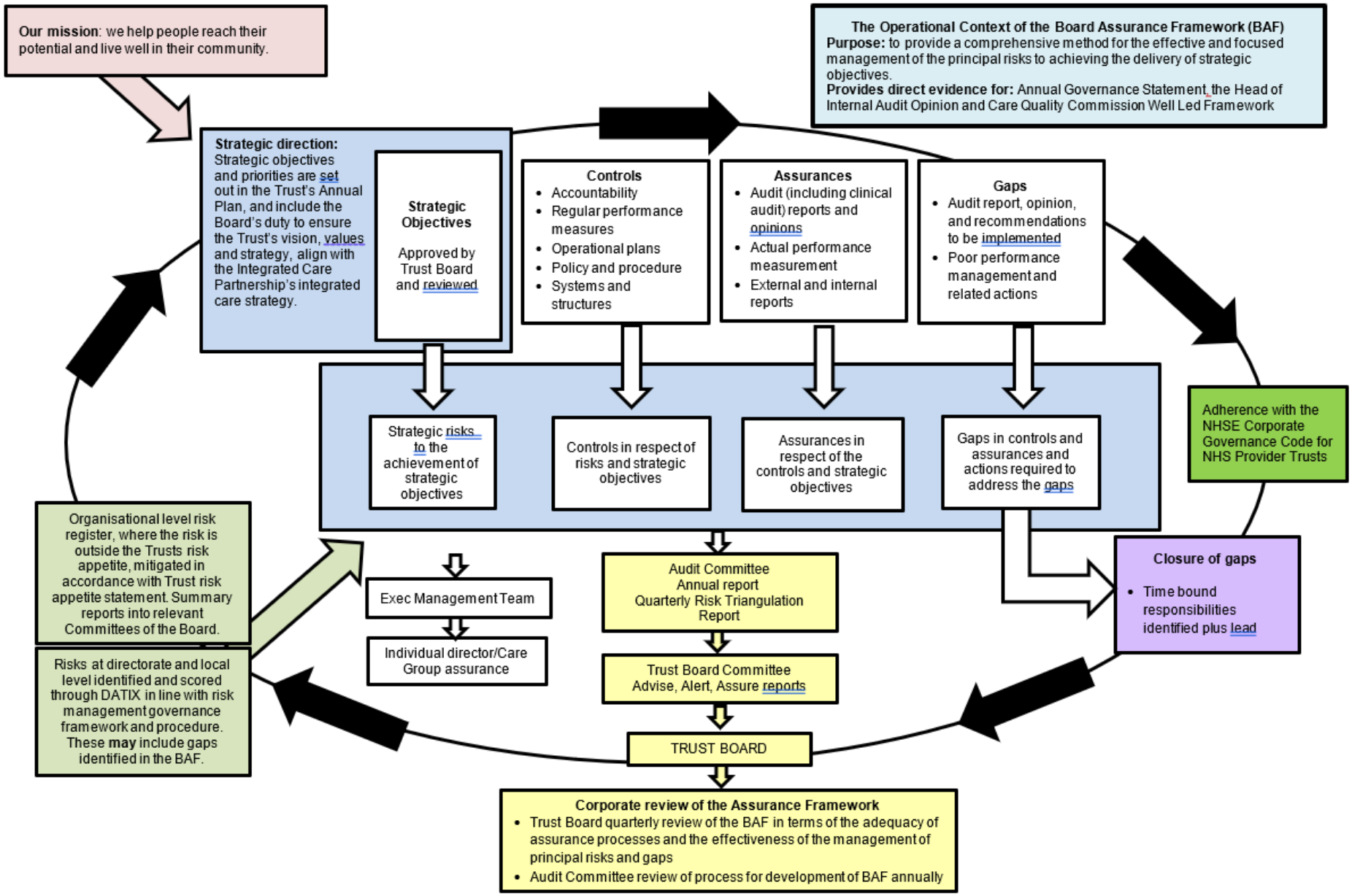
Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. EMT discussed the planning process for 2024/25 and noted that at this time, national planning guidance is still to be released. The Trust is being proactive in its planning assumptions as much as possible, but it was agreed that national planning guidance must be received in order to consider its impact on the Trust for the year ahead, and the grading of this risk.

Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels. Improvements in a number of key metrics over time have been taken into consideration. Specific examples include the fact there has been a net increase in substantive staff of 308 whole time equivalents since April 2022 and our staff turnover rate of 12% is amongst the lowest in the region. Whilst further work is required, as the level of

	recruitment and retention is not consistent across all services it is recommended that the risk rating be reduced from Amber to Yellow. The view of EMT is that the ratings of individual strategic risks for Q3 are representative of the operating environment and pressures within our services.
Recommendation:	**Trust Board is asked to DISCUSS this report and APPROVE the proposed updates to the Board Assurance Framework.**

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust



Board Assurance Framework (BAF) – 2023/24

Overview of current assurance level:

The rationale and the individual risk RAG ratings are set out in the following pages.

Strategic objective	Strategic risk	Page ref	2023/24			
			Q1	Q2	Q3	Q4
Improve health	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		Y	Y	Y	
	1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision		Y	Y	Y	
	1.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve		Y	Y	Y	
	1.4 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy		A	A	A	
Improve care	2.1 The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives		A	A	A	
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		Y	Y	Y	
	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.		A	A	A	
	2.4 Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience		TBC	A	A	
Improve resources	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		Y	Y	Y	
	3.2 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		Y	Y	Y	
	3.3 Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand, reduced accessibility to services and less efficient service provision		Y	Y	Y	
Make this a great place to work	4.1 Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels.		A	A	Y	
	4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively		Y	Y	Y	

Strategic objective	Strategic risk	Page ref	2023/24			
			Q1	Q2	Q3	Q4
	4.3 Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.		Y	Y	Y	

Key:
Lead Directors: CEO = Chief Executive Officer, DFR = Director of Finance, Estates & Resources, CPO =Chief People Officer, DNQ = Chief Nurse/Director of Quality and Professions, CMO = Chief Medical Officer, DSC = Director of Strategy and Change, COO = Chief Operations Officer, DPD = Director of Provider Development

Committees: AC = Audit Committee, QSC = Quality and Safety Committee EIC = Equality, Inclusion and Involvement Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, WRC = Workforce & Remuneration Committee CC = Collaborative Committee

EMT = Executive Management Team, OMG = Operational Management Group, MC = Members' Council, ORR = Organisational Risk Register

Controls and Assurance inputs: I = Internal, E = External, P = Positive, N = Negative

RAG ratings:

G	= On target to deliver within agreed timescales
Y	= On trajectory but concerns on ability / confidence to deliver actions within agreed timescales
A	= Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales
R	= Actions will not be delivered within agreed timescales
B	= Action complete

Risk appetite:

Strategic risks: Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.	**Risk appetite Open/High**
• Delivering transformational ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services. • Delivering the Trust social responsibility and sustainability strategy in line with the NHS long term and green plans • The risk the Trust fails to innovate and fulfil its strategic ambitions • Ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination	

Strategic objective 1: Improve health	**Lead Director(s)**	**Monitoring and assurance**	**Overall assurance level**				
			2022/23	**2023/24**			
Links to ORR (risk ID numbers): 275, 695, 812,1157, 1511,1624, 1689	As noted below.	EMT, QSC, MHA, Trust Board, CC	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
			Y	**Y**	**Y**	**Y**	
Strategic risks – to be controlled, consequence of non-controlling and current assessment							
Ref	**Description**						**RAG rating**
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**						**Y**
1.2	**Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision**						**Y**
1.3	**Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve**						**Y**
1.4	**Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy**						**A**

Rationale for current assurance level (strategic objective 1: improve health)
• Integrated Care Boards are now in place and strategy refreshes took place in January 2023 • NHS Long Term Plan requires integrated care boards to grow investment in mental health services faster than the NHS budget overall, aligned to specific service requirements that will be common across all districts. • Health & Wellbeing Board place-based plans have been contributed to through board discussions, commented on and where appropriate, agreed. • Active and full membership of Health & Wellbeing Boards. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good and partnership working was acknowledged to be strong • Strong and robust partnership working with local partners, working through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield (boards and committees). • Coordinating provider for West Yorkshire Adult Secure collaborative and lead provider for South Yorkshire Adult Secure collaborative, and partner in provider collaboratives regionally • Coordinating provider for forensic child and adolescent mental health services (FCAMHS) for Yorkshire and the Humber • The Trust is part of the Mental Health Learning Disability & Autism provider collaborative in the South Yorkshire Integrated Care System • A range of executive and board arrangements with trusts, integrated care boards and other stakeholders in each of the places where the Trust operates. • Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong.

Rationale for current assurance level (strategic objective 1: improve health)
• The Trust has been involved in the development of place-based plans and priority setting. • The trust is part of the Provider collaborative established in Calderdale led by CHFT which focusses on climate, social value and integrated neighbourhood teams. • Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield. A similar approach has been developed in Kirklees. The Trust is also a member of the mental health partnership in Barnsley and has a formal alliance agreement in place with Barnsley primary care via the Barnsley Healthcare Federation to strengthen the joined-up community offer. • Stakeholder engagement plans in place. • Friends and Family Test feedback from service users continues with noted variance in areas of low returns and low scores are being explored. Results continue to be triangulated with other feedback. Insight report, and Healthwatch. • Work is taking place in CAMHS to further enhance child and family engagement in Kirklees with a focus on inequalities. • The Trust insight report feeds into the Executive Management Team meeting and Equality, Inclusion and Involvement Committee • Integrated Performance Report (IPR) summary metrics month 8 23/24 - out of area beds – green, children and young people accommodated on an adult inpatient ward – red, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – 85.8%, clinically ready for discharge (previously delayed transfers of care) – red. • Transformation and priority programmes, including the measurement and impact on strategic risks, reported to EMT and Trust Board through the Integrated Performance Report (IPR). In addition EMT receive a monthly priority programme report showing progress against annual objectives. • Internal audit reports. • Patient experience and engagement toolkit in place. • Trust website rated good on Accessible Information Standard. • Trust health inequalities approach developed drawing on the Kings Fund framework and relevant aspects of Core 20 plus 5. • Trust engagement with Barnsley place through place partnership forums and community networks • Clear value proposition for our social prescribing offer in our places. • The Trust continues to improve insight using the new health inequalities and data interactive tool to inform the health inequalities plan. • Comprehensive creative and cultural offer through Creative Minds and recovery colleges in each of our places to diverse communities. • The Trust is playing a key role in developing the West Yorkshire Integrated Care System creative health hub. • Older people's transformation in progress, consultation has started in January 2024. • Compliance with the public sector equality duty. • Approach developed and implemented with Voluntary Community Sector partners in each of our places to strengthen insight involvement and co-production. • Equalities interactive data and insight tool and approach developed. • Mandatory training in place for all staff on equality and diversity. The Trust has completed a review of mandatory training in respect of equality and diversity which will inform future plans. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report to Board on compliance with Equality Delivery System annually. • Mandatory Freedom to speak up training in place for all staff and managers to ensure that any service line issues are raised and addressed early. • Work on waiting lists across the Trust is being carried out with a focus on health inequalities and reports into Finance, Investment and Performance committee quarterly. • Chief allied health professional recruited and in place, this provides enhanced governance and oversight of allied health professional roles. • Chief psychological professional recruited and in place, this role provides leadership and oversight of psychological professions within the Trust. • The Trust is working with partners across all of our places to reduce health inequalities. • Asset based community engagement process developed and introduced to improve engagement with place-based communities. • Waiting list management in SystmOne is complete and waiting list report is presented to the Finance, investment, and performance committee on a regular basis.

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level							
			2022/23		2023/24					
Links to ORR (risk ID numbers): 275, 773, 905, 1078, 1132, 1159, 1424, 1522, 1530, 1545, 1568, 1649, 1650 1757, 1758,1820	As noted below.	EMT, QSC, WRC, Trust Board	Q4		Q1	Q2	Q3		Q4	
			Y	A	A	A	A			

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
2.1	**The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives**	A
2.2	**Failure to create a learning environment leading to lack of innovation and to repeat incidents.**	Y
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.**	A
2.4	**Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience**	A

Rationale for current assurance level (strategic objective 2: improve care)
• A band 7 Speech and Language Therapist has been established to take a lead role in our approach to dysphagia. • Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. • Trust developing overarching operational data quality improvement plan which will be monitored by Improving Clinical Information Group (ICIG) and Operational Management Group (OMG)

Rationale for current assurance level (strategic objective 2: improve care)
• Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 8 shows: Friends & Family (F&F) Test MH – Green F&F Test Community – Green, safer staff fill rates – green, IG confidentiality breaches – green. • Improvement work around the FIRM risk assessment and care planning continues and the impact of work so far is showing positive change in performance. This is being led by a task and finish group. • Waiting list management in SystmOne is complete and waiting list report is presented to the Finance, investment, and performance committee on a regular basis. • Investment in Estates and Facilities and IT infrastructure. The Trust estates strategy is in the process of being updated. • Clinical services monitor OPEL levels to guide our emergency responses Partnership arrangements are at different stages of development in each of the places in which we provide services. • Data quality and improving access to care work is progressing. • Each care group has a data quality work stream. • Improving access to care workstream is in place and reports to the mental health improvement group and includes a review of waiting list work which references health inequalities. • Staff commitment to the Trust values is evidenced through the excellence awards and regularly reviewed as part of the Trust appraisal and supervision process. • Quality Improvement (QI) culture continues to be embedded with a particular emphasis on our learning from QI approach and application in practice of our IHI training. This includes any response to CQC actions. • Themes from serious incident investigations, are identified through the patient safety oversight group (formerly clinical risk panel), and improvements are reported through clinical governance clinical safety committee. • In the main, positive Friends and Family Test feedback from service users. There is noted variance in areas of low returns and low scores, and solutions are being explored to increase the number of responses. Results continue to be triangulated with other feedback, Insight report, and Healthwatch. • Patient Safety Incident Review Framework went live in the Trust on 1 December 2023. PSIRF includes an enhanced analysis of thematic learning as part of the framework. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Regular analysis and reporting of incidents through clinical risk panel, and quarterly analysis of all incidents through the incident management report through Quality and Safety Committee (QSC) and Trust Board. • Development of trust wide arrangements for learning and improving standards, recognised by CQC and NHSE. The Trust has processes in place to capture learning from innovation and change. • Internal audit reports – waiting list management audit and emergency preparedness, resilience and response audits have received significant assurance. • 89% compliance with internal audit actions. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good. • Bed occupancy and patient acuity has been consistently high, particularly in adult acute, psychiatric intensive care units (PICU) and medium secure forensic services. • Freedom to speak up audit completed which received limited assurance. All actions complete and in order to give further independence the role has been moved from the People Directorate to Corporate Governance. • Cyber awareness tested with staff by means of a survey and phishing exercise. E-mail accreditation in place with action plan for 22/23. • Trauma informed organisation steering group is in place with piloted identified teams – senior responsible owners are the chief people officer and chief nurse/director of quality and professions. • “The care group quality and safety report” is presented to all EMT and QSC meetings to provide assurance on the quality impact of operational pressures in care groups. • Care group performance reports provide additional performance information to the Board and are presented in all public meetings. • Medical workforce race equality standard lead (MWRES) being appointed to work with the Trust EDI lead to ensure the Trust is in keeping with national race standards and indicators in the medical directorate.

Strategic objective 3: Improve resources	Lead Director(s)	Monitoring and assurance	Overall assurance level				
			2022/23	2023/24			
Links to ORR (risk ID numbers): 275, 812, 852, 905, 1080, 1114, 1217, 1319, 1368, 1432, 1585	As noted below.	EMT, AC, WRC, Trust Board, FIP	Q4	Q1	Q2	Q3	Q4
			Y	Y	Y	Y	

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
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**	Y
3.2	**Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives**	Y
3.3	**Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand, reduced accessibility to services and less efficient service provision**	Y

Rationale for current assurance level (strategic objective 3: improve resources)
• Financial arrangements are in place for 2023/24 and will remain predominantly on a block basis. Longer term planning due to commence shortly and anticipated to be two years in detail and three years at high level. • Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are on a cost per case and cost and volume basis. Taking a year view this presents a medium level of risk to the Trust. • The Trust has submitted a break-even plan with a 4 % efficiency requirement. • There is sustained acuity and demand leading to ongoing pressure on beds. However, we have seen a decrease in the use of out of area beds which has been sustained for three months. • Internal audit reports – waiting list management audit and emergency preparedness, resilience and response audits have received significant assurance. • Head of internal audit opinion for 22/23 was significant assurance. • Integrated Performance Report (IPR) summary metrics have been updated to reflect the new strategic priorities for 23/24 • Cash balance at month 8 of 2023/24 is £ £74.8m. • Partnership arrangements are established within each place. • Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place.

Rationale for current assurance level (strategic objective 3: improve resources)
• Lead provider collaboratives for forensics, CAMHS and eating disorders in West Yorkshire are established. The South Yorkshire and Bassetlaw adult secure lead provider collaborative went live in May 2022The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region which went live on 1 April 2023. • Mental health investment standard and other recent income growth continues to support our financial position. At present, all places continue to invest to a level compliant with MHIS. The Trust is in the process of agreeing final contracts as a provider. • Inflationary pressures are challenging for revenue and capital planning. Reviews are under way to consider mitigating actions. • Updated priority programmes for 2023-24 are aligned to strategic objectives and will be monitored as part of the IPR reporting. • Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. • The Trust has an approved digital strategy, due for renewal in 24/25. • Capacity has been obtained to progress Digital dictation in the Trust and is on track for delivery during 23/24 Standing financial instructions and scheme of delegation approved by Trust Board (January 2023) and Members Council (February 2023). • On track to deliver 23/24 break even financial plan.

Strategic objective 4: Make this a great place to work	Lead Director(s)	Monitoring and assurance	Overall assurance level				
			2022/23	2023/24			
Links to ORR (risk ID numbers): 1151, 1157, 1614, 1729	As noted below.	EMT, WRC, Trust Board	Q4	Q1	Q2	Q3	Q4
			A	Y	Y	Y	

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
4.1	**Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels**	Y
4.2	**Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively**	Y
4.3	**Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies**	Y

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Vacancies in key areas – vacancy levels across clinical functions • Increased use of bank in preference to agency and use of medical locums to manage current level of vacancies. • Agency scrutiny group is in place to monitor and reduce agency spend across the Trust. • Staff turnover rates have stabilised but vary between care groups and service lines with turnover in inpatient areas presenting the highest numbers. The Trust benchmarks well against peer organisations. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good. • Changes to the Integrated Performance Report (IPR) to improve oversight and of workforce data at both Board and Board Committee level. • Staff survey has been completed for 2023 and the results will be released in spring 2024. The Trust in comparison to similar local organisations is in a relatively positive position. • The exit process for leavers from the Trust has now been revised following an internal audit process. Outcomes of exit interviews are reported into PRC. • The Trust now has a full and substantive board including both executive and non-executive roles and new associate non-executive director. • The Trust is reviewing its development programme across all levels of leadership and management. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • A range of staff networks are in place including REACH Race, Equality and Cultural Heritage (formerly BAME), LGBT+, disabilities, staff side and working carers. Staff networks attend at Board on rotation and all network meetings are attended by representatives of the People directorate. • Full-time lead Freedom to Speak up Guardian is in post and annual report is taken through PRC. A freedom to speak up steering group has been developed that will now report into PRC. Additional freedom to speak up guardians have been appointed (three posts) • Freedom to speak up mandatory training in place for all staff and managers to ensure that any service line issues are raised and addressed early. • Clear roles communications are in place for Equity guardians, FTSU champions, Staff Side champions and RESPECT champions. • The Trust continues to build on and improve a positive partnership with Staff side, including fortnightly formal meetings with the People Director and bi-monthly trust partnership forums including members of EMT. • Open and just culture approach has resulted in reduced disciplinary and other formal casework across the Trust. • Year to date recruitment continues with 513.2 WTE starters since April 2023. • The inclusive leadership programme development was commissioned in May 2023, and a planned event to took place in November with extended EMT. A series of engagement events have now taken place across the Trust with recommendations and actions being formulated for early 2024. • A full-time diversity and inclusion lead in post to support diversity and inclusion across the Trust. • Staffing levels are being maintained through the real time monitoring and deployment of staff across functions to ensure safety for all services. • The appraisal window has been widened to ensure more flexibility for the appraisal process, particularly for those in front line services. • Values based recruitment and appraisal processes are embedded within the Trust. • Regular engagement between the chief people officer and staff governors to ensure staff voice is represented and gather insight into staff experience. • OD and wellbeing facilitator is in post from 11 September 2023 to support and improve staff experience within the Trust. • Board development programme now in place for 23/24 which is driven by Trust values and recognises the Boards duty to lead and role model behaviours and culture. • Trust values are embedded in appraisal and leadership development programmes across the Trust.

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Trust Board discussions are consistently linked to the Trusts values, and all Board members are encouraged to challenge themselves and each other to lead through values, and model Trust behaviours

Strategic 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

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4, 2.4
C02	Operational Management Group (OMG) meetings identify and rectify performance issues and learn from good practice in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire and South Yorkshire mental health, learning disability and autism collaborative and associated workstreams. (I, E)	DPD/DSC	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC/DPD	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR/DPD	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C07	Director lead in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C08	Formal contract negotiation meetings with integrated care boards, NHSE boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are in place for 2023/24 with actions in place (I, E)	DNQ	1.1, 1.4, 3.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	CEO	1.1
C12	Partnership Fora established with staff side organisations to facilitate necessary change. (I)	CPO	1.1
C13	Priority programmes supported through programme/change management approach. (I)	DSC	1.1
C14	Project Boards for change programmes and work streams in place, with appropriate membership skills and competencies, project plans, project governance, risk registers for key projects in place. (I)	DSC	1.1, 1.2
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C16	Operational leadership arrangements provide a link to each place and have oversight of service pathways to minimise unwarranted variation. (E)	COO	1.1
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in SY provider alliance. (I, E)	DSC	1.1, 1.4
C18	Meetings with Healthwatch organisations in each place. (E)	DSC	1.1
C19	Process and approach in place to support formal consultation on the Trust's strategic direction. (I, E)	DSC	1.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Quality and Safety Committee and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1,2, 1.3
C126	Commissioning intentions are factored into operating plans as part of the planning process aligned to national guidance. (P, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities (P, N, I).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	COO	1.1, 1.2, 3.1, 3.2
C168	The Executive Management Team (EMT) have reviewed key internal and external meetings to make sure the Trust has effective representation as required. (I, E, P)	DSC	1.1
C181	Operational and Care Group structures are in place to reflect care pathways (I,P)	COO	1.1
C187	Governance arrangements are in each place in both West and South Yorkshire integrated care systems, and in place. These will be subject to effectiveness reviews when required.	DSC/DPD	1.1
C201	South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative now in place. Operating in private and meetings to be public for January 2024	DSC/DPD	1.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In response to the need for ICS's to make a 30% savings to running costs, consultation processes with ICB staff have now commenced. In addition, re-structuring at NHS England is taking place with an aim to reduce its own running costs by 40%, and the potential to impact on the Trust's ability to achieve its strategic objectives and service provision across places will need to be reviewed when the consultation process is complete and cost savings achieved. Reviewed in January 2024 to be reviewed further in April given the external political environment. To review for further update in January 2024.	April 2024	DSC/DPD
Levels of engagement with primary care networks could differ by place and lead to inconsistent development of services. The Trust is working in partnership to develop the detail of the local transformation development plan. We continue to work with primary care networks in each of our places to harness the benefits of the Additional Roles Reimbursement Scheme (ARRS) mental health practitioners implemented in each place. This is within the context of mental health community transformation in each place. Regional and national conversations are taking place regarding modelling and implementation. The Trust will continue to engage with primary care through the community transformation programme and place based integrated care forums. Reviewed in January 2024, Work continues further update to be provided in April 2024.	April 2024	DSC/DPD
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight... Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. To review again in April 2024.	April 2024	DSC/DPD/COO

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.. (I) (P)	DSC	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. An annual report is now received directly by QSC. Quality monitoring visits programme in place for 2023/24 are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A16	Update reports on WY and SY ICS progress.	Routine report into EMT and Board. (P) (I)	DSC/DPD	1.1
A17	Update reports from Barnsley, Calderdale, Kirklees, and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (P, N) (I)	DSC / DPD	1.1, 1.2
A19	Proactively involved as a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated to Trust Board (P) (I, E)	DPD / DSC	1.1
A20	Reports are reviewed by EIIC, QSC and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision

Controls (strategic risk 1.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4, 2.4
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C07	Director lead in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C14	Project Boards for change programmes and work streams in place, with appropriate membership skills and competencies, project plans, project governance, risk registers for key projects in place. (I)	DSC	1.1, 1.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Quality and Safety Committee and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C22	Operations management structure reflects an approach to ensuring consistent delivery of services. (I)	COO	1.2
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS Older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities.	CMO	1.2/1.3
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1,2, 1.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. This is focussed on a place-based planning approach overseen by the introduction of integrated care board (ICBs) (P, E, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C140	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – monthly meeting with CQC local relationship manager and quarterly engagement meetings between DNQ & CQC. (P) (I)	DNQ	1.1 1.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meeting take place between Chief Executive and Directors. (P) (I)	CEO	All
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities. (P, N, I).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	COO	1.1, 1.2, 3.1, 3.2
C149	Operational structure includes oversight of pathways across the organisation that reach into each place. Stakeholder analysis updated November 2023. (P, N, I).	DSC/COO	1.2
C190	Place based plans in place and the Trust has been fully engaged in the planning process	DSC/DPD	1.2
C193	Alignment of Trust plans with Integrated Care Boards and alignment of operational and quality plans through place governance structures	DNQ/DPD	1.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
	directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.			
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. An annual report is now received directly by QSC. Quality monitoring visits programme in place for 2023/24 are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A17	Update reports from Barnsley, Calderdale, Kirklees, and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (P, N) (I)	DSC/DPD	1.1, 1.2
A20	Reports are reviewed by EIIC, QSC and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance reports (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Patient Safety Oversight Group (formerly Clinical Risk Panel) including the undertaking proportionate investigations and dissemination of lessons learnt and good clinical practice across the organisation. PSIRF is in place from 1 December 2023.	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Quarterly Incident Management report" which includes learning from serious incidents (P, N) (I)	DNQ	1.2, 2.2
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN quality performance is monitored through Clinical Governance Group (CGG)	Monthly Integrated Performance reporting (IPR) to CGG, EMT, Finance, Investment & Performance Committee and QSC and Trust Board. (P, N) (I).	DNQ	1.2, 3.1, 3.3
A26	Great place to work strategy completed in line with national people plan in April 2021	Signed off by Trust Board in April 2021. Update reports into EMT and People & Remuneration Committee. (P) (I)	CPO	1.2
A85	The delivery plan for the Great Place to Work strategy including the OD agenda has presented to and approved by PRC for 23/24.	Updates on delivery of the plan will be provided at every PRC meeting and will be provided to Trust Board through the triple A report (P,N,I)	CPO	1.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
The planning process for 23/24 is complete and the Trust will now begin to look at longer term planning for years two and three for 24/25 and 25/26. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of the pandemic including recovery and restoration, inequalities, and capital planning. Finance is working up a three-year long term financial plan (LTFP) which will come back through FIP and Board. The Trust is looking to align its medium-term financial plan with the West Yorkshire ICS timetable and assumptions. Reviewed regularly through FIP. Currently it is anticipated that the Trust will have a LTFP in place by Q1 2024/25 to align with the integrated care system, this will be subject to national planning guidance timelines.	April 2024	DFR
The new people directorate structure is in place but gaps within the people directorate could pose a risk to both achievement of outcome and timescales. New staff started in post during Q2 and they continue to progress through their induction process and forming part of a cohesive leadership team.	April 2024	CPO

Strategic risk 1.3
Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C07	Director lead in place to support revised service offer through priority programmes and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C23	Strategic priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework. (I)	DSC	1.3
C24	All non-training grade senior medical staff participate in a job planning process which reviews priority areas of work against strategic objectives for senior clinical leaders. (I)	CMO	1.3
C25	Participate in national benchmarking activity for mental and community health services and act on areas of significant variance. (I)	DFR	1.3
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I,E)	DSC	1.3, 1.4
C27	Governors supported to involve people at a locality level, Toolkit in place. (I, E)	DSC	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DSC	1.3, 1.4
C29	Process in place to demonstrate compliance with the public sector equality duty. (I)	DSC	1.3
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee. (I)	DSC	1.3, 1.4
C31	Joint Needs Assessment (JNA) data reflected in all service EIAs. (I)	DSC	1.3, 1.4
C32	JNA data used to identify involvement approaches. (I)	DSC	1.3
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DSC	1.3
C34	Provision of information, leaflets, and posters which meet the Accessible Information Standard. (I)	DSC	1.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.3
C38	Trust website rated good on Accessible Information Standard. (P, I, E)	DSC	1.3, 1.4, 2.4
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS Older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities.	CMO	1.2/1.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	DFR	1.1, 1,2, 1.3
C127	Communication leads network established in places and across ICSs (P, I, E)	DSC	1.3
C128	Senior level representation at Health & Wellbeing Boards in each place. (P, E)	DSC	1.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DSC	1.3
C130	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication. (P, I, E,)	DSC	1.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.3
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Director of Finance, Estates and Resources and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DFR	1.3, 2.1
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities. (P, N, I, E).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C162	CHATpad is a tablet available on every Trust ward which allows for communication with a loved one, carer, friend, staff member or advocate via zoom and is used to capture patient views using an online survey. The use of tablets is promoted to patients, visitors, carers and advocacy services to retain contact and improve communication. (P, I)	DSC	1.3
C163	Approach to capturing insight and service user feedback from a range of stakeholders in place (insight report) (P, E, I)	DSC	1.3
C164	The EIA tools have been created, including the Trust wide EIA and literature (P, I)	DSC	1.3
C170	Data collection is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard has been established and continues to develop insight and ensure this is used to inform improvements and service change including the development of Equality Impact Assessments (EIA's) (I,E,P,N)	DSC	1.3
C171	Health Intelligence support role in place (I, P)	DSC	1.3
C184	Targeted programmes are being delivered through linked charities (I, E, P)	DSC	1.3
C199	Partnership group established as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	1.3

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Data collection is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard is now being used and continues to develop insight to ensure improvements and service change are now taking place thorough case studies. Service improvement work continues to use EIA insight to support the approach. Operational teams now have access to the BI intelligence that supports the Trust Dashboard and work continues to evolve.	July 2024	DSC

Assurance (strategic risk 1.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A20	Reports are reviewed by EIIC, QSC and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P,N,I)	DSC	1.3,2.1
A91	West Yorkshire older peoples mental health work stream steering groups provides updates	Regular updates from the steering are presented to West Yorkshire mental health learning disability and autism board (P/N/E)	CMO	1.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
The Trust is now rolling out the enhanced equality and diversity training to all senior staff identified as essential to job role. This training is in month 6 of a 12 month roll out period. This is being led by the equality and involvement team. Equality impact assessment (EIA) training continues Review further in January 2025.	July 2024	DSC

Strategic risk 1.4 **Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy**

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4,2.4
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire and South Yorkshire mental health collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC	1.1, 1.4, 2.3
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C08	Formal contract negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are in place for 2023/24 with actions in place (I, E)	COO	1.1, 1.4, 3.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C17	Member of South Yorkshire mental health, learning disability and autism programme board. Partner in emerging SY provider alliance. (I, E)	DSC	1.1, 1.4
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Quality and Safety Committee and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I, E)	DSC	1.3, 1.4
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DSC	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DSC	1.3, 1.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee (I)	DSC	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DSC	1.3, 1.4
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.3, 1.4, 2.4

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C37	Equality, Inclusion and Involvement Committee and sub-committee in place. (I)	DSC	1.4
C38	Trust website rated good on Accessible Information Standard. (I)	DSC	1.3, 1.4
C40	Photo symbol package available to staff. (I)	DSC	1.4
C41	Patient experience and engagement toolkit in place. (I)	DSC	1.4
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C148	All services have a baseline Equality Impact Assessment (EIA) in place. (P) (I)	DSC	1.4
C185	Improving access to care priority programme established (P, I)	DSC	1.4
C186	Dashboard and business intelligence tools in place to help address health inequalities	DSC	1.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In response to the need for ICS's to make a 30% savings to running costs, consultation processes with ICB staff have now commenced. In addition, re-structuring at NHS England is taking place with an aim to reduce its own running costs by 40%, and the potential to impact on the Trust's ability to achieve its strategic objectives and service provision across places will need to be reviewed when the consultation process is complete and cost savings achieved. Reviewed in January 2024 to be reviewed further in April givent he external political environment. To review for further update in January 2024.	April 2024	DSC/DPD
Health inequalities data and analytics are now available. The next stage of development is to educate to use the best to inform service change and development and building feedback processes to reflect and improve. In line with gaps in control and assurance for risk 1.3 to review further in July 2024..	July 2024	DSC/DPD

Assurance (strategic risk 1.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A20	Reports are reviewed by EIIC, QSC and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Patient experience service reports to Trust Board (annual) and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy review updates report into QSC Committee.	Routine reports into QSC via IPR and annual report scheduled in 2023/24 work plan. Quality strategy published March 2023. (P) (I)	DNQ	1.4, 2.3
A35	Equality interactive tool presented to Equality, Inclusion, and Involvement Committee	Regular reports and papers provided. (P) (I)	DSC	1.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 2.1

The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives

Controls (strategic risk 2.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C42	Access to the model hospital to enable effective national benchmarking and support decision making. (E, I)	DFR	2.1
C43	Development of data warehouse and business intelligence tool supporting improved decision making. (I)	DFR	2.1
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and yearly report to Trust Board. (I)	DFR	2.1
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.1

Controls (strategic risk 2.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly incident risk scan through the Patient Safety Oversight Group where all red, amber, staffing related, and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 4.1
C48	Improving Clinical Information & Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.1
C49	Internal process to impact assess and review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.1
C50	Change control process in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR	2.1
C51	National benchmarking data is reviewed at the benchmarking group and then analysed and taken to OMG, EMT and Finance, Investment & Performance Committee. (I)	DFR	2.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Chief Operating Officer and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DFR	1.3, 2.1
C172	Data quality and waiting list management project lead in post from December 2021 (I, P)	DFR	2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Substantive funding has been secured to continue rolling out and managing SystmOne waiting lists across the Trust. Recruitment has commenced for a substantive waiting list lead to ensure the continued development and monitoring of waiting list management across the Trust. The majority of teams that require waiting list functionality now have this in place and reporting is now being utilised by care groups to manage waiting lists. Further review in April 2024.	April 2024	DFR

Assurance (strategic risk 2.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A37	Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested.	Included in monthly IPR to OMG, EMT and Trust Board. Regular reports to Audit Committee. (P) (I)	DNQ/DFR	2.1
A38	Progress against SystmOne optimisation reviewed by Clinical Safety Design Group, EMT and Trust Board.	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. (P) (I)	DNQ	2.1
A39	Quarterly Board Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly risk register reports to Board. Triangulation of risk, performance, and governance present to each Audit Committee. (P) (I)	DFR	2.1
A40	Data quality focus at OMG and ICIG which is reported into EMT and QSC. Data quality is also referenced in the Brief	Regular agenda items and reporting of at ICIG and OMG. (P, N) (I)	DNQ/COO	2.1
A41	Benchmarking reviews and deep dives conducted at Finance, Investment and Performance Committee.	Reports provided regularly. (P) (I)	COO / DFR	2.1
A42	OMG management and governance processes.	OMG minutes taken into EMT on a regular basis. (I) (P)	COO	2.1
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P,N,I)	DSC	1.3, 2.1, 2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 2.2
Failure to create a learning environment leading to lack of innovation and to repeat incidents.

Controls (strategic risk 2.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	2.2, 2.4, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C55	Quality Strategy is in place achieving balance between assurance and improvement. (I)	DNQ	2.2

Controls (strategic risk 2.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C57	Leadership and management arrangements established and embedded at Care Group and service line level with key focus on clinical engagement and delivery of services. (I)	COO	2.2, 4.1
C58	Learning lessons reports, are shared across Care Groups, including post incident reviews, and are included in quarterly and annual incident management reports. (I)	DNQ	2.2
C59	Risk Management Governance Framework in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	CEO/DFR	2.2
C60	Weekly serious incident summaries to Executive Management Team (EMT) supported by monthly reports to OMG, quarterly reports to Quality and Safety Committee and Trust Board. (I)	DNQ	2.2
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DSC	2.2
C139	Process established for the use of improvement case studies which are then shared by the communications team and published on the Trust website. (P, I)	DSC	2.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C161	Learning from innovation process through use of SBAR structure to create short learning case studies which are shared with all staff via the Trust headlines (P, I)	DSC	2.2
C173	The use of external experts for serious incident investigations and reviews when appropriate (P, N, I, E)	DNQ	2.2
C174	Internal audit report received demonstrating significant assurance against SI action planning (November 2022) (P,I,E)	DNQ	2.2

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**

Assurance (strategic risk 2.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Patient Safety Oversight Group (formerly Clinical Risk Panel) including the undertaking proportionate investigations and dissemination of lessons learnt and good clinical practice across the organisation. PSIRF is in place from 1 December 2023.	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Our Learning Journey Report" (P, N) (I)	DNQ	1.2, 2.2
A44	Risk scan update into each EMT meeting.	Risk scan update into EMT meeting. (P, N) (I)	DNQ	2.2
A45	Assurance reports to Quality Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	Routine report to each Quality Committee of risks aligned to the committee for review. (P) (I)	DNQ	2.2
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.2, 4.1
A47	Examples of co-production in recovery colleges and Creative Minds	Reports to CFC and to Corporate Trustee for Charitable Funds. Creative Minds produce reports that go to CFC and recovery colleges report into OMG. (P, I)	DSC	2.2
A48	Inpatient structure provides assurance of operational grip in relation to record keeping.	Routine matron checks reported through Care Group governance groups and in governance report to QSC. (P) (I)	COO	2.2
A51	Action planning from the assurance paper in relation to the Panorama and Dispatches	Reports go into the clinical governance group (CCG), EMT and then QSC	DNQ	2.2
A57	Learning from the East Kent review of maternity services has been incorporated into broader patient safety structures	Reported via the Care Group Quality and Safety Report into QSC	DNQ	2.2
A90	A Trustwide approach to shared decision making and co-production is in place to support the delivery of personalised care and innovation in response to NICE guidance (NG197). An action plan is in place.	Reports into EIIC, and QSC (E, I, P)	DNQ	2.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Quality and Safety Committee (QSC) and the clinical governance group continue to monitor the embedding of learning from SI action plans. The committee monitors the development of reports to evidence the link between the incident and the learning and further review will take place in April 2024.	April 2024	DNQ
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR risk 852). Bespoke and ad-hoc training was re-introduced from January 2023. Comms campaigns, action plans and thematic reviews continue. Fluctuating numbers of incidents are being reported with no real trend identified. The cause of most incidents continues to be information disclosed due to human error and a comms campaign is continuing to address this. Mandatory training standard of 95% was achieved for the submission of the data security and protection toolkit for 30 June 2023, and continues to be monitored (currently 93.86%). As part of the information governance communications campaign stories with associated learning are communicated via the intranet to help all staff understand the real impact of information governance breaches.	April 2024	DFR
Work on the inpatient priority programme is underway and is using learning to improve safe and effective care delivery, this is part of the priority programme for 23/24. The work is required in order to align the Trust with the national and regional inpatient Quality Transformation Programme for Mental Health, Learning Disabilities & Autism transformation.	April 2024	COO

Strategic risk 2.3
Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care.

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3, 2.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC/DPD	1.1, 1.4, 2.3, 2.4
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 2.4, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3, 2.4
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3, 2.4
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3,2.4, 4.1,4.2 4.3
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3, 2.4
C47	Weekly incident risk scan through the Patient Safety Oversight Group where all red, amber, staffing related, and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 2.4, 4.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3, 2.4
C63	Care Closer to Home Partnership Meeting includes a group established as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	2.3
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.3, 2.4
C65	Safer staffing policies and procedures in place to respond to changes in need. (I)	DNQ	2.3, 2.4
C66	TRIO management system monitoring quality, performance, and activity on a routine basis. (I)	COO	2.3, 2.4
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	CPO	2.3, 2.4
C68	Targeted improvement support in place to deliver waiting list management improvement plans to support people awaiting a service / treatment. A workstream for Improving Access to Care is focussing on improving the way that we reduce waits, increase access and reduce inequalites. This reports through the priority programmes. (I) (ORR 1078, 1132)	COO	2.3, 2.4
C69	Process to manage the CQC action plan. (I)	DNQ	2.3, 2.4
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C142	Healthwatch provide external assurance on standards and quality of care. (E) (P) (N)	DNQ	2.3, 2.4
C145	Service user survey results reported to Quality and Safety Committee and Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3, 2.4
C160	Operations leadership have implemented frequent inpatient staffing meetings to ensure inpatient wards are staffed safely and staff redeployed according to need (P, I)	COO	2.3, 2.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight. Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. To review again in April 2024.	April 2024	DSC/DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust currently does not have safer staffing establishments in place for community services, this is being developed as part of the community services transformation programme. Update was included in the six-monthly safer staffing paper that went to April Board. The safer staffing report went to QSC in November 2023, and it was agreed to be deferred for presentation to January Board (2024) to enable further assurance to be incorporated into the report including community safer staffing.	April 2023	DNQ

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. An annual report is now received directly by QSC. Quality monitoring visits programme in place for 2023/24 are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A33	Patient experience service reports to Trust Board (annual) and QSC.	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy review updates report into QSC Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2023/24 work plan. Quality strategy published March 2023. (P) (I)	DNQ	1.4, 2.3
A49	CQC self-assessment process.	Reviewed by EMT as part of preparation for CQC inspection process. (I)	DNQ	2.3
A80	Healthcare inequalities dashboard	OMG, EMT and EIIC and EIIC sub committee reviewed also included in IPR. Reviewed by Improving access to care group to focus on activity but allows trends over time to be identified (I) (P)	DSC	2.3
A81	CAMHS referral monitoring	CAMHS governance group monitors referrals numbers to monitor pressure on core CAMHS services (P) (N) (I) (E)	COO	2.3
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P, N, I)	DSC	1.3, 2.1, 2.3
A88	Mental health oversight group is in place to monitor the improving care priority programmes. The internal oversight group operates within the Trust and reports into EMT but work is shared with the partnership group for support and challenge with feeds back into the Trust.	This group reports into EMT on a monthly basis (P, N, I)	COO/DNQ	2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Care Closer to Home work continues, with r focus on patient flow and discharge, including continuing the principles of the national one hundred day discharge challenge. Spikes in demand are still present and these are closely managed, and patients are repatriated to their local areas where possible. Complaints and incidents are monitored by the service line which is Trust wide. Thus, acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. Additional funding to support discharge packages continues to be available in each place. The use of out of area usage remains an area of focus with improvements noted in August and September. The gap will remain until evidence of sustained reduction is seen. Care closer to home has resulted in a reduction in Trusts out of area bed use. The current gap in assurance is whether the Trust is able to maintain this position in the long term. Additionally, work is taking place to provide assurance in relation to the impact on other service areas as a result of reducing out of area placements. Review in April 2024.	April 2024	COO
Specific demand for children's neurodevelopmental (ADHD.ASD) assessments in Calderdale and Kirklees exceeds capacity. Resources have been agreed with commissioners to try and improve the position. Additional support is in place form an external partner. Demand continues to rise beyond commissioned capacity. Demand and capacity with commissioners is being revisited. In all areas demand for adult ADHD services is beyond commissioned capacity, this is in line with the national picture. Work is taking place in each ICS to understand the rising demand and agree how this can be addressed. On 4 December the West Yorkshire ICS hosted an autism summit and next steps are being established. Review in April 2024.	April 2024	COO

Strategic 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

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4,2.4
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 2.4, 4.1,4.2 4.3
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Quality and Safety Committee and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4, 2.4
C26	Community reporting is available as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I,E)	DSC	1.3, 1.4, 2.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee. (I)	DSC	1.3, 1.4, 2.4
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DSC	1.3, 2.4
C34	Provision of information, leaflets, and posters which meet the Accessible Information Standard. (I)	DSC	1.3, 2.4
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.3, 1.4, 2.4
C47	Weekly incident risk scan through the Patient Safety Oversight Group where all red, amber, staffing related, and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 2.4, 4.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	2.2, 2.4, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 2.4, 4.1
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	2.4, 4.1, 4.3
C115	Appointment of diversity and inclusion belonging lead established as part of the Trust's overall leadership and management development arrangements. (I)	CPO	2.4, 4.2
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.3, 2.4
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed March 2022 with future board development programme being established. (P,I)	CPO	2.4, 4.2
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.3, 2.4
C155	Trust Board engagement with staff networks (P, I)	DSC	2.4, 4.2
C156	Appointment of Freedom to Speak up Guardians, Equity Guardians, Civility and respect champions, and diversity and inclusion lead roles (P, I)	CPO	2.4, 4.2
C157	Values based recruitment processes in place (P, I)	CPO	2.4, 4.2
C158	Values based appraisal system (I,E,P,N)	CPO	2.4, 4.2
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	CPO	2.4, 4.2
C188	The great place to work strategy acknowledges the diversity challenge in senior roles across the Trust for 23/24 (P,N,I,E)	CPO	2.4, 4.2
C189	Trust Board development programme in place for 23/24 led by the Chief People Officer building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives (P, I, E)	CPO	2.4, 4.2
C191	Trust medical appraisal and revalidation process aligns to general medical council report (Fair to refer 2019)	CMO	2.4
C194	Waiting list management in SystmOne is in place	DSC	2.4
C195	Patient Safety Oversight Group (formerly risk panel) (executive trio membership) receive information on all incidents referencing protected characteristics, irrespective of incident grade. (P) (N) (I)	CMO/DNQ/COO	2.4
C196	Micro aggression guidance is in place, which includes reference to all protected characteristics	DSC	2.4

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**

Assurance (strategic risk 2.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A20	Reports are reviewed by EIIC, QSC and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4, 2.4
A33	Patient experience service reports to Trust Board (annual) and QSC.	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3 2.4
A35	Equality interactive tool presented to Equality, Inclusion, and Involvement Committee	Regular reports and papers provided. (P) (I)	DSC	1.4, 2.4
A74	Staff wellbeing survey results reported to Trust Board and / or People & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	2.4, 4.1, 4.2, 4.3
A78	Continuing international recruitment and the development of new roles as part of increasing workforce supply. Virtual international recruitment portal signed off by EMT. Establishment of new roles group to look at development of new clinical roles.	Reported into PRC Committee (P,I)	CPO	2.4, 4.1, 4.3
A80	Healthcare inequalities dashboard	OMG, EMT and EIIC and EIIC sub committee reviewed also included in IPR. Reviewed by Improving access to care group to focus on activity but allows trends over time to be identified (I) (P)	DCS	2.3, 2.4
A84	Health inequalities data with support from staff network groups to be used to improve understanding of staff groups	Reported to the Improving Clinical Information Group (ICIG). As part of WRES and WDES, presented to PRC and Trust Board annually. (P) (I) (E)	CPO	2.4, 4.3
A87	Flair survey completed to provide insight into staff experience of inclusion and diversity matters in a timely fashion	Analysis and actions to be monitored by PRC (P,N,I)	CPO	2.4, 4.2
A89	Waiting list report including analysis in relation to protected characteristics	Reported into FIP committee (I, E, P, N)	DSC	2.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight... Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. To review again in April 2024.	April 2024	DSC
A high-level action plan is required to address themes which link to work already in place and clarifies how to progress the rating of this risk from amber to yellow. There is a requirement to continue with actions identified within current plans, including the equality, diversity and inclusion action plans, and people directorate plans.	April 2024	DSC
Following a meeting between the executive trio and international nurse recruits, it has been identified that more work and support is needed to successfully integrate international nurses into Trust teams and ways of working. A working group has been established by the deputy director of nursing, quality and professions which will report into EMT, and PRC. The group is developing training and learning materials to improve clinical skills and knowledge in terms of care planning, risk assessments, and the application of the mental health act.	April 2024	DSC
In addition, the above People business partners are assisting clinical teams to improve the integration and experience of international nursing colleagues.	April 2024	DSC

Strategic 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

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C79	Finance managers aligned to Care Groups acting as integral part of local management teams. (I)	DFR	3.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	3.1
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	3.1
C82	Annual financial planning process, cost improvement programmes (CIP) and Quality Impact Assessment (QIA) process. (I)	DFR, DNQ	3.1
C83	Financial control and financial reporting processes. (I)	DFR	3.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	3.1
C85	Patient level costing now in place. First national submission made December 2023 (E, I)	DFR	3.1

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of finance and performance on a rotational basis (I)	COO	3.1, 3.2
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	3.1, 3.3
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DSC	3.1, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	COO	1.1, 1.2, 3.1, 3.2
C197	The Trust is aligned to the NHSE/ICB framework for enhanced financial controls.	DFR	3.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Trust has previously not fully achieved its recurrent CIP targets (Linked to ORR risk 1076). The Trust needs to have a fully developed CIP plan for 23/24 including QIA. CIP challenge for 23/24 is currently expected partially through non-recurrent measures. Plans need to progress to identify further recurrent schemes. Work is ongoing on value for money schemes in order to create financial efficiency – gap remains until the schemes are in place and delivering. Reviewed in January 2024.	April 2024	DFR / COO

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG)	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and QSC and Trust Board. (P, N) (I).	COO	1.2, 3.1, 3.3
A58	Monthly focus of key financial and performance issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG (P, N) (I)	COO	3.1, 3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Care Closer to Home work continues, with r focus on patient flow and discharge, including continuing the principles of the national one hundred day discharge challenge. Spikes in demand are still present and these are closely managed, and patients are repatriated to their local areas where possible. Complaints and incidents are monitored by the service line which is Trust wide. Thus, acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. Additional funding to support discharge packages continues to be available in each place. The use of out of area usage remains an area of focus with improvements noted in August and September. The gap will remain until evidence of sustained reduction is seen. Care closer to home has resulted in a reduction in Trusts out of area bed use. The current gap in assurance is whether the Trust is able to maintain this position in the long term. Additionally, work is taking place to provide assurance in relation to the impact on other service areas as a result of reducing out of area placements. Review in April 2024.	April 2024	COO

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Increasing expenditure on staffing in inpatient wards with spend higher than income. This remains an issue as we progress through 23/24 due to the Trust maintaining safety and quality on inpatient wards where acuity and demand remains high. Quality and safety remain priorities in line with Trust values. Establishment review has been completed. Reviewed in January 2024 and a further update will be provided in April 2024	April 2024	DFR

Strategic risk 3.2
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.

Controls (strategic risk 3.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are in place for 2023/24 with actions in place (I, E)	COO	1.1, 1.4, 3.2
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of	COO	3.1, 3.2
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	3.1, 3.2
C94	Agreed Trust workforce plan in place which identifies staffing resources required to meet current and revised service offers. Also describes how we meet statutory requirements re training, equality, and diversity. (P, N), (I)	CPO	3.2
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.2
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.2
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	3.2
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR/DPD	3.2
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2023-24 priorities. (P), (I)	DSC	3.2
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	COO	1.1, 1.2, 3.1, 3.2
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P,I)	DSC	3.2
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P, I)	DSC	3.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is to review its workforce plan over 2023/24 aligned to joint work between Finance and People directorates to review establishment. As part of the work for the 23/24 operational and finance plan the finance, operations and people leads will work to develop a revised plan for 23/24 to mitigate this risk. Work is ongoing to establish the most effective way to compare finance establishment and workforce data. This is a longer term work plan for review in April 2024.	April 2024	CPO/COO/DFR

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee and are received at Board half yearly. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG)	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and QSC and Trust Board. (P, N) (I).	COO	1.2, 3.1, 3.2
A58	Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG and Finance, Investment & Performance Committee. (P, N) (I)	COO	3.1, 3.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**

Strategic risk 3.3 **Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand, reduced accessibility to services and less efficient service provision**

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C36	Improving access group and improving equalities groups are in place to ensure services are inclusively locking in innovation.	DSC/DPD/COO	1.4,3.3
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and yearly report to Trust Board. (I)	DFR	2.1,3.3
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2,3,3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.2,3.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.2,3.3
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	3.2,3.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR	3.2,3.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2020-22 priorities. (P), (I)	DSC	3.2,3.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	3.2,3.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1.2, 1.3. 3.3
C134	Workforce strategic groups established and is being reviewed alongside the new operational model and people directorate structure. (P, I)	DHR	2.3, 3.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC	3.2, 3.3
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P,I)	DSC	3.2 3.3
C169	Digital Strategy and Innovation Group meets quarterly to assess potential new and emerging digital opportunities (P, I)	DSC	3.3
C200	Creativity and creative practitioner roles have been implemented in inpatient services with positive initial outcomes. (I, P)	DSC	3.3

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**

Assurance (strategic risk 3.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	1.2, 3.1, 3.2, 3.3
A75	Digital Strategy updates presented to Trust Board	Reports into Trust Board bi-annually (P, I)	DFR	3.3
A79	EMT assurance against the Trust position and actions relating to emerging national priorities and digital maturity in line with Trust Digital Strategy	Reports presented to EMT and OMG, as required, through 23-24 (P,I,E)	DFR	3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 4.1

Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels

Controls (strategic risk 4.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly incident risk scan through the Patient Safety Oversight Group where all red, amber, staffing related, and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 4.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	2.2, 2.4, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C57	Leadership and management arrangements established and embedded at Care Group and service line level with key focus on clinical engagement and delivery of services. (I)	COO	2.2, 4.1
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme which is currently under review. (I)	CPO	4.1, 4.2
C102	Annual learning needs analysis undertaken linked to service and financial plans. (I)	CPO	4.1
C103	Established education and training governance group agrees and monitors annual training plans. (I)	CPO	4.1, 4.2
C104	Human Resources processes in place ensuring defined job description, roles, and competencies to meet needs of service, pre-employment checks done re qualifications, DBS and work permits. (I)	CPO	4.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	DNQ	4.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	CMO	4.1
C107	Great place to work strategy annual delivery plan approved by PRC (March 2023)	CPO	4.1
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	2.4, 4.1, 4.3
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies, and procedures. (I)	CPO	4.1

Controls (strategic risk 4.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C112	Trust Workforce plan in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements regarding training, equality, and diversity. (I)	CPO	4.1
C113	Good partnership working with a range of Higher Education Institutions (HEI'S) to discuss undergraduate and post graduate programmes. (E)	CPO /DNQ/CMO	4.1
C114	Appraisal process to discuss individuals' intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. Improved exit questionnaire process implemented. (I)	CPO	4.1
C135	International recruitment process in place, and the development of new roles with a view to increasing workforce supply (P) (E)	CPO	4.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C165	Chief medical officer is a general medical council sponsor for international fellows which contributes to the sustainable workforce model. (P, E, I)	CMO	4.1
C178	Agency scrutiny group established which is chaired by the director of finance to ensure agency standards are fully adhered to (P,I)	CPO/DOF	4.1

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Mental Health Investment Standard funding in 22/23 created significant new opportunities across the West and South Yorkshire systems. The great place to work strategy delivery plan is introducing a greater focus on workforce redesign and new roles which is helping to mitigate this risk. However, Mental Health Investment Standard plans for 23/24 are still be established and may create further pressure. Reviewed in July 2023 October 2023, January 2024. The operational planning changes for ICS's is impacting on the progress of this work. To review further in April 2024.	April 2024	CPO
The impact of growth in budget and establishment is likely to result in growth in vacancies in Q4. A revised recruitment and marketing plan for 2023 has been developed focussing on the Trust role as an anchor institution and linking with local networks and education providers to recruit to vacancies and encourage diversity. Planning process is complete with a trajectory of 3% across the Trust for the year 23/24. The gap remains due to the continuing growth in establishment. Review in January 2024 and current staff sick ess rates are 5.1% at the end of Q to review in April to establish if trajectory has been achieved.	April 2024	CPO

Assurance (strategic risk 4.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into QSC. (P) (I)	DSC	2.2, 4.1
A66	Annual Mandatory Training report goes to PRC an Quality and Safety Committee (QSC) Committee.	QSC Committee receive annual report (P) (I)	CPO	4.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	4.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	CPO	4.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	4.1
A70	Recruitment and Retention performance dashboard.	Quarterly report to the People and Remuneration Committee. (P, N) (I)	CPO	4.1
A71	Safer staffing reports included in IPR and reported to CG&CS Committee. (ORR 905,1158)	Monthly IPR goes to the Trust Board and EMT six monthly report to Trust Board. (P)	DNQ	4.1
A72	Workforce Strategy implementation update report.	Quarterly report to the PRC Committee. (P) (I)	CPO	4.1
A73	Annual appraisal and, objective setting cycle in place	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	4.1, 4.3
A74	Staff survey results reported to Trust Board and / or People & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	2.4 4.1, 4.2, 4.3
A78	Continuing international recruitment and the development of new roles as part of increasing workforce supply. Virtual international recruitment portal signed off by EMT. Establishment of new roles group to look at development of new clinical roles.	Reported into PRC Committee (P,I)	CPO	4.1
A83	Agency scrutiny group report providing details of spend, governance arrangements, trends, hotspots and quality assurance.	Reported into PRC and FIP (P,N,I)	CPO/DFR	4.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR 1151). Working with MHLDA group across the West Yorkshire MHLDA programme and a renewed focus on retention. Reviewed in April, July and October, Jan 24progress on medical and nursing recruitment has been positive in certain areas of the Trust over the last four quarters, however, severe national and global challenges remain, and achievement of full establishment is a long-term ambition. In view of this to be reviewed in April 2024 given context of national and global issues.	April 2024	CPO

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 4.2

Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme which is currently under review. (I)	CPO	4.1, 4.2
C103	Education and training governance group in place to agree and monitor annual training plans. (I)	CPO	4.1, 4.2
C115	Appointment of diversity and inclusion lead as part of the Trust's overall leadership and management development arrangements. (I)	CPO	4.2
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed March 2022 with future board development programme being established. (P,I)	CPO	4.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C154	Regular and consistent updates and communications throughout the Trust via the View and the Brief (P, I)	DSC	4.2
C155	Trust Board engagement with staff networks (P, I)	DSC	2.4 4.2
C156	Appointment of Freedom to Speak up Guardian, Equity Guardian, Civility and respect champions and diversity and inclusion and belonging lead roles (P, I)	CPO	2,4 4.2
C157	Values based recruitment processes in place (P, I)	CPO	2.4 4.2
C158	Values based appraisal system (I, E, P,N)	CPO	2.4, 4.2
C159	Leadership and development programme to support talent management approach (I, E, P, N)	CPO	4.2
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	CPO	2.4, 4.2
C179	Developed internal transfer system which is now to be promoted and embedded (P) (I)	CPO	4.2
C188	The great place to work strategy acknowledges the diversity challenge in senior roles across the Trust for 23/24 (P,N,I,E)	CPO	4.2
C189	Trust Board development programme in place for 23/24 led by the Chief People Officer building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives (P, I, E)	CPO	2.4, 4.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
WRES and WDES are in place but there is not an LGBT equivalent, and this is being considered by the People directorate to be incorporated into future reporting. Work on completion of the WRES and WDES to provide meaningful action plans is ongoing and to be presented to Board in October. Following completion of this work consideration of an LGBT equivalent will take place. Review further in April 2024	April 2024	CPO

Assurance (strategic risk 4.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A74	Staff survey results reported to Trust Board and / or People & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	2.4, 4.1, 4.2, 4.3
A87	Flair survey completed to provide insight into staff experience of inclusion and diversity matters in a timely fashion	Analysis and actions to be monitored by EMT and PRC (P,N,I)	CPO	4.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
On Boarding system is in the implementation stage which will give insight into lead time and areas where efficiencies can be made. Issues have arisen in relation to the provider and increased costs for implementation. Further update to be provided in April 2024.	April 2024	CPO

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 4.3
Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies

Controls (strategic risk 4.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C110	Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	2.4, 4.1, 4.3
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	4.3
C117	Access to wellbeing apps. (I)	CPO	4.3
C118	Comprehensive Occupational Health Service offer.	CPO	4.3
C119	Integrated care system Workforce Support Hub in place. (I)	CPO	4.3
C121	Promotion and accessible offer of flu vaccination programme for all staff within the Trust with clear targets. (I)	CPO	4.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C180	Diversity, inclusion and belonging lead in place(P) (I)	CPO	4.3
C182	Wellbeing is to be embedded in recruitment, induction and onboarding initiatives (P) (I) I	CPO	4.3
C183	Wellbeing capacity within the Organisational Development (OD) team has been expanded (P, I)	CPO	4.3
C192	Medical appraisal has a wellbeing section which is reviewed by the appraisal and validation team throughout the year (aligns to GMC fair to refer report 2019)	CMO	4.3
C198	The occupational health service has completed all aspects of the trauma informed pilot, including training and ROOTS assessments. Maintaining and developing practice underpinned by trauma informed principles remains a priority of the OH team.	CPO	4.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Staff sickness rates have increased from 4.6% in Q1 to 4.9% at the end of Q2 and 5.1% at the end of Q3. The people directorate continues to work closely with line managers to help support staff and work in partnership with trade unions to ensure the staff wellbeing offer is effective and make adjustments as necessary. The Trust continues to benchmark well against other like organisations. The current focus is on stress and anxiety as identified area of improvement. An internal audit on processes to manage of sickness/absence is taking place in April 2024.	April 2024	CPO

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A73	Annual appraisal, objective setting and PDP timelines are in place for 2022/23	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	4.1, 4.3
A74	Staff wellbeing survey results reported to Trust Board and / or Workforce & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	2.4, 4.1, 4.2, 4.3
A76	Routine scan of national guidance as part of horizon scanning	Discussed fortnightly at people leadership team (PLT). (P, I, E)	CPO	4.3
A77	Review of hotspots in relation to support to staff / staffing levels	Discussed fortnightly at people leadership team (PLT). (P, I)	CPO	4.3
A78	Review of workforce information by the People & Remuneration Committee and Trust Board.	Reported to Trust Board through IPR. (I)	CPO	4.3
A82	Robertson Cooper survey is now targeted at areas of concern/ hotspot areas.	Reports into the People and Remuneration Committee and EMT as part of the annual wellbeing review(P) (I)	CPO	4.3
A84	Health inequalities data and support from staff network groups to be used to improve understanding of staff groups	Part of WRES and WDES (P) (I) (E)	CPO	4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
In reference to the management of sickness/absence an Internal audit will be completed by the end of April 2024, following which the outcome will be reported to PRC and Audit Committee.	July 2024	CPO

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Quarter 3 Corporate / Organisational Risk Register 2023/24**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Asma Sacha - Corporate Governance Manager		
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives and have controls and actions in place to mitigate those risks.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	References to the Board Assurance Framework are included in the ORR where applicable.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The board of directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership (ICP), Integrated Care Board (ICB), and place-based partnerships. The board of directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives.		
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. Assessment of allocated risks is a standing agenda item at all Board committee meetings.		
Executive summary:	**Corporate / Organisational Risk Register** The Corporate/ Organisational Risk Register (ORR) provides Trust Board with oversight of organisational risks that are significant in nature and have been escalated by the Executive Management Team (EMT). Risks that could have an impact across the Trust are reported to the Executive Management Team (EMT) monthly as per the Risk Management Framework. Risks on the ORR are aligned to the Trust's strategic objectives:		

Our four strategic objectives	
Improve health	**Improve care**

	Improve resources **Making SWYPFT a great place to work** All organisational risks are assigned to relevant Board Committees for discussion and oversight, and they report to Board through the individual committees triple A report (Alert, Advise, Assure). The full corporate/ organisational risk register is reviewed on a quarterly basis by EMT, and individual risks are reviewed monthly by the responsible director with the corporate governance team. At each review controls, actions, risk scores and completion dates are considered and updated as required. There are two new risks for Quarter 3.

New risks

Risk ID	Risk Owner	Description
To be confirmed	Chief Nurse and director of quality and professions	Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individuals are not supportively heard, do not suffer personal detriment and that they do not receive feedback on action(s) taken which demonstrate listening and learning.

A new risk has been developed by the Chief nurse and director of quality and professions (DNQ) in relation to speaking up following discussion at the October Trust Board. DNQ has reviewed the risk score and is proposing, consequence as 3 moderate x likelihood as 3 possible with an overall risk score of 9 (amber). The control measures have been developed and reviewed by the Executive Management Team (EMT), Quality and Safety Committee (QSC) and People and Remuneration Committee (PRC).

Risk ID	Risk Owner	Description
To be confirmed	Chief Nurse and director of quality and professions/ Interim Chief People Officer	Risk that individuals do not feel safe from sexual harm. This includes being made to feel uncomfortable, frightened, or intimidated in a sexual way by any other person whilst being cared for, working for, or visiting the Trust.

Similarly a new risk has been developed related to sexual harm which has been reviewed by EMT. Chief Nurse and Director of Quality and Professions (DNQ) and the Interim Chief People Officer (CPO) have reviewed the risk score and are proposing, consequence as 4 major x likelihood 2 unlikely with an overall risk score of 8 (amber). The control measures have been reviewed at EMT, QSC and PRC.

Risk level 15+

Risk ID	Risk Owner	Description
1530	Chief Operating Officer	Risk that demand, through acuity or numbers continues to rise placing further pressure on access to services and waiting lists.

EMT requested this risk reviewed by the Chief Operating Officer (COO) and her leadership team as there was only one risk action in place. This risk relates to demand and the impact of the demand. The action

in place is appropriate, and additional actions are being managed through other risks, 1614 and 906 (staffing) 1338 and 1319 (inpatient bed – child and adult) 1078 and 1132 (waiting lists – child and adult) and 1649 (access and demand SALT).

Risk ID	Risk Owner	Description
1080	Director of finance, estates and resources	Risk that the Trust's IT infrastructure and information systems could be compromised by cyber-crime leading to a) theft of personal data b) Key system downtime and/or c) Inability to provide safe and high-quality care.

This risk has been reviewed by EMT. The control measures have been reviewed and condensed. The overall risk score can potentially be reduced once the business case for cyber security phase 2 enhancements to support the move towards advanced monitoring capabilities is presented to EMT. This has been agreed to put on hold until 2024/25 until plans are developed and agreed.

Risk ID	Risk Owner	Description
275	Director of strategy and change/ Chief operating officer/ Director of provider development/ Director of finance, estates and resources	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.

EMT has reviewed this risk and notes that the specific work regarding children's services should reduce the risk, as the proposition is to make the Trust a lead provider (or equivalent) and the Trust will therefore be able to have more transparent deployment of reduced income to address priorities. Quarterly reviews have been arranged to review local authority actions on reducing their spend (either generally or in respect of any contracts with the Trust), and the associated impact. If any serious risks are identified, the Trust can review and consider what mitigations can be put in place. Given the significant financial challenges in local authorities these are not guaranteed to address risk of deterioration.

Risk level <15 Risks outside the risk appetite

Risk ID	Risk Owner	Description
1568	Chief Operating Officer	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.

EMT identified whilst no incidents have been reported recently, the likelihood of the risk occurring remains the same, particularly whilst building work is taking place and the decant facility of Gaskell Ward remains in use. The scores are expected to remain until building work is complete. This will be reviewed in Quarter 4.

Workforce risks

Risk ID	Risk Owner	Description
905	Chief operating officer, Chief nurse and director of quality and professions	Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.

Risk ID	Risk Owner	Description
1614	Chief nurse and director of quality and professions	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.

EMT has reviewed the workforce risks and consideration will be given to review the themes and potentially merge risks 905 and 1614 in Quarter 4.

Risk level <15 Risks outside the risk appetite

Risk ID	Risk Owner	Description
1757	Chief Nurse and director of quality and professions / Director of finance, estates and resources	Failure to fully maintain and monitor medical devices to the Trust agreed standards and in line with relevant legislation may lead to patient harm.

EMT has reviewed this risk and updated the risk actions. Consideration will be given to review the risk score in Quarter 4 after a highlight report is produced by the Assistant Director of Nursing Quality and Professions which will feature medical devices oversight in response to actions already undertaken and improvement actions if still required.

Risk ID	Risk Owner	Description
1729	Chief people officer	Staff wellbeing may deteriorate which could exacerbate staffing challenges leading to a delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.

EMT propose to reduce the likelihood from 4 likely to 3 possible, reducing the overall risk score from 12 (amber) to 9 (amber). This is based on several factors including the Trusts staff stability index, staff turnover, current sickness and progress on actions including the appointment of a number of wellbeing champions in clinical areas.

Risk ID	Risk Owner	Description
1624	Chief operating officer	Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we can offer to someone who may have a mental health need in our local community.

EMT have noted improvements in inpatient flow have reduced the likelihood of a blockage within the 136 suite which therefore reduces the likelihood of the suite being unavailable. EMT is recommending a reduction to the likelihood from 3 possible to 2 unlikely, reducing the overall risk from 9 (amber) to 6 (yellow). The Chief Operating Officer is suggesting a further review in Quarter 4 may lead to the removal of this risk from the organisational risk register and to manage the risk operationally.

Risk ID	Risk Owner	Description
852	Director of finance, estates and resources	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.

EMT have identified the information governance (IG) training toolkit requirement is changing, and further work is required to be completed by 1 July 2024. Comprehensive risk actions are in place to mitigate this risk, but the risk of human error remains. There is a proposal for a reduction in likelihood from 3 possible to 2 unlikely with an overall reduction of the risk score from 12 (amber) to 8 (amber).

Risk ID	Risk Owner	Description
1319	Chief operating officer	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for Psychiatric Intensive Care Unit (PICU) or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.

EMT are recommending a reduction in likelihood from 4 likely to 3 possible with a reduction in risk score from 12 (amber) to 9 (amber), this reduction is due to patient flow improvements and a much reduced number of people being placed in an out of area bed.

Organisational level risks within the risk appetite

Risk ID	Risk Owner	Description
1758	Chief people officer/ Chief operating officer	The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care

This risk has been reviewed by EMT and remains under review dependant on the outcome from national conversations.

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Risk Owner	Description
1545	Chief Medical Officer	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic or as a result of the public inquiry.

This risk has been reviewed by EMT. The inquiry is currently underway and at parliamentary decision stage therefore the review date has been extended to April 2024 when the Trust should have outputs and further information.

Heat map

Appendix 1 shows the heatmap of the organisational / corporate risk register. In line with best practice the risk scoring, and total risk timelines show a longer-term trend from January 2021 to January 2024. The risk score shows the current figures for January 2024 and the projection if the proposals are accepted by Trust Board.

A summary of findings are below:

- The number of risks has increased from Quarter 2 2023/24 by **two risks**, bringing the total amount of risks from **35** to **37.**
- The **highest number of risks** are aligned to the Trust objective, **Improving Care**
- The **lowest number of risks** are aligned to the Trust objective, **Making this a great place to work**
- There is currently **one red risk** aligned to Trust objectives **Improving Health, Improving Care and Improving Resources.**
- There are **no** red risks aligned to Trust objective **Making this a great place to work.**
- The current accumulative risk score is **378** and this will increase to **382** if the proposals are accepted, which is an increase of **4.**
- The current average risk score is **10.8 (amber**). If the proposed changes are accepted, then the average risk score will be **10.3 (amber).**

Risk Appetite:	The ORR supports the Trust in providing safe, high-quality services within available resources, in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to REVIEW and COMMENT on the risk register and to confirm they are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.** **In addition, Trust Board is asked to:** • **APPROVE the new risk for speaking up.** • **APPROVE the new risk for sexual safety.** • **AGREE to the reduction in risk score for risk IDs; 1729, 1624, 852, 1319.**

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.
Business risks (8-12): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.

Risk appetite	Application
Minimal / low - Cautious / moderate (1-6)	• Risks to service user/public safety. • Risks to staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board. • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintain expenditure within limits agreed by the Board. • Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value.
Open / high (8-12)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners. • Risks to recruiting and retaining the best staff. • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services.

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme / SUI risk

Our four strategic objectives	
Improve health	Improve care
Improve resources	Making this a great place to work

KEY:
CE = Chief Executive
DFR = Executive director of Finance, estates and resources
CPO = Chief People Officer
DNQ = Chief nurse and director of quality and professions
CMO = Chief medical officer
DS = Executive director of strategy and change
COO = Chief Operating Officer
DPD = Executive director of provider development

AC = Audit Committee
QSC = Quality and Safety Committee
FIP = Finance, Investment & Performance Committee
MHA = Mental Health Act Committee
PRC = People & Remuneration Committee
EIIC = Equality, Inclusion, and Involvement Committee
CC = Collaborative Committee

Corporate/ Organisational Risk Register Quarter 3, 2023/24

Trust Board meeting: 30 January 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

New risks

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
New risk	Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individuals are not supportively heard, do not suffer personal detriment and that they do not receive feedback on action(s) taken which demonstrate listening and learning.	**DNQ**	QSC PRC	• Freedom to speak up structure in place with one Working Time Equivalent (WTE) guardian. • There are three Freedom to Speak Up (FTSU) support guardians. • 6 weekly meetings with Lead Director DNQ, non-executive lead for FTSU supported by Deputy Director of Corporate governance • Exec TRIO meet regularly with freedom to speak up guardian • Trust communications (View and Headlines) in relation to speaking up and updates via Trust intranet • FTSU guardian identifies and escalates detriment from any speaking up process • Staff are signposted to other areas of the Trust for support, occupational health, equity guardians, civility and staff guardians or staff side • Mandatory training for all staff on speak up, optional listen up and follow up training available	3 moderate	3 possible	9	1 – 6 Compliance risk	• Further embedding of the recently recruited freedom to speak up guardians (DNQ, April 2024) • Further development in relation positive comms from case studies (DNQ, April 2024) • Clearer feedback for people who have spoken up (DNQ, April 2024) • To recruit additional freedom to speak up guardians (DNQ, April 2024) • Focused intervention from executive TRIO into areas of concern (DNQ, April 2024) • Freedom to speak up self-assessment tool and improvement actions, Review March/April 2024 (DDCG) • To consider making listen up and follow up mandatory training subjects for all staff. (DNQ, April 2024)	30 April 2024	QSC PRC EMT Trust Board	4	**Note for Trust Board: New risk** Current risk score based on October 2023 sign off of self-assessment action plan at PRC and Trust Board.	February 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
New risk	Risk that individuals do not feel safe from sexual harm. This includes being made to feel uncomfortable, frightened, or intimidated in a sexual way by any other person whilst being cared for, working for, or visiting the Trust.	**DNQ /CPO**	QSC PRC	• Signed the NHS England sexual safety charter which reflects Trust commitment. • Reporting system in place via Datix in relation to all sexual safety incidents • The Trust reports via the Joint Safeguarding Strategic and Operational Subgroup and updates will continue through this group to EMT and the Quality and Safety Committee • The sexual safety improvement group will continue to meet every two months. • The sexual safety improvement group have completed an audit of the Sexual Safety Collaborative | Royal College of Psychiatrists (rcpsych.ac.uk) • Sexual safety policy in place • Lone working policy in place • For staff, Standards of Conduct in Public Service Policy (including managing conflicts of interest) in place • Bullying and harassment policy in place • Staff side • Freedom to speak up • HR and civility and respect champions	4 Major	2 Unlikely	8	Clinical risk 1-6	• The sexual safety improvement group oversees 15 actions against the sexual safety inpatient charter, reporting to EMT and the committee (DNQ, April 2024) • The sexual safety improvement group also oversees progress against 26 actions from the Royal College of Psychiatrists audit (DNQ, April 2024) • Trust communications to raise awareness (DNQ/ CPO, 2024/25)	30 April 2024	QSC PRC Executive Management Team (EMT) Joint Safeguarding Strategic and Operational Subgroup sexual safety improvement group Trust Board	4	**Note for Trust Board: New risk** Aligns to Sexual Offences Act and Trust policy in terms of definition. The actions against the sexual safety charter are currently either complete or on target.	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Junior doctors forums in place • Clinical tutors available										

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Risk level 15+

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1530	Risk that demand, through acuity or numbers continues to rise placing further pressure on access to services and waiting lists	**COO**	QSC	• Planning process. • Working as a key partner in each of the Integrated Care Systems. • Members of the place-based partnerships and integrated care boards • Health and wellbeing boards. • Digital and telephone solutions are part of the standard offer for service users. • Service delivery is prioritised to meet need, manage risk and promote safety with cross service and care group support utilised. • Escalation through the Operational Management Group (OMG) where demand cannot be met • Business continuity plans • Quality impact of increased demand is overseen in the Clinical Governance Group • Care pathways are designed to be flexed in order to respond to changes in demand. • Regular engagement with commissioners provides opportunity to consider changes in required capacity to meet demand.	4 Major	4 Likely	16	1 – 6 Clinical risk	• Further work will continue with the Intelligence Change Partner to understand and measure all the factors that contribute to perceived demand increase (COO, review February 2024) • Actions to manage the impact of demand are identified within other risk actions, specifically: 1614 and 906 (staffing) 1338 and 1319 (inpatient bed for child and adult) 1078 and 1132 (waiting lists child and adult) 1649 (access and demand for Speech and Language Therapy (SALT).	29 March 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	4	BAF ref SO 2 **Note for Trust Board:** This risk relates to demand. The impact of the demand is managed through other risks as listed in the risk actions column.	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1080	Risk that the Trust's IT infrastructure and information systems could be compromised by cyber-crime leading to a) theft of personal data b) Key system downtime and/or c) Inability to provide safe and high-quality care.	**DFR**	AC	• Microsoft Windows Defender with Advanced Threat Protection (ATP) • The Trust's computer estate remains comprehensively maintained and supported • Comprehensive security patching regime in place • Annual penetration testing in place • Appropriately skilled and experienced staff in post • Disaster recovery and business continuity plans annually tested. • NHS Digital Care Cert obligations fully met. • Information Governance training includes cyber security dimensions. • Key messages are communicated to • Data Security and Protection Toolkit (DSPT) Cyber and Information Governance standards met • Cyber Essentials Plus re-accreditation completed in 2023 • IT Service performance actively monitored and tightly controlled • Immutable backup functionality implemented. • Data retention policy in place • Annual cyber table top exercise • Multi-Factor Authentication (MFA)	5 Catastrophic	3 Possible	15	8-12 Strategic risk	• Business continuity plans reviewed as planned as part of an EPRR table top exercise in November 2023. A follow-on exercise is to be run in early 24/25 with more of an operational perspective.(DFR) • 6-monthly cyber security update reports provided to Audit Committee (DFR, ongoing) • Cyber security phase 2 enhancements to support move towards advanced monitoring capabilities business case presented to Executive Management Team, agreed to put on hold until 2024/25 plans are developed and agreed (DFR). • Cyber campaign and staff awareness communications schedule remains in place(DFR, ongoing) • Phishing campaign to be scheduled to raise/monitor staff awareness, yearly (DFR, ongoing) • Testing of Windows 11 completed ahead of Windows 10 going End of Life in 2025. (DFR, 2025) • Annual penetration testing in progress as planned (DFR). • Cyber Essentials Plus re-accreditation in progress (DFR, Feb 2024)	29 March 2024	IM&T Managers Meeting (Monthly) Digital TAG (Quarterly) Executive Management Team (EMT) AC (Monthly) IT Services Department service management meetings (Trust / Daisy) (Monthly) Trust Board	10	BAF Ref, SO 2 & 3 **Note for Trust Board:** The overall risk score can potentially be reduced once the cyber security phase 2 enhancements to support the move towards advanced monitoring capabilities business case is presented to EMT. This has been agreed to put on hold until 2024/25 until the plans are developed and agreed.	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				implemented across the Trust • Digital Technology Assessment Criteria (DTAC) requirements incorporated into procurement of digital/IT solutions and services. • Deputy Senior Information Risk Owner (SIRO) now in place.									
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	**DS/ COO /DPD /DFR**	QSC	• Agreed joint arrangements for management and monitoring delivery of integrated teams. • Weekly risk scan by Chief Nursing Officer and Chief Medical Officer • Care Group / commissioner forums – monitoring of performance – attendance at contract meetings. • Monthly review through performance monitoring governance structure via Executive Management Team (EMT) of key indicators and regular review at Operational Management Group (OMG) of key indicators. • Regular ongoing review of contracts with local authorities. • New organisational change policy includes further support for the transfer and redeployment of staff.	4 Major	4 likely	16	1-6 Clinical risk	• To work with partners in all places to address in year specific financial challenges. Quarterly reviews during 2024, next due 31/04/24 (DFR/ DPD) • To work with partners in Kirklees specifically to mitigate the impact of council funding for children and young people's mental health services (DPD, February 2024)	31 May 2024	QSC Care Group (monthly) Executive Management Team (monthly) Operational Management Group (regular) Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at Executive Management Team and Trust Board	6	BAF Ref: SO 1, 2 and 3. **Note for Trust Board:** The specific work regarding children's services arguably should reduce the risk, as the proposition is to make the Trust Lead Provider (or equivalent) and therefore able to have more transparent deployment of the reduced income to address priorities. Quarterly reviews have been arranged to review Local Authority actions on reducing	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Attendance and minutes from Health and Wellbeing board meetings. • Active involvement in the development and implementation of place based plans and priorities across West and South Yorkshire integrated care systems and place specific initiatives e.g. winter planning. • Clinical and quality Trust representation now established in all place based quality committees									their spend (either generally or in respect of any contracts with the Trust), and the associated impact. If any serious risks are identified, the Trust can review and consider what mitigations can be put in place. Given the significant financial challenges in local authorities these are not guaranteed to address risk of deterioration.	

Risk level <15 Risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1368	Risk that given demand and capacity issues across South and West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a Child and Adolescent Mental Health Services (CAMHS) bed. This could result in young people being care for on adult wards in the secure CAMHS estates or secure hospitals which could have an impact on the quality and experience of their care.	**COO**	QSC	• Bed management processes • Community options explored. • Protocol in place for admission of children and younger people on to adult wards. • Child and Adolescent Mental Health Services (CAMHS) in-reach support to mental health wards and to acute hospitals • Regular report to board (Integrated Performance Report) • Safeguarding team provides scrutiny of all under 18 admissions. • Leeds and York Care collaborative board and operational cell system wide (West Yorkshire) • System-wide panels review the demand and take action to address delays • Care, Education, Treatment Reviews (CETR) are in place for children with learning disability and autism. • Management and clinical supervision of staff • Collaborative development day took place in December 2023.	3 Moderate	4 Likely	12	1-6 Clinical risk	• Wrap around in reach Child and Adolescent Mental Health Services (CAMHS) support continues to be provided to children waiting for a bed in the acute Trust and/or in an adult bed. (COO, Ongoing action – review February 2024) • The executive TRIO ensure appropriate escalation to partners where an appropriate solution for a child is not available (TRIO review February 2024) • Participation in the collaborative work continues. (COO, review February 2024)	29 March 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Team (OMG) Trust Board	4	BAF ref: SO 3	February 2024
1568	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an	**COO**	QSC	• The leadership team monitor the use of seclusion across all areas • Seclusion rooms on different wards can be accessed if available. • Datix reporting and review process	4 Major	3 Possible	12	1-6 Clinical risk	• Learning from the work in forensics, Horizon and other similar organisations, is being used to inform improvements in acute services and will be overseen by the clinical environment and clinical safety group (DNQ, review February 2024)	29 March 2024	QSC Executive Management Team monthly Operational Manageme	4	BAF Ref SO 2 **Note for Trust Board:** Whilst no incidents have been reported recently, the	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	increased risk of harm.			• Urgent estates response process • A costed plan being implemented against agreed standards • Seclusion and segregation oversight group reports to the clinical governance group. • clinical environment, clinical safety group oversight.							nt Group (regular updates) Clinical Environment, clinical safety group Trust Board		likelihood of the risk occurring remains the same, particularly whilst building work is taking place and the decant facility of Gaskell is in use. The scores are expected to remain until building work is complete. This will be reviewed in Quarter 4.	
905	Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.	**COO DNQ**	QSC	• Recruitment and retention plan agreed • Monthly safer staffing reports to Trust Board and Operational Management Group via Integrated Performance Report with appropriate escalation arrangements in place. • Biannual safer staffing report • Medical staff bank established. • Allied Health Professionals master agency contract in place. • Staffing levels monitored locally by matrons and / or service managers. presenting need. • Risk panel monitors all incidents including the occasions where newly qualified nurses undergoing preceptorship are asked to take charge of a shift. • Care Group meetings review safer staffing	4 Major	3 possible	12	1-6 Clinical risks	• Roll out of Safe care ongoing throughout 2023/24 including review of effectiveness (DNQ/ CPO, March 2024 • Working with partners across Integrated Care System and the region continues as part of the inpatient service improvement programme (COO/ CPO, to review February 2024) • The focus on recruitment to inpatient areas continues (CPO, review monthly, Ongoing 2024) • A full review of inpatient ward establishments is nearing completion and reporting through the inpatient service improvement programme and will be presented to EMT by February 2024 (DNQ, February 2024)	29 March 2024	Executive Management Group (EMT) (monthly) Operational Management Group (OMG) Safer staffing inpatient and community group QSC Trust Board	6	BAF Ref, SO 2 & 3 **Note for Trust Board:** Consideration will be given to review the themes and potentially merge the workforce risks in Quarter 4.	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Staff redeployment process in place • Overtime is available as part of a range of temporary staffing options • Bank recruitment now embedded • New roles group leads on the development of a range of options including ACP (Advanced Clinical Practitioner)										
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided	**DFR**	FIP	• Board, Committee and Executive Management Team (EMT) oversight of progress made against cost saving schemes. • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems (ICSs). • Active engagement on place-based plans. • Enhanced management of Cost Improvement Programme (CIP) programme. • Integrated change management processes. • Non-Executive Director led Finance, Investment & Performance Committee. • Continued Mental Health Investment Standard funding. • System-wide funding provided on a fair shares basis. • Use of national and internal benchmarking information to support productivity improvements. • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services.	3 Moderate	3 Possible	9	1-6 Financial risk	• Draft longer-term financial sustainability plan in line with the ICB and to be presented to Board in 2024/25 for formal sign off in Quarter 2 2024/25 (DFR) • Reinstatement of efficiency delivery and monitoring. (DFR, Ongoing review via Operational Management Group monthly) • Implement patient level costing for use by Directorates (DFR, March 2024) • Implementation of Integrated Care Board (ICB) level cost controls effectiveness will be reviewed (DFR, Ongoing through 2024/25) • Staff engagement to develop efficiency ideas to be recorded on i-hub (to be evaluated in Q4, DFR)	29 March 2024	Executive Management Team (monthly) FIP (monthly) Operational Management Group Trust Board (quarterly)	4	BAF Ref, SO 3	February 2024

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				• Operational and financial plan in place for 2023/ 2024 • 2023/24 financial plan presented to and approved by the Board in March 2023 • Monthly financial reports to assess impact of inflationary pressures in particular working with estates and procurement to regularly update on actual increases to contract renewals or contractual inflationary uplifts (DFR, Monthly) • Implementation of Integrated Care Board (ICB) level cost controls are in place										
1757	Failure to fully maintain and monitor medical devices to the Trust agreed standards and in line with relevant legislation may lead to patient harm.	**DNQ /DFR**	QSC	• The Electrical Biomedical Medical Engineering (EBME) equipment / infection prevention and EBME contract has been reviewed and awarded, part of the new contract. • COO has circulated communication to Managers reminding them about medical device requirement • Equipment register in place • Purchasing process • Appointment of project manager • Raised awareness in the Care Group governance meetings and the QSC (see assurance and monitoring column) • Partnership working with Mid Yorkshire NHS Trust • A blue light alert was shared across the organisation in July 2023. • Project manager is in post and contract has been	4 major	3 possible	12	Clinical risk 1 – 6	• Review Medical devices workload and to appoint medical devices officer on bank contract for 12 months (DNQ and DFR, March 2024) • Full review of the Electrical Biomedical Medical Engineering / Equipment (EBME) list, ongoing review fortnightly, updated paper, funding extension was approved by Executive Management Team (DNQ and DFR) • There is a wider piece of scoping work being undertaken to review other servicing contracts for medical devices e.g. scales, bladder scanners etc (DNQ and DFR, Review monthly, ongoing) • Continue with the servicing programme (Trust wide) (DNQ and DFR, To review on an ongoing basis) • To review and cleanse the asset register data for medical devices (DNQ and DFR, weekly review, ongoing) • Areas continue to be contacted to ensure compliance in relation to service of devices (DNQ, March 2024) • Highlight report in development by the Assistant Director of Nursing, Quality	29 March 2024	Clinical governance / care group clinical governance QSC Safety and resilience Task Action Group Operational Management Group (OMG) Medical Devices Task Action Group Executive Management Team (EMT) Trust Board	2	**Note for Trust Board:** Consideration will be given to review the risk score in Quarter 4 after the highlight report is produced by the Assistant Director of Nursing Quality and Professions which will feature medical devices oversight in response to actions already undertaken and improvement actions still required.	February 2024

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				extended to December (may extend this further to March 2024) • Medical devices and safety alert group monitor EBME compliance figures quarterly. • Project manager reviews the EBME compliance figures monthly. • Medical devices/ new equipment request and approval form including trials has been updated. • Medical devices intranet pages updated. • Medical devices lifecycle flowchart has been produced (easy guide) and has been disseminated across all care groups/ intranet • Medical Devices Policy approved in November 2023 and staff notified via Trust communications.					and Professions, to show level of assurance with regards to medical devices oversight in response to actions already undertaken, and improvement actions still required. (DNQ, March 2024)				There are legislative impact in relation to this risk: Health and Safety at Work Act 1974 Medicines & Healthcare products Regulatory Agency (MHRA) bulletin, Device Bulletin – Managing Medical Devices, Guidance for Healthcare and Social Services Organisations DB2006(05)	
1820	There is a risk that the cumulative impact of staff shortages, high turnover of staff, high use of temporary staffing, low supervision rates, opportunity to release staff for training and high acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.	**COO CMO DNQ CPO**	QSC PRC	• Agendas and terms of reference for Care Groups and Operational Management Group • Weekly review of all amber and red incidents, all staffing incidents, and all incidents related to protected characteristics at Clinical Risk Panel • Seclusion and Segregation oversight group review in place • Operational Management Group and PRC receive detailed reporting • Safer Staffing reporting into monthly Integrated Performance Report • Incident, quality, and reporting monitoring in Care Group Quality and Governance Groups, and	3 moderate	3 possible	9	1-6 Clinical risk	• Develop a process to improve triangulation with regard to incidents / grievances / workforce issues, to identify hotspots (DNQ, Ongoing, March 2024) • To deliver the improvement plan relating to Quality and Safety within Mental Health, Learning Disability and Autism Inpatient services (DNQ, To review monthly, February 2024) • The supervision database is now working. Some anomalies are still being addressed to ensure all clinical colleagues are included. (DNQ, February 2024) • Continuing to progress the complaints improvement programme and developing metrics of performance and quality (DNQ, February 2024) • Inclusive culture and management engagement sessions to enable a plan to be developed (CPO, June 2024) • Developing an approach and policy to adopt just and learning principles	28 June 2024	Operational Management Group Executive Management Team Clinical Governance Group QSC PRC Trust Board	3	BAF Ref SO 2	February 2024

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				at the Clinical Governance Group • Quality Monitoring Visits, • Freedom to Speak up processes and , Equity Guardians and Dignity and Respect champions in place • Regular informal and formal meetings with Trust regulators • An agency scrutiny group meet to look at reducing agency workers and increase bank recruitment. • Review of themes from complaints • Strengthening the induction process about values and expected code of conduct • Work is complete on practice and reporting of supervision					across our employee relations, with the new Head of People Experience (CPO review June 2024) • To explore new and innovative ways to deliver learning and development to enable staff to be released in shorter periods (Ongoing, CPO)					
1729	Staff wellbeing may deteriorate which could exacerbate staffing challenges leading to a delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.	**CPO**	PRC EIIC	• Occupational health and wellbeing support centre guidance as part of the Workforce Support Hub. • Staff counselling. • Health lifestyle support on Stop Smoking and weight management. • Support and engagement from all staff networks. • Equality Impact Assessment of staff health and wellbeing offer and occupational health. • Effective supervision practices • Data analysis and hot spot reporting Trust wide • Communications brief with well being messages for all staff • Annual flu vaccination programme in place • Financial wellbeing information and support available to staff	3 Moderate	~~4 likely~~ 3 possible	~~12~~ 9	1-6 Compliance risk	• Local action plans in relation to 2022/23 staff survey results are being implemented and a review of actions undertaken and shared with teams in advance of the 2023 staff survey (CPO review July 2024)	31 July 2024	Safer staffing reports (monthly) Moving forward group PRC EIIC Operational Management Group Executive Management Team Trust Board	9	BAF Ref: SO 4 **Note for Trust Board:** There is a proposal to reduce the likelihood from 4 likely to 3 possible, reducing the overall risk score from 12 (amber) to 9 (amber). This is based on several factors including staff stability index, staff turnover, current sickness and progress on actions including the	February 2024

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				• Wellbeing embedded in recruitment, induction and onboarding initiatives • The majority of Wellbeing champions appointed in each of the clinical areas									appointment of a number of wellbeing champions in clinical areas.	
1614	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.	**DNQ**	QSC PRC	• All Datix which relate to staffing issues are presented to the weekly clinical risk panel and escalated to Executive Management Team as appropriate. • Inpatient services priority programme in place • Internal reporting including waiting lists, length of stay, complaints, concerns and compliments • Safety and quality relayed clinical incidents • Clinical risk and care plan improvement project in place • Quality Monitoring Visits • Bank and agency staffing • Critical incident de briefs • Safer staffing groups • Freedom to speak up guardians in place and expanded • Quality focused updates from in-patient areas are presented to the Clinical Governance Group • Protocol is in place to support safe practice during seclusion and restraint when working with reduced substantive staff • 'Tendable' (outcome monitoring tool) is in place in Mental Health Inpatient Units • Safecare has been rolled out in Forensics and Barnsley Mental Health Inpatients in September 2023	4 Major	3 possible	12	1-6 Compliance risk	• New roles processes are being explored across the West Yorkshire Mental Health Collaborative (DNQ, March 2024) • Further roll out considered of Tendable in Forensic and community services (DNQ, March 2024) • Safecare is being rolled out in the Dales, Ward 18 and Lyndhurst (DNQ Review Ongoing, 2023/2024)	29 March 2024	Operational Management Group Executive Management Team Trust Board QSC PRC Trust Board	6	BAF Ref SO 4 Note for Trust Board: Consideration will be given to review the themes and potentially merge in Quarter 4.	February 2024

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1689	Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in the provision of services potentially exacerbating existing health inequalities for our service users.	**DS**	EIIC	• Integrated strategy and associated annual action plans • Equality Impact Assessments (EIA) including action tracker in place • SystmOne equality data accessible via the Intranet • Annual Equality Report • Equality Involvement and Inclusion Committee and sub-committee • Internal audit and assurance • Equality dashboard • Making Data Count approach established e.g. waiting list report • Improving access to care priority programme established • Equality Delivery System (EDS) • Training and awareness sessions in place • Working with partners in each place to address inequalities through place partnerships • Health and care plans for 2023/24 all agreed in each place and Trust is a partner in these. • Equality data quality improved Triangulation of information from Trust systems, patient experience and involvement/engagement now in place • Targeted programmes in place through linked charities • Key priority programmes incorporating health inequality actions in place • Equality Impact Assessment (EIA) and equality and inclusion themed development	3 Moderate	3 possible	9	1-6 Compliance risk	• Developments of narratives and case studies to demonstrate impact and continuous improvement (DS, ongoing action, no change) • Involvement in place-based health inequalities programmes and contribute to these (DS/DPD/COO, ongoing, review March 2024) • Embed the EIIC and inequalities priorities within workplans for care group equalities (DS/COO, Quarter 3 2023/24) • Comms plan to be developed to share examples of impact more systematically following the production of the annual report (March 2024, DS)	29 March 2024	Recovery and reset monthly Executive Management Team EIIC quarterly meeting and bi-monthly sub-committee Executive Management Team Trust Board	6	BAF Ref SO 1	February 2024

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				sessions and diversity training ongoing programme in place • Dashboard reviewed in EIIC as part of routine monitoring (waiting times and access)										
1624	Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we can offer to someone who may have a mental health need in our local community.	**COO**	QSC	• Coordinated approach to staffing the 136 unit between Intensive Home Based Treatment Team (IHBTT) and inpatient areas • Bed management processes • Staff rotas • Multi-agency 136 group (regular meeting) • Joined up work with the police and integrated systems is in place in all areas regarding Section 136. • Process for inpatient care delivery when someone is delayed in the 136 suite. • Datix reporting • Additional staffing capacity agreed (Barnsley) • Clinically ready for discharge escalation processes	3 Moderate	~~3 possible~~ 2 unlikely	~~9~~ 6	1-6 Clinical risk	• Work is progressing well across both Integrated Care System (ICS) to review 136 access and pathways across Calderdale, Barnsley, Kirklees and Wakefield with a view to optimising resources and facilitating admissions to local areas wherever possible. (COO, Review February 2024 • South Yorkshire Integrated Care System (ICS) are working through options for 136 provision for 16-18 year olds (COO, review April 2024)	30 April 2024	QSC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board (each meeting through integrated performance report)	3	BAF ref: SO 1 Note for Trust Board: The improvements in inpatient flow have reduced the likelihood of a blockage within the 136 suite and therefore reduces the likelihood of the suite being unavailable. EMT is therefore recommending a reduction to the likelihood from 3 possible to 2 unlikely, reducing the overall risk from 9 (amber) to 6 (yellow). The COO is also recommending a further review in the next Quarter with a view to closing this risk on the organisational risk register but managing the risk operationally.	February 2024

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1511	Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.	**DFR**	CC	• Partnership agreement in place with all partners and risk share arrangements in place with NHS providers for West Yorkshire • Commissioning Hubs established in South Yorkshire and West Yorkshire with all staff in post • Financial management and control processes in place, including monthly analysis of financial position, and reporting to Provider Collaborative Boards in West Yorkshire and South Yorkshire. • Quarterly contract meetings in place with sub-contracted partners to ensure oversight of any financial, quality and clinical mitigations • Monthly Patient Safety and Quality Meeting (West Yorkshire) and Clinical governance meeting in place to ensure oversight of any quality and clinical risks and mitigations • Clinical Lead roles in place West Yorkshire and Clinical Director in place for South Yorkshire. • Focus and clinical oversight of patient repatriation plans in place Risk register maintained for the programme Quality assurance processes and monitoring in place across the Collaboratives, which continues to develop • Trust Provider Collaborative Committee established with work plan in place	4 Major	3 possible	12	1-6 Financial risk	• Partnership agreement and risk share in South Yorkshire – discussions ongoing (DFR, end of March 2024) • Submitted benchmarking information as part of national return across the West Yorkshire providers, evaluation to follow in Q4 (DFR, Q4 2023/24) • Progress sub-contracts to signature, a number are outstanding (DFR, ongoing) • Ongoing dialogue with NHS England to resolve contractual position in relation to South Yorkshire provider (DFR, ongoing)	29 March 2024	CC Executive Management Team (monthly) Trust Board	4	BAF ref: SO 1	February 2024

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South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Process and governance structures developed and agreed for South Yorkshire ASPC (Adult Secure Provider Collaborative)										
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	**COO**	QSC	• Incidents reported on Datix and reviewed through risk panel. • First point of contact in all areas • Children waiting for a neurodevelopmental assessment with mental health needs are supported by core Child and Adolescent Mental Health Services (CAMHS) • Emergency response process for those on the waiting list. • Routine wellbeing checks and support is offered to children who are waiting. • Waiting list initiatives CAMHS performance dashboard • Active participation in Integrated Care System - CAMHS work • Ethnicity monitoring in place. • Technological solutions are embedded. • CAMHS Improvement Group • The Improving Access to Care Priority Programme • Changes to delivery system in crisis and eating disorder pathway increase access	4 Major	2 Unlikely	8	1-6 Clinical risk	• Actions relating to access to Child and Adolescent Mental Health Services (CAMHS) and reducing inequalities continue to be implemented as part of the Improving Access priority workstream (COO, review February 2024 • Work within Kirklees continues in order to agree capacity for assessment beyond March 2024. (COO, April 2024)	29 March 2024	OMG QSC Executive Management Group – monthly Individual district performance reports reviewed by care group Trust Board	6	BAF Ref SO 2 Short term funding has been agreed until March 2024 to support Kirklees Neurodevelopmental assessment.	February 2024
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	**COO**	QSC	• Feedback through insight reports, customer service contacts and friends and family tests • Waiting lists reported through the care group meetings to Operational Management Group	4 Major	3 Possible	12	1-6 Clinical risk	• Waiting list reports are provided on SystmOne and being rolled out to all areas and include hidden waits (COO/ DFR, review February 2024) • Deprivation data has recently been included alongside ethnicity data – reporting on analysis and understanding of this data will be	31 March 2024	Performance reporting to Operational Management Group QSC	6	BAF Ref SO 2	February 2024

ORGANISATIONAL LEVEL RISK REPORT

NHS South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Alternative services are offered as appropriate. • People waiting are offered contact information if they need to contact someone urgently or their needs escalate • Individual bespoke arrangements are in place as appropriate for service users and carers. • Report to Financial Investment and Performance Committee routinely with exception report to Quality and Safety committee. • Waiting list initiatives • Ethnicity monitoring is now in place to monitor whether there is a disproportionate impact for specific communities or groups. • Priority programmes report to Board, Executive Management Team and Operational Management Group • Internal audit					improved through the waiting list report (COO, February 2024) • The personalised care and support workstream and the improvements to care planning workstream are considering how clinical risk can be informed by inequality issues (TRIO, February 2024)		Executive Management Team monthly. Assurance report to QSC Committee. Individual district performance reports reviewed by Care Group. Trust Board			
1159	The risk of fire at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	**DFR**	AC	• Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by Senior Managers. • Quarterly review undertaken by Estates Trust Action Group. • Weekly risk scans are completed by the Trust's Fire Safety Advisor • Adherence to standards for the provision, installation, testing and planned maintenance of fire safety equipment and systems. • The identification of standards for the control	4 Major	3 Possible	12	1-6 Compliance risk	• Task and finish group working on implementation of smoke free policy for the remainder of the Trust sites (CMO, March 2024). • Task and finish group to continue to review the impact of the implementation of smoke free policy (CMO, March 2024). • The rollout programme reviews of the sprinkler system at the Estates TAG and fire risk assessment take place yearly (Yearly, DFR, Capital Programme process for 23/24 and beyond commenced at December 2023 Estates TAG. • Annual fire risk assessments to be completed annually by March every year (once a year, March, the next one will be March 2024 (DFR). • Compliance reviewed monthly with Learning and Development and	29 March 2024	Executive Management Team Estates Trust Action Group (monthly) Safety Trust Action Group (Quarterly) Operational Management Group (monthly)	6	BAF Ref, SO 2	February 2024

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South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				of combustible, flammable or explosive materials • Delivery of fire safety awareness training • Fire safety training compliance broken down by face to face and e-learning which is measured monthly at Operational Management Group. • Emergency procedures in place to ensure early recovery from unforeseen incident involving fire. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme, new inpatient builds and major developments fitted with sprinklers. • Reinforcement of rules and fire safety message in locations where additional oxygen could be used. • Health and Safety annual report submitted annually to Trust Board. • QSC and the Audit Committee are updated (AAA report) at each committee meeting as part of routine sub-committee updates (monthly, DNQ) • The use of vapes on acute wards to support the smoke free policy has been agreed and a specific manufacturer has been identified with supplies only being available through the Trust • The annual statement of fire safety compliance approved by Executive Management Team on 11 January 2024					reported to OMG (consistently reporting exceeded target of 80%) monitoring will continue until 31 March 2024 (DFR, March 2024)		AC Trust Board			

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Implementation of smoke free policy on most Trust sites										
1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention • Restraint reduction • Covid-19.	**DNQ CMO**	QSC	• Clear policies and procedures, and reporting in place, providing framework for the identification and mitigation of patient safety risks. • Appropriate Operational Management Group (OMG), Clinical Governance Group and QSC escalation arrangements in place. • Reducing restrictive practice and intervention (RRPI) improvement plan implementation. • Formulation of informed risk management (FIRM) assessment training. (DNQ) • A group established to focus on improving performance in clinical risk assessment and care plan performance • Clinical Risk Panel monitors all staffing incidents to ensure appropriate actions to be taken including scans of all red and amber patient safety incidents • The Clinical Environmental Safety Group oversees ligature risk • Patient Safety Specialist Roles in place • Trust wide learning forum, (SI) facilitated by the Nursing Directorate. • The Reducing Restrictive Practice and Intervention (RRPI) team support learning with front line colleagues	4 Major	2 Unlikely	8	1-6 Clinical risk	• Recent Learning Disability Mortality Review (LeDeR) reports identifying Covid-19 impact on learning disability community are being reviewed for organisational learning opportunities and reported into EMT (DNQ, Ongoing) • Complaints policy and metrics subject to further review with regards to quality and response times. Revised proposal agreed and under implementation (DNQ, Ongoing further to agreement in EMT) • We have a task and finish group who continue to meet, focused on an enhancing consistency of oversight of serious incidents and serious incident action completion across care groups (DNQ, Ongoing) • Task and finish group looking at RRPI and medicines administration (ongoing, March 2024, CMO / DNQ)	29 March 2024	Performance & monitoring via Executive Management Team QSC Operational Management Group Trust Board Patient Safety report & incident report as well as monthly reporting in the Integrated Performance Report	6	BAF ref: SO 2	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• RRPI Team are supporting a shared approach to the Collaborative Bank • Regular Patient safety learning events • Quality strategy approved. • Care group governance is aligned to ensure consistency. • RRPI TAG										
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	**DFR**	AC	• Internal audit report on the Data Security and Protection Toolkit for 2023/24 was substantial. • Trust maintains access to information governance training for all staff and achieved the annual mandatory training target of 95% presented to Board in June 2023 (annual). • Designated Caldicott guardians and Senior Information Risk Owner (SIRO) (and deputies) in post. • Qualified and experienced data protection officer in post • Trust has appropriate policies and procedures that are compliant with General Data Protection Regulation (GDPR). • Improving Clinical Information and Governance group in place which is the governance group with oversight of information governance issues reporting into Executive Management Team. • Communications and awareness plan e.g. use of blue light system to highlight specific breaches.	4 Major	~~3~~ ~~possible~~ 2 unlikely	~~12~~ 8	1-6 Compliance risk	• Increase in training available to teams including additional e-learning and self-assessment using workbooks. (DFR, end of April 2024) • Bespoke team training in relation to information governance incidents will be rolled out over 2023/24 (DFR, June 2024) • Currently working on improving processes for capturing positive consent to share using a digital solution (DFR, March 2024) • Review into access hierarchy for Trust bespoke systems to be completed by Information governance manager (DFR, February 2024) • To raise awareness internally due to data sharing via programmes such as Microsoft excel where appropriate safeguards haven't been built in to avoid information governance breaches (DFR, February 2024)	30 June 2024	ICIG Operational Management Group Executive Management Team AC Trust Board	4	BAF Ref, SO2 **Note for Trust Board:** Comprehensive risk actions are in place to mitigate this risk, although the risk of human error remains. There is a proposal for a reduction in likelihood from 3 possible to 2 unlikely with an overall reduction of the risk score from 12 (amber) to 8 (amber). The IG training toolkit requirement is changing, and further work is required to be completed by 1 July 2024.	February 2024

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South West Yorkshire Partnership NHS Foundation Trust

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				• Data protection impact assessment process • Targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents and 'hot-spot-areas. • Formal decision logs are maintained for any temporary changes to policies as a result of wider incidents. • Confidentiality clause in staff contracts plus data protection included in managers' induction checklists • Processes in place for rectifying inaccurate or incomplete data and for erasing erroneous or inaccurate data • Trust communications in place to ensure services are aware of processes for ensuring differences between addresses on SystmOne and the NHS Spine are actioned • Information governance administrator now in post									
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for Psychiatric Intensive Care Unit (PICU) or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed.	**COO**	QSC	• Bed management process. • Ongoing partnership work with commissioners • Improving Mental Health Oversight Group • Improving Mental Health Partnership Group • Agreed governance structure • Workstreams in place to address specific areas • Routine reviews of care whilst out of area are in place. • Pathway for people with trauma informed emotionally unstable	3 Moderate	~~4 likely~~ 3 possible	~~12~~ 9	1-6 Clinical risk	• The actions in place that aim to reduce admissions and reduce length of stay with a focus on effective discharge from hospital to remain in place and are reviewed on an ongoing basis to ensure they remain fit for purpose (COO February 2024) • Continue to ensure escalation of clinically ready for discharge issues through to the multi-agency discharge meeting process (COO review February 2024) • Continue to use the West Yorkshire secondary care pathways work to consider implementation of a system wide approach to management of out of area beds to manage peaks in	29 March 2024	OMG QSC EMT Trust Board	4	BAF ref, SO 3 **Note for Trust Board:** EMT are recommending a reduction in likelihood from 4 likely to 3 possible with a reduction in risk score from 12 (amber) to 9 (amber), this reduction is due to patient flow	February 2024

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	The distance from home will mean that their quality of care will be compromised.			personality disorder is in place with a programme of training ongoing. • Barriers to discharge reports link into place-based delays in discharges. • Clinically ready for discharge escalation through multi agency discharge events in each Place. • Specific leadership at associate director level for patient flow. • Patient flow dashboard					demand. (COO, review February 2024) • Teams continue to work with partners across the Integrated Care System to make best use of the available resources to support discharge. (COO, February 2024) • Maintain progress on assurance reporting for wider impact of reduced out of area use (COO, February 2024) • Use learning from partners in relation to the continuity of care principles COO review March 2024)				improvements and a much reduced number of people being placed in an out of area bed.	
1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.	**DFR**	FIP	• Detailed internal capital planning and prioritisation process. • Integrated Care System (ICS) capital allocation process. • Internal cash availability. • Approved updated digital strategy. • System capital planning process. • Effective communication of Trust capital priorities to West and South Yorkshire Integrated Care System (ICS) partners. • Capital allocation for 23/24 meets out needs • The overarching Integrated Care Board (ICB) capital allocation and their tracking of system wide expenditure against it • Refreshed estates strategy ratified at July 2023 Trust Board • Estates strategy approved.	3 Moderate	4 Likely	12	1-6 Financial risk	• Consider the emerging cost pressure inflation risk in relation to construction costs and the impact on our capital plan (DFR, ongoing review for each scheme within the capital plan, 2023/24) • Consider how a revised Bretton scheme can be delivered within a reduced capital budget envelope (DFR,Q4) • Capital costs are incorporated into the older peoples strategy which is due to go to public consultation (DFR, February 2024) • To consider the ambitions within the Estates Strategy vs available resources (DFR, March 2024)	29 March 2024	Executive Management Team (monthly) FIP (monthly) Trust Board	4	BAF ref: SO 3	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1157	Risk that the Trust does not have a diverse and representative workforce at all levels which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population served and fails to achieve national requirements linked to Equality Delivery System2 (EDS2), Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).	**CPO**	EIIC	• Annual Equality Report. • Equality Impact Assessment. • Staff Partnership Forum. • Development and delivery of joint WRES, WDES and EDS2 action plan with local implementation actions being developed • Focus development programmes. • Review of recruitment with staff networks as and when needed. • Links with Universities on widening access. • Policy for bullying and harassment between colleagues. • Full time freedom to speak up guardian structure, resources, and associated policies • Workforce Strategy 2021-2024 supporting SWYPFT as a Great Place to Work • Establishment of staff disability network and LGBT network. • Working Carers Staff network established • Civility and Respect Guardians in place to support cultural change and staff experience decision-making groups • Internal review panels in place for disciplinary and grievance cases related to discrimination on the grounds of race. • Race Forward programme is established with a series of meetings now in place • Ongoing engagement with regional partners and our regional lead from NHS England with regards to disparity in ethnicity representation across nurse bandings	3 Moderate	3 Possible	9	1-6 Compliance risk	• Equity Guardians to be further embedded across services, work has started to further develop the roles and links with the diversity inclusion and belong lead (CPO and DNQ, Ongoing) • Race Forward action plan to tackle racial abuse from service users and families, is being co-produced with the Race Forward Group and taken forward by the Diversity, Inclusion and Belonging Lead (DNQ, review March 2024). • To review the feedback from the engagement sessions with Leadership and Talent development coach to develop recommendations and actions (CPO, March 2024) • Use of staff survey data year on year to improve staff experience with a focus on feedback from all diverse groups (CPO, June 2024) • FLAIR survey concluded. Recommendations and actions now being taken forward by diversity and inclusion and belonging lead together with the findings from Phase 1 work with the Leadership and Talent development coach (CPO,March 2024) Head of People Experience review of staff networks now complete, the recommendations will be presented to EMT (CPO,February 2024)) • Development of equality dashboards for EIIC to track data, progress and improvements (CPO, ongoing)	29 March 2024	Executive Management Team (EMT) (quarterly) EIIC Committee (quarterly) Trust Board	6	BAF ref, SO 1 and 4	February 2024

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				• Microaggression resource has been developed by the Race Forward group and is on the Trust intranet. • Phase 1 work completed by Leadership and Talent Development Coach to support inclusive culture									

Organisational level risks within the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1840	The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight.	**CPO/ DNQ**	PRC	• Appraisal policy in place • Regular workshops and training on appraisals • Intranet guide, resources and support regularly updated. • Regular Trust wide communication • Regular monitoring by PRC and Trust Board through the Integrated Performance Report • Local systems are in place to ensure completion and oversight of appraisals • People, Performance and planning lead has commenced • Supervision of the clinical workforce policy (next review December 2024)	3 Moderate	4 Likely	12	8-12 Business Risk	• A decision taken to expand the scope for a new system to include a wider learning management system which would include appraisals, talent management and broader learning. This is out for initial expressions of interest through procurement process (CPO, Review October 2024) • Extended the Workpal contract for a further 12 months to enable a full and proper procurement process to take place (Review October 2024) • Inpatient Lead supporting improvement work across the wards (COO, DNQ, January/ February 2024) • Work has commenced between the people planning performance and PB&R team to develop wider workforce systems and capacity through the use of business intelligence reporting (CPO, review March 2024) • Local arrangements being created to record appraisals, these need to be moved from paper based recordings to the Workpal system (COO, This continues to be reconciled, to review in February 2024)	29 March 2024	PRC Executive Management Team (EMT) Operational Management Group (OMG) Trust Board	6	BAF Ref: SO4 Systems interoperability (ESR does not link to the system so managers are not automatically assigned correctly)	February 2024

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1839	Maintaining people who are clinically ready for discharge in an inpatient bed impacts on bed capacity.	**COO**	QSC	• Patient flow processes establish barriers to discharge on admission • Routine multidisciplinary reviews • Care programme approach and care plans in place • Improving Mental Health Oversight Group • Improving Mental Health Partnership Group • Care Closer to Home steering group • Workstreams in place to address specific areas • Pathway for people with trauma informed emotionally unstable personality disorder is in place. • Barriers to discharge reports link into place-based delays in discharges - Multi Agency Discharge Meetings.	3 moderate	4 likely	12	8-12 Strategic risk	• Continue to implement the improvement plan (COO review February 2024) • Clinically ready for discharge issues continue to be escalated through to MADE meetings ,improvement work and the partnership group (COO February 2024) • Where MADE meetings have not reached a solution, a Gold command meeting will be established. (Ongoing, COO review February 2024) • The secondary care pathway in West Yorkshire is used to share learning of themes to barriers to discharge to inform future work streams. Similar work has commenced in South Yorkshire (Ongoing, COO to review in February 2024) • Review is underway in relation to the identification and reporting of people who are clinically ready for discharge in Forensic services (COO to review February 2024)	29 March 2024	Executive Management Team Operational Management Group QSC Trust Board	6	BAF Ref: SO2	February 2024
1758	The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care.	**CPO/ COO**	PRC	• Risk is reviewed monthly due to ongoing industrial action • Active business continuity and emergency planning processes in place • Established good partnership working with staff side and trade unions • Mutual aid arrangements in place with our two Integrated Care Systems • Regular reporting to Operational Management Group and Executive Management Team • High level comms messages agreed.	3 Moderate	3 possible	9	8 – 12 Strategic Risk	• Follow national guidance issued by NHS England and NHS Employers • Understanding the potential numbers of staff taking industrial action through information provided by the unions to enable us to assess the impact on services (CPO, Ongoing) • Continue to develop supportive communication messages to staff asking for support to maintain essential service (Ongoing as information emerges, 2023/24) • Multi-disciplinary operational work in place to manage the impact of industrial action and mitigate risks (Ongoing, COO, CMO) • Trust will be kept informed via paper to PRC (COO/ CPO/ CMO, as required)	29 March 2024	PRC Operational Management Group Executive Management Team Joint Information Cell Task and Finish Group Trust partnership forum Trust Board	9	BAF ref: SO 2 **Note for Trust Board:** This risk remains under review dependant on the outcome from national conversations.	February 2024

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Stepping down procedure agreed. • A separate strike committee was established to manage and consult with the British Medical Association on the terms and conditions for those doctors striking. This group can be reconvened as needed. • Silver command meetings to manage industrial action by junior doctors and consultants • Report to People and Remuneration Committee and Quality and Safety Committee by exception										
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy	**DS**	QSC	• Annual objectives and programmes in place • Service quality metrics in place • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems • Regular review and update of the strategy by Trust Board. • Quality improvement process in place for all significant change. • Equality Impact Assessment in place Trustwide • Annual objectives and priorities and programmes in place • Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives.	3 Moderate	2 Unlikely	6	1-6 Clinical risk	• Close involvement in Barnsley place to monitor potential impact and take measures to mitigate. (DS and COO March 2024) • To ensure digital innovations that support modernisation of clinical services are tested and developed with clinical teams (DFR/ DS/ COO Ongoing) • To further embed creative and cultural approaches in clinical services and integrated pathways (DS/ COO, March 2024) • Review and update all of you approach to support systematic impact and improvement (DS, March 2024) • To deliver priorities within the sustainability strategy, (DS, March 2024) • Develop and introduce sustainability impact assessments (DS, March 2024)	29 March 2024	EMT (monthly) Transformation board (monthly) Operational Management Group (weekly) QSC Trust Board	6	BAF Ref: SO1 & 2	February 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Involvement in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. • Trust-wide integrated change process in place • Focus on working towards the strategic ambitions of the Trust. • Internal place integration group now established • Stakeholder engagement plans reviewed and in place. • Measures in place to monitor the impact of the headline initiative from the social responsibility and sustainability strategy for responsive and inclusive services										
812	Risk the creation of local place-based solutions which change clinical pathways and financial flows could impact adversely on the quality and sustainability of other services.	**DS**	QSC	• Progress on system and service transformation reviewed by Board and Executive Management Team (EMT). • Quality Impact Assessment process for Cost Improvement Programme and Quality Innovation Productivity and Prevention (QIPP) savings in place. • Alignment of contracting and business development functions • Bi-annual Executive Management Team and Trust Board investment appraisal report • Progress on system and service transformation reviewed by Executive Management Team and Trust Board. • Active engagement in West Yorkshire and	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• On-going review with Integrated Care Boards of our plan during 2023/24 (DPD, 31 March 2024) . • To continue to develop Barnsley Integrated Health and Care Alliance with partners delivering on agreed plans and priorities (DS/COO, March 2024) • Consider the guidance on responsibility and partnership working and how we build capacity and capability to respond (DS/ DPD March 2024) • Development of Trust clinical strategy (CMO/ DNQ March 2024)	29 March 2024	QSC Executive Management Team (monthly) Trust Board	6	BAF Ref, SO 1 & 3	February 2024

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				South Yorkshire Integrated Care System (ICS) • Financial control process to maximise contribution. • West Yorkshire Mental Health and Learning Disability collaborative services board • Approach to collating and reporting insight from stakeholders place. • Horizon scanning for new business opportunities. • Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. • Clinical and quality Trust representation in place and Integrated Care System level quality boards (DNQ/CMO) • Trust have been involved in all Place based plans									
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	**DS**	QSC	• Transformation projects required to include engagement with external partners to ensure alignment. • Use of workshops with external stakeholders to co-produce changes. • Communications through contract meetings and other working groups to ensure appropriate sharing of information. • Regular team-to-team meetings with commissioner organisations to ensure strategic alignment.	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• Proactive development of relationships with GP Federations to identify opportunities for collaboration and alignment is underway. (DPD/ COO, Review March 2024) • Maintain strong links with national bodies to influence local and national systems thinking in relation to mental health and community services. (DS/ CE, Ongoing, review March 2024) • Alignment of priorities through provider alliances and integrated care partnership (DPD, March 2024) • The Equality, Involvement, Communication and Membership strategy is in place with action plans agreed. Delivery of key actions ongoing. (DS, review March 2024)	29 March 2024	Bi-monthly focus by EMT on transformation. QSC Trust Board reports as appropriate	6	BAF Ref, SO 1 & 2	February 2024

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				• Quarterly Partnership Board meetings. • Active participation at all levels in Integrated Care Systems and other place-based planning initiatives. • Equality, Involvement, Communication and Membership strategy. • Stakeholder plan developed with regular review through Executive Management Team • Business cases approved by Calderdale, Kirklees and Wakefield commissioners • Stakeholder plans in place • Involvement in the Overview and Scrutiny Committees (OSCs) regarding transformation proposals as required. • The prospectus that sets our Trust Offer has been reviewed and refreshed • Trust transformation and significant change plans aligned with commissioner's plans as set out in local Integrated Care System place-based plans Trust Board approved stakeholder engagement plan.									
1649	The current inconsistency in Speech and Language Therapist (SALT) provision could compromise the quality of care available in response to	**DNQ CMO**	QSC	• Situation, Background, Assessment, Recommendation (SBAR) issued communicating importance of identifying choking risks • Choking awareness training slide pack produced and circulated • Multi-disciplinary Team choking risk assessment	3 Moderate	3 Possible	9	8-12 Strategic risk	• Audit planned regarding compliance and quality improvement for the choking screening tool (DNQ, Undergoing audit, review February 2024) • Review of process/es for staff when patients are on escorted and unescorted leave and have an existing choking need – a draft set of principles have been produced and are going through internal clinical governance processes for approval.	29 March 2024	QSC Operational Management Group Executive Management Team (monthly) Trust Board	6	BAF Ref: SO 2	February 2024

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	choking incident.			for all inpatient areas in place • The Trust secured the services of an independent Speech and Language Therapist (SLT) provider to deliver additional SLT resource in Barnsley and in Wakefield inpatient services • An E-learning programme on ESR has now been rolled out essential to job role • A learning event from the thematic review is also available to watch on the Trust intranet (information regarding choking) • All wards are delivering protected mealtimes. • Adult Dysphagia and Choking Policy has been approved by Executive Management Team • All choking incidents and the progress of the choking action plan is reported to each Trust Board as part of the Complex Serious Incident Report • Trust wide SALT business case is now complete					These will then be shared with inpatient settings (DNQ, February 2024) (Trust central resource for SALT. Substantive funding from Wakefield, Calderdale and Kirklees has been confirmed. Barnsley place have agreed to fund the service using non-recurrent funds until the end of the 23/24 financial year (DNQ, April 2024)					
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.	**COO**	QSC	• Anti-climb measures in each garden worked through with estates • Induction / update for staff includes access to garden areas • FIRM risk assessments identify clinical risks and safety plans • Safe and supportive observation of patients at risk policy is in place	4 Major	3 Possible	12	8-12 Business risk	• Where necessary to maintain safety, a blanket restriction is applied in order to manage an immediate risk. This will be for the shortest time possible and within the guidance. (COO/DNQ, Review quarterly) February 2024 • Each area will maintain a risk assessment to understand the potential climb risks. (COO, ongoing, review quarterly February 2024) • Where appropriate, supervised access to garden areas is maintained.	29 March 2024	QSC Clinical Environment Safety Group (CESG) Executive Management Team (monthly)	6	BAF ref: SO 2 Note: There are ongoing discussions at the CESG re: how the organisation needs to manage this risk;	February 2024

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				to manage individual risks. • Ward security checks are in place in each area and safety systems and alarms are part of this • Blanket restrictions are now in place where necessary as there are gaps under the fence where contraband can be placed under or through • Improvement work in the garden area at the Dales is complete.					(ongoing, review quarterly (COO, February 2024) • The clinical environment safety group meeting will review this risk and make a recommendation regarding future actions (DNQ, Review every 6 months, March 2024) • Operational, clinical and Estates teams are working together in the clinical environment clinical safety group to use learning from previous incidents to improve across all areas (COO/DNQ review February 2024) – see notes. • The clinical safety group continue to review the findings of the incident which took place in October 2023 and review the risk (see comments) (DNQ February 2024)		Trust Board		incidents are discussed to ensure that the learning is shared across the clinical areas and estates and facilities provide an update on any work undertaken in a timely manner. This ensures that clinical areas are aware of how to manage the risk and how to manage the acuity and complexities of the service group across our inpatient areas. Additionally, at the CQC engagement meeting on 11/12/2023 a conversation was held regarding the garden area at the Oakwell centre, where it was acknowledged that the Trust has evidenced consideration of the risk and mitigations to manage the risk. The conversation also identified that CQC are awaiting the receipt of some photographs to assist them in the guidance	

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
													they provide to us. The risk rating remains the same.	
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives, potentially resulting in the Trust or system not meeting service users' needs	**DS**	AC	• Programme prioritisation processes. • Overall priority progress reports via monthly Integrated Performance Report. • Individual priority programmes via governance groups of change and partnership board, OMG and EMT. • Resources established aligned to programmes. • Annual planning process. • Leadership framework to build capability and to include change competencies. • Quality strategy approved and implementation plan established. • Integrated Change and Improvement Network established to develop critical mass across the organisation. • Development and implementation of interim executive leadership arrangements now in place • Additional capacity aligned to the Trust to support Alliance and partnership work in Wakefield, Kirklees and Barnsley • Additional capacity secured for identified programmes	3 Moderate	3 Possible	9	8-12 Strategic risk	• Agree resource availability to support system-wide programmes of work. (Annually, as needed, in line with business planning and priority programme setting) (EMT, ongoing review) • Review prioritisation and include stopping some activities based on risk assessment. (DS, in line with quarterly review of programmes and capacity, May 2024) • Build capability to enhance capacity through programmes including Institute for Healthcare Improvement (IHI), QSIR (Quality, service improvement and redesign programme) and other development programmes (DS, March 2024) • Discussions ongoing with each place Integrated Care Board (ICB) team to review opportunities for transfer of capacity as part of ICB operating cost review (DPD, March 2024)	29 March 2024	Quality Strategy update to QSC AC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board	9	BAF Ref, SO 3	February 2024

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• The new Quality Strategy was approved by Trust Board.										
1432	Risk of lack of succession planning and talent management may lead to gaps in key roles and fail to promote diversity	**CPO**	PRC	• Workforce plans include succession planning and talent management. • Leadership and management framework in place • Coaching and mentoring offer • Appraisal Policy • Board succession plan reviewed annually • Comprehensive management and leadership programmes • Key element of Trust Workforce Strategy. • Shadow Board Programme and Reciprocal mentoring programme • Streamline Internal transfer process established • Bank opportunities available for all substantive staff	3 Moderate	3 Possible	9	8-12 Strategic risk	• Develop our approach to diversity and leadership including our approach to talent management, (CPO, review June 2024) • Supporting Fellowship Programme across the system as opportunities arise (CPO, Ongoing 2024) • Organisational Development plan being developed (CPO, review February 2024) • Review of succession plans following new Board appointments (CPO, Review February 2024) • Raising awareness via the staff network groups on opportunities and strategies (CPO, Ongoing) • Working with our places and systems to collaborate on integrated career pathways and opportunities (CPO & DNQ ongoing work)	29 March 2024	PRC Executive Management Team Trust Board	4	BAF Ref: SO 3	February 2024
1151	Risk of being unable to recruit and retain clinical staff due to national shortages and growth in mental health investment/ commissioning which could impact on the safety and quality of current services and future development.	**CPO**	QSC PRC	• Safer staffing levels for inpatient services agreed and monitored. • Weekly risk scan by DNQ and CMO to identify any emerging issues, reported weekly to Executive Management Team. • Reporting to the Board through Integrated Performance Report. • Datix reporting on staffing levels. • Strong links with Universities. • New students supported whilst on placement. • Regular recruitment plans and processes.	4 Major	3 possible	12	8 - 12 Business Risk	• Further consideration taking place to identify the rights systems needed to support our recruitment and onboarding systems (CPO, review March 2024) • Explore any potential collaborative recruitment initiatives with West Yorkshire Mental Health and Learning Disabilities and Autism Collaborative (CPO, ongoing) • To broaden the care certificate for all new non registered support workers (CPO, review March 2024) • Internal transfer system to continue to be promoted (CPO Ongoing 2023) • Working through the NHS workforce plan to understand implications and actions (CPO, Review February 2024) • Review the numbers of international nurse recruits while considering the	29 March 2024	Care Group (weekly) QSC PRC Executive Management Team (monthly) Trust Board	9	BAF Ref, SO 3, 4 **Note for Trust Board:** Consideration will be given to review the themes and potentially merge in Quarter 4.	February 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Retention plan developed. • Working in partnership on international recruitment. • Inpatient ward workforce review with revised skill mix. • Marketing of the Trust as an employer of choice. • Workforce planning processes including development of new clinical roles and inclusion in all new business cases. • A careers microsite is now live • Review of entry level qualifications in support worker roles complete					impact on clinical teams (CPO, review March 2024) • Improvement work taking place to support international recruits to be fully operational on the ward (CPO/DNQ, review March 2024)					

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	**DNQ**	QSC	• Policies and procedures revised to take account of Covid-19. • Publication of Covid-19 guidance on the intranet. • Communication to all staff as required. • Provision of appropriate personal protective equipment during any outbreak, in line with national guidance. • Bronze, silver and gold command incident processes available to be reinstated as and when required. • Infection Prevention Control of infection support in place. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • Situation, background, assessment, recommendation (SBAR) templates are produced to share learning from outbreak management investigations. • Timely delivery of flu vaccination programme • Routine reviews of IPC Board Assurance Framework reported to NHS England and NHS Improvement via QSC committee. • Ongoing review of IPC practice in line with regional and national guidance, and local feedback. • High risk groups / vulnerable patients, either due to underlying health conditions or certain	4 Major	3 Possible	12	1-6 Clinical risk	• Work continues around promotion of vaccination programme to service users as part of the admission process, and to staff as part of the national campaign. (DNQ, Ongoing) • Continuing monitoring and review for learning of any Covid-19 cases and outbreaks (DNQ, review ongoing) • Currently delivering the autumn/winter flu vaccination programme 2023/24 (DNQ / CPO) •	29 March 2024	QSC Executive Management Team (monthly) Moving Forward Group Operational Management Group Improving Clinical Information Group (ICIG) Trust Board	4	BAF ref: SO 2	February 2024

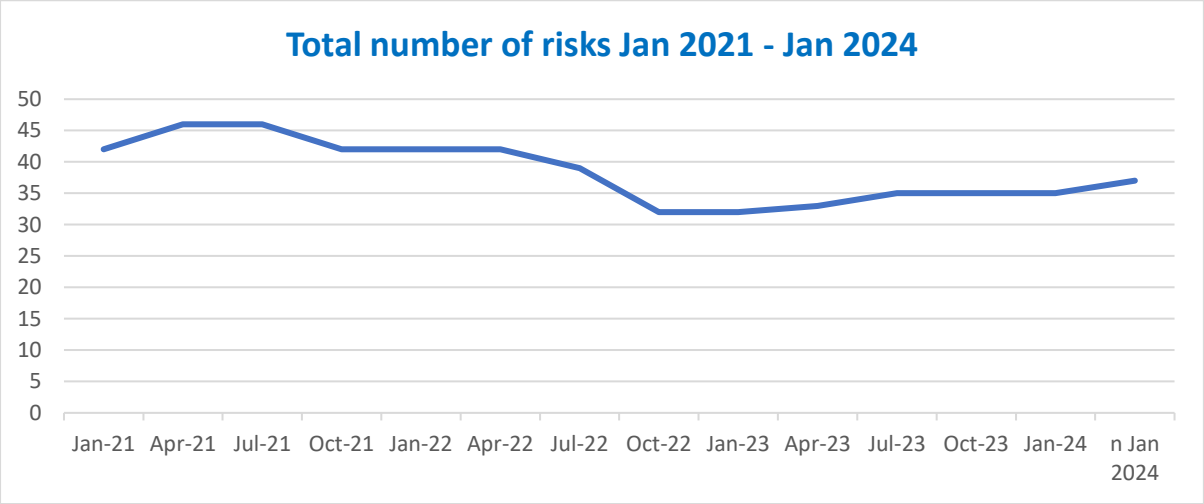
Risk ID	Description of Risk	Risk Owner	Nominated Committee	Control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				protected characteristics (notably people from a Black and Minority Ethnic (BAME) background, and people with a learning disability), identified by clinical teams and treatment plans reviewed. • Service user Covid-19 vaccination programme is delivered in line with national guidance. • Action plan related to the Physical Health Optimisation Strategy is regularly reviewed by the Physical Health Lead and with updates.										
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic or as a result of the public inquiry.	**CMO**	AC	• Covid Inquiry lead, Executive lead (CMO) and oversight committee (Audit) in place, linked into national inquiry • Learning events and covid inquiry task and finish group established. • Document control in place for all levels of command structure including hard copy (safe haven) • Reports to EMT, Audit Committee and Trust Board via AAA report.	4 Major	3 Possible	12	1-6 Compliance risk	• Regular reinforcement of key messages to staff (DS, In progress and will continue, ongoing) • Covid task and finish group to continue to prepare for the inquiry in line with national guidance (DDCG, April 2024) • The Trust anticipates involvement in modules 4 and 6, however given the framework for the modules we will not be core participants but will support Acute and Local Authority colleagues.(DDCG, Review April 2024)	31 July 2024	AC Moving Forward Group Covid Inquiry Task and Finish Group Operational Management Group Executive Management Team Trust board	6	**Note for Trust Board:** The inquiry is currently underway and at parliamentary decision stage therefore the review date has been extended to April 2024 when the Trust should have outputs and further information.	April 2024

Appendix 1

Trust Board
30 January 2024
Organisational Risk Register (ORR)
Quarter 3 analysis, January 2021 – January 2024

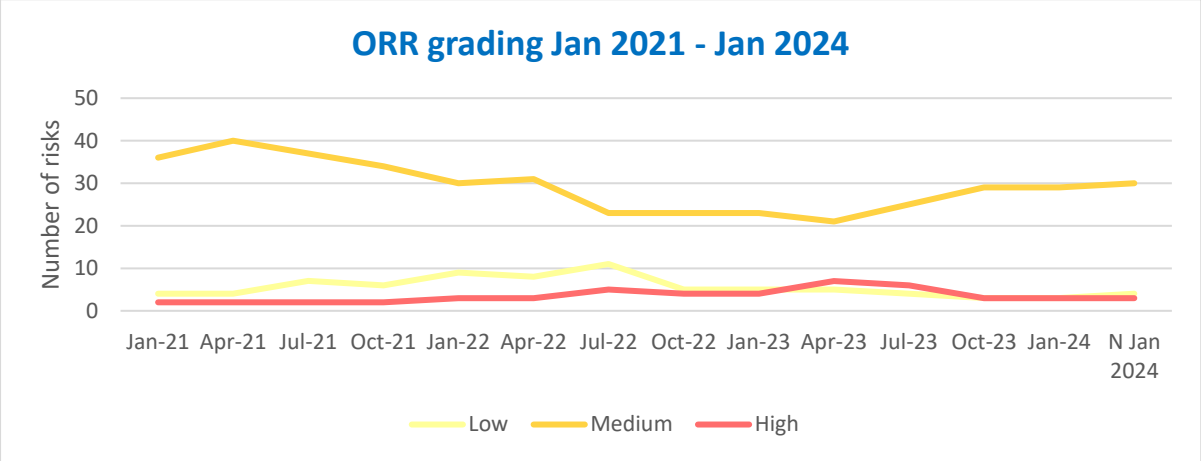
This heat map includes figures from the current Organisational Risk Register from January 2021 to January 2024 as well as the proposed changes.

Total number of risks from January 2021 to January 2024



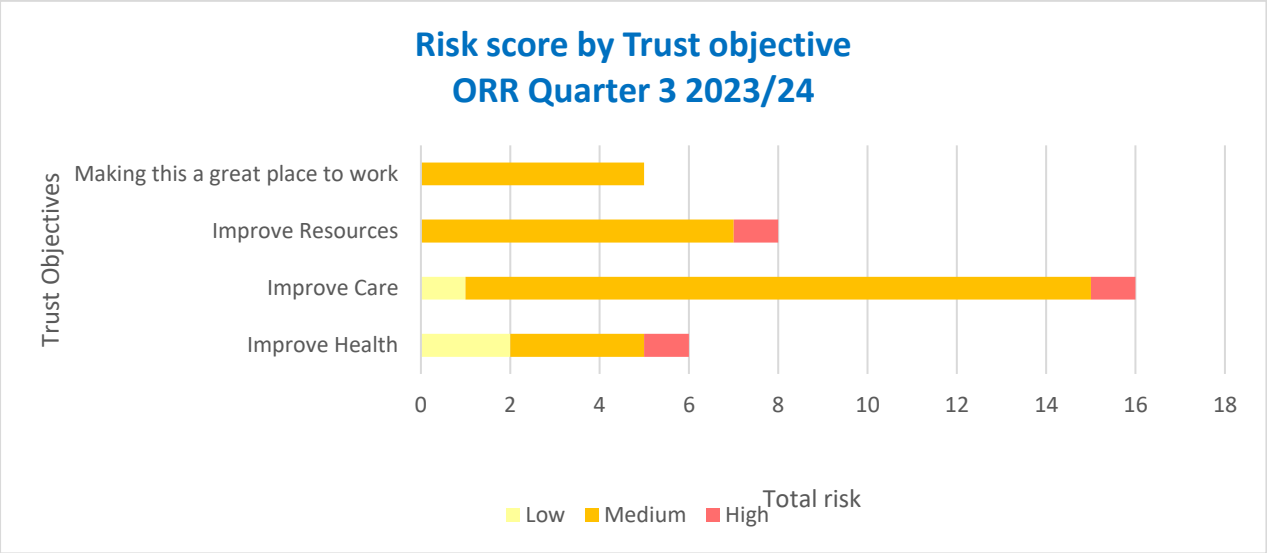
Proposed changes = N Jan 2024

Total risk by grading from January 2021 – January 2024

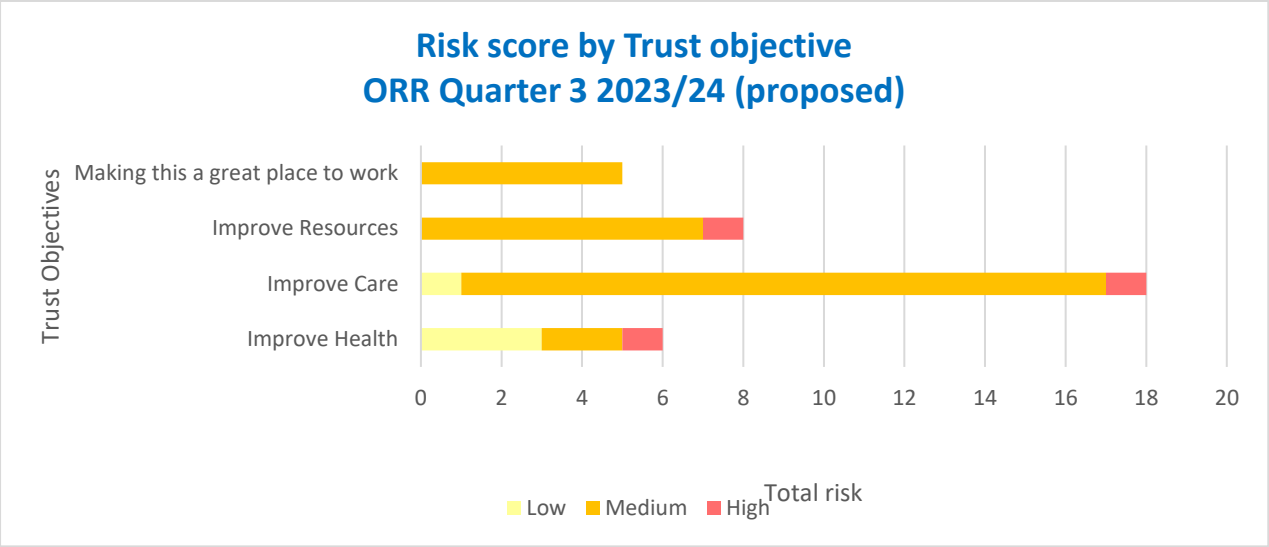


Proposed changes = N Jan 2024

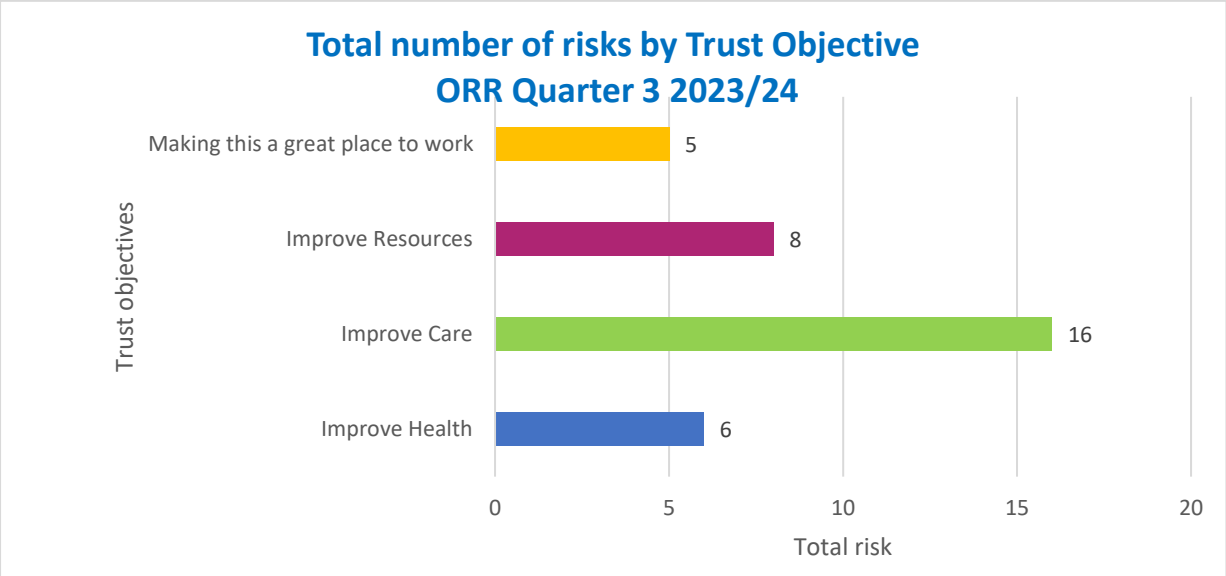
A current breakdown of Trust objectives ORR Quarter 3 2023/24



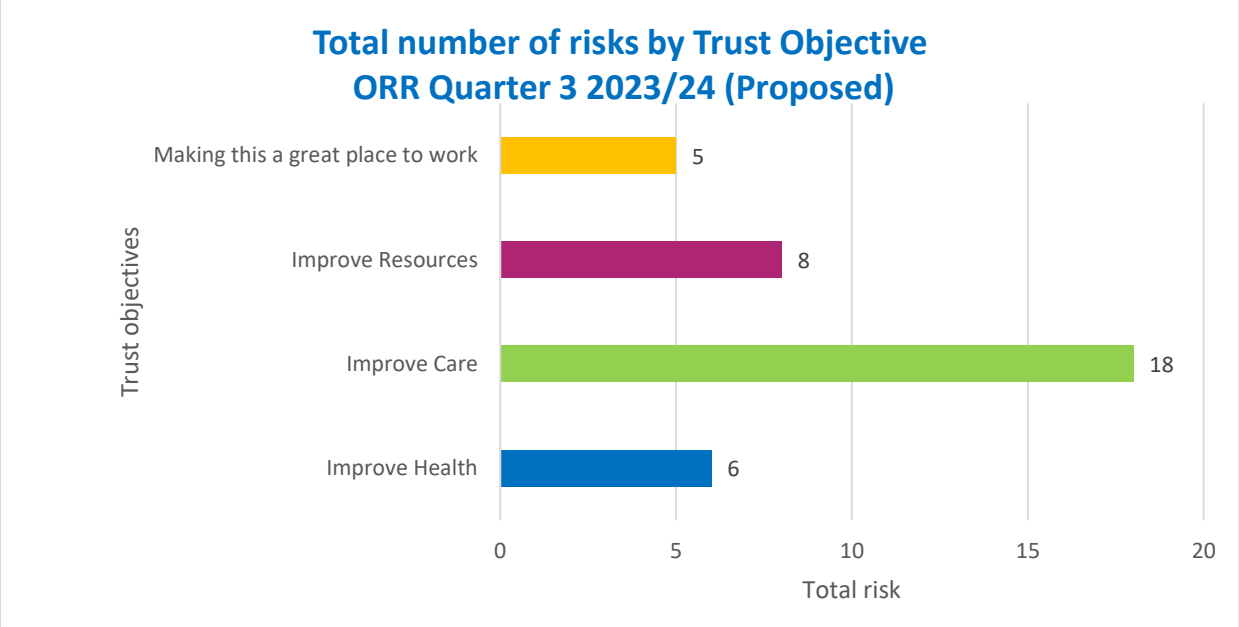
Proposed changes



Total number of risks by Trust objectives ORR Quarter 3 2023/24



Proposed changes



There has been an increase in the total number of risks under Trust objective, Improving Care by two risks.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.3

Private/Public paper:	**Public**		
Title:	**Annual Planning**		
Paper presented by:	**Sean Rayner- Director of Provider Development** **Adrian Snarr- Director of Finance, Estates and Resources**		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of our annual plan supports the effective use of resources and our wider strategic objectives, by ensuring we have the financial resources in place to deliver high quality, patient-centred care both as a Trust and wider system partner.		
Purpose:	The purpose of this paper is to provide Trust Board with an update on the development of the Trust operating plan for 2024/25.		
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 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 a system approach to planning, and also developments and discussions in progress where relevant.		

Any background papers / previously considered by:	An update on the Trust financial plan was presented to, and discussed, at EMT Time Out on 18th January 2024. A verbal update on planning was provided to the Finance, Investment & Performance Committee in January 2024.
Executive summary:	On 22nd December 2023, NHS England (NHSE) wrote to ICBs and Trusts to provide an update on planning for 2024/25. It was advised that: • 2024/25 priorities and planning guidance would not be published until the new year. • Systems and providers should not wait to start planning until the guidance has been published. • Financial allocations for 2024/25 have been published. • The overall financial framework will remain consistent, including the payment approach used to support elective recovery. • System plans will need to achieve and prioritise financial balance. • The priorities and objectives set out in 2023/24 planning guidance and the published recovery plans on urgent and emergency care, primary care access, and elective and cancer care will not fundamentally change. • The key requirements will be for systems to maintain the increase in core urgent and emergency care (UEC) capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service. • The final position and performance expectations will be confirmed in Planning Guidance. • Initial planning returns will be expected by the end of February. Preparatory work has been taking place both internally and at ICB level. The attached paper provides an update on expected planning priorities, the development of the Trust Plan, and outlines a planning timetable, which will be confirmed once guidance is received. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update on the development of, and timescales for, the Trust operating plan for 2024/25.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024

Agenda item 9.3

Annual Planning

1. Introduction

The purpose of this paper is to provide Trust Board with an update on the development of the operational plan for 2024/25.

2. Background

On 22nd December 2023, NHS England (NHSE) wrote to ICBs and Trusts to provide an update on planning for 2024/25.

It was advised that:

- 2024/25 priorities and planning guidance would not be published until the new year.
- Systems and providers should not wait to start planning until the guidance has been published.
- Financial allocations for 2024/25 have been published.
- The overall financial framework will remain consistent, including the payment approach used to support elective recovery.
- System plans will need to achieve and prioritise financial balance.
- The priorities and objectives set out in 2023/24 planning guidance and the published recovery plans on urgent and emergency care, primary care access, and elective and cancer care will not fundamentally change.
- The key requirements will be for systems to maintain the increase in core urgent and emergency care (UEC) capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service.
- The final position and performance expectations will be confirmed in Planning Guidance.
- Initial planning returns will be expected by the end of February.

The following documents were shared.

- Draft NHS Standard Contract for 2024/25 and associated documents.
- Proposed amendments to the NHS Payment Scheme for 2024/25.
- Updated Joint Forward Planning guidance for 2024/25.
- Guidance on developing 2024/25 Joint Capital Resource Use plans.

3. Mental Health

In the absence of planning guidance, and assuming as set out in the letter from NHSE priorities and objectives set out in 2023/24 planning guidance do not fundamentally change, key planning objectives in relation to mental health are expected to be:

- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0 –25 accessing NHS funded services (compared to 2019)
- Improve numbers of adults and older adults receiving a course of treatment for anxiety and depression via NHS Talking Therapies and achieving reliable recovery.
- Increase access to transformed community mental health services.
- Improve the quality and safety of care in inpatient settings by working towards eliminating inappropriate adult acute out of area placements.
- Recover the dementia diagnosis rate to 66.7%
- Recover access to perinatal mental health services in line with the national ambition for 66,000 women accessing NHS funded services.

4. Urgent & Emergency Care (UEC)

Key planning objectives in relation to urgent and emergency care (UEC) are expected to be:

- Systems to be delivering performance of at least 76% against the 4 hour UEC standard by the end of 2023/24, and drive further performance improvement through 2024/25.
- Systems support improvement in Ambulance handover and response time performance.

5. People with a learning disability and autistic people

Key planning objectives in relation to learning disability and autism are expected to be:

- Increase in proportion of people on GP Learning Disability registers who have an annual health check.
- Increase in proportion of people who have had an Annual Health Check, who have a Health Action Plan.
- Increase in proportion of people of people on GP registers, who are also on the GP Learning Disability registers.
- Delivery of 100% of LeDeR reviews (Learning Disability Mortality Review) within 6 months of notification.
- Delivery of 35% of LeDeR reviews, as focused reviews.
- Inclusion of people with a learning disability, and autistic people in Health Inequalities measures, as per Core20+5.
- Reduction in adults with a learning disability or autism in mental health hospitals (no more than 30 people per million population).
- Reduction in adults with a learning disability or autism in mental health hospitals (between 12-15 per million population).

6. Community Health Services

In the absence of planning guidance, and assuming as set out in the letter from NHSE, priorities and objectives set out in 2023/24 planning guidance do not fundamentally change, key planning objectives in relation to community services are expected to be:

- Maintain full geographic rollout and continue to grow services to reach more people, extending operating hours where demand

necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance.

- Increase the number of referrals from all key routes, with a focus on Urgent and Emergency Care (UEC), 111 and 999, and increase care contacts.
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development.
- Achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2-hour UCR demand within 2 hours.
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth.
- Improve capacity in post-UCR services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission.

7. Care Group Plans

To support Trust and system level plans, work has been underway in the Trust to develop draft plans at Care Group Level and Corporate Services Level, covering the following areas;

- Care group strategy, quality and performance.
- National and local priorities.
- Inequalities approach.
- Workforce challenges and requirements.
- Estates and digital requirements.

Workshops with each service area were held in October and November 2023 to facilitate completion of plans and included representation from Operations, Finance, Strategy and the People Directorate.

Final templates will be completed for each area to ensure a consistent set of assumptions available for narrative, workforce and finance submissions.

8. Approach by Place and Internal Trust Planning Timetable

Meetings have been established in each of our ICBs in order to support plans which the Trust is fully engaged in. In West Yorkshire, all providers have been asked to complete activity and workforce returns, in order not to wait for planning guidance and formal templates to commence the work.

The diagrams below set out the system approach to planning, and the West Yorkshire approach to plan development, with each Place developing plans which will be consolidated at ICB level.

Figure 1: Whole-system approach to operational planning

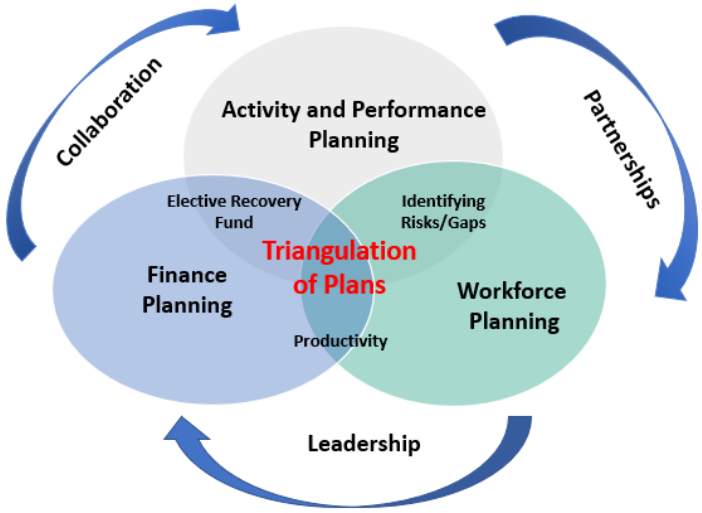
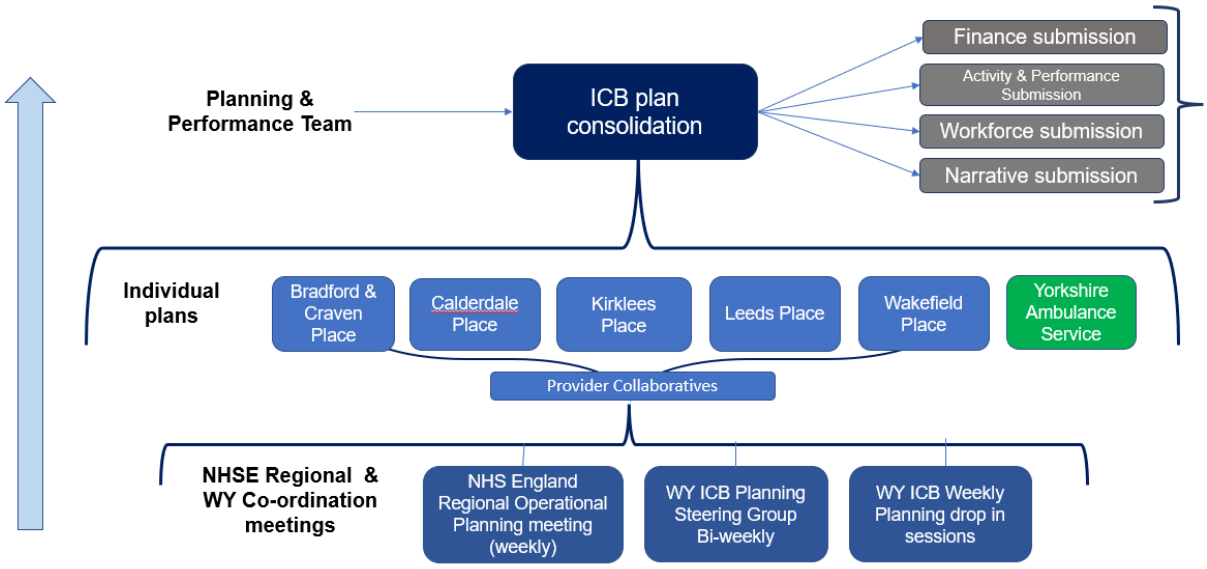


Figure 2: West Yorkshire ICB Operational Plan Development



It is envisaged that, once planning guidance is published, Place- based meetings will also be established. The Trust is working to the following indicative timetable (noting this may change when guidance is published). A first ICB plan submission is expected at the end of February, therefore the Trust will need to review governance arrangements for sign off of the plan once timescales are confirmed.

Date	Key Milestones	Lead
January 2024	Planning guidance issued.	All
January 2024	Non functional templates issued: • Activity and performance • Workforce • Finance	NHSE
18th January 2024	EMT Time Out- financial planning discussion.	Adrian Snarr
22nd January 2024	Update provided to FIP	Adrian Snarr
30th January 2024	Update to Board	Sean Rayner Adrian Snarr
TBC	Functional planning templates issued: • Activity and performance • Workforce • Finance • ICS narrative	NHSE
2nd February 2024	Deadline for West Yorkshire activity and workforce templates to be shared with ICB.	Mel Wood Richard Butterfield
8th February 2024	Update provided to EMT	Sean Rayner Adrian Snarr
February 2024 tbc	Internal deadline for completion of activity and workforce templates	Mel Wood Richard Butterfield
February 2024 tbc	Deadline for contributions to place plans	Izzy Worswick
February 2024 tbc	Board sign off of draft plan	Sean Rayner Adrian Snarr
End of February 2024 tbc	First ICB Plan Submission	ICB
7th March 2024	Update provided to EMT Final finance submission approved.	Sean Rayner Adrian Snarr
March 2024 tbc	NHSE Checkpoint meetings	Izzy Worswick
18th March 2024 tbc	Final financial plan shared with FIP	Adrian Snarr
March 2024 tbc	Final plan sign off from Board	Adrian Snarr
March 2024	Final ICB Plan - submit to region	ICB

9. Next steps

Planned next steps in the development of the annual plan are as follows:

- Receipt of national planning guidance.
- Completion of Care Group and Corporate Service plans.
- Development of Trust draft workforce and financial plans.

Recommendation

Trust Board is asked to:

- **NOTE** the update on the development of, and timescales for, the Trust operating plan for 2024/25.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.4

Private/Public paper:	**Public**		
Title:	**Bi-annual safer staffing report**		
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Paper prepared by:	Colin Hill, Specialist Advisor for Safer Staffing Kath Hemming, Assistant Director of Nursing, Quality and Professions		
Mission/values:	• We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of this report is to provide assurance to Trust Board members with regards to the Trust's oversight and response to Safer Staffing requirements including: Right Staff: Right Skills: Right Place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with the then NHS Improvement (NHSI) Developing Workforce Safeguards policy 2018. The report also provides an outline of the work in progress and plans in place for the future to ensure the Trust's clinical areas are staffed to deliver safe and effective services.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.3 - Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care Risk 3.3 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and sustainability of safer staffing levels Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust works closely with partners across the integrated care systems and learning and good practice is shared through informal and formal networks. One example of this is the work described in the report to develop a collaboratively develop bank staff resource between the Trust and two West Yorkshire provider colleagues.
Any background papers / previously considered by:	This report was reviewed by Quality and Safety committee on 9th January 2024, where it was recommended to Board. The committee plan to formally review the structure and content of this report. The non-executive director chair of the committee and the chief nurse / director of quality and professions are both involved in this review. This report is submitted to the Quality & Safety Committee and Trust Board twice each year.
Executive summary:	Safer staffing remains a priority within the Trust. This report provides an outline of the work in progress and plans in place for the future to ensure our clinical services are staffed to deliver safe and effective services. Making decisions about staffing follows a triangulated approach which includes three key expectations: Right Staff; Right Skills; Right Place and Time. Our approach to these is detailed within the report, highlighting our commitment to deliver safe care which promotes good outcomes for our service users and a positive experience for our workforce. Safer staffing remains a challenge both locally and nationally, and this report highlights the work taking place in the Trust to mitigate and manage this, in an attempt to create a sustainable position. We will be reviewing the format of the report for Quality and Safety Committee in April 24 and subsequently Trust Board, to provide clearer presentation and analysis of the data and include further triangulation of data at ward level. The aim of this will be to enhance the level of assurance provided to committee and Board. Key points to note include: **Safer staffing levels** • Local, regional and national challenges with recruitment of health and care staff continues. • There continues to be a high reliance on bank and agency shifts to reach / maintain safe staffing. • There are occasions when unfilled registered nurse shifts are replaced with health care assistants to meet safer staffing numbers, leaving a deficit in skill mix. • The registered nurse fill rate has continued to improve which, has a positive impact on care. • Overall shift fill rate has remained consistently high, which indicates wards are busy with high acuity.

	• There are robust escalation processes in place. **Recruitment activity** • In the current year to date (from April) we have seen a total of 339.5 starters and 285.9 leavers. Our vacancy position continues to reduce (17.6% last year, currently at 16.3%). • Recruitment activity is 35% higher in the past 6 months than in the previous 6 months and the Trust has seen more starters than leavers in all four of the last quarters preceding this report. • A number of actions have been implemented to support recruitment and retention of staff, including international recruitment, flexible working, and recruitment of bank and agency staff. This has allowed us to reduce our vacancy rate and maintain high fill rates whilst reducing agency usage. • The Trust continues its current recruitment activity which includes widening entry level opportunities for new starters and expanding our reach for advertising in all roles. • Through our international nursing recruitment programme we have successfully recruited 110 nurses. An improvement plan has been developed to support their further integration into the clinical areas based on feedback from the nurses and the clinical areas. **Benchmarked performance** • When benchmarked against the latest workforce statistics published by NHS England on nhsdigital.nhs.uk (May 2023) the Trust has the lowest turnover rate in our region and the highest for the staff stability index. • Care hours per patient day benchmarking with regional providers shows variance across our wards. **Quality assurance** • We continue to utilise the Mental Health Optimal Staffing Tool (MHOST) to support staff modelling and template review processes. • Reporting mechanisms are in place and we are exploring how these can be further strengthened, to understand the full quality impact on care and experience of staffing levels. • Staff continue to report staffing concerns on Datix (the Trust's incident reporting system) and these are reviewed at the patient safety oversight group (formerly clinical risk panel).
Recommendation:	**Trust Board members are asked to RECEIVE the content of this report.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
Bi-Annual Safer Staffing Report
November 2023 (submitted in January 2024)

1. Purpose of report

The purpose of this report is to update and provide assurance to Trust Board members with regards to the Trust's oversight and response to safer staffing requirements including: right staff, right skills, right place; establishment reviews; workforce planning; new and developing roles; and recruitment and retention in line with the then NHS Improvement (NHSI) Developing Workforce Safeguards policy 2018. It will provide an outline of the work in progress and plans in place for the future to ensure our clinical areas are appropriately staffed and can deliver safe and effective services.

The report will cover the points within the Trust Board safer staffing checklist (Appendix 1) to enable Trust board members to have the information required to assure themselves that the trust continues to staff services in a way that enables the delivery of safe and effective care. The time frame of the report is April to September 2023.

2. Background

All NHS trusts are required to deploy sufficient, suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. They should also have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and always keep them safe. The approach used must reflect current legislation and guidance where it is available, (National Quality Board (NQB), Safe sustainable and productive staffing, 2016).

To demonstrate how the Trust approach this, regular papers on safer staffing have been presented to committee and Trust Board and the Trust reports monthly on safer staffing through the Integrated Performance Report (IPR) and other reporting mechanisms related to quality of care, service user, and staff experience. This report builds upon the safer staffing paper presented at committee and Trust Board in April 2023.

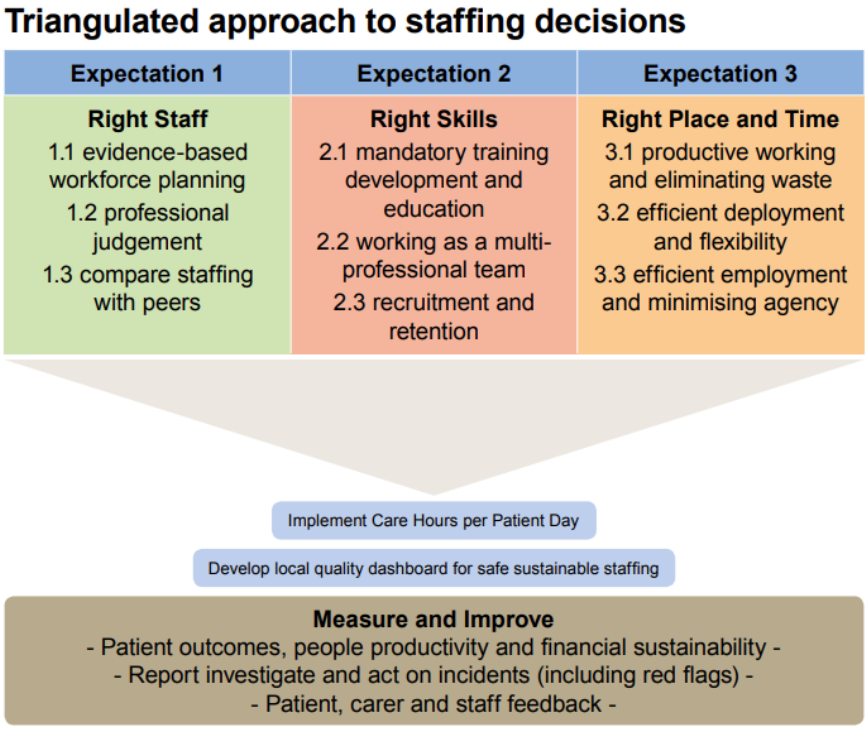
3. Introduction

Safer staffing remains a priority of the Trust, as well as regionally and nationally. There are significant challenges with workforce across all health and social settings, meaning services are working hard to manage and mitigate risks to ensure safe and effective care is delivered. This requires complex decision making on a regular basis by registered clinical and operational colleagues as well as at specialist advisor and executive management level.

The responsibilities from a professional nursing perspective are clear as outlined below:

"It is the responsibility of every registered nurse in the UK to ensure they are working in environments that have safe staffing and to report to senior management when safe staffing levels are not achieved" (Nursing and Midwifery Council, 2014).

Making decisions about staffing should follow a triangulated approach. The flow chart below from the National Quality Board supports providers of NHS services with the delivery of the right staff, with the right skills, in the right place at the right time (National Quality Board, 2016).



Below are some examples of how the three expectations are demonstrated within our Trust.

Right staff

- Our Trust continues to utilise the Mental Health Optimal Staffing Tool (MHOST) when looking at establishment reviews and revising templates to incorporate new roles and responsibilities.
- The review of the establishments within older aged adults and working aged adults has been completed and is currently being quality reviewed.
- During the process of reviewing the establishment, we ensure that we retain the principles of safe staffing (NQB's 2016 guidance)

Figure 1: Principles of safe staffing

- Managers are empowered to use a range of interventions, for example, the use of bank and agency to ensure safer staffing where unexpected clinical complexity and acuity is encountered.
- We continue to analyse comparative data regionally and nationally to ensure that we remain at the forefront of best practice and remain involved in various groups developing a more robust data set.
- This analysis has shown that there is an improving trajectory in our fill rate, and therefore the delivery of the expected Care Hours per Patient Day for registered staff. The continued recruitment activity, for both substantive and flexible staffing, will support this positive trajectory.

Right skills

- Mandatory training continues to be an area of focus within the Trust. A series of deep dives have been undertaken to understand challenges with meeting compliance in key areas and action plans are in place to ensure recovery. This includes ensuring that the flexible staffing resource complies with the mandatory training targets.
- With support of the learning and development team, we are reviewing the training curriculum of our master vendor agencies to ensure they remain relevant to our subject matter.
- Ensuring we embrace the skill set of our internationally educated (INE) colleagues enhances our service offer, whilst ensuring that the challenges of integration of these colleagues are understood and that we develop a bespoke strategy to support this
- A continued effort to focus on staff wellbeing and development to support the retention strategy.
- At the end of September 2023, appraisals compliance was 73.3%, mandatory training compliance was 93.6%, supervision was 65%m with plans for further improvement in place.

Right time and place

- Demand and capacity modelling with our community teams is currently taking place, to understand the expected capacity required to deliver safe and effective care.
- The use of Safecare to review the impact on quality indicators.
- The commitment to be sustainable and eliminate unwanted variation and waste.

- The flexible approaches to working hours, flexible working and peripatetic teams will support vacancy recruitment. The soft launch of a collaborative bank with Bradford District Care and Leeds & York Partnership NHS Trusts with a pilot group of staff
- We will also be monitoring the effects, positive or negative, on our fill rates as this comes online.

4. Current Position

Workforce planning and additional roes

Ensuring that the Trust delivers a safe and effective standard of care remains a core principle. This creates an ongoing need to ensure we have sufficient staff, with the right skills and experience, to deliver this care. Due to the current employment market, providing these resources remains challenging and increases the pressure on our existing workforce, which in turn has an impact on staff wellbeing, as well as potentially impacting on the quality of care we are then able to offer. However, through the centralised assessment centres, international recruitment, online recruitment events as well as various other interventions, we have managed to increase the number of staff recruited into the Trust in the past 12 months. Within inpatient areas we have reduced vacancies to 18 for band 5s at the time of writing this report, and are continually working to fill them. Support will continue to identify and take action in difficult to recruit areas.

The nursing workforce plan is currently under development and will be available early in the new year. This will allow us to report on more specific figures regarding vacancies and turnover rates.

We continue to focus on the recruitment of registered nurses (RN) to meet the skill mix needs of our inpatient and community teams. RN recruitment continues to be impacted by the number of newly trained colleagues compared to the requirement, leading to the Trust engagement with the international nursing recruitment programme. Further detail about this work is discussed later in the report.

The nursing associate role has grown from 36 on the programme between November 22 and April 23 to 39 currently on the programme. We are also supporting 19 qualified nursing associates to top up to a RN through the registered nursing degree apprenticeship (RNDA), and a further 21 health care assistants (HCA) to complete the full 4-year RNDA programme. Further growth to the nursing associate role and RNDA apprenticeship will be determined by the Trust workforce plan.

We continue to have HCA vacancies, with the majority of these being at band 3 level rather than band 2. Following recent discussions with colleagues in the Care Groups, we will be supporting current band 2s to develop their skill set to match the requirements of the band 3.

A peripatetic workforce is being reintroduced, to reduce our reliance on bank and agency colleagues and provide a pipeline of substantive recruits, however recruitment has been impacted by the need to fill all substantive vacancies within our teams. We have utilised nearly all identified resources to cover vacancies in teams. In January 2024 we plan a recruitment focus on the peripatetic workforce.

E-Rostering
In line with the 360 audit recommendations and NHS England (NHSE) standards we have introduced an e-rostering steering group, as well as continuing to send the weekly e-rostering report regarding the utilisation and effectiveness of the system. This provides oversight and scrutiny of the system and its usage. The steering group will include a check and challenge process from a systems perspective and will be aligned to operational processes as well.

The transition onto the e-rostering system continues in line with the rollout plan that was presented and accepted at EMT in August 2023. Currently, 73% of the clinical workforce is now using e-rostering. The roll out continues with Barnsley CAMHS recently going live. There is a planned roll out to the urgent community response team in mid-January 2024, followed by the neighbourhood rehabilitation service at the beginning of February 2024. This allows for a better understanding of the resource available (capacity) compared to the acuity (demand) within the teams. It also supports the utilisation and deployment of the staffing resource to ensure the reduction of any clinical risk.

Safecare
To date, Safecare has been rolled out across the forensic wards and the Oakwell Centre in Barnsley and training to roll out the tool across Kirklees and Calderdale has commenced. This can identify staffing issues and where redeployments would be beneficial to mitigate safety issues due to staffing across a service/locality, which will lead to more efficient staffing decisions. In addition to redeploying staff, Safecare also offers a more flexible and easier method of performing day-to-day rostering updates, such as adding absences.

As part of incident reporting, Safecare allows staff to record ‘red flags’ where an incident has happened or aspects of required clinical care have not been provided. This can be triangulated within the system when looking at staffing levels and patient dependency/acuity at the point at which the incident happened. These incidents can be reviewed and updated in the system to ensure correct escalation and subsequent incident reporting are followed.

There have been inconsistencies in compliance with the tool across the wards in each of the services with some of the early positive results of use of the system declining, (see table below).
Rollout position to current date:

Forensic wards		**Oakwell Centre**	
Sept 22	**Dec 23**	**Oct 23**	**Dec 23**
54%	46%	60%	42%

There are several factors which impact on uptake, one of which includes the services following the process set out in the standard operating procedure regarding operationalisation of the system. This also includes oversight and reviews of the data not being followed to ensure that regular data is reported and accurately reflects dependency and acuity levels within the area.

An action plan will be developed which will be monitored through the safer staffing group and shared in the next reporting period. The action plan will set the plan to achieve compliance

with the tool usage and if compliance cannot be achieved set out a timeframe for review as to whether the Trust continues to use the tool. Compliance with the tool will be monitored via the monthly safer staffing group.

We continue to engage with staff pre, and post roll out and implement actions following lessons learned. These include:

- More in-depth training on the clinical aspect of the tool.
- Introducing and improving understanding of the data that can be collected and how this can be used.
- Further engagement with the service managers to include walk arounds and sharing invites to the ward manager events to discuss usage and outcomes.
- Offering Safecare champion training so experts are at hand, this has had a positive impact uptake so far.
- Refreshing the questions and answers (Q&As) to reflect the discussions had during the walk rounds.
- Giving access to bank and agency staff, along with training, to promote consistency of usage.

These interventions have aided staff being more cognisant with the tool and gaining a higher compliance of completion with those currently implementing the tool, in comparison to earlier rollouts. Revisiting early implementors to reinvigorate engagement and compliance will be included in the action plan.

Safer Staffing Levels

Trust wide community safer staffing data is not currently available to replicate the inpatient data that is presented in the monthly IPR and safer staffing reports. This is due to the information not being available through electronic reporting systems, such as e-rostering. The roll out of this system to community teams will enable the relaunch of the piece of work to implement a staffing judgement tool within community teams. A plan for this will be developed and overseen by the safer staffing group prior to the completion of transitioning all community teams to the health roster, which is planned to be completed by the end of December 2024

Although centralised data is not currently available for community, there is ongoing establishment template work with individual community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes. In order to provide effective and efficient support to meet establishment templates, we continue with the review process to ensure that any changes are in line with national benchmarking, recommendations and best practice guidance.

We have continued to engage with our community colleagues to:

- Offer support where staffing shortages have been identified.
- Support service and template reconfiguration processes on individual basis.
- Recruit bank specialists to support the services.
- Support the Allied Health Professional locum requirement.

- Gain a better understanding of the individual area, staffing challenges and requirements.

We will be supporting the learning disability (LD) service with their review of a staffing judgement tool that has been specifically developed for LD services. This is used currently in Bradford District Care Trust, who also have an LD assessment and treatment service.

An establishment review of older people and working age adult mental health wards has been undertaken during 2023 and is currently in the quality checking process. A plan for ongoing establishment reviews in line with the National Quality Board's (NQB) publication 'Developing workforce safeguards' (2018), which sets out a requirement for the Board of Directors to receive a report outlining the assessment or resetting of the nursing establishment and skill mix by ward or service area at least annually will be developed within the next reporting period and progress against the plan will be monitored by the safer staffing group.

The mental health optimal staffing tool (MHOST) will be embedded within the establishment review plan as we have used this tool effectively in staff modelling and template review processes and also within the recent inpatient establishment review.

Staff wellbeing

There continues to be an indication through staff networks, staff side and staff surveys that our staff remain under pressure and feel stressed at times. Continued monitoring of the data and intelligence will help us to understand where we have pressure points, and where things are working well to share learning and act.

Staff wellbeing remains a key area of focus within the Trust, and workstreams have been established to ensure we continue to provide support where and when it is required. These include a focus on staff wellbeing to support a reduction in sickness rates and ensuring staff have a good working experience. This will support retention as we continue to look at creative options to fill staffing vacancies. The Trust continues to proactively support staff groups to ensure that our resources are directed to where they are needed. Examples of this are:

- Further recruitment and development of workplace wellbeing champions.
- Review and updating of our workplace wellbeing intranet site.
- Promotion of men's health.
- Delivery of Schwartz rounds which are acessible to all SWYPFT staff.
- Support for the menopause.
- Occupational health/staff counselling offering reflective spaces.
- Working group to ensure our wellbeing offer is trauma informed.
- Promotion of wellbeing conversations.
- Support for staff following clinical incidents.
- "Your voice counts" – listening to staff feedback about their experience and working alongside them to shape wellbeing initiatives.

Care Certificate

Since the last report the safer staffing team have supported the development of the Trust's care certificate lead's plan for the roll out of the care certificate to bank health care assistant colleagues. This will ensure there is a consistent standard across our substantive and bank

workforce in knowledge, skills and behaviours. A proposal of how this will be implemented will be presented to operational management group (OMG) for approval.

Safer Staffing Group

In April's report we stated that we would be reviewing the safer staffing group through a review of membership and terms of reference. Attendance at the monthly meeting had been low, leading to a number of meetings being cancelled. During this period the membership has been reviewed and the terms of reference refreshed. Attendance at the meeting has improved with representation from all clinical areas of the Trust attending at the last meeting in November 2023. The group is monitoring the work around Safecare and e-rostering in addition to the monthly data that is reported to board through the IPR.

There will continue to be a phased implementation of improvements to the group and the actions that it undertakes as we are working to receive more feedback regarding safer staffing issues from the care groups. An update on the improvements and meeting uptake will be shared in the next report.

Involvement in the National Performance Advisory Group

We continue to ensure appropriate representation within the national performance advisory group for safer temporary staffing, which will ensure the Trust is kept abreast of changes and involved in national developments around Safer Staffing. We continue to collaborate with Northeast and Yorkshire NHS trusts to gain a consensus on reporting and managing safer staffing.

5. Quality measures

The Trust maintains accurate and up-to-date information of "composite indicators" on the Electronic Staff Record System (ESR) in relation to the proposed safer staffing indicators as follows:

- Staff sickness rate.
- Completed appraisals.
- The proportion of mandatory training completed.

The most recent Trust figures:

	Trust Overall	**Inpatient Wards**
Staff sickness rate (taken from the ESR at the end of September 2023)	**5.2%**	**6.5%**
Appraisals completed at the end of September 2023	**73.3%**	**66.9%***
The proportion of mandatory training completed at the end of September 2023	**92%**	**86.9%**

* Please note, board are aware of some of the challenges with regards to our confidence in the appraisal data reporting. Local reporting indicates significantly higher appraisal performance.

These indicators are also reported within the IPR and indicate whether safer staffing levels are being met in relation to quality and experience. Analysis of the data is provided monthly by the specialist adviser for safer staffing group.

In comparison with the bi-annual safer staffing report in April, there has been a slight reduction in staff sickness rates for inpatient wards (7.2% in April 23) and an increase in the mandatory training completed in the Trust overall (89.6% in April) but a slight decrease in the inpatient wards (88.8% in April).

Since the last bi-annual safer staffing report, the Care Quality Commission (CQC) have inspected our working adult age wards including the psychiatric intensive care units (PICU) and forensic units. The Trust received “must do” actions against regulation 12 “safe care and treatment” in relation to training and also regulation 18 “Staffing”. The report was published on the 6 December 2023 and a response plan has been submitted to the CQC which outlines our approach, the care groups have developed action plans to achieve the “must do” actions.

Sickness absence

Sickness absence in September was 4.7% and above local threshold, with a rolling 12-month position of 5.3%. The projection for March 2024 would see no change in absence for the year, with the rolling 12-month position remaining at 5.3% and above the target of 4.4%. Focused support with managers on long term sickness, has been undertaken in the care groups which has previously had a positive effect on the absence rate. The forensic care group, people directorate business partner role is working closely with forensics to identify hotspots and targeted reduction. Business partners are now in place for each of the care groups.

Estates and facilities absence remains high at 7.7% in July but has reduced in the last two months, the focus remains on sickness meetings, monthly reports to individual managers and increased personal development support to address the high absence. This increase has been seen due to small increases in long term sickness cases (2) in the area.

In the Trust, stress related absence still accounts for the largest reason at 35.2%. This remains constant around 34-37% Trust wide.

Sickness absence impacts on staffing levels on the ward, and whilst we achieve around 90% fill rate on bank request (93% in November), it is typically short notice requests, which are required within less than 12 hours that remain unfilled.

Appraisals

Ensuring that staff receive regular appraisal in line with the requirements of the trust’s appraisal policy is a CQC “must do” action for the Trust within the working age adult and PICU wards. Working age adult and PICU leadership team have an established process for ensuring appraisals take place. The service manager is working with the appraisal system manager to ensure service data is accurately reflected on the Workpal appraisal system. The care group continue to review the appraisal data weekly to ensure that performance remains above the trust target.

Mandatory training

As part of the Trust's oversight with regards to 'right skills', overall mandatory training is at 92.5% compliance which exceeds the Trust target of 80%, this has increased from 92.0%. The Trust is in a positive position in all areas, with only three areas not currently RAG rated as green. Reducing restrictive practice interventions, (RRPI) training is one area in month below the Trust target. Targeted actions are in place and compliance is reported monthly to EMT with hot spot reports reviewed by the operational management group (OMG).

The Trust position for information governance data security training saw a further increase in July to 96.9% from 96.8% reported and remains above the 95% threshold. Cardiopulmonary resuscitation (CPR) also remained above the 80% threshold.

Training for cardiopulmonary resuscitation and RRPI were a "must do" action for working age adult wards and PICU following the CQC inspection. The care group service manager is working with ward managers on ensuring staff receive mandatory training as a priority. RRPI is now above target at 85.1% (November 23). There remain some challenges in relation to compliance with CPR training. These have been escalated as required, with actions in place to address.

Both the working age adult wards/PICU and the forensic inpatient services received "must do" actions for staff to receive training on meeting the needs of people with a learning disability and autistic people at a level appropriate to their role. We are rolling out the Oliver McGowan LD and autism training. At the time of writing, 1,133 staff have now completed the e-learning component of the Level 1 training across the Trust, which is approximately 23% of the workforce, with plans to promote the webinar aspect of Level 1 training once it is available (expected February 2024). The Care Groups are monitoring compliance as part of existing senior management.

6. Reporting and data analysis

The Trust's ambition at all times is to ensure that there are sufficient numbers of registered nurses on each shift to meet patients' needs and provide an appropriate level of support to unqualified staff, in line with the established staffing ratios for each ward. Following the recent CQC inspections, the Trust also received a "must do" action with regards to this, which has actions in place to respond to. In this section we will explore the data that is available to demonstrate our position against achieving this. The Trust produces a monthly integrated performance report (IPR) which includes a position on safer staffing and the fill rate for wards.

Key highlights in the data below are the following:

- The fill rate of shifts on our wards has steadily improved with filling vacancies and increasing the bank staff numbers. We are averaging over 91% fill rate of flexible staffing requests.
- There continues to be fluctuation in all areas overall, influenced by demand on services
- Wards are still exceeding 120% fill rates, which is a sign of acuity for both day and night. However, the night fill rate has decreased by 5% on the previous report, but the day fill rate has increased by 10%.

- Day fill rates for registered staff has improved overall since March, due to a reduction in overall vacancies, and has improved following recruitment of newly qualified staff in September 2023.
- In terms of unfilled shifts (where requests for temporary staff have been made in response to staff absence or acuity, but it was not possible to fill that shift with an equivalent practitioner), there has been little variation in the numbers for most Care Groups following an overall improvement in April 2023. There has been improvement in the flexible fill staffing due to several large recruitment drives, which has led to significant reduction in the use of band 2 agency staff.
- Cover on a Monday has improved, which has historically been a challenging day, due to an agreement with the primary agency to encourage agency staff to work on a Monday following a weekend shift. We will be reporting on the impact of this in the April 2024 report, and reviewing how we can mirror this with bank staff.

The data demonstrates that our wards are staffed to safe levels, but it is important to note the potential impact on quality or patient experience when using a higher proportion of temporary staff. Over the year, the RN fill rate has continued to improve which has a positive impact on care. However, the overall shift fill rate has consistently remained over 100% (123%/124%) which demonstrates that our wards are busy and acuity remains high. This highlights the importance of implementing a rolling programme of establishment review in line with NHS England (NHSE) standards to ensure that capacity meets demand.

Future bi-annual safer staffing reports will triangulate the data around shift fill rates to other information available, such as incident reporting, to review the impact on care provided and any harm caused.

Shift fill rates

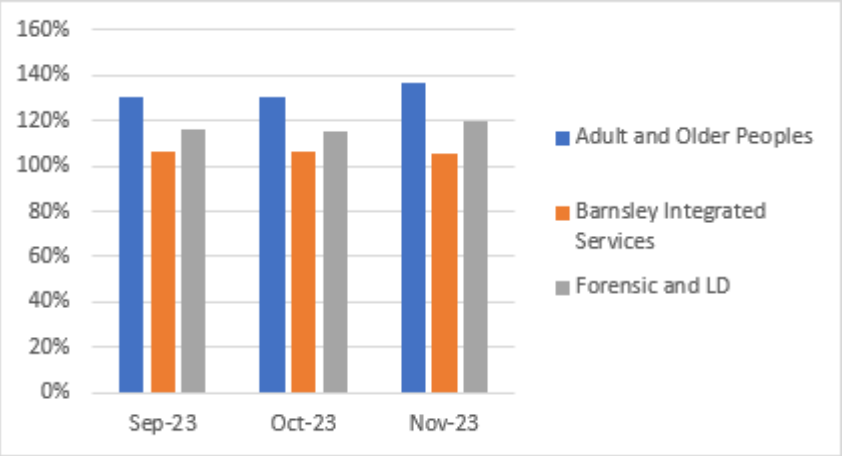
The fill rate is the number of shifts that have been filled in comparison to the ward establishment. The ward establishment is the number of staff that were identified in 2015 or 2019 when the previous establishment review was undertaken. At that time there was no definitive staff modelling tool, unlike today where we have the evidence based MHOST. Previously we used a combination of the available resource and developed an adaptive tool. Staffing requirement (demand), by its nature fluctuates dependent on the acuity of the service users and therefore often exceeds the establishment template (capacity).

The analysis of shift fill rates between March 2023 and August 2023 indicates:

- The Trust continues to reach over and above the fill rate of 100%. However, some shifts continue to be replaced with Health Care Assistants (HCAs) when RNs are unavailable, therefore impacting on the effectiveness of skill mixing This can lead to a qualitative impact on aspects of patient care including reduced access to activity or more difficulty in supporting Section 17 leave. This is monitored through Datix, as well as impacting on the delivery of supervision or timely completion of reports.
- The fill rate is achieved by utilising over 5,000 bank and agency shifts per month.
- The 100% or above fill rates should be read with caution as it does not necessarily demonstrate that we are meeting the demand within inpatient services which includes the quality indicators of safer staffing, such as ensuring timely interventions, delivery

of an individual's full care planned needs, staff release for supervision, training, and development.

- The fill rate of shifts has continued to steadily improve, in line with filling vacancies and increasing bank staff numbers. In the last three months the number of unfilled shifts has been between 374 (November) and 560.
- Overall fill rates have continued to fluctuate in all areas. This is influenced by the demand on services and how many requests can be filled, (see table below, please note that the reporting has changed from the previous report in April, where it was reported by business delivery units to care groups and therefore direct comparison cannot be made).



- Where the fill rate falls below the optimal level then staffing allocations are looked at to manage clinical risk and ensure safe and effective care is delivered. This occurs on a scheduled basis throughout the week looking at projected shortfalls, utilising staff hours and flexible staffing to cover shortfalls where possible, as well as on a shift-by-shift basis.

Day fill rates overall

- There have been two occasions where wards have fallen below the threshold of 80% This is a decrease of two occasions within the previous six months.
- There were 63 instances, an increase of 10, where wards were filled to 120% and beyond, which is indicative of acuity.

Day fill rates Registered Nurses

- There were 51 incidents (189 incidents in April), a decrease of 38 on the previous six months, where inpatient areas fell below the 80% threshold for registered staff.
- This figure has improved overall since March, and we would expect this to improve following the recruitment of newly qualified staff in September 2023. The impact of this will be explained further in the April 2024 version of this report.
- Day fill rates for registered staff has improved overall since March due to a reduction in overall vacancies within inpatients and has improved again following improved following recruitment of newly qualified staff in September 2023.

Night fill rates overall

- Over the last six months there have no instances, in line with the previous period, where a Care Group has fallen below 90% for night shift fill rates.
- There were no wards, consistent now for a period of 12 months, which fell below 90%
- There were 14 occasions, a reduction of one, where a ward fell below 100%
- There were 96 occasions, a decrease of five on the previous report, where a ward exceeded 120%, again indicative of acuity.

Night fill rates Registered Nurses

- There were 80, a decrease of seven, occasions when wards fell below the 100% fill rate for registered staff.
- In comparison between the night fill rate and the day rate, 21 fell below 80%, a decrease of nine on the previous six months. These were supported by local escalation plans and/or with HCA cover.
- In the same period wards exceeded 120% coverage on 43 occasions which was an increase of 14 on the previous period.

Unfilled shifts Registered Nurses

- There has been little variation in numbers for most Care Groups during this reporting period following an overall improvement in April 2023.
- There may be occasions when shifts for Registered Nurses have been converted into HCA shifts to ensure safe staffing numbers of the ward.
- We continue to be able to fill weekend shifts and weekends more easily than during the week however, covering Monday, which was historically a challenging day, has improved. Since the last report an intervention has been agreed with the primary agency which encourages agency staff to work on a Monday following a weekend shift. We will be looking at the impact this has had and report in the April 24 report, and we will be reviewing how we can mirror this with bank staff.
- There is a large shortfall in shift fill, and this is often due to an increase in requests for shifts. This is also reflected in the fluctuation seen within the RN figures. However, again, this shows an improving trend since the last report.
- Overall fill rates per ward have been maintained at a safe level (see table below). Some wards that are supporting other areas, following a clinical risk assessment and decision, have dropped below the 90% fill rate. At the same time other neighbouring wards have breached 120% fill rate.
- The fill rate of flexible staffing, following several large recruitment drives, has been improved to over 90% fill rate in the last 2 months which has also led to a trend of utilising slightly less agency band 2 staff.

Overall Fill Rate	Month-Year					
Unit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Appleton	93%	90%	92%	93%	92%	93%
Ashdale	101%	108%	106%	109%	107%	104%
Beamshaw	119%	114%	130%	116%	128%	116%
Beechdale	172%	162%	151%	156%	158%	164%
Bronte	105%	99%	98%	100%	98%	101%
Chippendale	118%	119%	121%	119%	117%	122%
Clark	112%	104%	111%	112%	127%	121%
Elmdale	109%	116%	98%	105%	116%	107%
Enfield Down	88%	93%	92%	90%	83%	92%
Hepworth	98%	103%	103%	97%	96%	98%
Johnson	151%	149%	154%	156%	155%	156%
Lyndhurst	96%	89%	93%	95%	94%	105%
Melton Suite PICU	147%	143%	151%	174%	167%	171%
Neuro Rehab Unit	122%	124%	122%	112%	115%	105%
Newhaven	122%	119%	123%	127%	125%	125%
Poplars	205%	211%	203%	207%	205%	224%
Priestley	107%	107%	109%	99%	91%	95%
Ryburn	97%	99%	97%	98%	112%	99%
Sandal	129%	108%	129%	128%	99%	100%
Stanley	127%	127%	148%	124%	119%	114%
Stroke Rehab Unit	103%	107%	109%	100%	103%	108%
Thornhill	107%	112%	103%	94%	97%	103%
Ward 18	105%	116%	114%	124%	129%	117%
Waterton	136%	125%	118%	126%	121%	122%
Willow Ward	134%	165%	173%	171%	161%	165%
Ward 19 - Female	124%	100%	98%	118%	119%	101%
Ward 19 - Male	114%	124%	111%	116%	122%	114%
Nostell	124%	149%	121%	120%	130%	134%
Crofton	225%	194%	188%	194%	203%	193%
Walton PICU	123%	118%	131%	126%	127%	138%
Horizon	141%	143%	145%	145%	137%	145%
Overall Shift Fill Rate	**124%**	**123%**	**124%**	**124%**	**124%**	**124%**

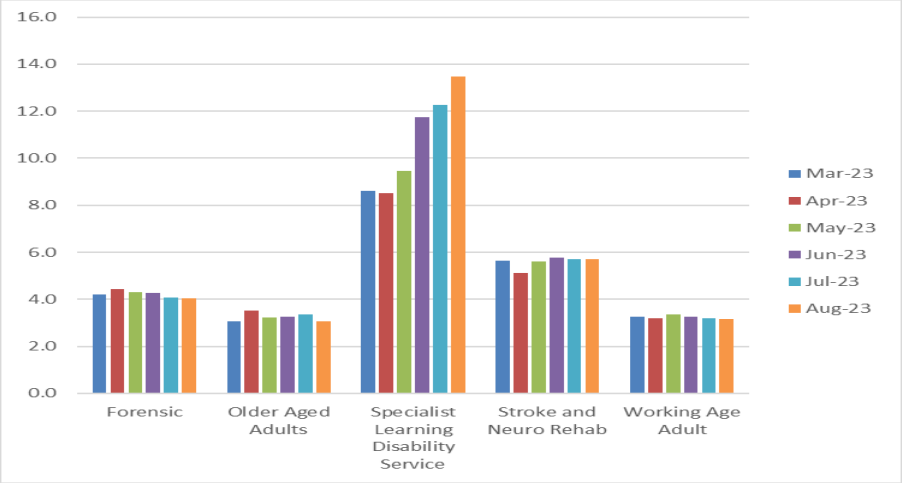
Fill Rate Key for RNs and All Staff:	RNs - Less than 80% fill rate; All staff - Less than 90% fill rate
	Greater than or equal to 120% fill rate

Care Hours Per Patient Day

The Trust is required to publicly declare staffing fill rates for inpatient settings as well as the Care Hours Per Patient Day (CHPPD) for each inpatient area. CHPPD is the amount of care hours delivered to our service users by our inpatient workforce. It is split into registered nurses (RNs) and health care assistants (HCAs). We continue to compare our trends within the data to influence the overall narrative of demand on the wards versus capacity of resources.

The chart below shows that during the last three months, apart from the specialist learning disability (LD) service at Horizon Centre, there has been a slight decrease in the delivery of the CHPPD hours for RN staff. As newly qualified and internationally recruited nurses receive their PIN numbers from the Nursing and Midwifery Council (NMC) we would expect to see an improvement in this figure from October 2023 onwards.

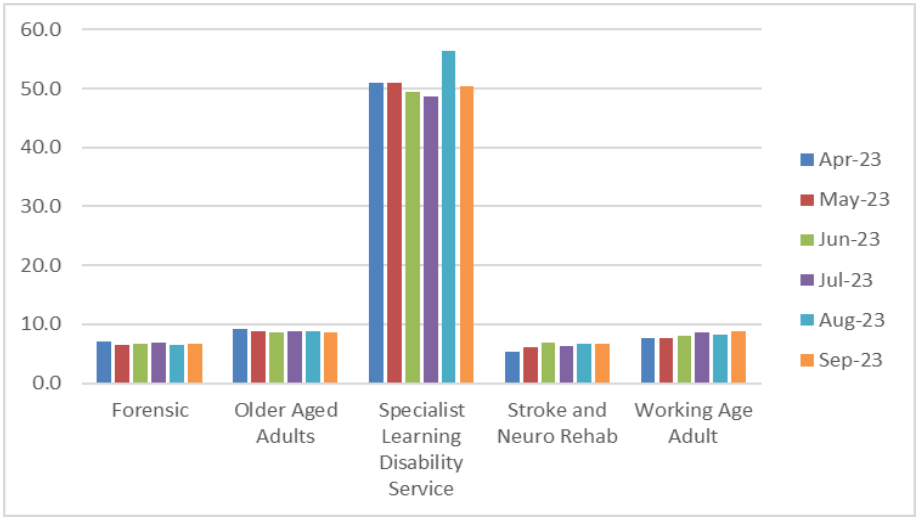
CHPPD Average Trend RN



The chart below shows a more consistent pattern to the delivery of CHPPD within the HCA workforce, albeit with a greater fluctuation within learning disabilities due to the nature of the bespoke care packages being delivered.

Due to the successful recruitment of both substantive and flexible band 2 HCAs this has slightly improved, and we would expect this to continue in the next six-month period.

CHPPD Average Trend HCA



The table below indicates how we benchmark in comparison to regional colleagues in fulfilment of the CHPPD expected rates for the various inpatient areas. Regional data rather than national data has been used in this report as the regional figures have been updated and provide a better benchmark than the national figures that have not been updated for an extended period.

Ward Name	Area	Care Hours Per Patient Day (CHPPD)			
		Trust		Regional Average	
		Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	Barnsley	2.6	5.9	3.4	7.8
Clark	Barnsley	3.3	8.0	3.4	7.8
Melton Suite PICU	Barnsley	4.0	26.4	5.0	18.1
Neuro Rehab Unit	Barnsley	4.9	6.2	5.8	6.9
Stroke Rehab Unit	Barnsley	6.5	7.1	5.8	6.9
Willow Ward	Barnsley	3.6	11.0	3.2	10.5
Ashdale	C & K	2.5	4.4	3.4	7.8
Beechdale	C & K	2.7	6.4	3.2	10.5
Elmdale	C & K	1.8	5.0	3.4	7.8
Enfield Down	C & K	3.9	6.8	3.5	5.4
Lyndhurst	C & K	4.7	7.2	3.5	5.4
Ward 18	C & K	1.9	6.7	3.4	7.8
Ward 19 - Female	C & K	2.4	4.0	3.2	10.5
Ward 19 - Male	C & K	2.4	5.4	3.2	10.5
Appleton	Forensic	6.4	7.8	3.9	8.4
Bronte	Forensic	6.1	9.9	3.9	8.4
Chippendale	Forensic	3.7	6.3	3.9	8.4
Hepworth	Forensic	3.9	4.7	3.9	8.4
Johnson	Forensic	3.8	11.6	3.9	8.4
Newhaven	Forensic	3.9	8.2	3.9	8.4
Priestley	Forensic	3.1	3.8	3.9	8.4
Ryburn	Forensic	3.8	3.7	3.9	8.4
Sandal	Forensic	3.8	8.3	3.9	8.4
Thornhill	Forensic	3.5	4.9	3.9	8.4
Waterton	Forensic	3.2	5.0	3.9	8.4
Crofton	Wakefield	3.5	8.8	3.2	10.5
Horizon	Wakefield	11.0	50.4	7.8	20.6
Nostell	Wakefield	3.0	6.8	3.4	7.8
Poplars	Wakefield	4.2	16.5	3.2	10.5
Stanley	Wakefield	2.3	4.1	3.4	7.8
Walton PICU	Wakefield	4.5	14.8	5.0	18.1

*N.B. the colours are to differentiate the data, not to infer a level of performance.

At present we are showing variation and fluctuation across our services. Wards at the Dales in Halifax, (Ashdale, Beechdale and Elmdale wards) benchmark lower than the region figures, most of the forensic wards benchmark broadly in line with regional wards of a similar kind, and the Horizon Centre benchmarks much higher than the region. Of note, both the Horizon Centre learning disability assessment and treatment unit and forensic services have relatively fewer regional colleagues to benchmark against, so this might limit confident comparability of data.

7. Actions taken to manage and mitigate risks

Safer staffing is a high priority area and therefore action is required to be taken when there is a shortfall in the required staffing numbers or where there may be an impact on the quality of care delivered due to staff availability, skill mix, skills, or experience.

There continues to be guidance and support available when a staffing shortfall or issue is identified. This is escalated through the local safety huddles or staffing meetings where staff redeployment will be discussed and escalation plans, both local business continuity and safer staffing, would be activated.

These escalation plans are varied and will be used at different stages. Following the e-roster policy will allow a more robust planning of the rosters utilising staff appropriately, ensuring we follow the guidelines for annual and study leave, utilising the flexible staffing resource after all

other internal options have been exhausted increases consistency in the delivery of care as well as ensuring this is done in the most cost-effective way.

When no further staffing resource is available then decisions of reducing or redeploying staff are based on clinical risk assessments by senior and experienced clinicians. If staffing has been reduced and there may be an impact on patient care, then staff are asked complete an incident form so that this can be reviewed as to why this happened and how it can be avoided going forward. The reporting of such incidents is under review to make it more reliable and timelier, Safecare has a red flag system enables manager notification in a more timely way and could reduce the need for incident reporting and therefore reduce extra work and duplication for staff.

The specialist advisor for safer staffing can offer advice and guidance. Of note, mental health inpatient services continue to have senior colleagues working seven days a week, to ensure timely escalation of any staffing challenges, action and support.

Safer staffing is discussed through the monthly safer staffing group, and issues escalated to clinical governance group, operational management group, executive management team, quality and safety committee and Trust Board as required. This provides multiple escalation points each month whereby any risk issues can be identified, plans to mitigate and support can be implemented and provides an opportunity to review the impact of the situation and any actions taken. There are several staffing related risks held on the local and corporate risk registers to capture the risks and plans in place to reduce impact.

Decision making about risk follows the tool on page 2 and considers the right staff, right skills, right time, and place. An example risk management tool is embedded in appendix 2.

As a Trust we are mandated to ensure that we have regular establishment reviews, Developing-workforce-safeguards.pdf (england.nhs.uk) with the most recent having been completed for Working and Older aged adults with outcome plans being formulated and discussed. There is currently no plan of further establishment reviews. A plan will be developed in the next reporting period months and will include the parameters, in line with best practice, of the reviews.

Some of the actions taken to reduce or mitigate risk in the last reporting period include:

- Increasing our international recruitment program with 40 nurses recruited until the end of September.
- Continually increasing bank and substantive recruitment to increase the flow of staff coming into the Trust. With 65 band 5 offers made and 422 bank staff, including leave and returns, joining our flexible staffing resource in 2023.
- Critically reviewing reasons for staff leaving to assist with retention plans.
- Vacancies and sickness were mitigated through local escalation plans, where staff (such as ward managers, senior professionals) were identified to cover.
- We have completed regular audits of our master agency vendors to ensure compliance with training is complete. These have highlighted minimal or no issues. We will continue to regularly audit to ensure best practice.

- The Trust has also supported a clinical career pathway for nurses that include lead nurses, nurse practitioners, non-medical prescribers, and advanced clinical practitioners.
- New roles have been considered where sustained challenges with recruitment are identified. The new roles group review any proposed changes to skill mix to ensure care can be delivered safely and effectively without unintended consequences, along with the completion of a quality impact assessment. An example of a role that has been supported through this process is the advanced clinical practitioner (ACP).

Additional steps have been taken to ensure there is always a RN present on all wards.

These steps include the following:

- Reallocation of staff
- Ward manger cover
- Basing supernumerary team leaders on the wards

Initiatives to support the HCA shortfall include:

- Increasing the number of experienced staff being taken onto and working with Leeds York Partnership (LYPFT) and Bradford District Care (BDCT) on the collaborative bank project, which went live in a pilot phase in December 2023
- Recruiting onto the peripatetic workforce across the Trust which will increase the flexible staffing available s

We have also increased the levels of staff within the flexible staffing workforce with the table below showing the recruitment year to date.

YEAR TO DATE 23	EXTERNAL	LEAVER & RETURN	TOTAL
RN	07	32	39
HCA	271	23	294
OTHER	46	43	89
TOTAL	**324**	**98**	**422**

8. Datix and incidents

From April 2023 until September 2023 there have been 108 incidents reported that highlighted staffing related issues compared with 133 reported in the April 2023 safer staffing report, (a decrease of 25). Forensic and LD (learning disability) services account for a substantial proportion of these, and we use the data to focus on hotspot areas.

There were a further 12 incidents where RN preceptees were reported to be on a ward with no additional qualified cover present. This does not always describe the interventions in place, including ward manager or team leader cover being based on the ward, to mitigate the risk and support the preceptee. In addition, work is ongoing to ensure that clinical skills are recorded correctly in e-rostering and that when a clinician has completed their preceptorship programme it is updated.

Please note that these are only incidents that have been reported. Continued efforts to ensure more appropriate reporting including utilising Safecare as described previously are ongoing.

Whilst we continue to encourage staff to report issues regarding staffing, evidence would suggest this remains under reported when triangulated with staff surveys and wellbeing questionnaires as well as soft intelligence. We will continue to support staff in reporting incidents and are looking at how we can improve the feedback in a timely manner so that staff can see and feel that they are being listened to and without causing duplication. A meeting with the patient safety team is also in place to look at alternative ways to increase or quantify the reporting.

All reported staffing incidents, irrespective of how they are rated, are monitored through the Trust's weekly patient safety oversight group (formerly the clinical risk panel) and through the safer staffing meeting with a focus on the impact on patient safety and quality of care. Where Section 17 leave is cancelled or tasks have not been able to be fulfilled a conversation takes place between the safer staffing lead and the clinical area (practice governance coach, ward manager or the service manager).

Further work is ongoing to ensure we accurately capture information on how staffing issues impact on Section 17 leave. This work will be discussed at the safer staffing group where trends and themes will continue to be considered as part of this ongoing work.

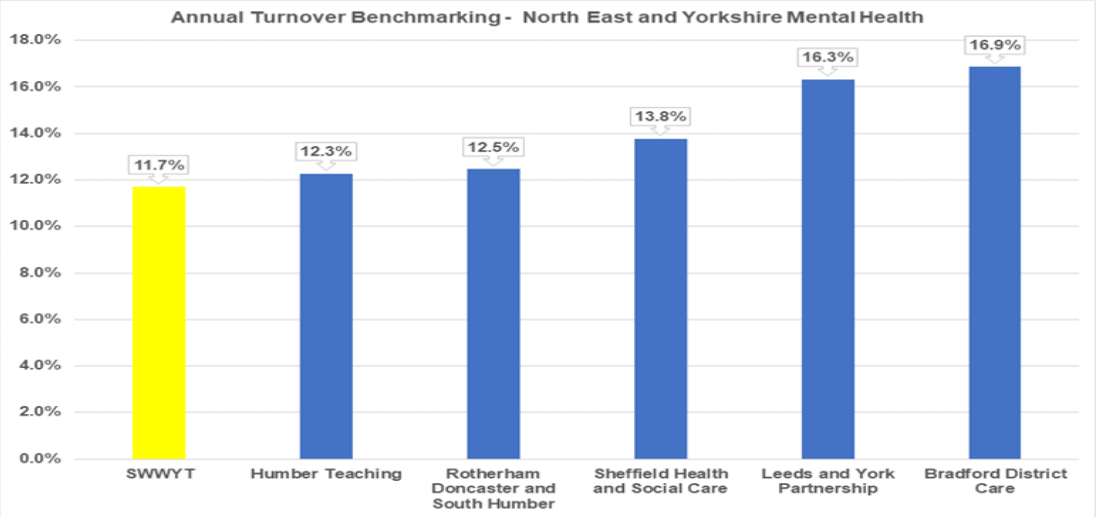
9. Recruitment & Retention – October 2023

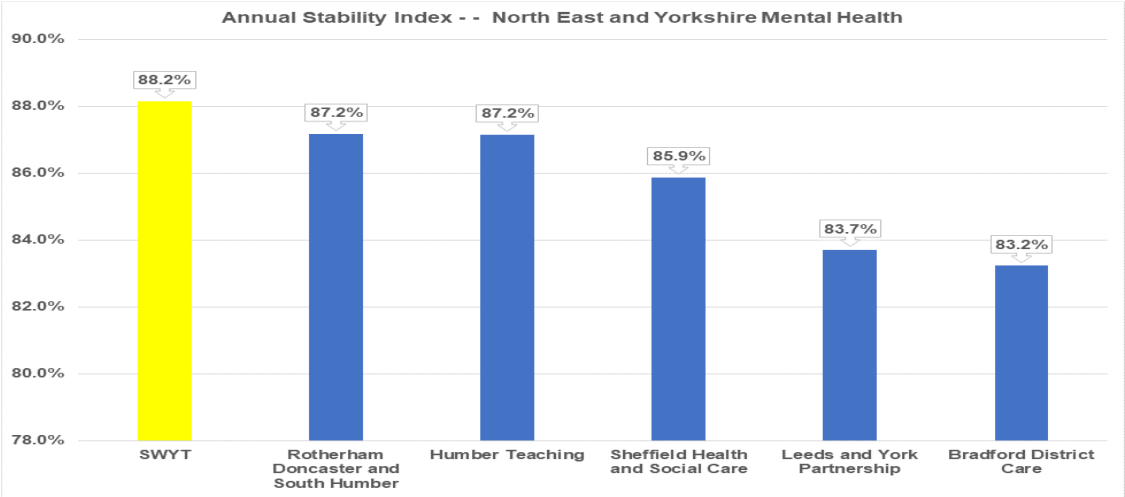
Our number of substantive staff in post remained stable through the first six months of this financial year despite the pressures on recruitment, retention, and increased service acuity. Staff in post has risen by 2.5% (106.16 wte) since April, but this has been partially offset by an increase to our establishment at the same time (53.80 wte). This time last year our position was similar with a 1.35% rise (55.17 wte). We are projected to outperform against our plan of 3% growth by March 2024 (5% projected to March 24).

Staffing pressures remain high across our inpatient and forensic wards due to vacancy gaps and competition to obtain bank and agency. Bank hours worked continues to increase and this is seen as a positive as staff are taking up more requests to fill availability. In the current year to date (from April) we have seen a total of 363.85 starters and 290.63 leavers. Our vacancy position continues to reduce (17.6% last year, currently at 16.3%)

Our external turnover rate (cumulative) turnover at end of September was 12.8%. Recruitment activity is higher than the same period last year with an average of 80-100 NHS Jobs adverts being processed each week and an average of 125 offers in progress at any one time. Work is ongoing to provide a resourcing dashboard to include key metrics for recruitment activity and time to hire.

External turnover is projected to be 12.8% by March 2024 which would be a reduction from last year's position of 13.5%. When benchmarked against the latest workforce statistics published by NHS England on nhsdigital.nhs.uk (May 2023) the Trust has the lowest turnover rate in our region and the highest for the staff stability index (see charts below). This is an indicator of staff in post remaining in post over 1 year.





We have seen a total of 64 retirements since April. The Trust saw a total of 100 retirements last year and 131 the year before and this time last year we had 49 retirements, so presently there is an expected increase in retirements. Given this expectation we are exploring how to further engage with staff whose intention it is to retire early. This is in addition to work the Trust already does to offer alternative options to remain in the Trust, including offering flexible retirement, taking on less pressured roles, joining the bank, changing to a new role etc. We recently celebrated the Trust's 100th 'Transfer Window' staff member successfully move internally within the Trust, rather than leave the Trust to seek alternative employment. The scheme has been running for two years.

In the April 23 safer staffing report, we said that we were planning to be part of a NHSE pilot allied health professional (AHP) international recruitment scheme for three occupational therapists with plans in progress through an agency. We have completed the pilot, and although there were challenges outside of our control regarding preferred and offered candidates who were unable to join the Trust, we have appointed 1 international AHP, starting in December 2023.

Our recruitment fair activity over the next few months includes several national fair attendances in Liverpool, Birmingham, and Leeds. We are also committed to several Touchstone events which focus on applicants who we might not effectively reach using traditional NHS recruitment routes. We are also attending local Pride events in Yorkshire and several university and further education events across Yorkshire over the coming months.

There have been several planned values-based assessment centres held through October and subsequent months, which have focused on substantive and bank band 2 HCAs and band 5 nurses. We will also be introducing assessment centres in local areas to increase engagement with local communities.

The NHS England regional healthcare support worker lead attended our assessment centre on the 30 September 2023, allowing us to showcase our values-based recruitment programme and offer. Further to this we are looking to have representatives from Leeds and York and Bradford District Care trusts attend to showcase how the collaborative bank work might benefit.

Recruitment activity continues to remain high in all areas of the Trust. The Trust continues to see more starters than leavers in the first six months of this financial year. So far this year we have recruited 363.85 WTE staff. In the same period, we have seen 290.63 WTE leavers. Our growth rate stands at 4.13% this year which is ahead of our targeted growth. We have seen high standards of applications that has enabled us to recruit strong candidates. Flexible staffing recruitment has been particularly successful.

The Trust continues its current recruitment activity which is already widening entry level opportunity for new starters and expanding our reach for advertising all roles. We continue to recruit band 5 nurses (21 have been offered roles since October 2023 to date). Alongside this we will:

- Continue to engage with recruitment fairs. We have set out a 12-month plan of engagement across a wide number of recruitment opportunities which include international, national, university and further education, and diverse/local engagement opportunity, LGBQT+ focused recruitment and engagement events.
- Widen our recruitment reach outside of NHS Jobs. This includes widening reach into national online job boards (Indeed, Monster, LinkedIn, eCruit, JobFair, TotalJobs, Reed and others).
- Link with Job Centre Plus (JCP) to promote entry level roles across estates, ancillary roles, and admin which have already been successful avenues to employability
- Utilise a series of rolling adverts on NHS Jobs for band 5 nursing, HCA roles and bank availability.
- Enhance the social media presence of our advertising, communications, and marketing.
- Make improved use of the internal transfer scheme and above the bar process; matching staff who are looking to leave the Trust to alternative roles.
- Further development and enhancement to our career's website and our Trust recruitment micro site.

The move to both a new application tracking system (ATS) and onboarding system to ensure effective and efficient end to end recruitment (Genius), has been paused following a review as part of the rapid improvement group for recruitment whilst we assess the market for a wider solution that incorporates other needs (learning management system and appraisal). The focus in the short term is to work with NHS Jobs support team to understand the ability to meet the challenges within NHS Jobs. Resourcing leads are working closely with strategy and change colleagues regarding an improvement plan.
Other actions to support retention:

- Refer a friend scheme for existing staff.
- Implementation of Trust wide recruitment and retention group, which will continue the work of the Inpatient recruitment taskforce group.
- Continue strengthening our action plans and response to intelligence gathered from our exit feedback procedure. The response rate continues to increase. We received a 66% response rate in Q2 this year, up from 48% in Q1 and see a total response rate of 57% in year. Reporting is in place to operational leads, professional leads and people directorate business partners in order to evaluate feedback and develop local plans to address areas for improvement.

The continuing work around recruitment and retention has allowed us to reduce our vacancy rate, improve our retention rate and maintain high fill rates whilst reducing agency usage.

International Recruitment
The Trust has worked with one agency to meet its commitment to appointing 70 band five mental health nurses to be recruited into the Trust by the end of the December 2023 in line with NHSE International Nurse Recruitment (INR) national program of supporting increasing the number of nurses on the NMC register by 50,000 by 2024. We have received funding from NHSE in three tranches which has allowed us to support this program.

Since December 2021, we have now successfully appointed 110 nurses into the Trust through the scheme. Since April 2023, 65 of the planned 70 nurses for 2023/24, have started in the Trust already with 50 on the wards and 15 in OSCE training. We have one final cohort planned with a starting date of February 2024.
As a result of our successful recruitment campaigns and higher than expected numbers we have temporarily suspended all direct international nurse recruitment opportunities whilst we are focus on our pre-arranged nurses via agency recruitment that are currently awaiting start dates.

We are still seeing significant delays in available appointments for NMC accreditation due to demand nationally for places. This is taking an average of 18-20 weeks to achieve. These delays are national capacity issues beyond our control and are being experienced across the system, not just by ourselves. First time pass rates for NMC accreditation have also dropped to 50% within the Trust (and nationally). This correlates with the marking criteria making it harder to pass first time.

Whilst there has been positive feedback from operational colleagues and the internationally recruited nurses around integrating on to the wards, there have also been some challenges, in particularly, around the wards and the nurses' expectations and preparedness when started

working in the clinical areas. A “Tea for Quality” session was held with the internationally educated nurses currently working on the wards to understand their experiences and challenges to inform future improvement work. The executive trio of chief nursing officer, chief operating officer and chief medical officer are also now meeting regularly with the internationally educated nurse colleagues to ensure that concerns are heard and acted on by board level colleagues.

A solution focused workshop, led by an external facilitator, was held in September 2023 with representation from the people directorate, nursing and quality directorate, integrated change team and the Care Groups, to ensure all the issues and challenges are captured and a coordinated approach to supporting the nurses and clinical areas is put in place. An action plan has now been developed and agreed and will be monitored by international educated nurses (IEN) group meeting, which has agreed that going forward the international nurse recruits will be changed to international educated nurses (IEN).

Improvement actions underway include:

- Early allocation meetings with Care Groups have been established to identify vacancies and placement of the nurses to support induction to the wards.
- Process mapping is being undertaken to understand the staff member’s journey from advertising of roles through to them being settled on a ward, with tasks and responsibilities identified with owners throughout, this will include timeframes.
- New roles to be implemented to support the international educated nurses. Information regarding these roles to be shared Trust wide once established.
- The accommodation offer has been reviewed with new premises secured in Wakefield, Calderdale, and Barnsley.
- We have implemented a reciprocal mentoring scheme and collaborative meetings with Rotherham, Doncaster and South Humber Trust who have similar numbers of mental health IEN and are experiencing similar challenges.
- Further support for ongoing pastoral support for IEN beyond their initial 12-week placement in training. This includes peer support, equality and inclusion support, ongoing cultural support and implementation of Schwartz rounds for international nurses.

Once we have successfully completed the onboarding of nurses already in receipt of conditional offers our plans for IEN delivery going forward will be based around future cohort delivery of supplementing and supporting vacancy gaps, after planning our expected domestically trained newly qualified nurse recruitment in Care Group and annual workforce planning.

Medical international recruitment continues to be successful; we have recently recruited five international fellows who are in the pre-employment check stage and are still planning for October/November start dates. Overall, the number of doctors recruited from overseas in the last two years is 24.

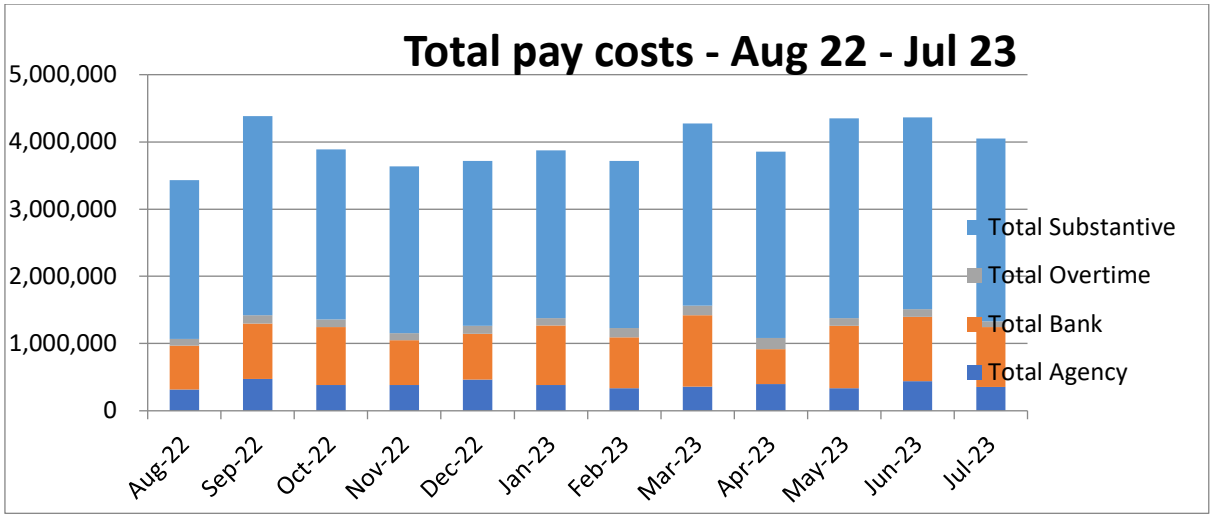
10. Bank and agency usage

We continue to recruit onto the Trust bank as well as ensuring only active and appropriate colleagues remain registered on the bank. During August 2023, using this month as a reference point, bank, and agency staff worked 875 RN shifts (702 in April report) and 4,667 HCA shifts (3891 in April) on inpatient wards. We have seen a small but steady decline in the usage of band 2 agency staff in line with our agency reduction program.

We have re-established an agency scrutiny group to help understand the deployment of agency staff and this has helped increase our collective understanding of both the individual deployment of agency locums and any exit plans in place to replace them with bank or substantive staff. We have flattened the recruitment processes for agency locums who have been deployed within the Trust and this has already to a decrease in agency usage of band 2 HCAs, reducing admin agency to almost zero and directing the bank resourcing focus to meet the Trust's needs. This helps support the Trust moving towards its target of seeing a £1.7m reduction in agency spend by April 2024 to meet our financial control target of 3.7% agency spend.

The graphs below show the percentage of bank, agency, and substantive costs within inpatient services. At the last reference period we had little change in the breakdown of flexible staffing although there was a 1% shift from agency to bank. Bank and agency spend equates to 43% of our inpatient HCA spend (slight increase from 40% in April) and 15% of registered nurses. We are looking at ways of reducing this with improvements in recruitment and retention as well as fast tracking agency staff onto bank.

The two graphs below show there was an overall fluctuation in spend reflective of substantive staff in post and the usage of the flexible staffing resource throughout the year and our latest reference point of July 2023 shows a decrease of £313,099 on spend on inpatient staffing which was as a result in a decrease in spend in all areas on the previous month.



The collaborative bank with Bradford District Care Trust and Leeds and York Partnership is progressing with a pilot commenced in December 2023, with eight individuals selected from across the three Trusts. This pilot will allow us to test our systems whilst progressing with the alignment of paperwork, training and any other issues that are identified. We are fully engaged in supporting this process and have held question and answer events for managers and staff in December with further planned in January 2024.

11. Future Actions

Safer staffing remains an area of focus for the Trust and as identified within this report there are a range of actions and oversight structures to ensure consistent safe staffing is experienced by our workforce and our service users. Of note, this is in the context of significant staffing pressures, both locally and nationally.

During the next reporting period, priority actions in the Trust will include:

Ensuring that community staff teams continue to be brought onto the e-rostering system in line with the rest of the Trust, following the project plan that has been adopted following scrutiny by both OMG and EMT.

- Develop an action plan within the next 6 months to increase compliance with Safecare and to review future use of the tool.
- Establish a rolling plan within the next 6 months for ensuring establishment reviews take place and are reported to Trust Board on a regular basis.
- Develop a plan to re-establish the work to implement a staffing tool for our community teams once e-rostering is implemented.
- Continue to review data sources to ensure accurate and consistent reporting. This includes incident reporting and access to Section 17 leave (as a proxy measure of staff availability).
- Continue to expand the staff bank to support other areas including allied health professionals and community teams.
- Continue to strength the functionality of the safer staffing group to ensure quality and safety of staffing within our clinical areas.
- Continue to support the roll out of the collaborative bank.
- Supporting with the development of retention plans.

- Contributing to implementation of the Trust's Recruitment & Retention Strategy.
- Maintaining links with NHSE on return to practice programme for nurses, financial support for the introduction of nurse associates and encouraging collaborative banking and agency intelligence particularly across integrated care system.
- Continue to recruit onto the peripatetic workforce and offer continued support through the flexible staffing resource.

12. Summary

Against the national backdrop of shortages in registered nurses, the Trust continues to make progress in filling vacancies. Retention remains in the spotlight as, particularly in inpatient areas, we have a staff group that is relatively inexperienced due to staff moving into new roles, gaining promotions, or moving into community teams. Ensuring sufficient numbers of staff in post is prioritised to maintain safe care. This will mean that there are times when we need to adjust the skill mix to ensure cover, e.g. adjusting the skill balance on the shift with more healthcare support workers. This will impact on the experience of care for the people admitted to our wards.

The Trust continues to respond to flexible staffing requirements by increasing the number and activity of staff on the Trust bank. We continue to use the accelerated process for getting agency staff onto bank and bank staff into substantive roles. There also continues to be more starters than leavers in the Trust.

Actions are in place to monitor and mitigate risks and escalation processes are well embedded to ensure our clinical teams feel supported. There are further opportunities to hear the voice of our service users and frontline colleagues and ensure they are aware of the actions which are in place to support them and the broader workforce. Monthly reporting will continue through our integrated performance report and will be monitored through the Trusts governance processes.

Some staff are feeling pressured as indicated through staff surveys, staff side and soft intelligence. Staff wellbeing is a priority for the Trust and we have been proactive in implementing a number of initiatives, including support groups and workstreams so staff have a good working experience. We ensure that we work collaboratively with our partner trusts including the collaborative bank to enhance the resources available to our teams whilst ensuring that they are compliant and consistent with our Trust values. Increasing substantive recruitment and therefore reducing agency spend will also support in the delivery of effective and sustainable care.

Paper prepared by:
Colin Hill, Specialist Advisor for Safer Staffing
Kathryn Hemming, Assistant Director for Nursing, Quality and Professions
Supported by:
Carmain Gibson- Holmes, Deputy Director of Nursing, Quality and Professions
Richard Butterfield, Head of recruitment and resourcing
Appendix 1

Trust Board Safer Staffing Checklist

1.Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?

Board receives regular presentations on staffing (e.g., IPR reports, regular assurance visits from Board members to the wards/departments to learn about and understand the services better (e.g., Quality and Exec Trio visits).

2.Are there processes for escalating issues identified by staff, patients, or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services? Acuity is regularly and routinely monitored on wards including need for 1:1 observation. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system and regular reporting to safer staffing group.

3.Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence-based approach? How can the calculator tools be best deployed in delivering this?

Originally the Trust has developed a bespoke decision support tool which was utilised to decide on the original staffing templates. We have moved to utilising the most up to date evidence tool available which has been utilised in staff reviews to date and will be for the Trust-wide inpatient establishment review. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.

4.What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?

Managers are empowered to use a range of interventions (e.g., use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement. Specialist Advisor for Safer Staffing is available to offer advice and support as required.

5.How are the needs of Mental Health service users incorporated in staffing?

Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.

6.As well as staffing measures outlined by the NQB are their measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?

Complex benchmarking and performance data is widely available throughout the organisation and drills down to Team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.

7.How this ward staffing information might be presented differently within a Mental Health setting where the ward-based Team is not the only valuable resource available? Monthly reporting on Trust website and safer staffing exception report shared with all services monthly and summary information provided in IPR.

8.How are the challenges of filling specific Mental Health roles handled e.g., recruitment training etc.?

We have particularly good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. We attend national recruitment events and are lead providers in a regional collaboration looking at international recruitment. Training needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.

9.How is the commissioner kept informed about best practice in Mental Health so that informed commissioning decisions are made?

Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

Appendix 2

Example of a Localised Escalation Plan

Stages	Who does this involve	Detail of step	Names	Responsibility
Across the wards	Stanley, Nostell, Poplars, Crofton, Walton	Check excess staff including office days.	Ward staff	Ward Manager/Matrons/On call manager/ Senior Nurse
Additional hours to existing staff	Ward and Unit staff	Offer alternative days off etc. to staff.	Ward staff	Ward Manager/ On call Manager/Matrons
Bank Staff	SWYT bank office	Send through health roster.	Bank staff	Ward Manager/Nurse in Charge/On call manager/ Matrons
Overtime offered	Trust Staff	Overtime is available to cover vacant shifts.	Substantive staff	Matrons/ General Manager
Agency Staff	SWYT bank office/ out of hours direct to agency	Send through health roster/ call direct.	Agency Staff	Ward Manager/ on call manager/ Matrons
Review seconded staff	Ward Staff	Review all staff secondments.	Ward Staff	Matrons/ General Manager
Review staff on sick (incl. long term) regarding temporary alternative duties to support services and return to work.	Staff on Sick	Review alternative duties for appropriate staff currently off sick.	Substantive staff	Ward Managers & Matrons/ General Manager
Review alternative roles for staff who are working from home due to being classed as extremely clinically vulnerable due to COVID-19 or other pandemics	Staff judged to be clinically extremely vulnerable	Review of staff in this group to redeploy into appropriate alternative roles.	Substantive staff Bank Staff	Ward Managers & Matrons/ General Manager/ Safer Staffing lead
Review staff leave and offer carry forward to next year if necessary	Ward Staff	Look at flexibility within planned annual leave.	Substantive staff	General Manager

Check registered nursing staff availability from other services	Psychiatric liaison Team, CMHT, IHBT, EIS. On Wakefield site: Forensic services via Newton Lodge and Horizon Centre. Across the Trust: Barnsley then C&K.	Assess whether other areas can support the inpatients safely. Ensure that staff have the correct skill set and adjust interventions accordingly.	Staff who have the appropriate training and knowledge. All registrants.	General Manager for AWA General Manager for Community Teams. Deputy Director
Identify non-clinical registered nursing staff (e.g., managers, PGC, nurse consultants) who can cover shifts or parts of shifts or carry out tasks within their capabilities i.e., audits, supervision	Within Care Group. Across the Trust: Nursing and Professions Directorate, L&D, EMT.	Access support from non-clinically based registrants	Can be provided by Safer Staffing Office or Workforce Information	General Manager
Temporarily Redeploy Community/non-ward clinical staff from within Care Group on secondment	Any Professional registrant who is on an external secondment	Review all secondments external to the Care Group and evaluate whether they can be temporarily stopped.	General Managers Workforce Information	General Manager Deputy Director
Temporarily Redeploy registered nursing staff from other areas on secondment	Any Professional registrant who is on an external secondment	Review all secondments external to the Care Group and evaluate whether they can be temporarily stopped.	General Managers Workforce Information	General Manager Deputy Director

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2023
Agenda item 9.5

Private/Public paper:	**Public**		
Title:	**Care Quality Commission (CQC) inspection reports**		
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Paper prepared by:	Darryl Thompson, Chief Nurse / Director of Quality and Professions		
Mission/values:	All of our regulated activity is aligned to the Trust's values, which are fundamental to delivering safe health care: • We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of this report is to update Trust Board members with regards to the outcome of the Trust's CQC inspections in May 2023, of acute wards for adults of working age and psychiatric intensive care units (PICUs) and forensic inpatient and secure wards. The report also describes the action taken by the Trust since the inspection. Both reports are now published on the CQC website and are included within the papers. It is also important to note that the ratings issued by the CQC for these two areas has not changed the Trust's overall rating of Good.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Regulatory oversight and the quality and safety of care within these services aligns with all BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	All partners have been informed of the Trust's ratings. The Trust aspires to be outstanding and continues to learn and put actions in place to improve all services to the population it serves.		

Any background papers / previously considered by:	Prior to their publication, both of these inspection reports (both the draft and final versions) were shared with all Trust Board members, and update papers were also received in the private section of Board meetings.
Executive summary:	On Wednesday 6 December 2023 the reports for the CQC inspections into forensic inpatients and acute inpatient/PICUs were published on the CQC website. Nine wards were visited for each inspection. **The following ratings were given:** • **Forensic inpatient and secure wards:** The overall rating for the service has reduced from good to requires improvement. The rating for each of the domains of safe, effective, responsive and well-led is requires improvement, and caring is rated as good. • **Acute wards for working age adults and psychiatric intensive care units:** the overall rating for the service remains as requires improvement. Each domain is rated as requires improvement. Key observations for Trust Board members to note: **Forensic inpatient and secure wards rating** The overall rating for this service moved from good to requires improvement. The service received 7 must do actions against seven regulatory requirements, and 7 should do actions. Areas of good and outstanding practice were identified, alongside positive comments regarding staff developing holistic, recovery-oriented care plans informed by a comprehensive assessment, staff treating patients with compassion and kindness, and understanding the individual needs of patients, actively involving patients and families and carers in care decisions. Areas of learning included ensuring ligature risk assessments are up to date and accessible to staff, understanding and practice with regards to duty of candour, ensuring behavioural support plans are in place and ensuring that all staff receive appropriate training to enable them to meet the needs of people with a learning disability and autistic people. **Acute wards for working age adults and psychiatric intensive care units** The overall rating for this service has remained as requires improvement. The service received 16 must do actions against nine regulatory requirements, and 12 should do actions. Areas of good and outstanding practice were noted in the report, alongside positive comments with regards to culture, staff treating people kindly and with respect, and senior leaders having created a culture on the wards where patients and staff felt supported and were able to express their views.

	Areas of learning included care planning (including family and carer involvement), reducing restrictive physical interventions (including prone restraints), staffing, appraisal rates and ensuring all staff receive appropriate training to enable them to meet the needs of people with a learning disability and autistic people. **Action since the inspection:** Some areas of learning were addressed rapidly after the visit across all wards covered by the inspections, most notably with regards to ligature oversight and staff receiving appraisals. There has also been the establishment of a quality improvement approach to reducing restrictive physical interventions, with a specific focus on reducing prone restraints across all wards. Improvement plans are in place for all the must do and should do actions, and monthly meetings have been established chaired by the chief nurse / director of quality and professions, to assure the evidence oversight to complete the actions response Progress will be reported directly to the Executive Management Team and Quality and Safety Committee, with escalation to Trust Board should there be concerns with regards to any of the actions' progress. As a Trust we welcome feedback from our regulators and the opportunity to learn and improve our services. Regular engagement meetings remain in place with the CQC.
Recommendation:	**Trust Board members are asked to RECEIVE and NOTE this report.**

South West Yorkshire Partnership NHS Foundation Trust

Forensic inpatient or secure wards

Inspection report

Trust Headquarters
Fieldhead, Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924327000
www.southwestyorkshire.nhs.uk

Date of inspection visit: 16, 17 and 18 May 2023
Date of publication: 06/12/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Forensic inpatient or secure wards

Requires Improvement 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

We rated the service inspected as requires improvement. Overall, we rated safe, effective, responsive, and well-led as requires improvement and caring as good.

We visited 9 of the forensics wards provided by the trust at the following locations:

Fieldhead

Newhaven ward, a 16 bedded low secure/ learning disability ward.

Bretton Centre:

Sandal Ward, a 16 bedded low secure ward.

Thornhill ward a 15 bedded low secure ward.

Ryburn Ward, a 7 bedded low secure ward.

Newton Lodge:

Priestley ward, a 17 bedded medium secure ward

Johnson ward, a 15 bedded medium secure ward

Chippendale ward, a 12 bedded medium secure ward

Appleton ward, an 8 bedded medium secure/ learning disability ward

Hepworth ward, a 15 bedded medium secure ward

We also carried out a Mental Health Act monitoring review visit on Bronte ward, at the same time as the inspection. This will follow the normal process for these reviews.

Our rating of services went down. We rated them as requires improvement because:

- Some aspects of ward environments were not safe. Up to date ligature risk assessment were not always accessible to staff. Equipment was not always checked to ensure it was in date and safe to use in an emergency. Records showed the temperatures in some clinic room fridges were not always kept within the required range.

Our findings

- Staffing pressures meant there were high levels of bank and agency staff on some wards which impacted on the quality of care patients were receiving. Staffing pressures also meant that patient's leave was sometimes cancelled.
- Staff did not always use least restrictive practices. On one ward, we found high levels of restraint, including prone restraint being used.
- Staff did not always consider individual circumstances when applying restrictions.
- Positive behavioural support plans were of variable quality, not always informed by psychological formulation and were not always used effectively to reduce incidences of prone restraint on wards.
- Supervision levels varied across wards. Staff on some wards did not receive regular supervision and it was not clear if staff had received the required level of supervision as set out by the trust. Staff did not always attend regular team meetings.
- Not all staff had received training on meeting the needs of patients with a learning disability or autistic people. This training was not mandatory for all staff and although training for staff on learning disability wards had been introduced in April 2023, it had not been completed by all staff.
- Staff did not always respect patients' privacy and dignity. Staff sometimes accompanied patients on leave in scrubs which identified them as a patient of the hospital. The therapy room on one ward was not sound proofed and private conversations could be heard on the ward.
- Governance processes did not always ensure managers had full oversight of quality or ensure that ward procedure ran smoothly. We found significant variations between wards which included the completion and recording of staff supervisions and mandatory training. On some wards meaningful activities were not always available to patients. Prone restraint was not monitored and managed effectively.
- Staff did not fully implement the trust's duty of candour policy. A written letter of apology was not always sent to people as required and senior staff were not clear about this requirement.

However:

- The service mainly provided safe care. The ward environments were mostly clean. The wards mostly had enough nurses and doctors to ensure the wards were safe. Staff mostly assessed and managed risk to individual patients well. Staff managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams mostly included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers mostly ensured these staff received training and appraisals. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Our findings

How we carried out the inspection

During our inspection we visited 9 wards which were based on 3 sites at Newton Lodge, the Bretton Centre and Newhaven.

During our visit we:

- conducted 9 ward tours.
- spoke with 31 members of staff.
- spoke with 25 patients.
- spoke with 9 carers.
- checked 22 records and reviewed a range of seclusion and restraint records.
- observed a handover and a multi-disciplinary team meeting.
- conducted an evening visit.
- carried out medication checks.
- reviewed a range of policy and documentation.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

Most but not all wards were clean, well furnished, and fit for purpose. Not all wards were well maintained. Aspects of the ward environment were not safe because ligature risk assessment were not up to date on most wards and equipment had not always been checked to ensure it was safe to use.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all ward areas. We found the ligature risk assessments for most wards were out of date. New ligature risk assessments had been carried out but were in draft, had not been approved by managers and were not available for staff to view. The process between staff conducting a ligature risk assessment and this being approved was lengthy, taking up to 6 months to complete. Ligature risk assessments were not easily accessible, and several managers found them difficult to locate. We highlighted this to the trust following our inspection and they took measures to ensure ligature risk assessments were more easily available to staff. Fire risk assessments were in place for all wards and were up to date.

Our findings

There were potential ligature anchor points in the service. Staff knew about some but not all potential ligature anchor points. Staff had received an induction which included information about the location of these. Staff mitigated ligature anchor points through locking rooms, staff awareness and individual care planning. The trust were undertaking a programme of door replacements which involved installing door alarms which would alert staff if a patient attempted to use a ligature from a door. This work was ongoing at the time of our inspection.

There was no mixed sex accommodation.

Staff had easy access to alarms. Most patients had easy access to nurse call systems, however a nurse call alarm in one patient's bedroom and a nurse call alarm in a visitor's room had been turned off and this had not always been regularly monitored.

Maintenance, cleanliness and infection control

Most ward areas were clean, well-furnished and fit for purpose. However, we found some wards had areas that were not well maintained. For example, Johnson ward had areas of poor décor, the seclusion room shower had gaps in the panelling that presented a risk because they could be used to self-harm and the communal bathrooms required maintenance. There were stains on the carpet and floors of several wards. Ryburn ward had some furniture that was stained and needed replacing. The trust had an estates and facilities team who carried out maintenance on site.

There was an issue with the drains on Chippendale ward, one patient told us sewage sometimes came out of the drains. Staff told us that this occurred when maintenance staff unblocked toilets. Maintenance records showed there had been an issue with the drains in March 2023 and this had been fixed.

Staff cleaned wards but we found gaps in some cleaning records where recording had not taken place. The trust told us these related to occassions when patients had not wanted staff to access their bedrooms. Following our inspection, the trust put a process in place to escalate to ward managers, repeated refusals for rooms to be cleaned. Rooms were then identified to be deep cleaned to ensure patient safety.

Staff followed infection control policy, including handwashing. All staff were wearing surgical face masks in clinical areas. This was in accordance with the trust policy at the time of our visit.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Most clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly, cleaned, and maintained. However, staff on Johnson ward had not checked the red bag, containing resuscitation equipment and emergency drugs, since March 2023. This check was meant to occur weekly. We raised this during our inspection and staff took action to address this issue.

Some of the equipment on Johnson ward was out of date. This included syringes and a first aid kit. We also found staff were not using the soft close lids for boxes containing used needles, which meant these were not securely stored.

Daily clinical fridge temperatures had not always been recorded on Priestley ward and the maximum fridge temperature recording for Priestley ward exceeded the recommended temperature on a regular basis. It was not clear whether staff had taken any action in response to this. We found staff were not recording minimum and maximum clinical fridge temperatures on Johnson ward and there was no space on the form to do this.

Our findings

Safe staffing

The service had enough nursing and medical staff who had received basic training to keep people safe from avoidable harm. However, not all staff knew the patients well because there were high levels of bank and agency staff on most wards.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

Overall, the service had reducing vacancy rates. Vacancy rates on some wards were quite high, particularly in relation to nursing vacancies. For example, Johnson ward had a nursing vacancy rate of 3.1 full time equivalent and a nursing support vacancy rate of 5.8 full time equivalent, and Sandal ward had a nursing vacancy rate of 4.3 full time equivalent and a nursing support vacancy rate of 2.5 full time equivalent. Other wards had much lower vacancy rates. The trust had taken on extra staff in other roles to support wards with vacancies.

The service had high rates of bank and agency staff. Managers requested staff familiar with the service and some agency and bank staff were familiar with patients. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates, although these varied between wards. The turnover rate for the year was 14.6 % across all wards that we visited. This was above the trust target for 10-12%, however registered nursing vacancies had reduced from 35 whole time equivalent to 12 whole time equivalent during the financial year.

Levels of sickness varied across wards. For example, Priestley ward had high levels of sickness at 17% in April and Hepworth ward had low sickness levels with no sickness for April. The average sickness across the year for all wards was 8%. Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. However, we were told that not all shifts were filled. Ward managers could adjust staffing levels according to the needs of the patients, for example extra staff were requested when patients required one to one observations.

The trust moved staff between wards to ensure high risk areas were covered. This meant wards where patients had less complex needs, often had poor staffing levels which impacted on patients' leave and activities.

There had been 7 incidents where a lone preceptee, who is a newly qualified nurse, was left in charge of a ward for part or the whole of a shift. When this occurred, it was reported and investigated as an amber incident. The nurse could access support from senior staff on another ward during these times.

It was not clear patients were receiving regular one to one sessions with their named nurse. Records did not always demonstrate evidence of this. However, patients told us that permanent staff found time for them. The trust told us, the named nurse on duty engaged with service users and spent some time in conversation with them during each shift. Managers had recently implemented a strategy which involved blocking out days for nurses to carry out one to one sessions with patients.

Patients sometimes had their escorted leave and activities cancelled across most wards, this included the occasional cancellation of medical appointments, although these were prioritised. An average of 14% of escorted leave was cancelled in the year prior to our inspection. This was partly due to staffing pressures The trust had a recruitment plan in place to reduce vacancies and the impact of staffing vacancies on patients and staff numbers were increasing.

Our findings

Staff shared key information to keep patients safe when handing over their care to others. Staff held handovers between each shift and ensured key information was shared to help keep patients safe.

Medical staff

The service had medical cover at all times. A doctor was available to attend the ward quickly in an emergency. **Staff told us they could get hold of a doctor when they needed one. There was an on-call system operated by managers and this included an on-call consultant and access to acute doctors.**

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. However, some staff's training was out of date. Food safety compliance was low across most wards, for example, 63% of additional clinical staff and 50% of nursing staff on Newhaven and 58% of additional clinical staff and 64% of nursing staff on Priestley ward had completed this course. 72% of staff had completed this course across all wards we visited. Cardiopulmonary training compliance also varied across wards. For example, 67% of additional clinical staff on Priestley ward and on Ryburn ward had completed this course. However, overall compliance for this course across the wards was 80%. Overall compliance for all wards and staff groups was at 90%. The trust told us there was a focus on ensuring staff had completed reducing restrictive practice and cardiopulmonary resuscitation training.

The mandatory training programme met the needs of most patients and staff. However, learning disability and autism training was not mandatory across the service and had only been mandated for Newhaven ward in April 2023.

The Health and Care Act 2022 introduced a new legal requirement for all registered health and social care providers to ensure that their staff receive training in learning disability and autism, at a level appropriate to their role. This requirement has been in place since 1 July 2022. Newhaven ward employed learning disability nurses and a learning disability psychiatrist alongside mental health nurses to support patient need and the trust had started to roll out the Oliver McGowan training. However, this training was still being developed. 67% of staff had completed the tier 1 programme of this training. Previous to this, the trust were unaware of how many staff had completed learning disability and autism training because the training was available but not mandatory or monitored. This was concerning because staff were supporting patients with learning disabilities and with autistic spectrum disorder who had complex needs.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff did not consistently develop and implement good positive behaviour support plans or follow best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised assessment tool, and reviewed this regularly, including after any incident. The trust used the Formulation Informed Risk Management tool across the service. Most risk assessments were up to date, however we found 2 risk assessments on Johnson ward that were out of date. These were updated following our inspection.

Our findings

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff mostly updated risk assessments and care plans following incidents.

Staff could not always observe patients in all parts of the wards. Some wards had mirrors which enabled staff to observe areas of the ward that were outside of a line of sight, but we found other wards did not have mirrors. For example, Appleton ward had a number of blind spots which were not covered by mirrors. Staff told us CCTV was used to cover the blind spots, however following our inspection, the trust clarified this was not the case. Following our inspection, the trust told us they were adding additional mirrors to support the safety of staff and patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Restrictive interventions were in place. Some of the restrictive interventions were in response to identified risks. However, there were some blanket restrictions that were applied widely, for example all the courtyards were supervised for all patients except for patients on Ryburn ward. This was because a patient had absconded from one of the wards. Patients were also only provided with decaffeinated drinks, despite the trust telling us that there was patient choice between caffeinated and non-caffeinated drinks. There were also restrictions around cutlery which was managed according to levels of patient need and risk on each ward. Wards had a blanket restriction risk register which was reviewed monthly.

It was not clear staff always made every attempt to avoid using restraint by using effective de-escalation techniques. Although restraint levels were quite low on most wards, restraint levels on Newhaven were high. 155 restraints had been carried out in 6 months prior to our inspection.

Staff sometimes carried out prone restraint which is a type of physical restraint which involves holding a person chest down. This was rarely used on most wards, however the level of prone restraint on Newhaven ward was high. This was concerning because prone restraint can impact on patient's breathing. There had been 17 prone restraints in the 6 months prior to our inspection. This had involved 4 different patients with 1 patient being involved in 12 episodes of prone restraint.

We reviewed 5 prone restraints on Newhaven ward and found staff were not always carrying out observations following a prone restraint. Staff had not carried out observations following a prone restraint in 3 out of the 5 restraints reviewed and it was unclear whether they had carried out observations following 1 other restraint.

We also found that on two occasions the patient was in prone restraint on more than one occasion during restraint.

However, prone restraints were mostly short in duration. One prone restraint lasted 4 to 5 minutes all other prone restraints lasted less than 2 minutes. Staff took patients out of prone restraint as soon as possible. Where staff restrained patients, this could occasionally result in prone restraint being used unintentionally. For example, if a patient

manoeuvred into prone restraint. It also included very short periods of prone restraint where a patient required being placed in seclusion under restraint and was resisting to enable staff to withdraw safely. The trust had invested in safety pods and were working towards alternative strategies for restraining patients. Since our inspection the trust provided additional training for staff on Newhaven ward.

We were not assured that positive behavioural plans were used to help reduce instances of restraint. For example, we reviewed 7 incident reports for prone restraint and 4 of these stated that the positive behavioural support plan or staying well plan had not been initiated or reviewed.

We reviewed 4 positive behavioural support plans for patients who had experienced prone restraint. Positive behavioural support plans were of varying quality and were not always informed by psychological formulation. One positive behavioural support plan had an accompanying psychological formulation and key issues identified in the formulation which may have helped support the patient however, these were not present in the positive behavioural support plan. Plans did not always contain information that were helpful to staff understanding the patient and some plans contained information that focused on the negative behaviour of patients with less information relating to how staff could support them.

Although the trust had reviewed each individual prone restraint episode, there had been no longitudinal review of individual patients subject to prone restraint to identify patterns of behaviour and how prone restraint could be avoided. There was also no evidence that staff had carried out any recent meaningful or regular functional analysis of behaviour for each patient subject to prone restraint.

Occasionally the incident reporting wording did not accord with people receiving person-centred care as they used phrases such as ‘care seeking behaviour’. This was concerning because the language used was not reflective of a person centred response to the patient’s distress.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed 4 seclusion records and found these were completed accurately and appropriate reviews had taken place. We found one record did not contain an exit plan, which is a plan to help a patient understand what needed to be achieved for them to leave seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. There had been one episode of long-term segregation in the last 6 months across the wards we visited.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received mandatory safeguarding training for adults and children at an appropriate level.

Our findings

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had up to date safeguarding policies for adults and children which provided staff with clear guidance about safeguarding procedures. The trust also had a safeguarding team and staff told us they could obtain advice and support about safeguarding concerns from this team.

Staff followed clear procedures to keep children visiting the ward safe. There were family rooms which provided appropriate facilities for visits with children and the service had procedures in place for assessing and supervising these visits.

Staff access to essential information

Staff did not always have easy access to clinical information. Most care records were comprehensive though and stored securely.

Patient notes were comprehensive and most risk assessments were up to date. However, 2 out of 3 records we looked at on Johnson ward did not have an up to date risk assessment. Staff had identified this and work was ongoing to address this.

Staff told us there could be problems accessing the computer system as it did not always work.

Most records were kept electronically and these were stored securely. Some patients had files containing basic information that could be accessed easily. We found 2 of the 3 paper files on Newhaven did not contain this information. This meant staff who did not know patients well did not always have quick access to information about them.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust used an electronic medicines management system which supported the administration of medication. Staff completed medicines records accurately and kept them up-to-date.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Leaflets could be printed off to provide information for patients about their medicines.

Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended the wards weekly to audit medication and were available to support staff with medication queries.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The primary care team carried out physical health monitoring and liaised with staff on the ward regarding any concerns that related to their medication.

Track record on safety

The service had a good track record on safety.

Our findings

There had been no never events in the 12 months prior to our inspection.

The trust monitored and categorised incidents according to severity with red and amber incidents being the most serious. There was 33 of these incidents between October 2022 and April 2023. These included 3 incidents of violence and aggression, 1 incidence of absconding from a low secure courtyard and 7 incidences of a lone preceptee left in charge of a ward for part or the whole of a shift.

There were clear responses to these incidents to reduce the likelihood of recurrence.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff were not following the duty of candour correctly.

Staff knew what incidents to report and how to report them. Staff accessed the trust's reporting system to report incidents and there was a system in place to ensure this was escalated to the appropriate manager to review.

Staff raised concerns and reported incidents including serious incidents and near misses in line with trust policy.

Staff including some senior staff did not fully understand the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. However, staff did not always provide patients with a written apology. This is a requirement of the duty of candour. The trust policy states that all verbal apologies should be followed by a written apology, however staff understanding was that a written duty of candour letter was to be offered rather than sent as standard practice.

Managers debriefed and supported staff after any serious incident. Managers told us psychologists were often involved in debriefs and that sometimes other teams such as the resuscitation team would provide debriefs following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were monitored by the trust to identify any trends and themes.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were sent emails with learning from investigations. The trust also offered learning lessons events meetings where incidents would be reviewed and learning shared.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, a physical weight monitoring pathway had been developed in response to a serious untoward incident.

Is the service effective?

Requires Improvement 

Our findings

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements. However, positive behavioural support plans varied in quality, and we were not assured these always supported staff to understand patients effectively.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The trust had an assessment ward where each patient received a thorough assessment.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The service completed a range of care plans for each patient, which focused on different areas of care. Not all patients had a one page profile or other documentation which staff could refer to quickly for key information.

Staff regularly reviewed and updated care plans when patients' needs changed.

Most care plans were personalised, holistic and recovery-orientated. However, some were written in a professional tone and did not reflect the patient's voice. The trust told us they had an improvement group who were addressing this and taking actions to improve the voice of the patient in care plans and risk assessments.

Positive behavioural support plans varied in quality and did not provide clear guidance to enable staff to provide patients with consistent care or manage their distress. Psychological formulations were not always completed or used effectively to inform the positive behavioural support plans. We saw one plan had an accompanying psychological formulation, but key information identified in the formulation was not included in the positive behavioural support plan.

Different templates were used to create positive behavioural support plans which caused inconsistencies in quality, for example, 2 patients had an easy read template with a care plan template which provided some basic positive behavioural support information, 1 patient had a positive behavioural support plan which included details of a traffic light system to help staff identify how to support the patient when presenting with different levels of agitation, but no easy read plan. One patient had a positive behaviour support plan which was formulated on a template designed to support staff create a positive behavioural support plan with relevant prompts and an easy read plan. Following our inspection, the trust put plans in place to improve the quality of positive behaviour support plans.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Patients on all wards had access to a psychologist, who carried out a range of interventions with patients including cognitive behavioural therapy; dialectical

behaviour therapy; eye movement desensitisation and reprocessing therapy; trauma self-management and mental health awareness. Wards also had occupational therapists, who provided one to one and group sessions across wards. This provision was impacted by staffing challenges at the time of our inspection. Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. Staff supported patients with a variety of physical health concerns including patients with diabetes and cancer. Care plans were in place to ensure patients were supported with these concerns. Staff completed National Early Warning Score (NEWS2) with patients. This is an assessment for monitoring patient's physical health. However, we were told there was an issue with the system which meant a patient's air/oxygen intake could not be recorded properly which affected the accuracy of the score.This issue was resolved following our inspection.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, patients received a choking assessment and were referred to a dietician for support where this was identified as an issue.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a range of activities across wards to support patients to lead healthier lives. These included walking groups, access to the gym, sports groups including badminton and football and a healthy eating group. This was ward led and some wards offered a range of activities, whilst other wards had limited access to healthy activities.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Technology was sometimes used to support patients. For example, wards had a tablet they could use for feedback and patients could access computers, where this was risk assessed as being safe to do so.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers carried out a clinical records review which assessed compliance with a range of information including reviewing the quality of care plans and risk assessments, whether these were up to date, whether consent to share had been updated and completion of nutritional screening tools. Managers identified gaps and put plans in place to address these.

Skilled staff to deliver care

The service had access to a range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided appraisals and an induction programme for new staff. However, they did not always support staff with supervision and opportunities to update and further develop their skills.

The service mostly had access to a range of specialists to meet the needs of the patients on the ward. This included occupational therapists, speech and language therapists, dieticians and psychologists. Medium secure wards also had access to social workers.

Managers mostly ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, we were concerned staff had not all received relevant learning disability and autism training.

Our findings

Managers gave each new member of staff a full induction to the service before they started work. Bank and agency staff also received inductions.

Managers supported staff through regular, constructive appraisals of their work. Overall appraisals were at 83%, although Priestley ward had a low compliance rate at 62.5%.

Staff did not always receive regular supervision. Staff supervision levels varied between wards. Staff were expected to receive 6 hours clinical supervision and 6 hours management supervision a year. It was unclear how this compliance was being monitored and the trust told us there were some issues with monitoring supervision which they were in the process of addressing. Staff were not receiving monthly supervision on most wards, for example an average of 37% of staff received supervision monthly on Johnson ward, whereas 89% of staff were receiving supervision each month on Thornhill. Most staff received supervision quarterly. The trust also offered group supervision from psychology and the trust told us these were well attended.

Managers did not always make sure staff attended regular team meetings. This varied between wards but we were told that some wards had not had regular team meetings due to the difficulties with getting staff together. Minutes from team meetings were shared with all staff.

Managers mostly identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff undertook trauma informed training and Mary Seacole training where this related to their role.

Managers recognised poor performance, could identify the reasons and dealt with these promptly.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multi-disciplinary team meetings to discuss patients and improve their care. Patients met with the multi-disciplinary team once a week. There was a range of professionals at multi-disciplinary meetings including psychiatrists, nurses and occupational therapists and psychologists. Carers could attend multi-disciplinary meetings if they wished, however carers fed back that this was not something they did regularly.

Ward teams had effective working relationships with other teams in the organisation. Staff regularly liaised with other teams such as speech and language therapists, dieticians and the physical health team in order to support patients.

Ward teams had effective working relationships with external teams and organisations. For example, staff regularly liaised with the Ministry of Justice, the police, housing and advocacy organisations about patient's care and treatment.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice's guiding principles.

Our findings

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Where appropriate, staff used easy read rights to help patients understand their rights. Advocates were sometimes used to support patients with understanding their rights.

Staff were not always able to make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was partly due to insufficient staff to facilitate this.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and could access them when needed. Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Staff had regular contact with the Mental Health Act office who carried out regular audits. The Mental Health Act office sent regular reminders about tribunals and patients' rights being read to staff on the ward.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of the five principles. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff understood and knew how to access.

There were no deprivations of liberty safeguards applications made in the last 12 months.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff gave us examples of when they had carried out capacity assessments with patients, when they had concerns about a patient's ability to make a specific decision.

Our findings

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They mostly respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were mainly discreet, respectful, and responsive when caring for patients on wards. We saw positive and responsive interactions between staff and patients on most wards. Staff mainly responded to patients' individual needs.

Patients said most staff treated them well and behaved kindly. Patients told us permanent staff were kind, respectful and good at listening.

Most staff gave patients help, emotional support and advice when they needed it. Patients told us staff were lovely and that they felt listened to. Patients told us about staff who they felt they could go to for support. For example, some patients told us they felt they could speak to the ward manager if they had any concerns and other patients told us the ward psychologist was really helpful.

However, some patients told us that bank and agency staff were less responsive than regular staff and some bank and agency were judgemental and were less caring than permanent staff. Patients also told us they felt unhappy about staff wearing scrubs when they were out in the community because this meant they could be identified as a patient when they were on escorted leave.

Staff directed patients to other services and supported them to access those services if they needed help. Patients were referred to services to support them with a range of issues such as housing, healthcare needs, and legal issues.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in most care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Our findings

Staff involved most patients in their care and gave them access to their care plans and risk assessments. However, we found some care plans were written using nursing terminology and were clinical in tone. Following our inspection, the trust told us they were undertaking work to improve the patient's voice in care plans.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, staff discussed patients' medication with them and helped them understand the effects of this. Staff used easy read information and additional explanations to support their communication with patients.

Patients were involved in decisions about the service, when appropriate. Staff held regular community meetings with patients to share information and listen to patient feedback about the service. Patients were also supported to take part in local service user involvement forums within the wider area. Patient representatives would attend these meetings and feedback to other patients on the ward. Patients, who had leave, had the opportunity to attend service user involvement activity off the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held community meetings to provide patients with the opportunity to provide suggestions and discuss concerns about the ward. Patient representatives were also invited into monthly managers meetings to give feedback about patient concerns on the ward. Staff also carried out patient surveys to obtain feedback from patients about their experience on the ward.

Staff made sure patients could access advocacy services. Advocacy services regularly attended the ward and patients had access to independent mental health advocates where required.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always inform and involve families or carers. Staff told us carer involvement had reduced during Covid 19 and that involvement in activities were starting to be reintroduced. The trust had a carers project officer and carers champions who identified and supported carers within the service.

Carers provided us with a mixed response regarding their involvement. Some carers told us that staff kept them informed and other carers told us communication was poor, and staff did not always get back to their queries regarding their loved ones. Most carers told us that they were not involved in their loved one's care plan.

Staff helped families to give feedback on the service. Feedback forms were available for families to give feedback to the service. Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Our findings

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning. Discharges were carefully planned to help patients prepare for discharge.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. At the time of our inspection there were no delayed discharges on the wards

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe, however not all bedrooms had an en-suite bathroom. There were quiet areas for privacy. The food was not of good quality and patients could not always make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Most bedrooms had an en-suite bathroom, however the bedrooms on Sandal ward and Thornhill did not have en-suite bathrooms.

Patients had a secure place to store personal possessions.

Not all wards had a full range of rooms and equipment to support treatment and care. Wards varied in the space they had available for patients. Priestley ward lacked one to one space. One of the quiet rooms had been turned into a hydration station during the Covid 19 pandemic and this still remained. The other one to one room lacked privacy. Conversations held in the room could be heard in communal areas. The trust told us that action had been taken following our inspection to improve the privacy of the room.

Work had been undertaken on some wards to update and improve the ward environment, for example Appleton ward had a sensory/relaxation room that had been equipped in consultation with patients. The service had also refreshed its visitors' rooms including providing a range of toys and resources for children.

Patient kitchens, although present, were mainly unused. Due to ongoing Covid 19 restrictions, patients were only allowed to use them during 1-1 assessment sessions with occupational therapy staff. This impacted on patient activities, particularly in relation to patients who did not have section 17 leave and therefore had to remain on the ward. Following our inspection, these restrictions were reviewed and the use of the kitchens was returned to pre-pandemic use.

Our findings

Patients could make phone calls in private. Some wards had a telephone room and there were arrangements on some wards for patients to have a basic mobile phone that they could make calls from. This was individually risk assessed.

All wards had outdoor space. Patients on all wards except for Ryburn ward could access this space under supervision. Patients on Ryburn ward had unsupervised access to outside space, due to this being a rehabilitation ward.

Patients could not always make their own hot drinks and snacks and were dependent on staff to do this for them. However, this was based on the needs and risks on the ward. We observed staff making patients hot drinks on request and patients told us they could generally get a hot drink fairly quickly.

The service offered a variety food. However, most patients we spoke to told us the food was unpleasant because it was reheated on the ward which affected the texture. This had been raised at community meetings and the catering manager was invited to some of these meetings to discuss concerns about food with patients.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Patients had some access to opportunities for education and work. There were some opportunities for patients to access education on the ward, for example patients could study English and maths and we were told some patients accessed college. Some of the patients also had jobs on the wards and were financially rewarded for these.

Staff were not always able to help patients to stay in contact with families and carers. Families told us contact with their loved ones had sometimes been difficult, particularly during the Covid-19 pandemic and that escorted visits were often cancelled.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service could access information leaflets available in languages spoken by the patients and local community. The service had an online animated induction to the ward, and this was also available in a variety of languages.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Wards had access to multi faith rooms and there were arrangements for spiritual leaders to visit wards.

Following incidents at the service, staff and patients worked together to create a cultural events calendar to promote positive education and a greater understanding of diversity in all its forms. This involved the ward hosting events throughout the year, that helped staff and patients improve their understanding of different religions and cultures.

Our findings

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers did not always know how to complain or raise concerns. However most felt as though they could if they needed to, and most patients and carers felt they would be able to raise issues with staff and these would be taken seriously.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, changes had been made to security systems as result of a complaint that had been made to the service, which meant these systems were more robust.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The ward had a clear management structure to support the service. This included a general manager, a medical clinical lead, a quality and governance lead and an inpatient clinical manager for medium secure services and low secure services.

Staff told us that ward managers and inpatient clinical managers were visible on the wards. Managers were supportive and staff felt they could approach them with any concerns they had. Staff told us they rarely saw members of the senior executive team.

However, the executive trio had a programme of planned visits to wards, and other members of senior management had visited wards as part of oversight, assurance and engagement, including quality monitoring visits and attendance at learning events.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Our findings

Ward managers could tell us about the trust vision and values and told us about how they modelled these values within teams. Staff were aware of the providers visions and values.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Most staff told us they had a supportive team who worked together well. Most staff told us they felt respected and valued. Staff felt that high numbers of bank and agency staff caused some challenges and stress for the staff team and that this sometimes impacted on patient care.

Staff were aware there was a whistleblowing policy and that the trust had a freedom to speak up guardian. All staff told us they could raise any concerns they had about patient care with managers.

Governance

Our findings from other key questions did not demonstrate that governance processes operated effectively at team level. Some areas for improvement were not always identified or acted on in a timely way. Performance and risk were mostly managed well.

Managers attended governance meetings every month and had regular meetings with a governance coach. There was a range of meetings in place to review particular areas of governance, these included a monthly security meeting, a monthly medium secure management meeting and a fortnightly ward manager meeting. Senior managers attended some of these meetings to provide feedback and to enable information to be escalated where needed. Senior managers attended a daily management huddle in order to review the last 24 hours and identify any immediate actions regarding safety, quality and performance. However, these meetings did not always ensure that governance was effective at ward level.

There was a range of policies and procedures to provide guidance to staff. Policies and procedures generally provided clear information and advice for staff. However, we found some of the procedures on the wards were out of date. For example, the care of keys and security procedure and the search procedure we looked at on Newhaven were out of date.

Some governance systems were complex and lengthy. This resulted in the ligature risk assessments being out of date, due to it taking up to 6 months to go through the relevant governance processes. When we highlighted this, the trust told us this was an issue they had identified and they were putting measures in place to address this. Following our inspection, the trust produced a folder for each ward containing key risk information.

There were inconsistencies in service quality across the wards. For example, some wards offered a range of activities for patients, whereas other wards provided very limited activities. Cancelled activities were not collated which meant that there was no process for monitoring this and the potential impact to patients. Following our inspection, the trust took action to improve information gathering and reporting relating to these concerns. Levels of compliance with supervision varied between wards with some wards achieving high levels of compliance and others much lower. Levels of compliance with training varied significantly between wards, staff groups and courses.

The trust were not monitoring restraint effectively. Staff were not monitoring restraint from a longitudinal perspective or carrying out functional analysis. When we highlighted this following our inspection the trust identified learning and improvements in relation to monitoring restraint and positive behavioural plans.

Our findings

Staff training was not comprehensive. The trust had started to put training in place to support staff working with people with learning disability and autistic people, however this was very recent and not completed with staff or embedded in the service.

Staffing was a challenge across the service and this impacted on patient care. However, the trust had a recruitment plan in place to increase staffing and plans were in place, to allocate staff to areas with the highest levels of risk and patient vulnerability.

Staff were not carrying out the duty of candour in accordance with legislation. This requires that a verbal apology is followed by a written apology. Although, this is reflected in the trust policy this was not being followed by staff and this had not been identified through trust systems.

Following our inspection the trust told us they had taken a range of actions in reponse to the issues that we raised immediately following our inspection. This included work carried out on ligature risks to improve staff understanding and access to ligature risks, work on fridge temperature recording, the completion of one page profiles and work on positive behavioural plans and work on improving the quality of the food. They also told us they had taken action to improve contact with families, were addressing the concerns around the staff wearing scrubs when they were out with patients and had carried out work to increase supervision and training compliance rates. The trust told us they had shared lessons learnt across the trust, regarding the checking of equipment.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust held a risk register for the forensics service where key risks were identified, mitigated and reviewed. Managers knew about this and were able to escalate any risks that were relevant to the service.

The trust had a system in place for identifying risk from incidents. These were then reviewed by the relevant members of senior staff including the safeguarding team. Learning was identified and disseminated to staff.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff carried out a range of audits and there was a system in place for reviewing these. The trust also carried out a programme of quality monitoring visits including reviewing specific aspects of wards such as infection prevention control.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The trust engaged with other local health and social care providers to ensure that patient needs were met. This included engagement with the police, housing and social care providers to provide support for patients during their time at the service and to support their needs once they had been discharged. The trust had links with the acute hospital and access to primary care to support patients with their physical health needs.

Our findings

Learning, continuous improvement and innovation

The trust had a culture of learning and improvement. Staff were involved in a range of projects to improve services and the wellbeing of patients. For example, the forensic service was involved with testing, treating and raising awareness about hepatitis C.

Staff were also involved in a project which aimed to provide more gender sensitive risk assessments for use in forensic psychiatry settings.

Staff and patients were involved in projects to improve the physical health of patients including providing swimming sessions for some of the patients and a football project which provided the opportunity for patients to engage with other patients form the community and play football together as a team.

Our findings

Outstanding practice

We found the following outstanding practice:

- Following incidents at the service, staff and patients worked together to create a cultural events calendar to promote positive education and a greater understanding of diversity in all its forms.
- The trust initiated a community football project. This involved patients and staff playing in a team together against other locally based social care related organisations, charities, groups, and societies. Hosting the event in community settings provided wider opportunities for service users to engage with other patients from the community who shared common interests/hobbies.

Areas for improvement

Action the Trust MUST take is necessary to comply with its legal obligations. Action a Trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the Trust MUST take to improve:

- Regulation 9 (3)(a)(b) The trust must ensure patients, who require them, have relevant, behavioural support plans that enable staff to meet their needs and provide person centred care.
- Regulation 10(1)(2)(a) The trust must ensure confidential spaces where service users share sensitive information are private and that conversations cannot be overheard by others.
- Regulation12(d)(e) The trust must ensure ligature risk assessments are up to date and accessible for all staff and that all equipment used has been checked to ensure it is safe to use.
- Regulation 13 (4)(b) The trust must ensure that the use of restraint is proportionate to the risks posed. This includes ensuring person centred attempts at de-escalation have been attempted in line with patients' care and positive behavioural support plans prior to restraint. The trust must also ensure prone restraint is only used as a last resort and is carried out safely.
- Regulation 17(1) The trust must ensure that it is accurately monitoring and managing the quality and safety of all wards and ensure it has effective oversight of the use of prone restraint and is managing this appropriately.
- Reg 18(2)(a) The Trust must ensure all staff are receiving the required level of supervision and training in accordance with trust policy. The Trust must ensure all staff receive appropriate training to enable them to meet the needs of people with a learning disability and autistic people.
- Regulation 20 The trust must ensure that all staff understand the duty of candour and follow this correctly. Staff must send a letter following a verbal apology.

Action the Trust Should take to improve:

- The trust should ensure that patients are able to engage in a range of activities across all wards.

Our findings

- The trust should ensure patients are supported to take section 17 leave, particularly where this involves patients attending medical appointments.
- The trust should consider its options for improving the provision of food for patients.
- The trust should ensure patients privacy and dignity is considered when staff accompany them on section 17 leave, in relation to the wearing of scrubs.
- The trust should ensure that all patient's one-page profiles are easily accessible for staff.
- The trust should ensure where appropriate carers have opportunities to be involved in their loved ones support.
- The trust should ensure that restrictions are individually assessed and blanket restrictions are a proportionate response to risks posed.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 1 other inspector, 1 assistant inspector, 3 specialist advisors and 1 expert by experience. The inspection team was overseen by Sheila Grant – Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

South West Yorkshire Partnership NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

Trust Headquarters
Fieldhead, Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924327000
www.southwestyorkshire.nhs.uk

Date of inspection visit: 16, 17 and 18 May 2023
Date of publication: 06/12/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement ➔➔

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service.

We rated the service as requires improvement, with all five domains of safe, effective, caring, responsive and well led rated as requires improvement.

We visited all of the acute and psychiatric intensive care unit (PICU) wards provided by the trust at the following locations:

The Dales, Calderdale Royal Hospital:

- Elmdale ward, a 24-bed female acute ward
- Ashdale ward, a 24-bed male acute ward

Priestley Unit, Dewsbury and District Hospital:

- Ward 18, a 23-bed mixed gender acute ward

Fieldhead Hospital, Wakefield:

- Nostell ward, a 22-bed female acute ward
- Stanley ward, a 22-bed male acute ward
- Walton PICU, a 14-bed mixed gender PICU

Kendray Hospital Barnsley:

- Clark ward, a 14-bed female acute ward
- Beamshaw ward, a 14-bed male acute ward
- Melton PICU, a 6-bed mixed gender PICU

Our rating of services went down. We rated them as requires improvement because:

- Staffing pressures within some specific staff groups were impacting on the experience of patients and the quality of care they received.
- Physical restraint of patients in the prone position (face down) was used more frequently than national guidance recommends.

Our findings

- People were not always adequately monitored following the administration of emergency medication or while in seclusion.
- People did not always have access to psychological therapies in line with recommended national guidance relating to their condition (for example, individuals with a diagnosis of personality disorder).
- A high proportion of staff were not having regular performance appraisals in line with the trust's appraisal policy.
- Staff were not receiving mandatory training on meeting the needs of people with a learning disability and/or autistic people in line with the national recommendation that all staff working within a CQC registered service should receive this at a level appropriate to their role.
- When people had their capacity to consent to their treatment formally assessed, this was not always appropriately documented in their care records.
- Records did not always show that people using the service and their relatives were meaningfully involved in their care.
- At Kendray Hospital the wards were running at over 100% occupancy (due to the practice of admitting new patients to the bed of someone who was on authorised leave from the hospital) and there had been a number of admissions to non-bedroom areas such as lounges.
- The care environment did not always meet the needs of the patients, particularly where people had additional needs due to protected characteristics such as disability or religion.

However:

- The wards were clean and free from avoidable risks including ligature risks, staff regularly assessed environmental risks and took action to mitigate these.
- Staff complied with best practice in relation to infection prevention and control including hand hygiene and wearing appropriate personal protective equipment.
- Medicines were managed safely and records of the storage and administration of medicines were accurate and up to date.
- Staff were aware of their responsibilities in relation to safeguarding adults at risk of abuse and raised safeguarding concerns appropriately.
- Staff complied with the requirements of the Mental Health Act and the Mental Capacity Act.
- Staff treated people kindly and with respect, we observed positive and supportive interactions between patients and staff on the wards.
- People could give feedback about their experience and changes were made as a result of this. Complaints were investigated in a timely manner and people received a response to their concerns.
- Senior leaders created a culture on the wards where patients and staff felt supported and were able to express their views.
- There were systems in place for monitoring the quality of care and effective assurance processes to inform the trust board of the standard of care on the acute and PICU wards.

How we carried out the inspection

Our findings

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

• visited all 9 wards and looked at the quality of the environment

• spent time on the wards observing how staff were caring for people

• observed a governance meeting and a ward round

• spoke with 33 patients on all 9 wards

• spoke with 12 relatives/carers

• spoke with 7 care co-ordinators for patients on the wards

• received feedback from a independent mental health advocate who visits the wards

• spoke with members of the senior management team including 1 service manager, 1 matron, 7 ward managers and 2 clinical leads

• spoke with 6 doctors including consultants, specialty doctors and junior doctors

• spoke with 25 other staff members including nurses, health care assistants, occupational therapists, activity coordinators, psychologists and discharge coordinators

• looked at the prescription charts for all patients, 20 full sets of care and treatment records and other care records, for example seclusion and restraint records

• looked at a range of policies, procedures and other documents relating to the running of the wards.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

The patients we spoke with gave us a mixture of positive and negative feedback about the service. People mostly told us that the wards were clean, they felt safe and staff managed incidents of aggression well. Some people told us there was always enough staff on duty, but some said the wards were often short staffed and there were a lot of agency workers, particularly on the night shift, which had a negative impact on the quality of their care at times. Most of the people we spoke with said their community leave and/or activities had been cancelled due to staffing pressures on at least one occasion.

People told us that staff treated them kindly and, if they had been subjected to any restrictive interventions such as physical restraint or seclusion, this had been done respectfully and safely. People usually felt they were given enough information about their medicines and said they could access a doctor when they needed to, although some people

Our findings

said there were delays in doctors attending out of normal working hours. Some of the people we spoke with said they felt involved in their care and they were able to give feedback about their experience, but some people felt less involved. People told us that staff gave them privacy as much as possible and they were able to access quiet spaces on the ward. Everyone we spoke with was able to access fresh air sometimes, but patients at The Dales, Priestley Unit and Kendray Hospital had more limited access to outside space, which some people found frustrating.

People gave positive feedback about the occupational therapy support they were receiving overall. Some people said there was not a lot to do on the ward, particularly at weekends. Some people told us that the care environment did not meet their individual needs, for example cultural dietary needs or accessibility needs due to a disability. People knew how to raise concerns about their care and they mostly told us that these were taken seriously and problems were addressed.

The carers we spoke with told us that they were happy overall with the care their relative was receiving in hospital. They said the wards or visiting rooms they saw when they visited were clean and they were able to visit as often as they liked, spending regular time with their relative both at the hospital and away from it (when the person had been granted leave). Relatives told us that most of the staff were kind and supportive towards their family member, although some people told us that individual staff members seemed less interested in their relative, particularly on the night shift.

Several of the carers we spoke with said the ward their relative was on seemed to be short staffed. Some of the people we spoke with said they did not feel that staff kept them informed about their relative's progress or involve them in decisions and most said they had not been offered any information about the support available to them as a carer. Some relatives said they felt there was a lack of organisation and streamlined processes on the wards, which made it challenging for them to keep up with how their relative was doing.

Is the service safe?

Requires Improvement 

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and fit for purpose.

Safety of the ward layout

Staff usually completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Each ward had a ligature risk assessment which was reviewed annually. All but one of the ligature risk assessments had been signed off by a manager and ratified by the trust's Quality and Governance meeting prior to our inspection. The outstanding risk assessment was completed in October 2022 but had not been signed off by a manager or ratified through the trust's governance processes prior to our inspection. This was completed immediately following the inspection. On Ward 18 we were not able to access the ligature risk assessment on the ward as staff were unable to locate it. Also, not all wards had a copy of the approved and ratified ligature risk assessment as the copy they had was still in draft form. However, staff were aware of where environmental risks were and measures were in place to mitigate these. We were told that the trust was already aware of issues with the sign off process for ligature risk assessments which could lead to delays. We were assured by the trust following the inspection that all wards now had

an approved and ratified copy of their ligature risk assessment stored in accessible folders. The trust has also assured us that following our inspection a system of ward matrons' spot checks was implemented, to ensure staff are aware of the location of these folders and the information contained in the assessments. There was also a fire risk assessment for each ward which had been reviewed in the 12 months prior to our inspection.

Staff could observe patients in all parts of the wards. Where there were blind spots, these were mitigated through the use of mirrors and staff supervision in certain areas, for example the gardens at Kendray Hospital.

All the acute wards apart from Ward 18 were single sex. On the mixed sex wards (Ward 18, Walton PICU and Melton PICU) the male and female bedrooms were on separate corridors and there were female only bathrooms and lounges available.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Door top alarms had been recently installed across all the acute and PICU wards due to the risk of someone using their bedroom door to anchor a ligature. However, these were not in use on all wards at the time we inspected. Where this was the case, we were told this was because staff needed to complete training on the alarms, which was in progress. The trust informed us that this was progressing in accordance with the planned programme of phased implementation of these environmental improvements. The trust confirmed in October 2023 that the door top alarms are now in use on all the acute and PICU wards. Some areas on the wards were kept locked due to the presence of ligature risks in these rooms.

Staff had easy access to alarms and patients had easy access to nurse call systems. Each room had a nurse call point and they were also situated throughout the communal areas on the wards. Staff were issued with portable alarms at the start of their shift.

Maintenance, cleanliness and infection control

Ward areas were clean, well-maintained, well-furnished and fit for purpose. We saw cleaning taking place throughout our time on all the wards we visited. The patients we spoke with on all the wards said the care environment was kept clean and relatives who had visited the hospital also said this. One patient raised concerns about the sofa in the lounge on Nostell ward having a ripped cover. We were told a repair had been requested in relation to this.

Staff made sure cleaning records were up-to-date and the premises were clean. The trust carried out regular audits of the cleaning documentation and the care environment to ensure the premises were being cleaned to an appropriate standard. We saw cleaning records for all 9 wards for the 4 weeks prior to our inspection which showed that regular cleaning and environmental monitoring was taking place during this period. Two of the seclusion rooms at Elmdale and Fieldhead Hospital were not clean when we inspected them. One had food on the floor and a puddle of water in the bathroom and the other had a toilet which was heavily soiled. We were told both these rooms had been vacated earlier that day and requests had been put into housekeeping for them to be cleaned. The cleaning records were broken down by room for the wards at Fieldhead and Kendray and so could provide assurance of regular cleaning of the seclusion rooms. This was not the case for The Dales and Ward 18. However, we did see evidence that environmental audits were in place on Ward 18 which included documented checks of specific ward areas including the seclusion room.

The stairwell at The Dales which patients used to access the secure garden needed refurbishment. The trust confirmed this was scheduled to take place in July 2023. Following the inspection we received photographic evidence from the trust confirming that these planned refurbishment works were completed in September 2023. Clark ward was also in need of refurbishment and we saw evidence that plans were in place for this to start immediately following our inspection. The trust informed us in October 2023 that this refurbishment programme had commenced.

Our findings

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored better than similar locations across England for cleanliness and for condition, appearance and maintenance across all the trust sites where the acute and PICU wards are based.

Staff followed the infection control policy, including handwashing. At the time we inspected the trust still required staff to wear surgical face masks in clinical areas to limit the risk of spreading COVID-19 within the hospital. We observed staff complying with this requirement.

Seclusion rooms

The seclusion rooms on all four sites allowed clear observation and two-way communication. They all had a toilet and a clock. In the seclusion room on Elmdale ward the ceiling smoke alarms had been removed from the ceiling. We were told this was due to the risks presented by a patient who had vacated the room earlier that day. The alarms were located and replaced while we were on site.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We saw records which confirmed the resuscitation equipment was checked by staff and replenished as needed.

Staff checked, maintained, and cleaned equipment. We saw records which confirmed this in the clinic rooms and we did not identify any equipment which was in need of cleaning or repair during the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, there were staffing pressures within specific groups which were impacting on patient care.

Nursing staff

The service had enough staff to keep patients safe. The trust's safer staffing data for 2022/23 showed an average shift fill rate of 117% across the acute and PICU wards. Staff and managers told us shifts were usually fully staffed. Some patients told us there were usually enough staff around to meet their needs but some said the wards were often short staffed, particularly at night. All the wards we visited except for Ward 18 were fully staffed when we inspected in terms of overall numbers.

However, some of the staff and patients told us that there were not always enough qualified nurses working on shifts. This was particularly the case at Kendray Hospital and the wards we visited at Kendray were not staffed to full establishment in terms of qualified nurses when we inspected. This resulted in the ward manager of Clark ward being the only qualified nurse on the ward for a period in the afternoon, when the only other qualified nurse included in the shift numbers had to attend a ward round meeting off the ward. Staff on Beamshaw ward also told us that there was not always an experienced nurse on the ward but just one who was shared between Clark and Beamshaw wards. The trust informed us following our inspection that there was only 1 occasion since October 2022 when there was only one registered nurse covering Clark and Beamshaw ward. We were also informed that, since March 2020, there has been senior leadership duty cover for these wards 7 days a week. Some patients at Kendray Hospital told us it was sometimes hard to get the attention of a nurse because they were so busy. Other members of the multi-disciplinary team, for example occupational therapists, told us that sometimes they were counted as part of the ward staffing numbers due to a shortage of nursing staff. Most of the relatives we spoke with told us they felt the wards were short staffed when they visited their family member.

Our findings

The service had low vacancy rates. Across all the acute and PICU wards there was an average vacancy rate of less than 2 whole time equivalent (WTE) staff per ward.

The service had high rates of bank and agency staff. Over the 4 weeks preceding our inspection the average proportion of staff on each ward who were bank or agency workers was 49% on Ward 18, 46% at Fieldhead Hospital, 40% at Kendray Hospital and 33% at The Dales. This included the bank and agency workers needed to bring the ward team up to the minimum safe staffing level and any additional staff needed to cover enhanced observations and other specific needs on the wards.

Some of the patients we spoke with said there were a lot of agency staff and they would like a more stable staff team so they could build more of a rapport with staff members. Some of the staff we spoke with at Kendray Hospital told us there was a high reliance on agency nurses due to vacancies for registered nurses, particularly on the night shift. Patients at Kendray Hospital told us there were too many agency staff working at night and they did not find these staff members as supportive or approachable as the day staff. Staff at Kendray Hospital also raised concerns about some night staff falling asleep during their shift. The ward manager was aware of these concerns and had taken action to address them by sending an email to all staff to remind them of their responsibilities and the trust policy in relation to night work. On the day we inspected Nostell ward there was a high proportion of agency staff on the shift (3 out of 7 staff members were agency workers).

Managers requested bank and agency staff who were familiar with the service. Ward managers told us they tried to use substantive staff picking up additional bank shifts or regular agency staff as much as possible. Staff and patients told us that day staff were usually familiar to them, but sometimes at night the staff team was less familiar due to a high use of agency workers. At Kendray Hospital in particular we were told this put additional pressure on substantive staff, who were understandably favoured by patients over less familiar staff when they needed something.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The wards had induction checklists which were reviewed with agency staff when they worked their first shift on the ward. There was also written information available for agency nurses, although the booklet we saw on Clark ward was out of date as it included information about paper prescription charts but electronic prescribing had been introduced across the service. We did not see any evidence that this had resulted in any medicines errors or inappropriate practice. The trust told us that the booklet was updated following our inspection to accurately reflect the electronic prescribing arrangements on the ward.

The service had average turnover rates. The average rolling 12-month turnover rate for all staff at the time we inspected across the acute and PICU wards was 13%, which was slightly above the trust's target of 10-12%. Some staff told us they felt turnover was high.

Managers supported staff who needed time off for ill health. Staff told us they felt well supported by the trust and they were able to take time off sick if they needed to.

Levels of sickness were mixed. Five out of nine wards were below the national average for NHS services (5.5%) for the period 1 April 2023 to 31 January 2023 and four out of nine were above average for the same period. Where levels of sickness were higher, we were told this was usually due to the impact of the COVID-19 pandemic.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, not all wards were staffed up to full establishment of qualified nurses when we inspected.

Our findings

The ward managers could adjust staffing levels according to the needs of the patients. Ward managers told us that if people's needs changed, for example if a patient needed an enhanced level of observations, they could request additional staff.

Patients did not always have regular one to one sessions with their named nurse. Some patients told us they did not know who their named nurse was and they were not being offered one to one sessions with anyone. Staff told us this was not always possible due to the staffing pressures faced by the wards which sometimes resulted in there being fewer qualified nurses on a shift than the required number in the staffing plan. The trust had tried to mitigate the impact of this by introducing a system where each patient was allocated to a team of nurses and healthcare support workers so that, if their named nurse was not available, they would have access to other familiar and consistent staff for one to one support.

Patients told us that they sometimes had their escorted leave cancelled because there was not a staff member available to support them. The trust stated that whenever this happened it was reported as an amber incident on the Datix incident reporting system, but some of the ward staff we spoke with said they did not think this always happened. A high proportion of the patients we spoke with told us that their leave had been cancelled on at least one occasion due to staffing issues during their current admission. The incident records showed that cancelled leave was reported as an incident on 4 occasions across all 9 acute and PICU wards between 1 April 2023 and 23 May 2023.

The trust prepares an annual report in relation to section 17 leave and the most recent report (2021/22) stated that 98% or more of patients' authorised section 17 leave went ahead as planned in the working age adult, older people and rehabilitation inpatient services (which includes all the acute and PICU wards covered by this inspection). However, due to the feedback we received from patients and staff, we were not assured that the trust's governance processes were capturing all instances of cancelled leave. Staff were prompted to record any cancelled section 17 leave for each patient on the handover record template for some wards but not all. The trust told us that the recording of cancelled leave on the handover template was ward specific, where matrons had identified a need to monitor the issue more closely for assurance. We saw evidence in team meeting minutes from Kendray Hospital that staff had raised concerns about the redeployment of qualified staff between wards which they felt was impacting on patients' section 17 leave at times.

The service had enough staff on each shift to carry out any physical interventions safely. Staff and patients told us they felt safe on the wards. Patients told us staff were effective at de-escalating aggressive incidents and intervening to ensure people were kept safe from harm.

Staff shared key information to keep patients safe when handing over their care to others. Handover meetings took place on all the wards we visited. They were attended by all ward-based staff on the incoming shift and the nurse in charge of the outgoing shift. Records were kept of the information shared at handover, which included a summary of any risks relating to each patient's care, an overview of their activities and mental state during the previous 12 hours and any incidents which had occurred.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. Ward staff told us they could access a doctor quickly, including out of hours. Patients told us they were usually happy with how often they got to see a doctor but some people told us they had to wait for longer than they wanted, especially if a doctor had to be called out unexpectedly. The relatives we spoke with said they were happy with their family member's access to medical care during their hospital admission.

Our findings

Managers could call locums when they needed additional medical cover. However, this was rarely necessary as all the wards we visited had substantive consultants and junior doctors in post. Some medical staff were working their notice periods, and we were told that recruitment was ongoing to ensure there was no gap in medical provision to the wards.

Mandatory training

Staff had usually completed and kept up to date with their mandatory training. Across the acute and PICU wards overall over 80% of staff were up to date with all mandatory training modules except for cardiopulmonary resuscitation (CPR) training, which was at 74% compliance when we inspected. We were told this was due to the impact of the COVID-19 pandemic on the availability of face-to-face training sessions and there was a recovery programme in place to address this. The trust had also identified other areas for improvement in the provision of mandatory training, for example on three wards less than 70% of staff were up to date with their physical interventions training and there was also targeted work ongoing to address these shortfalls. We were told that ward managers and senior leaders made every effort to ensure sufficient numbers of Reducing Restrictive Practice Interventions (RRPI) and CPR trained staff were allocated to each shift to ensure the safety of patients. Following the inspection the trust informed us that compliance rates for both modules have improved to 83% of staff for CPR training and 86% of staff for RRPI training, as at October 2023.

The mandatory training programme was comprehensive and met most of the needs of patients and staff. All staff were required to complete a mandatory programme of training which was a mixture of e-learning and face to face sessions including safeguarding, CPR, reducing restrictive practice interventions (RRPI), information governance, mental health legislation, equality and diversity, infection prevention and control and health and safety.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers had their own systems for monitoring staff completion of mandatory training and sent out reminders when staff needed to complete updates. The data was also collated centrally and used to drive improvement programmes where particular courses or staff groups were showing as outliers in terms of mandatory training compliance.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and usually followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, restraint was not always carried out in line with national guidance and people were not always adequately monitored during and following restrictive interventions.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The trust used the Formulation Informed Risk Management tool (FIRM) on all the acute/ PICU wards. The trust audited FIRM completion and and the creation of a staying safe plan for each patient to ensure this was taking place promptly following admission. The April 2023 audit showed that over 90% of patients had a completed risk assessment and staying safe plan within the required timescales across all the acute and PICU inpatient services.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Most of the patients we spoke with said staff supported them to be safe at the hospital. However, some patients raised concerns about being able to deliberately

harm themselves on the ward without staff taking action to prevent this or giving them any support on preventative strategies. For one patient, where this was the case, we saw that they had a risk assessment and care plan relating to their deliberate self-harm, but these were focused on how to keep the person safe following the self-harming behaviour rather than any preventative action which the patient or staff could take.

Staff identified and responded to any changes in risks to, or posed by, patients. Risk assessments were reviewed and care plans were updated when people's risks changed, for example following incidents.

Staff could observe patients in all areas of the wards. Blind spots were mitigated with mirrors and measures were in place to restrict access to areas where people could be at risk of serious harm if they were not supervised by staff.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. On all the acute and PICU wards we were told the policy was to only conduct personal searches, including of people's bags, if there was an identified risk that this person may bring banned items on to the ward such as alcohol or illicit substances. None of the patients we spoke with raised any concerns about inappropriate searches of themselves or their bedrooms.

Use of restrictive interventions

Levels of restrictive interventions were low overall. Patients and staff on all wards told us physical restraint did not happen frequently. We requested data from the trust which showed low overall levels of seclusion and restraint on the acute and PICU wards. In relation to physical restraint there were 856 instances across 9 wards in the 12 months preceding our inspection (an average of 8 restraints per ward per month). In relation to seclusion there were 208 instances involving 153 patients on the 7 acute wards and 113 instances involving 66 patients on the 2 PICUs in the 12 months preceding our inspection. Use of rapid tranquillisation was also low, with a total of 84 instances involving 63 patients across all 9 wards in the 12 months preceding our inspection. The patients we spoke with, who had experienced restrictive interventions, told us staff had acted safely and treated them respectfully. One person raised concerns about receiving an injury in a previous restraint. This had not previously been raised and the ward manager immediately took steps to investigate this and report the concern to the local safeguarding team.

However, the trust's data showed a high level of restraint in the prone (face down) position – out of 856 instances of restraint across the 9 wards in the 12 months preceding our inspection, 196 were in the prone position for at least part of the intervention (23%). Staff told us prone restraint was sometimes used to enable staff to safely exit seclusion. This was particularly the case at Fieldhead Hospital (with 50 prone restraints on Walton PICU, 19 on Nostell ward and 19 on Stanley ward) and Kendray Hospital (with 15 prone restraints on Beamshaw ward and 10 on Clark ward). Prone restraint is not recommended practice due to the risk of obstruction of the individual's airway in this position. National Institute for Health and Clinical Excellence guidance on managing violence and aggression in mental health services states that prone restraint should be avoided where possible. The Mental Health Act Code of Practice states that there should be no planned or intentional restraint in the prone position unless there are clear reasons for this.

The trust confirmed that in 2022/23 they had identified reducing prone restraint as a priority area in their governance work around reducing restrictive practices generally. We saw extracts from the trust board and sub-committee minutes which evidenced this. The Reducing Restrictive Practice Interventions (RRPI) team were exploring alternative strategies to prone restraint and introducing an alternative exit method for seclusion which should reduce the use of restraint in the prone position. The RRPI team are also in the process of establishing RRPI champions for each ward to promote

training, best practice, communication and quality improvements. Following our inspection, the trust told us that they had implemented further improvements to reduce the incident of prone restraint on the acute and PICU wards including investment in safety pods, re-accreditation with the Restraint Reduction Network, review of exit strategies from seclusion and improved Datix reporting and data analysis.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. On Nostell ward, a targeted piece of work in line with the Royal College of Psychiatry's Reducing Restrictive Practice Collaborative Programme had been carried out since the last CQC inspection, which had resulted in an overall 60% reduction in restrictive practices and 69% reduction in physical restraints. At the time of our inspection the trust was preparing to roll this project out across the rest of the acute and PICU wards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. People told us staff tried to de-escalate incidents verbally before resorting to physical interventions.

Staff understood the Mental Capacity Act definition of restraint and worked within it. There were a number of informal patients on the wards when we inspected. These patients were given information about their right to leave the ward and we saw no evidence to suggest anyone was being subjected to an unlawful deprivation of their liberty. However, at Kendray Hospital we observed patients frequently having to ask for doors to be unlocked to access lounges and the secure garden. The bathrooms were also locked as there were ligature risks in these rooms and the baths could not be used by patients without staff supervision. Following our inspection, the trust told us that options were being reviewed to have the assisted bath removed and replaced with a standard bath, which could be used without supervision in appropriate circumstances and which would reduce the ligature risks in the patient bathrooms.

Staff did not always follow NICE guidance when using rapid tranquilisation. The trust's template document prompted staff to document checks as recommended by NICE guidance on the short-term management of violence and aggression in mental health settings, however these records were not being consistently completed by staff. At times there were valid reasons for this, for example the patient being in seclusion and too unsettled for staff to be able to enter safely. However, even in these circumstances it is likely to have been possible for staff to record basic information such as the patient's level of consciousness and respiration rate and this was not always documented. Following our inspection, the trust told us that gaps in record keeping following rapid tranquillisation had been identified as an area for improvement in the inpatient service's Quality Priority Plan in April 2023 and that work was already ongoing to address this.

When a patient was placed in seclusion, staff did not always keep clear records to demonstrate they followed best practice guidelines. The seclusion records we reviewed showed staff were not always documenting observations or nursing, medical and MDT reviews at the intervals stated in the Mental Health Act Code of Practice. We were told that the trust was in the process of implementing electronic record keeping in relation to episodes of seclusion. Following the inspection the trust informed us that this was being rolled out across the inpatient services and monitored by the trust's RRPI Action Group. Some of the patients we spoke with who had been secluded during their time on the ward said they were not offered food or drink regularly. Some staff told us they did not think all their colleagues were aware of the intervals at which a patient in seclusion should be reviewed by a doctor or a nurse, because the seclusion policy was too long and complicated. Following the inspection, the trust told us that the intervals at which patients must be reviewed by a doctor or nurse are clearly set out on an easy read flow chart within the Seclusion Policy and these charts are also displayed on the walls of the seclusion areas on all wards.

Our findings

There were no patients in long-term segregation on the acute or PICU wards when we inspected. The data provided by the trust showed that there were two instances of long-term segregation across all 9 wards in the 12 months preceding our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Training on safeguarding children and adults from abuse was part of the trust's mandatory training programme for all staff. The trust safeguarding team had also recently provided safeguarding supervision sessions to staff at The Dales.

Staff kept up-to-date with their safeguarding training. The trust's training data showed that 83% of staff were up to date with safeguarding adults training and 87% of staff were up to date with safeguarding children training across the acute and PICU inpatient services at the time we inspected.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The staff and patients we spoke with did not raise any concerns about patients experiencing any discrimination on the grounds of race, gender, sexual identity or any other protected characteristic. Staff told us there was a zero tolerance policy in relation to hate crime on the wards.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The staff we spoke with told us their training had equipped them with the knowledge they needed to identify concerns about abuse and report them appropriately. They were able to give examples of things they would report as safeguarding concerns and they could describe the procedure for doing so, for example completing body maps and following the trust's safeguarding reporting process. The records of safeguarding referrals showed that a range of concerns about potential abuse and neglect of vulnerable people were being identified and referred to the relevant local safeguarding teams.

Staff followed clear procedures to keep children visiting the ward safe. There were designated visiting areas separate from the main wards where child visitors could spend time with their relative safely.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The managers and staff we spoke with about safeguarding were able to clearly describe the process for raising concerns and were aware of their personal responsibility to raise safeguarding concerns as soon as possible. The records confirmed safeguarding concerns were identified and referred to the appropriate local authority.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All the wards used the same electronic record keeping system and this could be accessed from staff laptops and desktop computers on all wards.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff on all wards had access to the patient's records from their community care and any previous inpatient admissions, where these were provided by the trust.

Our findings

Records were stored securely. Staff used smart cards and passwords to access the system and we observed staff ensuring screens were locked before they walked away from desks.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust used an electronic prescribing system which was in use on all acute and PICU wards. Staff told us they were finding this system, which had been recently introduced, beneficial in supporting them to manage medicines safely. The trust's pharmacy team carried out quarterly audits in relation to medicines management, most recently in January 2023, which demonstrated medicines were being managed safely across all acute and PICU wards. The trust confirmed that, at the time we inspected, all registered nurses had received training and competency assessments in relation to using the electronic system. However, due to the way medicines training was recorded (at individual ward level), we were not able to see training records which evidenced this. The trust confirmed conversations were taking place between the Directorate of Nursing, Quality and Professions and the pharmacy team to agree how to strengthen the monitoring and oversight of medicines management training.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw evidence in people's records that their medicines were reviewed by their responsible clinician at regular multi-disciplinary ward rounds. Most patients told us they were happy with the information they had been given about their medicines, but some people said they were not given enough information, for example about side effects. Following the inspection, the trust informed us that all patients are offered information about potential side effects to their medicines on admission and on an ongoing basis throughout their admission.

Staff completed medicines records accurately and kept them up-to-date. We reviewed the prescription charts for all patients on the electronic system and we did not identify any prescribing or administration errors.

Staff stored and managed all medicines and prescribing documents safely. The prescribing system was password protected and only accessible from designated terminals. We inspected the clinic rooms on all acute and PICU wards and we found that medicines were being stored safely and appropriately.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. All the wards received input from a pharmacist, who was responsible for reviewing patients' medication when they were admitted to the wards.

Staff learned from safety alerts and incidents to improve practice. Information on lessons learned from medicines errors was shared with staff in team meetings and via email updates.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The use of 'as required' medicines was reviewed during patients' ward rounds to ensure this was not being used excessively or to control behaviour. At Kendray Hospital we were told that some of the night staff offered 'as required' medication more frequently and some patients felt this was to make sure they had a quiet night. The ward manager was aware of these concerns and action was being taken to ensure staff working at night were monitored and any concerns were addressed. Following our inspection, the trust informed us that PRN medication usage is reviewed in each patient's ward round and regular use would trigger a review to consider if a regular prescription or a change to the patient's care planning was warranted.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When people were taking medication which had the potential to impact their physical health, due to the type of medication or the dose prescribed, regular physical observations were usually taking place as required, although we identified one record where the commencement of a high dose anti-psychotic was prescribed and physical health monitoring checks had been recommended but not actioned.

Track record on safety

The service had a good track record on safety.

There were no incidents investigated at the trust's highest 'serious incident' level on the acute and PICU wards in the 12 months prior to our inspection. There were 3 incidents investigated at the next most serious 'service level investigation' level. There were 3 patient deaths related to the acute and PICU wards in the 12 months prior to our inspection – two of these were due to natural causes. The cause of the third death (which occurred while the patient was undertaking unescorted section 17 leave in the community) was not known at the time of our inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The hospital used the Datix incident reporting system and all the staff we spoke with about incidents confirmed they were confident using this and they knew what types of event should be reported.

Staff reported serious incidents clearly and in line with trust policy. The staff we spoke with confirmed they used the trust's Datix system to report untoward incidents and they were aware of what needed to be reported as an incident.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The trust monitored compliance with the duty of candour in its weekly performance audit on all acute/PICU wards.

Managers debriefed and supported staff after any serious incident. Managers told us that de-briefs would be arranged for staff following serious incidents, with input from the ward's psychology team as needed. We saw evidence that a programme of ongoing support was implemented for staff following a particularly serious incident on Clark ward.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incident investigation reports included details of how the patient and/or their relatives had been involved in the incident investigation, including the opportunity for people to contribute to the scope of the investigation and the specific questions which would be considered.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received emails which included lessons learned from incidents. The hospital also had a system of 'Blue Light' alerts, which were used to highlight learning from serious incidents to staff, we saw examples of these prominently displayed in ward offices.

Our findings

Staff met to discuss the feedback and look at improvements to patient care. Themes and trends from incidents were regularly escalated to the trust's Quality and Governance meeting and the trust shared details of improvement work carried out due to incident data analysis including the introduction of safety huddles across the acute and PICU wards, a sexual safety initiative on Ward 18 (a mixed gender ward) and a reducing restrictive practice collaborative on Nostell ward.

There was evidence that changes had been made as a result of feedback. For example, following a serious incident where a patient had successfully fixed a ligature to a ligature-safe bathroom fitting using Blu-tack, the trust had added Blu-tack to the banned items list for all wards. This restriction was in place on all the acute and PICU wards and was being complied with (for example through safer methods being used to display information on ward noticeboards). The staff we spoke with were aware that Blu-tack was not allowed on the ward and the reason for this.

Managers shared learning with staff about never events that happened elsewhere through the trust's system of issuing 'Blue Light' alert notices. We saw these notices being displayed on some of the wards we visited to ensure the information was highlighted to staff. The alerts were also accessible to all staff on the trust's intranet.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were holistic and recovery-oriented, however they were not always adequately personalised.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All the records we reviewed included evidence of a comprehensive assessment of the patient's mental health needs. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. People were receiving physical observation checks using the NEWS2 early warning system at least weekly, and more frequently if they had physical health conditions which required an enhanced level of monitoring.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. People usually had care plans in place on their records relating to their health and social care needs and any specific risks relating to their care. However, people did not always have care plans in place relating to individual needs arising from their protected characteristics, for example gender identity, when this would have been appropriate.

Staff regularly reviewed and updated care plans when patients' needs changed. All the care plans we reviewed had either been written or updated recently.

Care plans were holistic and recovery-orientated. Care plans were bespoke for each patient rather than being on pre-written templates. All the sets of records we reviewed included a discharge plan which included meaningful information about how the patient was being supported in their pathway to leaving acute inpatient care. However, it was not always possible to see how the patient's voice was being captured in the care plans and there was little clear evidence of patient

involvement in the planning of their care. Following our inspection, the trust informed us that a care plan and risk assessment improvement group is working to address this and to ensure, where it is not possible for a patient to be involved in their care planning, that this is referenced and consideration is given to who could be involved on their behalf.

Best practice in treatment and care

Staff provided a range of treatment and care for patients, however this was not always based on national guidance and best practice. Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. There was a written standard operating procedure (SOP) for both the PICU and acute services which was informed by a range of relevant national best practice guidance including from the Department of Health, NHS England and the National Institute for Health and Clinical Excellence. However, some of the guidance referenced in the SOPs were out of date, for example the PICU SOP refers to the Standards for Better Health, which were superseded when the Health and Social Care Act 2008 came into force. We did not see any evidence that this had resulted in a negative impact on patient care, and the trust informed us following the inspection that this had been addressed.

Staff usually delivered care in line with best practice and national guidance. However, we identified some occasions where people's individual needs were not being met because they were not receiving the level or type of psychological support which would be nationally recommended best practice in light of their diagnosis, for example a lack of psychological therapy provision for some patients who had a diagnosis of personality disorder. Some of the staff we spoke with said they felt the psychology provision on the wards could be improved. Following our inspection, the trust informed us that access to direct psychological support for patients has been improving since 2022, with new appointments made at consultant psychologist and senior psychologist levels, as well as an increase in assistant psychologists in post. This has enabled an increase in the provision of one to one psychological assessment and therapy, group therapies, complex case clinical supervision, debriefing sessions and supervision for MDT staff and trust wide liaison and service development work to improve person-centred psychosocial support.

Staff identified patients' physical health needs and recorded them in their care plans. People had specific care plans for long-term physical health conditions, for example diabetes.

Staff made sure patients had access to physical health care, including specialists as required. People with long term physical health conditions had care plans relating to their needs and their records showed they were receiving input from relevant services. People told us they felt well supported in relation to their physical health.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. People had their risk of malnutrition assessed on admission and had their food and fluid intake monitored where required. All patients were weighed weekly to ensure they were not losing or gaining unhealthy amounts of weight during their admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients at all of the 4 sites we visited had access to a gym which they could attend with staff support whether or not they had been granted section 17 leave. The gym on Ward 18 was closed for refurbishment when we inspected, but we were told that patients were able to access the gym on Ward 19. The patients we spoke with told us the occupational therapists offered good support in relation to healthy lifestyle choices.

Our findings

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The Health of the Nation Outcome Scale (HoNOS) was used and we saw completed HoNOS assessments on the records we reviewed.

Staff used technology to support patients. On some wards a mobile application was being used by lead nurses and matrons to carry out spot checks in relation to a range of quality indicators. The application could then be used to generate reports which were used to inform the board assurance processes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Each ward was overseen by a modern matron and part of their role was to monitor the quality of the care plans. This was done through a process of random 'dip' sampling on a weekly basis. More detailed audits were also carried out on specific wards, for example to test the implementation of learning following changes to practice or an untoward incident.

Managers used results from audits to make improvements. Each ward had a quality priority plan which pulled together learning from a number of sources, including audits, to ensure actions were taken to address lessons learned and identify priorities for improvement.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care, although staffing pressures within particular groups had led to patients not always having access to the support they needed. Managers supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, staff were not always supported with regular performance appraisals.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Patients on all the wards we visited were receiving care from a multi-disciplinary team of professionals including psychiatrists, mental health nurses, occupational therapists, psychologists and physiotherapists.

However, we saw evidence that staffing shortages within the occupational therapy team were impacting on the availability of regular therapeutic activities on the wards and in the community. The activity timetables for some of the acute/PICU wards for April and May 2023 showed that on multiple days during the week there were no organised activities taking place. Walton PICU and all wards at Kendray Hospital were running on a reduced timetable in May 2023 due to staffing pressures. Activities were also cancelled on 4 occasions in the 2 months prior to our inspection due to staff unavailability. Following our inspection, we were told that sickness absence and staff vacancies had been impacting the occupational therapy teams at Kendray Hospital, Fieldhead Hospital and Priestley Unit at the time of our inspection. The trust has advised us that this staffing position has improved since our visit and additional therapeutic activities are now taking place on these wards.

Some of the people we spoke with raised concerns about there not being much to do on the wards and we also saw this had been raised at recent community meetings. Some patients mentioned additional activities they would like to be able to do, such as art and cooking. Some of the staff we spoke with said the staff shortages had caused them to experience work-related stress due to the expectation that they would support patients with activities which would usually be led by the occupational therapy team in addition to their usual duties. The trust stated that one to one activities were offered by ward staff to mitigage the impact of this and recruitment campaigns were ongoing to fill the occupational therapy vacancies as soon as possible.

Our findings

The trust had also started a collaborative community project with a social enterprise made up of artists to provide accessible art sessions to patients on all the acute and PICU wards. This was done to improve the offer of meaningful activities and to reduce the number of incidents taking place at weekends, when historically there had been fewer activities on offer. We received positive feedback from patients about these sessions on the wards where they had commenced.

Managers usually ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, we did find there was often a shortage of registered nurses working on the wards compared to the numbers of nursing associates, trainee nursing associates and support workers. Ward managers were aware of this and recruitment was ongoing to increase the numbers of registered nurses working in the acute and PICU service.

Managers gave each new member of staff a full induction to the service before they started work. Substantive staff completed a comprehensive induction and we saw evidence that when new bank and agency workers worked their first shift on the ward they completed an induction checklist with a permanent member of staff.

Managers did not consistently support staff through regular, constructive appraisals of their work. The appraisal data for the acute and PICU wards showed appraisals were not taking place in line with the trust's appraisal policy (which recommends annual appraisals). On six out of the nine acute and PICU wards, less than 30% of staff had received an appraisal in line with the trust's policy at the time we inspected. The lack of compliance with the trust's appraisals policy across the acute and PICU wards was recognised by the trust in March 2023 and in response to this the service managers had developed a wellbeing plan, which included a review of the appraisal system as a key action. Following our inspection, the trust told us that, by September 2023, 100% of staff were up to date with their appraisals except for on Ward 18, where compliance was at 96% due to staff sickness absence.

Following the inspection the trust shared additional evidence with us to demonstrate that all the acute and PICU wards are working to a target of completion of all registered nurses' appraisals for 2022/23 by 30 June 2023 and healthcare assistants' appraisals for the same period by 14 July 2023. We received updated appraisal figures from the trust which showed that implementation of this plan was positively impacting the number of completed appraisals, which were over 80% complete on 4 of the 9 wards by June 2023.

Managers supported staff through regular, constructive clinical supervision of their work. In quarter 4 of 2022/23 all the acute/PICU wards ensured they met the trust's supervision compliance target of 80%, with 7 out of 9 wards being 100% compliant. In quarter 1 of 2023/24, which was still ongoing at the time of our inspection, 6 out of 9 wards were at 90% compliance or over and the other three were on track to be compliant by the end of the quarter.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The permanent staff members we spoke with said they were able to attend team meetings and they also received email updates. However, regular bank staff said they did not always receive updates following team meetings. We were told that this was not always possible as bank staff may work on different wards and that significant updates are cascaded to bank staff through handovers, ward notices and a range of staff bulletins.

Managers identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. Most of the staff we spoke with told us they usually had time to complete their mandatory training modules

within working hours. Staff also gave us examples of specialist training they had received to support them in their roles, for example in relation to particular physical health conditions. Ward managers confirmed staff were able to request training and said registered nurses received an annual allocation of funding from the trust for training and professional development.

Managers made sure staff received some specialist training for their role. Ward managers told us specialist training had been offered to staff, for example physical healthcare training and psychological therapies. However, the nationally recommended Oliver McGowan Mandatory Training on Learning Disability and Autism had not yet been rolled out across the trust as a mandatory training module and no staff working on the acute and PICU wards had completed this training at the time we inspected. The trust told us that staff had access to learning disability and autism e-learning, however this was not a mandatory training module at the time of our inspection. It is a requirement of the Health and Care Act 2022 that regulated healthcare providers must ensure all staff receive learning disability and autism training at a level appropriate to their role and the Oliver McGowan training package is the nationally recommended training which is designed to ensure compliance with this. The trust's Education and Training Governance Group approved the adoption of this training as a mandatory module in April 2022 and the trust was in the planning stages of this piece of work at the time we inspected, with a target for 60% of the workforce to have received this training in the first year of the roll out.

Managers recognised poor performance, could identify the reasons and dealt with these. The ward managers we spoke with were able to describe how they would deal with performance and disciplinary issues in a proportionate way, to ensure staff were supported and people using the service were protected from harm.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary ward round meetings were taking place at all four sites during the week we inspected. These meetings were attended by staff from all disciplines within the multi-disciplinary clinical team as well as the patient and their advocate if needed. The care co-ordinators we spoke with told us they were usually invited to the patient's ward rounds.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handovers took place on the wards twice a day and information was shared between the outgoing and incoming staff to ensure any changes to people's needs or the risks relating to their care were highlighted. Records were kept of handovers and these records were easily accessible to staff in the ward offices. However, we identified some variation in record keeping relating to handovers due to the template documents being different for each ward.

Ward teams had effective working relationships with other teams in the organisation. We were told that the introduction of the lead nurse role on the acute/PICU wards had improved partnership working between teams across the service line and more widely within the organisation.

Ward teams had effective working relationships with external teams and organisations. Commissioning case managers and care co-ordinators were usually invited to attend the ward round meetings and arrangements were made for them to use video-conferencing facilities. The care co-ordinators we spoke with told us they had a positive working relationship with the MDT at the hospital and could give examples of collaborative working, for example for patients approaching discharge from the ward.

Our findings

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. However the requirements of the Code of Practice were not always complied with.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff we spoke with about the Mental Health Act had a level of knowledge of the Act which was appropriate for their role.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust had a team of Mental Health Act administrators who the ward staff could access for advice and support as needed.

Staff knew who their Mental Health Act administrators were and when to ask them for support. All the managers and staff we spoke with were aware of how to access the trust's Mental Health Act administrators and said they were helpful in supporting staff with Mental Health Act queries.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Ward staff had access to these via the trust intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw evidence that Independent Mental Health Advocates (IMHAs) regularly visited all the acute and PICU wards. Patients told us they were able to speak with an advocate when they wished. The trust produced an annual Independent Mental Health Advocacy report – the most recent version of this showed a 95% rate of compliance with the IMHA requirements in the Mental Health Act and Code of Practice in the 2021/22 financial year. This report also showed that 477 patients across the trust's inpatient services saw an advocate in quarter 1 of 2022/23, an increase from 309 in the previous quarter. The advocate who shared feedback with us said senior staff worked well with them and were supportive of advocacy on the wards, but individual members of ward staff could be less accommodating of advocates, making advocates and patients feel like advocacy was an inconvenience and failing to inform them of the times of patients' ward rounds.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence in the records that people were reminded of their rights under the Mental Health Act (or as an informal patient) regularly. People told us they had been given information on their rights in a format they could understand. The trust audited patients' records to ensure people were being regularly reminded of their rights and the August 2022 report showed a rate of 95% compliance with the requirements of the Mental Health Act and Code of Practice across the inpatient services as a whole (including detained patients and informal admissions).

Staff did not always make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The trust's annual report on section 17 leave accessibility from February 2023, which covered the period from 1 April 2021 to 30 December 2022, showed that at least 98% of all episodes of approved leave went ahead in each quarter during this period across the acute and PICU services. However, we were told by some members of staff and patients that sometimes staffing pressures prevented patients with only escorted section 17 leave from leaving the hospital as frequently as recommended by their responsible

clinician and therefore it is possible that the trust's governance systems were identifying all instances of cancelled section 17 leave, for example if specific occasions of cancelled leave were not being reported as incidents on the Datix incident reporting system. Following our inspection, the trust told us that all wards plan staffing levels to meet patient needs and can request or plan additional staffing to support patient leave where this is planned in advance.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. This was monitored by the trust in the annual consent to treatment audit, which showed people had access to SOADs as required by the Mental Health Act.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. These records were stored centrally with the trust's Mental Health Act administration team. Ward staff were able to access these on request.

Informal patients knew they could leave the ward freely and the service displayed posters to tell them this. All the informal patients we spoke with were aware of their right to leave the ward whenever they wished. Posters relating to informal patients' rights were not displayed on all the wards we visited, but all patients received a pack of written information, including informal patients' rights, on admission and were reminded of their rights regularly.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. All the records we reviewed included a discharge plan. People's care co-ordinators were involved in their multi-disciplinary ward round meetings so that plans could be made for any after-care they were entitled to following discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The trust audited a number of aspects of compliance with the Mental Health Act including access to advocacy, consent to treatment, access to section 17 leave and information sharing about rights.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed capacity for patients who might have impaired mental capacity. However, capacity assessments were not always clearly documented on people's records.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The staff we spoke with had a good understanding of the requirements of the Mental Capacity Act if a patient did not have the capacity to make certain decisions about their care.

There were no deprivation of liberty safeguards applications made in the 12 months preceding our inspection. Managers and staff confirmed there were no informal patients on the wards who would be prevented from leaving at the time we inspected.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff were able to access the full suite of trust policies from the wards via the trust intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Ward managers confirmed that the Mental Health Act administration team was also available to support staff with queries about the Mental Capacity Act.

Our findings

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. People told us they were given verbal and written information about their care that they were able to understand.

Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. Not all the records we reviewed included clear records of capacity assessment, including where the patient needed to make an important decision and we would have expected to see a documented assessment of their decision making capacity relating to this. The trust's annual report on consent to treatment from January 2023 identified that 17% of the records reviewed as part of this audit did not include a documented assessment or statement relating to the patient's capacity to consent and only 23% of the records included a full capacity assessment in addition to a statement of capacity. The report included recommendations for improvement work to ensure that staff clearly documented their assessment of the individual's capacity to consent to their treatment. Following our inspection, the trust informed us that the lead matron had undertaken a review of two randomly selected records per ward and had identified no concerns in relation to staff following the trust policy when undertaking a capacity assessment where this is required and documenting it clearly. The trust stated that a formal audit will be undertaken to confirm these findings and this will be shared through the trust-wide Clinical Governance Group.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw evidence on the records of best interests meetings taking place if decisions needed to be made on behalf of someone who lacked capacity.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. The trust's Mental Health Act Committee received a quarterly report providing statistical analysis on the use of the Mental Capacity Act 2005 and concordance with the trust's policies relating to mental capacity. This report included a specific section relating to the Mental Capacity Act and exception reports of any instances of failing to comply with the legislative requirements were provided to the committee. This governance process had led to the planned improvement work in relation to documentation of capacity assessments referred to above.

Is the service caring?

Requires Improvement 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. On all the wards we visited we saw staff treating patients with respect. Support with personal care needs was provided in a discreet way.

Staff gave patients help, emotional support and advice when they needed it. Staff at all levels including managers were responsive to patients who were in distress or who asked for support. People told us they felt that staff were there to support them if they needed it.

Our findings

Staff supported patients to understand and manage their own care treatment or condition. The patients we spoke with told us the medical and ward staff had explained their diagnosis and treatment to them in a way they could understand. Written information was provided to patients on admission to each ward to help them understand the care and treatment they would be receiving.

Staff directed patients to other services and supported them to access those services if they needed help. People told us they had been supported to access other services, for example drug and alcohol services and community projects.

Patients said staff treated them well and behaved kindly. Most of the people we spoke with said the staff were compassionate and treated them really well. People said things like "nothing is too much trouble" and "some staff go above and beyond". Some patients said that occasionally the night staff were not as friendly, for example if a lot of agency staff were working who were not familiar with the ward.

Staff usually understood and respected the individual needs of each patient. We observed some positive and supportive interactions on the wards which showed staff knew the patients well and understood their individual needs. However, we did identify some isolated instances where individual patients were not being fully supported if they had specific needs, for example due to a specific diagnosis or cultural needs, as detailed elsewhere in this report.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke with told us they would feel confident to raise concerns if they observed a colleague treating a patient in a way they felt wasn't right.

Staff followed policy to keep patient information confidential. We did not observe staff discussing patient care in communal areas inappropriately. Records were stored securely and we observed staff complying with best practice in relation to information governance.

Involvement in care

Records did not always show that staff meaningfully involved patients in care planning and risk assessment, however they did actively seek patient feedback on the quality of care provided. The trust ensured that patients had easy access to independent advocates but ward staff were not always supportive of advocacy.

Involvement of patients

Staff usually introduced patients to the ward and the services as part of their admission. Ward managers told us patients had an orientation to the ward with a member of staff on admission. Most patients said they had been shown round the ward when they were first admitted but some people said this had not happened. Patients were also given written information when they were admitted to the ward which included a range of useful information.

It was hard to see from the care records how much staff involved patients or gave them access to their care planning and risk assessments. The format of the care plans and risk assessments did not support the entry of meaningful information about patients' views. Some of the people we spoke with said they felt involved in their care planning, but some people said they did not feel involved and had not been offered a copy of their care plans. Some people said they did not feel they had enough time in ward rounds to express their views about their care or ask questions. The advocate we spoke with shared some concerns about staff not giving patients the opportunity to speak in ward rounds and said they were not always told when ward rounds were taking place so they could attend to support the patient's involvement. Following our inspection, the trust informed us that a care plan and risk assessment improvement group is

working to improve record keeping of patient involvement in care planning and we saw evidence of how this is being monitored through the trust's governance processes. The trust also advised that a My Ward Round booklet has been developed on Walton PICU to support patients in considering the topics they may wish to discuss at their ward round. This was well received by patients and as a result is now being rolled out.

Staff usually made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We observed a ward round where an interpreter was involved to support the patient in understanding the information shared, which was an example of good practice in meeting individual needs.

Staff involved patients in decisions about the service, when appropriate. Community meetings were taking place regularly on the wards and when people were involved in the meetings this was noted in their care records. Some of the patients we spoke with told us they had been involved in decisions about the ward and they were aware that the community meetings were taking place regularly.

Patients could give feedback on the service and their treatment and staff supported them to do this. People were given information in their ward information packs about how to give feedback about their care. Regular community meetings were held on each ward and we saw minutes which showed people were able to raise a range of issues at these meetings with the support of staff. Some of the people we spoke with told us they attended the community meetings and this was also documented in people's daily care records. Staff also kept records of feedback received from other sources, for example written feedback submitted on the wards and online feedback to ensure any trends arising from this could be identified and addressed.

Staff usually made sure patients could access advocacy services. Independent mental health advocates regularly visited the wards and the patients we spoke with confirmed they were able to access an advocate when they needed to, including to support them at their ward round meetings. However, the advocate we spoke with felt that ward staff were not always supportive of advocacy.

Involvement of families and carers

Staff did not always support, inform and involve families or carers. The patients we spoke with who wanted their families to be involved in their care said they felt the staff on the ward supported and informed their families well. However, some of the relatives we spoke with said they did not feel staff kept them informed. Some relatives said it was hard to get hold of someone on the ward when they called and others said the systems on the ward felt chaotic. Others were happy with the level of information and support they recelved from staff as a family member of someone on the ward. Following our inspection, the trust shared information with us about ongoing improvement work in relation to relative and carer involvement. This includes the roll out of carers awareness training for staff, membership of the Carers' Trust Triangle of Care scheme since July 2023, additional information provided to family carers and improved monitoring of record keeping in relation to carer and relative involvement.

Staff did not always help families to give feedback on the service. Some relatives we spoke with told us they were able to express their views about their relative's care, but others said it was harder to be involved.

Staff did not always give carers information on how to find the carer's assessment. A written information booklet for carers had been produced on Ward 18, Priestley Unit, but this did not include any information on how to access a carer's assessment. The carers and family members we spoke with all told us they had not been given any information about the support available to them as carers.

Our findings

Is the service responsive?

Requires Improvement 

Access and discharge

Staff did not always manage beds well. A bed was not always available when a patient needed one. However, patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

There were significant pressures on the acute and PICU beds, particularly at Kendray Hospital. Beamshaw ward was running at over 100% occupany when we inspected (due to some patients being on long-term section 17 leave in preparation for discharge and other patients having been admitted to these bedrooms). There had been occasions when a new patient had been admitted to a non-bedroom area at Kendray Hospital, such as the small quiet lounges, the extra care area adjacent to the seclusion suite and, on one occasion, the seclusion suite itself (with the door open). Ward staff told us this increased the pressures on them due to no additional staff being allocated to the shift to account for the additional work required to nurse a patient in a non-bedroom area. The advocate we spoke with told us that patients had raised concerns with them about this as well. Following our inspection, the trust told us that these admissions were made in order to facilitate care as close to home as possible for people who urgently needed an inpatient admission, in recognition of the potential negative impact which can result from out of area hospital admissions. We were also informed that beds of patients who are on section 17 leave are only used for new admissions following a risk assessment and a review of the likelihood of the patient's leave being rescinded.

The trust shared data with us which showed that between May 2022 and April 2023 all acute and PICU wards were running at an average occupany of over 90% and 4 of the 9 wards were running at an average occupany of over 100% due to the practice of admitting patients to beds which were still nominally occupied by patients undertaking longer term section 17 leave in preparation for discharge from the hospital. This particularly affected the male wards, all of which had an average occupancy rate of over 100% for this period. Staff at Kendray Hospital told us they were concerned that sometimes patients chose not to go on leave because they did not want to risk losing their bed.

When people had been assessed as requiring admission but a bed was not immediately available, a risk assessment was carried out and a package of wrap around care was put in place to ensure they were kept safe and cared for as intensively as possible in the community while awaiting admission. Shortly prior to our inspection, in May 2023, the trust implemented a new data monitoring system which enabled them to monitor waiting times for admission to the inpatient wards.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Rates of delayed discharge were low – at the time we inspected there were 6 patients across all 9 wards who were clinically ready for discharge but whose discharge had been delayed. In all 6 cases this was due to non-availability of safe and suitable accommodation for them to move on to in the community and the trust provided a summary of the actions being taken to ensure the person was discharged as soon as possible. The average length of stay for the 12 months prior to our inspection was less than 70 days on all acute and PICU wards (with a range of 41 to 67 days).

Our findings

The service had low out-of-area placements. Out of 159 patients on the acute/PICU wards when we inspected, 7 were placed by commissioning authorities outside the area covered by the trust. In all 7 cases this was due to the patient's community placement and therefore GP practice being outside the geographical area covered by the trust, but care coordination responsibilities for all these patients remained with the trust.

Managers and staff worked to make sure they did not discharge patients before they were ready. People told us they felt supported in relation to the plans for their discharge from hospital. However, when patients went on leave there was not always a bed available when they returned. This had happened on 2 occasions since 1 April 2023 at the time we inspected. This led to a patient who had to come back from leave unexpectedly having to spend a night sleeping in a non-bedroom area on a mattress on the floor. The trust told us following our inspection that there had been no further admissions to a non-bedroom area at Kendray Hospital between May and September 2023. The trust informed us that patients are only admitted to a non-bedroom area where this is unavoidable, in the patient's best interests and for the shortest possible time.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interests of the patient. The staff we spoke with told us that people were not usually moved between wards. None of the patients we spoke with raised any concerns about being transferred between wards inappropriately.

Staff did not move or discharge patients at night or very early in the morning. Managers told us transfers and discharges would take place within daytime hours unless a transfer at less sociable hours was unavoidable.

Managers told us people could usually be transferred from the acute wards to one of the trust's PICUs if they needed more intensive care.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Rates of delayed discharge were low and we saw evidence that staff were taking action to progress people's discharges as quickly as possible. Patients did not usually have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. All the records we reviewed included a discharge plan and progress towards discharge was reviewed in patients' multi-disciplinary ward rounds. Several managers and members of staff said the trust's discharge coordinators played a really valuable part in expediting discharges and addressing any barriers to people moving on from the wards. The care coordinators we spoke with told us the ward staff worked collaboratively with them in relation to people's discharges.

Staff supported patients when they were referred or transferred between services. The patients and staff we spoke with did not raise any concerns about how transfers between the trust's services and further afield were managed. The care coordinators we spoke with told us the trust communicated with them well when their patient was transferred between wards.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward usually supported patients' privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could usually make hot drinks and snacks at any time. However, the care environment did not always fully meet people's needs.

Our findings

Each patient had their own bedroom, which they could personalise. People did not usually personalise their rooms due to the short-stay nature of the wards. There were no shared rooms and most of the rooms also had an en suite toilet and shower. There were two rooms which were not en suite and there was a bathroom immediately adjacent to these rooms.

Patients had a secure place to store personal possessions. Patients had lockable cupboards in their rooms.

Staff used a full range of rooms and equipment to support treatment and care. However, people did not always have unrestricted access to these. At Kendray Hospital the activities room was in a separate occupational therapy suite which could only be accessed with staff supervision. We were told this was because it was a central facility which was used by more than one ward and therefore staff supervision was required to ensure patient safety due to patient mix and environmental risk management factors.

On Ward 18 the activities room and gym were closed due to ongoing refurbishment and patients had expressed frustration about the length of time this had been going on for in recent community meetings. Staff on Ward 18 acknowledged that the lack of space had impacted on the provision of patient activities. We were told that patients had access to the gym on Ward 19 and could partake in activities in other areas of the ward to mitigate the impact of this. Following our inspection we were told that the refurbishment works had progressed and were due to complete in October 2023.

On some wards we were told there were not enough private rooms for patients to meet with staff one to one. Patients on Stanely ward told us there used to be an art room which they had enjoyed using but this was not there anymore. Following our inspection the trust informed us that the art room on Stanley ward was not closed permanently and was due to re-open in October 2023. During the time it was closed, art supplies remained available to patients to use in other areas of the ward.

Some patient areas were still being used as staff 'hydration stations' due to the requirement for staff to wear surgical face masks in clinical areas to minimise the risk of COVID-19 transmission within the hospital. We were informed following the inspection that this policy had been changed and the areas designated as hydration stations had all been restored to patient use.

At The Dales there were some privacy issues with the environment because there was no privacy screening on the windows which overlooked the garden, which was shared with Ashdale ward, or on the windows of a small patient seating 'pod' which overlooked the main hospital car park. Following our inspection, we were told that plans were in place for the replacement of these windows with glazing units containing integral blinds.

The service had quiet areas and a room where patients could meet with visitors in private. All the wards we visited had separate quiet lounges and private rooms to meet with visitors. On Clark ward the quiet lounge was kept locked due to the individual risks of one patient. We were told if other patients wished to access this they just had to ask staff to let them in. The relatives we spoke with confirmed they were able to meet with their family member in private, but relatives of patients at Kendray Hospital said that staff had to wait outside the room because the visiting rooms were not on the wards.

Patients could make phone calls in private. Patients were allowed their own mobile phone on the ward unless there were particular risks relating to this for the individual. If a patient did not have access to their own phone then there was a phone room or a ward mobile they could use.

Our findings

All the wards had outside space but patients could not always access these easily. The secure garden areas at Kendray Hospital, Priestley Unit and The Dales were locked and could only be accessed with staff support. We were told that this was due to environmental risks in these secure gardens, which could only be mitigated by staff supervision for some patients. While we were on these wards we observed patients frequently having to ask if they could access the garden areas. Some of the people we spoke with at Kendray Hospital and on Ward 18 told us they did not have as much access to outside space as they would like as staff were sometimes too busy to facilitate this. The garden at The Dales was shared between the male and female wards so patients could only access this at designated times. Some of the patients we spoke with at The Dales also said they wished they could have more access to outside space. The patients we spoke with at Fieldhead Hospital told us they could freely access the secure gardens.

Patients could usually make their own hot drinks and snacks and were not dependent on staff. However, we were told on Melton PICU that people had to ask staff if they wanted a hot drink. Following our inspection the trust informed us that this is not usual practice on Melton PICU and was the result of a temporary blanket restriction due to the needs of an individual patient on the ward at the time we inspected. The trust has confirmed that this restriction has now been removed and patients on Melton PICU are able to make their own hot drinks.

The service offered a variety of good quality food. We saw menus for the 4 weeks prior to our inspection which showed people on all wards had a range of healthy and nutritious dietary options, including options to meet specific dietary needs such as vegan, gluten free and Halal menus. We were also told that patients had access to fresh fruit and other snacks between mealtimes. The people we spoke with mostly said the food was good and they had plenty of choice, including vegetarian options. However, some people said there was not much variety and several people told us that they were not always able to access food which met their cultural and religious needs, including Halal food not always being available. Some of the relatives we spoke with said their family member had told them the food wasn't great.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work as much as possible, bearing in mind the short-stay nature of the service and how acutely unwell many people were.

Staff helped patients to stay in contact with families and carers. The written information packs provided to patients when they were admitted to all the wards included information on visiting times and other advice on how to maintain contact with family members and friends. All the family members we spoke with confirmed they were able to keep in regular contact with their relative throughout their admission.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. We saw that most patients had access to community leave and they were utilising this to engage in a range of activities in the community and to keep in touch with their families and friends.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients as the care environment did not always meet the needs of those with a protected characteristic. However, staff usually helped patients with communication, advocacy and cultural and spiritual support.

Our findings

The service could usually support and make adjustments for disabled people and those with communication needs or other specific needs. However, we identified a lack of accessibility for wheelchair users at Priestley Unit. On other wards, some of the people we spoke with told us that they struggled to access some areas, such as the dining rooms, due to mobility impairments.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information packs provided to all patients on admission included this information and there was also information about rights and the trust's complaints process displayed on noticeboards on all wards except Ward 18 Priestley Unit (which was undergoing renovation). We were told following our inspection that the noticeboard on Ward 18 has now been replaced.

The service had access to information leaflets available in languages spoken by the patients and local community. Staff were aware of how to access these online if people needed them.

Managers made sure staff and patients could get help from interpreters or signers when needed. We observed a ward round where a patient was supported by a British Sign Language interpreter and it was also clear from patients' records they had access to interpreters where needed.

The service usually provided a variety of food to meet the dietary and cultural needs of individual patients. The menus for the 4 weeks prior to our visit showed that people had access to food to meet a range of dietary and cultural needs. However, some patients told us they did not always have access to food which met their needs, for example Halal food for Muslim patients.

Patients did not always have access to spiritual, religious and cultural support. Although all the wards had a multi-faith room on site, these were separate from the locked ward and some people told us they were not always able to access as much spiritual support as they would like. Following our inspection, the trust told us that there is additional support in place for patients' spiritual, religious and cultural needs, including regular visits by faith leaders to inpatient areas, pastoral counselling, ongoing support from trained volunteers and mindfulness and self-compassion courses.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The patients we spoke with told us they knew how to complain about their care and said they had access to advocacy to support them with this as needed. Written information on how to raise a complaint was included in the information packs provided to all patients on admission.

The service clearly displayed information about how to raise a concern in patient areas. This was displayed on the noticeboards on all wards except Ward 18 Priestley Unit. We were told this was because some of the noticeboards on this ward had been taken down due to the ongoing refurbishment of this ward. The ward information pack provided to all patients on admission included information on how to raise a complaint, including on Ward 18. The trust confirmed following our inspection that the noticeboard on Ward 18 had also been replaced due to completion of the refurbishment works.

Staff understood the policy on complaints and knew how to handle them. The staff members we spoke with knew how to support people to raise concerns both informally and formally through the trust's complaints process.

Our findings

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The people who we spoke with, who had raised a complaint, told us they had received a response. The trust monitored compliance with the timescales for responding to patient complaints.

Managers investigated complaints and identified themes. The trust received 33 formal complaints in the period 1 May 2022 to 30 April 2023. The trust's records showed these complaints had been fully investigated unless this was not possible due to the patient not confirming their consent to their records being reviewed.

Staff protected patients who raised concerns or complaints from discrimination and harassment. The patients we spoke with who had raised a complaint about their care did not feel they had experienced any discrimination as a result of this.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they received emails with information on lessons learned from incidents and complaints. We also saw evidence in team meeting minutes that patient feedback was shared with staff.

The service used compliments to learn, celebrate success and improve the quality of care. A spreadsheet of compliments received was maintained (30 were received in the period from 1 May 2022 to 30 April 2023) and staff told us they sometimes received feedback about compliments received about their ward during team meetings.

Is the service well-led?

Requires Improvement 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. The trust's values and a summary of patients' rights were clearly outlined in the written information packs provided to all patients on admission. Staff on all wards told us managers promoted a positive culture for people using the service. Following media coverage of cultural concerns arising at another mental health trust, the trust introduced weekly 'culture conversations' within the modern matron team to increase the likelihood that any concerns about the culture on the wards would be promptly identified and addressed.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. We observed ward managers and more senior leaders interacting with patients on the wards, showing a genuine interest in their wellbeing and any feedback they wished to share. Several of the carers we talked with spoke positively about the support and communication they had received from ward managers, clinical leads and more senior leaders during their relative's admission.

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff and patients discussing behaviours and values. The trust's governance processes included a range of quality assurance systems which included senior leaders (up to and including members of the executive team) spending time on the wards and speaking with patients and staff.

Our findings

Managers promoted equality and diversity in all aspects of running the service. None of the staff we spoke with raised any concerns about discrimination or unequal treatment due to any protected characteristic. We saw evidence that action was taken to support staff who experienced verbal discriminatory abuse at work, for example racist comments.

We observed a meeting of the senior leadership team at The Dales. The service managers, clinical leads and ward managers worked effectively together to share information and enable flexible partnership working across the whole service.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Ward managers were able to describe how they made the trust's vision and values meaningful to the staff on the wards. Staff members were aware of the trust's vision and values and could describe how they used these to inform how they supported people.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff received equality and diversity training as part of their mandatory training package. However, not all staff had received learning disability and autism training in line with nationally recommended best practice.

Staff felt able to raise concerns with managers without fear of what might happen as a result. All the staff we spoke with said they would feel comfortable raising concerns and they did not fear any negative treatment if they did. Ward managers told us how they worked hard to promote an open and blame-free culture on their wards.

Staff felt respected, supported and valued by senior staff, which supported a positive and improvement-driven culture. Staff at all levels within the organisation told us they felt valued as trust employees and they were happy with the level of support available to them from managers and colleagues.

Governance

Our findings from the other key questions usually demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, we found inconsistency across the wards in relation to how information was recorded, which led to areas where quality issues were not being consistently identified or addressed.

Governance processes were usually effective and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support. There was a clear reporting structure from 'ward to board' with clinical and operational managers for each site who worked together effectively to ensure the quality of care was continuously monitored and any improvement issues were addressed promptly.

However, we found inconsistency across the wards in relation to how information was documented. For example, cleaning records did not always prompt staff to document the cleaning of individual areas so it was not always possible to use these records for assurance that the wards had been thoroughly cleaned. On some wards specific booklets were used to document seclusion checks but on others these were documented on the patient's electronic progress notes. We found that nursing, medical and MDT checks in compliance with the Mental Health Act were not consistently being documented when people were secluded. Following our inspection the trust informed us that a review of the electronic

record keeping system for episodes of seclusion has been commenced across the acute and PICU wards to ensure that seclusion records include complete and accurate records of the checks carried out. We also found physical health checks in accordance with national best practice guidance were not being consistently documented following rapid tranquilisation of patients. The trust's governance systems may not have identified the extent to which section 17 leave was being cancelled due to staffing pressures, as concerns about this were reported to us by patients and staff on the wards which were not reflected in the number of reported incidents of cancelled section 17 leave. Some of the handover meeting templates prompted staff to record if each patient had experienced cancellation of their section 17 leave and some did not.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. Each ward had a quality priority plan which enabled managers to track the implementation of improvements driven by learning from audits, complaints, incidents and feedback. These plans were reviewed and updated by managers at monthly governance meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. It was clear from people's care records that risk assessments and care plans were regularly reviewed and updated as people's needs changed.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. The trust's governance processes included ongoing assessment of compliance with legislation including the Mental Health Act, the Mental Capacity Act and the Health and Social Care Act.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards. Improvement projects were delivered using recognised quality improvement methodology, such as Plan, Do, Study, Act (PDSA) cycles. These resulted in demonstrable improvements on the wards, for example the implementation of a new safety huddle process on Ashdale ward.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

At the time of our inspection the trust's lead matron was taking part in NHS England's Quality Transformation Programme for Mental Health, Learning Disability and Autism services. Ashdale ward was involved in the Yorkshire and Humberside Patient Safety Collaborative (PSC) work that formed part of the NHS England's Mental Health Safety Improvement Programme and the National Collaborative Centre for Mental Health (NCCMH) in Reducing Restrictive Practice (RRP).

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

We saw evidence of the trust working in partnership with other providers within the local health economy both at executive level and on individual wards. People using the service and their families had opportunities to become

involved in the development of the service. The wards usually worked well in partnership with advocacy organisations, which helped to give people using the service a voice and improve their health and life outcomes. We also saw local arrangements for partnership working, such as links between individual wards and local safeguarding teams and police forces.

Learning, continuous improvement and innovation.

The trust shared a number of examples of innovative practice and continuous improvement with us including:

- A collaborative project with a community organisation, which had been introduced on all the acute and PICU wards to improve the offer of meaningful activities and to reduce the number of incidents taking place at weekends, when historically there had been fewer activities on offer. We received positive feedback from patients about these sessions on the wards where they were already taking place.
- A project focusing on safer discharge from hospital, working collaboratively with community services to review and improve discharge practices from the wards, interpreting learning from serious incidents and developing business intelligence reports to support safer discharge processes.
- Nostell ward's participation in the Royal College of Psychiatry's Reducing Restrictive Practice Collaborative Programme, resulting in an overall 60% reduction in restrictive practices and a 69% reduction in physical restraints on this ward.
- A pilot project to improve pharmacy provision to the acute and PICU wards at Fieldhead Hospital, by enhancing patient experience and understanding around pharmacological treatment and improving processes of medication dispensing.
- A pilot on Clark ward to improve the provision of trauma-informed care and to develop a trust-wide framework for this, co-produced by managers, ward staff and patients.
- A quality improvement project on Beamshaw ward in partnership with the trust's quality improvement and assurance team to reduce instances of violence and aggression on the ward.
- Participation by some of the physiotherapy team in a community research project around promoting physical activity as a route to improving mortality rates for people diagnosed with a mental illness.

The development of sensory and autism friendly practice within the occupational therapy team at Kendray Hospital, including the provision of additional training on sensory integration and the creation of a sensory room for patients.

Our findings

Outstanding practice

The introduction of a new role of lead nurse on all acute and PICU wards had been very positively received by staff as providing a range of benefits including establishing links between the wards, sharing good practice, supporting with complex cases, peer supervision and support. The lead nurse for Stanley ward won the trust's Leader of the Year award for 2022 and the lead nurse for Walton PICU received a highly commended award in the same category in 2023.

Several of the managers and members of staff on the wards praised the discharge coordinators, which was also a relatively newly created post. We were told how these members of staff played a valuable role in addressing the complex challenges which could impact on people moving on from the wards once they were well enough to leave, which also relieved some of the pressures on ward managers.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that people have care plans in place to meet their needs and minimise any risks relating to their care, taking into account best practice guidance relating to their diagnosis and their individual circumstances including any protected characteristics (Regulation 9(1) and (3)).
- The trust must ensure that people (and, where relevant their relatives and/or carers) have the opportunity to be meaningfully involved in their care, are supported to access independent advocacy and are offered a copy of their care plans, unless this is not possible due to the person's individual circumstances (Regulation 9(1) and (3)).
- The trust must ensure that action is taken to reduce the number of restraints in the prone position which are taking place on the acute and PICU wards, in line with the Mental Health Act Code of Practice and national clinical best practice guidance (Regulation 12(2)(b)).
- The trust must ensure that monitoring checks are carried out in line with national guidance to the greatest extent possible on each occasion following the administration of rapid tranquilisation and when patients are secluded (Regulation 12(2)(b)).
- The trust must ensure that staff receive regularly updated training on cardiopulmonary resuscitation and responding to violence and aggression (Regulation 12(2)(c)).
- The trust must ensure that action is taken to address the patient flow issues impacting on bed occupancy rates and admissions, particularly at Kendray Hospital, to reduce the reliance on leave beds for new admissions and prevent the need to admit patients to non-bedroom areas (Regulation 15(1)(c)).
- The trust must ensure that the planned refurbishment works at Kendray Hospital, Priestley Unit and The Dales are progressed as quickly as possible to ensure patients on these wards have access to a care environment which meets their needs, including those relating to any protected characteristic, and where they are not subject to avoidable restrictions on their freedom of movement within the ward (Regulation 15(1)(c)).

Our findings

- The trust must ensure that the care environment on all wards supports patients' privacy and dignity, particularly when wards are overlooked by areas accessed by patients of another gender or the general public (Regulation 15(1)(c)).
- The trust must ensure that, when a patient's capacity to consent to their treatment or to make another important decision is assessed, a record of this assessment and the outcome is kept within their care records (Regulation 17(2)(c)).
- The trust must ensure that sufficient numbers of appropriately qualified staff are available to meet people's holistic needs during their admission, including the provision of regular meaningful and therapeutic activities for patients both on the wards and away from the hospital if the patient is granted leave (Regulation 18(1)).
- The trust must ensure that there are sufficient numbers of registered nurses on each shift to meet patients' needs and provide an appropriate level of support to unqualified staff, in line with the established staffing ratios for each ward (Regulation 18(1)).
- The trust must ensure that action is taken to address the current high rates of bank and agency staff working on the acute and PICU wards and to ensure that the use of agency and bank workers does not negatively impact on the quality of patient care (Regulation 18(1)).
- The trust must ensure that staff receive regular appraisals in line with the requirements of the trust's appraisal policy (Regulation 18(2)(a)).
- The trust must ensure that staff receive training on meeting the needs of people with a learning disability and autistic people at a level appropriate to their role (Regulation 18(2)(a))
- The trust must ensure that record keeping in relation to environmental risks is kept up to date and is available for ward staff to refer to when needed. (Regulation 17(2)(b)).
- The trust must ensure that, when patients are secluded, they receive observations and medical, nursing and MDT reviews at the intervals stated in the Mental Health Act Code of Practice and clear records are kept to evidence this (Regulation 17(2)(c)).

Action the trust SHOULD take to improve:

- The trust should ensure that staff complete their training on the door top alarms so these can be implemented across all acute and PICU wards as soon as possible.
- The trust should ensure that the written information for agency workers at Kendray Hospital is reviewed and updated to include accurate information on the trust's medicines management systems.
- The trust should ensure that more accessible records are kept of medicines management training and staff competency assessment to provide high level assurance that all staff who require these training updates are receiving them.
- The trust should ensure that clear records are kept on all wards of instances where section 17 leave is cancelled due to staffing pressures and that action is taken to address any concerns identified from this data.
- The trust should ensure that patients are able to access medical care as quickly as possible when this is needed, including out of hours.
- The trust should ensure that all patients who meet the criteria for enhanced physical health monitoring due to their medication start receiving these checks as soon as possible following the prescription of the medication.

Our findings

- The trust should ensure that the restrictions on patients' access to certain areas of the wards at Kendray Hospital are kept under regular review and kept to the minimum level of restriction necessary to keep people safe from avoidable harm.
- The trust should ensure that care plans for people at risk of deliberate self-harm include guidance for staff on how to support the person to minimise the risk of them resorting to self-harming behaviour as well as guidance on how to support them if self-harm does occur.
- The trust should ensure that patient feedback on the availability of food to meet dietary and cultural needs is taken into account when menus are planned for all wards.
- The trust should ensure that patients are able to access hot and cold drinks and snacks at all times on all acute and PICU wards unless this has been individually risk assessed as unsafe.
- The trust should consider amending the cleaning records template for The Dales and Priestley Unit to align with the other trust services and provide assurance that specific areas of the ward are being regularly cleaned in line with the trust policies.
- The trust should consider reviewing the seclusion policy to make this more accessible for staff to use in practice.

Our inspection team

The team that inspected the service included a CQC lead inspector, 2 other inspectors, 1 assistant inspector, 1 specialist nursing advisor, 1 specialist medical advisor and an expert by experience. The inspection team was overseen by Sheila Grant - Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.6

Private/Public paper:	**Public**		
Title:	**Freedom to Speak Up Biannual update report January 2024**		
Paper presented by:	Estelle Myers, Freedom to speak up guardian		
Paper prepared by:	Estelle Myers, Freedom to speak up guardian		
Mission/values:	Staff feeling confident to speak up is key to the Trust's values, which are fundamental to delivering safe health care: • We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of this report is to provide a biannual update to Trust Board members in line with the requirements of the Freedom to speak up governance processes, and follows the presentation of the annual report to Trust Board in July 2023. Please note, the national data is provided in this report as it was unavailable at the time of publication of the Trust annual report in July 2023.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2 – Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 2.4 – Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. Risk 4.2 – Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	A robust system and structure for freedom to speak up in the Trust is crucial to ensuring that the needs and concerns of our patients and staff are identified, listened to and acted on. This is a key duty for the Trust as a provider within the integrated care systems.		

Any background papers / previously considered by:	The FTSU annual report (July 2023) was presented to Trust Board. This paper has previously been reviewed by the Executive Management Team and the People and Remuneration Committee.
Executive summary:	The Trust retains a clear commitment to support colleagues who wish to speak up, to listen to and learn from what we hear, and to follow up and make changes in response to what we hear. There is a clear structure in place to ensure oversight of all contacts with our freedom to speak up guardians, with identified non-executive and executive leads for speaking up. The national data shows that the Trust continues to perform in line with peer trusts for the national quarterly pulse survey data and has maintained its position within Quartile 2 for FTSU reported cases. In quarter three (Q3) of 2023/24 there was a small decrease in the total number of concerns. The number of anonymous concerns has stayed the same in Q2 and Q3 as did the number of concerns relating to inappropriate attitudes and behaviours. There has also been an increase in Q3 in the number of concerns relating to bullying and harassment compared with Q2. In the year to date, there have been two reports of detriment (detriment is defined within the paper). Since April 2023, five cases have been taken through FTSU process and the following themes have been identified: staff behaviours and attitudes, team issues and access to training. October 2023 was “speak up month”. This saw teams wearing green on Wednesdays to support speaking up and promotional items shared with community teams. Discussions about potential barriers and solutions to speaking up took place in team meetings, the details of which are included in the attached report. As of November 2023, mandatory training with regards to speaking up was at 94.75% against a target of 85%. For the remaining quarters of 2023/24, work will continue on a thematic review with the quality directorate, to triangulate issues from complaints, incidents, quality monitoring visits (QMV’s) and patient feedback. The output of which will be used to develop targeted work with teams. The report provides assurance that the organisation has the appropriate policy, systems and processes in place for the oversight and management of Freedom to speak up across the Trust.
Recommendation:	**The Board is asked to RECEIVE and NOTE this report on Freedom to Speak Up in the Trust.**

Making Freedom to Speak Up business as usual.

NHS South West Yorkshire Partnership NHS Foundation Trust

Freedom to Speak Up (FTSU) – Biannual Update report January 2024

1. Introduction

As part of FTSU governance processes this report provides a biannual update to the Trust Board and follows the presentation of the annual report in July 2023. The national data is provided in this report as it was unavailable at the time publication of the annual report presented in July 2023.

2. FTSU Guardian update

- The lead Freedom to Speak Up Guardian (FTUSG) for the Trust has attended and chaired one quarterly meeting in October for the Yorkshire and Humber regional Freedom to Speak Up network, at which it was announced that the network will merge with North East and Cumbria, and the Trust Guardian will continue to chair this merged network (North East and Yorkshire).
- Since the annual report, three additional guardians (Ruth Neil, Eve Winstanley and Melissa Burgoyne) have been trained and joined the team. This strengthens the FTSU capacity across the Trust.
- The Trust has updated its freedom to speak up (FTSU) policy in line with NHS England (NHSE) recommendations and this was approved by Executive Management Team (EMT) on 20 April 2023, ahead of the January 2024 deadline.

3. Governance Systems and Processes

The FTSU reflection and planning tool self-assessment has been completed and reviewed and approved by the FTSU steering group, EMT, and People and Remuneration Committee (PRC), and the action plan is presented to Trust Board alongside this update report. The associated action plan will be monitored via the above groups and updates presented to Trust Board in the annual report in 2024/25. There continues to be strong organisational commitment to supporting staff to raise concerns.

The Board has also been provided with the following papers:

- Response to Lucy Letby trial verdict Board paper (September 2023)
- Patient experience Annual Report (including complaints) (September 2023)
- Trust-wide Incident Management Quarterly Reports (September and November 2023).

All of these document patient, carer and staff experience, and are triangulated by the FTSUG for themes and learning. In addition, there is in place:

- Meetings every six weeks continue to be held with the lead Non-Executive Director (NED) for speaking up, Interim Chief People Officer, Chief Nurse / Director of Quality and Professions, Deputy Director of Corporate Governance and the FTSUG, to review cases and themes, as well as support with case management.
- Regular reports on strategy and action plans are provided to the People and Remuneration Committee (PRC) and assurance is provided to Trust Board through the Committee via the Alert, Advise Assure (AAA) report.
- The FTSU steering group continues to meet.
- In this period there has not been a case that has required the complex case review to be convened.
- The lead FTSUG attends Operational Managers Group (OMG) on a quarterly basis to provide updates to the group.

Further evidence of this ongoing commitment is seen with the addition of a risk onto the organisational risk register "Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individual are not supportively heard, do not suffer personal detriment and that they do not receive feedback on action(s) taken which demonstrate listening and learning." The associated action plan is contained in Appendix 2. This risk is owned by Quality and Safety Committee, with clear links to People and Remuneration Committee.

4. 2023/24 Activity report

The FTSUG is required to report on all contacts made to the team. The majority require signposting and out of a total of the 46 people contacting FTSU from April 2023 to end December 2023, only six cases have been taken allocated as FTSU cases, of which five are closed and one is currently under investigation.

Since April 2023 the timescales for closure were 130 days, 100 days, 44 days, 47 days, and 38 days. The cases which were over the timescale of 35 working days were due to the complexity of the issues raised about the teams, and the need to ensure all actions were complete. Regular feedback between staff and the FTSUG and manager took place. The remaining open case marginally outside of the timescale due to the complex issues raised. The other 40 individuals have been signposted elsewhere for advice and support e.g., staff side support.

5. The nature of the concerns and cases

Patient Related Cases

None of the current cases relate directly to patient care. However, it is acknowledged that all cases may indirectly impact on patient care.

Public Interest Disclosure at work (PIDA) cases

To date 2023/24 no cases have met the definition of disclosures of public interest at work.

Detriment

To date in 2023/24, two cases of detriment have been reported since the last report. The previous cases were resolved internally. Detriment is defined by the national guardian's office as including such as the person being ostracised, given unfavourable shifts, being overlooked for promotion, or moved from a team. The executive management team (EMT)

have reviewed previous cases of detriment for learning. The organisation has in place a great place to work strategy which is aligned with the freedom to speak up strategy. The Trust's journey to become trauma informed will also help to improve the organisational culture with regards to speaking up. The lead FTSUG has close links which include regular meetings with people directorate business partners and our organisational development team to support learning and prevention of detriment. All cases of detriment are fully investigated with oversight from the Non-executive Director for freedom to speak up and support to the individual via occupational health.

Previous learning from detriment cases has included the introduction of a complex case review process, which is convened when multiple teams are involved in a speak up case to ensure that appropriate responses are in place and co-ordinated. This learning has been shared with care groups via the FTSU steering group.

6. Data and benchmarking Information

This update report contains the national data which was not available previously in the annual report submitted in July 2023. The national benchmarking data is provided in detail at appendix 1.

2022/23 data shows that concerns have come from all Care Groups, with the majority still in adult and older people's mental health, followed by learning disabilities and autism services, and then Barnsley integrated services. This helps show that the message about speaking up has reached all areas of the Trust.

2022/23 data shows that concerns have been raised from all staff professional groups apart from Medical and Dental practitioners. The FTSUG continues to attend the Junior Doctor Forum and the Chief Medical Officer meetings to continually raise awareness of the role and the Trust also has a medical raising concerns forum through which issues can be raised.

Our Trust has seen a decrease in the percentage of concerns coming from nurses, administrative/clerical and medical and dental practitioners in 2022/23 and an increase in the percentage of concerns coming from allied health professionals (AHP) and additional professional scientific and technical compared with 2021/22. This was a service rather than professional group issue.

Further detail is as below about the numbers of different staff groups coming forward:

Staff group	**National change**	**Trust change**
Nurses and midwives	Increase	Decrease
Administrative and clerical	Decrease	Decrease
Allied health professionals	Decrease	Increase
Medical and dental professionals	No change	Decrease
Not known	Decrease	Increase
Other	Increase	Decrease

Further information is also contained in the table at Appendix 1.

The Trust has seen a difference in the professionals coming forward compared to the national data, the main one being that no medical staff came forward with concerns via the FTSU route in 2022/23. Of note, there is continued attendance by the FTSUG at medical meetings. The reasons for the changes in demographics will be explored via the FTSU steering group.

When a case is closed this is done in agreement with the person coming forward (unless the concern has been raised anonymously) and the investigating manager. The manager's template also highlights any opportunity for lessons learned.

Feedback from closed cases has been limited and a new method for collecting data has been agreed in conjunction with the FTSU steering group. Surveys are completed at the start of the process, when the case is closed, and 3, 6 and 12 months following closure. Due to the relatively low numbers of concerns the Trust receives via this process results will be included in the annual report for 2024/25.

Consent from persons completing feedback for information to be shared anonymously for use in reports has been gained. This will be included in the annual report for 2024/25 so as to provide a year's worth of data. An action plan has been developed to improve feedback as part of the communications and engagement plan.

Model Hospitals data (Quarter 2) for the staff survey shows that the Trust is above peer average and national value for Employee Engagement Score, Advocacy Score and Involvement Score and in line with peer average and national value for Motivation Score. See Appendix 1 for further data.

7. Communication engagement and training

One of the key activities of the Guardian is to increase visibility and promote speaking up channels for staff. The Guardian does this through face-to-face visits into services, developing posters and promotional materials, one to one meetings, attending the Trust's Welcome Event, providing training to the individuals joining the Trust through the care certificate programme and continuing to be visible on the forensic wards (which is facilitated as the Lead guardian is key trained and so can have unaccompanied access to the forensic wards). In addition to speaking to staff, the FTSUG has:

- Worked with communications colleagues to ensure the continued update of the FTSU intranet page.
- Worked with information and technology management colleagues to develop the screensaver, to include the new guardian details.
- Supported a number of initiatives as part of the October 2023 "Speak Up" month, the theme this year is 'breaking down barriers'. These initiatives include:
    - A video has been produced by with the Chief Executive, Chief Medical Officer, Chief Nurse and Director of Quality and Professions, Chief Operating Officer, and Lead Non-Executive Director for Freedom to Speak up.
    - Attending team meetings across the Trust to talk about breaking down barriers to speaking up.
    - Continuing to promote 'Speak up, Listen up, Follow up' training modules to improve uptake from staff.

- Promoting “wear green Wednesdays” in support of Freedom to Speak Up, which saw team pictures being shared on social media.
- Distributing FTSU business cards across the Trust.

8. Potential barriers to speaking up.

This year’s theme of breaking down barriers, was explored with teams during FTSU month in October 2023. During sessions teams were asked to identify potential barriers and solutions for the NHS to consider. As a Trust we will be considering these in the FTSU steering group and how we might build these into a “myth buster” communication plan.

Potential barrier	**Staff proposed solution**
Negative experience	See the information as positive and give feedback.
No change	Feedback needed on what has been changed as a result
Unpopular	Use anonymous route
Blame culture	Reinforce open honest culture with continual engagement
Reporting	Knowing about the anonymous routes
Repercussions	Create the right forums to hear concerns, publicise the roles and routes for reporting.
Too busy	Set aside protected time to listen to concerns.
Investigations	Reassurance about the process and what happens and that you are looking for improvements.
Fear	Anonymous routes can be publicised, reassurance of the confidential space, create a place of trust.
Confidentiality	Anonymous routes can be used
Remit	Publicity about the process, including pen pictures of guardians. More visibility across Trust.
Routes	To publicise all the different ways to make contact.
Visibility	Being more visible in all areas
Managers skills	Direct the person to somewhere for a second opinion, use anonymous routes, listen actively as it is a key part of the role.
Battle	Take the concern to someone else, perhaps more senior
Making things worse	Improve communication about the process
Causing trouble	Anonymous reporting
Confidence	Creating openness and reassurance that improvements are welcomed.
Perception	Speaking up is about anything that gets in the way of doing a good job.
Communication	Better filtering of messages and sense checking
Protected	Welcome information and listen compassionately
Stress	Understand the support available and the timescales
Old boys club	Call people out and explain this is not tolerated
Stigma	Create an open culture
Prove its not here	Listen to the person openly with understanding
Lack of objectivity	Direct person to another route, Freedom to speak up guardian, union or external routes
Senior staff	Reminding everyone that the Freedom to speak up role is there to support all staff.

9. Training completeness

Freedom to Speak Up training has been developed by Health Education England and contains three modules, Speak Up, Listen Up and Follow Up. The Trust has adopted Speak up training as mandatory and the two other modules are on an as required basis for managers and senior leaders.

Training figures show that mandatory training for Speak up training is at 94.75% against a target of 85% as at the end of November 2023. Currently the Trust "Listen up" training is voluntary and has no set target, at the time of writing this report 39 people have completed and 20 people have been trained in "Follow up". Ongoing promotion of these optional modules via FTSUG attendance at OMG and via comms will be continued.

10. Lessons Learnt

Following feedback and evaluation of cases and learning, the following lessons learnt have been identified and will be used as case studies with managers and senior leaders and are shared via the FTSU steering group. Below are managers' learning and reflections from the cases.

- "Staff satisfaction/morale has clearly been affected in recent months. Further discussions are currently taking place to identify actions. Some of the changes needed to be autocratic to start with and can now move to be more staff led and the wellbeing groups are up and running."
- "Work was already planned about looking into microaggressions and racist incidents, but the scope will be extended to include staff to staff wording as well as patient to staff words and how this can make you feel."
- "Sometimes the QMV are on days when staff are not in and are potentially not able to contribute. A reflection on the way that we ask people to work in a different way and make sure the rationale of this is explained in a different way. Support from the Chief Psychologist on the development day."
- "To keep trying different ways of communicating with staff as they may not have seen the communication. As manager accepting that our staff may need information numerous times and in a variety of ways to be able to process this."
- "With the concern coming in anonymously it is difficult for us to gain specific details. The concern was discussed in the team meeting and the whole team feel they treat all staff equally and fairly. We have able to have open conversations in our team with all staff. Bank and agency staff continue to be invited to the team meetings. Last 6 months' friends and family tests are always positive."

Work is also ongoing to improve organisational awareness of and learning from people speaking up, including:

- a thematic review with the nursing, quality and professions directorate to triangulate issues from complaints, incidents, quality monitoring visits and patient feedback, the output of which will be used to develop targeted pieces of work with teams.
- continue to deliver the reflection and planning tool action plan
- team visits across the Trust
- a short survey to be completed during FTSUG visits.

11. Themes from cases since April 2023

The FTSUG is required to report on all contacts made to the team. The majority require signposting and only five cases have been taken through the full FTSU process. Since April 2023, of the 46 people who have contacted FTSUG, one case is currently being managed as an open FTSU case. This case relates to team issues and staff behaviours.

The other 45 cases related to pay and contract, processes, team issues, staff safety and working practices, and bullying and harassment. These have been signposted to having conversations with the individual concerned or a manager above, use of unions for support with the issue, or to seek advice from advisors from the people directorate.

12. Cases raised through FTSU process since April 2021 to March 2023

The data tables seen in Appendix 1 provide numbers of concerns and categories during 2021/22 and 2022/23. There have been 31 cases from April 2021 to March 2023 that have been taken through the FTSU process. The timescales for resolution have been variable due to the nature and complexity of the cases, with 12 that were closed within a 35 working day timescale. These cases were of a more complex nature and regular feedback between the manager, individual and FTSUG was maintained. The manager's template was introduced in September 2021 and has helped to improve timescales for case closure and learning from the cases.

For 2021/22 five out of eighteen cases taken through the FTSU process were closed within a 35 working day timescale. Those over the timescale were more complex team issues which involved input from organisational development to resolve. The themes of these cases were team issues, staff conduct issues, issues with managers, issues with the suitability of the estate, staffing issues, and racism.

For 2022/23, six out of eleven cases that were taken through the FTSU process were closed within a 35 working day timescale. Again, those over timescale were more complex team issues and required support from organisational development colleagues to resolve. The themes of these cases were staffing issues, bullying in teams, staff working environment and patient safety related issues.

13. Reflection and planning tool action plan update

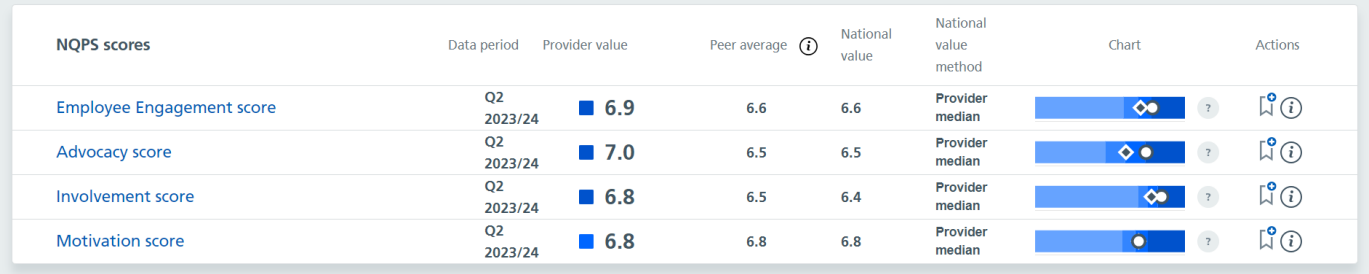
An update on the actions required as part of the FTSU reflection and planning tool is contained in Appendix 2, and all actions are on track to be completed within the timeframe.

14. The national quarterly pulse survey

This survey provides a consistent approach for listening to staff. Our Trust continues to be above or equal to both national and peer medians on all four domains, meaning that the Trust continues to perform at the same level as national and peer trusts. The Trust continues to aim to improve, and this is reflected in the reflection and planning tool action plan.

Our peer Trusts are Bradford District Care NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Humber Teaching NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Rotherham Doncaster and South

Humber NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust.



NQPS scores	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Employee Engagement score	Q2 2023/24	6.9	6.6	6.6	Provider median		
Advocacy score	Q2 2023/24	7.0	6.5	6.5	Provider median		
Involvement score	Q2 2023/24	6.8	6.5	6.4	Provider median		
Motivation score	Q2 2023/24	6.8	6.8	6.8	Provider median		

The score for the staff engagement theme is derived from nine questions, grouped into three themes: advocacy; involvement; and motivation; which are described in Appendix 1.

15. Summary

This update report highlights the Trust's continued commitment to Freedom to Speak Up and the strengthening of the governance systems. Themes are shared at the FTSU steering group to ensure shared learning. The report provides assurance that the organisation has the appropriate policy, systems and processes in place for the oversight and management of FTSU across the Trust.

Of note, feedback from the recent CQC inspection in May 2023 on the inspection of acute wards for adults of working age and psychiatric intensive care units "All the staff we spoke with told us they would feel confident to raise concerns if they observed a colleague treating a patient in a way they felt wasn't right." and CQC inspection in May 2023 of forensic inpatient or secure wards: "All staff told us they could raise any concerns they had about patient care with managers."

The national data shows that the Trust continues to perform in line with peer trusts for the national quarterly pulse survey data and has maintained its position within Quartile 2 for FTSU data (where quartile one would indicate lower numbers and quartile four would indicate higher numbers of reported FTSU cases). This shows that the message about speaking up continues to be received by staff in a way that is comparable to similar organisations. The action plan demonstrates the Trust's commitment to its learning and improvement journey and how FTSU interconnects with the wider Trust journey to become a trauma informed organisation.

It is further planned that for 2023/24, the reporting timetable is brought in line with financial years, to enable better comparison of data and the annual report be presented to Trust Board in July 2024.

16. Recommendation

The Trust Board are asked to receive and note this update report.

Appendix 1

Information and data

The National Quarterly Pulse Survey (NQPS)

NQPS scores	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Employee Engagement score	Q2 2023/24	6.9	6.6	6.6	Provider median		
Advocacy score	Q2 2023/24	7.0	6.5	6.5	Provider median		
Involvement score	Q2 2023/24	6.8	6.5	6.4	Provider median		
Motivation score	Q2 2023/24	6.8	6.8	6.8	Provider median		

Employee Engagement Score

Our Trust sits within Quartile 4 with the highest 25% of Trusts, from the data we scored 6.9. When compared with other peer trusts it is noted Derbyshire Healthcare NHS Foundation Trust scored 7.1 along with Leeds and York Partnership NHS Foundation Trust, with Humber Teaching NHS Foundation Trust scored 7.3 who also sit in quartile four. Rotherham Doncaster and South Humber NHS Foundation Trust sit below us in quartile 2.

Advocacy

The positive movement on involvement contrasts with the slight fall in the advocacy score. The score fell from 6.8 in 2021 to 6.7 in 2022. This is down from a peak of 7.2 during the pandemic in 2020.

There was fall in advocacy of the NHS as an employer and as a place to be cared for. Staff that would recommend their organisation as a place to work fell from 59.4 per cent to 57.4 per cent. The percentage of staff that would be happy with the standard of care provided by their organisation fell from 67.8 per cent to 62.9 per cent.

These scores reflect pressure on staff and concerns over quality of care. It will take overall improvements in NHS staff experience and resourcing to make significant shift to these scores. (NHS staff employers 10 March 2023).

Again, our Trust sits within Quartile 4 with a score of 7.0 along with Bradford District Care NHS Foundation Trust. Leeds and York Partnership NHS Foundation Trust sit above us with a score of 7.1. Derbyshire Healthcare NHS Foundation Trust scored 7.1 and Humber Teaching NHS Foundation Trust scored 7.3 who also sit in quartile four. Below us in quartile two sits Sheffield Health and Social Care NHS Foundation Trust with a score of 6.0. although the Trust compares favourable with our peers, we are always aiming to improve and this is reflected in the reflection and planning tool action plan.

Involvement

There has been a positive improvement in the involvement score, increasing to 6.8 in 2022 compared with 6.7 in 2021. This was driven by an increase in staff feeling able to make improvements happen in their area of work, rising to 54.3 per cent in 2022 from 53.2 per cent in 2021. The other involvement questions remained broadly stable.

These improvements reflect the range of activity being carried out in trusts on staff involvement, and may be linked to a greater focus on staff feedback. There is still considerable variation

between trusts and scope for further improvement in these scores, however (NHS staff employers 10 March 2023).

Our Trust is within Quartile 4 and has a score of 6.8, along with Bradford District Care NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust. Leeds and York Partnership NHS Foundation Trust performed the highest with a score of 7.2.

Motivation
Nationally the level of motivation marginally decreased from 7 in 2021 to 6.9 in 2022. This is largely due to a small decline in staff feeling enthusiastic about their jobs, which fell from 67.4 per cent to 66.9 per cent. This reflects the wider pressures on staff, including concerns over workload (NHS staff employers 10 March 2023).

Our Trust is within Quartile 3 with a score of 6.8, along with Greater Manchester Mental Health NHS Foundation Trust.

Above us in quartile 4 were Derbyshire Healthcare NHS Foundation Trust scored and Humber Teaching NHS Foundation Trust scoring 7.2.

There is a need to explore the data further and this is contained in our action plan for the reflection and planning tool.

Case number comparisons over last 2 years.
Each year the number of cases received is continuing to rise, reflecting how the message about speaking up has been received across the Trust and the continued impact of having Speak up training as a mandatory subject.

Date Period	Time period	Number of concerns
2021/22	All	39
2022/23	All	53
2023/24	Q1	17
2023/24	Q2	15
2023/24	Q3	14
2023/24	Q4	TBA
Total to date for 23/24		**46**

Concerns broken down by Care Groups

Concerns per area **21/22**	Number	Number of staff in locality	Concerns per area **22/23**	Number	Number of staff in locality
Barnsley Integrated Services	5	1157	Barnsley Integrated Services	7 ⇑	1179
Adult and Older people mental health	18	1708	Adult and Older people mental health	16 ⇓	1755
CAMHS	3	362	CAMHS	8 ⇑	386
Forensic Services	10	437	Forensic Services	3 ⇓	447
Learning disabilities and Adult ASD and ADHS	2	217	Learning disabilities and Adult ASD and ADHS	12 ⇑	219
Support services	1	773	Support services	4 ⇑	811
Unknown	0	0	Unknown	3 ⇑	0
Total	**39**	**4654**	**Total**	**53**	**4797**

Over time it can been seen that awareness has increased, as the latest data shows reporting from all Care Groups, which was the same for the previous year. There has been a decrease in numbers of concerns from Forensics and Adult and Older people's mental health whilst there has been an increase from all other care groups comparing 2021/22 with 2022/23. The increase in the Learning Disabilities and Adult ASD and ADHD highlights where a team issue has been raised and appropriately dealt with via the FTSU process.

Number of cases reported during 2022/23

	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	**Total Numbers to date**
No of FTSU cases	11	11	12	19	**53**
No related to patient safety	2	2	5	9	**18**
No related to bullying and harassment	1	0	0	5	**6**
No of cases suffering a detriment	0	1	1	0	**2**
No of cases submitted anonymously	1	1	1	1	**4**
No related to worker safety	10	10	6	10	**36**
No related to inappropriate attitudes or behaviours	4	3	5	4	**16**

Number of cases reported during 2023/24

	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	**Total Numbers to date**
No of FTSU cases	17	15	14	TBA	**46**
No related to patient safety	6	0	0	TBA	**6**
No related to bullying and harassment	6	3	6	TBA	**15**
No of cases suffering a detriment	0	0	2	TBA	**2**
No of cases submitted anonymously	5	3	3	TBA	**11**
No related to worker safety	12	12	6	TBA	**30**
No related to inappropriate attitudes or behaviours	9	5	5	TBA	**19**

Data trends for 2023/34 indicate the numbers of FTSU cases have decreased over each quarter.. In Q3 of 2023/24, the number of anonymous concerns has remained the same as Q2 and Q3 2023/24. Concerns are falling into the worker safety category then bullying and harassment. Currently there are two cases of reported detriment which are under investigation at the time of writing this report.

During speak up month in October 2023/24 there was a slight increase in the number of cases, from two in 2022/23 to five in 2023/24.

Comparing the first three quarters for 2022/23 with the first three quarters for 2023/24 we can see a small increase in the numbers of cases. A decrease in numbers of cases related to patient safety, an increase in numbers of cases related to bullying and harassment. An increase in reported detriment and an increase the number of anonymous cases, an increase in cases related to worker safety and inappropriate attitudes and behaviours.

Concerns by professions

Overleaf is the table with the data. The last report was unable to contain this due to the national data not being available at the time.

Profession 2021/22	% nationally	SWYPFT number and %	Profession 2022/23	% nationally	SWYPFT number and %
Nurses/Midwives	28.5%	10 (25.6%)	Registered Nurses/Midwives	29.0% ⇑	12 (22.6%) ⇓
Administrative/ clerical/ cleaning/ catering/maintenance/ ancillary staff	21.3%	4 (10.3%)	Administrative/ clerical	20.2% ⇓	5 (9.43%) ⇓
Allied Health Professionals	13.2%	4 (10.3%)	Allied Health Professionals	11.2% ⇓	8 (15.1%) ⇑
Nursing/ Healthcare assistants	10.3%	11 (28.2%)	Additional clinical services	9.8% ⇓	15 (28.3%) ⇑
Doctors/ Dentists	6.5%	2 (5.1%)	Medical and Dental	6.5% ⇔	0 (0%) ⇓
Corporate service staff	5.1%	0 (0%)	Healthcare scientists	1.4%	0 (0%)
Ambulance (operational)	3.5%	0 (0%)	Ambulance (operational)	1.3%	0 (0%)
Social Care	0.5%	1 (2.6%)	Additional professional scientific and technical	4.0%	5 (9.43%)
Public Health	0%	0 (0%)	Estates and ancillary	4.3%	2 (3.77%)
Commissioning	0.1%	0 (0%)	Students	0.9%	1 (1.89%)
Not known	6.9%	0 (0%)	Not known	6.3% ⇓	3 (5.66%) ⇑
Other	4.1%	7 (17.9%)	Other	5.2% ⇑	2 (3.77%) ⇓

Numbers of staff per professional group

Staff group 2021/22	Headcount	Number of staff that raised a concern	%	Staff group 2022/23	Headcount	Number of staff that raised a concern	%
Additional scientific and professional	377	8	2.12	Additional scientific and professional	405	5	1.23
Additional clinical services	1080	11	1.02	Additional clinical services	1116	15	1.34
Administrative and clerical	952	4	0.42	Administrative and clerical	991	5	0.50
Allied Health Professionals	349	4	1.15	Allied Health Professionals	362	8	2.21
Estates and Ancillary	325	0	0.00	Estates and Ancillary	333	2	0.60
Healthcare Scientists	2	0	0.00	Healthcare Scientists	2	0	0.00
Medical and Dental	169	2	1.18	Medical and Dental	175	0	0.00
Nursing and Midwifery registered	1397	10	0.72	Nursing and Midwifery registered	1408	12	0.85
Students	0	0	0.00	Students*	0	1	
Not known	0	0	0.00	Not known	0	2	
Other	0	0	0.00	Other	0	1	
Total	**4651**	**39**		**Total**	**4792**	**53**	

*headcount not available

Some variance in the patterns is shared with professional leads via OMG. The highest percentage per staff group has moved from additional clinical services to allied health professionals. As described earlier in the report this was a service rather than professional issue.

Model Hospitals data

Quarter 1 data 2023/24 can be seen below. Nationally and regionally, we sit in quartile 2. The data is separated into quartiles where quartile 1 is low numbers and quartile 4 is higher reported numbers. This has been maintained at this level since the annual report in July 2023. This shows the continued levels of reporting and the presence of an open culture within the organisation.
Our peer Trusts are Bradford District Care NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Humber Teaching NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust.

FTSU: All Cases	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Total cases reported to FTSU Guardians	Q1 2023/24	17	31	24	Provider median		
Total cases reported to FTSU Guardians per 1,000 WTE	Q1 2023/24	4.02	7.60	4.67	Provider median		
Total cases reported to FTSU Guardians (12 month rolling average)	Q1 2023/24	17	31	24	Provider median		

The Trust is below peer average and national value with a total of 17 cases reported in Quarter 1. Looking at the total cases reported in a 12 month rolling average, the Trust is below the national value and peer averages for total cases reported and continues to sit within quartile 2 (this means that we report fewer cases compared to our peer Trusts). There are three peer Trusts below us that also sit in quartile 2 and six peer Trusts above us, three within quartile 3 and three in quartile 4.

FTSU: Cases relating to Bullying & Harrassment	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Bullying and harrassment cases reported to FTSU Guardians	Q1 2023/24	6	6	4	Provider median		
Bullying and harrassment cases reported to FTSU Guardians per 1,000 WTE	Q1 2023/24	1.42	1.60	0.73	Provider median		
Bullying and harrassment cases reported to FTSU Guardians as % of total cases	Q1 2023/24	35%	22%	16%	Provider median		
Bullying and harrassment cases reported to FTSU Guardians (12 month rolling average)	Q1 2023/24	6	6	4	Provider median		

The Trust is above national value and peer averages for total bullying and harassment cases in quarter 1. The Trust is in line with the peer average but above the national value when looking at cases in a rolling 12month period.

The Trust sits in quartile 3 for numbers of cases reported in a rolling 12 month average with a value of six. There are three peer trusts that sit within the same quartile, two peer trusts sitting in quartile 2 and three peer trusts in quartile 4.

FTSU: Cases relating to Patient Safety & Quality	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Patient safety and quality cases reported to Freedom To Speak Up Guardians	Q1 2023/24	6	6	3	Provider median		
Patient safety and quality cases reported to FTSU Guardians per 1,000 WTE	Q1 2023/24	1.42	1.73	0.48	Provider median		
Patient safety and quality cases reported to FTSU Guardians as % of total cases	Q1 2023/24	35%	22%	12%	Provider median		
Patient safety and quality cases reported to FTSU Guardians (12 month rolling average)	Q1 2023/24	6	6	3	Provider median		

The Trust is above the national value and in line with peer average for quarter 1 for patient safety and quality cases. The Trust is in line with peer average for cases reported over a 12 month rolling average, but above the national value.

The Trust is in quartile 4 for this with a total of six, with six peer Trusts also in quartile 4, two peer trusts in quartile 3 and one in quartile 1.

FTSU: Cases relating to Detriment as a result of Speaking Up	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians	Q1 2023/24	0	1	0	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians per 1,000 WTE	Q1 2023/24	0.00	0.28	0.00	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians as % of total cases	Q1 2023/24	0%	3%	0%	Provider median		
Cases of Detriment as a result of Speaking Up reported to FTSU Guardians (12 month rolling average)	Q1 2023/24	0	1	0	Provider median		

The Trust did not report any detriment as a result of speaking up in quarter 1. This is below the peer average but the same as the national value.

The Trust is in line with the national value and below the peer average in a 12 month rolling average. This demonstrates that people who have spoken up have not suffered as a result.

There are six peer trusts who have reported more cases of detriment than our Trust.

FTSU: Cases reported anonymously	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Cases reported to FTSU Guardians anonymously	Q1 2023/24	5	3	1	Provider median		
Cases reported to FTSU Guardians anonymously per 1,000 WTE	Q1 2023/24	1.18	0.74	0.07	Provider median		
Cases reported to FTSU Guardians anonymously as % of total cases	Q1 2023/24	29%	9%	2%	Provider median		
Cases reported to FTSU Guardians anonymously (12 month rolling average)	Q1 2023/24	5	3	1	Provider median		

The Trust is above both peer average and national value for cases being reported anonymously in quarter 1. The Trust is above peer average and national value for cases being reported in a rolling 12 month average with a score of 5 and sits in quartile 4. There are five peer trusts that are also in quartile 4 and one peer trust in quartile 3.

FTSU: Cases relating to Worker Safety	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Worker safety cases reported to FTSU Guardians	Q1 2023/24	12	11	5	Provider median		
Worker safety cases reported to FTSU Guardians per 1,000 WTE	Q1 2023/24	2.84	2.79	0.96	Provider median		
Worker safety cases reported to FTSU Guardians as % of total cases	Q1 2023/24	71%	32%	20%	Provider median		
Worker safety cases reported to FTSU Guardians (12 month rolling average)	Q1 2023/24	12	11	5	Provider median		

The Trust is above the national value and peer average for cases related to worker safety in quarter 1. This category is about how safe an individual feels, not just physically but also psychologically. Our Trust sits within quartile 3 for worker safety cases within a rolling 12 month average, with four peer trusts in the same quartile, two peer trusts above us and two peer trusts below us.

FTSU: Cases relating to other Inappropriate Attitudes and Behaviours	Data period	Provider value	Peer average	National value	National value method	Chart	Actions
Other Inappropriate Attitudes and Behaviours cases reported to FTSU	Q1 2023/24	9	9	7	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU (12 Month Rolling Average)	Q1 2023/24	2.13	1.71	1.30	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU % of total cases	Q1 2023/24	53%	15%	29%	Provider median		
Other Inappropriate Attitudes and Behaviours cases reported to FTSU per 1,000 WTE	Q1 2023/24	9	9	7	Provider median		

The Trust is in line with peer average for numbers of cases related to attitudes and behaviours and is above the national value for number of cases reported in quarter 1. The Trust is in line with peer average and above national value in a rolling 12 month average. The Trust sits within quartile 3 for number of cases related to attitudes and behaviours, with three peer trusts sitting also in quartile 3 and two peer trusts sitting above us in quartile 4, and one peer trust below us in quartile 1.
The tables above indicate that the Trust continues to support and champion freedom to speak up across the Trust. At the end of 2023/24, all of the available data will be analysed against the reflection and planning tool to ensure that we are using the latest intelligence to frive our improvement work.

Appendix 2

Reflection and Planning Tool Action plan update

Blue complete, Green within timescale

	Development areas to address in the next 6–12 months	Target date	Action owner	Progress
1.	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 2024	FTSUG/Deputy Director Corporate Governance	Shared November 2023 via FTSU Steering group
2.	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	Paper presented to EMT September 2023
3.	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	FTSU question is on local induction page 4 for all staff complete 28 December 2023
4.	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	Survey is sent out to staff and results to be collated at end of March.
5.	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	Staff survey results are being reviewed by People directorate on track for completion.
6.	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	Current strategy aligns to Great place to work delivery plan. Staff engagement living our values planned for March 24 and a review of both strategies to be completed after this.

7.	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	This is to be included as part of questions when visiting sites to explore Flair survey as a possibility.
8.	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	Questions currently being developed – visits January to March to be organised.
9.	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	Review on track to be submitted to July 24 Board paper.
10.	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	On track to be completed for July 24 paper to Board
11.	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	On track to be completed for July 24 paper to Board
12.	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	Current communication plan in place to promote FTSU
13.	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	On track for completion

14.	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	3 new guardians in place and trained 31 October 2023.

	Development areas to address in the next 12–24 months	**Target date**	**Action owner**	**Progress**
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	December 2023 meeting has been held on track
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	FTSUG regular attendance at Operational management group
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	To be reviewed following 12month data set
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	To be reviewed following 12month data set

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	Progress
1.	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	FTSU communication plan in place
2.	Recruitment of FTSUG via fair and transparent process from REACH network	31 March 2024	Estelle Myers	FTSU communication plan in place
3.	Clear process for addressing detriment, all cases are independently investigated and overseen by lead NED	31 March 2024	Estelle Myers	FTSU communication plan in place
4.	Feedback on ease of finding policy has been received by FTSUG	31 March 2024	Estelle Myers	FTSU communication plan in place
5.	Speak up training is mandatory	31 March 2024	Estelle Myers	FTSU communication plan in place
6.	Emotional support in place for FTSUG	31 March 2024	Estelle Myers	FTSU communication plan in place
7.	New policy contains process for speaking up	31 March 2024	Estelle Myers	FTSU communication plan in place

Organisational Risk Register

Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individual are not supportively heard, do not suffer personal detriment and that they do not receive feedback on action(s) taken which demonstrate listening and learning.

1.	Further embedding of the recently recruited FTSUG's	31 April 2024	DNQ	Ongoing with Lead FTSUG
2.	Further development in relation positive comms from case studies	31 April 2024	DNQ	An ongoing programme to collect stories to be shared via Communication plan part of reflection and planning tool action plan see above.
3.	Clearer feedback for people who have spoken up	31 April 2024	DNQ	Those individuals who use FTSU process get feedback on closure and learning is taken through EMT to committee and Board.
4.	To recruit additional FTSUG	31 April 2024	DNQ	Ongoing process
5.	Focussed intervention from executive TRIO into areas of concern	31 April 2024	DNQ	Executive TRIO involved when required in FTSU concerns.
6.	FTSU reflection and planning tool improvement actions review March/April 2024	31 April 2024	DDCG	See actions above
7.	To consider making Listen up and Follow up mandatory training subjects for all staff	31 April 2024	DNQ	Executive management discussion January 2024

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.7

Private/Public paper:	**Public**		
Title:	Equality, Diversity, and inclusion Annual Report 2022/2023		
Paper presented by:	**Dawn Lawson - Director of Strategy and Change**		
Paper prepared by:	Dawn Pearson - Associate Director Communications, Involvement, Equality, and Inclusion		
Mission/values:	Equality and diversity acts as the golden thread so we can continue to put the person first, and in the centre, improve and aim to be outstanding. The report describes the Trusts progress on equality and diversity to ensure people reach their potential to live well in their communities whilst ensuring families and carers matter. The annual report is an annual publication, so we are respectful, honest, open, and transparent about our progress. The forward view will ensure we are relevant today and ready for tomorrow.		
Purpose:	The purpose of the paper is to provide Trust Board with the final draft of the 'Equality, Diversity and Inclusion Annual Report 2022-2023'. The annual report is a requirement of our Public Sector Equality Duty.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 1.4 - Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 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 annual report demonstrates that the Trust is meeting its public sector equality duties and statutory legal obligations in line with Integrated Care Board (ICB) guidance and acts as golden thread across all priority programmes.		
Any background papers / previously considered by:	The Trust has an integrated Equality, Involvement, Communication and Membership Strategy agreed by Trust Board in December 2020. The strategy is supported by clear action plans with progress reported at each meeting. The annual report is received each year by Trust Board.		

Executive summary:	The 'Equality and Diversity Annual Report' is an opportunity to update on the progress we have made in the period 2022/2023 in relation to equality, diversity and inclusion for people who use our services, staff, carers, their families, and communities. The annual report also provides an overview of some of our plans for the next year. Publishing this report forms part of the legal requirement under the Specific Duty in the Public Sector Equality Duty (PSED), part of the Equality Act 2010. The general duties under the Public Sector Equality Duty demonstrate the importance of paying due regard and ensure the Trust maintain the general duties set out below: • Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. • Advance equality of opportunity between people who share a protected characteristic and those who do not. • Foster good relations between people who share a protected characteristic and those who do not. Once approved the report will be published with the support of the communications team and feature engaging images and highlight specific areas of improvement highlighted in an appendix 1.
Recommendation:	**Trust Board are asked to APPROVE the final draft report prior to publication.**

South West Yorkshire Partnership NHS Foundation Trust

With all of us in mind

Equality, diversity, and inclusion annual report

1. Introduction

Our Trust belongs to us all. It considers the voices of service users, carers, families and friends, our staff, board members and people who live in the local communities we serve. We take this responsibility very seriously. It is fundamental to how we communicate with and work alongside everyone.

Our mission is to help everyone to fulfil their potential and live well in their community. This is supported by a clear set of values that put people at the heart of everything we do. Addressing inequalities in health such as barriers to accessing services and waiting times have continued to be a key focus this past year. A key part of this has been improving the quality of our data so we can understand what that data is telling us which has been made possible with the recruitment of a health analyst to support this work. Our data resources now mean we can start to use the data and monitor patterns and activity through the lens of equality.

We have also progressed work with partners to increase the involvement of children and young people and increase our membership. A key outcome has been the increased recruitment of young people as governors. We have also maintained and built on our connection with the voluntary and community sector and increased our approach to involvement by introducing 'community connectors.' Our commitment to carers is evident through our level 2 carers status accreditation, led by our awarding winning team. The Trust continues to maintain a strong focus on racial inclusion, tackling stigma and discrimination whilst building a diverse workforce, cultural competency, and leadership, working closely with our wider system partners to develop shared resources and approaches.

Whilst we know there is still much more that we need to do, this year the Trust has made considerable progress in delivering on our equality and public sector equality duty and work is progressing at pace to ensure we continue to build on our progress in the forthcoming year and beyond. To ensure we comply with our statutory responsibilities under the Equality Act 2010 especially the Public Sector Equality Duty, (PSED) and the Health and Social Care Act 2022 we must consider equality and involvement at each stage of service delivery including as part of any decision-making process.

The Trust believes that an integrated approach to equality, involvement, communication, and membership has help us deliver on our inclusion agenda. We know that each of these areas has its own drivers and legal obligations which we need to adhere to and deliver on. Our approach to equality will be driven by involving people and will ensure our methods and approaches are reflective of the audience we are aiming to reach. This means that a one size fits all or single approach will not provide the right conditions. Our commitment will be to always understand our audience before we start any activity.

The Trust has an Equality, Involvement, Communication and Membership strategy Equality-Involvement-Communication-and-Membership-Strategy.pdf (southwestyorkshire.nhs.uk) and supporting annual action plans to ensure an integrated approach to delivering on our strategic objectives. Using the principle of involvement to underpin everything we do; we will drive equality and inclusion across our Trust..

2. About the Trust

We are South West Yorkshire Partnership NHS Foundation Trust, a specialist NHS Foundation Trust that provides community, mental health, learning disability, and autism services to the people of Barnsley, Calderdale, Kirklees, and Wakefield. We also provide some secure (forensic) services to the whole of West Yorkshire. All our services are focused on principles of recovery and co-

production, working with the strengths of each person and those of their carers and wider community.

The Trust also provides services that promote healthier communities and prevention through supported self-care, recovery focused approaches, peer support and community involvement, and volunteering to supported employment. The Trust's recovery colleges, linked charities Creative Minds, Spirit in Mind, Mental Health Museum, and significant volunteering services, as well as Altogether Better (a national organisation that is hosted by the Trust) further contribute to this. Set out below are our vision, mission, and values.

Our vision:

To provide outstanding physical, mental, and social care in a modern health and care system.

Our mission:

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

Our values:

We are a value-based organisation, this means our values are followed by all our staff and underpin everything we do:

- We put the person first, and in the centre.
- We know that families and carers matter.
- We are respectful, honest, open, and transparent.
- We improve and aim to be outstanding.
- We are relevant today and ready for tomorrow.

Our strategic objectives are:

- Improve health.
- Improve care.
- Improving our use of resources
- Make this a great place to work.

Our priorities for 2022/2023

Our priorities are driven by understanding equality and addressing inequality through inclusive involvement. This is one of three golden threads that run through everything we do. In addition, the Trust's improving health objective this year has been to address inequalities, improve involvement and focus on equality in each of our places.

3. About our population (infographic to add)

According to the latest census data 2021 The Trust serve 1.237 million people living across South and West Yorkshire, this is an increase of 17,000 people since 2011. This is broken down by the local authorities of Barnsley which is 244,572 (an increase by 5,272 since 2011), Calderdale 206,631 (decrease by 3169 since 2011) , Kirklees 433,213 (decrease by 6,787 since 2011) and Wakefield 353,370 (an increase of 21,370. The Trust also have services and staff in North Leeds, Sheffield, Doncaster, and Rotherham.

Most of the care we provide is delivered in local communities. This means we work in all the villages, towns, and cities, from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east, to Hoyland and the Dearne Valley to the south of Barnsley, and all points in between. Our population lives in a mix of rural and urban areas. In all communities the 2021 census tells us:

- Overall, the population total average of male and female reflects the England average. The England average is male 49.2% and female 50.8%, with female reporting higher across all local areas.
- Across all ages Kirklees now has the highest 0-18 population at 22.6% with Calderdale second highest at 21.8%. Barnsley has a higher age population 60-79 at 21.1%
- Christianity (highest in Barnsley at 51.3%) and Islam (which is highest in Kirklees at 18.5%) respectively are both the highest reported religion and belief.
- We know that white people England average of 81%.
- Of the other ethnicity Black or Black British people comprised 4.2% in England and in Kirklees 2.3%.
- Asian or Asian British in Kirklees 19.4% and Calderdale 10.5%
- The percentage population of people who reported having a disability was highest in Barnsley at 22% and Wakefield 20.1%.
- Gender identity different from registered at birth in England is 0.55% in Barnsley 0.74%, Calderdale 0.89%, Kirklees 0.9%, and Wakefield 0,81
- Marriage and civil partnership figures are again comparable to the England average with 44.7% of people married or in a civil partnership.
- The number of individuals who reported they provided more than 50 hours of unpaid care were highest in Kirklees (10,079 people) and Wakefield (10,861 people

4. About our workforce (infographic to add)

According to the Workforce Equality Monitoring Annual Report published March 2023 the **Trust employs 4,713** staff in both clinical and non-clinical support services. Our staff work hard to make a difference to the lives of service users, families, and carers (source: Workforce equality information - South West Yorkshire Partnership NHS Foundation Trust). Services delivered include mental health, learning disability, forensic, wellbeing services, some physical health, and an extensive range of community services.

The Board and Governors strongly believe they, and the workforce, should be reflective of communities we serve. Over the last year diversity has been retained across the Board with a good balance of gender, age, ethnicity, and sexual orientation. Governors use a targeted approach to support recruitment from local communities. Our workforce data is set out below:

- The data shows that 8.8% of our staff consider themselves to have a disability, an increase from the previous year's figure of 8.4% (2021) and 6.4% (2020). The total number of disabled staff is 414, this is an increase of 30 since last year.
- We see improvements in the number of staff reporting their religion and sexual orientation. Currently 82.5% of staff have provided data regarding their religion (an increase of 0.5%) and

88% of staff have provided data indicating their sexual orientation, an increase of 1.6% from last year's report.

- 87.7% of all staff consider themselves as White in 2022, which is a 1% decrease from 2021 data. Of the remaining 12.3%, the largest group (5.3%) consider themselves of Asian origin. The figure for Unknown, where staff declined to state their ethnicity, for the year 2022 is at 0.3%. This has increased marginally compared to last year which was at 0.2% of Trust staff. This year's percentage of Asian staff has increased to 5.3% from 5.1% in 2021. Percentage of Black staff has increased from 3.5% in 2021 to 4.2%. This is an increase of 0.7%.
- Gender – stable at 21% male 79% female – this is indicative of all NHS bodies and static from last year's report figures.
- In 2022 the Trust appointed 57 new Black staff (excluding medics). This includes international nurses and means compared to 2021 this is just over a 50% increase.
- The Trust is aware that the ethnic mix of the Trust is not reflected in the higher pay bandings. Actions are being developed to address this to ensure a more representative workforce from band 6 and above of all ethnicities.
- The data has shown an in increase in staff age group 30-39 of 0.8%
- Staff in the over 60 age bands has increased again in 2022 to 10.9%. The Trust is mindful that staff are choosing to work longer, and an older workforce may require consideration from a health and wellbeing perspective regarding initiatives and support to maintain them in employment.
- Training access data by ethnicity is broadly in line with the Trust workforce profile (staff in post)

All our staff receive mandatory equality and diversity training, and over the past year the Trust has achieved compliance of an average 94% across all staff groups.

In addition to mandatory training, staff receive specific training, and in the last year staff received training on all protected groups using a series of lunchbox talks, developed by the community using a short film. In addition, the Trust procured the development of enhanced training for equality and inclusion with a focus on bias, dominant identity with reflective practice built in.

There are four Trust staff networks. Each network is set up to engage and involve staff, ensure they have a representative voice, provide peer support and safe spaces as well as influence the Trust so we can ensure our approach to our workforce remains inclusive. Networks can influence our direction of travel, consider equality and address inequalities through discussion, participation, and leadership. The staff networks we have in place are listed below.

- Race Equality and Cultural Heritage (REaCH) staff network.
- Carers' staff network.
- Disabled staff network.
- LGBT+ staff network.

Monitoring our workforce

The Trust requirement for recording and monitoring the diversity of our workforce is further enforced by the requirement to implement a standard for race and measure the experience of staff with a disability. As A Trust we want to make sure that our workforce remains reflective and representative of our population. By doing so our service offer and work environments benefit. A diverse workforce means our awareness of cultural competency improves and our Trust becomes more inclusive for everyone.

Implementing the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) are requirements for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff. NHS organisations use the metrics data and local data to develop a local action plan and enable them to demonstrate progress against the indicators of disability equality.

You can see the full WRES and WDES data report and action plan for 2022/2023 on the Trust website

5. About our membership (infographic to add)

Members are made up of local people and staff. Being a member of the Trust means local people and staff have a greater say in how services are provided in the areas the Trust serves and how the Trust is run. Members have an opportunity to get involved and to shape the services we provide and as a foundation trust we are accountable to our members. In March 2023 the Trust had **8,358 public** and **4,651 staff** members. The membership database was refreshed in 2022-2023. All public members were contacted, and asked the following:

- If people wanted to remain a member – 522 people stated they did not want to.
- The preferred method of contact – most people wanted information by post 76.3% with email at 23.7%.
- If members wanted to be more actively involved with Trust business, of which 30% stated they did.

Our aim is to continue to develop our membership, so we can work more proactively with the 30% who want to have more involvement with the Trust, whilst continuing to increase representation, so it is reflective of the populations we serve. The diversity of our public members is set out below:

- **The age range of our members demonstrates that most are working age adults. The data is as follows, u**nder 25 stands at 1.9%**,** 26-35 is 21.8%**,** 36-45 is 13.8%**,** 46-65 is 33.7%**,** 66-80 is 17.8% and 80+ is at 6% with 5% not disclosing their age.
- **Members are representative of the population we serve** and are split across the localities as follows: 15.5% Barnsley, 14.5% Calderdale, 37% Kirklees, 25% Wakefield, 8% other parts of South and West Yorkshire.
- **The member's gender split is predominantly female** which does not reflect the gender split of the population we serve, 65% of members are female to 34.7% male, with 0.3% identifying as a gender not assigned at birth, left blank or prefer not to say.
- The data shows that **1.7% consider themselves to have a disability**, with most stating mental health as the main disability and a few stating a long-term condition or illness.
- **11.6% of our members declared they are carers.**
- **Members are predominantly white British** with 82% representation with Asian, Asian British, and Pakistani at 5.5%, Indian at 4.5%, African, Black Africa and Caribbean at 1.6% and other ethnic groups making up 8% which includes, Polish, Chinese, mixed background and other.
- **Members who stated their religious belief were identified as predominantly Christianity at 60%,** with other religions such as Islam, Jewish, Buddhist, Hindu, all under 1% or less. It is worth noting that only 4% of all members responding stated their religious belief.
- **95% of Sexual orientation was not declared**, with those responding reporting as heterosexual 3.8% and 1.2% reported as gay, lesbian, or bisexual.
- **95% of marital status was not declared,** of those who did 2% were married or in a civil partnership.
- **There are no records of members who are pregnant or who have given birth in the last 12 months.**

The Trust recognises that some members may wish to be more actively involved in the life of our Trust than others. We know that an effective membership can only be achieved if we embrace an inclusive approach, encourage diverse representation, demonstrate effective involvement, and ensure accessible information and communication. We will strive to create a culture of active involvement for as many members as possible through active engagement.

The Trust's Constitution sets out the role and duties of members. Information on membership is publicly available on the members section of the website.

Membership of the Trust is free, with few specific requirements apart from a lower age limit of 11 and no upper age limit. This year we have worked hard to increase our representation of young people which is now reflected within our governor population. More work to understand the involvement of children and young people will continue into 2024 with the support of our partners in each place. These partners, who already reach and work directly with children and young people, will help us adjust and improve our approach so it is more inclusive. Any improvement will be co-designed with the voice of young people at the centre.

6. Our strategic approach to equality and diversity

The integrated 'Equality, Involvement, Communication and Membership Strategy' was developed in 2020. Using the views of over 720 people including our diverse community (see full report here), the strategy is insight driven and offers a joined-up approach to delivering equality, involvement, communication, and membership.

The strategy is supported by accompanying annual action plans to ensure that the Trust has an integrated approach to improve the health and wellbeing of everyone. Our approach has always been to live our values and 'put the person first and in the centre,' ensuring the involvement of those who use our services is representative, that care is person centred and that our services are driven by robust insight and data.

7. Progress during the period 2022-2023

As a Trust we continue to be proud of the progress we are making. Despite the pandemic and increased pressure on both staff and services over the past few years the Trust has continued to build on the previous years' achievements.

Our strategy clearly sets out how we will measure our progress, and 'how we will know when we have got it right.' We have rated ourselves using a traffic light system with red meaning we have not achieved anything; amber we are on our journey, and green meaning we are progressing well.

Based on the information below this is how we have rated our progress this past year:

We know we have got it right when….	**Our rating**
Ensure we gather good quality data which can be used to support performance monitoring of service use.	
Ensure we work in partnership with partners and communities including the voluntary, community (VCS) and faith sector	
Ensure we provide person centred care which promotes inclusive, culturally and gender sensitive services	
Develop and sustain an equality competent organisation that demonstrates inclusive and diverse leadership and workforce	

To ensure people who access health and social care services, families, carers, and the public are involved	
To use equality and demographic data to ensure we inclusively involve the right people	
To use the assets in our communities and create the right conditions to involve local people. To ensure we are an exemplar in co-production	
To record, report and publish insight so people can see the information driving our service decisions	

In addition, we measure our progress using the Equality Delivery System (EDS). The results for the period 2022-2023 graded as 'achieving' and the detailed results can be found here [How well are we doing? - South West Yorkshire Partnership NHS Foundation Trust]

This is what we have done this year:

To support the collection of insight and data we have:

- ✓ **Created version 2 of a Trust wide mental health equality impact assessment (EIA) and toolkit.**
- ✓ **Maintained a resources library for equality publications and data and shared with care groups and teams.**
- ✓ **Progressed the All of You campaign which has improved our data quality for ethnicity by 20%**
- ✓ **Maintain a dedicated intranet page for staff to access resources and materials.**
- ✓ **Continue to use our health inequalities dashboard which we have now shared with system partners as an example of good practice.**
- ✓ **Improved equality data collection of our linked charities 'Creative Minds' and 'EYUP'**
- ✓ **Continue to Improve our service EIAs and action plans which are now part of our performance reporting. We have also developed a digital framework to digitise all EIAs by 2024.**

To support our approach to capturing the voice and views of people we have:

- ✓ **Developed a Trust wide approach to involvement called 'Connecting People' in partnership with leads from Calderdale and Kirklees who have the same approach.**
- ✓ **Working towards formal consultation on our older people inpatient transformation, following extensive engagement with partners and communities.**
- ✓ **Maintain a Trust wide approach to developing surveys which now all include equality monitoring as standard.**
- ✓ **Quarterly insight reports on the voice and views of people with contributions from our Governors, Healthwatch and partners are developed quarterly with you told us, we listened published on our website.**

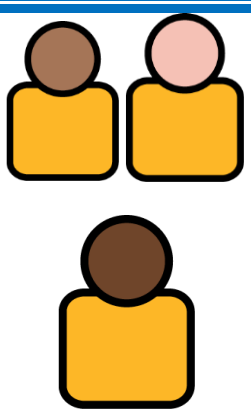
	✓ Supported the insight for the Trust wide Quality Strategy ensuring we captured everything we could that reflected the voice of service users, families, and carers. ✓ Used what we already know to inform the changes to Care Programme Approach (CPA), so the views of service users, carers and families were at the heart of our design. ✓ Continue to work in partnership with the Third sector to co-design and develop our service offer through grant scheme allocations.

To support our approach to workforce we have:

	✓ We continue to offer a range of support to our staff. ✓ We continue to provide our workforce with equality and diversity mandatory training. ✓ We are now rolling out a co-designed enhanced equality and inclusion training package as essential to job role for all leaders and managers. ✓ We continue to deliver monthly lunch box talks using films created by our community with an equality theme. ✓ We continue to support our international nurses with pastoral care and buddying. ✓ We continue to progress the work of 'All of you: Race Forward' which identifies how we will tackle racial abuse and harassment of staff by people who use our services. ✓ We rolled out the FLAIR survey for the first time this year. The survey will be delivered for a further 2 years so we can benchmark our progress.

We can demonstrate an improvement in outcomes and experience for specific groups protected under the equality act, including carers:

	✓ Disabled Staff network ✓ Monitoring and developing action because of Workforce Disability Equality Standard (WDES) ✓ New co-designed disability policy and plan on a page to highlight key actions. ✓ Learning Disability health checks ✓ Serious mental illness (SMI) checks in each area, delivered in partnership with our places. ✓ Green light toolkit for people with a Learning Disability ✓ Stomp and stamp approach to reduce over medication of adults with a learning disability. ✓ Disability awareness through visual stories and campaigns throughout the year ✓ Creative interventions through our linked charity 'Creative Minds.'



- ✓ Race Equality and Cultural Heritage (REACH) Staff network
- ✓ Dedicated leadership programme
- ✓ Monitoring and developing action because of Workforce Race Equality Standard (WRES)
- ✓ Forensic services deep dive to support culturally competent care which has led to a clear action plan.
- ✓ CAMHS Kirklees deep dive to identify and address inequalities in access to services which has resulted in funding 2 local VCS groups to improve the health of South Asian and Black young people.
- ✓ Continue to report on improvements to RACE equality data using our equality dashboard.
- ✓ Attended for the second year the Asian Professional Network Association (APNA)annual event with clinicians. Last year it led to clinical involvement in programmes and training.
- ✓ Celebrated South Asian heritage month with stories and cultural cuisine in our canteen and onwards.
- ✓ Reducing hate crime and incidents by working in partnership with local crime prevention officers to host several sessions for staff in each place location.
- ✓ Proud to support in partnership the 'Root out Racism' campaign.
- ✓ Specific cultural creative activities on our wards and in communities.

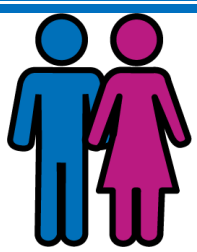
- ✓ Pronoun awareness, badges, and a film to raise awareness developed by young people has been shared with staff. A commitment to add this to staff signatures is being progressed.
- ✓ Celebrated trans gender awareness day in March with a staff development session led by a panel who answered openly any questions people had.
- ✓ Annual 'Pride' month long celebrations attending community events, sharing stories, media campaign and screen savers.
- ✓ Rainbow badge pledge
- ✓ Visible symbols of support in our built environment including a rainbow crossing and flags
- ✓ Transgender policy guidance now developed and available on the intranet. This includes a quick guide and tips for staff.
- ✓ Continued investment in 'Trans-Barnsley' a group hosted by our recovery college, with a visible identify and presence.
- ✓ Gender neutral toilets in all our estates

	✓ Specific creative interventions through our linked charity 'Creative Minds' ✓ A new working group to focus on further action has been set up. The LGBT+ group will look at the good practice framework against our approach.

	✓ Widening our faith connection in each of our places to ensure we can support people in our services. ✓ Prayer rooms in our buildings ✓ Pastoral care talk line ✓ Befriender service in all inpatient services ✓ Newsletter for inpatients ✓ Digital pastoral offer ✓ Celebration of faith calendar through communication, social media, and staff stories ✓ Improving prayer facilities by introducing Friday prayers through a volunteer Imam at our Fieldhead hospital site – open to all. ✓ Improving our ablution facilities for prayer by adding a facility at Fieldhead hospital Wakefield – due to be complete by 2024. ✓ Guidance for fasting and a prayer pack is now available and will be shared with teams in line with faith calendar to support staff and service users.

	✓ Thriving staff network with a dedicated post to progress support to all carers ✓ Identifying carers and recording of carer status for people who use services. ✓ Identifying carers and recording of carer status for our workforce ✓ Successfully rolling out the 'carers passport' ✓ Carers week celebrations including a community film, social; media stories and a celebration event. ✓ One of only a few Trusts to achieved Carer Confident status Level 1 and 2 – with our sights set on level 3 in 2024. ✓ Now part of 'Triangle of Care' working closely with services and teams to roll out a framework. ✓ Co-designed training on carers is now being delivered across our Trust, including our executive team. ✓ Support to carers for creative interventions and shorts breaks through a dedicated grant fund.

	✓ Menopause staff support group in place ✓ The Trust have a perinatal mental health service which also includes peer support workers.



- ✓ **There are male and female focussed activities in all our recovery colleges.**
- ✓ **Celebrating women through International Day of Women using media, stories, and events**
- ✓ **Continue to develop creative and recovery interventions with a gender focus through 'Creative Minds'**
- ✓ **Celebrate international men's health day using media, stories, and events.**

8. A focus on addressing inequalities in health.

Health inequalities are unfair and avoidable. To reduce health inequalities, we need to act to tackle them through actions with a specific focus on disadvantaged groups and deprived areas. We know that there are groups who are more adversely impacted. The Trust are using the CORE20PLUS5 approach to identify the target audience and the areas of improvement.

Work took place in 2022-2023 to address inequalities in Kirklees Child and Adolescent Mental Health Services (CAMHS), Forensic and Learning Disability services. The table below sets out our progress:

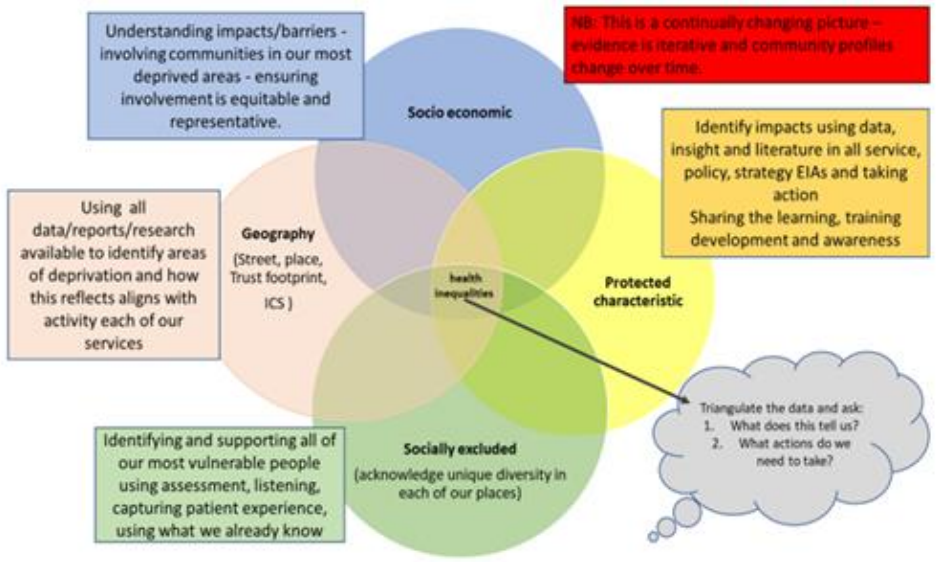
Inequality identified.	Our progress
Kirklees Child and Adolescent Mental Health Services (CAMHS) used our interactive tool to identify the postcodes of activity. The data told us that there were 2 specific areas that are underrepresented in services. These postcodes had a higher-than-average population of Asian, Asian British, and Black, Black African, Caribbean population.	Further work to investigate the data led to groups being identified. The team immediately improved their service information to ensure it is accessible. Focus groups were also held in postcode locations to engage young people. They told us, we should make our service more visible on social media, promote services better and be part of school PSE lessons. A wellbeing champions initiative has been set up within schools too. Parents, carers, and families were also engaged and most wanted more information and sign posting. A full report of this work can be found on: Engagement and consultation - South West Yorkshire Partnership NHS Foundation Trust The CAMHS team are now working with 2 voluntary and community organisations to directly target young people from Asian, Asian British, and Black, Black African, Caribbean population. These organisations have been funded to co-design a future offer that will ensure we reach communities.
A deep dive into Trust admissions data for Forensic services indicated service users aged 18 to 64 from mixed, Black, and other ethnic groups and Asian population aged 35 to 64 are	The 'our voice counts' project commenced in 2022 to further engage with patients of forensic services, their families and carers who represented mixed, Black, and other ethnic groups and Asian population. Trust staff were also interviewed. The aim of the project was to understand the pathway of the person to service and what could have been done differently.

more likely to be admitted and detained.	The report concluded in October 2022 and several recommendations have been made. These recommendations are now being progressed by the service. A full report of this work can be found on: Engagement and consultation - South West Yorkshire Partnership NHS Foundation Trust In parallel, work is to start with our communities through recovery colleges and wider involvement initiatives to identify and co-design solutions with community partners. This work will continue into 2024.
Learning disability services have been doing lots of work to ensure that people receive health checks to ensure we address inequalities in health outcomes for people who have a learning disability.	The Trust decided to look further into learning disability services as part of the equality delivery system (EDS2) in January 2023. The deep dive into learning disability services covered the whole pathway from the perspective of each protective group. A full report on our findings can be found here. How well are we doing? - South West Yorkshire Partnership NHS Foundation Trust Further work to look at the service level data using the NHS England and Improvement took place following this review and a programme of work to reduce waiting times is ongoing. We are also connected into the work on inequalities in each of our places and have seen some excellent improvements recently in the uptake of annual health checks for people with a learning disability particularly in Barnsley and Calderdale.

Inequalities in health, housing, income, barriers to accessing services and discrimination remain and there is need for improvement across each of our places. We know these inequalities put people at greater risk of ill health, mental ill health, or distress. We also know that people who are mentally ill, those with a learning disability, and those who live in poverty face wider health consequences as a result. Systemic racism and prejudice also affect our Black, Asian and minority ethnic communities. More work needs to be done to ensure our services are accessible to everyone and reflect the populations we serve by ensuring we understand, inform, communicate, and involve those communities.

Our approach to improving and developing services is through the comprehensive use of Equality Impact Assessments (EIA) in every service. Our service EIAs include population data and service activity data (including staff profiles) broken down by each protected characteristic. This information means that we can identify at a service level any under or over representation in services, determine if the workforce is reflective of the population which may determine a barrier for access and if there are specific areas of inequality these groups experience which can be picked up in clear action plans. We have over 170 services who review their EIAs on an annual basis. EIAs also drive Trust policies and ensure that the approaches we develop consider and mitigate against any barriers for protected groups.

In addition, we also use a service improvement approach. We are using the Kings Fund tool to help us drill down further into the service level data so we can further capture and collate insight to inform a more targeted approach. The diagram below sets out our Trust approach:



Going forward into 2023 -2024 the Trust golden thread and priority programme to work in partnership with each of our places will continue to ensure the Trust retains a focus on addressing health inequalities as a priority.

9. Governance

The Trust's Equality Inclusion and Involvement Committee and sub-committee has been established to act on behalf of the Board and to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy to improve access, experience, and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

The Trust works with a range of partners across the system including West Yorkshire and South Yorkshire Integrated Care Board (ICB) to ensure a partnership approach to system transformation. In addition, senior leaders work at a place-based level, led by local authorities and commissioners to ensure the Trust is part of local decisions and can respond in partnership to protect and support the most vulnerable. The Trust uses the Joint Needs Assessment (JNA) intelligence to understand the local population and the Equality Impact Assessment (EIA) as a tool to inform service impacts, identify actions and ensure service improvement.

10. Our forward view

The Trust will continue to focus on providing high quality care that is culturally and spiritually appropriate with staff who are reflective of the local population through inclusive recruitment and retention. We will also ensure all our priority programmes are driven using robust data and insight that ensure we hear the voice and views of everyone and identify and address health inequalities. Our Trust objectives set out in our Equality, Involvement, Communication and Membership (EICM) Strategy and the actions are set out below.

11.1 Trust equality objectives

1. To ensure we gather good quality data which can be used to support performance monitoring of service use and improve outcomes among those from the most deprived neighbourhoods including Black, Asian, and Minority Ethnic communities, people with a disability including Learning Disability, ASD and Autism and people who identify as LGBTQ+, young people and carers.

Action 2024/2025:

- Continue to promote the 'All of You' campaign to improve data quality and collection for all protected groups.
- Ensure we record carers, capture digital and communication preferences
- Continue to improve the Equality, Involvement, and Inclusion (EII) Committee dashboard and metrics; using case studies to demonstrate our progress.
- Continue to improve the use of Trust equality data using the data strength framework.
- Continue to resource and support the use of the Kings Fund 'Health Inequalities' tool.
- Ensure Patient Carer Race Equality Framework (PCREF) metrics form part of routine capture and reporting.
- To collect, analyse and publish information in the annual report 2024/25 in relation to health inequalities to fulfil the section 13SA of the National Health Service (NHS) Act 2006
- Deliver Equality Delivery System (EDS) 2022
- Identify socio-economic as a deprivation indicator which can be used in Equality Impact Assessments (EIAs) to ensure we consider impact alongside protected groups and carers.

2. To ensure we provide person centred care which promotes inclusive, culturally and gender sensitive services, delivered by a diverse and representative workforce who seek to understand and pro-actively address inequalities and challenge discrimination

Action 2024/2025

- Reach out to a range of community faith networks to improve the Trust offer of 'Spirit in Mind'.
- Continue to develop awareness of different religions and beliefs through information and communication channels.
- Continue to celebrate the faith calendar giving visible parity to all religion and beliefs.
- Map community befriender offers in each of our places and embed in volunteer services.
- Explore the use of volunteers as creative practitioners in inpatient settings.
- Continue to increase our Creative Minds offer using creative interventions in partnership with Voluntary and Community Sector (VCS)
- Continue to work with and co-design our service offers in partnership with the VCS sector.
- Continue to build on our commitment to carers by delivering Triangle of Care (TOC) and carers training to staff).

3. To ensure we work in partnership with partners and communities including the voluntary, community and faith sectors to improve access to services and ensure those from our most deprived neighbourhoods have equal access to pathways of care

Action 2024/2025

- Ensure every service has an up-to-date EIA and accompanying action plan to address impacts.
- Ensure staff are compliant with Equality Diversity and Inclusion (EDI) mandatory training.
- Ensure managers and leaders as part of essential to job role complete the enhanced EDI training.

- Offer staff equality, diversity and inclusion development sessions.
- Continue to reflect images and language in all information/ social media and publications that are inclusive of everyone.
- Further embed the accessible information standard (AIS) /disability policies and develop through development and a short how to guide.
- Using a change approach and quality improvement (QI) methodology in service improvement areas to address health inequalities and develop case studies.
- Review our estates using the 'PLACE' audit with representatives who reflect our communities.

4. To develop and sustain an equality competent organisation that demonstrates inclusive and diverse leadership and workforce addressing the balance of power and ownership at all levels and improve equality of opportunity for staff and volunteers

Action 2024/2025

- Focus on inclusive recruitment & retention at all levels in the Trust.
- Commence a co-produced approach to leadership and talent management.
- Continue to deliver the 'Flair' survey to understand racial bias and deliver an action plan on improvements.
- Continue to deliver on All of Your Race Forward
- Continue to increase the recruitment of diverse peer support workers.
- Continue to support staff networks.
- Assess against the national LGBT framework.
- Enhance sense of belonging by delivering on EDI High Impact Action Improvement Plan
- Delivery on recommendations from Inclusive Leadership Culture Programme

11.2 Trust wide involvement objectives

1. To ensure people who access health and social care services, families, carers, and the public are involved in shaping health and care proposals and plans. To use what we already know as a starting point, so we do not repeat conversations or create involvement fatigue.

Action 2024/2025

- Involve local people in the development of the Trust Strategy, Equality, Involvement, Communication and Membership Strategy, Digital and Clinical Strategy
- Continue to develop a Trust wide understanding of involvement through training.
- Ensure that all priority programmes use insight data and involvement to drive activity.
- Continue to transfer the offer of a central survey monkey account to ensure management of surveys including use of equality monitoring.
- Develop a Trust wide insight bank to support programmes, strategy development and design.
- Develop a framework for consultation using the Older People Service (OPS) transformation approach and learning.

2. To use equality and demographic data to ensure we inclusively involve the right people at the very beginning of a process to influence the development and design of services

Action 2024/2025

- All involvement approaches include a clear stakeholder map to help ensure we reach the right target audience as part of a planned approach to involvement.
- Joint needs assessment (JNA) and demographic data is used and analysed to ensure we use the right methods and approaches for involvement.

- Increase membership involvement through an approach which includes dedicated web page, newsletter, and place-based forums.
- Continue to increase representation of young people on the members council and identify an inclusive approach.
- Continue to work with place-based colleagues in the Voluntary and community sector (VCS) and Healthwatch to improve children and young people involvement.
- Continue to capture equality data to demonstrate involvement in decision making so that it is reflective and representative.
- Increase the diverse representation of volunteers in the Trust.

3. To use the assets in our communities and create the right conditions to involve local people, going to where people and ensuring they remain involved.

Action 2024/2025

- 'Connecting People' programme will deliver a minimum of 4 training sessions in a year to increase our asset database.
- Continue to roll out and promote the asset-based approach, promoting internally for use by the Trust.
- Continue to recruit a diverse pool of assets to ensure reach into all our geographical locations, groups, and settings.
- Utilise our assets to deliver programmes of work ensuring they use the resources available.
- Continue to support our governors to involve people in our local communities.
- Work with the voluntary and community sector organisations in each of our places to deliver programmes of work.
- Continue to work with each place including Healthwatch to support involvement of communities in the delivery of place plans.

4. To ensure we are an exemplar in co-production - through equal and reciprocal relationships with communities and professionals; recognising that both partners have vital contributions to make and ensuring we have a clear reward and recognition approach.

Action 2024/2025

- To develop several tools which can support co-production.
- To develop and deliver development sessions on co-production approaches to managers.
- To gather case studies which demonstrate our approach to co-production.
- To roll out our reward and recognition approach across the Trust
- Increase our Peer Support Worker approach to ensure we have lived experience represented in all service settings.
- Deliver a volunteer to career approach in targeted areas of deprivation.

5. To record, report, and publish insight so people can see the information driving our service decisions and actively demonstrating how we are using the intelligence we capture to deliver service improvement and patient centred outcomes

Action 2024/2025

- To use what we already know as a starting point by developing a framework to capture insight.
- To continue to ensure we record and report involvement activity using templates and recording equality data.

- To publish timely involvement reports on the website and provide updates.
- To align our approach with our service improvement, change and QI approach.
- To ensure involvement and insight reports inform all strategies.
- To continue to consolidate insight through a quarterly insight report and update using ‘you told us, we listened’.
- To develop a patient stories approach that is trauma informed.

11. Our legal and statutory obligations

The Trust is committed to being responsive and supporting the needs of the diverse population it serves, reflected in the Trust’s values. Equality and diversity are not an ‘add on,’ they are central to all we do as a provider of services, as an employer, and as part of the public sector. People who use the Trust’s services are all different and diverse in their requirements and needs. Equality is about creating a fairer organisation in which everyone can fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense and treating everyone with fairness and understanding, not necessarily treating everyone the same.

To ensure we comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED) and the Health and Social Care Act 2022, we must consider equality and involvement at each stage of service delivery including as part of any decision-making process. Information on the obligations we must work to can be found on the following links:

The Equality Act 2020

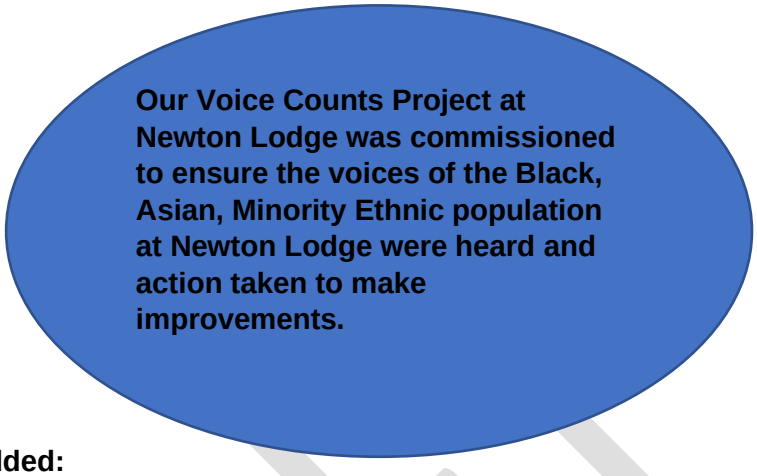
Public sector equality duty

NHS Constitution

Health and Care Act 2022 (legislation.gov.uk)

South West Yorkshire Partnership NHS Foundation Trust

Appendix 1: Annual report additional content – 'sound bite' style text to be included in and amongst the document in the form of a bubble e.g.



Other examples to be added:

- **The All-Age Forensic Community Services adult teams are working with the Yorkshire and Humber network to develop an engagement strategy for working with forensic service users in the community.**
- **A guidance document has been developed to support staff in the management of hate crime / challenging incidents in within services.**
- **A project has been undertaken within the service to support improving Friends and Family feedback. The service has developed QR codes, which are now available on business cards, leaflets and within carers packs and additional ChatPad.**
- **The Trust now have strategic health facilitators in all 4 Places. These facilitators are members of the partnership forums for people with learning disabilities where accessible information is shared. Easy read as standard is also improving.**
- **A peer support worker with lived experience has been appointed to the Horizon ward.**
- **A RESPECT project approach was established, and the service has been celebrating a wide range of cultural events throughout the year.**
- **A co-produced forensic animation shares the example of a journey a person may follow if they are admitted to a forensic ward and the support, care, and treatment they will receive.**
- **The Forensic service has evolved an active culture of patient involvement. This encompasses a range of forums including service user and carer involvement groups.**
- **Looking at the admission rates of people from Black Asian Minority Ethnic backgrounds into older people wards to address any inequality.**
- **Race as a factor of abuse: support ongoing work with ward staff regarding reporting of incidents and collaboration with the police**

- **Ensuring estates are accessible: An evaluation of all sites is underway and action plans are in place. Addressing issues of blue badge parking and ensuring letters make the parking arrangements clear to people.**
- **Addressing inequalities (responding to 20% mortality gap): Physical health checks for service users checking for high cholesterol and diabetes, from a finger prick test.**
- **Quality improvement work is underway around service users with dementia and oral hygiene.**
- **Focus on faith and religion: Contact made with local religious leaders to come along and attend a ward staff meeting to allow time for question-and-answer sessions. Increase in chaplain attendances.**
- **Recovery college: currently working with the long-term conditions steering group to see how we can better support and provide self-management for long term conditions such as cardiac disease, diabetes, and smoking cessation.**
- **Recovery college and reach into the Asian population working with a local mosque to understand and improve our reach, accessibility, and delivery.**
- **Speech and Language Therapy - Aim to make Barnsley a place where people say, "Hey, it's ok to stammer."**
- **Volunteering increased to offer volunteering in community services to support staff in their role.**
- **The Liaison and Diversion service in Barnsley has a Learning Disability Nurse within the team which is beneficial due to the need for early identification of learning disability.**
- **The end-of-life care team has reviewed and subsequently revised My Care Plan, an individualised plan of care for those in the last days of life which promotes co-planning and a person-centred approach to care. The assessment is seen to reflect more of a "what matters to me" and "how best to support me" style and very much encourages dialogue and discussion between the person.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 9.8 – Assurance from Trust Board Committees

Collaborative Committee

Date	5 December 2023
Presented by	Mike Ford (Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	**Alert:**
	• The Committee reviewed reporting on the focussed surveillance levels for two wards where SWYFT is the provider and questioned whether this is consistent with reporting being provided via the Trust IPR.
	
	Advise:
	• The Committee received a paper reviewing the progress of the West Yorkshire Adult Secure collaborative against the objectives set out in the original business case and questioned what level of success could have been achieved without following a collaborative approach. The conclusion was that progress has been made which would not have been possible without collaboration.
	  ○ Areas of progress include improvements in ensuring service users are supported in are and the needs of WY population being met in WY; further work needed to reduce distance from home.
	  ○ Specifically, the scrutiny provided by the Commissioning Hub is seen as key driver of progress. A quarterly oversight meeting is held with NHSE Specialised Commissioning and we have received positive feedback on the work done within the commissioning hub.
	  ○ Furthermore, the WY collaborative is seen as mature when compared to other collaboratives nationally.
	  ○ Future work will focus on the need to reduce distance from home and addressing the overall length of stay
	• Similar paper on South Yorkshire collaborative to be received at future meeting.
	• The Committee ratified the recommended option for the future commissioning options for Forensic CAMHS (Phase 2 Collaborative) and the Adult Specialist Forensic Community Service business case
	
	Assure:
	• The Committee continues to receive reporting on the latest financial forecasts for both West Yorkshire and South Yorkshire Adult with both collaboratives forecasting surpluses. However, these remain subject to change as a result of exceptional packages of care. It is important to note these positions as they have a relatively significant impact on the overall Trust forecast.
	• The Committee continues to receive reporting across the following areas from both collaboratives
	  ○ General performance (occupancy/discharges/delayed discharges/length of stay)
	  ○ Contracting
	  ○ Quality
	  ○ Risk

	• We were pleased with the work carried our to drive consistency of this reporting across collaborative • The Committee has previously requested reporting on Phase 2 collaboratives – this is to follow
Approved Minutes of previous meeting/s for receiving	Minutes of 3 October 2023

Equality, Involvement and Inclusion Committee

Date	13 December 2023
Presented by	Erfana Mahmood (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • The Patient and Carer Race Equality Framework (PCREF) was a recommendation following the national Mental Health Act Review in 2018. In October 202 NHS England published its first Advancing Mental Health Equalities Strategy laying out plans for addressing inequalities in access, experience and outcomes in mental health care and a commitment to develop a PCREF. This framework will now be rolled out by NHS England across all mental health trusts and will form part of the Care Quality Commission (CQC) assessments. The Trust have already mapped current work against the actions, and these will be embedded in the 2024/2025 equality action plan. • NHS England's inclusion health framework, which highlights the key actions trusts could take to ensure their services are equitable and accessible for inclusion health groups will be reviewed against 2024/2025 action plans as part of the delivery of our priority programme to reduce health inequalities. • Annual report for Equality, Diversity and Inclusion has been agreed by the committee. The report looks back on 2022/ 2023 and highlights progress. The report is now with Trust Board for sign off. **Advise:** • Care Group update: Children and Adolescent Mental Health Service CAMHS presented by Claire Strachan. The highlights included positive progress on service EIAs, information on the newly formed 'Childrens Services Experience, Equality and Improvement Action Group', a piece of work to look at the relationship between attending services and the barriers of poverty. Mental Health in Schools Teams in Kirklees have also developed links with the Brunswick Centre (a registered charity) who now deliver training to support schools with LGBTQ+ students. Barnsley CAMHS and Chilypep also worked together to consult young people on what an ideal Mental Health Service would look like to them. 156 young people responded and this insight will help improve the offer to young people. In addition, the team continue to improve their offer to carers, and adapt the Friends and Family Test (FFT) approach using QR codes to increase responses. • EDS2022: The committee received the first set of evidence for domains: o Domain 2: Workforce health and well-being o Domain 3: Inclusive leadership. • The domains have gone through an evaluation process, with evidence collated and presented at a peer review. The evidence so far had resulted in an mean average grading of 'Developing' overall.

	The themes for Domain 2: Commissioned or provided services are perinatal mental health, Accessible Information Standard (AIS) and Children and Adolescent Mental Health Service (CAMHS). A stakeholder event will be held on 11 January to review evidence presented and grade. The final Trust grading will be agreed by a small group of EIIC members. • A focus on the Carer staff network achievements and progress was presented by Gillian Cowell, Carer Lead, who had prepared the presentation. The presentation provided an overview of the achievements of the staff network, which included feedback from the staff carers retreat. Progress to ensure staff carers have a voice in Trust policies and procedures and continue to gain staff confidence to self-identify and shape their network. There are over 90 attendees and a distribution list of over 81 staff carers in the network. **Assure:** • The Trust commitment to carers annual update highlighted our significant progress on this agenda including our 'Carers Passports' for both unpaid carers and staff, to support them to access the right help and advice. The 'Triangle of Care' (TOC) which is now being rolled out across all services in the Trust to ensure the carer, clinician and patient are all appropriately involved in the patient journey. Carers Week and Carers Rights day events funded from the NHS Charities Together £30k therapeutic activity funds. Rolling out carer awareness training whilst supporting the level 3 carer confident accreditation continues to be a consistent focus. • The EII exception and highlight report provides assurance that the Trust has delivered on the Trust wide strategy action plans 2023/2024 for both equality and involvement. This month the committee were asked to approve a recommendation that more work is required to develop the metrics for equality data (not including ethnicity which is already set. • National, local, and regional updates which include legislation and publications are presented at every EIIC. The Committee remain assured that the Trust is embedding any recommendations, good practice and policy or legislative changes through the action planning process and wider Trust. • Progress on the Equality dashboard and metrics continues using case studies to evidence the use of the data to identify areas of improvement. The workforce data focuses this quarter on Ethnicity and shows an improvement in attracting staff from an ethnic background, so we are reflective of our communities (current baseline for the Trust is 18%) our population data where the average across all 4 places is just over 13.25%. A case study of the incident data from Datix of staff where an incident has been recorded in relation to race and ethnicity has shown that the Trust need to do more work to address the level of reported incidents. • Kirklees Child and Adolescent Mental Health Services (CAMHS) case study was presented following data found in March 2021 where 2 specific postcode areas were underrepresented in services. The study sets out the significant improvements to reduce health inequalities that has resulted from this data and the work with schools and communities to gather more insight to inform improvements. • WRES and WDES reports presented more work to identify incorporating actions into existing plans continues, including the EDI

	improvement plan which sets out clear metrics that will ensure the Trust has a framework to provide assurance on the WRES.
Approved Minutes of previous meeting/s for receiving	Minutes of 13 September 2023

Audit Committee

Date	9 January 2024
Presented by	Mike Ford (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Action outstanding regarding responsibility for oversight of ligature audit activity between Audit and Quality & Safety Committee. **Advise:** • The change to the BAF grading process previously discussed at Board was approved. • The Committee agreed that it was appropriate for there not to be any measures to be added to the IPR regarding any increased legal risks arising from the Covid inquiry (as discussed at previous Board, Committees were asked to confirm this for any risks on the ORR not currently reported by/reflected in the IPR). • Positive progress reported in implementing the actions arising from the limited assurance internal audit report into E-rostering. • Various papers received covering Advance preparation for annual accounts process including ratification of accounting policies and treatments relating to accounting standards • Further update given regarding action plan to address issues raised by NHSE assessment of Trust's EPRR preparedness **Assure:** • Specific paper presented to confirm alignment of Audit Committee's terms of reference with best practice as set out in the Healthcare Financial Management Association • Positive assurance received from regular reporting of o ORR risks assigned to Audit Committee o Triangulation of risks between ORR and IPR o Internal Audit and Counter Fraud activity by 360 Assurance o Treasury Management o Health & Safety activity • Papers were received covering o Further positive update on Trust's controls in place relating to Cyber Security and actions in place to improve our level of security o Procurement activity with focus on major contracts and tender waivers
Approved Minutes of previous meeting/s for receiving	Minutes of 10 October 2023

Quality and Safety Committee

Date	9 January 2024
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)

Key items to raise at Trust Board	**Alert** • The committee reviewed and approved the risk scoring for two new risks; risk that teams and individual members of staff do not feel confident that the trust has a culture of speaking up and risk that individuals do not feel safe from sexual harm. Risk scores of 9 and 8 respectively were approved. (Both risks are still to be allocated a risk number). • The committee reviewed the recommendation to reduce the risk scores for Risk 1624 and 1319. Risk 1624, specifically that services pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites and a recommendation to reduce the likelihood from 3 possible to 2 unlikely. Risk 1319, specifically that there will be no bed available in the trust for someone requiring admission to hospital for Psychiatric Intensive Care Unit (PICU) or mental health inpatient treatment and the reduction in score around likelihood from 4 likely to 3 possible. The committee sought further assurance on the rationale for both of these which centred on patient flow improving and as a result approved the reduction in scores. • The committee acknowledged and highlighted the ongoing discussions around Risk 1650 and inpatient areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury. • The committee were made aware of a risk that had recently been identified around the inequality of provision for children with learning disability to access Barnsley CAMHS (Child Adolescent Mental Health Services). The board are advised (as were committee) that this has been escalated to Barnsley and discussions are taking place. **Advise** • The committee welcomed the Infection Prevention Control (IPC) team representatives who shared their experience, priorities and challenges. Their work was acknowledged and the members showed their appreciation for all their expertise and hard work recognising that this is often an area that is not as visible as others. As a board we can continue to support and promote the importance of IPC through role modelling and showing leadership when out and about by asking about Bare Below the Elbow and Hand Hygiene. • The committee was informed that a new care group has been implemented - Children and Family. • The committee welcomed the update on the publication of the best practice guide to reducing harm from ligatures and noted that this included people with a learning disability and mental health wards. • The committee received the Safer Staffing report which had undergone further work and development based on previous feedback. There is a commitment to continue to improve this report and work together on its purpose and how we can develop it so it provides insight into care groups and services and expert analysis which can evidence that our services are safely staffed and the steps we are taking to address any issues. **Assure** • The committee were assured that the work on Out of Area beds continues to be sustained and that there is no evidence that this had an adverse impact on the wider system.

	• The committee discussed the recent Industrial Action by junior doctors and were assured that there had been no direct harm as a result of this, notwithstanding previous discussions and recognition that the longer-term impacts are still unknown. • The committee received the Reducing Restrictive Practice Intervention (RRPI) update and there was a robust debate and discussion. As a result, the committee will continue to continue to receive the update and monitor the ongoing improvement. Some specific areas are going to be investigated including benchmarking data on intramuscular medication (IM) and how this correlates with the use of prone restraint. • The committee were assured about a culture of learning, improvement and candour with the sharing of the full report of the Autism/Autism Spectrum Disorder (ASD) invited review undertaken by the Royal College of Psychiatrists. The committee were assured by the actions already undertaken in response to the recommendations and the plan to continue to improve. • The committee received the update on the Clinical and Strategic approach to Learning Disabilities which is led by the Medical Director and requested an update on the compliance expectation of the Oliver McGowan training.
Approved Minutes of previous meeting/s for receiving	Minutes of 14 November 2023

People and Remuneration Committee

Date	16 January 2024
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 compliance had risen to 73.1% this month. Whilst this is still behind trajectory progress was acknowledged and more assurance gained with a target in place of 100 week. • The Organisational Development detailed plan was presented and received. The committee will receive quarterly updates on progress. **Advise:** • The interim CPO presented a report on current activities taking place across the people directorate, this included an update on the continuing pressures that the industrial action is having on the trust. • Confirmation that the high-level staff survey results had been received but embargoed and can only be used internally. It was agreed the data could be shared with NEDs. • Uptake of the flu vaccine is still low but in line with other trusts. • The committee received an update from the recruitment, retention and engagement team on the work taking place to recruit locally. This is in-line with our sustainability strategy. The programme has seen excellent progress. • Freedom to speak up monthly report was received highlighting mandatory training at 94.75% • The recruitment and retention plan update was received, showing some excellent progress on band 5 recruitment now at full establishment.

	Assure: • The agency and scrutiny group reported great progress on agency spend and an improved forecast of £8.9m. • Workforce IPR highlighted key areas of concerns and included some good benchmarking data. Discussion concentrated on key areas such as on Forensics, Estates and facilities and inpatient services. • Workforce growth now stands at 4.1% ahead of plan. • Absence remains stable at 5.2%. The activity around absence management was presented to the committee. • The 90day plan for the people directorate was presented. On the back-drop of high vacancies and changes in leadership within the people directorate, the plan gave the committee confidence around a plan of improvement with clear targets and accountability.
Approved Minutes of previous meeting/s for receiving	Minutes of 21 November 2023

Finance, Investment and Performance Committee

Date	22 January 2024
Presented by	David Webster (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Significant capital balance remaining to spend in the last 3 months (~£6m), reassurance was provided in the committee, but not able to get assurance that this was going to be spent. Committee has asked for a forecast spend grouped by risk level to provide further assurance (more for future years) • Planning guidance has yet to be issued, with deadline to submit forecasts remaining the same (end of Feb). This provides significant pressure for the finance team, and the committee ask the Board to acknowledge and agree that this is not acceptable, and feedback to relevant stakeholders across the NHS where possible. • MHIS update provided which shows some of the children and young people investments are tracking behind due to resourcing challenges. The children and young people posts are in the balance proving to be harder to fill than others. **Advise:** • No changes to financial sustainability in year, and long-term capital remains a challenge, albeit tracking behind capital spend in 23/24. • Agency now on track to target • Core trust surplus in December offset by adversity in the collaboratives. • An agreement has been reached with Tilbury Douglas for capital projects, which allows for better procurement, planning and ultimately execution of projects. **Assure:** • Focus on out of area beds continues, and trend remains positive, which has delivered financial benefits, and enabling service users to be provided with care closer to home. • Work has been carried out with other collaboratives to align reporting and ensure treatment of financials is consistent, demonstrating improved collaboration, but strengthening financial position given alignment.

	• Heatmap presented to act as cover sheet for IPR, which has been developed following feedback to provide greater focus on key areas. The committee were supportive of this development, agreeing it supported a more focussed review. •
Approved Minutes of previous meeting/s for receiving	Minutes of 20 November 2023

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

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Equality, Inclusion & Involvement Committee meeting held on 13 September 2023 Via Microsoft Teams

Present:	Marie Burnham (MBu) Dawn Lawson (DL) Mike Ford (MF) Erfana Mahmood (EM) Mark Brooks (MB)	Chair of the Trust (Chair of Committee) Director of Strategy & Change Non-Executive Director Non-Executive Director Chief Executive
Apologies:	David Webster (DW) Claire Hartland (CH) Aboobaker Bhana (AB) Greg Moores (GM) Iffath Hussain (IH) Chris Lennox (CL) Carmain Gibson-Holmes (CGH) Sue Threadgold (ST) Donna Somers (DS)	Non-Executive Director HR Business Manager Equality & Involvement Manager Chief People Officer Diversity, Inclusion & Belonging Lead Director of Services, Adults and Older People Mental Health Deputy Director of Nursing, Quality & Professions Deputy Director LGBT+ staff network Chair/Ward Manager
In attendance:	Sue Barton (SB) Rachel Irwin (RI) Dawn Pearson (DP) Gillian Cowell (GC) Paul Cartwright (PC) Catherine Musegedi (CM) Heather McKnight (HMc) Lindsay Jensen (LJ) Rachel Lee (RL) Zahida Mallard (ZM) Melissa Harvey (MH) Sophie Hempsall (SH) Mike Garnham (MG) Sarah Whiterod (SW)	Interim Director of Strategy & Change PA to Director of Strategy (author) Associate Director Communication, Involvement, Equality and Inclusion Carers staff network Chair/Carer Support Worker Head of Marketing and Communication Staff Side Lead for Equalities Equality & Involvement Manager Deputy Chief People Officer Non-Executive Director Equality & Involvement Manager General Manager, Adult Community Services Associate Director for Nursing & Professions Health Intelligence Analyst/Information Manager Associate Director of Nursing, Quality & Professions

Section 1 – Standing Opening Items

EIC/23/51 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) welcomed everyone to the meeting. Apologies were noted as above and the meeting was deemed to be quorate and could proceed. MBu advised that Sue Barton (SB) would cover the meeting from 2.45 pm as she needed to leave at that time. MBu confirmed that herself and SB had discussed the agenda earlier and would pick up with Dawn Pearson (DP) and Dawn Lawson (DL) how to rationalise this for future meetings at the next agenda setting.

Action: Marie Burnham, Dawn Lawson & Dawn Pearson

EIC/23/52 Declarations of interest (agenda item 2)

None.

EIC/23/53 Minutes of previous meeting held on 12 June 2023 (agenda item 3)

The minutes were agreed as an accurate record.

It was AGREED to APPROVE the minutes as an accurate record of the meeting held on 12 June 2023.

EIC/23/54 Matters arising from previous meeting and action log (agenda item 4)

Mark Brooks (MB) mentioned that a few actions had not been completed from June and acknowledged that this was due to capacity challenges over the last few months, however, we need to ensure plans are in place to complete before the next meeting. He also noted that some of the updates were in progress and should be more specific.

EIC/23/55 Actions from Trust Board (agenda item 5)

No specific actions raised at Trust Board.

EIC/23/56 Review of Committee related risks and any exception reports as required (agenda item 6)

SB advised that there were three risks, all due to be reviewed this month.

Risk 1729 – MB wanted to reduce the likelihood and to understand where we were getting the oversight from and what impact the local action plans were having.

Risk 1689 – MB felt the wording 'restoration of services' was no longer appropriate given that it had been included in the immediate aftermath of the pandemic, plus some of the controls should actually be comments. This needs feeding back to the corporate governance team. He also felt that some of the actions i.e., Risk 1157 were too wordy and could be more concise.

Mike Ford (MF) was keen to understand whether completing the actions was going to get the risk to the level of the appetite/target risk set.

MBu asked if EMT cross referenced with the other risks held by other Committees to avoid duplication. MB confirmed that mostly they were assigned to one Committee but there could be some overlap. MF confirmed that the wellbeing risk is shared between this Committee and the People Remuneration Committee.

SB confirmed that the risks would be updated prior to the next meeting. Lindsay Jensen (LJ) confirmed she was happy to be involved looking at the wellbeing risk.

Action: Dawn Lawson & Lindsay Jensen

Rachel Lee (RL) asked for more detail about the local action plans in relation to staff survey results being implemented. MB confirmed this wasn't in the risk register. SB advised that the care groups are on rotation reporting into Committee so would get more detail from these. Sophie Hempsall (SH) would be providing today's report on Barnsley Community Services which hopefully would provide the assurance RL required.

The Committee NOTED the current Trust-wide corporate/organisational level risks.

EIC/23/57 Context report – National, ICS and Trust level (agenda item 7)

DP advised that she would provide a cover sheet for the context report summarising the highlights for the next meeting in December.

Highlights included: -

- Mental health and wellbeing plan – NHS England were looking at this but have now decided to look at a major conditions strategy. The physical health paper will include conditions such as cancer, respiratory disease, dementia, MSK as well as mental ill health and tackling health disparities. Awaiting further information.
- NHS EDI improvement plan – have already mapped as a Trust what we are doing and this has gone through EMT and into EI&I Sub Committee and are starting to think about how this embeds into the work we are already doing.
- Wider determinants of health – deep dive by Dame Clare Moriaty, Chief Executive of Citizens Advice Bureau, how the impact of ill health is much more led by economic and physical environment and less about the clinical care received – calling for connections between this type of advice as well as care.
- Cliff Edge – how integration can support inclusion health groups and the health and care system as a whole.
- Protected patterns around illness in England. The number of people living with major illness is projected to increase by 37% – over a third – by 2040.
- Poorer care and lower life expectancy for ethnic minorities with a learning disability. The average age of death for people with a learning disability who are from an ethnic minority is 34 years, just over half the life expectancy of white counterparts, at 62 years of age. Need to ensure we get reasonable adjustments in place e.g., access and translation services and making sure our services are culturally appropriate and staff reflect our population.
- Supporting LGBTQ+ patients – not making assumption about identity and need to think about training our workforce. We are working on the LGBTQ+ framework to map some of the items against it to see what we can do to improve.

MB would like to try as a Trust to do some high level promotion around learning disabilities and life expectancy (22-26 years younger than general population and in fact even lower in Barnsley). Subha Thiyagesh is the Exec champion on learning disabilities and there is a focus on this at the face-to-face extended EMT session in a couple of weeks. We need to do all we can to reduce this life expectancy gap.

Erfana Mahmood (EM) asked if there was any way to make this report more simplistic for teams as it contained so much information and also whether we circulated to our networks. DP confirmed she presented the slides and update from Committee to care groups and OMG and also shared literature directly with teams if they are working on a specific topic. Zahida Mallard (ZM) collates all the information which is provided in the report. There is also a literature bank on the intranet. DP advised that they could share with the networks in future. MF felt the summary sheet which will be prepared for the next meeting will also help in disseminating some of the key points.

The Committee NOTED the contents of the context report.

Section 2 – Insight, feedback, and programme updates

EIC/23/58 Staff network update (agenda item 8)

LJ provided some highlights: -

Iffath Hussain (IH) has been supporting the networks. Naomi Fernandez (NF) started a couple of weeks ago as Head of People Experience. The networks have highlighted some of the challenges around forming a network and attending events and groups. IH and NF will be visiting all the networks to try and understand what they need and what support we can offer and a report will go to EMT with some suggested proposals for approval i.e., protected time for network chairs to carry out their duties, what admin might be required and funding pots to help achieve some of their actions. The networks are very valued.

Disability Network
LJ advised that the presentation today would be from the disability network.

REaCH
Catherine Musegedi (CM) advised that there were currently 3 steering group members. Will be encouraging others to apply and are just trying to keep the network afloat at present. Planning a celebration event this year on 27th October to coincide with Black History month.

Carers Network
Gillian Cowell (GC) advised that the network continues to grow and that this will hopefully get larger after the roll out of the staff carers awareness training.

Staff carers retreat at Parceval Hall on 24th November – fully booked and have a short list for the next. Hopeful this could be an annual event and a funding pot would be useful for the future to forward plan.

First brew to renew held in Wakefield – well attended. Next in Barnsley on 5th October and then Calderdale and Kirklees.

Continue to maintain our level 2 status. Following a meeting with Care UK, we believe we could achieve level 3 which would mean we would be the first Trust in the North of England to gain this level if successful and the second Trust in the UK.

Continue to support staff carers on 1 to 1 and group basis.

Network elections taking place in November.

EM mentioned EyUp! charity being able to support the staff carers network.

LGBTQ+
The network will have its election process starting next month to appoint a new chair with potentially additional generic steering group members.

Have a communication action plan and LJ attended a meeting where there were lots of ideas how to move forward.

Pronoun posters are now on display and people can start to use their pronouns on their signature on Teams.

MB stated the importance of the staff networks and what a good job they had done over the years and that they were now in a transition stage due to chairs and steering group members moving on or positions expiring and that it was important to take a step back to ensure we give networks the support they require to function effectively. NF will be meeting all the networks and sending out a questionnaire to see what the barriers are for becoming a steering group member, what is working well, what isn't and what realistic support they need from the Trust. We need to mirror other Trusts and offer the appropriate level of protected time.

MF mentioned NF doing some work to protect that time but noted that Jacob, Nasheen and Racquel have had to move on from being chair and vice chair of the REaCH network and wondered if we could encourage them to stay on from a continuity point of view. MF mentioned that he would like to see the celebration event done properly rather than quickly – the 27th October makes sense from Black History month perspective but need to ensure it is a success. CM is keen to do this event as meetings are always online and not face to face and it will be a good networking event where

people can drop in and see each other face to face and find out what's important and how to move forward. CM advised that it was not so much about protected time but what support they could get from the People Directorate too. Most of the network are clinical and time is limited but would be good to get some commitment from the directorate. MBu wants the networks to be successful so we need to support them appropriately. MBu thanked GC for her hard work as the carers network is now thriving.

LJ advised that unfortunately Elaine Shelton (ES) was not able to join the meeting but the slides had been prepared by her.

Network Aims

- To empower & support staff with a disability/ongoing long term health condition to achieve and/or maintain their potential.
- Maximise the contribution of staff in delivering the Trust mission, values and strategic objectives.
- To help shape and influence policies & procedures within the Trust to ensure that equality is proactively considered.

Last 12 months

- Network election process underway.
- Joint review of network polices with the view to identify protected time for chair.
- Continue to increase membership numbers by engagement at welcome event – need to look at what we can do to promote this across the Trust.

What's Next

- Develop annual comms plan and action plan with support from DIB Lead.
- Newly appointed network chair to attend all network chairs meetings to join collective workstreams and build alliances.
- Update network internet page to make mention of newly appointed steering group, annual network members meetings and/or event details.

What We Need To Do

- Review all disabled staff network related comms with the view to develop new screensaver, signature line, logo and lanyards.
- Sunflower membership plan considered.
- Develop network members blogs and set up social media page for staff to share experiences and stories.

MBu liked what all the networks do collectively and she is hoping that NF will pull this all together and develop it further.

MB advised that Miriam who recently joined the Trust has a physical disability and uses a wheelchair and has been able to provide insight around access into Block 7 – what's easy and what's difficult – and we can learn from people's lived experiences.

MF asked what sunflower membership was. LJ advised that in terms of the lanyard, this showed that an individual had a disability. Some disabilities, conditions or chronic illnesses are not immediately obvious to others so it would encourage inclusivity, acceptance and letting everyone know that you might need extra help, understanding or just more time.

MBu left the meeting and SB covered the remaining items, agreeing to catch up after to ensure all was reported on the assurance form to Trust Board.

The Committee NOTED the staff network update and presentation.

EIC/23/59 Care Group Highlight Report (agenda item 9)

Sophie Hempsall (SH) presented a paper on behalf of Barnsley Community Services, which comprises physical health, mental health, stroke and neuro rehabilitation – highlights included: -

- 3 key EIA actions in progress, all RAG rated amber - one around marriage and civil partnership, one around people omitting/refusing to give information pertaining to protective characteristics and one around improvements in data capture on protected characteristics in physical health SystmOne units.
- Total service EIAs – improving picture around numbers outstanding. None which are excelling but several achieving, a large amount developing and 1 underdeveloped and 1 which needs reviewing.

Equality highlights: -

- The Trust has a policy for service users which includes best practice in supporting people from the LGBT community (Children's SALT) - There is an NHS rainbow lanyard/badge campaign. Staff have requested the rainbow pin badge and are wearing it as part of a clear message to service users that we are open, non-judgmental and that service users can have an open and honest conversation about their sexuality if appropriate with our team members.
- Barnsley community mental services have developed pronoun posters collaboratively with TransBarnsley and the E&I team.
- Staff returning from maternity leave (Children's SALT) - We make sure all staff returning from maternity leave, who continue to breastfeed, are aware of their right to request a private area where they can express and store breast milk. To date, one member of staff who has returned from maternity leave has requested this facility.
- SWYPFT staff recognise disability (Continence and Urology Service) - Specific toileting aids can be given to those who have mobility and dexterity issues. The service aims to give people as much independence as possible.
- Understanding the needs of a diverse population.(Live Well Wakefield - Discussion around pronouns is invited regularly in the office environment within the service and some members of the team have opted to include this information on their email signatures. Clients are invited to inform us of their preferred pronoun and name. This is documented on client records and staff actively take note and adhere to the client's requests.
- Understanding the needs of a carer from carer perspective. The Family and Friends Team in Barnsley have developed a support plan for carers called the CAN Plan. This focuses on the carers Choices, Aspirations and Needs and is completed collaboratively with the carer and is carer led with emphasis on the carers perspectives on what they want and how it can be achieved rather than it being service led.

Involvement highlights: -

- Palliative, end of life and supportive care at home team. The end-of-life care team has reviewed and subsequently revised My Care Plan, an individualised plan of care for those in the last days of life which promotes co-planning and a person-centred approach to care.
- Live Well Wakefield - When the team hasn't been able to contact a client, 'opt in' letters are sent. The letter explains that they haven't been able to successfully contact them, asking them to "opt in" and contact the service if they wish to receive support. Feedback was received from clients that this may be interpreted as being negative, which can negatively impact on their health and wellbeing. The service is reviewing and re-writing the letters also incorporating a trauma informed approach.
- School Age Immunisation Service - NHS England's North East and Yorkshire School Aged Immunisation Service Stakeholder Engagement took place in 2022. They undertook service user and stakeholder engagement to help understand if the service currently meets the

needs of all regional populations and if any improvements could be made for the procurement of the new School Aged Immunisation Service. This survey was shared via our schools, local GPs, via social media and with our children and young people partnerships.

MB advised that he had had a couple of people contact him to advise that they had been subject to racial abuse or are aware of this. MB asked what was done about this to prevent it from happening again. SH advised that this was discussed at general manager/operational manager level and addressed through HR processes. Looking at ways to address this more thoroughly going forward as currently don't have an equality and involvement forum and hope to set this up this year or next to bring issues to light so a wider discussion can take place. Will also link in more with Estelle in Freedom to Speak Up as it is an ongoing concern.

ZM advised she had seen Datix today and felt that some managers sometimes don't know what to do with what is being said/don't have the tools to manage it so it keeps happening and this has a ripple effect not only on that individual as they share with colleagues internally but they also take this information back to the communities in which they live. MB advised that Monique Carayol (who delivered a session in Pontefract some months ago around talent management and supporting people with protected characteristics advance their careers) is attending the EMT Time Out in November. It is our responsibility to call it out, make sure it isn't overlooked and do the right thing to eradicate racist comments. EM felt it was a cultural issue and undermines the work we do and will affect the work environment and some aspects of how services are delivered.

The Committee NOTED the contents of the Care Group highlight report.

EIC/23/60 Patient/Public Story/Campaign (agenda item 10)

DP presented a film about sight loss (Sam talking about her disability and things that would help her in her day-to-day life particularly when accessing health services).

The Committee NOTED the film.

EIC/23/61 Insight report (agenda item 11)

DP confirmed that this report comes to Committee twice per year, goes to EMT and is a collection of the issues which have already been resolved in the system and not issues being left.

Quarter 1 – March May – themes around community mental health team, crisis support, the Dales and ADHD.

Quarter 2 – June-August – themes around waiting times for CAMHS, autism, older people's mental health services and talking therapies.

MB mentioned that it was a very lengthy report and could possibly be summarised for future meetings. MB asked how well we promoted the inbox and if people were aware that this was how they could comment. DP advised that governors can use this together with Healthwatch colleagues and ICBs and that they are currently looking at offering to MPs.

MF mentioned there was quite a lot of feedback around single point of access but it didn't appear to have been picked up in the we responded section. Heather McKnight (HMc) advised that single point of access was identified in the you said, we listened section in Quarter 2 and an update will be provided this quarter confirming what progress has been made. MF asked if he could pick this up with HMc outside of the meeting.

Action: Mike Ford & Heather McKnight

MF asked if people with coeliac were different from people with gluten intolerance and wondered if our response regarding gluten free menus doesn't respond to coeliac. SH confirmed that if you had coeliac disease, gluten free was the way to manage it.

EM mentioned that single point of access was an issue. MB confirmed it was a challenging environment. Melissa Harvey (MH) confirmed that they respond to everything which comes in and note all the feedback. They speak to over 1200 service users per month. Management are doing everything they can to support staff who are dealing with a high volume of people in distress and are looking at an initiative to ensure that everyone leaving SPA has had a positive experience.

The Committee NOTED the update.

Section 3 – Strategy and Policy

EIC/23/62 Strategy and Policy (agenda item 12)

Nil.

Section 4 – Performance Reports

EIC/23/63 Equality dashboard (agenda item 13)

SB advised that the dashboard had been updated.

LJ presented the disability workforce information.

Looked at information in terms of recruitment and the likelihood of people being shortlisted for a role which was 0.79% - 1 is what we hope to achieve. Breakdown by pay band as below:-

Recruitment by pay band 1-4: 0.9
Recruitment by pay band 5-7: 0.76
Recruitment by pay band 8+ : 0.62
Medical/dental : 0.91

Training figures:-

Training completed 6% (all staff)
Training completed 6% (excluding medics)

No disabled staff entering a formal disciplinary process over the last 12 months.

Abuse/harassment of staff - Quarter 2: 53 x total of incidents reported, 1 of which was disability related.

ZM mentioned a discrepancy between this report and the WDES regarding capability and having a disciplinary, but this could just be due to the time frame. LJ confirmed this was the case.

DP reported that the report detailed the proportion of population which were recorded as from an ethnic minority group as follows:-

SWYT 14.2%, Barnsley 3.1%, Calderdale – 13.9%, Kirklees – 26.4%, Wakefield 7.0% and referrals in Kirklees were quite high.

Mike Garnham (MG) had built on a paper presented to the Mental Health Act Committee and Equality, Inclusion & Involvement Committee last September and updated it using the format developed around health inequalities and how different ethnicity groups accessed services.

MG advised that to help highlight variation in access to mental health services, an Equality Metrics Comparison Tool has been developed that pulls together information from various sources into a single table. It allows comparison of various metrics by ethnicity, deprivation, age and gender and quickly highlights variation. As this report continues to develop, other metrics will be included.

MG presented information on the Adult and Older People's Community Mental Health services. Hopeful to bring in additional metrics going forward.

SB thanked MG for the work on this and asked what we were going to do with it. DP advised that the data and insight will also inform the older people mental health service inpatient transformation equality impact assessment and ensure that any inequalities or further lines of enquiry are picked up as part of this programme.

MF asked when we will see specific actions being taken as a result of the work and start receiving cases studies to say this is the data we have found, this is what we are doing about it and this is how we changed the data as a result of the actions we took. DP confirmed that they were starting to get the case studies together and will report back on the work in December regarding the CAMHS service in Kirklees. Lots of work has taken place and will put some in the annual report. The team are now actively working with those communities and addressing improvements in a co-designed and co-productive way. The data is organised now in a way we can meaningfully use it and start to make improvements.

The Committee NOTED the development of the dashboard.

EIC/23/64 Equality, Involvement, Communication and Membership strategy implementation action plan highlight report (agenda item 14)

DP provided some highlights: -

- EIAs – all green and graded with some fantastic examples. Some teams are excelling in the way they are doing an EIA.
- One of the actions around developing a toolkit using survey monkey had a deadline of July but needs to be deferred as outside our control. The licencing and contract has provided some challenges. The team are doing an options approval and will take through governance and EMT. May not use survey monkey.
- FLAIR survey findings and recommendations have been shared with EMT and will be shared with the REaCH network and Race Forward to ensure the Trust monitor the identified actions and progress and look at additional opportunities to support staff. First year of survey and want to ensure we have the right actions in place to address the recommendations. The second survey will be done in January.
- As part of our commitment to carers, the Trust are introducing the Triangle of Care model across all services. The Triangle of Care means including carers at all levels of care, giving them equity in the service user journey, and help promote safety, support recovery and improve wellbeing.
- Improving prayer and ablution facilities for staff.
- Community connectors programme actively running – 48 connectors trained – delivering 3 sessions of training.
- The transformation of older people services is now gaining pace and a huge amount of work has taken place to involve all stakeholders. The Trust is currently moving towards consultation and work is progressing to develop a consultation plan in partnership with each of our places, consultation materials and a robust EIA. This work will help us to deliver a consultation in Autumn 2023.

DP flagged that they wanted to think about the metrics around the data collection on some of the percentage targets and review the data threshold and come back to Committee with a

proposal in December and also ask for a grace period with regard to the toolkit and survey monkey until January.

CM mentioned that the FLAIR survey had been shared with members of the REaCH network but not staff side and had also come to them with recommendations. MB suggested that before we repeat the survey in January, we take a step back and work with the networks and other interested parties around how we manage it next time, looking at who we need to engage with and the time scales. DP advised that this was the first time we have run this and the recommendations were from the independent organisation. We ran with their recommendations but we can shape our own. We need to work on getting it right for the second round and make sure it lands with our networks and staff side are fully sighted on it.

MB mentioned Race Forward and that over the last 7 years there have been many stop/starts with this and wanted more understanding about whether we had this right, what we had learnt from it, what positive difference it is making and what else we might need to do.

Action: Dawn Lawson & Dawn Pearson

LJ mentioned that we were speaking to different stakeholder groups, networks and staff side using the FLAIR survey results as an opportunity for more engagement. LJ feels that January is too soon and may need to push this back. LJ would also like to see what's happening with Race Forward and what impact it is making.

The Committee NOTED the report and APPROVED the revised timeline for the development of a toolkit and to progress the evaluation and review of the metrics to improve data collection.

EIC/23/65 Equality Standard update (WRES & WDES) (agenda item 15)

LJ updated on the WRES and WDES annual reports. The data was produced at the end of May, submitted and published on the NHS England website. Now have until the end of October to put together our thoughts and actions about what our data is telling us in terms of improving and making a difference.

For both, a draft action plan had been produced (work in progress). These are quite lengthy and could do with being more concise but still have time to do a bit more work on them before they go to Trust Board. May also be worth focusing on just two or three priorities rather than doing too many.

WRES Headlines: -

Have seen a small increase in BME staff in the workforce as of 31st March 2023 to 12.8% - approximately 94 staff working in the Trust. Positive.

The first 4 metrics look at the workforce demographics and the others are based on the likelihood of being shortlisted, entering into formal disciplinary, training etc. These have improved from last year. Disciplinary – now below half this year. Have done some work around this process and early resolution. The metrics from 5-9 are taken from the staff survey and are mixed but can see BAME colleagues have a worse experience of bullying and harassment than white colleagues so need to see if Race Forward is helping.

The WRES action plan is broken down by those metrics and attempts to showcase what the actions are we are taking.

EM is a supporter of overseas recruitment but wanted to know if there was any way we could pull out the figures of whom we are recruiting locally from our BME community. LJ confirmed that we didn't use NHS Jobs to recruit international nurses so they weren't coming through the same data

sources so didn't think they were included but could double check. MB felt they weren't included. ZM mentioned that some of the information was from NHS Jobs and some was from the staff survey so we weren't using a consistent data set. Also, hears a lot about EDI but the WRES data across the system may look like it has improved due to international recruitment. LJ confirmed it was a national reporting tool and we get data from different sources. ZM also mentioned that in future we would also have to include bank staff and medical. LJ advised that they hadn't done medical WRES this year and were in the process of looking at a post to support this and have chosen to do the bank WRES next year.

LJ will look at the action plan once again and take on board any comments from this Committee as well as the People Remuneration Committee to streamline it. Looking at 2 or 3 things is the way forward rather than diluting it with too many but want to showcase the whole breadth and scope of what we are doing in a concise manner.

MF noted that the number which had moved the most dramatically is the likelihood of BAME staff entering a formal disciplinary process and was this because of the action we took or because numbers are insignificant – LJ confirmed it was a bit of both and that during Covid they had brought in an early resolution process to deal with any conduct issues much earlier than going to a formal disciplinary, had introduced a cultural competence questionnaire and ensured we had a diverse group of people looking at this on the decision making.

WDES headlines: -
LJ advised that the WDES was similar in terms of the approach. Have seen an increase in people feeling able to disclose their disability – those non-declaring are reducing but more work to do with our networks around this. Seeing from the staff survey that disabled people are feeling that they don't have the same opportunities and are feeling bullied and harassed so this is an area to focus on.

The WDES action plan had been produced but again needs to be more concise to show that the actions taken are going to make a difference, some of which will be long term.

EM felt that we were gathering meaningful data and that equality and inclusion was the golden thread but still have some entrenched issues which haven't moved on for years e.g., bullying, harassment and access. EM asked if it was possible to work out the priorities in the short, medium and long term.

Action: Lyndsay Jensen & Iffath Hussain

The Committee NOTED the update.

EIC/23/66 Equality Delivery System (EDS 2022) Update (agenda item 16)

ZM advised that having had conversations in early August with West Yorkshire ICB EDI leads that they have stated they would do some data around the Core20PLUS5 and choose a maternity based service and A N Other. In the paper, there are two pathways/streams of work which we will be collecting/capturing evidence on.

Meeting held on Monday advised there may be an additional service around children and young people's mental health. Have a proposed timeline for when we can get our internal evidence and scoring before we take it out to the stakeholder panels in January.

DP advised that we wanted to progress and get a structure around it so we had to push back this week as we had agreed as a system the work we would do across Calderdale, Kirklees and Wakefield as well as Barnsley. The broader ICB decided the theme needed to change but we are

negotiating with them. We need to be able to get the resources in place to be able to do the deep dive and can't do that in a short time frame.

MF asked how we were meant to recommend these themes align with West Yorkshire but also meet the needs of South Yorkshire. DP advised that both systems are doing slightly different variations of the same thing so have negotiated with the ICB the themes which will add value to what they are doing but ensure we are doing one thing for our Trust and not just for one place. Their focus is around children and young people services and have not yet committed to the themes.

The Committee NOTED the update.

EIC/23/67 Internal Audit Reports (agenda item 17)
Nil.

Section 5 – Annual Items
EIC/23/68 Draft Equality, Diversity & Inclusion Annual Report for Trust Board (agenda item 18)
DP advised that this was the first draft of how we might present the annual report and that it was a work in progress. The data is still being updated but Committee were asked to comment on the format, layout and content. The forward planning and the actions we are going to focus on will be done in December with the aim to publish in January/February.

Action: All

Section 6 – Governance
EIC/23/69 Governance (agenda item 19)
Nil.

Section 7 – Standard Closing Items
EIC/23/70 Work Programme (agenda item 20)
Noted.

EIC/23/71 Items to bring to the attention of Trust Board or other Committees (agenda item 21)
SB detailed items to be included in the assurance form: -

- Risks and review of risk register.
- Importance of staff networks and discussions around how we support them and the work that NF is going to do.
- Highlights from the Barnsley Community Services care group report and the deep dive into all the work which is happening.
- Patient story.
- Equality dashboard and our work around what we are going to do next.
- WRES and WDES.
- Annual report.

MF suggested we should also share the themes which have come out of the insight report with the Board.

EIC/23/72 Any Other Business (agenda item 22)
None.

EIC/23/50 Date of next meeting (agenda item 23)
The next meeting will be held on 13 December 2023.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Audit Committee held on 10th October 2023 (Virtual meeting, via Microsoft Teams)

Present:	Mike Ford (MF) David Webster (DW)	Non-Executive Director (Chair of the Committee) Non-Executive Director
Apologies	Mandy Rayner (MR)	Non-Executive Director (Deputy Chair)
In attendance:	Rob Adamson (RA) Imran Ahmed (IA) (item 9) Caroline Jamieson (CJ) Claire Croft (CC) Leanne Hawkes (LR) Lianne Richards (LH) Nick Phillips (NP) Adrian Snarr (AS) Julie Williams (JW) Nicola Wright (NW) Paul Foster (PF) (item 15) Jane Wilson (JWi)	Deputy Director of Finance Head of Procurement Senior Manager, Deloitte Principal Anti-Crime Specialist Deputy Director, 360 Assurance Client Manager, 360 Assurance Deputy Director, Estates & Facilities Director of Finance and Resources Deputy Director of Corporate Governance Partner, Deloitte Assistant Director of IT Services & Systems Development Note taker

AC/23/77 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF) welcomed everyone to the meeting. Apologies were received from Mandy Rayner, and the meeting was deemed to be quorate and could proceed.

MF 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.

AC/23/78 Declaration of interests (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board or subsequently.

AC/23/79 Minutes from the meeting held on 11 July 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Audit Committee meeting held on 11 July 2023 subject to the recommended changes.

MF made reference to a comment Mark Brooks, CEO, had made in Trust board around the triangulation report and there being lots of cross referencing between committees and he confirmed this would be discussed further during the triangulation report update.

MF referred to page 18 of diligent and a comment that Claire Croft (CC) had made around exception reporting, and he wondered if this should have been captured as an action. CC responded that at the previous meeting JW advised that this was work SWYPFT could do, and it would be picked up as part of the risk assessment and the actions from that.
JW agreed to discuss this further with CC outside the meeting and then update JWi in terms of the wording around this action.

ACTION: Julie Williams

Nicola Wright (Deloitte), referred to page 5 the external audit progress update where it stated that Deloitte signed the opinion and that it was modified as discussed at the last meeting. She said this reads as if the opinion was modified, and their opinion was not modified it was unqualified. NW felt it would be helpful if this was made clearer in the minutes.

ACTION: Julie Williams

AC/22/80 Matters arising and action log from the meeting held on the 11 July 2023 (item 4)

It was recommended to close the following actions:
AC/23/67, AC22/57, AC23/73, AC23/74, AC23/76, AC/22/57, AC23/33, AC23/48

AC23/73 ligature audits
MF remarked that there was an action delegated from Board for the committee to look at the ligature work within the health and safety activity. At the previous meeting it simply stated in the report that there are ligature audits. In the matters arising it states this has now moved to Quality and Safety Committee (QSC), so MF was unsure whether the committee had fulfilled its requirements enough in terms of overseeing this.
JW commented that she attends the QSC where the ligature audit programme and works are discussed in detail and also how ligature risks are mitigated in clinical settings. She said in terms of the report from Nick Phillips (NP), Estates is only a part of this, and any capital spend around those ligature risk audits is discussed with clinical colleagues as part of the capital work plan.
NP commented that the Clinical Environment Safety Group also reports in through the Quality Safety Group (QSG).

JW remarked that we need to be very mindful of duplication between committees.

MF said the key question for him is what the Board actually asked us to do as a committee and when was it asked.
AS wondered if it might help initially if an example of a ligature audit report that goes to QSC is shared with the committee.

MF thought the easiest thing to do may be to raise the question in the next private board session so they can confirm whether or not they are receiving the right level of assurance and that the committee have fulfilled their responsibilities.

ACTION: Mike Ford

It was RESOLVED to NOTE the updates in relation to the action log.

AC/23/81 Actions delegated to Audit Committee from Trust Board (item 5)
MF confirmed there were no further actions delegated from the Trust Board to Audit Committee.

AC/23/82 Consideration of items from the Organisational Risk Register allocated to the Audit Committee (agenda item 6)
JW presented the update stating that a tracked changes version of the paper had been circulated to committee members.
MF remarked he was happy to take the paper as read. He referred to a comment he had made at the previous meeting around capacity and the late delivery date against this.
JW responded that the risks are reviewed on a quarterly basis, and they are also monitored by OMG and EMT so they would look at any changes and any risks to delivering those system wide objectives by the year end. She said she was not concerned about the capacity challenge as what we are saying is we would expect that risk to have been fully mitigated by the end of May 2024. Also as mentioned earlier Dawn Lawson has now started in her role so this has mitigated quite a significant risk in terms of our ability to meeting our strategic objectives and the priority programmes.

MF remarked that whilst he hears all that is being said, if he looks at the risk action on capacity there is a mention of stopping some activities based on risk assessment and the date for this is May 2024, so his argument is, isn't this is a bit late to be stopping something if we have a March 2024 year end.

AS explained that we will be into a planning round within the next month or so, and the plans should be concluded by the end of March for implementation financial year 2024/25 so he agreed that an action date of May 2024 feels two months too late in that planning cycle. He agreed to take an action away to understand what the rationale was behind that date of May 2024 and see if it needs to be revised or the explanation amended.
MF agreed with this suggestion.

ACTION: Adrian Snarr/Julie Williams

MF referred to the Covid Inquiry risk which has quite a high level of risk compared to our appetite, he said currently he is not hearing or reading anything that suggests we as a Trust are in the line of sight for the Inquiry.
JW responded that the level of this risk reflects the unknown in the Inquiry and currently the focus is very much on the government's role in the management of this and they have not moved on the module where they will look at individual NHS/social care organisations. She said there is nothing on the radar to say that we have a high level of risk as an individual organisation, but we were part of a wider system and that is the reason is has been kept at this level of risk, and this will continue to be monitored.
JW confirmed they are as fully prepared as they can be and have all the documentation required for the next stage of the Inquiry.

It was RESOLVED to NOTE the current Trust-wide corporate / organisational level risks, relevant to this Committee, and NOTE comments made in relation to the risk content, risk levels and risk appetite.

AC/23/83 Triangulation of risk, performance, and governance (agenda item 7)

JW presented the update stating she would take the paper as read. She stated the committee will see that this report continues to develop, and as mentioned earlier she agreed to take away an action to look at where some of the risks are going to multiple committees, and report back on this at the January meeting.

ACTION: Julie Williams

DW referred to the Section 136 suites, he said whilst he appreciates this is quite operational and that is why it is not included in the Integrated Performance Report (IPR) he wondered whether being part of the wider system does this put more pressure on our partners when these suites are out of action and as a result would it make it more of a strategic risk.

JW responded that it would certainly put pressure on the local police force, and they are currently changing the way they respond to mental health incidents, Carmain Gibson Holmes is leading on this programme of work for the Trust. She confirmed it is definitely down to a day to day operational assessment rather than strategic impact at the moment and this is being continually monitored.

AS remarked that when the relationship with the police changes around how they respond to mental health incidents, the actual pressure around the availability of S136 suites will not necessarily change but the implications of S136 unavailability might have more strategic or partnership implications.

MF asked what the committees views on him doing an annual call out to the board on this section of the report, with a view to receiving confirmation at board level that they are comfortable that these 6 risks do not feature either in the IPR or on the Board Assurance Framework (BAF).

AS responded that an annual call out to the board was a good idea and although he did not think we should change the IPR he thinks we should keep it in mind when we start doing the care group and ward level analysis. He suggested that JW takes this away for OMG to see what their view is on this.

JW agreed that an annual call out to the board would be helpful, although she takes assurance from the OMG minutes, so can see that these are discussed in detail. Also, there is an OMG escalation report through EMT, so if any of the risks were starting to become issues they would come through EMT.

MF confirmed he would make a note of this for the AAA report. He commented that when he first chaired the committee there was only one risk that fell into this category and now there are 6 and this feels like a gentle drift towards there being more exceptions to the overall concept of triangulating between the different reports.

ACTION: Mike Ford

MF thanked JW for the update.

It was RESOLVED to NOTE the updates on the Triangulation of risk, performance, and governance.

AC/23/84 External Audit Progress Update (agenda item 8)

Nicola Wright presented the update stating that following the completion of their work it had been agreed at the previous meeting that the long form auditors annual report would be brought to this meeting for information, she said the report was in the usual format and brings together all the work that has been carried out in the year.

NW remarked that she just wanted to reiterate what she had said earlier in that Deloitte did not modify the opinion as they did not have any significant weaknesses to report when they looked at the Value for Money (VFM) arrangements. She said they did highlight some recommendations in the more detailed narrative of the report and both RA and AS have provided feedback on these. NW informed the committee that in relation to the annual auditors report she had presented a summary set of slides at a meeting with the governors.

MF remarked that some of the VFM comments were around the provider collaborative arrangements and our role as coordinating provider, and AS and himself need to bring this to the attention of the Collaborative committee in terms of the actions raised and what we are doing about them. AS agreed to meet with MF outside the meeting to discuss how they are going to approach this.

ACTION: Mike Ford/Adrian Snarr

MF passed on his thanks to NW, CJ and the team at Deloitte for all the work that had gone into getting the Trust through this process. He remarked that he had attended a meeting of Audit Committee chairs for all West Yorkshire provider trusts yesterday and there were still some that were not filed yet, so he said the Trust are in a good place.

It was RESOLVED to NOTE the External Audit update.

AC/23/85 Procurement update (agenda item 9)

Imran Ahmed (IA) presented the update stating that having done a full review of the format of previous reports, this is a new format which includes 5 sections, the contents of which are all more appropriate for the Audit Committee. He remarked that in terms of the items that have been removed, these were being reported at other meetings that he attends on behalf of the trust.

Key headlines:-

- Four contracts which exceeded the Trust's tender/quotation threshold were awarded in the first quarter of 2023/24, totalling £1.77m.
- In comparison with the same period (Q2) in 2022-23, quotation/tender waiver activity is

lower in 2023-24 in both the number of overall waivers and the total value which is £146,600 (8% lower for the same period last year).

- Eleven major contracts are currently in progress for Q3 which are or have been formally tendered via the Trust's eTendering solution or through frameworks.
- Contract expenditure £1.5m
- Non contract expenditure £32m
- The trend for the second quarter shows a high level of contract compliance and has seen a reduction in spend for both Contract and Non-Contract Expenditure from the previous quarter.
- Following a meeting with Claire Croft (CC) (360 Assurance) it was suggested that as well as the current self-declaration of no conflict of interest signed by the evaluation panel, further due diligence will be introduced to make the current process more robust. The Procurement Lead will undertake a company house check of individuals on an evaluation panel and people listed for the bidding companies and where there are links in names, further due diligence will be carried out to ensure there is no conflict. This will be done for 10% of the tenders carried out throughout the year and details will be shared with the Audit Committee.

MF thanked IA for the update.

DW questioned whether IM was looking at directors, shareholders and people of significant control in relation to companies' house checks.

IA responded that he has looked at the people part and it lists all the ones who are active. DW remarked that there are two parts to this, directors and persons of significant control.

IA responded that he appreciated the feedback from DW and he will focus on this more next time.

JW commented that IA could also look at the Trusts declaration of interests, as all senior decision makers complete a declaration of interest form. MF commented that having read the paper it suggests IA has already looked at this.

IA confirmed they have looked at these and that this is going beyond this for further due diligence.

MF remarked that as this is the new version of the report he would appreciate if IA could let him know outside the meeting which items he has removed so that he can endorse this version going forward. He said it would also be helpful if IA could provide a list of abbreviations in future reports.

ACTION: Imran Ahmed

MF remarked that he was keen to understand the context around expenditure and he asked IA if he could try and reconcile this in future reports, also could he ensure that whatever the proportion of total expenditure is for this year/quarter that what is being presented in future relates to this. He appreciates that it is difficult ask as some of these future contracts are going to be expenditure spread over years to come.

ACTION: Imran Ahmed

MF remarked that as IA had joined the trust quite recently it would be good if in a future report at some point he could give the committee a sense of what he thinks to SWYPFTs procurement processes and the department he is heading up. Also, how we as an organisation carry out our procurement against what he might consider to be best practice he has seen elsewhere or best practice generally. MF said there was no rush for this and if he wanted to take 6 months or so

that is fine, but he felt it would be useful for the committee to learn from his experience elsewhere, and where we potentially may be able to improve going forward.

ACTION: Imran Ahmed

AS stated that the West Yorkshire level of controls that are either in place or coming in place and non pay expenditure is one of these. He said the work that IA is doing in the team and also with RA and himself is particularly around making sure we market test wherever possible to demonstrate value for money, not only for ourselves, but this is the evidence we will provide externally that we have good control and grip over our non pay expenditure. He explained that some of this will be extracted into system wide assurance and there is clearly a lot of focus on agency.

MF asked how much of the agency spend does IA control. AS responded that he does not control it, it is the budget holders and the clinical decision makers who own this, but it all goes via the procurement team as it should all be on framework contracts.
MF asked if we are recruiting a member of agency staff will it still come through procurement opposed to an HR route.
RA responded that procurement would help set up the master vendor contracts etc but the normal day to day things would go through the temporary staffing team as they do not have authority to go off framework.

MF thanked IA for a really good report and helpful update.

It was RESOLVED to NOTE the Procurement update.

AC/23/86 Treasury Management Update (agenda item 10)

RA presented the update stating interest rates remain very positive with 14 consecutive increases in a row, which means the GBS base rate received for all our accounts is 5.25% which is really positive. He stated this does not significantly change the Trust approach to treasury management however it does increase the incentive to ensure that the cash position is maximised in order to secure the highest possible return and support the overall Trust financial position.

DW remarked just for clarity, of the 14 consecutive rate increases the last one was not an increase, so the Bank of England are suggesting they are now about at the top and could potentially start to come down over the next couple of years.

RA responded that he has flagged in the report that the Libor rate on the day had come down on the previous quarter, which is an indicator that he needs to pick up with Susan Baines, Head of financial accounting about where our investment threshold was with a view to locking some of that money in.

MF commented that based on the comment from DW we might want to have a slightly different look at this in the next quarterly report and maybe give it a bit more time on the agenda.

AS remarked that at least two of our neighbouring trusts are into a position where they are having to borrow cash via the treasury. He explained there is a mechanism in place that says cash can be redistributed but there is not a massive amount of appetite for this currently, but there are definitely some risks in there as part of the system.

MF referred to the appendix where Greg Moores is listed as a signatory he asked if this was causing any issues, and do we have enough cover. RA responded yes we do have enough cover.

It was RESOLVED to NOTE the Treasury Management update.

AC/23/87 Losses and special payments (agenda item 11)

MF confirmed the committee would take this paper as read unless anyone had any further questions. There were no further questions asked.

It was RESOLVED to NOTE the Losses and special payments update.

Imran left the meeting at this point.

AC/23/88 Internal Audit Update (agenda item 12)

Lianne Richards presented the update stating she would take the report as read and just pull out the key messages:-

- Report issued for Accessible Information Standard, this provided limited assurance and the full report was included with the papers.
- Memo issued for stage 1 of Head of Internal Audit Opinion work programme. One low risk finding has been raised regarding oversight of committee related risk at the Collaborative committee and action has already been taken to address this.
- Terms of reference have been agreed for the following:-
  - Care group governance
  - Policy management framework
  - Financial ledger and reporting
  - Charitable funds.
- Final draft reports issued for the waiting list management audit (from the 2022/23 Internal Audit Plan) and Emergency Preparedness, Resilience and Response (from the 2023/24 Internal Audit Plan); both have been allocated significant assurance.
- A scoping meeting was held for the quarter 3 (Q3) patient observations and seclusion audit and draft Terms of Reference have been issued.
- The Trust has requested that we commence the absence management (sickness) audit in Q4 (the Terms of Reference has already been agreed and was included in our July 2023 progress report); this is due to current resource pressures in the people directorate.
- The Trust has requested that the data quality audit (suggested focus is people data) is commenced in late Q4 to allow the internal work which is currently being undertaken around workforce data to progress.
- The Trusts follow up position as of 29 September 2023 is:
  - first follow up rate: 75%
  - overall follow up rate: 83%

  At the time of writing this report there were two overdue actions, one was from the FIRM risk assessment report and the other was from the e-rostering report.

MF confirmed the committee were happy to approve the changes to the internal audit plan.

MF commented that in relation to the audit opinion is he right in that 360 Assurance are going to introduce a new opinion level which is moderate. LR responded yes this is correct.
MF asked how we will do this in terms of annual reporting as we list how many we have had with each rating.
Leanne Hawkes (LH) remarked that she did not think it would make any difference as in the annual opinions there was a moderate option in there anyway. In the audit assignments there wasn't that option, but occasionally they might split an opinion if it was a clear divide and something they were looking at, so it will be almost like the moderate element is going to replace

some of those splits to explain they have got some variation, and this will be for the full year so should not impact in anyway.

MF stated he is trying to understand whether there could have been any discrepancies in the 2022/23 annual governance report if there had been this new method of reporting.
LH provided the committee with the background as to why they made this decision.
She said there was nothing to be concerned about and nothing would have changed, moderate opinions will only be issued by exception, and they would hope these would be fairly limited.

JW confirmed that when 360 Assurance issue a draft report, they have an internal process, as do we where we question each other and ourselves internally before there is a final rating added and she has no concerns around the governance around this at 360 Assurance or here at SWYPFT. JW explained that she has also been thinking about how this can be presented in the annual report to make it easier for the reader, so rather than narrative as previously presented, she felt it would be better putting it in a table format to show how it is worked out.

MF agreed with this suggestion.

MF remarked his only other question was on the client KPI's and is there a particular issue around this and do we need to take action against this.

AS responded there is not one single issue, but it does maybe reflect pressure on certain functions, and we are tightening our tracking on this. We acknowledge there has been some slippage from our previous high standards, so for the audits that are in the system now, we are going to put these onto more frequent follow ups to ensure the actions are followed up on time. We do encourage people to set a realistic target date for an action when an audit is signed off.

AS confirmed that JW and himself were trying to support 360 Assurance but they are also trying to emphasise to people once they sign off a report with a committee date for an action that they need to be held accountable for this. He said they have been quite lenient with extensions, but as they have started to see more extension requests coming through they are trying to reverse this trend.

MF remarked that he is going to raise these two points in his triple AAA update to the board as both the management response and the information staff availability have both started to slip compared to the standard we set.

AS felt this was a good idea and it would not come as a surprise to anyone on the exec team as JW and himself have presented them with a written narrative stating the same.

ACTION: Mike Ford

Accessible Information Standard report.

LR stated this report has been issued with limited assurance. She said that firstly for context she wanted to highlight the concerns raised at national level regarding the implementation of AIS and that further information around this is included within the report. Following discussions with a range of trust staff, 360 Assurance did find that there is lots of work ongoing at the trust to develop the accessibility of the information. One of the key areas for improvement is around developing reporting arrangements specifically on compliance with the AIS. 360 Assurance also undertook some deep dive testing to assess the trusts position against a sample of must requirements from the AIS and this did identify some gaps, so it has been recommended that the Trust undertakes a full self-assessment against the AIS.

AS remarked that there are 4 actions in here, in relation to the last recommendation that is in the report, whilst it is a low impact risk we have to get TPP, which is our SystmOne service provider to amend something on their system. If the national profile of this work is similar, other clients

should be flagging it and it should get a green light through for an amendment, if our trust is the only one, that could potentially cause some delay in getting them to change their system. In relation to the other areas, as LR said there are some national concerns. In relation to the limited assurance report, this was probably not a huge surprise to us and we are on a journey and we have made some really good progress with what we have done and we have made some comprises and workarounds to get to where we are, and some of this is about embedding it into our systems, predominantly to rely on SystmOne as our clinical system as the source to record it all and then it should track through.

AS remarked that we feel comfortable that we can move from where this report sees us to where we need to be quite quickly because we have the ground work in place. Nationally we will see some themes coming out through this because there will be other organisations like 360 Assurance looking at this and there would be challenges elsewhere. He confirmed we will do what we need to do internally and also link externally to make sure any shared learning can be picked up within this organisation.

MF thanked AS for the update, he remarked that if Darryl Thompson is attending the committee meeting in April to present the risk assessment and care plans, it would make sense for this item to also come back for an update at that meeting.

JW agreed that was a good idea.

ACTION: Julie Williams

It was RESOLVED to NOTE the Internal Audit update and APPROVE the changes to the internal audit plan.

AC/23/89 Counter fraud progress update (agenda item 13)

Claire Croft (CC) presented the update stating she just wanted to pull out some of the key messages from the report:-

- Currently undertaking some work to determine whether any members of staff have worked elsewhere whilst in receipt of paid absence from the Trust.
- Continuing to issue fraud alerts and prevention notices to the Trust and seeking responses where appropriate to confirm that appropriate counter fraud measures are in place.
- Recently seen an increase in mandate fraud attempts. Unfortunately, one trust was defrauded in excess of £850k. Having investigated the incident it was apparent that although the controls were in place they were not being applied. CC confirmed she has spoken with AS about the Trusts supplier bank account changes, which are done through using Shared Business Services and they are awaiting assurance from SBS on their processes.
- CC followed up with the Trust for a response in relation to some guidance issued around employment agency staffing and the trust are currently looking at how best to enact this guidance.

MF thanked CC for the very helpful update. He referred to page 4 of the report the' NHS violence and reduction standard' which has been made available here and he asked did she think this would also be useful for the Quality and Safety Committee (QSC).

AS responded yes, and this links into some of the de-escalation work we do, and so not only can we flag it through a committee, but we can also flag this at the Operational Management Group (OMG) meeting to see if there is something they want to pick up there.

CC confirmed it is also important to note that the Trust does have its own security management

specialist who will have this on their radar, she said she was also happy for their lead to provide any support if needed on this work.

Nick Phillips (NM) confirmed that we are looking at this with the local security management specialist and he thanked CC for the offer of help.

ACTON: Julie Williams

MF referred back to the recent mandate fraud incident, he asked CC if 360 Assurance had looked at the specifics of what went wrong at the Trust that had suffered the loss, and had they looked at this against our own procedures to make sure that we are protected against something similar.

CC responded this was not a sophisticated attack, the trust concerned simply did not follow any of the processes for changing bank account details, so it is quite clear why it happened. AS explained that SBS has a robust process in place and he did say that he would go back to seek reassurance that this was still their process or if they have enhanced it. He was not aware they have ever had a successful mandate fraud against them.

RA remarked that he had received an email from SBS this week confirming that this process had been enhanced further with additional steps being added to the process to make it even more robust.

Counter fraud risk register

JW presented the update stating there was an action for this risk register to come to the committee twice yearly and this has now been added to the workplan. The report includes track changes so the committee can clearly see the changes from the previous report, she said she was happy to take the report as read.

CC remarked that it is good to see that risk 1085 is on here and it is important to track this through this process.

MF confirmed the committee were happy to agree the reduction to the risk level of 1803.

He remarked that risk 1796 stood out for him as we are saying this is the highest risk, and yet our target is still to be beyond appetite and he asked CC if this is just a reflection of that we might not stop human error, and also a reflection of what she sees in other organisations.

CC responded yes it is.

DW remarked that this is the action he shared with Paul Foster last time in that there is now proactive AI software in place and if we think this is a big risk and one outside of our appetite it might be worth exploring that software further.

MF remarked this is a difficult one and is a bit like our Cyber one generally and he is struggling to see how we are going to get this down under appetite.

AS commented that PF does have the details from last time and that he is constantly refreshing the cyber risk paper, he said he would pick this up separately with PF outside the meeting.

ACTION Adrian Snarr

MF remarked that this is the one that if we can get it down to possible it's the only way we are going to get down to our risk target level and it may be one we have to live with even though it is above our appetite. He said it will be very useful looking at this each quarter.

MF thanked CC for her update.

It was RESOLVED to NOTE the Counter fraud progress update.

AC/23/90 National Cost Collections update (agenda item 14)

RA presented the update, he apologised to the committee for the omission of another paper that should have been part of the pack. He agreed that Jane Wilson (JW) would circulate this to committee members following the meeting.
RA explained that the National Cost Collection is a mandatory annual cost collection exercise that all Trusts and NHS Foundations Trusts are required to complete and submit to NHS England under the terms of the Trust provider licence. It includes the fact that the trust has moved to a Patient Level and Information Costing System (PLICs) methodology. RA stated that as it currently stands the Trust is in a great place to make the submission, the problem we have and have been flagging throughout is that NHS England is not necessarily ready to accept our submission. He explained that the data submission window opens next week and in order for our data to flow through this system the data validation engine needs to work, and currently it does not, so even though we as a Trust are ready to go we are not sure exactly what this is going to mean for us.

AS commented that NHS England have changed the collection system, imposed deadlines on people but then do not have the mechanisms in place to receipt it all. He explained that this process is about the governance for submission, the important thing is that we will be able to start to analyse the outputs and be able to understand from a benchmarking point of view where our organisation sits cost wise and feed the outputs in to FIP as part of the benchmarking agenda. He said there is quite a lot of national focus on costing and NHS England really want to see some quality improvement in mental health services and consistency because we are probably 10-15 years behind the acute sector largely because their costing drove their income and ours are not explicitly linked.

MF asked if the people at system level will review this. AS responded that yes he would expect them to.
MF remarked that having failed to spot there was a missing paper he had taken his assurance from appendix c which was the reconciliation.
MF commented that the Trust had been audited by Ernst & Young in 2021, and what is the audit requirement, as it sounds pretty irregular. RA responded that there is a national rolling programme, and this was a one off.
AS remarked that they do samples across the country, he felt there may be a focus on mental health because they want to tie it into some costing and currency development.
MF remarked that there is also a testing element to the submission and does this count as audit work. RA responded this is a validation of the data and part of the checking process.

It was RESOLVED to NOTE the National Costing Collections update, the Committee confirmed they were happy to discharge any further sign off responsibility to the Director of Finance.

AC/23/91 Systems Development Update (agenda item 15)

MF welcomed Paul Foster (PF) to the meeting and stated he could take the paper as read; he asked him to pull out the key highlights from the report for the committee:-

Key highlights:-

- Preparing for the introduction of windows 11.
- Applied some cosmetic changes to the Windows 11 environment to minimise impact on staff, this is really where the Start and Shutdown buttons are located on screen so that they stay in the same place as they do now on Windows 10. The menu/toolbar location for these buttons' changes in Windows 11 but we have applied that local amendment.

- Testing our automated upgrade process.
- Microsoft licensing, lots of work ongoing nationally with NHS England renegotiating the new NHS wide licensing agreement. The commercial model has been released and we have started to raise orders based on this for our own Trust licensing agreement. Whilst costs have significantly increased across the NHS, 45% discount from the retail Microsoft prices is reportedly the best deal globally.
- In relation to password security, the Trust has very robust and strong security password controls in place. An opportunity has arisen to further strengthen this process through our IT provider Daisy who now have a specialist resource available that performs activities such as mimicking what happens when we do a penetration test.
- A business case has been developed which will be considered by EMT towards the end of Q2 this financial year, which aims to bring in some additional proactive countermeasures that will aim to reduce down the organisations risk rating for cyber, which is highest rated risk on the register, noting significant associated recurrent revenue consequences.
- Standards and controls, in the last 6 months there has been a lot of activity, with the penetration test being completed in January 2023, the report findings were presented to the Committee at the April 2023, this has also been incorporated in the report being presented today. The findings were extremely positive with no high or critical risks raised, only a handful of medium and low risks highlighted, with most of these having been addressed now. Plans are in place to address any remaining ones during the financial year.
- The Trust continues to consistently respond to the high severity care certs issued by NHS England, and we acknowledge all within stipulated timelines.
- Standards and accreditation, the key thing for the committee to note is that we have also been successful in getting the reaccreditation for cyber essentials plus which was completed in quarter 4, last financial year.
- Continuous work ongoing around the communications for staff to maintain awareness around cyber. A workforce cyber evaluation survey was conducted in December to gauge understanding of staff's awareness of cyber security, and the responses will help to inform and influence how will shape the communications focused on cyber into 2023/24.
- In March 2023, NHS England published the national cyber security strategy through to 2030, it recognises the important role that individual organisations play, it also understands and highlights the need for a more collaborative approach at system and place level. In terms of the Trusts controls measures and safeguards, we align very well against the direction of travel with that strategy. In support of this, we contribute and proactively engage on an ICS level with cyber forums and activities.

DW remarked there is lots going on as always which is brilliant, one thing for him was in regard to the ones where we are integrating with acute partners, have we had that one tested from a penetration test perspective. PF responded that they have.

MF praised the work that is being done and the volume of work that is being undertaken and is there a danger that we are implementing so much we may not potentially maximise the benefit of all of these. PF agreed that this is a large agenda and that all the safeguards are in place. He explained that some of these areas are quite specialist in the main and the team are working very closely with the teams.

MF remarked that as Audit Committee members, they make an assumption that these are the enhancements that the clinicians want as they have not been involved in the prioritisation of this.

He asked are we happy that there is an appropriate process in place to say these are the right priorities we are doing.

AS responded that we are getting towards the end of our current digital strategy and PF and the team are embarked on an engagement process so that we make sure we get the right priorities into the next one. He explained it might be that when we sign off the strategy it might not be that granular that it has everything in this list from PF, but it will have the general direction of travel.

MF remarked that fundamentally it's a question of whether the trio, which is Subha Thiyagesh, Carol Harris, and Darryl Thompson have signed off that these are the right projects.

PF responded yes and the priorities are mainly coordinated through the Clinical Safety Design Group also which is the main vehicle that any system change control dimension goes through.

MF commented that in relation to the other end of the life cycle he was conscious that this committee receives any summaries of any post implementation reviews, so cost versus budget benefits realisation timescale, and how robust is that process and where does this get reviewed.

PF responded that the feedback is captured, and the majority of the benefits tend to be more qualitative, although there are some quantitative ones from some of this. He explained that the model TPP have for their system is all encompassing so as they release new functionality there are no additional costs associated with that development.

MF asked if the Trust could turn down enhancements. PF responded that there is core functionality which means everyone receives that update, also there is no downtime associated with SystmOne as they do their updates on a monthly basis which makes things much easier.

DW remarked that from a commercial perspective this is just an overhead and if you don't do it you will lose out on opportunities.

MF commented that he wondered what the role of the committee is in reviewing this, and although he was happy to receive this report as it is very assuring in terms of the work being done, he wondered whether it would be better placed going to the QSC, and he said this is one to think about going forward.

PF stated that the purpose for this report is for assurance, and it does provide a deeper dive beyond what the wider digital strategy updates provide to EMT and Trust Board, and the EPR is a key cornerstone of the NHS provider organisation digital agendas.

MF remarked that he is more than happy to receive this report, but he wants to ensure the committee are making the best use of their time and the role of the committee is to support and challenge and provide assurance, and it is about making sure we do this in an appropriate way.

JW commented that this committee owns the information risks for the organisation such as IG and Cyber and a lot of our system developments are to mitigate risks. She explained there is another layer of governance that sits underneath this, which is the improving clinical information group (ICIG) and the Digital TAG, and it might be worth us looking at what comes here and how it comes here as part of the annual work programme next year.

MF responded that he agreed with this but he said his contention would be that there are a lot of other risks that are assigned to different committees where the implementation of a new system or a new enhancement is one of the actions needed to mitigate the risk that sits with these other committees, and because we are the ones getting oversight of systems development are other committees missing out on understanding how their risk is going to be mitigated going forward. He suggested there was a need for further discussion around this outside of the meeting.

ACTION: Julie Williams

MF thanked PF for the helpful update.

It was RESOLVED to NOTE the Systems Development Board update.

AC/23/92 EPRR Core Systems Update (agenda item 16)

NP provided the update stating that the Trust needs to make an annual submission each year regarding our state of readiness for EPRR. He explained there are changes to the submission every three years and that these have become far more frequent post Covid.

Following extensive works over the past three months we have been working with wider partner colleagues to assess and understand the new evidence requirements. The Trust have declared an initial compliance rate of 79% which is Partial compliance. NP explained that a total of 248 pieces of evidence have been sourced and submitted against relevant standards to achieve this level of compliance and that in order to move to Substantial compliance a minimum compliance rate of 89% is required, this equates to the completion of actions against 6 further standards.

NP explained that whilst the initial assessment of the standards is in line with previous years, there is concern that this will be reduced based on the new assessment process and guidance. A reduction in compliance is expected both locally and at a regional level. Discussions with wider Mental Health partners has identified we are all in very similar positions and subsequently working together to improve our compliance status. Works will continue in the background to progress the partial standards to ensure a strong compliance report against the standards in the September 2024 submission. NP confirmed that the final report will come to the committee.

AS remarked that there is an acknowledgement at national level that they have raised the bar for full compliance, and although we do not want to be partial compliant he felt this is where most people would land in this first iteration of the new way of doing it.

MF asked what the scales for compliance are. NP agreed to forward these to MF.

ACTION: Nick Phillips

MF remarked we seem to be missing three standards. NP responded that some of these relate to acute only. MF remarked are we saying with regards to the 9 partially compliant, that we are not going to be able to get these compliant this year. NP responded yes this is correct.

MF thanked NP for the update.

It was RESOLVED to NOTE the EPRR Core Systems update.

AC/23/93 Annual Work Programme (agenda item 17)

JW remarked that following what has been picked up at the meeting today in terms of risks, particularly the ligature risk and what should be coming here, she suggested that MF, AS, JWi and herself meet to discuss the workplan.

ACTION: Julie Williams

MF commented that in theory the committee should have received a progress report from Deloitte for this year. NW responded that the audit planning work would be starting shortly and that they had recently received a letter about the contract being extended.

AC/23/94 Agreement of Committee Meeting Dates for 2023/24 (agenda item 18)

MF confirmed the committee dates looked fine and the only one that may be subject to change was the Annual Accounts sign off meeting in June. He confirmed the committee would hold this date until they hear anything further.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Quality & Safety Committee meeting
Tuesday 14 November 2023
9.00am – 11.15am
Microsoft Teams

Present:	Nat McMillan (NM) Carol Harris (CH) Darryl Thompson (DT) Kate Quail (KQ) 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 Chair of the Trust (from 10am)
Apologies:	Julie Williams (JW) Dr Subha Thiyagesh (STh)	Assistant Director of Corporate Governance & Risk Chief Medical Officer
In attendance:	Sarah Harrison (SLH) Yvonne French (YF) Kiran Rele (KR) Carmain Gibson-Holmes (CGH)	PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Legal Services Consultant Psychiatrist Deputy Director of Nursing, Quality and Professions

QS/23/225 Welcome, introduction and apologies (agenda item 1)

The Chair, Nat McMillan (NM) welcomed everyone to the meeting and apologies were noted as above.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed.

NM outlined the Microsoft Teams meeting protocols and etiquette.

QS/23/226 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/23/227 Minutes from previous Quality and Safety Committee meeting held 17 October 2023 (agenda item 3)

The minutes were approved as an accurate record. Darryl Thompson (DT) thanked Sarah Harrison in terms of the last minutes and the navigation that was needed for the private items.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 12 October 2023 as a true and accurate record.

QS/23/228 Matters arising from previous Quality & Safety Committee meeting held 17 October 2023 and action log (agenda item 4)

The action log was reviewed and updated as follows:

- QS/23/209 CQC - Inpatient and Community survey.
  DT informed that the update was not included in the Chief Nurse report this time and would be included in January. The Patient Experience Report (agenda item 11) contains the patient survey which will also be included in the Chief Nurse for the January Committee.

- QS/23/211 Care group report- inequity issues around access to attention deficit hyperactivity disorder (ADHD) assessment.
  Carol Harris (CH) advised that this update was included in the care group report later in the agenda but confirmed that the business cases were complete and have been submitted. Contract negotiations are continuing. Any issues will be escalated to the committee. Complete.

- QS/23/212 Reducing Restrictive Physical Interventions (RRPI) Annual Report
  DT informed that a broader RRPI paper will be discussed later in the agenda that includes a section on prone restraint. This includes the feedback that was given verbally by DT at Trust Board.

  NM advised that Trust Board still have questions and the need for assurance and therefore further discussions on what is being reported and recorded as a Trust, with a second element of how we receive assurance around the appropriate use of prone restraint and progress with regards to alternative injection sites. Marie Burnham (MB) and Kate Quail (KQ) were in agreement with NM. DT advised that as well as the RRPI group meetings there are also task & finish groups and benchmarking groups which have been set up which include Mersey Care, Leeds and Bradford trusts, to help address the issues that have been raised. These include a half day timeout which will take place early in the New Year.

  NM would like to keep this action live until the Committee have assurance around the work that is happening and the outcomes.

- QS/23/176 Staff/Team Story
  No further update.
  MB would like a meeting for herself, DT, Subha Thiyagesh and Dawn Lawson and Jane Milner from the people directorate to discuss mandatory training requirements for volunteers.
  Action: DT

  Due to the non-clinical aspect of this action it was agreed to close this and move it across to PRC. NM will inform Mandy Rayner of this.
  Action: NM

- QS/23/175 Review of Committee related risks.
  No further update.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates.

QS/23/229 Committee related risks were reviewed in accordance with the terms of reference. Including:

DT informed that there were two new risks for the Committee to consider in terms of relating to this Committee and also wording.

NEW RISK
"Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individuals are supportively heard, do not suffer personal detriment and that they receive feedback on action(s) taken which demonstrate listening and learning".

DT advised the Committee that this was in response the Countess of Chester concerns.

The risk focuses on culture and the confidence of clinical colleagues and others to speak up through the processes available.

NM queried why this would be aligned to this Committee as freedom to speak up annual reports go to PRC. KQ agreed and that Trust Board had agreed that the freedom to speak aspects of the workplans would sit with PRC.

NM suggested that the risk was viable however not for this Committee.

CH agreed that the way the risk is currently worded this it should be addressed within PRC, however should risk be that patents would come to harm because of not speaking up then it would sit with QSC.

DT will provide the feedback to EMT to discuss.
Action: DT

NEW RISK
"Risk that individuals do not feel safe from sexual harm. This includes being made to feel uncomfortable, frightened, or intimidated in a sexual way by any other person whilst being cared for, working for, or visiting the Trust".

It was noted that this was a potential overarching cross committee risk and is a potential concern for people in our care and also our staff.

DT advised that the Trust has signed the NHSE Sexual Safety Charter which reflects the Trust commitment to this issue.

NHS England » Sexual safety in healthcare – organisational charter

NM queried whether the wording was quite right in this risk and wondered if "sexual harm occurring" should be included and would like EMT to consider.

NM noted the difficulty of where this could sit as it does straddle PRC and QSC, however felt that this was predominately QSC with links to PRC.

CH advised that there was a potential clinical issue with staff and thinks that this would sit neatly in this Committee with a link to PRC.

DT noted that safety is in the title of this Committee and agreed that the risk would sit better with this Committee.

Committee agreed to align the risk to QSC however the wording would need to be amended.
Action: DT

CH advised that Mike Ford had raised in Audit Committee around some risks that appears in QSC that don't have any performance metrics in the IPR (namely seclusion, medical devices). MB and NM suggest a further discussion at Trust Board. NM will include in the AAA escalations.

DT advised that an update paper on medical devices will be going to EMT and DT will bring back to a future Committee.

RISK ID 1530 (demand on acuity)
NM noted the ongoing work which has been shared previously, however acknowledged that some of the data was not correlated with what was in the report and an update will be brought back to a future meeting.

It was RESOLVED to RECEIVE the update.

QS/23/230 Staff / Team Story (agenda item 6)

No story to share this month.

QS/23/231 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 of topics discussed:

- Subha Thiyagesh and DT have asked to meet with the Bradford Coroner in relation to recent comments around clinical risk assessment and will share the recent improvement work.
- Feedback from the Committees that DT has attended at Place where there has been a focus on children and young people care, response to the Countess of Chester with regard to mortality oversight and the role of the medical examiner.
- Neuro-developmental assessment.
- Prone restraint.
- PSIRF.
- West Yorkshire LeDER noted as a focus of conversation across Place Quality Committees.

MB queried as to why DT and Subha were both needed to visit the coroner. DT advised that they both have a clear role in terms of relationship management and serious incident sign off for the Trust.

KQ queried the whether the following had been discussed at EMT:

- Whether there were any cost improvement plans (CIPs) for the rest of this financial year.
- The risks in Kirklees Health & Social Care Partnership around children's and young people's care.

DT advised that when risks have been discussed at Place, DT relays this information across to Julie Wiliams as conscious mapping.

CH advised that there was a large reduction in the out of area bed usage and a large reduction in agency staff use, and teams are working through the vacancies factors in each areas.
KQ would like to see a full programme of the CIPs.
Action: TRIO

QS/23/232 Quality Account Production Update (agenda item 8)

Included at item 7.

QS/23/233 Quality and Regulatory Oversight Paper (agenda item 9)

The paper had been circulated to all members prior to the meeting.
Carmain Gibson-Holmes (CGH) gave a brief update to the Committee.

The report for November 2023 contained the following information:

Care Quality Commission reports into Forensic inpatients and Acute inpatient/psychiatric intensive care units (PICU)
The draft reports following the CQC inspection of acute and PICU and Forensics, which took place 16-18 May 2023, were sent to the Trust on Friday 15 September 2023.

Quality Monitoring Visits (QMVs) recently undertaken:
Throughout August and September 2023 there were three QMVs completed:

- Clark Ward - 10th August
- Melton Suite (psychiatric intensive care unit) - 24th August
- Bronte Ward - 5th September

CQC Update
The CQC are changing to develop on the four key themes from their strategy, use learning from the pandemic, to simplify their processes, to allow them to be more responsive to change, to enable a focus on people's experience of care and to work closely with integrated care systems.

CQC State of Care report 2022/23
On 20th October 2023 the CQC published their annual 'State of Care' report. This report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

Mental Health Act (MHA) Visits
MHA visits take place regularly on our wards. The legal team oversee this process and the monitoring of inspection reports and the culmination and oversight of actions following the visits.

The following reports on MHA inspections have been returned to the Trust since the previous paper in October 2023:

- Thornhill Ward at The Bretton Centre, Fieldhead hospital

CQC Pharmacy Interviews
The Trust's Pharmacy Team has been approached by the CQC regarding the next routine medicines engagement calls. This is not an inspection and CQC will not rate services following the call.

KQ noted that it was a really good and helpful paper, however wanted to discuss the quality monitoring visits. Within the report the dates noted were not the dates that the non-executive directors NEDs) have received, therefore this will impact on NED availability. CGH apologised for this and will look into it with the team. MB agreed with KQ and would like to get a forward plan if possible.

DT thanked the NEDs for highlighting the confusion with the dates and reaffirmed that NEDs are essential to the visits. MB noted that NEDs have been substituted with Governors on visits which should not be happening due to the different roles and requirements. NM was also concerned that she hadn't been on a visit in over a month. DT gave assurance that the team are now clear that non-executive director involvement in a QMV is not interchangeable with governor involvement.
Action: CGH to speak to the team.

The Committee agreed that the report was helpful but would like to see this strengthen with the evidence to support statements.

It was RESOLVED to RECEIVE the Quality & Regulatory Oversight Paper.

QS/23/234 Patient Safety Strategy Update (agenda item 10)

CGH noted that this paper was taken as read.

A brief update on progress:

Patient Safety training

- An update of progress with Level 1 patient safety training
- Level 3 training has been completed

Learn from Patient Safety Events (LFPSE)

- There was a delay with RL Datix in relation to developing the right software.
- The upgrade to the live system with the enhanced LFPSE functions took place on 24/09/23 with a further upgrade on 02/10/203. There remain issues nationally with Datix and the LFPSE functionality.
- A risk does remain in relation to NRLS failing nationally prior to going live with LFPSE, this would be we would have to input into the system manually.

Patient Safety Incident Response Framework

- PSIRF Policy has been approved by the clinical policy ratification group and is awaiting approval by EMT.
- PSIRF plan was presented to Trust Board on the 31 October 2023, with a go live date of the 1 December 2023.

Patient Safety Partners

- The patient safety support team have successfully recruited three volunteers as patient safety partners.

Impact

The national agenda for patient safety is resulting in a number of major patient safety workstreams (that are running concurrently for local planning and implementation. These are all associated with specific timescales for implementation and involve a complex volume of additional work.

Strengths

All patient safety projects are progressing as planned and we are in a more advanced position than many other trusts.

The Committee thanked the team for all their work with PSIRF and will watch with interest the impact when this becomes implemented.

It was RESOLVED to RECEIVE the Patient Safety Strategy Update.

QS/23/234 Patient Experience Update (agenda item 11)

CGH brief update in terms of an AAA.

Alert:

- Due to capacity with the Quality Improvement and Assurance Team, some workstreams are still in the development phase. This includes some of the new service line patient experience surveys. The aim is to have these developed and in place across all areas by January 2024.

Advise:

- 2023 Community Mental Health Service User Survey field work is underway, and we are already reported to have a 20% response rate on this year's survey so far
- Patient Experience Dashboard - a draft dashboard has been designed by Performance and Business Intelligence (P&BI). This is in the process of being tested within the team. The first version is expected to be ready by January 2024 and will be shared widely once complete.
- Wakefield District Health & Care Partnership Experience of Care Network
  Due to capacity, the team were unable to attend the meeting in October but continue to be part of this network.

Assure:

- An audit of Friends and Family Test is currently underway identifying services / teams that have not received any responses. This is being shared with quality governance leads and support will be provided to services / teams to review their collection methods
- Patient Experience Improvement Framework
  NHS England have advised the framework is expected to be rolled out in April 2024. At present we are reviewing this and providing feedback on the documentation prior to national sign off.
- Patient Experience Group
  The next meeting has been organised for late November 2023 to discuss the format of the group and agenda with the aim of increasing attendance and engagement.
- Complaints backlog awaiting allocation to a complaints advisor

There are currently no complaints on a backlog awaiting allocation to a complaints advisor

The Committee was happy to receive the update.

It was RESOLVED to RECEIVE the Patient Experience Update.

QS/23/235 Care Group Quality and Safety Report (agenda item 12)

CH advised the Committee of the pressing issues within the report.

Key Issues for November Committee

Paediatric audiology

Committee members will be aware from the Trust Board integrated performance report, that the Barnsley care group escalated a concern regarding access to paediatric audiology diagnosis within 6 weeks of referral and had been working towards solving this in October 2023. Although improvement has been noted, full compliance with the target in October was at risk due to the capacity of audiologists. This is an issue shared across South Yorkshire

Integrated Care Board (ICB) and an immediate solution, for example collaborative working or even subcontracting is not available.

Trust Board and the finance, investment and performance committee will have oversight of the care group's performance against the target, but specifically quality and safety committee will be concerned that hearing loss impacts a child's ability to communicate and importantly, learn to socialise and make friends and will need assurance on how the negative impacts of a wait are being mitigated. The data shows that the longest wait for a diagnostic appointment for the 45 children whose appointment was more than 6 weeks in September, was 11 weeks. Additionally, the wait time for a general audiology appointment, i.e., not a diagnostic appointment, is 3.6 weeks. If parents or children need support whilst waiting for a diagnosis, a general appointment can be offered. This provides assurance that the impact on children is being reduced but it does not eradicate the risk and the team are taking actions to bring all waits for diagnosis back to within the target of 6 weeks.

ADHD pathway for people with a learning disability
Business cases have been developed in relation to the unmet need for assessment of ADHD (attention deficit hyperactivity disorder) and are going through the contract negotiation processes. No funding has been confirmed as of yet. As requested, committee will be updated on the progress and the risk will be managed through the learning disability risk register.

Patient flow
The work to reduce out of area placements and provide care closer to home has the potential to impact on people potentially waiting longer to come into hospital whilst being supported by community teams or intensive home-based treatment teams (IHBTTs). Close connectivity between workstreams / priority programmes is in place to mitigate this, and a person-centre, 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 able to be tracked through the electronic patient flow system, and is being monitored closely and cross-referenced with incidents pertaining to patient safety in community teams. Monthly summary meetings are in place between operational and priority programme lead staff to track progress and triangulate data and qualitative information. Further work is underway to determine how this can be provided as an assurance report.

Prone restraint
As reported to Trust Board, the executive trio has been involved in detailed work with the reducing restrictive physical interventions team. The update is provided in a separate paper to committee.

Plastic bags
Following the death of the person on Ashdale Ward and the discussion at Clinical Risk Panel, an urgent review of the use of plastic bags was undertaken, to enable any immediate areas of risk to be identified and mitigations put in place. The preferred position initially was to ban all plastic bags in all inpatient areas and CQC documentation indicates that this would not be considered a blanket restriction. A meeting was convened at very short notice with colleagues from across the Care Groups and corporate teams, and further consideration demonstrated this would not be practicable to implement across the entire estate. The risk is not limited to plastic carrier bags and extends to bin bags and aprons, which are essential items in certain circumstances. Therefore, a blue light alert was initially issued to advise staff that access to plastic bags and similar items should be considered as a controlled item with access guided by individual service user risk assessment. However, this is being further reviewed to ensure that it more accurately sets out the context of the incident as learning emerges, and for it to be as clear as possible in the required response of clinical colleagues when plastic bags are identified as a risk for anyone admitted into Trust care. This will be finalised at the Clinical

Environment Safety Group meeting on 8 November 2023, before being published and shared across the Trust.

Safety and security
A specific incident relating to a patient posting photos of himself on social media holding a firearm led to a discussion in clinical risk panel on assurance that staff are confident in both search and lock down procedures. The police supported the ward, and processes were in place should the person have returned to the ward. However, the police found him in the community and he was returned to the ward. Actions were taken away to ensure all parties were clear about their required responses, including such as reception colleagues out of hours.

International recruitment
The executive trio are concerned that some of the international nurses are reporting a poor experience, and ward / operational managers have also identified that they need additional support to help the nurses.

Concerns range from individual personal and pastoral issues to potential delays with completing preceptorship, and some nurses struggling to pass their objective structured clinical examination (OSCE) before they can register with the Nursing and Midwifery Council (NMC) and commence preceptorship. Until they register, they are working in a support worker role in the ward numbers, and as such aren't able to maximise learning opportunities.

Work led by the deputy director of nursing, quality and professions is underway and the executive trio will also meet with the international nurses in November to understand what changes can be made to better support them.

The executive trio are also aware of the gap in pastoral support for international doctors and plans are in place to look at a joint approach.

Clinical supervision
Clinical supervision performance has not been reported recently through the integrated performance report, as work on the recording system has been taking place. Whist actions are still required to allow local authority employed staff to use the system, the system is now functional. Teams report some backlog in recording but have recognised that supervision uptake is not where it needs to be. Messages on the importance of supervision, especially when times are busy or challenging, are being strengthened through both line management and professional leadership. Supervision training is still being delivered. It was initially paused as the policy was being reviewed but has now been re-established. It will be reviewed once the new policy is approved so that the training fits with the policy.

The Croft
The positive working arrangements and partnership with the local authority have been put to the test recently as a young person with very complex needs and significant experience of trauma was admitted to The Croft. Cultural differences between the local authority and health resulted in a significantly different approach to managing risk that had not been fully understood or anticipated when the service was established. The situation was escalated to the leadership teams in the Trust and local authority who were able to work with staff from both areas to agree a plan to meet the needs of the young person and further work will take place to understand how the learning from this can improve the future service offer.

Invited review of service – Adult ASD
The final report has been received. The team had already started work on the draft recommendations and will work collaboratively with other teams to agree further actions. Progress and next steps will be set out in an action plan that will also incorporate the new information set out in the operational guidance to deliver improved outcomes in all-age

autism assessment pathways published by NHS England. This may supersede some of the pathway recommendations within the report.

The action plan and proposed communication with staff and wider stakeholders will be discussed at the executive management team before being shared with Committee in January 2024.

Reducing Restrictive Physical Interventions
CAMHS staff are not usually expected to use physical restraint and their training is focussed on de-escalation and safe exit from a situation. A very recent incident has demonstrated that there may be occasions where CAMHS staff, particularly those providing support whilst the child is not at home but in another care setting, are involved in holding a child to maintain their safety, or, for example, when might need to remove a ligature or weapon. The training requirements for the CAMHS crisis teams are therefore being reviewed. In addition to this, consideration is being given to the training needs of adult staff who may be called upon to restrain a young person, age 16-18 who has been admitted to an adult bed. This will be reported through the quality and governance structure to EMT.

Building better healthcare awards
The awards celebrate the achievements in the built healthcare environment. The Patients' Choice Award is chosen by patient representatives, from across all categories, for the entry deemed to have the biggest impact on patient experience and outcomes. Thank you to the work carried out by Creative Minds, the Trust won that award for the Caring Garden on the Fieldhead site.

MB thanked CH for the update and asked a query in relation to recurrent problems and how long would an issue be ongoing before action is taken in terms of a deep dive and asked when was the last one, where and why.

CH reported that Johnson Ward had a deep dive which was still running through EMT and a deep dive was carried on Horizon Ward which had also been to EMT and this Committee. CH reported that individual issues within wards might not cause a specific problem but if a range of issues all come together across a ward this would raise a concern. CH noted an example of current concerns due to leadership team absence and advised that this would be monitored through operational processes and escalated as appropriate.
MB informed that in the past a blended indicator approach which could give a forewarning with trends has been used and CH informed that the current process involving the executive trio meant that all incidents are run through them, including all care groups, results from QMVs and any other concerns. These are then reported by the executive trio to EMT.

DT advised that when concerns are raised, quality monitoring visits are used as a deep dive given how robust they are. Also, there is now access to such as ward by ward appraisals data. The care group quality and safety report could be an option to then triangulate areas of concern to the Committee.

KQ agreed that a wider discussion is needed regarding this. KQ noted that it is about triangulation and turning that into learning and action, and informed the group of a previous reporting of specific concerns (racism towards a patient from staff) to herself, others and then Trust Board which appears to have been taken no further after being discussed in various meetings. CH recalled the specific issue from 2019 and noted that this had not been a feature of quality monitoring visits or other visits / sources.
KQ also commented that a document which headlines the CIPs would be beneficial which shows the outcomes, benefits etc.

CH advised KQ that they are aware of concerns through the reporting of incidents related to protected characteristics and the All of You: Race Forward meetings are discussing and also

progressing action on these issues. CH also informed that the CQC had received a concern from black staff believing they have been treated unfairly in forensic services. Forensic teams are looking at race issues specifically with regard to the experience of international nurses which has in turn become a wider project. There was a question regarding why additional external support was required and CH advised the forensic team themselves and Mark Brooks suggested a review from an external expert would be helpful in order to think differently about the approach to resolving the issue.

CH reminded committee that although learning may have been established and implemented previously, all incidents are used as a learning opportunity where we check that actions are in place and being effective.

The Quality Care Group and Safety Report was RECEIVED and NOTED.

QS/23/236 Safer Staffing 6 Monthly Report (agenda item 13)

CGH noted that this paper had been taken as read.

Safer staffing remains a priority and challenge within the Trust. The work underway to mitigate and manage this risk as well as to improve the situation sustainably is highlighted below:

Key areas to note include:

- Local, regional and national challenges with recruitment of health and care staff continues.
- A number of actions have been implemented to support recruitment and retention of staff, including the development of new roles to support career progression, international recruitment, flexible working, and recruitment of bank and agency staff.
- In the current year to date (from April) we have seen a total of 339.5 starters and 285.9 leavers. Our vacancy position continues to reduce (17.6% last year, currently at 16.3%)
- Through our international nursing recruitment programme we have successfully recruited 83 nurses
- The Trust continues its current recruitment activity which is continuing to widen entry level opportunity for new starters and expanding our reach for advertising all roles.
- There continues to be a high reliance on bank and agency shifts to reach / maintain safe staffing.
- There are occasions when unfilled registered nurse shifts are replaced with health care assistants to meet safer staffing numbers, leaving a deficit in skill mix.
- There are situations where service user and staff experience is impacted by available staffing numbers.
- There are robust escalation processes in place.
- We continue to utilise the Mental health Optimal Staffing Tool (MHOST) to support staff modelling and template review processes.
- Reporting mechanisms are good but could be strengthened further to understand the full quality impact on care and experience.
- Staff continue to report staffing concerns on Datix and these are reviewed at clinical risk panel.
- Care hours per patient day benchmarking with regional providers shows variance across our wards.
- Recruitment activity is 35% higher in the past 6 months than in the previous 6 months and the Trust has seen more starters than leavers in all four of the last quarters preceding this report.
- When benchmarked against the latest workforce statistics published by NHS England on nhsdigital.nhs.uk (May 2023) the Trust has the lowest turnover rate in our region and the highest rating for the staff stability index.

It is not expected that the staffing pressures will ease significantly within the next reporting period and therefore plans remain in place to help mitigate the quality and experience impact. There are clear actions identified for the next reporting period, progress will continue with actions already in place and the Trust will continue to monitor safer staffing and take action to ensure service user, staff and service safety.

There was a general discussion that the report did not offer the required level of assurance, and did not contain some of the content that has previously been asked for. NM noted that some conversations have taken place outside of the committee with DT with regards to the timely receipt of the report in time for it to be meaningfully reviewed prior to committee. NM as Chair will escalate this.

NM will speak to the interim Chief People Officer outside of the meeting.
Action: NM

DT informed the Committee that after delays with previous safer staffing reports, escalation processes had been put in place in terms of what was required but the challenges continue. The new interim Deputy Chief People Officer is going to review the approach to this report going forward to ensure time delivery, and also a move from presenting data to presenting analysed intelligence.

MB would like the NEDs to pick this up collectively within their meetings.

MB asked whether the international recruitment had stopped. CGH informed that this had paused for the time being but was not reflected in the paper due to the time lapse in preparing the report however MB would have like a verbal up on this.

Committee agreed that the paper in its current form will not be recommended to be sent to Trust Board and should be deferred from Board. Further work is to be undertaken on the report prior to resubmission.

The Report was NOT ACCEPTED by the Committee for recommendation to Trust Board.

QS/23/237 Trustwide Incident Management Report Q2 (agenda item 14)

CGH noted that this paper had been taken as read and gave the highlights to the Committee.

Key headlines follow:

Incident Management Trustwide 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. This is then reflected in grading changes in the live Datix system and will be monitored going forward.

Learning from experience

Learning from experience has been incorporated which shares the learning from incidents in Q2 2023/2024 and examples of learning in practice.

Serious Incidents

- There were 2 serious incidents reported in Q2 2023/2024.
- 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 incidents in the most effective ways, 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.
- 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.

NM wanted more information around the increasing trend in red incidents until the regrading has been undertaken.

DT had asked this question of the patient safety support team and they advised that they do get a cycle of a higher number of red incidents and then upon review in terms of actual harm they can reduce in number, and therefore the peaks that were felt in the immediacy can flatten out.

NM also noted that on page eight of the report it mentioned the falls specialists analysis of incidents and would like to know evidence to support this in future reports.

NM was happy to see that pressure ulcers remain in the sights of the Trust and was glad that vigilance with regards to pressure ulcers remains.

The Committee were happy to recommend for approval at Trust Board.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/238 Internal Audit Reports as appropriate (agenda item 15)

Nil.

QS/23/239 Annual Ligature Report (agenda item 16)

DT gave a brief update to the Committee and noted the following:

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 (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)

Clinical Environment Safety Group (CESG) meetings continue, where we maintain oversight of environmental suicide and 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 colleagues. The CESG monitors and evaluates process of assessing, prioritising and mitigating ligature risks across the Trust.

In addition, the report provides an overview of 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.

Overall, ligature risk assessment processes are in line with national expectations. Improvements have been made to the Trust's oversight of ligature risk assessment and local ligature risk awareness further CQC feedback, but this work falls outside of the timescale of this report.

Dr Kiran Rele (KR) reported that he is seeing younger adults with similar problems relating to ligatures.

NM noted that there was a lot of information contained in the report however did not feel quite assured on all outcomes for the people on the wards.

DT advised that conversations had taken place in terms of further assurance and would make a commitment to add this detail to get this report ready for Trust Board

The Committee was happy with this approach.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/240 Medical Education Report (agenda item 17)

Dr Kiran Rele gave a brief update to the Committee and took the report as read.

The annual assurance process is to demonstrate the department is achieving its obligations and future-proofing its services, as well as ensuring that EMT 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 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, core trainees and higher trainees.

KR noted that Leeds medical school received a quality monitoring visit in July 2023 which had a positive outcome and since then other sites have been visited and informal feedback has been good.

Th general medical council (GMC) are undertaking a national survey which collects feedback from both trainees and trainers, which again has received positive feedback.

KR noted the achievements within the report and noted that the Trust should be very proud of these.

NM noted the report as a helpful update, and stated that it was good to hear the achievements and that the challenges are being addressed

The Committee were happy to receive and approve the annual report.

It was RESOLVED to RECEIVE and APPROVE the report.

QS/23/241 Advanced Clinical Practitioners Report (agenda item 18)

CGH gave a brief update to the committee and the report was taken as read.

Advanced clinical practitioners (ACP) are health care professionals who are educated to master's level and have developed the skills and knowledge to allow them to take on expanded roles and an extended scope of practice in caring for service users. The ACP role is highlighted in the NHS Long-Term Plan as central to helping transform service delivery and better meet local health needs by providing enhanced capacity, capability, productivity and efficiency within multi-professional teams.

Key highlights from the report:

- Background and detail about ACPs, the role and the direction of NHS England in enhancing the workforce.
- The current position within the Trust, including the number of qualified and trainee ACPs (tACPs).
- The NHS England governance maturity matrix, which supports providers to understand where they are with governance and delivery of an advance clinical practitioner workforce.
- Future developments for supporting the development of ACPs across the Trust, including workforce planning, supervision, clinical placements and an organisational approach.

NM would like PRC to also be aware of this report and it was agreed that going forward this should sit with PRC Committee.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/242 Reports from Formal Sub-Committees (agenda item 19)

QS/23/242a Drug & Therapeutic TAG (agenda item 19.1)
The report was taken as read and received.

QS/23/242b Infection, Prevention and Control (agenda item 19.2)
The report was taken as read and received.
CGH noted an error on this update. There have been six outbreaks and not two.

CQS/23/242c Joint Safeguarding (agenda item 19.3)
There was no update for this item.

QS/23/242d Reducing Restrictive Physical Interventions (agenda item 19.4)
The report was taken as read and received.
CGH highlighted the reduction in the number of restrictive physical interventions in September which is the lowest in the last 12 months.

QS/23/242e Improving Clinical Information Governance Group (agenda item 19.5)
There was no update for this item.

QS/23/242f Clinical Governance Group (agenda item 19.6)
There was no update for this item.

QS/23/242g Clinical Ethics Advisory Group (agenda item 19.7)
There was no update for this item.

QS/23/242h QUIT (agenda item 19.8)
The report was taken as read and received.

QS/23/242i Safer Staffing (agenda item 19.9)
Included at item 13.

QS/23/242j Physical Health (agenda item 19.10)
There was no update for this item.

QS/23/242k Nutrition Steering Group (agenda item 19.11)
The report was taken as read and received. DT advised that this was a new group overseen by Sarah Whiterod, Associate Director of Nursing, Quality and Professions.

QS/23/242l Falls Q2 Update (agenda item 19.12)
The report was taken as read and received.

QS/23/243 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 20)

Alert
Safer Staffing Report not recommended for Board, requiring further work prior to submission
New risks discussed with regards to teams and individual members of staff not feeling confident that the Trust has a culture in which 'Speaking Up' is encouraged, and a risk that individuals do not feel safe from sexual harm
Ongoing work around RRPI, restraint reduction and prone restraint reduction
Accessing pediatric audiology, risk of potential harm and mitigations in place
The experience and induction of international nurses
Serious incident related to a plastic bag – sharing of learning discussed.

Advise
Patient Safety strategy update received
Patient Experience update received. West Yorkshire LeDER noted as a focus of conversation across Place quality committees. ADHD access for assessment discussed
Oversight of improvement work underway within the priority programmes

Assure
QIA programme overview reviewed
An update on the Trust's quality monitoring visits was received
Improvement work with regards to out of area bed use
Recommendation of Trust-wide incident management report Q2 for approval at Trust Board
Annual Ligature Report reviewed, recommended that following agreed further development, to be submitted for approval at Trust Board
Medical Education Report was received and approved by Committee.

QS/23/244 Risk Register review (agenda item 21)
No further risks to discuss.

QS/23/245 Work Programme (agenda item 22)

There were no further updates for this item.

QS/23/246 Date of next meeting (agenda item 23)

The next meeting will be held on 9 January 2024 (MS)

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of People and Remuneration Committee meeting held on 21 November 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 Richard Butterfield Diane Taylor Greg Moores	Chief Operating Officer Head of Recruitment and Resourcing Associate Director of HR Operations Chief People Officer
In attendance:	Lindsay Jensen (LJ) Chris Lennox (CL) Naomi Fernandez (NF) Richard Meyers (RM) Julie Williams (JW) Nikki Macfarlane (NMac) Rachel Lee John Laville Ellaine Flintoff	Interim Chief People Officer Operations Director Head of People Experience Acting Head of People Development Deputy Director of Corporate Governance Interim Deputy Chief People Officer Associate Non Executive Director Lead Governor/ Public Governor for Kirklees PA to Chief People Officer

PRC/23/234 Welcome, introduction and apologies (agenda item 1)

Mandy Rayner welcomed Nikki Macfarlane, Interim Deputy Chief People Officer to the meeting and John Laville who would be observing the meeting. MR informed the meeting that Nat Macmillan would be joining at 10am. Introductions were then made around the group.

PRC/23/235 Declarations of interest (agenda item 2)

There were no declarations of interest.

PRC/23/236 Minutes from previous People and Remuneration Committee meeting held on 11 September 2023 (Redacted) (agenda item 3.1)

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on 11 September 2023 as a true and accurate record.

PRC/23/237 Matters arising from previous People and Remuneration Committee meeting held on 11 September2023 and action log (agenda item 4)

- PRC/23/186 International Nurses Reckonable Service (Leeds Teaching Hospitals NHS Trust)
  Shared at Trust Partnership Forum, work is being carried out for every nurse to understand what their reckonable service is. A form has been developed, to assist with identifying their individual pay point within the band. This has been shared with staff side who have agreed with process. A panel will be set up to ensure we are applying the process consistently. This should be completed in the next few weeks. Action can be closed.

- PRC/23/215: Integrated Workforce Performance
  Richard Butterfield to report back at next meeting.

  Action: Richard Butterfield

- Risk Appetite
  Mandy Rayner (MR) to speak to Nat Macmillan (NM) and redefine the action for the next meeting.

  Action: Mandy Rayner

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for September 2023

PRC/23/237 Actions from the Trust Board (agenda item 5)

- Appraisals and deep dive and review plan.
- Review risk and risk score on industrial action
- WRES action plan to ensure meaningful metrics around race forward programme. NF to provide update for March meeting.

PRC/23/238 CPO update (agenda item 6)

Lindsay Jensen (LJ) Welcomed Nikki Macfarlane (NMac) and explained that she would be here for the next 6 months. Richard Meyers continues to act up in his position as Head of People Development.

There are still vacancies in some teams and additional recruitment is continuing. Development sessions with teams are taking place to ensure staff feel supported and that they understand the priorities and the vision. LJ thanked Nat McMillan (NM) for delivering a session at the People Directorate away day. Mandy Rayner (MR) also met with the SLT and PLT to enable people to share their pressures, ideas and the good things that are happening. LJ has encouraged people to attend the CIPD conference, it was also recognised that we require a transition plan to move from a traditional HR function to a People Directorate. Andrew Gibson worked with the team on solution focussed practices to identify our priorities and improvements at our away day, NF and her team are also helping with this. A full update will be given on onboarding in January. LJ flagged that issues have been identified with onboarding and ATS, a paper will be going to EMT. LJ has briefed MR on the issues. Challenges with recruitment capacity, all posts in the recruitment team have been filled 4 new members out of 6. There are challenges around inductions and learning and ensuring they are up to speed with systems along with ensuring staff are inducted correctly. We are expecting a T - Levels student in the new year. Improvement work with the change team has commenced. Work planned to put actions in place within the next month.

Working on recruitment data and this will be shared with OMG and EMT in the next few weeks. Currently working with volunteers, and Northern College to support work experience placements. Continuing with the Active HCSW assessment centres, numbers on bank have increased to 750, seeing really good fill rates and one of the highest in region. Further update in January.

Following feedback from our international nurses we have been leading some engagement events, exec trio met with 68 nurses, feedback from them includes what it is like working on wards. We have listened to this and we are looking at quick wins, i.e. workshops using a solution based focussed approach involving ourselves, operational managers, Carmain Gibson-Holmes and Vicky White from the change team to understand and to ensure we can fully support the nurses to be able to work in our wards effectively. Vicky White is supporting with an action plan with timelines, this is expected within the next week then further engagement will take place with nurses and ward staff to ensure all stakeholders have been involved with feedback.

There has been a review of the numbers joining us in the next few months to allow us to focus on the existing nurses rather than taking more on.

Priorities over the next 3-6 months for the People Directorate are being developed and shared with the staff, we are looking to bring T-level students from Barnsley College to undertake placements initially looking at corporate services and then rolling out into clinical areas. Currently working on the collaborative bank and this is now in the testing phase which will take place November/December. Andrew prince is looking at robotic processing to help with transactional work and is working with IT to look a processes that will reduce time. He is also working with Northamptonshire Trust who are the centre of excellence on robotics. Partnership working have a time out in October, facilitated by NF. Action plans and next steps were taken away from this event. NF working with staff side as they have staff who are retiring with regards to succession planning.

MBu asked LJ on a scale of 1-10 how confident is she that the directorate are coming together and will start delivering rather than being trained themselves? LJ said that the directorate have been made to feel supported. LJ thought that we are at a score of seven as people are new and still learning, they still need to understand strengths and understand where the gaps are but we are on a positive path. MBu questioned as to why the Organisational Development plan was still missing? LJ commented that she wanted to put some metrics in place and give assurance that the OD plan is not forgotten and NF will talk about this. Help is also required from NMac to move the OD plan forward. MBu commented that plans to ensure over 80% of staff will receive an appraisal is not good enough it should be 95% and this is an Ops management basic requirement. MB commented that when we started at the beginning of the year there was a significant number of priorities to be completed and that reducing the number of priorities and focusing on those that are an issue across the organisation is more sensible.

MB also commented on the questions raised on appraisals and that a separate paper is provided on this on the agenda. A realistic plan is required that shows improvement and agreed that the target percentage should be at 100%. We now know the teams that have a much lower uptake so we can focus on them. MR said she would concur that assurance is needed on appraisal data. Non-Execs need to be provided with assurance on appraisal data. The OD plan is a concern regarding the time it is taking to get over the line.

Julie Williams (JW) commented that recognising there is still work to do, recent experience working with recruitment is good in terms of processes. Janice Parkes is doing an incredible job in terms of training and developing new team members.

Information has come through on the Well led structure, it was suggested that Carmain should have a session with the directorate to look at well led and produce a priority plan to get ready for well led. Reducing priorities will help on what needs to be done.

It was RESOLVED to NOTE the update on the Chief People Officers Remarks / Update and comments made.

PRC/23/239 Staff story – Richard Pascoe - E-rostering (Agenda item 7.1)

Richard talked through the members of his team. The primary objective is the e-rostering rollout to all remaining clinical teams within the trust and roll out of safer care to all remaining inpatients within the wards. Ensuring in team development to understand systems and improve responses to queries and ensure timeliness.

As part of the NHS long term plan and the increased roll out of the e-rostering, the roll out continues, working with the new team to bring those on board, 71% of all clinical workforce is rolled out. Looking to further improve and grow as a team to enhance the roll out and our support to services and to teams using the system. Out of the recent audit it has been recommended we build in check and challenge and so we are looking to build this through a steering group to take the conversations forward. We sometimes see a different response from managers many are receptive to the benefits and e-rostering and safe care, some are onboard straight away, others don't understand or see how it works. Safe care adds on to all existing information in e-roster, it shows how may staffing hours are available takes on board the mental health optimal staffing tool and adds in dependencies of everyone on the ward and other unexpected activities which adds in extra hours required and works out the extra hours required for staffing. Which in turn can then build on to incident reporting requirements as it allows red flags to be created and this can be escalated to Datix etc. We are currently at mid-point on safer care roll out, 15 out of 31, shortly picking up with working age adults and rehab recovery in Calderdale and Kirklees. Anticipating completion in March to April for safer care, longer term view of all clinical workforce on system in 2025.

MB asked regarding effective rostering, what can we do to me more effective and what difference would it make? RP advised that we recognise ineffective practises on how service can be delivered, one example is flexible rostering areas, we are clear that absences should be managed weekly based on the staff group. Registered and unregistered staff on wards fluctuate week by week and are often outside of the parameters that are built into establishment budgets, therefore too many staff that are granted too much leave creates a pressure on the remaining staff to cover all the safer staffing template. That may lead to an increase of temporary staffing cover to meet the requirements of the ward within that week. On the opposite side, too few could take leave and likely to storing problems for a later date as leave still must be taken.

NM asked LJ how do we capture the benefits of roll out of safe care and how to we learn from it? How do we tangibly show the difference and how do we give assurance around safe staffing. LJ advised that we started to have check and challenge meetings and audits around safe staffing that gave some actions as we have not been using the intelligence from e-rostering in the best way. Having check and challenge helps to understand the benefits and measure against them. We can also use check and challenge for our own self-assessment and complete our own baseline along with using the intelligence to report into the committee. The services need to understand how to use this effectively. When everything works together this is when we will see the benefits. RP advised safe care information will give daily assessment and an immediate safety assessment in ward areas and this will lead into the establishment reviews.

MR picked up that RP had spoken of hoping to grow the team and asked if LJ was aware of this and will this happen, or will it create a risk?

MB advised that everyone has to be aware of the significant financial challenges in the NHS everyone has budget and everyone should be aware of it, they are encouraged to make decisions on how they spend it to cover critical gaps.

RP was thanked for his presentation which was well received by the Committee.

PRC/23/240 Draft Organisation Development Plan (Agenda item 8.1)

Naomi explained that the team have been working on what do they want on the OD plan, what is the direction of travel and what do we want to focus on. NF talked through the values-based approach. The OD plan focuses around a 5-year timescale as a lot of the things that are to be put in place take time but also due to a cultural shift and the culture we want to embed. Working with well led principals, reviewing and developing leadership management programmes, looking at inclusive leadership. Develop staff engagement plan. Utilising workforce data. This will have themed staff activities throughout the year and how we embed them in the work we do. Transition plan within the directorate and developing them to take action. What is the OD capacity within the directorate. Other pillars of work, LT workforce plan, recruitment, development, how are we developing our people. Catch ups are being held to ensure people are happy and hearing peoples voices.

NF's team are working across the directorate with all other directorates, focussing on the GP2W, wellbeing etc focussing on rolling out.

MB asked for an action to circulate and people to come back with initial comments. Engagement in this group and others is key. NF to link with Dawn Lawson to make sure the sequencing is right and ensure everyone is aligned.

Action: Naomi Fernandez

LJ, commented that colleagues have expressed concern about the apparent absence of a Trust OD plan and Naomi has picked this up in her new role. The presentation shared does need more engagement on and she welcomes feedback form committee members. Also, as we are looking at refreshing the wider people strategy in the new year we need to make sure this one aligns.

NM expressed concern that there are a lot of verbal items on the agenda from a good governance point of view need to be aware. NM not confident about the action and delivery of the OD plan as we have been hearing about OD plan for two years. How can we give board assurance confidence that we can deliver this. NM looking for deliverables. What are the deliverables as we were in the same position back in July, what are the levels of assurance? Learning cultures and compassionate leadership, what support are we giving managers in having difficult conversations and being able to hold the line.

MR agreed with the comments and requested some tangible traction.
LJ concurred with NM comments and confirmed that some of work is already happening but appreciated that this work is not being seen. NF confirmed that this has been built into the plan and one of the key areas is around how we measure progress. There is a piece of work with EMT/OMG on inclusive/compassionate leadership, a steering group has also been created on how we measure which feeds into WRES and WDES. Coaching and mentoring also included in this piece of work but this will take time and measurements will be applied.

Julie Williams (JW) offered the P&I teams assistance with measures and metrics reporting once the criteria and trajectory has been set.

It was RESOLVED to NOTE the update on Organisation Development Plan and the comments made.

PRC/23/241 Integrated Workforce Performance Report (Agenda item 8.2)

LJ updated that overall workforce staffing remains stable in the first seven months of the year, staffing posts have risen by 3.26% since April target to achieve a forecasted 4% growth by March 24 and we are on target.

Bank and agency spend remains high to support safer staffing gaps. Increase bank usage. More staff have taken up banks shift. Vacancy remains high but has reduced since March from 926.9 to 897.4.

Increase in recruitment activity, higher than last year currently progressing over 145 active recruitments at different stages, turnover in the first seven months is at 7.2%. We are predicting a lower rate this year around 13.5% which is a positive in terms of retention. Focusing on recruitment fairs and will be attending diverse events around Liverpool Leeds and Manchester.

International Nurses, have been successful, recruited 96 which is a success story but also realise that this number does bring with it challenges. We now need to ensure that the experience for those nurses is where we needs it to be. Once the nurses are fulfilling their roles it will make a big impact on our wards. Absence remains stable 5.2% last year was 5.4% we do expect this to rise over the winter months as normal. Appraisals are at 69.7% mandatory training 92.5% no areas rag rated. Deep dive into care groups has taken place, the information is now coming to the Board through the Trust IPR. Work with JW's team to understand the information and work through hotspots.

LJ advised that MB and MBu attend the welcome events and the events are at full capacity, it's great to see the amount of people coming through and this reflects the activity happening across our recruitment teams.

MB advised that the group needs to be aware that there is huge scrutiny on agency staff, work needs to be done to ensure we understand our own position. MB acknowledged that we had a gap in workforce planning at the moment. He asked that when we look at the age of our workforce and the number of people that would be retiring and we look at workforce planning, what would we be expecting our turnover to be? Over the last three or four welcome events we have seen a far greater number of people joining us without an NHS background, therefore how does this work for us in terms of induction in terms of how we enable them to become affiliated with the organisation and aligned with our values and understand the NHS.

MR recognised that MB's observation about people coming from outside the NHS is important so that we create a good experience.

MBu, expressed concern in relation to the IPR, she explained that the workforce has 5 different sections, that all focus on different sections and she has no assurance that she can say as chair where the problems are and in what specialities and in what departments. She does not know where the leadership problems are. MBu will pick this area up. MR agreed, needs to be developed in a way that show care group hotspots and leadership issues which need to be looked at.

NM confirmed that a similar discussion had taken place at FIP yesterday, discussion as a board required as to what information is needed. NM requested that some analysis to come to this committee from the HR Business Partners. NM requires the data to say what are the risks what are the concerns, where are we performing. How do we join this up into the cultural hotspots and leadership areas.

JW advised that there is work being undertaken with the People Directorate, in terms of pulling the data into the data warehouse to give automated feeds and this will help and would give people the headspace to do the analytics and the hotspot reporting and understand where the

risks are. Discussion needed regarding the hotspot information required at board and committee.

LJ suggested a discussion is required with JW team, regarding the hotspot data. Dataset required to be able to go out and have the conversations. People in place and have the data it is bringing the two together.

MBu advised that the data is there but we don't know how to analyse it, interpret it and tell the story from it which is performance analysis and interpretation. MBu was advised we had employed a member of staff to do this for the IPR for the board. This therefore needs presenting to allow decisions to be made. There was an issue between HR data and data sat on other systems MBu questioned are they now the same dataset?

MB advised that what has come to light over recent months is that historically we were very dependent upon one individual for this information, we are now working on a more robust process to move the data to the data warehouse although this won't happen quickly progress is being made.

JW advised that Vic Humble is the person we spoke about and we can see the benefits of her work. If the business partners have never done analysis before we need to help them understand it. They need to work with the care group directors who are skilled at understanding their own data.

MBu – expressed concern about the data and the KPI's and hotspots and will pick up with Mark and Mandy outside of the meeting.

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

PRC/23/242 Appraisal Improvement Plan (Agenda item 8.3)

Rich Meyers (RM) explained about the new activities required to increase the appraisal numbers along with explaining how he will address the challenges.

There are three major tensions, system, heart and minds and the data. The papers present current position and what its looked like over the last 15 months. It also looks at improvement plan and actions. One of the key enablers of driving forward the appraisals is a steering group which has been set up with three primary focusses. 1. Drive up all trust compliance to reach and maintain the 80% target, 2. Promote quality of appraisals to ensure meaningful and ongoing dialogue between appraisees and appraisers. 3. Support an appropriate tendering exercise and the adoption of a new system.

LJ added that the steering group is to use the data to identify where we need to improve and what has worked well in other areas using the expertise of our new staff to look at this through fresh eyes and create improvement plans. Forensics and Estates are some of the lowest areas. Then using the BP's to support managers to see what is needed to improve figures. We know the system is not perfect, and more time is needed to procure a new system. We will continue working with Workpal for next 12 months but will be looking a new system over the next 12 months. A meeting has taken place with the current supplier with tangible actions we can take going forward to enable appraisal reporting to improve.

MBu asked how does a line manager not know if they have done their appraisals and advised that it is not the HR departments responsibility to do appraisals, they are there to advise support and develop the leadership skills of mangers to do appraisals. MBu would like to know what areas of the trust appraisals are not being done and why?

MBu went on to say that Workpal does not stop an effective appraisal taking place. Not having an appraisal means staff do not know if they are valued, listened to appreciated or even enjoying their work.

Further to that MBu suggested that a target of 80% is not good enough. Every manager must have that level of responsibility that means their teams appraisals are completed. MBu wants to know what areas haven't and why they haven't and whether they are effective or not.

MB informed the committee that 80% is an initial target, it should be 95/100. Every team is getting either a weekly or fortnightly update on appraisals conducted within the teams which also comes to EMT every fortnight. An improvement plan is the only tangible measure to see the percentage go up. MB suggested that one appraisal is not enough, it should be appraisal plus 1:1 plus supervision. We need to ensure we have good data quality and to also ensure good comms, appraisals should be around culture. Once we have done all this, then we need to hold people to account.

Nikki Macfarlane (NMac) asked if appraisals are in the directors' objectives and should be checked if in Managers objectives.

NM requested that we need to be clear in the paper regarding targets that our organisation target remains 80%. NM looking for assurance that the focus remains on getting appraisals completed in the short term.

RM – It was more around appraisal being recorded rather than completed. It was that appraisals are happening but not being recorded.

MB confirmed that culture and process is key.

LJ was conscious that we do not want to spend time all our time on getting the system perfect it is about the culture and around hearts and minds. Some people will focus on that, and a separate team will focus on the procurement. MR asked for this to be picked up at every meeting.

JW questioned that prior to this year there were set timings for appraisals and now they are rolling, has this caused confusion. JW asked of the improvement plan, is it a smart plan does it have action deadlines, it would help from a governance management view. JW also updated that the appraisal data is in the process of being moved over to a data warehouse to have more control and then it can be shared wider to manager and team level, and this will be available within the next ten days.
MR advised that it is a cultural change that we need to embed. Continue to monitor through this committee.

It was RESOLVED to NOTE the update on Appraisal Improvement Plan and the comments made.

PRC/23/243 Guardian of Safe Working (Agenda item 8.7)

Richard Marriott (RMa) updated that Recruitment is doing well, particular issues effecting Calderdale which caused gaps, mostly vacant posts have been filled with locum doctors plus support from the international fellows this helped with rotas. Reasons for gaps relates to vacancies and people that have had to come off rotas for medical reasons and industrial action. Rotas are well managed by admin staff. MR asked regarding trainees spending time in their placement, this is in relation to Barnsley rota and foundation year one. In other parts of the trust foundation trainees are not on any on call rotas so they have more opportunities to spend time with teams on the wards but this never happened in Barnsley as they were kept on the medical on call rota.

A meeting has been arranged between our trust staff, Barnsley staff and the foundation TPD to resolve issues and enable the foundation one doctors to be on the same level as the others. RM will monitor to see an improvement. MBu thanked RM on behalf of herself and the board for the work he has been doing. RMa advised on issues with the rotas and the Allocate system and he will be attending meetings to help with this.

It was RESOLVED to NOTE the update on Guardian of Safe Working and the comments made.

PRC/23/244 Agency Scrutiny Group (Triple A Report)

A lot of scrutiny around agency spend, last month did see a reduction in spend. The figures are showing that the focus work that's happening has now reduced in terms on non-clinical agency staff. Looking at long term agency placement. Bank fill placements increasing, sustained improvement in terms of agency spend coming down from a risk point there is still a challenge as to whether we will meet the target for this year. NM expressed concerns with using a triple A report for this meeting. Triple A are used for board reporting and not for this level of meeting,

MR is the directorate making provision to not use Agency, this is the kind of detail that the committee needs. More information on workforce planning is required within the report.

It was agreed to amend the style of the paper for future meetings.

Action: Lindsay Jensen

It was RESOLVED to NOTE the update on Agency Scrutiny Group (Triple A Report) and the comments made.

PRC/23/245 Freedom to Speak Up Steering Group Update (Agenda item 8.5)

Julie Williams (JW) took the report as read and went to questions.

MR shared that the 85% mandatory training figure is good news.
MB observed, patient safety figure. JW commented that following Lucy Letby this raises concerns around FTSU not being used for what it was originally intended to be used for and how do we manage this in organisations. Not really seeing any real themes coming through with the incidents and claims. Operations have really bought into the FTSU steering group.
EM updated that we have a good reporting culture, we have seen patient relating concerns, interpersonal and team concerns that come through EM. Concerns that come through Datix are discussed at risk panel on a weekly basis. Equity guardians are also in place.

It was RESOLVED to NOTE the update on Freedom to Speak Up Steering Group Update and the comments made.

PRC/23/246 Freedom to Speak Up Reports (Self Assessment Reflection and Planning Tool) (Agenda item 9.1)

Estelle Myers (EM) explained that this is a requirement from the Guardians Office for all trusts to conduct a self-assessment and benchmark themselves. This isn't for us to benchmark against other organisations it's about looking at where we are as an organisation. This has to be published on our website by January. This will come to committee then will go to trust board in November.

Estelle Myers (EM) talked through the board reflection tool. EM has Worked with LJ, Dawn Pearson and has taken the report through the operations managers group, EMT and steering group. We have looked at where we are as an organisation and what we need to do to be better. At the end of the report the actions to be completed are listed.

MR asked if it is a fair assessment?
MB advised that some of the scoring felt a little subjective, but overall, it gave the right context and message. MR agreed. MR happy for it to go to trust board.

NM for the report to go to board an exec summary is required to pull out a highlight report as its too detailed. An analysis is required to be signed off before it goes to board.

It was RESOLVED to NOTE the update on Freedom to Speak Up Reports (Self Assessment Reflection and Planning Tool) and the comments made.

PRC/23/248 Staff Survey 2.01.58 (Agenda item 8.8)

Naomi Fernandez (NF) confirmed that staff survey completion stands at 50% and closes on Friday, aiming to be higher than 50%, activity building up this week and paper copies due back in which may boost the figure. Looking at what we are going to do next year as this is the main vehicle of hearing from our staff. Looking at how we work with teams to make this better next year. Want to come back to EMT with an engagement plan for the year but also ask what is required. Conversation with leadership team about how flexible do we want to be to get this information. Pods on the ground, paper copies, discussions required for a way forward for next year. Leeds community are at 60% Bradford District are at 50%. MBu was pleased with the energy and enthusiasm from the team.

It was RESOLVED to NOTE the update on Staff Survey and the comments made.

PRC/23/249 Flu Vaccine Update (Agenda item 8.9)

LJ updated that Flu vaccinations are taking place in house, 45% of frontline staff had had vaccination, clinics are still being offered. Still seems to be a general reluctance to take up jabs, but still encouraging and comms still being sent out.

Mbu asked if 45% was a standard percentage across the NHS? MB advised that we are above where we were last year. Not doing as well as acute, but as a Mental Health provider we are better than average.

It was RESOLVED to NOTE the update on the Flu Vaccine Update and the comments made.

PRC/23/249 Mandatory Training Report (Agenda item 8.10)

Richard Meyers (RM) updated that this is the annual report. The executive summary tells us that developments in overall compliance have gone up 0.6% on last year new subjects have been added and the process continues to be effective.

Headroom remains a challenge. We have undertaken an analysis to understand what can be dropped or relaxed, compared to other trusts our headroom is relatively healthy but work continues on how can we support increasing headroom for new starters. How can we balance headroom against the operational challenges. The report articulates some of the detail around CPR and RRPI. At the end of the report the RRPI action plan is included.
The format of the report could possibly be reviewed due to the length of the report.

MB commented that there is an increasing challenge in the amount of mandatory training when we have an increasingly pressurised service. RRPI has risen to a 3 or 4 day update. This puts pressure on our services.

NM commented that the performance is good and good to see where we are on compliance on mandatory training considering the added pressures. What could we learn from mandatory compliance to apply to appraisals?

MR we should acknowledge the overall performance is green.

It was RESOLVED to NOTE the update on the Mandatory Training Report and the comments made.

MB left the meeting

PRC/23/250 Great Place to Work Strategy – Report on Delivery Plan (Agenda item 9.2)

LJ updated 6 key priorities for the directorate over next three months. Many have been completed some however will move to next year.

NM commented that it is great to see the reprioritisation. Concerns from the committee were that the directorate was trying to do too much and now the goals are more realistic therefore the committee can really hold to account on what is being delivered.

MR concurred with the comments.

JW suggested the Papers are linked to the Plan.

It was RESOLVED to NOTE the update on the Great Place to Work Strategy – Report on Delivery Plan and the comments made.

PRC/23/250 Workforce Risk Register (Agenda item 10.1)

LJ shared the new risks and where they sit.

The first risk was about the speaking up culture and the action plan, the other around sexual safety incidents. We have been asked on a national basis to look at this. The controls and mitigations are yet to be developed.
Mike Ford has asked the committee to review the score on the risk around industrial action, current score is 3x3. Thinking about the impact should move the impact to 2? as we have managed the industrial action really well. This will be recommended to the committee.

MR asked for clarification on the two new risks and todays role as a committee. LJ confirmed that the risks were just being highlighted at the meeting today as a possible risk and will come back to this committee for approval if required.

NM asked whether these risks should be a shared risk with quality and safety committee, her view being that FTSU is this committee as this is where the reports come through and the risk around sexual harm should have a place in both committees.

MR asked are we as a committee happy to move the risk score on industrial action to 2.
CL expressed concern at moving the score down due to the issues from an operational point of view due to the impact on services and potential risk to patients and interruption to pathways.
MBu supports CL and feels that the score should stay at 3 for impact.

JW talked about the impact on Mandatory Training and suggested we stay as we are.

MR confirmed that we should keep the score where it is due to the impact of the industrial action. It was confirmed the score stayed at 3.

MR asked if the group was happy that the other scores stay as they are. It was agreed that they did.

It was RESOLVED to NOTE the update on the Workforce Risk Register and the comments made.

PRC/23/251 Local Clinical Excellence Awards (Agenda item 11.1)

MR advised that we have followed the same procedure that we approved last year. We did however say that we do something different this year. LJ updated that it was agreed thru JLNC arrangements and discussions were had around continuing with a fair share process between the BMA and JLNC. MR advised we are ratifying on a fair share process. All agreed on this.

It was RESOLVED to NOTE the update on the Local Clinical Excellence Awards and the comments made.

PRC/23/252 Items to bring to the attention of the Trust Board (Agenda item 11.2)

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 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 this and lacked some confidence in the trusts ability to meet the targets. 2. 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. 3. 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:
To highlight an issue that may require further monitoring (by the Committee) over a period of time 1. 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. 2. Uptake of the flu vaccine is low at 45%. This is the trend nationally.

3. 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. 4. The great place to work activity plan is making good progress. The plan has now been consolidated and prioritised. 5. The committee ratified the Clinical excellence awards. 6. The Very Senior Manager pay award was supported and approved.
Assure:
1. 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. 2. 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. 3. 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. 4. 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. 1. 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. 2. The risk around industrial action was discussed it was decided the score should stay the same as the impact has had a broader impact. 3. All other risks associated with the committee remain the same.
New risks identified: see above still to be approved

PRC/23/253 Annual Work Programmes (Agenda item 12)

Julie Williams (JW) advised on timing changes as to when the freedom to speak up reports would be brought to the meetings. Changes were accepted by the committee.

All attendees except Mbu,MR,NM and LJ left the meeting

PRC/23/254 Any other Business (Agenda item 13)

None

PRC/23/254 Review of Directors Pay and Annual Award 2023 (Agenda item 14.1)

It was RESOLVED to APPROVE the Directors Pay and Annual Award 2023

PRC/23/255 Approve Confidential Minutes from 11th September 2023 (Agenda item 14.2)

It was RESOLVED to APPROVE the Confidential minutes of the People and Remuneration Committee meeting held on 11 September 2023 as a true and accurate record.

PRC/23/256 Date and time of next meeting (Agenda item 15)

The next meeting will be held on 16th January 2024

Close

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 20 November 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:	Carol Harris Julie Williams	Chief Operating Officer Deputy Director of Corporate Governance
In attendance:	Adrian Snarr Rob Adamson Phil Shire Chris Lennox Mel Wood (item 11) James Waplington (item 12) Amanda Miller (item 13) Jane Wilson	Director of Finance, Estates & Resources Deputy Director of Finance Governor (observing) Director of Services, Adults & Older People Head of Performance and Business Intelligence General Manager, Older Peoples Services, Wakefield General Manager, Community, Wakefield Note taker

FIP/23/81 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting.
The above apologies were noted, 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/23/82 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/23/83 Minutes from the meeting held on 23rd October 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 23rd October 2023

FIP/23/84 Items delegated from Trust Board (agenda item 4)

DW confirmed that no new items had been delegated from Trust Board. He advised that there would be an update later in the meeting on the two areas outstanding, which are Out of Area (OOA) and Agency.

FIP/23/85 Matters arising and action log from the meeting held on the 23 October 2023 (item 5)

It was RESOLVED to NOTE the updates in relation to the action log.

FIP/23/86 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)

AS confirmed there had been debates with the various risk bodies and EMT as to whether the two key risks relating to this committee should be reconsidered. He said the capital risk is now tracking slightly higher than revenue because we know this is a live challenge and there is not

enough capital resource in the NHS, also not necessarily enough capital resource for us to realise all our ambitions within the estates strategy so we have increased the risk on this slightly.

AS confirmed the revenue risk is appropriate for this financial year, and it will be kept under review particularly as we go into the planning round.

DW remarked that we comment on this for the current year. AS responded yes we do but we will also need to consider in the Board Assurance Framework (BAF) if the long-term financial horizon is looking challenging and the correlation between the strategic risk and the operational risk. He added it is an operational risk so it is supposed to be here and now but actually in the last quarter of the year as we move into planning the here and now is what we are going to be doing for the year ahead so that would be the time to reflect on this.

DW said that this made sense to him.

NM remarked that this was also one of her reflections and one the committee should be cognisant of. She said for her there is something around how much oversight we have around the Cost Improvement Programme (CIP) given we are already in November. She said it was mentioned in the Quality & Safety Committee (QSC) last week in terms of quality impact assessments, and the general view had been that it would be picked up in FIP as to how much oversight we think we have got of the programme.
NM advised that Carol Harris and execs had informed them that there were some big pieces of work going on, and Kate Quail (KQ) had given a really good challenge in that they were not sure how sighted they would feel on this as board members and both Marie Burham, Chair of the QSC committee and herself had agreed with the challenge.

AS responded that this was a fair comment and it had been discussed at the EMT timeout last week. He explained that in some respects our efficiency programme this year is quite simple and there are only a small number of substantial items, one of them is interest on the bank account, and the other big one is OOA, and Chris Lennox and her team will provide an update on this later in the meeting. He said that whilst we have been tracking the money and the number of people in OOA placements, we have not explicitly linked it back to equality impact, and the paper that JW is presenting later on the agenda starts to do some of this. He confirmed that it has been acknowledged internally that we will need to do more on the transparency and visibility of the efficiency programme next year.
NM thanked AS for his update.

DW referred to the costing update, which was later on the agenda, he said is he right in thinking this is the update on where we are so far. RA responded that he had assumed this was the national cost collection update.
AS confirmed that this does start to get picked up for the first time through the financial forecast, he said there is not a specific update on 2024/25 this time but the work has started internally with RA as the finance lead and Izzy Worswick as the planning lead and bringing all of this together.
DW asked would it be fair to say the committee will be able to have a view of where we are at for the January meeting.
AS replied yes, a progress update would be provided at the January meeting.

ACTION: Rob Adamson

KQ commented that she had a broader question around CIPs and the impact on system finance etc. She asked, if the Trust have a gap and do not achieve our CIPs does this have an impact on the ICB finances and is it a risk that we have to report to them. Also, when we look at our CIPs do

we look at the impact or the risks for our Places, and vice versa when Calderdale and Huddersfield Foundation Trust (CHFT) are looking at their CIPs do they look at the impact on us.

AS responded that we do report our performance through to the ICB and it does have an impact if we or anyone else falls short because the ICB is the organisation who is required to balance this. He explained that if a failure of a CIP can be offset by something else it does not necessarily mean you fall short on your overall financial plan, we also share intelligence about what we are doing, so hopefully reduce the impact of one organisations efficiency impacting on another.

KQ asked do we know what other organisations' CIP plans are.
AS responded that we do informally share these, we also have a good network of sharing across the Places and if it was just inflationary we would just build it in our respective plans. He explained we are doing quite a bit of work, and for example, should we consider corporate back-office functions across the system as a way of operating at scale and saving money across the system rather than running individual teams, this would be a positive example of something we can do together rather than separately.

KQ thanked AS for providing assurance around this along with a very helpful update.

It was RESOLVED to NOTE the risks, relevant to this Committee,

FIP/23/87 Month 7 Finance Report update (agenda item 7)

RA presented the financial position for month 7.

Key headlines:-

- 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.
- The Trust has a target of reducing agency spend from £10.0m to £8.7m. Agency spend was £636k in October. This is a large reduction from the previous run rate. The year to date position is 14% 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. 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.
- Income & expenditure in October, excluding the financial impact of the provider collaboratives, is a £347k deficit. This is £236k worse than plan.
- 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.
- Non Pay – Pressures continue (both volume and inflationary cost increases) There has been positive reductions in out of area placement spend in month which is shown within the purchase of healthcare highlight report.
- 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. Due to the volatility of this area this forecast assumption remains a risk and this is factored into the Trust forecast scenarios.

- Value for Money / efficiencies – Increasing under delivery from £290k last month to £420k in month 7.
- Capital - 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.
- Cash does remains positive but has had a significant reduction in month. This had been previously reported due to the size of South Yorkshire Adult secure collaborative whilst invoices were awaited. These invoices did arrive and have now been paid.

KQ referred to capital and she asked how realistic is it that the full allocation will be utilised this year.
AS responded that RA and himself are pushing Estates and IT quite hard to make sure they get everything through. He said Estates will require close scrutiny between now and the end of the year to make sure we can utilise all the funds available. The seclusion room is the first big ticket scheme and then hopefully we can roll into some of the other ones quite quickly. For IT he said we just want to make sure we get orders on the system because the lead in time for IT is relatively short, so once we get to the point where we can order we will have a high degree of confidence in IT.

KQ thanked AS for the update.

DW referred to agency and the pie chart on page 10 of diligent, he said this does not seem to have been updated, and do we know where the reductions have been seen.
RA responded it is in inpatients, primarily both registered and unregistered, and the number of shifts booked have reduced, and the question for him now is, is this sustainable as we continue to move this forward.

AS remarked that from the agency scrutiny & oversight that we have been given, there is a lot of focus on individual posts across the organisation, but there is a significant area of spend that is driven by the rotas in the inpatient units which is not done at a post level, and it is done at a ward level through the roster system. He is aware through engagement with Carol Harris and Chris Lennox there was a view that we had a big opportunity on the unregistered workforce, which was a significant spend for us and had grown through Covid. He said this is one of the areas where we are starting to see some benefit, his assumption is through recruitment, so having recruited some people into those substantive roles we are therefore reducing the risk within the inpatient units. He agreed with RA in that there is some early optimism but he said one month does not make a trend so we just need to make sure the bank booking system in particular supports this can be sustained for any period.

KQ asked do we use overtime to reduce our agency.
CL responded that we do use overtime as one of the solutions and it is definitely something they look at before looking at agency. She said we are mindful of the needs of the whole workforce, so we have to maintain safe working hours for colleagues, and the challenges we have had across the inpatient units would not have been sustained by purely an overtime approach.

RA remarked we do use about £150k of overtime every month. He said for context pre covid we spent around £5k a month on overtime, so it has been a stepped change that has been continued as we continue to look at staffing challenges.

It was RESOLVED to NOTE the Month 7 Finance update.

FIP/23/88 Financial forecast update (agenda item 8)

RA commented that this is the same forecast as has been shared in previous months.

Key headlines:-

- 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 at least monthly and updated are included in the report. These assumptions act as an action list; to work through and confirm likelihood and impact to secure the year end position.
- The baseline forecast has been updated in month with increased costs forecast relating to out of area placement, one off Estates spend and reduced income based on activity assumptions in the Smokefree service.
- This baseline is broadly breakeven.
- The most likely scenario is now also presented as breakeven (was previously a surplus). This links into ongoing discussions to provide system financial, and operational, support. There are also new costs and risks which continue to present such as potential legal costs, additional payments to staff both via awards, payment arrears and vouchers.
- As in previous years the risks, and mitigations, will be worked through over the course of the year and included into the baseline as appropriate. Values, and the level of risk, will also be re-assessed each month.

DW referred to the legal provision and he asked if this formed part of the serious incidents report that is discussed in private board.
AS responded that he had not cross checked when this was last updated at private board, and he would check this with Subha Thiyagesh (ST), Chief Medical Officer, as this should be part of that log.
DW commented that he would like to ensure this is fed in to the private part of the board to make sure everyone is aware of how this all fits together.

ACTION: Adrian Snarr

NM remarked she did not expect the committee to comment on this, but that prior to the board meeting next week she would need to pick up her concerns that there had been no mention of this at the recent Quality and Safety Committee (QSC)., the committee should be briefed from a governance point of view.

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AS remarked that one of the fundamental things that we have been discussing across the West Yorkshire System, is a principal that no one will do better than plan. He said this discussion had taken place a little earlier this year because of the national position about reiterating plan. He explained that this month's risks and opportunities is quite critical for us, and we are still confident we will hit break even, and this demonstrates the opportunities and risks that get us there, but we now have to lock these in. He said there are some risks in there, but we have tried to mitigate those. In relation to the balance sheet, we are keen across West Yorkshire, bearing in mind we are separate statutory organisations to have some consistency on balance sheets, and how we estimate things, and we need to be mindful of this. He said it is tricky, but we think in terms of materiality we are in the right ball park.

It was RESOLVED to NOTE the Financial Forecast update.

FIP/23/89 Financial sustainability update (agenda item 9)

RA provided the update stating the purpose of the report was to provide the Committee with an insight on current financial performance against value for money schemes. This includes additional information, over and over that provided in the public board report, on scheme specifics.

Key headlines:-

- The Value for Money workstream, and delivery of financial efficiencies, has an essential role to play in the development and delivery of a sustainable Trust. There is an ongoing requirement to develop, and deliver, new cost reductions to support the medium-term plan.
- This has been largely paused during covid with 2023 / 24 a return to normal in terms of reporting externally. The target for 2023 / 24 is £11,969k.
- Year to date performance is £420k behind plan, an increase from £290k behind plan last month. This is forecast to continue with a value of £1,327k marked as red with no specific scheme to achieve in place. If additional savings were found this would improve the overall financial forecast.
- Those schemes marked as green present little risk and are forecast to deliver in line with target or better. This is helping to offset shortfalls in other areas.
- Action is required to progress efficiency opportunities both to secure the 2023/24 financial position and as preparation for 2024 / 25 where the requirement for recurrent savings will increase further.
- Progress to date has been limited, or at least in terms of clarity of reporting and recognition, and this remains a focus as a key workstream.
- Progress against each scheme will continue to be discussed at OMG and escalated to EMT as required.

NM commented that the challenge she is asking herself as a NED and board member is have we become a little bit complacent in this area because we are not in the same financial challenge as others, and so we are not relying on the value for money. She said for her, this is also around reputation and what does that mean for us in terms of risk.

AS responded that in terms of complacency, this was much wider, and he thought the NHS in totality probably was a little complacent coming out of Covid. He said we certainly have not had some of the pressures that some of our neighbouring colleagues, particularly the acute sectors have had, but having said that we are pretty close to delivering our efficiency programme. Some other organisations will have set overly ambitious efficiency programmes that they are now failing to deliver, and he thought we had done a lot of work with our operational colleagues to change the narrative. He said that conversations had started quite recently in OMG and our key message has always been that quality and safety is the primary driver and we will always recruit to positions to maintain that quality and safety.

CL commented that there are certainly different conversations taking place within care groups and that this is very tightly gripped operationally, with people respecting the challenges that everybody in the NHS is under and are responding well to that rigour.

It was RESOLVED to NOTE the Financial Sustainability update.

FIP/23/90 West & South Yorkshire collaborative financial update (agenda item 10)

RA provided the update and said the theme is very similar to that in previous months in that CAHMS and Adult Eating Disorders are both forecasting deficits for the year to date.

Key headlines:-

- West Yorkshire Adult Secure is reported as breakeven in the overall financial position with the risk / reward share enacted.
    - The current position suggests a significant surplus, which would be in line with previous years. This is after safer staffing investment into LYPFT and BDCT. SWYPFT remains pending.
- South Yorkshire Adult Secure financial position has improved in month due to revised assumptions on prior year charges.
- There is currently no risk / reward share in place for South Yorkshire.
- Forensic CAMHS is now included as a SWYPFT co-ordinated collaborative. This was previously led by SWYPFT under traditional commissioning / provider relationships.
- Maternal mental health provider collaborative is progressing with SWYPFT as co-ordinator.

RA informed the committee that the 3 trusts are looking at the possibility of a single way of reporting, as currently each trust is doing something similar. Confirmed that although the format of this reporting may change in future, the content will remain the same.

It was RESOLVED to NOTE the Provider Collaborative update.

FIP/23/91 Costing update (agenda item 11)

RA confirmed the National Costing submission window was due to open today and they are still awaiting formal confirmation from the national team that this will be happening. He confirmed that as a Trust we are in a position to submit, and that Victoria Brain had worked really closely with the national team, and we are the first Trust in the country to do testing on the current submission engine. He said unfortunately, when this was opened up to wider testing it broke again, and once the Trust are able to submit we will do so, it will then go through a process of centre checking, and this will formally close in mid-January. He said we will then be able to look at real live patient level costing evidence, which will result in lots of interesting information being brought to future FIP meetings.

It was RESOLVED to NOTE the Costing update.

FIP/23/92 Care closer to home update (agenda item 12)

James Waplington (JW) joined the meeting at this point to present the update, he shared a set of slides with the committee which outlined the work that is ongoing to reduce the number of OOA beds in use against the agreed trajectory, also the plans for continued improvement and sustainability. He outlined the correlation between a reduction in OOA usage through an improvement in providing care closer to home, and the potential for increased demand for agency staffing - specifically from inpatient wards, at a time when work is underway to significantly reduce the usage of agency staff on our inpatient wards and across the trust.

DW thanked JW for the update, he said it was great to see that all the concerted efforts over the past few months are now coming to fruition. He said his only concern would be that it is clear to see this has been a huge area of focus, and if we diverted our attention slightly, what controls are there in place to keep this on track.

JW responded that this is ongoing work and people do understand we are doing this, they do not necessarily understand why we are doing this, and we are focusing now on changing that culture.

NM commented that just to add to what DW has already said as a member of the Board she would like to thank JW, CL and the wider team for all the hard work around this, she said it is impressive to see the reduction on something that has been quite a tricky issue in the past, and she asked that her thanks be passed on to the wider team, it is very important for them to see that this work is being recognised.

NM remarked it is great to hear about the focus around the quality of care and it being around the patient pathway which has led to the improved financial position. It has also been great to hear about this personally from JW and the reasons behind this. She referred to the number of bed days at our different Places, and the fact that Kirklees are not being budgeted for the number of beds that are probably required and it feels like this is going to be a really stubborn issue in terms of being able to reduce this. It also means that if you are in Kirklees you are likely to have a poorer outcome and she asked CL if we were having conversations around this to try and improve the situation.

CL responded we have had long standing conversations with Kirklees commissioners about this and it goes back many years, there is also formal acknowledgement that they commission too few beds from us. She said they have been comfortable in some ways with acknowledging that this could mean that Kirklees people are more likely to go OOA, and there is a range of complexities underpinning this, but their commissioning stance has remained as it is. She said we do continue to have those conversations whilst also adopting a partnership approach to this improvement. CL advised that Kirklees commissioners are also formally involved in the partnership approaches to the priority programmes, and we continue to have those conversations about does their commissioning stance need to alter.

NM thanked CL for her very helpful update.

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KQ remarked it is impressive but there is also a note of caution as this is a system wide issue and it is about a system under pressure, and it needs a relentless amount of focus on lots of strands. JW responded that KQ is quite correct in that there is fluctuation, and what we have done for the first time here is tackle this system wide, and we are building sustainability into this.

CL stated we are very mindful that this needs to be sustainable and there is no sense of complacency with this, the reality of the situation is the Covid situation proved to be insurmountable. The key point to this work is, once it grows it is very difficult to bring back down, as it becomes embedded in terms of expectation and culture and the system expectations around it are also very strong. She said the care group has invested in this in terms of skill mixing and JW is an associate director 3 days of his time, to work exclusively on this and to bring the priorities group together.

DW commented that he would like to say a huge thank you to CL and her team for focusing on this, as it has made a huge difference, and he hopes that this can continue.

It was RESOLVED to NOTE the Care closer to home update.

James Waplington left the meeting.

FIP/23/93 Single Point of Access update (agenda item 13)

Amanda Miller (AM) joined the meeting at this point to present the update, she explained the rationale for the Single Point of Access review and also outlined the current challenges and the scope of the review leading to continued improvement and sustainability. She stated that a key area of focus for the review will be community mental health transformation developments in primary care in each of our places and how we can optimise care pathways for the people who use our services. Consideration will be given to the variation of service offer at place and the development of consistent overarching principles for all our Single Point of Access teams.

NM remarked that it is great to see all this work happening and to see that the review has been put in place, as this is something that has been discussed both here and at Board around those KPIs. She said there is something for her about, how will we retain some oversight of this at Board level as we do not necessarily need the operational detail in their role as NEDs. Also, the performance indicators in here are our high-level ones and do we have other ones. She explained her reason for asking this is that at the Members Council meeting on Friday they heard from one of the governors about the personal experience people have when coming through their care pathway.

AM responded that she is not sure how it feeds back to board but there are certainly strong governance procedures in place to ensure focus is kept on the SPA review, which is essential. She said the qualitative intelligence feedback is very important and hearing those stories and looking at what we can learn from those experiences really helps us to ensure we are improving the experience not only for the people using own services but also for their friends, carers, and family members. She said that SPA is no longer the single point of access and there are various access points now where people can access our mental health services, what is really important however, is that wherever someone enters the mental health services they have a really good experience and smooth pathway.

NM thanked AM for her helpful update, she said we really have improved around performance in this committee, and it is now about how do we improve further around the qualitative, so that we have quantitative and qualitative to really ensure we are being data led in the right way.

KQ thanked AM for the helpful update, she said it is great we are doing this review.
She referred to Barnsley as having the lowest number of referrals and fewer contacts than Calderdale and Kirklees, but the lowest performance in terms of the 14-day access, and she asked what action is taking place around this.

AM responded that Barnsley are currently experiencing some extreme challenges with workforce for various reasons and business continuity plans have been put in place, which are boosting the capacity of Barnsley SPA. She said they are also looking at what has worked well at other Places, so there are things that can be done, even though we still have the workforce pressures, which will help us improve performance, and it is about sharing that information. The further challenge is that in each of our Places the primary care landscape is quite different, but there are transferrable things that we have learnt which will make a positive impact.
AM remarked we are working very closely with Barnsley and are very optimistic that we are on the up in terms of improvement.

KQ commented that her understanding was that we have a really fantastic innovative primary care link between the Trust and primary care in Barnsley, so one might have expected that this could be leading the way.

AM responded it is also important to note on the referrals there is a lot of activity that takes place in SPA that does not actually lead to a referral, and we need to understand this more so we can take account of this.

DW thanked AM for the extremely helpful update.

It was RESOLVED to NOTE the Single Point of Access update.

Amanda Miller left the meeting.

FIP/23/91 Financial benchmarking – agency deep dive (agenda item 10)

RA provided the update stating he would take the paper as read, this is the standard report that goes to the Organisational Management Group (OMG) for more detailed discussion, and more laterally lately it has gone to the Agency, Scrutiny and Management Group in terms of information. In addition to providing additional detail and breakdown of type of staff and care group the report also highlights a number of key controls including off framework breaches, non-clinical utilisation. The detail also includes current action plans against each individual post. Registered and Unregistered nursing are considered as a whole with additional breakdowns provided.

DW referred to exceeding the guidelines and he asked RA if there was anything further he could share that would help him understand this further.
RA responded that this is a timeline issue and a breach against the capped rate and relates mainly to medics.
AS commented that as RA has stated most of the long-time agency roles are consultants in very hard to recruit specialties, and a number of these are in CAMHS, he said the challenge they have put back through the Scrutiny Group and through other routes is to make sure that this does not become the accepted norm, He said there is a risk that we focus on the turnover and forget those at the tail end who have been with us a long time, and we just want to make sure that this has a profile. He said we have also been working with ST and her medical staffing team through the Agency Scrutiny Group to see if we can devise some strategies to recruit to some of those very long-standing recruitment roles.

KQ referred to page 90 of diligent, stating that she had found the table breakdown helpful in terms of the percentage of pay for agency and permanent staff. She asked is it correct that 30% of the pay is for agency staff. RA responded it is correct for October, although it is exceptionally high for that month. KQ remarked this is deteriorating and the concern from a quality perspective as NM has alluded to several times is the quality link, and where we see this here in terms of performance then we also need to see that assurance, and for her this is about triangulating this information.

AS responded this was a good challenge from KQ and that this detail is shared back through operational management and the likelihood is they are already probably aware of these very high agency levels on a day-to-day basis. He explained the Agency Scrutiny Group is very much focussed on money and it does make consideration of the quality impact of us saying no to agency staff. He said he was not sure we pushed particularly hard enough on what the effect of having a third of a team on agency is having, and he felt this was one for CL and himself to take away to discuss with Carol Harris. He explained that with the exception of CAMHS pretty much everything else is inpatients which we would expect, so the question might be a specific one that asks how a community-based service has got into the top 10 list of agency pressures as it was not there previously. AS agreed to take away an operational question to see if they can explain the rationale behind this.

KQ asked AS if we also look at the qualitative impact on patient experience with children and families.

ACTION: Adrian Snarr

CL remarked that these conversations will be taking place at care group level, and there are certain complications with certain teams, for example it does depend on the size of the team and the concentration of different roles. She said we can certainly make this more prominent in terms of what we bring to the Agency and Scrutiny Group, as this agenda is developing, and some of those conversations are becoming more sophisticated in terms of what the care groups are expected to contribute qualitatively.

It was RESOLVED to RECEIVE the financial sustainability update and deep dive into Agency

FIP/23/92 Monthly performance update (agenda item 11)

Mel Wood (MW) presented the update stating that the papers shared with the committee today were also submitted to Private Trust Board. She confirmed the development work continues with regards to the IPR, and as part of the ongoing development of this last month a detailed ward performance section had been included for the first time, she said they would be happy to receive feedback on this or any other particular areas of focus the committee would like them to look at in the near future.

AS remarked just to be clear, these reports were taken to the private part of the board, where it was agreed that all future reports will go into the public section.

DW referred to the ward performance section of the IPR which although he found this useful, he wondered if it was too detailed for the board.
NM agreed with DW in that it was great to see, but she felt there was far too much detail for Board. She felt that as a NED and board member they are probably giving some mixed messages as to what level of detail they would like to see and she said she was happy to own that, she said for her now it is a question of how we get the balance right.

AS responded that NM is quite correct around the detail of this and he felt a lot of this centred around the conversations that took place previously around appraisals, and using this as an example, because we gave an aggregate position to the Board, what they were not sighted on therefore was some low performance areas, in particular, inpatients being one of them. He agreed that they need to have a think about what DW and NM have said and rather than give the board everything, maybe they just need to tell them the ranges. He said CL and himself would take this away as an action to have a further discussion with Carol Harris to look at the best way of doing this going forward.

ACTION: Adrian Snarr/Chris Lennox

CL remarked that whilst they always welcome comments and analysis from NEDs, her concern from an operational point of view about the ward level detail going into public board was potential dislodgement of confidence from members of the pubic in certain wards where the bold figures perhaps do not provide the whole context. She said that as a result of the IPR drills that are being done on a rotational basis, the team are drawing some of this analysis out and comparing between wards, or highlighting hotspots, so this is definitely evolving into the new way of producing this report.

MW thanked the committee for their comments which she said were really useful and helpful, she asked if the team should still include the same level of detail in this month's report.
AS responded that his suggestion would be we continue as normal, and if FIP feel minded to make a recommendation to the board to change this, they can then consider it.

DW remarked that for him the IPR is an executive update to the full board, and if we collectively as a board think there is something missing it is up to us to ask a question. His view is that the document format is subject to change month on month, and as long as the board are receiving the right level of detail with the right level of assurance around it, he would be happy with that.

NM remarked that she largely agreed with DW, but wondered, given we are a performance committee should that level of detail come here rather than it going to the full Board, and she felt there was still a need for a conversation at Board around the role of this committee. She said the point CL had made was a valid one and there is a real balance between transparency around our performance in areas, and also about what is going into the public domain, and when you just see figures they can be hard to understand, when you do not know the complexity around these. She felt there was also something around confidentiality of staff, as at the minute these numbers are quite big, but if they reduce around sickness, staff could arguably feel like they are identifiable. For this reason, NM felt there was still a need for a conversation around this at board around what the role of this committee could be.

KQ agreed with NM in that she found the detail particularly useful for committees, but she felt it only needed to be seen from an assurance point of view at Board, as this is clearly a performance report, and this is a performance committee.

AS remarked that just to remind everyone, one of the challenges we had in this committee historically is the timeline around IPR preparation going to the board, and not allowing a sub committee to scrutinise in advance of Board. He explained we started to put mechanisms in place so that areas that the Board had particular concerns on, we could retrospectively deep dive into those areas. He said we can introduce this to the board discussion around the level of detail that goes to the full Board as opposed to what comes to FIP.

DW agreed with this proposal, and he thanked MW for the helpful update.

ACTION: Adrian Snarr

It was RESOLVED to RECEIVE the Monthly performance update.

FIP/23/93 Waiting times report including Paediatric audiology update (agenda item 12)

CL presented the update stating she would take the paper as read, she asked if there was anything in particular the committee wanted her to go through in greater detail.

DW remarked there was nothing from his side and if the committee were happy we would go straight to questions.

KQ asked if the report included the entire backlog and waiting lists.
CL responded that it does, and a lot of work had been done qualitatively on this, particularly with regards to getting the information onto SystmOne.

KQ remarked that this work is great, particularly the focus on the health and inequalities aspect. She said one of the things to bear in mind going forward in the executive summary is around waiting times, and the need to be more specific around these.

CL responded that her challenge back would be that they prioritise waiting lists based on clinical need, and sometimes people's areas of deprivation, or background etc contribute to that clinical need, and her current feedback is that it needs to be on clinical need. She explained people are working on this and evaluating it, and thinking how we can better reflect inequalities into that clinical need, so we do not operate a unilateral prioritisation on the background of inequalities. She said people are becoming far more sophisticated about building that into individual risk evaluation about how people should be prioritised and if we wanted to do something different and say organisationally we prioritise from certain backgrounds or areas of deprivation or ethnicity we would need to give some more thought to this. She said at this point in time we do not, and people are reflecting that in their individual evaluation, but this is a very interesting and live area of consideration.

KQ responded that she is aware that some other trusts use risk stratification, also that some areas use this approach in terms of their waiting times.
CL responded we have not adopted this approach formally, but we are working closely with clinical colleagues and looking at this as we do recognise this challenge.

DW remarked his only other comment would be that the number of referrals for ASD and ADHD is far above what is expected, and are we seeing more people diagnosed, or is there something else we should be thinking of to stop people being referred.

AS responded that we are having a lot of discussions in Calderdale at the minute around how they have commissioned the assessment process because it is through Choice, and therefore choice is exercised at the point of going to the GP, there is no pre-screening, so what we are going to see is a continued increase in referrals coming through, and also an open ended financial cost because they have to have an assessment and that is chargeable through choice. He said Calderdale and Leeds are already seeing significant financial pressures coming through, but from a commissioned model it is very open through the choice agenda for people to get referred.

CL agreed with AS, she said she feels this is a societal challenge really and very much caught up with the Choice agenda, and also how people in communities feel that their needs can or cannot be met, and she hoped that some of the investment in primary care in transformation, whilst it is mental health focused, can contribute to that overall wellbeing and opportunities to improve people's quality of life without seeking a diagnosis. She said that this is a national position we are in, and commissioners will be well aware of the challenges in each of the Places.

DW thanked CL for the helpful update.

It was RESOLVED to RECEIVE the Waiting times report including the Paediatric audiology update.

FIP/23/94 Work plan (agenda item 13)

DW remarked that as agreed at the beginning of the meeting the work plan will be picked up at the next meeting.

FIP/23/95 Any other Business (agenda item 13)

AS provided the update-

<u>NHS finance letter and board sign off for forecast outturn.</u>
AS confirmed the Trust reconfirmed via email on Friday our plan to achieve a break-even position and this has therefore been fed into the ICB position. He stated there is a call for Chief Executives within West Yorkshire tomorrow, and a parallel one for South Yorkshire confirming what the ICB will send to NHS England.

PSR

AS remarked that we will probably add this to the agenda at some point in the future but just by way of context where it will impact on this trust is where we commission services as the adult secure lead provider, because we are in effect commissioning health services, and there may be changes to this. Also, where we have historically had to tender for services in parts of our region, this might diminish because tenders are not a prerequisite for health services anymore and there is now a different assessment. AS confirmed he would keep the committee updated but for now this is purely for information.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	**Director of Finance & Resources/Director of Strategy & Change**		
Paper prepared by:	**Deputy Director of Corporate Governance**		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for December 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 December 2023. Further developments of the IPR are ongoing in line with the development plan. A new section has been added at the start of the report to identify headlines. This section of the report identifies metrics for the month of December where there has been a change in performance or where expected levels are not being achieved – this will be updated each month to reflect the reporting months performance.		

The update for the Trusts priority programmes now includes a RAG rating to determine progress against the plan/progress against agreed timescales for each of the programmes.

Strategic Objectives and priorities

- A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 97% against a target of 90%. For the Trust derived indicators, as of December 2023, disability 47%, sexual orientation 45.5% 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 and there has been a light increase in recording over the last month.
- 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 - December figure of 85.9% is provisional. 175 exceptions have been reported in December, this data is being verified. Exceptions relate to potential recording issues on the clinical system by temporary additional staff who are supporting the services and further work is required to confirm data quality. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours.

Quality

NHS England Indicators (national)

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

- Significant service improvement work has led to inappropriate out of area bed days being slightly below trajectory with 85 days used in December, this is a significant improvement compared to the 6 months of the year but has increased slightly over the last quarter (66 in October and 75 in November). 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 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 64.3% in December from 63% reported in November, 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 and in line with the national picture, demand is now outstripping capacity. Improvement work across the ICS has commenced.
- The number of children & younger people with an eating disorder requiring urgent access to treatment dropped in December 23 with 75% achieving the 1-week standard for urgent cases and 87.5% achieving the standard for routine cases. Staff sickness has impacted three out of the four breaches for routine appointments. The urgent appointment that breached was due to the carer cancelling the appointment that was offered within the timescale.

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 a sustained 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 December data for care planning shows continued sustained performance above the 80% threshold since April 23, achieving 88% for the month.

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

A review of the data for community services indicated that performance should be monitored for a larger group of people. When reporting was revised performance shows a deterioration. The teams have broadened local monitoring and are working hard to improve performance and have identified additional learning which will support rapid improvement.

	To support patient safety, 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 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 challenging due to staffing/operational pressures in community learning disability services, with 81.6% - (40 out of 49) 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. 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** 95% of incidents reported in December 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 increased to 193 (153 in November). 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. • 100% of prone restraint incidents were for a duration of three minutes or less – this related to 8 incidents for the month of December 23. • There were 8 information governance personal data breaches during December 2023 which is which is the lowest so far during the current financial year. 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 December was 42. 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. • Data to identify the number of pressure ulcers which developed under Trust care where there was a lapse in care has been refreshed as part

	of the PSIRF go live and now shows an increase in the number of cases. The refresh identified a data issue and further work was undertaken to ensure the data included in this report for this metric aligned to other pressure ulcer reporting data in the Trust. All reported cases follow usual Trust policy regarding deep dive and root causes analysis and to identify learning. • There is one case of clostridium difficile (C.diff) reported for December 23. The case is deemed healthcare associated, a case review has been undertaken and will be presented at a post infection review (PIR) meeting for scrutiny and to establish if the case is avoidable or unavoidable. The case will also be reviewed for action through internal governance processes. • Number of responses provided within six months of the date a complaint received continues to be under the local threshold of 100% but continues to show a month-on-month improvement as work continues to work through a backlog. **Our People** • The Trust reported 4 RIDDOR incidents during quarter 3. All four reported incidents relate to violence and aggression (assault). In all reports, staff have been supported through their recuperation. Three out of the four incidents were reported within the 15-day timeframe to HSE with the third incident being reported at day 16 after the incident took place. The delay in reporting was due to delays in trying to establish full reasons for the staff absence which contributed to the late reporting in this instance. There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q3. • Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for December is 65.2% which is a slight deterioration from the refreshed performance for November which was 67.9%. As part of the supervision policy review an improvement programme is underway to increase uptake and recording of supervision across the clinical workforce, this includes making further changes to systems and reporting. • The Trust had 20 violence and aggression incidents against staff on mental health wards involving race during December - incidents 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 December. The number of people joining the Trust outnumbered leavers in December. Year to date, we have had 513.2 new starters and 360 leavers. Focus remains on recruitment and retention. • Overall turnover rate in December was 12% which is the same as last month and remains green as within threshold. • Sickness absence in December was 5.1% which is above local threshold, with a rolling 12-month position of 5.1%. Actions are in place to address hotspots and particularly in the Forensic care group.

	• Rolling appraisal compliance rate for December saw an increase, from 73.1% to 74.3. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals. • Triangulation is taking place between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and any specific actions required. • Overall mandatory training is at 91.9% compliance which exceeds the Trust target of 80%, this has reduced marginally from last month 92.1%. Cardiopulmonary Resuscitation (77%) and Information Governance (94%) are below the Trust targets. 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 into the Forensic care group can be found under item 10.2 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 December, and we have also provides a breakdown of the 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. • There is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three Registered Nurses, some of whom have recently completed their own preceptorship. • The Trust currently has higher than usual levels of vacancies in some 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) continues, and 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 December, the overall number of cases that were clinically ready for discharge was at 5.7%, this has reduced slightly from 5.8% 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. • 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. • There was one admission of an under 18 year old to an adult bed during December. 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. **Finance** • A deficit of £66k been reported in December 2023 which means that the year-to-date surplus is now £1.1m. This is £0.3m ahead of plan and on that basis the Trust remains on track to achieve its breakeven target for 2023/24. • Spend in December continued to be maintained at a lower level than the first half of the year. Spend is higher in December than November as this included a one-off benefit. Year to date expenditure is £6.8m and the forecast is £8.8m which is £0.1m more than target. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • Overall, the Trust cash position is £75.9m. Working capital management actions continue to maximise the Trust cash position. • 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

December 2023

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for December 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.

Headlines

This section of the report identifies metrics for the month of December where there has been a change in performance or where expected levels are not being achieved.

Strategic Objectives & Priorities

Metric	Change from last month	Variation/ Assurance
Improving Health		
Percentage of service users who have had their equality data recorded - disability	↑	
Percentage of service users who have had their equality data recorded - sexual orientation	↑	
Improving Resources		
Surplus/(deficit) against plan (monthly)	↑	
Capital spend against plan (monthly)	↓	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	↓	

Metric	Change from last month	Variation/ Assurance
Improving Care		
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	↑	
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↓	
Inappropriate out of area bed placements (days)	↑	
% service users clinically ready for discharge	↓	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	

Metric	Change from last month	Variation/ Assurance
Making SWYPFT a great place to work		
Sickness absence - rolling 12 months	↓	
Workpal appraisals - rolling 12 months	↑	
Staff supervision rate	↓	
Mandatory training - Cardiopulmonary resuscitation	↓	
Mandatory training - Information governance	↑	

Quality

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	↑	
Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care	↑	
% of prone restraint with duration of 3 minutes or less	↑	
% people dying in a place of their choosing	↑	
C Diff avoidable cases	↑	

People

Metric	Change from last month	Variation/ Assurance
Sickness absence - month	↑	

National metrics

Metric	Change from last month	Variation/ Assurance
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	↑	
Total bed days of Children and Younger People under 18 in adult inpatient wards	↑	
Total number of Children and Younger People under 18 in adult inpatient wards	↔	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	↓	
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↓	
Virtual ward occupancy	↓	

Care Groups

CAMHS

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Complaints with staff attitude as an issue	↑	
% of staff receiving supervision within policy guidance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
Eating Disorder - Routine clock stops	↓	
Eating Disorder - Urgent/Emergency clock stops	↓	
Information Governance training compliance	↑	
Reducing restrictive practice interventions training compliance	↓	
Sickness rate (Monthly)	↑	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
Information Governance training compliance	↓	
Reducing restrictive practice interventions training compliance	↓	
Sickness rate (Monthly)	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% bed occupancy	↑	
% of staff receiving supervision within policy guidance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
% of clients clinically ready for discharge	↓	
FIRM Risk Assessments - Staying safe care plan in 24 hours	↑	
Information Governance training compliance	↑	
Sickness rate (Monthly)	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
% of clients clinically ready for discharge	↑	
Information Governance training compliance	↑	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	
Reducing restrictive practice interventions training compliance	↑	
Sickness rate (Monthly)	↓	

Barnsley General Community Services

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% people dying in a place of their choosing	↑	
% of staff receiving supervision within policy guidance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
Information Governance training compliance	↓	
Reducing restrictive practice interventions training compliance	↑	
Sickness rate (Monthly)	↑	

Forensic

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy	↑	
% Service Users on CPA with a formal review within the previous 12 months	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
Information Governance training compliance	↑	
Sickness rate (Monthly)	↑	

Key

Improvement from last month but remains up to 5% below threshold	
No change from last month and remains up to 5% below threshold	
Deterioration from last month and remains up to 5% below threshold	
Improvement from last month but remains below threshold	
No change from last month and remains below threshold	
Deterioration from last month and remains below threshold	
Achievement of threshold and increased performance from last month.	
No change from last month and achieving threshold	
Achievement of threshold but decreased performance from last month.	

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

This section has been developed to 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 97% against a target of 90%. For the Trust derived indicators, as of December 2023, disability 47%, sexual orientation 45.5% 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 and there has been a light increase in recording over the last month.

• 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 - December figure of 85.9% is provisional. 175 exceptions have been reported in December, this data is being verified. Exceptions relate to potential recording issues on the clinical system by temporary additional staff who are supporting the services and further work is required to confirm data quality. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours.

Quality

NHS England Indicators (national)

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

• Significant service improvement work has led to inappropriate out of area bed days being slightly below trajectory with 85 days used in December, this is a significant improvement compared to the 6 months of the year but has increased slightly over the last quarter (66 in October and 75 in November). 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 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 64.3% in December from 63% reported in November, 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 and in line with the national picture, demand is now outstripping capacity. Improvement work across the ICS has commenced.

• The number of children & younger people with an eating disorder requiring urgent access to treatment dropped in December 23 with 75% achieving the 1-week standard for urgent cases and 87.5% achieving the standard for routine cases. Staff sickness has impacted three out of the four breaches for routine appointments. The urgent appointment that breached was due to the carer cancelling the appointment that was offered within the timescale.

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 a sustained 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 December data for care planning shows continued sustained performance above the 80% threshold since April 23, achieving 88% for the month.
For risk assessments, the December data shows a slight increase in performance from the previous month within inpatient services (90%).
A review of the data for community services indicated that performance should be monitored for a larger group of people. When reporting was revised performance shows a deterioration.
The teams have broadened local monitoring and are working hard to improve performance and have identified additional learning which will support rapid improvement.
To support patient safety, 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 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 challenging due to staffing/operational pressures in community learning disability services, with 81.6% - (40 out of 49) 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. 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

95% of incidents reported in November 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 increased to 193 (153 in November). 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.

• 100% of prone restraint incidents were for a duration of three minutes or less – this related to 8 incidents for the month of December 23.

• There were 8 information governance personal data breaches during December 2023 which is which is the lowest so far during the current financial year. 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 December was 42. 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.

• Data to identify the number of pressure ulcers which developed under Trust care where there was a lapse in care has been refreshed as part of the PSIRF go live and now shows an increase in the number of cases. The refresh identified a data issue and further work was undertaken to ensure the data included in this report for this metric aligned to other pressure ulcer reporting data in the Trust. All reported cases follow usual Trust policy regarding deep dive and root causes analysis and to identify learning.

• There is one case of c difficile reported for December 23. The case is deemed healthcare associated, a case review has been undertaken and will be presented at a post infection review (PIR) meeting for scrutiny and to establish if the case is avoidable or unavoidable. The case will also be reviewed for action through internal governance processes.

• Number of responses provided within six months of the date a complaint received continues to be under the local threshold of 100% but continues to show a month on month improvement as work continues to work through a backlog.

Our People

• The Trust reported 4 RIDDOR incidents during quarter 3. All four reported incidents relate to violence and aggression (assault). In all reports, staff have been supported through their recuperation. Three out of the four incidents were reported within the 15 day timeframe to HSE with the third incident being reported at day 16 after the incident took place. The delay in reporting was due to delays in trying to establish full reasons for the staff absence which contributed to the late reporting in this instance.
There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q3.

• Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for December is 65.2% which is a slight deterioration from the refreshed performance for November which was 67.9%. As part of the supervision policy review an improvement programme is underway to increase uptake and recording of supervision across the clinical workforce, this includes making further changes to systems and reporting.

• The Trust had 20 violence and aggression incidents against staff on mental health wards involving race during December - incidents 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 December. The number of people joining the Trust outnumbered leavers in December. Year to date, we have had 513.2 new starters and 360 leavers. Focus remains on recruitment and retention.

• Overall turnover rate in December was 12% which is the same as last month and remains green as within threshold.

• Sickness absence in December was 5.1% above local threshold, with a rolling 12-month position of 5.1%. Actions are in place to address hotspots and particularly in the Forensic care group.

• Rolling appraisal compliance rate for December saw an increase, from 73.1% to 74.3. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Triangulation is taking place between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and any specific actions required.

• Overall mandatory training is at 91.9% compliance which exceeds the Trust target of 80%, this has reduced marginally from last month 92.1%. Cardiopulmonary Resuscitation (77%) and Information Governance (94%) are below the Trust targets. 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 Forensic care group can be found under item 10.2 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 December and we have also provides a breakdown of the 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.
• There is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three Registered Nurses, some of whom have recently completed their own preceptorship.
• The Trust currently has higher than usual levels of vacancies in some 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) continues and 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 December, the overall number of cases that were clinically ready for discharge was at 5.7%, this has reduced slightly from 5.8% 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.
• 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.
• There was one admission of an under 18 year old to an adult bed during December. 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.

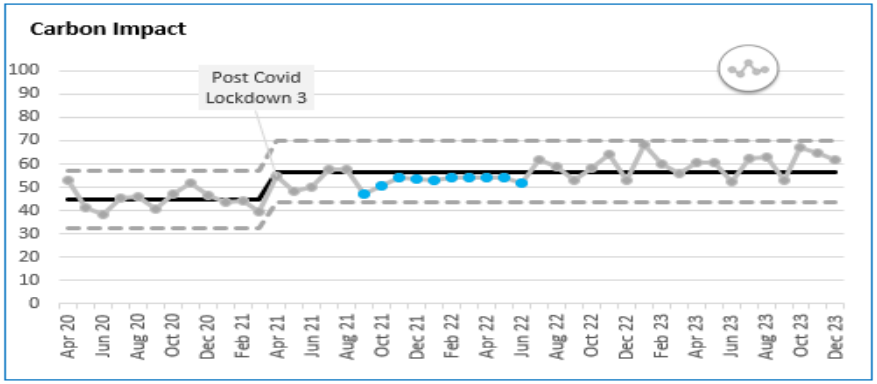
Finance

• A deficit of £66k been reported in December 2023 which means that the year to date surplus is now £1.1m. This is £0.3m ahead of plan and on that basis the Trust remains on track to achieve it's breakeven target for 2023/24.
• Spend in December continued to be maintained at a lower level than the first half of the year. Spend is higher in December than November as this included a one off benefit. Year to date expenditure is £6.8m and the forecast is £8.8m which is £0.1m more than target.
• Actions are in place to address agency spend, which is being overseen by the Trust's agency group.
• Overall, the Trust cash position is £75.9m. Working capital management actions continue to maximise the Trust cash position.
• Performance against the Better Payment Practice Code is 98%.

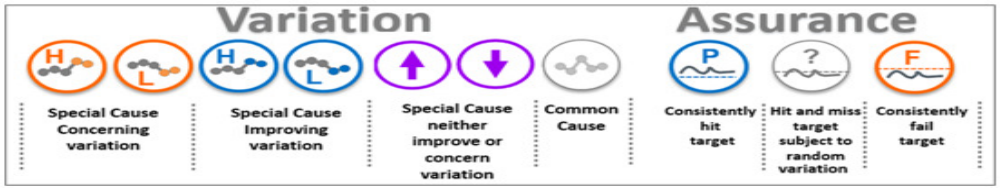
Improving health

Metrics	Threshold	Oct-23	Nov-23	Dec-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.7%	96.7%	97.0%		
Percentage of service users who have had their equality data recorded - disability	50%	46.2%	46.3%	47.0%		A statistical approach is being undertaken in order to work out a target that will be adjusted based on actual performance each month. The current threshold is 50%.
Percentage of service users who have had their equality data recorded - sexual orientation		45.0%	44.9%	45.5%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies	Service timely completion - 75%	82.6% Service	90.3% Service	88.5% 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%	96.3% Policy	96.4% Policy	95.8% Policy		
Completion of equality mandatory training	>=80%	95.5%	95.5%	95.6%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	0	1	1		2023/24 to be used as a baseline once sufficient data is available.
Carbon Impact (tonnes CO2e) - business miles	76	67	65	62		Data showing the carbon impact of staff travel / business miles. In December staff travel contributed 62 tonnes of carbon to the atmosphere.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	Q3 Due Feb 23				Q1 - 65.0%, Q2 - 66.0% 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	Oct-23	Nov-23	Dec-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	89.9%	92.5%	94.1%		December 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.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		70.7%	76.4%	70.7%		Broader parameters have been applied to incorporate the wider caseload and this shows as a drop in performance. The teams have broadened local monitoring and are working hard to improve performance and have identified additional learning which will support rapid improvement. Data for this metric has been refreshed back to April 23 to reflect the updated performance position.
% Service users on CPA offered a copy of their care plan	80%	87.5%	87.7%	88.0%		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	1077	1077	1077		
Registered substantive staff in neighbourhood teams	Establishment	173	173	173		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	24	28	20		Any increases will be monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	66	75	85		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%	5.2%	5.8%	5.7%		This means that people are not in the right environment to best meet their needs and in turn has an impact on available capacity. Active work with partners is in place to reduce barriers to discharge.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	610	721	702		Neurodevelopment waits remain a concern, even with the additional temporary capacity. This is in keeping with the national picture and forms part of the system wide work. These metrics calculate 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. Calderdale - The longest wait for those seen in the month was 746 days, the shortest was 680 days. Number on waiting list at end of December - 132. The longest waiter on the waiting list had waited 783 days.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	584	580	623		
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	77.8% 56/72	84.6% 44/52	81.6% 40/49		Nine out of a total of forty nine people were not seen, assessed and started treatment within 18 weeks, this remains a key concern and actions are underway as part of the improving access priority programme. A deep dive is underway and will report to the executive management team in February 2024. From November, referrals for a learning disability diagnosis only have been excluded from this data set as they are not for the assessment and treatment pathway. They are being monitored separately by the care group.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	90.8%	89.0%	91.2%		
Community health services two hour urgent response standard	70%	88.1%	87.4%	85.3%		
Referral to assessment within 2 weeks (external referrals)	75%	86.8%	84.8%	*85.9%*		December figure is provisional. 175 exceptions have been reported in December, this data is being verified. Exceptions relate to potential recording issues on the clinical system by temporary additional staff who are supporting the services and further work is required to confirm data quality.

Improve resources

Metrics	Threshold	Oct-23	Nov-23	Dec-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£101k)	£325k	(£66k)		A deficit of £66k has been reported in month. Although a deficit this is £132k better than plan. The year to date position is a surplus of £1,136k which is £266k ahead of plan.
Capital spend against plan (monthly)	£8.8m	(£1,406k)	(£1,000k)	(£789k)		The year to date position is £4.3m behind plan with spend of £2.0m for the year to date. The capital spend profile is heavily weighted into quarter 4, a plan is in place however there is a risk of slippage due to adverse weather and no time period for recovery. The funding allocation of IFRS 16 (leases) remains an unknown risk.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£636k	£210k	£564k		Agency spend has been maintained in December at a lower level than the first half of the year. November was lower due to a one off VAT benefit. This reduction is primarily in nursing categories (registered and unregistered) and is generally through reduced demand on ward areas.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£1032k	£1800k	£1,286k		The cumulative savings to date are £8.4m and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	4				All four reported incidents relate to violence and aggression (assault). In all cases, staff have been supported through their recuperation. Three out of the four incidents were reported within the 15 day time frame to HSE with the third incident being reported at day 16 after the incident took place. The delay in reporting was due to delays in trying to establish full reasons for the staff absence. There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q3.
Estates Urgent Response Times - Service level agreement (SLA)	95%	94.2%	96.1%	98.5%		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 was analysed and understood to be in part due to workload capacity and waiting for parts. The issues have resolved with performance in November and December above threshold.
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**	**Oct-23**	**Nov-23**	**Dec-23**	**Variation/ Assurance**	**Notes**
Turnover external (12 month rolling)	>12% - 13%<	12.4%	12.0%	12.0%		Rolling turnover remained in line with November 2023
Registered workforce growth	3% (by March 24)	4.7%				
Sickness absence - rolling 12 months	<=4.8%	5.2%	5.2%	5.1%		Absence rate in month reduced slightly to 5.1%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	>=78%	69.7%	73.1%	74.3%		For the month of December, the percentage rate increased to 74.3% but continues to remain below threshold. Work is taking place to understand the relation between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and whether there are any specific reasons.
% staff recommending the Trust as a place to work	65%	N/A				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%	64.6%	67.9%	65.2%		As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice. The data has been refreshed and performance has improved from 62.3% originally reported in October and 65.3% originally reported for November.
Mandatory training - Cardiopulmonary resuscitation	80%	79.7%	78.5%	77.0%		There was a slight increase in mandatory training in September, following the seasonal impact noted in August, however this has since dropped slightly and remains below threshold in December 2023. In order to maintain a safe environment, inpatient services ensure access to appropriately cardiopulmonary resuscitation trained staff on each shift.
Mandatory training - Reducing restrictive practice interventions	80%	82.9%	85.0%	81.8%		Performance has decreased slightly in December but 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%	91.0%	90.6%	90.8%		
Mandatory training - Information governance	95%	94.5%	93.4%	94.0%		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	Nov-23	Dec-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%	85.8%	84.2%	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)	8% (2/24)	17% (4/23)	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)	44.1% (12/27)	44.4% (4/9)	
	Written complaints – rate	trend monitor										
Service User Experience	Friends and Family Test - Mental Health	84%	82%	85%	91%	90%	90%	95%	89%	88%	94%	1
	Friends and Family Test - Community	95%	94%	97%	96%	93%	97%	96%	95%	97%	98%	1
Quality	Number of compliments received	N/A	50	66	33	35	22	17	18	35	16	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	32	38	27	24	31	18	23	19	10	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	2	3	3	5	2	2	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	1	1	0	0	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%	87.7%	87.6%	1
	Number of Information Governance breaches [3]	<12	12	9	14	13	16	8	9	11	8	2
	% of inpatients clinically ready for discharge	3.5%	2.4%	2.1%	4.6%	4.8%	5.7%	5.7%	5.2%	5.8%	5.7%	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%	89.9%	92.5%	94.1%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	65.0%	66.1%	74.0%	72.2%	71.3%	71.1%	76.4%	70.7%	2
	Total number of reported incidents	Trend monitor	1198	1327	1257	1156	1204	1150	1308	1319	1139	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	18	31	19	21	28	23	24	19	31	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	3	2	5	1	4	1	3	1	4	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	5	2	1	3	3	1	3	1	0	
	Safer staff fill rates	90%	123.5%	123.5%	123.7%	123.9%	123.8%	124.1%	123.5%	128.8%	128.7%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	94.4%	95.7%	93.1%	93.6%	92.1%	91.4%	91.3%	97.5%	96.2%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	29	42	40	36	43	43	28	31	22	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	2	1	0	1	2	0	3	6	4	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	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%	66.6%	100.0%	1
	Number of Falls (inpatients)	Trend monitor	34	41	43	33	33	34	48	46	42	
	Number of restraint incidents	Trend monitor	192	186	201	145	146	92	198	153	193	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting to start from Sept 23					64.2%	63.8%	67.2%	64.9%	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%	91.3%	66.7%	95.1%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	1	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	1 (under review)	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	
	Overall CQC rating		Good									
	CQC well - led rating		Good									

Quality Headlines

Quality Headlines cont…

1 - Attributable - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The Information Governance breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
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.

Quality Headlines

• In December there was a 65% reduction in the use of prone restraint, the second consecutive month of reduction in this practice.
• Overall number of restraint incidents - during December this increased to 193 from 153 in November. Further detail is provided in the relevant section of this report. The Trust's ongoing ambition is for a reduction in all restraint incidents, and reducing restrictive physical interventions training has a clear focus on interventions to prevent escalation of a situation to the point where restraint is required.
• Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care - the data for previous months has been refreshed as part of going live with PSIRF. The refresh identified a data issue and further work was undertaken to ensure the data included in this report for this metric aligned to other pressure ulcer reporting data in the Trust. All reported cases follow usual Trust policy regarding deep dive and root causes analysis and to identify learning. In December – there were four lapses in care - one related to a difference in clinical opinion about wound care classification and one which relates to who should carry out risk assessments for pressure damage – both of these are part of other work that is ongoing in the care group. One relates to delay in adding to Datix and recording a pressure ulcer and one to how and ulcer was managed. Both of these are managed through the ongoing training delivered to neighbourhood nursing.
• Performance for children's and adolescent mental health service (CAMHS) referral to treatment A review to ensure consistent support for people on waiting lists is being led by the waiting list improvement group.
• The number of people with a risk assessment/staying safe plan in place within timescale had increased slightly at 94.1% from 92.5% for inpatient services.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased slightly to 5.7% and remains above threshold. 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.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In November there were 42 inpatient 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 decreased to 8 during the month and remains below threshold - further detail is provided in the relevant section of this report.
• % people dying in a place of their choosing - performance against this metric increased to 95.1% , highlighting our focus on supporting the person's end of life care wishes.
• 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, as part of the Trust's focus on clinical safety and quality, and staff wellbeing

Patient Safety

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. The Trust's PSIRF plan and policy went live date of the 1st December.

Learn from Patient Safety Events (LFPSE)
Following Datix upgrades we are working on the transition to LFPSE however we are experiencing technical issues on Datix.

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 became mandatory November 2023. This is currently progressing well at 93% completed.
Training on engagement and involvement of those affected by patient safety incidents will be available for team managers and quality leads in January 2024.

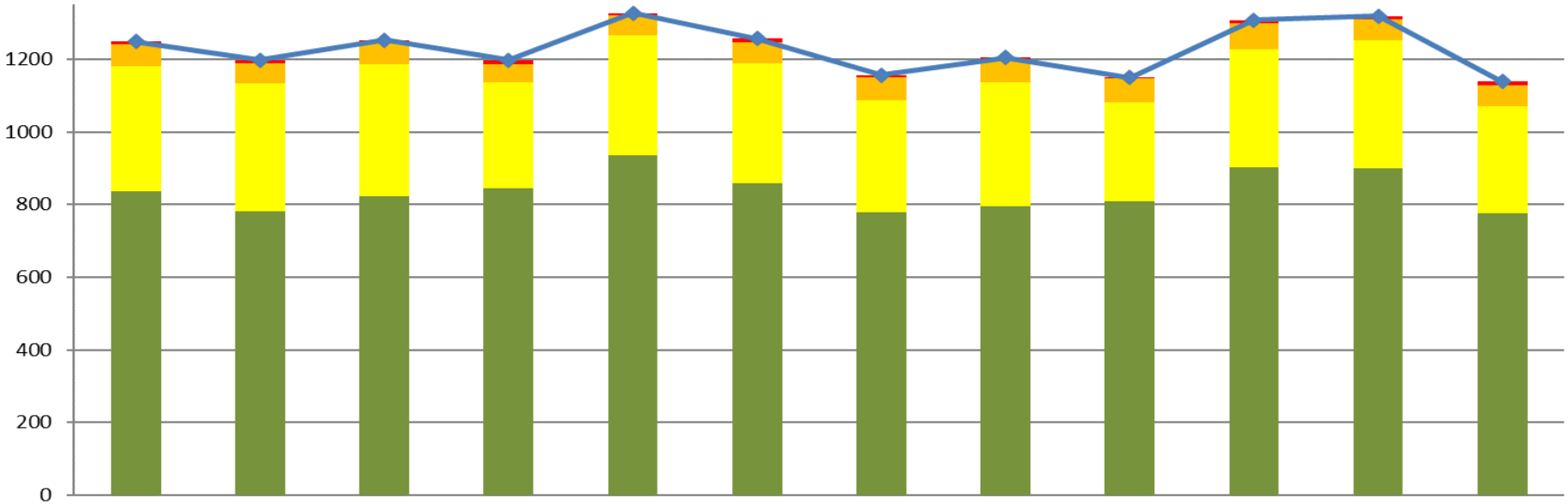
Patient Safety Partners
The three patient safety partners (volunteer roles) will be inducted into the patient safety team in February 2024.

Safety First

Summary of Incidents

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

95% of incidents reported in December 2023 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in December 2023



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Red (should not be compared with SIs)	8	9	9	12	7	11	7	9	3	8	10	10
Amber	59	56	57	51	55	58	63	60	66	72	57	58
Yellow	346	352	364	291	330	330	307	341	273	325	352	295
Green	835	781	823	844	935	858	779	794	808	903	900	776
Total	1248	1198	1253	1198	1327	1257	1156	1204	1150	1308	1319	1139

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click link for further details of the examples which includes information around sexual safety, learning from a serious incident/deaths, recording escapes and inappropriate use of 'toaster bags':

On 12th November 2023, a Trustwide learning forum was held to share learning between Care Groups and specialist advisors. The virtual event was very well attended and many positive examples of learning were shared. Presentations are available on the learning network page on the intranet.

The next event is on Wednesday 14th February at 1:00pm - 2:30pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

Patient Safety Alerts

Patient safety alerts issued in December 2023

Patient Safety alerts not completed by deadline of December 2023 - zero.

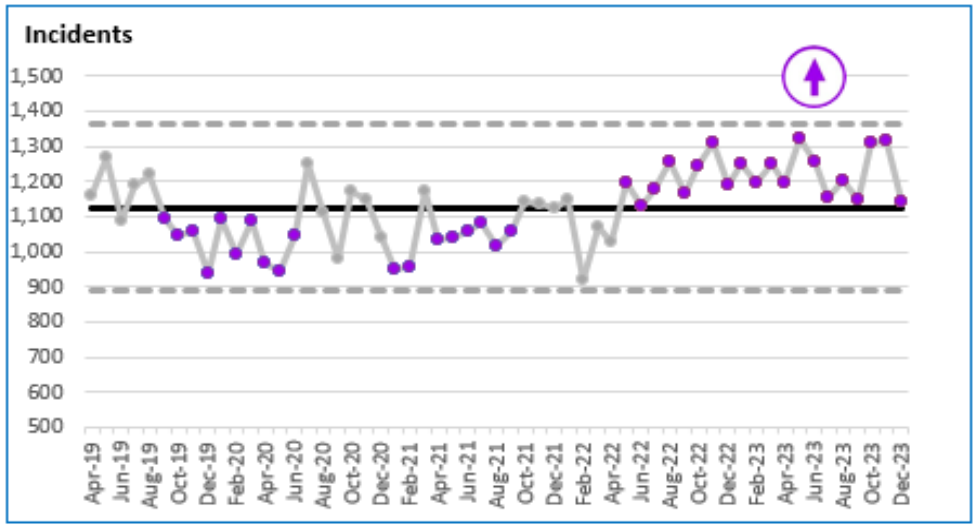
Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/014/NHSPS	Identified safety risks with the Euroking maternity information system	07/12/2023	No - alert not applicable to trust	07/06/2024	13/12/2023
NatPSA/2023/015/UKHSA	Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia – measures to reduce patient risk	08/12/2023	Yes - circulated for information	17/12/2023	08/12/2023
NatPSA/2023/016/DHSC	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba®) products	09/12/2023	Yes - circulated for information	22/12/2023	08/12/2023

Safety First cont…

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

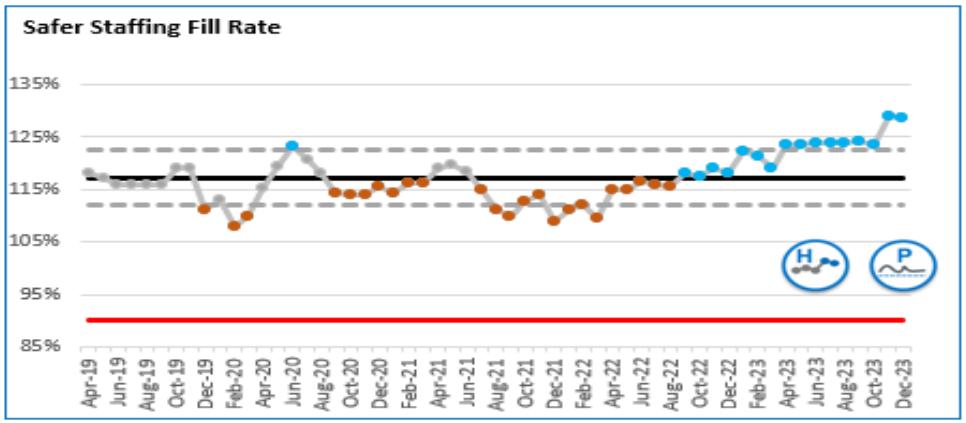
Breakdown of incidents in December 2023
31 moderate harm incidents including 22 pressure ulcer category 3 incidents and 5 self harm incidents.
4 incidents categorised as severe harm, all relating to pressure ulcers.
There were no patient safety related death during the month.

Incidents

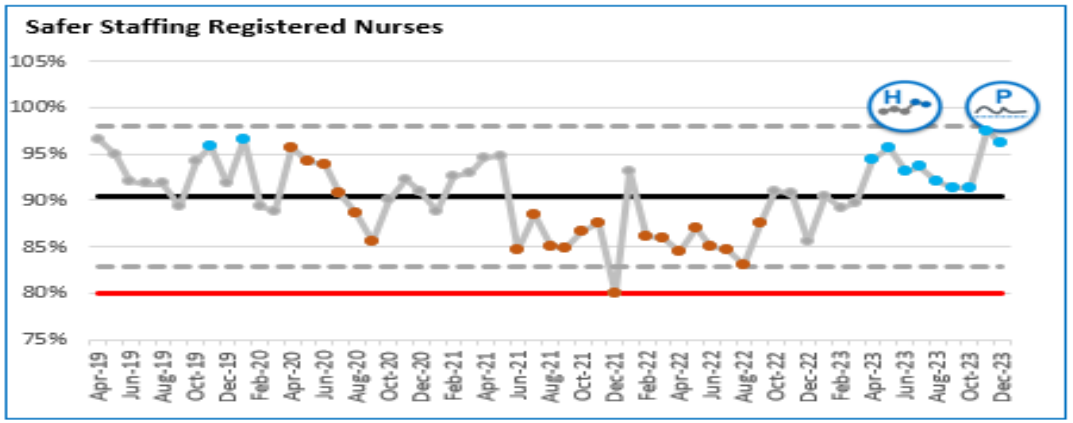


We remain in a period of special cause variation (something is happening and this should be investigated) in November due a continued increase in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting 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).

Safer Staffing Inpatients



The chart above shows that as at December 2023 due to the continued increasing staffing rate, we remain in a period of special cause improving variation.



The chart above shows that in December 2023 we remain in a period of special cause improving variation.

- In December there has been an increase on demand of the flexible staffing pool with a total of 288 more shift requests with the overall fill rate remaining high.
- Work continues to recruit UK trained staff. 8 newly qualified staff were placed in working age adult wards in January 2024.
- We have paused international recruited band 5 cohorts given our positive current staffing situation.
- The two agency scrutiny groups implemented to reduce our agency usage have started to take effect and are now on course to meet the required reduction (£10m agency spend in 2022-23 v control target of £8.7m by March 2024). This has been possible due to increased availability and usage of bank resource in all areas.
- Although we continue to sustain/improve the overall fill rate, we continue to fall short of the Registered Nurse (RN) fill rate for day shift and will continue to look at ways of improving this. This has meant that 20 wards (an increase of two) have fallen below the 90% RN day fill rate with nine wards below 80%, the same as in the previous month.
- In December no ward fell below the 90% overall fill rate threshold, this is in line with the previous three months.

Safer Staffing Inpatients cont…

Registered Nurses Days

Overall registered Day fill rates have decreased by 2.2% to 86.4% in December compared with the previous month.

Registered day rate	Nov-23	Dec-23
Adults and Older People	88%	86%
Barnsley Integrated Services	103%	96%
Forensic and LD	86%	85%
Overall shift fill rate	**89%**	**86%**

Registered Nurses Nights

Overall registered Night fill rates have decreased by 0.3% in December to 106.2% compared with the previous month.

Registered night rate	Nov-23	Dec-23
Adults and Older People	106%	104%
Barnsley Integrated Services	83%	82%
Forensic and LD	111%	113%
Overall shift fill rate	**107%**	**106%**

Overall Registered Rate: 96.2% (decreased by 1.2% on the previous month)
Overall Fill Rate: 128.7% (decreased by 0.1% on the previous month)

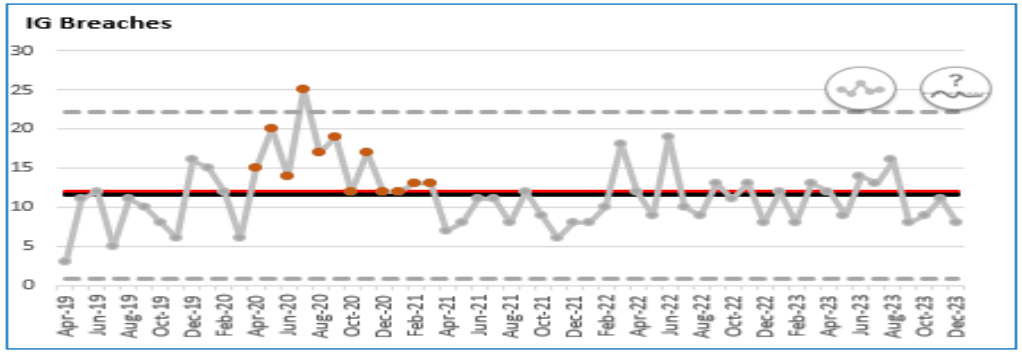
Fill Rate	Oct-23	Nov-23	Dec-23
Adults and Older People	130%	136%	136%
Barnsley Integrated Services	106%	105%	104%
Forensic and LD	115%	120%	120%
Grand total	**124%**	**129%**	**129%**

- Bank staff filled 52.33% (increased by 0.34% on the previous month) of RN requests for flexible staffing and 80.75% (increased by 4.86% on the previous month) of HCA requests.
- Agency staff filled 19.71% (a decrease of 0.22% on the previous month) of RN requests for flexible staffing and 14.92% (a decrease of 4.61% on the previous month) of HCA requests.
- Health Care Assistants showed an increase in the day fill rate for December of 1.6% to 155.0% and the night fill rate decreased by 0.6% to 155.3%.

Information Governance (IG)

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

Five breaches involved information being disclosed in error. Two incidents of record keeping issues were reported. One incident relating to a lost Dictaphone.



This SPC chart shows that as at December 2023 we remain in a period of common cause variation. We remain under the threshold with 8 breaches.

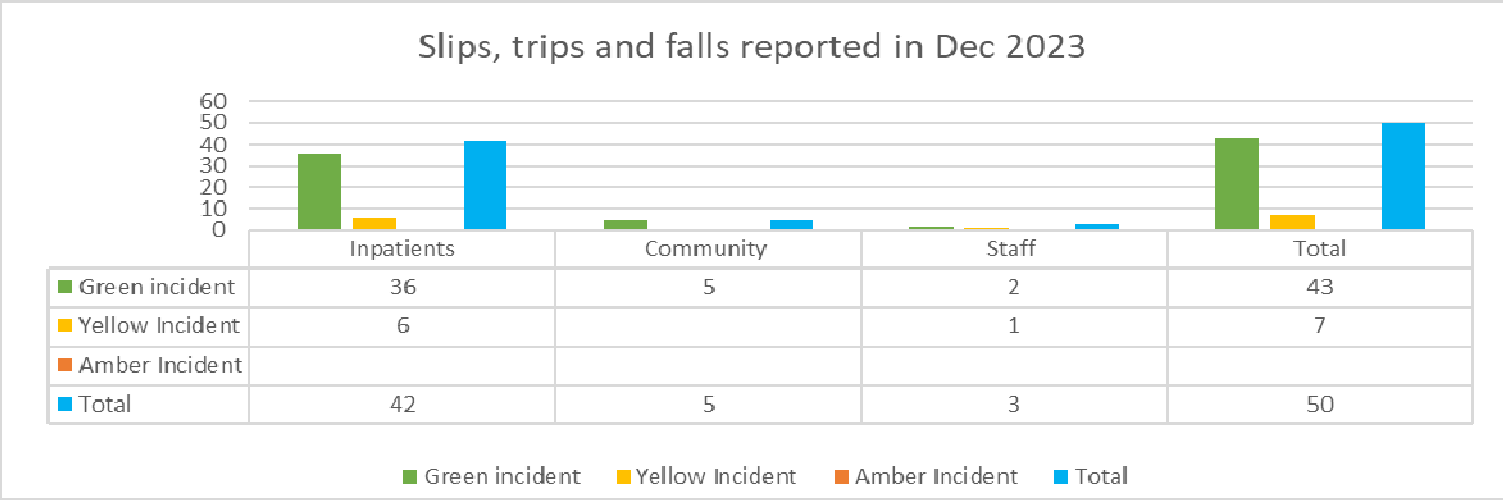
Commissioning for Quality and Innovation (CQUIN)

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. Quarter 3 submission is due to take place in March and full achievement of the applicable indicators for the quarter 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

In December there were 50 recorded slips, trips and falls, broken down as below. The Trust average is 3.1 falls per 1000 bed days (April to Dec 2023 average). National average is 3-5 falls per 1000 bed days.



	Inpatients	Community	Staff	Total
Green incident	36	5	2	43
Yellow Incident	6		1	7
Amber Incident				
Total	42	5	3	50

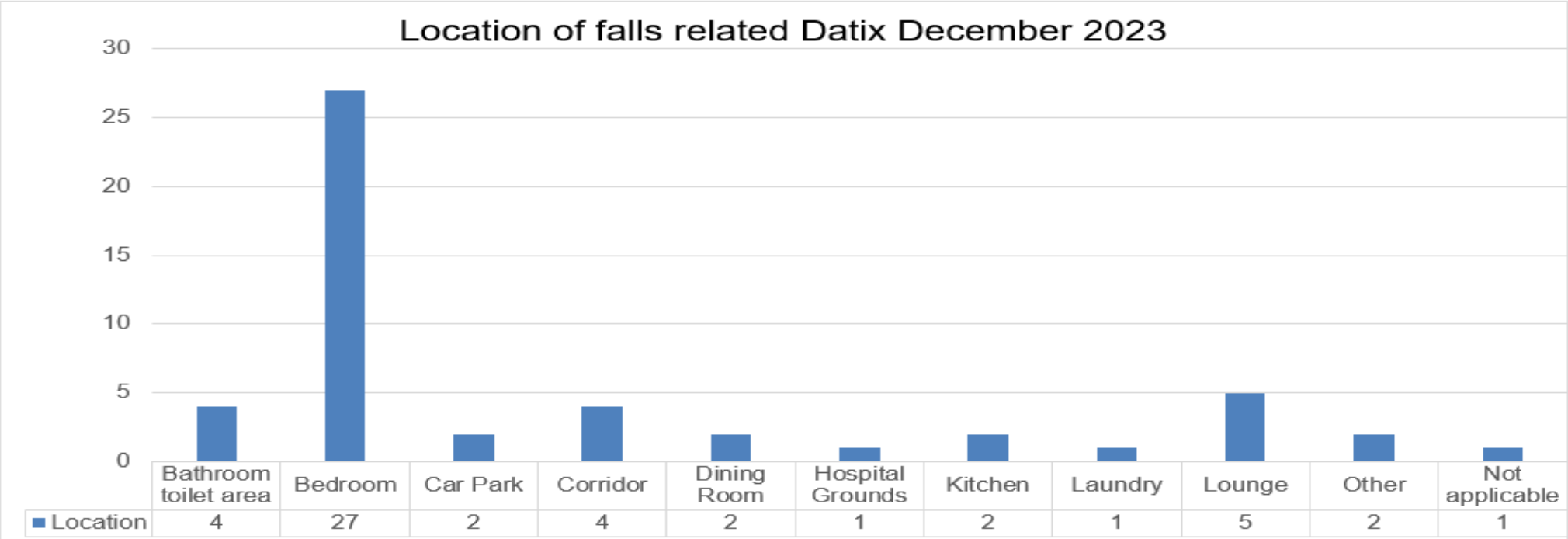
Inpatient related falls
Red: No red incidents have been reported
Amber: No red incidents have been reported
Yellow: 7 incidents, 6 for inpatients and 1 for a staff member
Green: 43 incidents (86% of all incidents), 36 for inpatients, 5 within community and 2 for staff

Trustwide Falls cont…

Falls by location

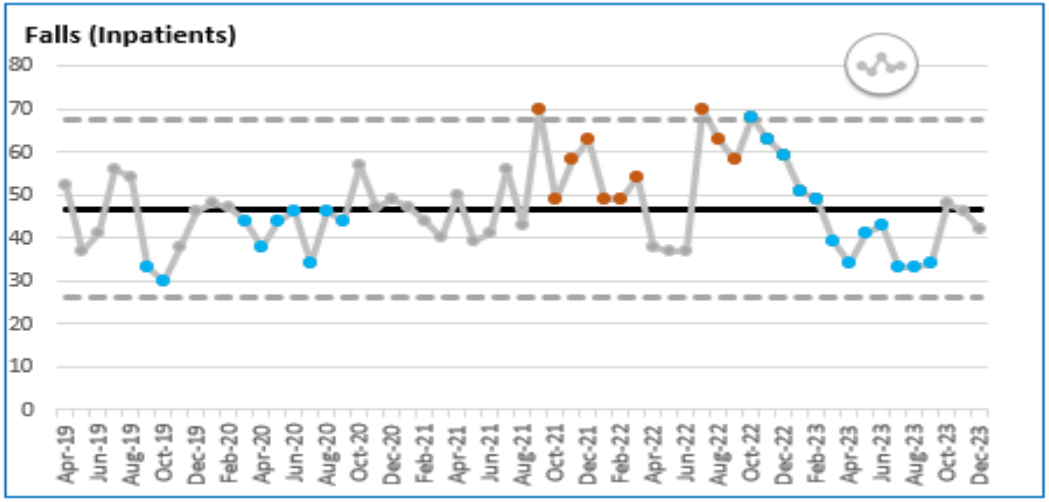
We continue to see a large number of falls within bedrooms. 50% of all reported falls occur in the bedroom area.

Research shows that single occupancy increases falls. The Trustwide falls coordinator is reviewing research around single occupancy bedroom and how other NHS Trusts have been able to manage falls risks and improve patient safety. Early indicators support a multi-disciplinary approach to falls reduction, with a strong focus on staff education. Further update to be provided once this work has been undertaken.



Falls (Inpatient)

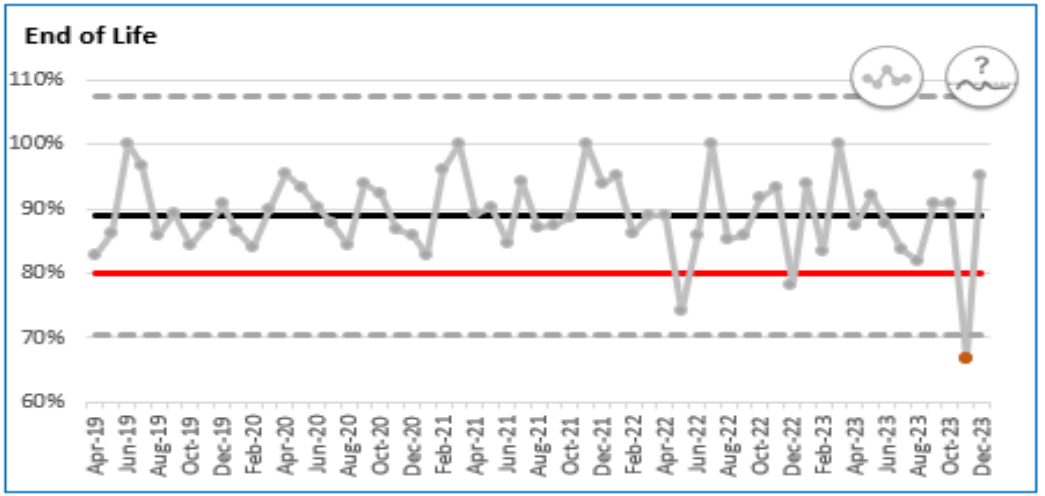
The total number of inpatient falls was 42 in December.



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

End of Life

The total percentage of people dying in a place of their choosing was 95.1% in December. As is noted in the Quality Headlines Dashboard, performance against this metric has increased above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in December 2023 the performance against this metric has re-entered common cause concerning variation (no concern). 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

- 98% would recommend community services
- 94% would recommend mental health services

	Target	October	November	December
Mental health community	85%	91%	92%	96%
Mental health inpatient	85%	84%	80%	97%
Learning Disabilities	85%	95%	100%	100%
ASD/ ADHD	85%	83%	63%	67%
CAMHS	75%	91%	88%	89%
Forensic	60%	100%	83%	75%
Mental health overall	84%*	**89%**	**88%**	**94%**
Barnsley Gen ops	95%	**95%**	**97%**	**98%**
Trustwide	**85%**	**92%**	**92%**	**96%**

** weighted for 2023/24*

- Satisfaction across all service lines increased this month except for Forensics.
- Forensics participate in a patient experience survey every six months which was recently undertaken throughout November. The survey includes the Friends and Family Tests, which is why November's results are significantly higher in both numbers and satisfaction. However, Forensics remain above target.
- ASD/ ADHD services satisfaction continues to increase and do the number of responses, although not significantly.

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

Safeguarding

Safeguarding Adults:
In December 2023, there were 33 Datix categorised as safeguarding adults. Twenty of these were graded as green, 12 were graded as yellow, and one was an amber Datix. The most common sub-categories of these Datix were emotional/psychological abuse, financial abuse, neglect concerns and hate crime.

The amber Datix was in reference to emotional, psychological abuse. This was reported to the local authority safeguarding team. In all cases reviewed appropriate actions were taken and local authority safeguarding referrals were made where required.

Safeguarding Children:
In December 2023 there were 11 Datix categorised as safeguarding children, five of these were graded as green, three were graded as yellow and three were graded as amber. The most common subcategories of these Datix were child protection other, sexual abuse and neglect.

The three amber Datix were responded to appropriately with referrals made to the local authority designated officer (LADO), social care and the police.

Complaints

- Acknowledgement and receipt of the complaint within three working days –23/23 (100% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 4/9 (44%)
- Number of complaints waiting to be allocated to a customer service officer – 5 (all have plans to be allocated)
- 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 – 21/12/2023 (see above for awaiting allocation)
- There were 23 new formal complaints in December 2023
- 16 compliments were received.
- 9 formal complaints were closed in December 2023 (decrease from 27 in November as backlog clears).
- Number of concerns (informal issues) raised and closed in December 2023 – 31
- Number of enquiries responded to in December 2023 - 87
- Number of complaints referred to the Parliamentary Health Service Ombudsman and upheld this financial year to date and how many upheld = 1

Infection Prevention Control (IPC)

Surveillance: There have been zero cases of E.coli bacteraemia, MRSA bacteraemia and MSSA bacteraemia.
There has been one case of C difficile on Willow Ward. The case is deemed healthcare associated, a case review has been undertaken and will be presented at a post infection review (PIR) meeting for scrutiny and to establish if the case is avoidable or unavoidable. The case will also be reviewed for action through internal governance processes.

Mandatory training: figures remain healthy and above Trust 80% threshold:
• Hand Hygiene -Trustwide Total – 94.0%
• Infection Prevention and Control - Trustwide Total – 93.1%

Outbreaks
December 2023, there have been:
• Two Covid-19 outbreaks on inpatient wards
• Two areas monitored for increase in prevalence of Covid-19 on inpatient wards
• One area monitored for increase in patients with gastric symptoms, no causative organism identified.

Covid-19 Clinical Cases
There has been an increase in positive Covid-19 cases on our inpatient wards. This is in line with national and regional figures. Services have been reminded through internal comms, of standard infection prevention and respiratory precautions.
There is a national increase of respiratory viruses

Reducing Restrictive Physical Intervention (RRPI)

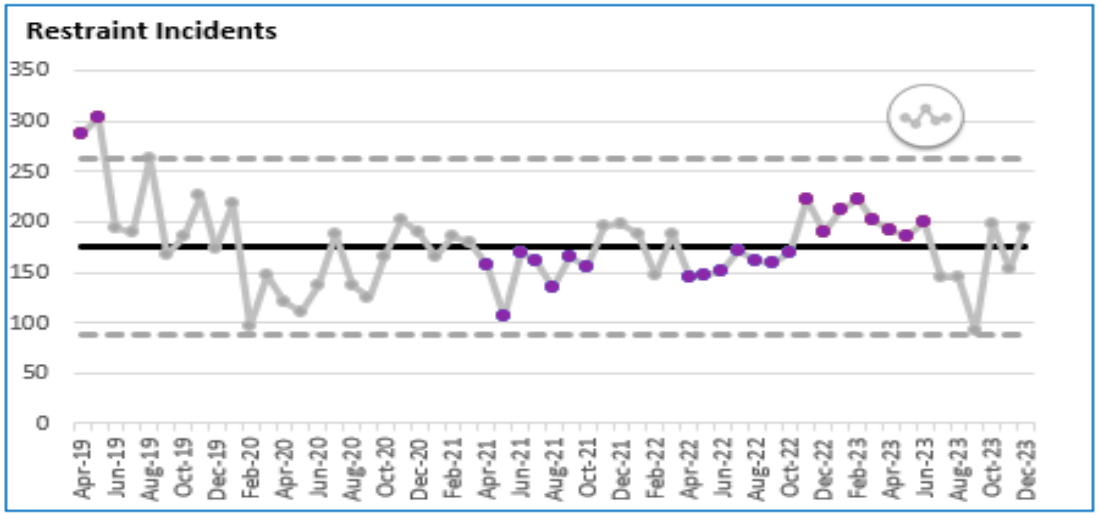
• There was an increase in the number of incidents of restraint in December 2023, however, the use of restraint and remains within normal variation.
• In December 2023 both Psychiatric Intensive Care Units (PICU) in Adult and Older Person Care Group have seen a reduction in the use of restraint and had no prone restraints.
• There has been 65% reduction in the use prone restraint across the Trust in December 2023. This is the second consecutive month of reduction in the use of prone.
• Quality improvement work continues to reduce restrictive physical interventions. Administration of intramuscular medication into the gluteal muscle remains the most common reason for prone restraint. A task and finish group has been established to review current practice and review alternative injection sites as a matter of priority. As part of this:
• Pharmacy colleagues have reviewed licencing of medication and which muscle groups they can be administered.
• RRPI team are reviewing alternative holds to support administration into deltoid muscle and seeking advice from Mersey Care Trust, assessing training needs for alternative injection sites and piloting these.
• We are also investing in additional safety pods to further reduce prone restraints, especially when exiting seclusion (training for this is being piloted).
• In December 2023 there was a reduction in the use of seclusion across the Trust. The previous two months had seen an increase in seclusion and this is being monitored through RRPI task and finish group. There is a 50% reduction in the use of seclusion compared to the same period last year.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	77	39.8%
Seated	42	21.7%
Safety Pod	19	9.8%
Supine	13	6.7%
Restricted escort	12	6.2%
Side	11	5.6%
Prone then rolled	9	4.6%
Prone	8	4.1%
Kneeling	2	1.0%

Duration of Prone Restraint	Total
0 - 1 minute	6
1 - 2 minutes	2

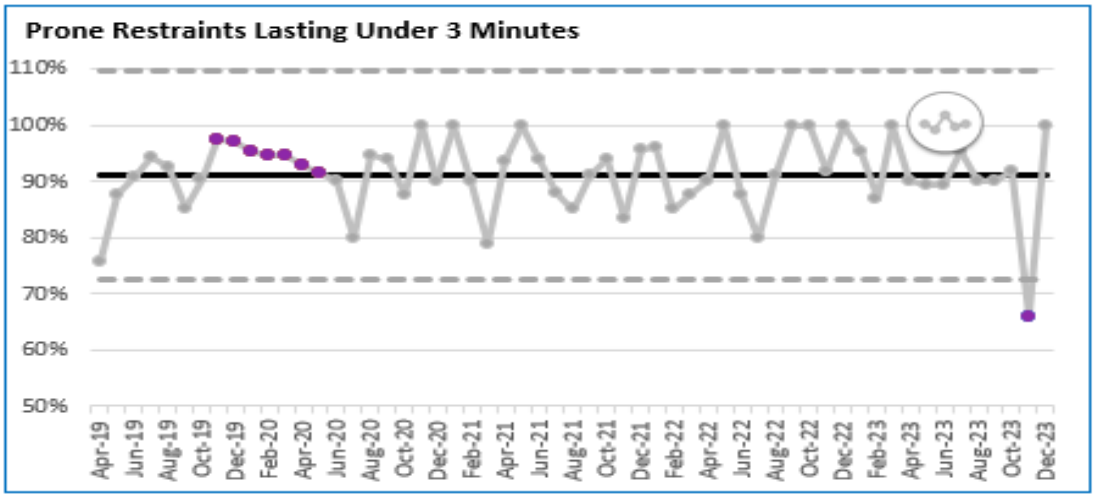
Team Using Prone Restraint Dec 2023	Total
Ashdale Ward	2
Elmdale Ward	2
Nostell Ward, Wakefield	1
Chippendale, Forensic	1
Johnson Ward (Newton Lodge)	1
Newhaven Forensic Learning Disabilities Unit	1

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in December 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, as anticipated, the proportion of prone restraints lasting under 3 minutes in December 2023, has re-entered common cause variation (no concerns) following the dip in performance last month.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Establishment	Improving Resources	Well Led	-	5,157.4	5,174.0	5,193.8	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4
Contracted Staff In Post (Ledger)			-	4,338.5	4,352.0	4,375.4	4,400.5	4,432.7	4453.2	4425.9	4442.5	4471.3
Vacancies			-	818.9	822.0	818.4	796.1	772.1	867.8	897.4	887.0	870.1
Turnover external (12 month rolling)			>12% - <13%	13.0%	12.2%	13.1%	13.0%	13.1%	12.1%	12.4%	12.0%	12.0%
Starters			-	45.8	54.9	57.5	53.9	64.0	63.3	69.4	61.6	42.8
Leavers			-	39.4	36.5	41.1	51.3	45.2	35.2	51.8	31.9	27.6
International Nurse Starters in Month			-	0	0	0	0	9	10	10	10	5
% Bank Fill Rates - Registered Nurses			-	Reporting commenced August 23				47.8%	49.6%	52.0%	59.1%	52.3%
% Bank Fill Rates - Health Care Assistants			-					69.8%	70.2%	75.9%	80.3%	80.8%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)								90.9%	90.3%	90.6%	93.4%	91.6%
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%)	209 - All staff (15.1%) 86 - excl medics (7.21%)	217 - All staff (16.0%) 90 - excl medics (7.7%)
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%)	963 (69.7%)	946 (69.8%)
Sickness absence - Rolling 12 month			<=4.8%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.2%	5.2%	5.1%
Sickness absence - Month			<=4.8%	5.0%	4.6%	4.6%	5.1%	4.7%	4.9%	5.2%	4.9%	5.1%
Employees with long term sickness over 12 months			-	1	0	0	0	0	2	2	0	1
Appraisals - rolling 12 months			May >=78% Overall >=90%	74.4%	74.9%	78.5%	76.5%	74.5%	72.5%	69.7%	73.1%	74.3%
Employee Relations - Suspensions (over 90 days)			-	0	0	0	3	3	3	4	2	2
Mandatory Training - TOTAL	Improving Care		>=80%	90.5%	90.9%	92.0%	92.1%	92.5%	92.1%	92.5%	92.1%	91.9%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	76.7%	76.2%	82.6%	82.8%	82.9%	85.0%	81.8%
Mandatory Training - Cardiopulmonary Resuscitation				75.5%	79.2%	81.3%	81.0%	79.9%	80.0%	79.7%	78.5%	77.0%
Mandatory Training - Clinical Risk				95.6%	95.4%	95.4%	95.2%	94.8%	94.0%	92.6%	91.3%	91.0%
Mandatory Training - Display Screen Equipment				96.5%	96.8%	97.0%	97.1%	97.4%	97.4%	97.4%	97.1%	97.0%
Mandatory Training - Equality & Diversity				96.0%	96.2%	96.2%	96.0%	95.9%	96.1%	95.4%	94.9%	94.9%
Mandatory Training - Fire Safety				90.2%	91.2%	92.8%	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%
Mandatory Training - Food Safety				78.0%	83.4%	86.4%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%
Mandatory Training - Freedom To Speak Up (FTSU)				93.2%	93.7%	94.0%	94.3%	94.7%	94.9%	95.0%	94.9%	95.0%
Mandatory Training - Infection Control & Hand Hygiene				91.5%	92.4%	94.1%	94.3%	94.3%	95.6%	94.2%	93.6%	93.1%
Mandatory Training - Information Governance (Data Security)			>=95%	90.6%	95.9%	96.8%	96.9%	95.3%	94.8%	94.5%	93.4%	94.0%
Mandatory Training - Moving & Handling			>=80%	95.5%	94.9%	95.2%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%
Mandatory Training - Nat Early Warning Score 2 (New S2)				92.5%	92.1%	93.8%	94.7%	95.2%	96.2%	96.0%	94.6%	94.1%
Mandatory Training - Mental Capacity Act/Dols				91.6%	93.6%	93.7%	93.4%	94.0%	96.7%	99.6%	99.2%	99.0%
Mandatory Training - Mental Health Act				91.6%	91.3%	91.2%	91.1%	92.2%	99.8%	91.2%	90.5%	90.2%
Mandatory Training - Prevent				95.4%	95.5%	92.1%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%
Mandatory Training - Safeguarding Adults				90.0%	89.7%	89.3%	89.5%	89.7%	93.9%	90.7%	89.6%	89.4%
Mandatory Training - Safeguarding Children				90.0%	90.7%	91.1%	91.2%	91.7%	89.7%	95.1%	94.4%	94.0%

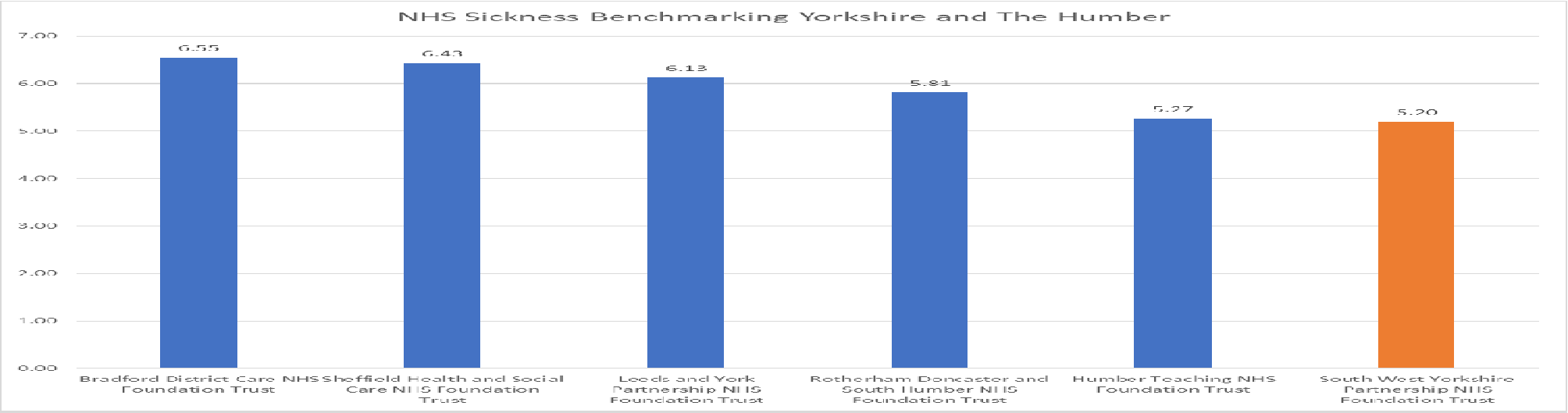
Notes:

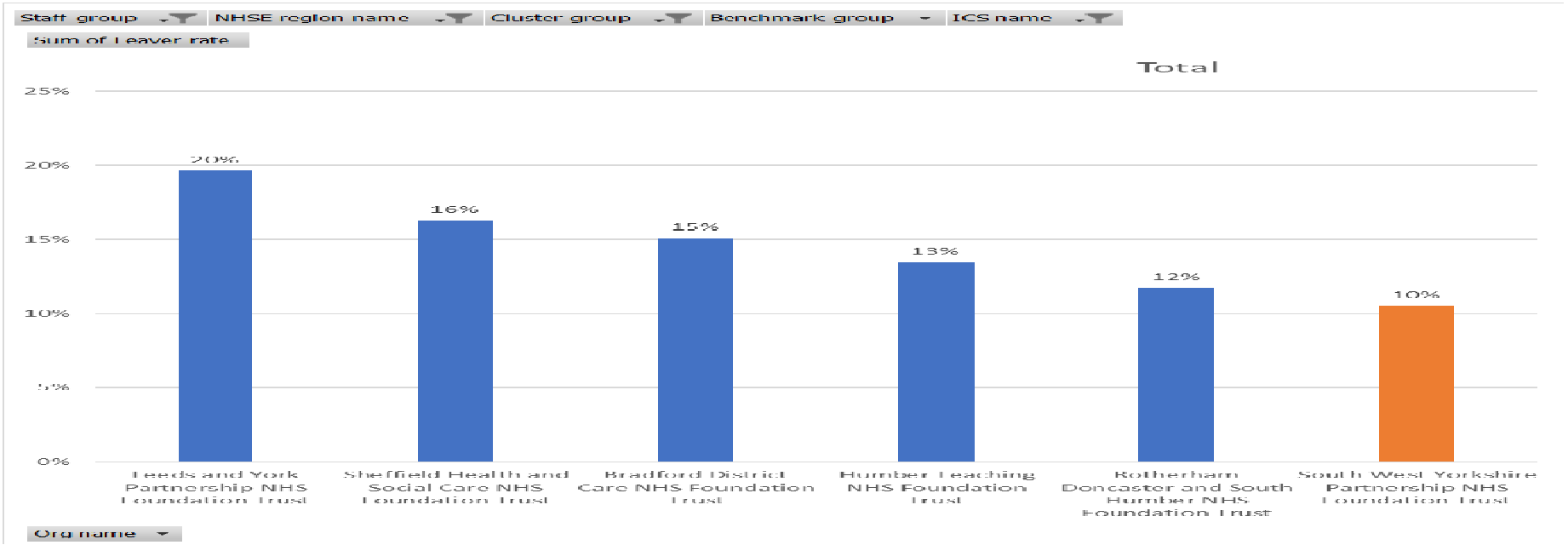
- Contracted Staff In Post (Ledger) - this has replaced the previously reported Staff in Post (ESR Last Day of the month)
- The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not include overtime, additional hours worked or agency.
- Starters/Leavers vs Staff in Post – Whilst our starters and leavers figures give us a true account of turnover growth it will not exactly match the overall staff in post movement from month to month as this also includes any contracted hours changes of existing staff in that same month.
- 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.

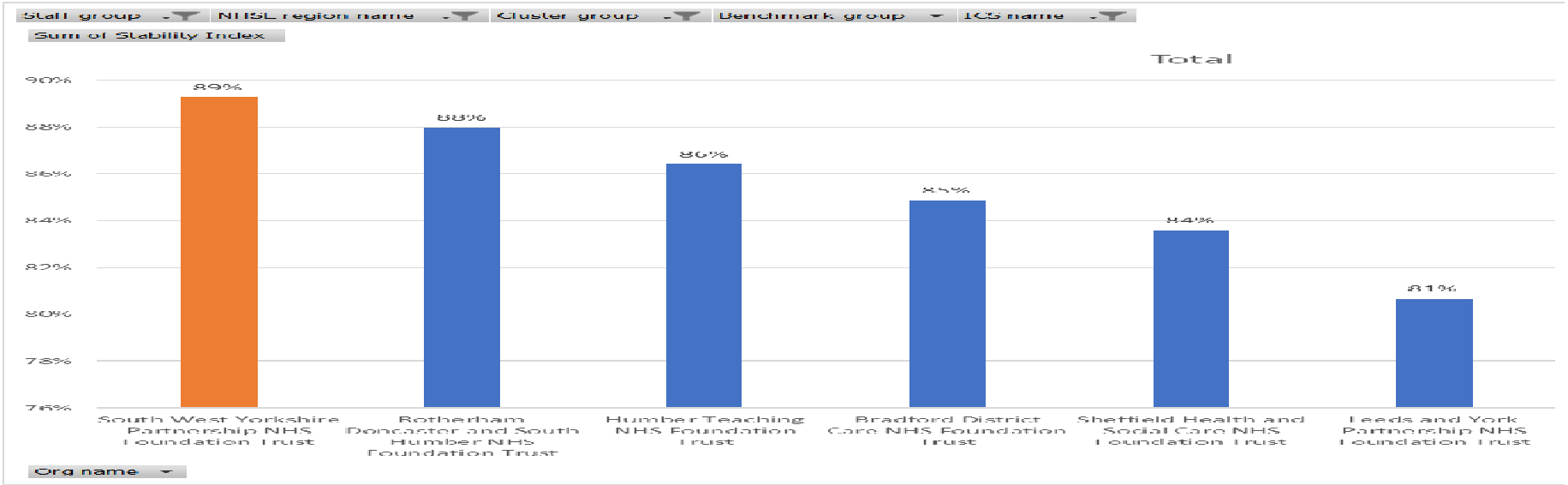
* 22 records had no ethnicity stated

Stability of the Workforce

• 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.
• Starters/Leavers vs Staff in Post – Whilst our starters and leavers figures give us a true account of turnover growth it will not exactly match the overall staff in post movement from month to month as this also includes any contracted hours changes of existing staff in that same month.
• Our substantive staff in post position continues to remain stable and has increased slightly in December. The number of people joining the Trust has dropped this month (42.8WTE) however we have still seen our leavers are less (27.6 WTE).
• Since April 2023 each month has consistently seen more new starters join the Trust compared with the number of employees who have left. Year to date, we have had 513.2 new starters and 360.0 leavers.
• As of December our Trust growth rate is 4.70% (staff in post). This is already exceeding our initial annual forecasted growth rate of 4%.
• Overall, our 12-month rolling turnover rate in December was 12.0% which has remained static since last month (12.0%) but remains within threshold.
• We have seen a decrease in our vacancies in December of 16.92 whole time equivalent however because of our establishment increasing, our vacancy rate has remained static at 16.3%.
• We have recruited a total of 80 International Nurses since April 23.
• Nurses who are yet to receive certificates of sponsorship but have received conditional offers of employment have been paused whilst the Trust reviews it's short-term nursing workforce plan. There will be no international nurse recruit cohorts in February 24 and March 24.
• When benchmarked regionally against other Mental Health Trusts we are seeing both the highest workforce stability rate and the lowest turnover (See graphs).




Staff group
NHSE region name
Cluster group
Benchmark group
ICS name
Sum of Leaver rate
Total
25%
20%
15%
10%
5%
0%
20%
16%
15%
13%
12%
10%
Leeds and York Partnership NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Org name


Staff group
NHSE region name
Cluster group
Benchmark group
ICS name
Sum of Stability Index
Total
90%
88%
86%
84%
82%
80%
78%
76%
89%
88%
86%
85%
84%
81%
South West Yorkshire Partnership NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Org name

Keep fit and Well

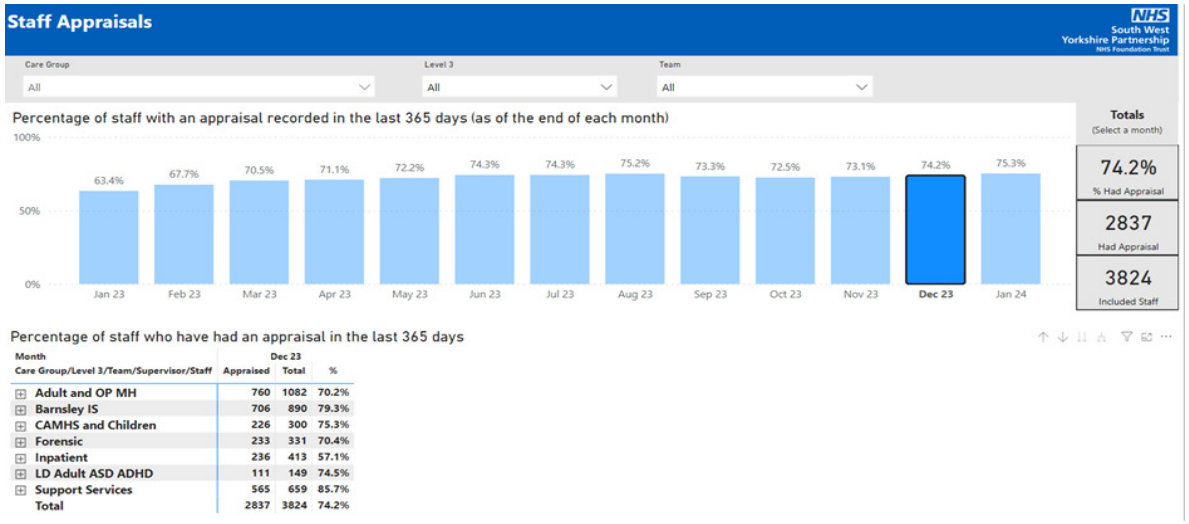
Absence

• Although the 'In month' sickness rate has increased this month (due to expected seasonal variances) we are still seeing the 12 month rolling absence rate has decreased slightly this to 5.1% (previously 5.2%).
• The overall 12 month rolling Barnsley Care Group have reduced their sickness rates to 4.9% (previously 5.1%), this is mainly contributed by the Mental Health Workforce which have dropped to 4.8% (previously 5.3%).
• Although Forensics remains high at 8.1% this has dropped since last month.
• Our additional Clinical Services (HCSW's) has also dropped in December to 5.9%% and remains above 6% since May 23.
• When compared to the July 23 published data by NHS England (This is the most recent benchmark data available from NHS Digital), we have the lowest sickness absence compared with other regional Mental Health Trusts (See graph).

Supportive Teams

Appraisals

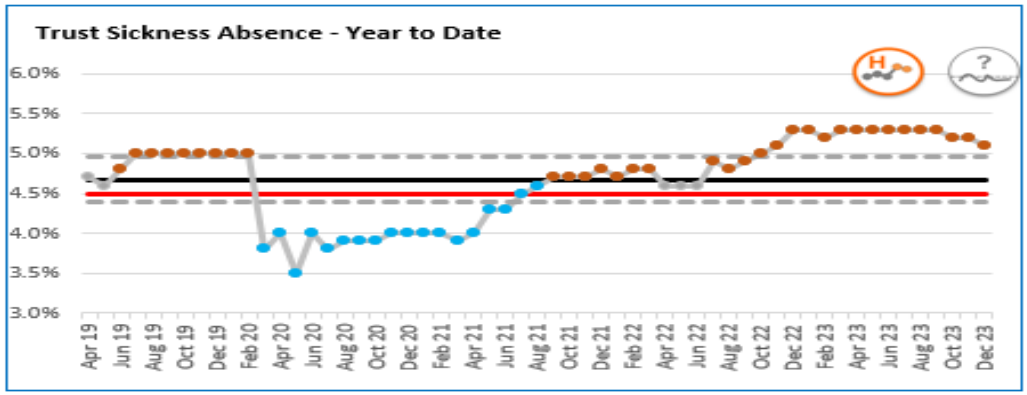
• A new online reporting system is now in place to support managers. This is driving improvement in uptake figures.
• There is now a focus on data quality particularly in ESR to align our Workpal data with the Organisational Hierarchy to further improve the new online BI reporting solution.
• For the third consecutive month we have seen an increase in the appraisal compliance rate. In December 2023 the rate increased to 74.2% compared to 72.5% in October 2023.
• A Workpal technical issue prevented managers from updating appraisals for several days in December. Despite this, we still managed to increase our compliance across the month which is a positive.
• Inpatient services have decreased in compliance for the third consecutive month. The rate in December is now 57.1%.



Training

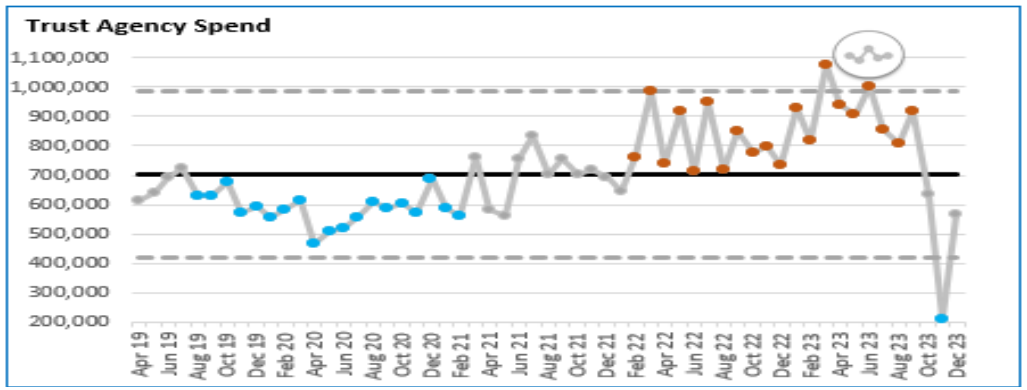
• Overall mandatory training has dropped slightly in December to 91.9%, however this still exceeds the Trust target of 80%.
• Although Information Governance is still below the Trust target in December we have seen an increase this month to 94.0%. These are reviewed at executive management group and operational management group on a weekly basis.
• Whilst the reducing restrictive practice interventions training has increased from 73.8% (April 23) we have seen a decrease in compliance to 81.8% (Dec 23)
• Safeguarding adults and children remains above target, however they have dropped in compliance for the third consecutive month.

Statistical process control charts



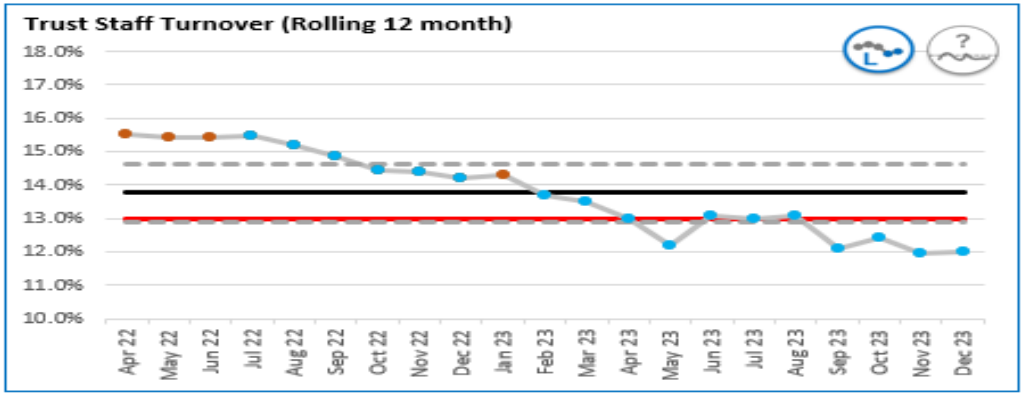
The SPC chart shows that in December 2023 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

From July 2022 this data also includes absence due to Covid-19.



The SPC chart shows that in December 2023, as anticipated after the VAT savings incorporated in November 2023, we have entered a period of common cause variation (no concern).

Please see finance appendix for further detail on agency spend.



The SPC chart shows that in December 2023, we have entered a period of special cause improving variation (something is happening and this should be investigated) following a sustained decrease in the turnover percentage over the past 9 months.

MEDICAL APPRAISALS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of doctors due to have an appraisal meeting in the reporting period	37	32	48	
Number undertaken in period	34	29	42	
Number not undertaken for which the RO accepts postponement is reasonable	2	3	6	
Percentage of appraisals taken place and submitted on time	92%	91%	88%	

MEDICAL REVALIDATIONS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of revalidation recommendations due in period	5	6	12	
Number of positive recommendations	5	6	11	
Number of deferrals	0	0	1	
Number of non-engagements	0	0	0	
Percentage of revalidation recommendations made	100%	100%	92%	

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	0	

National Metrics

Data as of : 24/01/2024 11:03:25

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	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 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	L	451	483	480	434	545	435	589	400	187	66	75	85
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		92.6%	91.4%	74.4%	87.1%	87.8%	88.6%	90.3%	93.1%	72.4%	83.3%	83.3%	82.9%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		57.1%	53.8%	53.8%	52.5%	53.4%	53.2%	50.4%	51.5%	51.6%	52.7%	51.6%	54.6%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	95.1%	95.7%	97.5%	97.9%	99.0%	99.6%	99.0%	99.5%	99.9%	100%	100%	99.7%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		87.9%	89.6%	87.2%	92.5%	90.6%	92.6%	87.7%	90.7%	88.6%	90.8%	89.0%	91.2%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		8	30	43	15	11	29	9	18	8	2	9	23
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		1	2	2	3	1	1	1	2	2	1	1	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	97.7%	97.6%	98.1%	97.8%	98.6%	99.4%	99.2%	98.3%	98.3%	99.0%	98.8%	98.6%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.8%	100%	99.8%	99.8%	99.8%	100%	99.8%	99.8%	100%	99.9%	99.8%	99.8%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?	L	87.5%	80%	87.5%	50%	80%	100%	70%	66.7%	100%	100%	100%	75%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	88.6%	100%	95.8%	77.8%	95.8%	100%	92%	91.3%	96.6%	91.4%	93.5%	87.5%
M15	Data Quality Maturity Index		95%	P		99.4%	98.2%	98.2%	99.4%	99.2%	99.5%	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1641	1415	1532	1306	1603	1579	1470	1403	1477	1745	1713	1317
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P	H	98.1%	99.1%	98.9%	98.9%	98.4%	99.0%	99.2%	99.7%	99.0%	99.1%	99.4%	99.2%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	36	44	30	25	34	26	37	38	34	35	38	25
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					72	51	81	51	67	53	64	60	70	68	45	37

National Metrics

Data as of : 24/01/2024 11:03:25

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
M30	Number of detentions under the Mental Health Act (MHA)					100	94	86	93	101	93	101	100	97	96	86	96
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					20%	19.1%	20.9%	21.5%	17.8%	12.9%	25.7%	19%	22.7%	24.0%	18.6%	19.8%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			96.3%	95.5%	97.8%	97.5%	97.6%	97.8%	98.4%	98.4%	97.1%	97.7%	98.1%	97.3%
M34	% Clients in settled accommodation	⚠	60%			84.4%	84.4%	84.6%	84.2%	84%	84.3%	83.8%	84.3%	84.3%	84.8%	85%	84.5%
M35	% Clients in employment	⚠	10%			11.7%	11.4%	11.2%	11.2%	11.5%	11.7%	12.0%	12.3%	12.6%	12.2%	12.3%	12.6%
M41	Completion of a valid NHS number		99%			100%	100%	100%	100%	100.0%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0%	100.0%
M42	Completion of ethnicity coding for all service users		90%			99.4%	99.4%	99.4%	99.4%	99.5%	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%	99.4%
M43	Community health services two hour urgent response standard		70%			87.6%	85.0%	83.7%	87.3%	86.6%	86.1%	88.0%	89.5%	88.6%	88.1%	87.4%	85.3%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500						1523	1719	2335	1509	1667	1656	1726	1844	1303
M45	The number of incomplete Referral to Treatment (RTT) pathways		2300												2009	2289	2019
			2400									1782	1982	2168			
			2500						1933	1835	1592						
M46	Count of 2-hour urgent community response first care contacts delivered					796	648	761	826	953	910	935	1019	1003	929	862	929
M47	Virtual ward occupancy		80%						82.9%	44.3%	92.9%	51.4%	57.1%	60%	57.5%	78.8%	64.3%
M48	Community services waiting list		5430									5024	5170	5048			
			5469												4952	4886	4808
			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								3934	3946	3943	3933	3917	3896	3891	3882	3855
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact								10988	11128	11131	11150	10966	11068	11166	11234	11057
M170	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%			88%	91.6%	79.8%	60.7%	53.3%	82.5%	66.7%	64.1%	75.3%	74.3%	63.0%	64.3%
M171	% Admissions gate kept by crisis resolution teams		95%			98.9%	99%	98.2%	100%	99%	100%	96.6%	100%	99.1%	100%	97.9%	100%

National Metrics

Data as of : 24/01/2024 11:03:25

NHS South West Yorkshire Partnership NHS Foundation Trust

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

• The percentage of service users waiting less than 18 weeks from point of referral to treatment remains above the target threshold at 99.7%

• 72 hour follow up remains above the threshold at 91.2%.

• The percentage of service users waiting for a diagnostic appointment for less than 6 weeks in the paediatric audiology service remains below threshold at 64% in December. 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 4.5 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 has seen a slight decrease in performance in November to 75% though low number do impact these figures. The routine access to treatment measure has dipped further under the 95% threshold at 84.4%. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

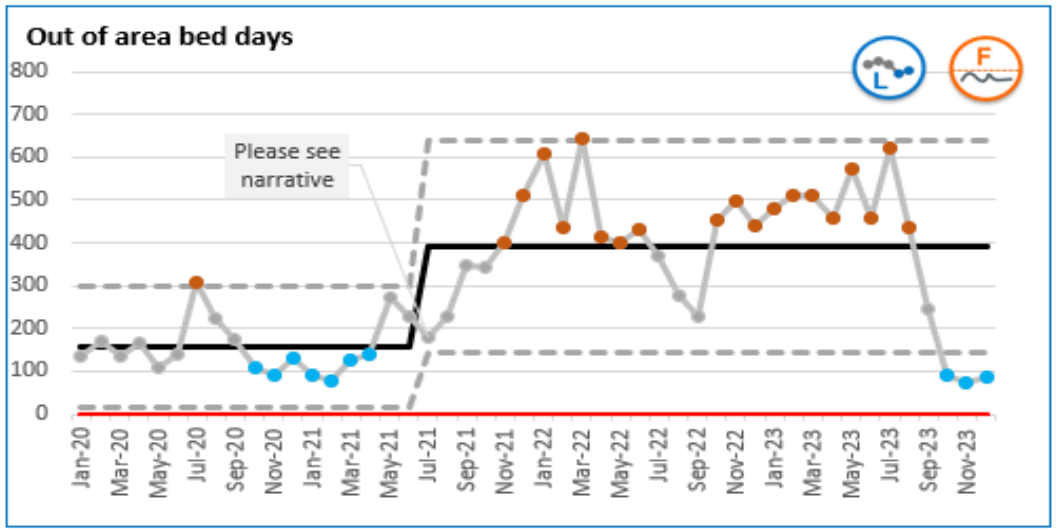
• During December 2023, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 23 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care 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 54.6% for December. 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 December. 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 December 2023 we remain in a period of special cause improving variation (something is happening and this should be investigated). 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.

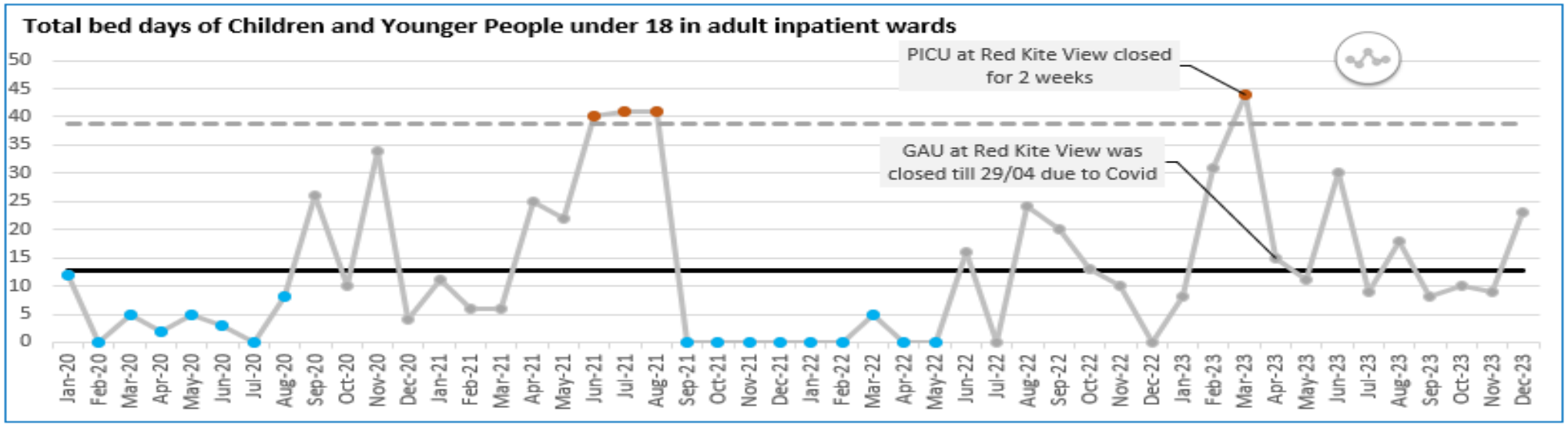
Summary	Actions	Assurance
The Trust has seen a sustained reduction in the number of inappropriate out of area bed days and remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme 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 December the following data quality issue has been identified in the reporting:

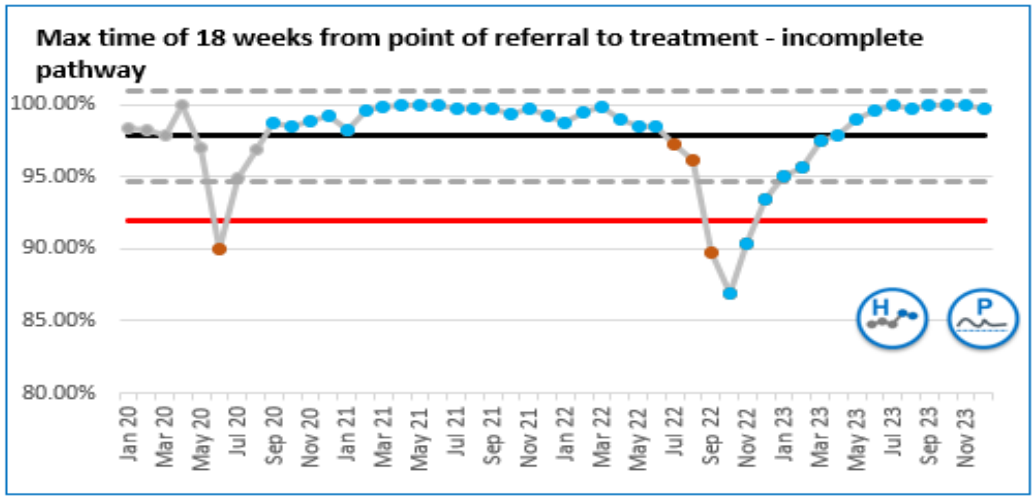
- The reporting for employment and accommodation shows 16.6% of records have missing employment and/or accommodation status with a further 1.5% that have an unknown employment status and 1.3% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

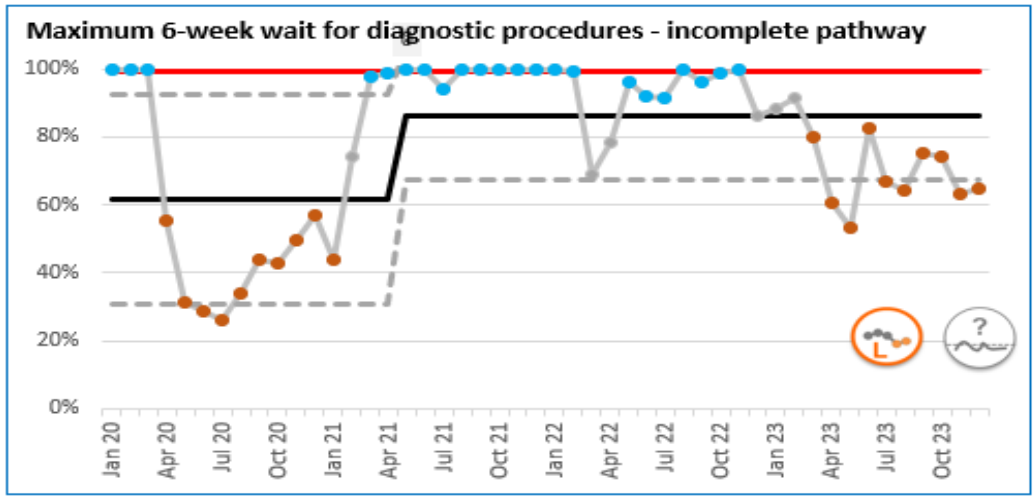
Analysis



The statistical process control chart (SPC) above shows that in December 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

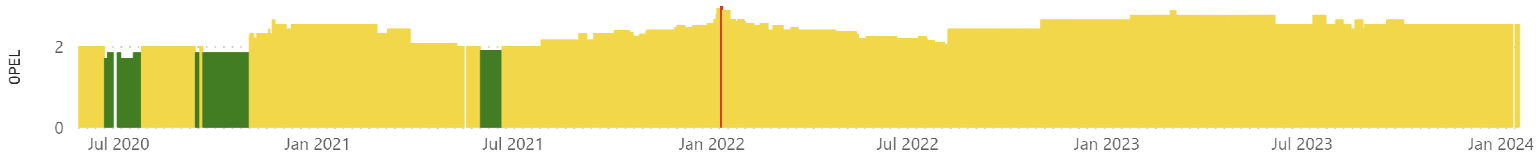




The SPC charts above show that for December 2023 we are currently in a period of special cause improving variation (something is happening and this should be investigated) for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. For clients waiting for a diagnostic procedure we remain in a period of special cause concerning variation (something is happening and this should be investigated) 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.

Overall Headlines
Appraisals remain a priority. These are being booked, with work to address reporting underway.
Triangulation is taking place between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and any specific actions required.
Gaps in mandatory training are being addressed through management support and oversight, with staff being booked into available dates.



Current average OPEL level

2.56

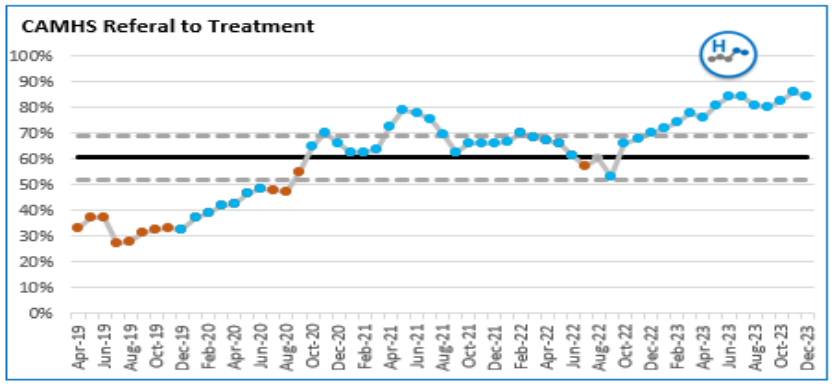
Key
OPEL Level 1
OPEL Level 2
OPEL Level 3
OPEL Level 4

Child and adolescent mental health services (CAMHS)

Headlines
Neurodevelopment waits remain a concern, even with the additional temporary capacity. This is in keeping with the national picture and forms part of the system wide work.
A new risk of increased waits for core CAMHS has been identified through the decommissioning of Northorpe Hall in Kirklees and changes to the pathway. The risk is being managed through the risk register and work with commissioners in the Place is underway.

CAMHS

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	76.7%	76.7%	
% Complaints with staff attitude as an issue	< 20%	50% 1/2	0% 0/1	
% of staff receiving supervision within policy guidance	80%	76.5%	75.1%	
CAMHS - Crisis Response 4 hours	N/A	97.1%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.7%	74.7%	
Eating Disorder - Routine clock stops	95%	85.2%	84.4%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	75.0%	
Information Governance training compliance	>=95%	91.7%	93.2%	
Reducing restrictive practice interventions training compliance	>=80%	83.3%	67.5%	
Sickness rate (Monthly)	4.5%	4.3%	3.6%	
% rosters locked down in 6 weeks				



As you can see in December 2023, we remain in a period of special cause improving variation (something is happening and this should be investigated). For further information see narrative below.

Alert/Action

• Waiting time numbers for Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Kirklees remain a concern. Robust action plans are in place (with transformation programme support) but the shortfall between commissioned capacity and demand remains. Agreement for additional temporary capacity in place, 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 and remained on CAMH waiting list – actions underway to address this.
• A new risk is reported regarding the decommissioning of Northorpe Hall and changes to the children's pathways in Kirklees, that could see an increase in waits for core CAMHS. Work across the Place and with commissioners is taking place and the risk will be managed through the risk assurance process.

Advise

• Appraisals are being prioritised in each team and expected to achieve target January 2024.
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. Routine referrals below target at 85.2% but importantly all children with an urgent need are seen within the 4 hour standard for emergency referrals. Breaches in routine referrals relate to staff sickness in ARFID pathway, new processes in place to ensure all of these cases are seen in a timely manner and passed to appropriate services.
• Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.

Assure

• Staff wellbeing remains a focus. Each CAMHS team has an agreed action place in place as a direct response to the staff survey.
• 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

Headlines

Although out of area reduction has been maintained, there has been an increase in the number of people who are clinically ready for discharge. Work is ongoing to ensure consistent application of the criteria and, importantly, work is underway in each place to address the barriers to discharge.

The wards are reporting an increased pressure from the number of learners who require support. Support has been drawn from retired, experienced nurses.

The sickness rate is above the Trust threshold on some wards and is due to a combination of long-term absence, pregnancy related illness and seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.

Under-performance in mandatory training, supervision and appraisal is being addressed through line management support and oversight.

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	70.5%	74.1%	
% Assessed within 14 days of referral (Routine)	75%	84.8%		
% Assessed within 4 hours (Crisis)	90%	99.0%		
% Complaints with staff attitude as an issue	< 20%	10% (1/10)	37.5% (3/8)	
% of staff receiving supervision within policy guidance	80%	68.1%	65.9%	
% service users followed up within 72 hours of discharge from inpatient care	80%	89.0%	91.2%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.7%	97.5%	
% Treated within 6 weeks of assessment (routine)	70%	96.7%		
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	78.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	76.4%	70.2%	
Information Governance training compliance	>=95%	93.1%	93.7%	
Reducing restrictive practice interventions training compliance	>=80%	66.2%	66.1%	
Sickness rate (Monthly)	4.5%	4.3%	4.6%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	74.3%	56.7%	
% bed occupancy	85%	93.1%	82.9%	
% Complaints with staff attitude as an issue	< 20%	0% (0/8)	17% (1/6)	
% of staff receiving supervision within policy guidance	80%	69.7%	65.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.4%	78.6%	
% of clients clinically ready for discharge	3.5%	7.0%	7.6%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.5%	94.1%	
Inappropriate Out of Area Bed days	92	75	85	
Information Governance training compliance	>=95%	92.2%	93.0%	
Physical Violence (Patient on Patient)	Trend Monitor	18	12	
Physical Violence (Patient on Staff)	Trend Monitor	57	52	
Reducing restrictive practice interventions training compliance	>=80%	85.1%	82.3%	
Restraint incidents	Trend Monitor	99	***84***	
Safer staffing	90%	136.3%	136.1%	
Sickness rate (Monthly)	4.5%	4.6%	6.3%	
% 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. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
- 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 are at a minimum and are essential to meet a person's needs. 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 (CRFD) spend in hospital and to explore all options for discharge solutions / alternatives to hospital, underpinned by the work on the 100 Day Discharge Challenge. Some wards have a higher number of people who are waiting for discharge due to the requirement for specialist placements for people with complex needs, for others the percentage of those delayed is due to the small numbers of patients on the ward, and in other cases judicial processes are required which can be lengthy. Work is ongoing to ensure the categorisation of CRFD is applied consistently.
- There is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three 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. There has been successful recruitment in Wakefield and Barnsley SPAs and staff are expected to be in post by the end of March 24.
- 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. December figure is provisional. 175 exceptions have been reported in December, this data is being verified. Exceptions relate to potential recording issues on the clinical system by temporary additional staff who are supporting the services and further work is required to confirm data quality.
- The Talking Therapies recovery rate for December is 58.58% for Kirklees and 50.88 for Barnsley, both achieving the national standard of 50%. The recovery rate 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.
- 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. The percentage compliance is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours and this is generally due to high acuity, bed occupancy or when an agency nurse is in charge of the ward. At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

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.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users. Achievement of the target is being maintained with continued support from Quality and Governance Leads.
• Care Programme Approach (CPA) review performance is above target in all areas, action plans and support from Quality and Governance Leads remain in place.
• 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. Data cleansing is underway to ensure that WorkPal and Trust performance data reflect actual appraisal activity in service areas.
• For all inpatient wards there has been a review of internal processes to ensure we are capturing all exclusions for supervision figures (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. Furthermore, there has been particular focus at ward level to understand and address where supervision levels are low. For example, on Ashdale and Elmdale there has been a number of band 6 vacancies impacting on supervision capacity so the matron team is providing supervision sessions for staff.
• The sickness rate is above the Trust target on some wards which is due to a combination of factors such as long-term absence, pregnancy related illness and seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• 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.
• There is a good reporting culture for restraint interventions within the care group. There is a higher incidence of restraint on Walton which is not unusual in a PICU (Psychiatric Intensive Care Unit) environment. All restraint incidents are reviewed by the RRPI (Reducing Restrictive Practice Interventions) team and no areas of concern have been identified.
• Work continues towards meeting required concordance levels for Cardio Pulmonary Resuscitation (CPR) training and RRPI training - this has been impacted by some issues relating to access to training and levels of did not attends. There are issues with CPR course cancellations in addition to changes in course times not aligning with shift patterns.
• 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

• Intensive home based treatment 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 bed usage has 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

Headlines

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
Communication with key stakeholders is planned in relation to The Royal College of Psychiatry invited review service report and associated action plan.

Learning disability services:
Key concern remains the number of people who are seen, assessed and commence their plan within 18 weeks. The data relates to 9 breaches out of 49 people. Work is underway as part of the Improving Access priority program. A deep dive will be reported to the executive management team in February 2024.
The Horizon team received positive feedback from an external commissioner in relation to the care and treatment reviews. The feedback provided additional assurance of the improvement work undertaken.

LD, ADHD & ASD

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	74.5%	74.7%	
% Complaints with staff attitude as an issue	< 20%	0% (0/2)	0% (0/5)	
% of staff receiving supervision within policy guidance	80%	74.3%	74.6%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	56.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	76.5%	
% of clients clinically ready for discharge	3.5%	75.0%	66.0%	
Information Governance training compliance	>=95%	92.6%	93.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	84.6%	81.6%	

LD, ADHD & ASD

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	13	19	
Reducing restrictive practice interventions training compliance	>=80%	72.7%	75.4%	
Safer staffing	90%	148.9%	156.2%	
Sickness rate (Monthly)	4.5%	3.2%	4.9%	
Restraint incidents	Trend Monitor	17	***10***	
% rosters locked down in 6 weeks				

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

Alert/Action

- Friend & Family Test – ↓ 67%, efforts continue to improve opportunities for feedback and engagement.
- West Yorkshire ICB Neurodiversity Project – the service continues to contribute to this project.
- Quality standards for adult ADHD assessments have been agreed at ICB level. Discussions on implementation continue across West Yorkshire.
- Referral rates for both ADHD and Autism continue to be higher than pre pandemic referral and are monitored within service.
- Actions are underway to address the recommendations in the Royal College of Psychiatry invited review report.

Advise

- Collaboration with Bradford District Care Foundation Trust continues. At the request of the commissioner the service will change its management of referrals This is to enable 500 historical cases to be prioritised. Based on current referral rates, there should be no waiting list for the Bradford Autism Pathway by July 2025.
- ADHD referral rates remain high in all areas with growing waiting lists. Currently over 4,500 people are waiting for an ADHD assessment just in the Barnsley, Wakefield, Kirklees and Calderdale regions. This is representative of the national picture.
- Autism referral rates also stay high. However, minimal waits for assessments exist in Barnsley, Kirklees and Wakefield due to implementation of a screening and triage step aligning with NHS England guidance published in April 2023.

Assure

- All key performance indicator targets met.
- Plans are in place to address reducing restrictive practice intervention training shortfall (76.7%).
- Relationship with Bradford working very well.
- Excellent levels of supervision (95.2%) and appraisal (100%) across the team.

Learning disability services:

Alert/Action

• Appraisal performance remains a focus plans are in place to ensure compliance across the Care Group. Current compliance is 74.4%. Supervision ↑69.7%.
• Plans in place to address training hotspots in cardio pulmonary resuscitation, information governance and restrictive practice intervention.
Community Services
• Resource requirements identified to support the ADHD pathway for people with a learning disability and a business case for funding currently being drafted.
• Following system changes and training, team managers are now managing waiting lists as a single team waiting list as part of the ongoing improvement plans to reduce waiting list times.
• Business case for additional ADHD resource now submitted to commissioners. Waiting lists for cases are increasing with no interim solution in place.
ATU (Assessment & Treatment Unit)
• Speech and Language 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 both ways with the Bradford ward seeking support from national peers.

Advise

Greenlight Toolkit
• Work continues to progress.
Community
• Challenges continue with the recruitment of specialist in Speech and Language and Occupational Therapy.
• Significant improvement in medical recruitment overall although the appointed Consultant in Barnsley has not taken up post. Process for recruitment is underway.
• Locality trios are improving their clinical pathways locally including crisis, behavioural and dementia.
ATU
• Improvement work continues to be embedded into the service.
• Internal staff training programme continues re Positive Behaviour Support, Trauma Informed Care, Active Support and Autism.

Assure

• Benchmarking community teams against Senate standards is underway. Community improvement plan continues to progress.
• Internal LeDeR group now established to ensure learning is embedded into internal processes and wider learning is shared within the Trust.
• Positive feedback from Bradford commissioner received following a recent community treatment review which acknowledges recognition of improvements made on Horizon.
• Benchmarking review date now scheduled for QNLD (Quality Network for Learning Disability) standards.

Barnsley General Community Services

Headlines

Paediatric audiology waits remain a significant concern, with increased demand outstripping capacity. Action plan is being revised. Additionally, concerns have been raised in the national audit with integrated care system action plans being developed.
Staffing in the neuro rehabilitation unit remains a concern. Safer staffing shows 'green' because over- establishment levels are used to maintain safe care. The establishment is being reviewed.
Clinical supervision uptake and recording is a concern and is being addressed through line management support and oversight.

Barnsley General Community Services

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	73.3%	77.8%	
% Complaints with staff attitude as an issue	< 20%	0% (0/2)	0% (0/1)	
% people dying in a place of their choosing	80%	66.7%	95.1%	
% of staff receiving supervision within policy guidance	80%	42.9%	37.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.7%	77.6%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	94.6%	94.0%	

Barnsley General Community Services

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	100.0%	99.9%	
Maximum 6 week wait for diagnostic procedures	99%	63.0%	64.3%	
Reducing restrictive practice interventions training compliance	>=80%	75.0%	100.0%	
Safer staffing (inpatient)	90%	105.1%	104.4%	
Sickness rate (Monthly)	4.5%	4.8%	3.9%	
% rosters locked down in 6 weeks				

Alert/Action

- Barnsley Integrated Community Equipment Service (BICES) – increase in home loan equipment costs from 2 main suppliers (Drive and Harvest).
- Appraisals - many of our 32 service lines are at 100% and we continue to work on data cleansing linked to ESR.
- Clinical supervision will receive focused attention with the development of an improvement plan with support to specific areas with lowest rates of clinical supervision. Initially we need to look at cleansing the data and understanding how the data is pulled in order to establish which areas are struggling.
- Paediatric Audiology:
  - Audiology national audit outcomes – service to develop improvement plan and meet with integrated care system.
  - Service improvement plan to address waiting times is currently being implemented.

Advise

- NRU (Neurological Rehabilitation Unit) Safer staffing report recently circulated shows green however to note this is because untrained staff are used to supplement trained staff levels on the unit. A position paper has been sent to operational management group (finance).
- Yorkshire Smokefree Doncaster – outcome of tender submitted before Christmas is pending.

Assure

- CQUIN for Lower Limb Assessments continues to improve currently at 81% with a RAG rating change to green. This has now been removed from the risk register.
- Community health services two-hour urgent response standard – service continues to work with performance and business intelligence to adjust data flow for this measure. Work ongoing to identify exemptions which will improve data quality and performance.
- Community Services 2-hour crisis response target is above the 70% threshold (85.3% as at December

Forensic Services

Headlines

Sickness is a significant concern, particularly in low secure. The people directorate business partner is leading a deep dive into sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.

Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.

Supervision performance is excellent, and learning is being shared with other areas.

Forensic

Metrics	Threshold	Nov-23	Dec-23	Variation/ Assurance
% Appraisal rate	>=90%	69.0%	74.4%	
% Bed occupancy	90%	80.9%	82.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	92.3%	92.3%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	92.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.1%	71.7%	
% 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%	90.9%	92.6%	
Physical Violence (Patient on Patient)	Trend Monitor	1	3	
Physical Violence (Patient on Staff)	Trend Monitor	13	14	
Reducing restrictive practice interventions (RRPI) training compliance	>=80%	80.9%	80.3%	
Restraint incidents	Trend Monitor	26	***20***	
Safer staffing	90%	115.8%	114.6%	
Sickness rate (Monthly)	5.4%	9.2%	8.1%	
% rosters locked down in 6 weeks				

Alert/Action

• Bed Occupancy – Newton Lodge 86.38%↑, Bretton 77.83%↑, Newhaven 75.00↑. 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 flow across the pathway.
• Sickness absence – continues to be a concern particularly at the Bretton Centre. Managers within the service are working with the People Directorate to support staff to return to work. The People directorate are currently undertaking an audit on compliance with the sickness absence process.
• Vacancies & Turnover –Service continues to focus on recruitment and retention. Band 5 vacancies have 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 fully realised.

Advise

• Plans to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative and the options appraisal for commissioning arrangements moving forward is in the final stages of completion.
• Mandatory training overall compliance: Newton Lodge – 92.6%; Bretton – 90.0%; Newhaven –93.1%
The above figures represent the overall position for each service. There are some hotspots in information governance and cardio pulmonary resuscitation across the care group. Reducing restrictive practice interventions remains a hotspot in Newhaven only with significant improvement in Bretton and Newton Lodge.
• 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 (89.6% using locally determined metrics). Trajectory for Care Group compliance is end of January.
• 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.
• Care programme approach compliance has dropped to 92.3% work is being undertaken to understand and address this.

Assure

• High levels of data quality across the Care Group (100%).
• 100% compliance for HCR20 being completed within 3 months of admission.
• Friends and family test remains green
• 25 Hours of meaningful activity 100%.
• All Equality impact assessments across Forensic services have been completed for 23/24.
• Supervision – all wards and teams above 90%.

Inpatients - Mental Health - Working Age Adults

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

Sickness
• Long-term absence, pregnancy related illness and seasonal illness are impacting wards above the Trust threshold. Appropriate actions are in place.
• Specific challenges on Ashdale relate to two recent serious incidents. Occupational Health are involved and support is in place.

Supervision
• Exclusions are being recorded on a monthly basis.
• Band 6 vacancies on Ashdale and Elmdale are impacting on supervision capacity. The matron team is providing additional supervision sessions.
• The majority of wards are achieving the Trust supervision target.

Mandatory Training
• Performance has been impacted by some issues relating to access to training.
• Cardio pulmonary rehabilitation course cancellations and changes in course times not aligning with shift patterns have impacted on compliance.
• Plans are in place to ensure appropriately trained staff are on duty across all shifts at all times.

Bed Occupancy
• All working age adult wards exceed the bed occupancy target and capacity to meet demand for beds remains a challenge.
• Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.

Clinically Ready For Discharge (CRFD)
• Availability of specialist placements for people with complex needs can delay discharge
• High percentage affect due to small numbers of patients on the ward
• Work is ongoing to ensure the categorisation of clinically ready for discharge is applied consistently.

FIRM Risk assessments
• Improved for the majority of wards.
• Percentage compliance is significantly impacted by small number of admissions.
• Non-compliance often due to high acuity, bed occupancy or when an agency nurse is in charge of the ward.
• At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed

Restraint Incidents
• Good reporting culture for restraint interventions within the care group.
• Higher incidence of restraint on Walton in keeping with a PICU (Psychiatric Intensive Care Unit) environment.
• All restraint incidents are reviewed by the RRPI (Reducing Restrictive Practice Interventions) team and no areas of concern have been identified.

Note - For Ward 19 - The physical violence and restraint incident data cannot be split by male and female.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	5.5%	6.7%	9.6%
Supervision	80%	85.2%	90.1%	90.1%
Information Governance training compliance	>=95%	88.5%	92.9%	96.2%
Reducing restrictive practice interventions training compliance	>=80%	80.8%	82.1%	73.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	85.7%	92.3%
Bed occupancy	85%	103.9%	97.9%	109.2%
Safer staffing	90%	124.2%	130.3%	131.8%
% of clients clinically ready for discharge	3.5%	9.3%	6.1%	5.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	75.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	5	0	0
Restraint incidents	Trend Monitor	25	5	***4***
Prone Restraint incidents	Trend Monitor	3	1	***1***

Clark Suite

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	5.3%	2.5%	3.5%
Supervision	80%	35.0%	71.4%	85.7%
Information Governance training compliance	>=95%	90.0%	90.5%	95.0%
Reducing restrictive practice interventions training compliance	>=80%	94.7%	95.0%	94.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.0%	85.7%	90.0%
Bed occupancy	85%	91.7%	90.5%	82.7%
Safer staffing	90%	120.9%	139.5%	129.7%
% of clients clinically ready for discharge	3.5%	15.1%	15.5%	16.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	60.0%	50.0%	91.7%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	4	4	3
Restraint incidents	Trend Monitor	11	3	***2***
Prone Restraint incidents	Trend Monitor	1	2	***0***

Melton Suite

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	14.1%	5.0%	6.0%
Supervision	80%	71.4%	100.0%	100.0%
Information Governance training compliance	>=95%	87.0%	87.0%	87.0%
Reducing restrictive practice interventions training compliance	>=80%	87.0%	87.0%	82.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.9%	73.9%	69.6%
Bed occupancy	85%	97.8%	98.9%	100.0%
Safer staffing	90%	171.8%	150.8%	153.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	50.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	2	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	0
Restraint incidents	Trend Monitor	4	3	***1***
Prone Restraint incidents	Trend Monitor	0	1	***0***

Nostell

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	0.0%	1.4%	2.1%
Supervision	80%	78.6%	100.0%	92.3%
Information Governance training compliance	>=95%	88.9%	96.6%	93.3%
Reducing restrictive practice interventions training compliance	>=80%	96.2%	100.0%	96.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.3%	89.3%	89.7%
Bed occupancy	85%	94.3%	92.4%	87.8%
Safer staffing	90%	123.7%	128.7%	122.0%
% of clients clinically ready for discharge	3.5%	14.4%	16.4%	18.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	1	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	1
Restraint incidents	Trend Monitor	14	4	***6***
Prone Restraint incidents	Trend Monitor	0	1	***2***

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	9.1%	9.7%	7.5%
Supervision	80%	70.4%	100.0%	100.0%
Information Governance training compliance	>=95%	96.0%	95.8%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	92.0%	91.7%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.0%	83.3%	80.0%
Bed occupancy	85%	99.1%	95.5%	88.6%
Safer staffing	90%	126.6%	134.8%	163.3%
% of clients clinically ready for discharge	3.5%	11.0%	8.6%	10.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.3%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	0
Restraint incidents	Trend Monitor	2	3	***2***
Prone Restraint incidents	Trend Monitor	1	1	***0***

Walton

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	8.9%	6.1%	6.2%
Supervision	80%	44.4%	87.5%	100.0%
Information Governance training compliance	>=95%	89.5%	89.5%	94.6%
Reducing restrictive practice interventions training compliance	>=80%	81.1%	81.1%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	59.5%	62.2%	69.4%
Bed occupancy	85%	89.6%	94.8%	93.5%
Safer staffing	90%	137.4%	152.0%	140.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	3	3	3
Restraint incidents	Trend Monitor	23	13	***3***
Prone Restraint incidents	Trend Monitor	12	5	***0***

Ashdale

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	10.9%	9.4%	12.1%
Supervision	80%	24.2%	50.0%	72.7%
Information Governance training compliance	>=95%	90.3%	92.9%	96.6%
Reducing restrictive practice interventions training compliance	>=80%	87.1%	89.3%	82.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.3%	71.4%	69.0%
Bed occupancy	85%	100.7%	94.7%	96.5%
Safer staffing	90%	118.5%	131.8%	133.3%
% of clients clinically ready for discharge	3.5%	1.5%	5.3%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.3%	95.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	5	2	3
Physical Violence (Patient on Staff)	Trend Monitor	1	3	2
Restraint incidents	Trend Monitor	8	5	***4***
Prone Restraint incidents	Trend Monitor	2	0	***1***

Ward 18

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	5.0%	3.4%	4.9%
Supervision	80%	43.3%	90.9%	23.1%
Information Governance training compliance	>=95%	96.4%	90.3%	91.2%
Reducing restrictive practice interventions training compliance	>=80%	75.0%	83.9%	82.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	80.6%	82.4%
Bed occupancy	85%	98.2%	93.6%	93.8%
Safer staffing	90%	107.2%	120.8%	119.4%
% of clients clinically ready for discharge	3.5%	6.5%	1.8%	2.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	88.2%
Physical Violence (Patient on Patient)	Trend Monitor	4	2	3
Physical Violence (Patient on Staff)	Trend Monitor	4	12	9
Restraint incidents	Trend Monitor	5	21	***13***
Prone Restraint incidents	Trend Monitor	1	7	***0***

Inpatients - Mental Health - Working Age Adults

Elmdale

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	11.3%	7.0%	6.6%
Supervision	80%	66.7%	70.0%	30.0%
Information Governance training compliance	>=95%	90.9%	90.9%	82.6%
Reducing restrictive practice interventions training compliance	>=80%	86.4%	90.9%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.3%	66.7%	54.5%
Bed occupancy	85%	97.2%	94.9%	90.6%
Safer staffing	90%	101.7%	114.3%	139.4%
% of clients clinically ready for discharge	3.5%	1.4%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	90.9%	100.0%	80.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	6	1
Physical Violence (Patient on Staff)	Trend Monitor	2	5	3
Restraint incidents	Trend Monitor	8	19	***9***
Prone Restraint incidents	Trend Monitor	0	1	***2***

Inpatients - Mental Health - Older People Services

Crofton

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	7.1%	3.3%	0.7%
Supervision	80%	34.8%	90.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	96.2%
Reducing restrictive practice interventions training compliance	>=80%	82.6%	83.3%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.3%	91.7%	91.7%
Bed occupancy	85%	91.9%	90.2%	81.7%
Safer staffing	90%	180.4%	177.1%	183.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	70.0%	100.0%	85.7%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	7
Restraint incidents	Trend Monitor	4	4	***14***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Poplars CUE

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	6.0%	1.1%	2.9%
Supervision	80%	59.3%	83.3%	100.0%
Information Governance training compliance	>=95%	100.0%	96.3%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	84.6%	88.0%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	83.3%	87.5%
Bed occupancy	85%	67.5%	69.6%	67.3%
Safer staffing	90%	216.7%	235.3%	207.1%
% of clients clinically ready for discharge	3.5%	34.1%	39.4%	30.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	4	1	0
Physical Violence (Patient on Staff)	Trend Monitor	15	12	12
Restraint incidents	Trend Monitor	35	14	***11***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	9.9%	2.8%	4.2%
Supervision	80%	81.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	90.9%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	76.2%	81.8%	81.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	52.4%	45.5%	42.9%
Bed occupancy	85%	89.0%	84.7%	77.7%
Safer staffing	90%	106.5%	170.9%	154.0%
% of clients clinically ready for discharge	3.5%	0.3%	0.0%	41.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	4	3
Restraint incidents	Trend Monitor	0	3	***4***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Beechdale

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	12.1%	9.8%	9.0%
Supervision	80%	61.5%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	95.8%
Reducing restrictive practice interventions training compliance	>=80%	87.5%	91.7%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.3%	82.6%	82.6%
Bed occupancy	85%	94.4%	93.1%	84.9%
Safer staffing	90%	150.5%	141.8%	130.1%
% of clients clinically ready for discharge	3.5%	9.2%	17.1%	9.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	88.9%	83.3%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	3
Restraint incidents	Trend Monitor	0	1	***5***
Prone Restraint incidents	Trend Monitor	0	1	***0***

Ward 19 - Male

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	1.1%	1.6%	3.4%
Supervision	80%	75.0%	100.0%	100.0%
Information Governance training compliance	>=95%	95.5%	95.8%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	81.8%	79.2%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.8%	83.3%	75.0%
Bed occupancy	85%	96.1%	91.6%	83.0%
Safer staffing	90%	108.9%	107.3%	107.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	2	1
Physical Violence (Patient on Staff)	Trend Monitor	0	6	3
Restraint incidents	Trend Monitor	2	8	***5***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Ward 19 - Female

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	20.3%	7.0%	12.9%
Supervision	80%	58.8%	100.0%	100.0%
Information Governance training compliance	>=95%	89.5%	89.5%	94.7%
Reducing restrictive practice interventions training compliance	>=80%	78.9%	77.8%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	47.4%	38.9%	44.4%
Bed occupancy	85%	87.3%	86.4%	81.5%
Safer staffing	90%	94.9%	105.7%	111.5%
% of clients clinically ready for discharge	3.5%	6.6%	6.9%	7.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	87.5%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	2	1
Physical Violence (Patient on Staff)	Trend Monitor	0	6	3
Restraint incidents	Trend Monitor	2	8	***5***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Mental Health - Rehab

Enfield Down

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Appraisal rate				
Sickness	4.5%	2.8%	2.7%	3.6%
Supervision	80%	100.0%	100.0%	84.2%
Information Governance training compliance	>=95%	94.1%	98.1%	96.1%
Reducing restrictive practice interventions training compliance	>=80%	80.0%	84.3%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.3%	77.8%	79.5%
Bed occupancy	85%	44.6%	48.9%	48.1%
Safer staffing	90%	94.7%	94.2%	92.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	0	1
Restraint incidents	Trend Monitor	3	1	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Lyndhurst

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Appraisal rate				
Sickness	4.5%	5.1%	4.6%	6.0%
Supervision	80%	55.6%	71.4%	85.7%
Information Governance training compliance	>=95%	96.2%	92.3%	92.6%
Reducing restrictive practice interventions training compliance	>=80%	64.0%	66.7%	60.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	80.8%	80.8%
Bed occupancy	85%	62.9%	67.1%	64.7%
Safer staffing	90%	120.8%	123.4%	124.3%
% of clients clinically ready for discharge	3.5%	9.9%	9.6%	10.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Forensic - Medium Secure

Ward Level Headlines - Forensics

Medium Secure

- Supervision above 80% on all medium secure wards.
- Sickness variable across medium secure. Management of sickness absence is a focus across the care group. The service is currently being supported by the People Directorate to undertake more detailed analysis to inform future actions. An audit is being undertaken to assess compliance with the sickness absence policy across all wards. It is noted that staff with underlying medical conditions tend to be directed to Wards that are a part of the rehabilitation pathway not the acute pathway by occupational health as part of supportive measures to keep staff in work.
- Improvements have been made in the overall compliance for reducing restrictive practice interventions but Hepworth and Priestley have further improvement work to be done to reach the target.
- Bed occupancy in Appleton is lower due to an overall reduction in referrals for LD beds in medium secure.
- Cardio pulmonary rehabilitation compliance on Appleton, Hepworth, Priestley, Johnson and Waterton is currently lower than expected. Remedial actions are being developed to prioritise cardio pulmonary rehabilitation compliance.

Low Secure

- Sickness across all four low secure wards is very high, particularly Thornhill and Ryburn. The service is currently being supported by the People Directorate to undertake more detailed analysis to inform future actions. An audit is being undertaken to assess compliance with the sickness absence policy across all wards. It is noted that staff with underlying medical conditions tend to be directed to Thornhill and Ryburn.
- Cardio pulmonary rehabilitation compliance on Thornhill and Sandal is currently lower than expected. Remedial actions are being developed to prioritise cardio pulmonary rehabilitation compliance, and staff have been booked on upcoming courses in Jan/Feb - further cardio pulmonary rehabilitation training dates are not available beyond February 2024.
- Bed occupancy in low secure apart from Ryburn is below expected targets. This is similar to other low secure services across West Yorkshire. The reduction in Thornhill's occupancy is due to recent discharges. The care group is monitoring bed occupancy closely and liaising with the commissioning hub.
- Supervision is above 85% on all areas and is 100% on Ryburn and Sandal.
- Incidents on Newhaven noted to be higher than elsewhere in low secure reflecting challenging behaviours in a small group of service users. The service is currently undertaking a detailed piece of work on the use of prone restraint and implementation of positive behaviour support planning as a means to reduce incidents overall.

Appleton

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	5.0%	6.4%	5.9%
Supervision	80%	95.5%	80.0%	100.0%
Information Governance training compliance	>=95%	95.5%	87.5%	87.0%
Reducing restrictive practice interventions training compliance	>=80%	81.8%	87.5%	82.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	76.0%	79.2%
Bed occupancy	90%	66.9%	62.5%	62.5%
Safer staffing	90%	92.9%	96.8%	97.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1
Restraint incidents	Trend Monitor	3	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Bronte

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	7.2%	0.3%	0.0%
Supervision	80%	95.5%	83.3%	100.0%
Information Governance training compliance	>=95%	100.0%	95.2%	95.7%
Reducing restrictive practice interventions training compliance	>=80%	94.7%	85.7%	78.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.9%	81.0%	78.3%
Bed occupancy	90%	88.9%	71.9%	95.9%
Safer staffing	90%	98.2%	100.3%	99.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	1	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Chippendale

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	6.7%	9.2%	7.2%
Supervision	80%	100.0%	100.0%	88.9%
Information Governance training compliance	>=95%	90.9%	84.2%	89.5%
Reducing restrictive practice interventions training compliance	>=80%	100.0%	100.0%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.4%	84.2%	84.2%
Bed occupancy	90%	100.0%	91.7%	91.7%
Safer staffing	90%	121.6%	122.7%	128.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	2
Physical Violence (Patient on Staff)	Trend Monitor	2	2	2
Restraint incidents	Trend Monitor	3	4	***4***
Prone Restraint incidents	Trend Monitor	2	2	***1***

Hepworth

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	0.4%	2.5%	8.5%
Supervision	80%	73.3%	100.0%	86.7%
Information Governance training compliance	>=95%	96.6%	90.3%	96.6%
Reducing restrictive practice interventions training compliance	>=80%	79.3%	77.4%	72.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	67.9%	73.3%	70.4%
Bed occupancy	90%	85.8%	88.0%	83.2%
Safer staffing	90%	97.5%	104.8%	96.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	1	***1***
Prone Restraint incidents	Trend Monitor	0	1	***0***

Inpatients - Forensic - Medium Secure

Johnson

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	5.3%	10.3%	7.4%
Supervision	80%	92.6%	83.3%	92.3%
Information Governance training compliance	>=95%	93.1%	87.9%	93.5%
Reducing restrictive practice interventions training compliance	>=80%	89.7%	87.9%	87.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.0%	66.7%	67.7%
Bed occupancy	90%	86.7%	86.7%	86.7%
Safer staffing	90%	143.6%	140.7%	137.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	4	2
Restraint incidents	Trend Monitor	0	4	***1***
Prone Restraint incidents	Trend Monitor	0	0	***1***

Priestley

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	5.4%	10.3%	11.0%	8.4%
Supervision	80%	83.3%	88.9%	77.8%
Information Governance training compliance	>=95%	90.9%	86.4%	91.3%
Reducing restrictive practice interventions training compliance	>=80%	81.0%	76.2%	77.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	76.2%	72.7%
Bed occupancy	90%	78.2%	88.2%	93.5%
Safer staffing	90%	94.8%	91.2%	97.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Waterton				
Metrics	**Threshold**	**Oct-23**	**Nov-23**	**Dec-23**
Sickness	5.4%	1.0%	2.8%	5.6%
Supervision	80%	90.0%	100.0%	90.9%
Information Governance training compliance	>=95%	90.9%	90.5%	85.7%
Reducing restrictive practice interventions training compliance	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.7%	66.7%	57.1%
Bed occupancy	90%	91.5%	93.8%	85.3%
Safer staffing	90%	118.8%	123.3%	121.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	0	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Forensic - Low Secure

Thornhill				
Metrics	**Threshold**	**Oct-23**	**Nov-23**	**Dec-23**
Sickness	5.4%	17.2%	18.3%	9.8%
Supervision	80%	23.1%	91.7%	100.0%
Information Governance training compliance	>=95%	95.2%	90.9%	91.3%
Reducing restrictive practice interventions training compliance	>=80%	85.7%	95.5%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	66.7%	59.1%	56.5%
Bed occupancy	85%	77.2%	56.9%	56.3%
Safer staffing	90%	115.6%	117.9%	109.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	5	***0***
Prone Restraint incidents	Trend Monitor	0	1	***0***

Sandal				
Metrics	**Threshold**	**Oct-23**	**Nov-23**	**Dec-23**
Sickness	5.4%	9.5%	12.4%	14.0%
Supervision	80%	100.0%	100.0%	90.0%
Information Governance training compliance	>=95%	88.5%	87.0%	82.6%
Reducing restrictive practice interventions training compliance	>=80%	80.8%	82.6%	82.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	61.5%	60.9%	52.2%
Bed occupancy	85%	74.8%	77.5%	85.9%
Safer staffing	90%	104.2%	119.2%	128.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***3***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Forensic - Low Secure

Sickness	5.4%	19.1%	22.6%	37.8%	Sickness	5.4%	11.7%	12.6%	6.1%
Supervision	80%	100.0%	100.0%	100.0%	Supervision	80%	92.0%	87.5%	88.9%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%	Information Governance training compliance	>=95%	92.0%	92.3%	92.3%
Reducing restrictive practice interventions training compliance	>=80%	80.0%	80.0%	71.4%	Reducing restrictive practice interventions training compliance	>=80%	84.0%	73.1%	80.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	80.0%	57.1%	Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	80.8%	76.9%
Bed occupancy	85%	77.9%	97.1%	100.0%	Bed occupancy	85%	74.0%	71.9%	75.0%
Safer staffing	90%	100.0%	100.1%	102.8%	Safer staffing	90%	122.5%	134.8%	124.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A	FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0	Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0	Physical Violence (Patient on Staff)	Trend Monitor	10	4	6
Restraint incidents	Trend Monitor	0	0	***0***	Restraint incidents	Trend Monitor	17	10	***9***
Prone Restraint incidents	Trend Monitor	0	0	***0***	Prone Restraint incidents	Trend Monitor	4	3	***4***

Inpatients - Non-Mental Health

Headlines

• Sickness – both NRU and SRU have seen high levels of sickness. Long term sickness impacts this on both units and this is being managed as per SWYFT sickness absence processes.
• Supervision – remains a concern. A concentrated focus has been underway since November. Work is underway to understand and address recording concerns. A workaround is being developed to ensure external supervision can be recorded and monitored.
• Cardio pulmonary rehabilitation – Long term sickness has impacted the availability of staff to be released. The roster system ensures access to appropriately trained staff at all times and actions are underway to address underperformance.
• Bed Occupancy – NRU occupancy is impacted by the 4 beds for spot purchase being closed due to staffing levels.

Neuro Rehabilitation Unit (NRU)

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	9.4%	7.4%	7.3%
Supervision	80%	57.1%	57.1%	21.4%
Information Governance training compliance	>=95%	93.1%	92.9%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.1%	70.4%	74.1%
Bed occupancy	85%	62.1%	66.7%	66.7%
Safer staffing	90%	104.3%	103.8%	99.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	0
Prone Restraint incidents	Trend Monitor	0	0	0

Stroke Rehabilitation Unit (SRU)

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	2.7%	6.8%	6.9%
Supervision	80%	11.7%	19.4%	31.0%
Information Governance training compliance	>=95%	95.1%	100.0%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.9%	70.7%	67.2%
Bed occupancy	85%	89.2%	65.8%	82.5%
Safer staffing	90%	108.1%	106.1%	108.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	0
Prone Restraint incidents	Trend Monitor	0	0	0

Inpatients - Mental Health - Learning Disability

Headlines

- Improvements in supervision noted on Horizon due to an improved system of rostering supervision.
- Cardiopulmonary resuscitation training is currently a hotspot with remedial actions in place.
- Information governance training and reducing restrictive practice interventions also receiving focussed attention to improve compliance.
- High levels of service users who are clinically ready for discharge is due to service users requirements for complex packages of care to be sourced within the community. This has been escalated through the assessment and treatment unit delivery group.

Horizon

Metrics	Threshold	Oct-23	Nov-23	Dec-23
Sickness	4.5%	7.1%	6.4%	6.1%
Supervision	80%	80.0%	90.9%	81.8%
Information Governance training compliance	>=95%	91.7%	94.4%	97.3%
Reducing restrictive practice interventions training compliance	>=80%	76.5%	79.4%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.9%	68.8%	60.6%
Bed occupancy	N/A	50.0%	50.0%	56.9%
Safer staffing	90%	143.4%	148.9%	156.2%
% of clients clinically ready for discharge	3.5%	75.0%	75.0%	66.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	12	13	18
Restraint incidents	Trend Monitor	12	17	***10***
Prone Restraint incidents	Trend Monitor	3	1	***0***

The following section highlights the performance against the Trust's strategic objectives and priority change and improvement programmes for 2023/24.
The Trust has in place a robust system for the development, agreement and governance of these priority areas of work: Framework for governance and assurance.
Programme plans are in place with key agreed milestones identified and reporting against these will be provided at the identified date or by exception.
Progress against milestones and other updates by exception are reported in this section.

Progress key	
G	On track against plan and/or on schedule within agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	Work taking place with partners in each of our four places to address inequalities. Internal work on data and metrics is supporting this work and developing our understanding of the impact of services on different cohorts of people. Please refer to the equality, inclusion and diversion report at agenda item 9.7 on the this months Trust board agenda. This report will be utilised to develop key performance indicators to be included in the performance report as part of the IPR development plan.	
Improving care	Transform our Older People inpatient services	**OPS Transformation Programme:** Final preparation for consultation took place in December 2023 and formal public consultation launched in January 2024. A range of events are being planned from mid-late January and into February. The consultation launch, drop in events and online meetings have been advertised through a variety of channels. A range of briefing sessions have been held with colleagues and partners supporting the consultation process including advocacy, community assets and people supporting the events. A mid-point review will be organised for mid-February.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Improving Access to Care Programme** **1. Waits for CAMHS Neurodevelopmental Services in Kirklees and Calderdale:** All staff are now in post to support the referral part of the Kirklees pathway. Current wait time to complete the referral appointment has reduced from 2 months to 6 weeks since new pathway introduction (initially 4 months at start of project). Recruitment activity in support of the assessment part of the pathway is underway. Interviews scheduled for end of January for an assistant psychologist. with proposed start date of March/April 2024. Substantive funding to provide post diagnostic support secured and recruitment process has begun with proposed start date of March/April 2024. Transition work with adult attention deficit hyperactivity disorder (ADHD) services continues to work effectively. In Calderdale waiting times are reducing in line with the reduction in referrals through choice. However, it is noted there is a significant backlog in processing referrals at first point of contact – advised of 600 waiting review of clinical suitability, and a further 600 to be processed before this point. The Trust continues to be involved in discussions with the integrated care board and West Yorkshire collaborative. **2. Waits for Community LD (CLD) services:** New processes and use of SystmOne waiting list management functionality have been introduced across all CLD teams to support management of waiting lists, reduction in breaches, and variation in the ability of each locality service to be able to meet the 90% target. End of phase report submitted to the Trust's improving access to care programme steering group and support given to scope next phase of work including benefits realisation from phase one. Update report to executive management team to be provided by CLD services in February 2024. **3. Improving Access to Core Psychological Therapies:** Project initiation activity completed with key areas of focus identified and alignment with other improvement work such as single point of access (SPA) review. Work has commenced on initial qualitative and quantitative data collection and developing a baseline understanding of current core psychological therapies activity, scheduled for completion in March 2024. **4. MH Single Point of Access Review:** February 2023: Liaise with peoples' services in regards staff views and collate information on staff turnover, sickness and reasons for leaving SPA service – ongoing. December 2023: Liaise with communications, equality and involvement team in regards service user and carer views. We have received information on themes of complaints which has highlighted need to understand service user expectations of SPA (including capacity and prescribing ability) – Complete December 2023: Review anecdotal partnership feedback. We have commenced engagement with programme managers in Place to understand GP views/ expectations of SPA - progressing. Complete February 2024: Feedback from Serious Incidents has led the group to review the development of a Substance Misuse focus – ongoing. February 2024: Collate and present 'What we Know' information to inform recommendations in final report. – on track April 2024: Review completed, and improvement plan developed – on track May 2024: Report submitted to EMT for approval to move into improvement implementation – on track. **Care Closer to Home (CC2H) Programme** Sustaining reduction in out of area admissions. Check & challenge peer review first meeting held/further discussions Jan/February 2024 A further assurance meeting to be arranged prior to commencement of Barnsley pilot. Engagement workshops with all partners have now been scheduled for February/March 2024 **Inpatient Priority Programme** Therapeutic – final Terms of Reference and re-formatted action plan agreed January 2024 Discharge Oversight Group – initiatives updated by working group, progressing with leads identified. Workforce – Support for international recruits, career progression discussions, staff engagement strategy and Health and Wellbeing offer conversations are all progressing. Data – Senior leadership team reviewing all data which is looked over at weekly performance and oversight meetings **Community Transformation (MH)** 22/12/23: Create comms and engagement action plan to manage change and establish delivery groups to implement changes. Rescheduling owing to delay in feedback from steering group. A draft higher-Level communication has been developed and taken to steering group in January for approval. 31/1/24: High level mapping of service processes across the Trust's services completed and analysis on schedule. 30/03/24: A sub-group of the interoperability operational severe mental illness/physical health checks (SMI/PHC) steering group is currently reviewing SMI/PHC templates and SNOMED coding on templates within SWYPFT and Ardens' templates used in primary care. 30/4/24: Review of cardiometabolic guidance – 2 pilots taking place and are on schedule. Ongoing: Working together with project management office leads across localities to maintain alignment, sharing communications and learning as the community mental health transformation programmes develop.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving care	Improve safety and quality	**Care planning and risk assessment** Work is progressing in line with the improvement plan. Task and Finish groups have commenced focussing on systems and digital improvements and good practice, policy and training. A quality dashboard and quality metrics is being developed alongside the change intelligence partner. **Personalised care (moving on from Care Programme Approach)** Ongoing: Commencing in December, members of the group have met with the Centre for Mental Health (CMH) Research to support development of guidance to support systems to improve community mental health assessments and support post-Care Programme Approach (CPA) in line with the NHSE Position Statement on Moving away from CPA. The Steering Group continue to engage with the Avon and Wiltshire National Network Meeting; The Regional Community of Practice for NEY and the Local West Yorkshire Network meetings. 22/12/23: Supporting Triangle of Care implementation group with development of Self-Assessment Framework -completed. 14/02/24: Produce preliminary draft principles for key worker and multi-disciplinary team (MDT) functions in preparation for engagement. Completed. 14/02/24: staff, service users and carers communication and engagement plan for implementation of key worker and MDT functions developed – progressing to schedule.	
Improving use of resources	Spend money wisely and increase value	**Value for money** On plan to secure value for money target for 2023/24 Non pay schemes are progressing though identified limited financial savings have been realised to date with perceived challenges around pace and capacity. Escalation in place to operational management group and executive management group. Cost savings initiatives generated through annual planning sessions and Thinking Differently workshops have been themed and shared with leads for consideration. Thinking Differently workshops continue to be offered at the request of services. Linking in with West Yorkshire Integrated Care Board transport cost saving project. SWYPFT leading on mental health secure transport. initial data gathering exercise scheduled for completion in February 2024, prior to premarket engagement with transport providers. Review of taxi use across the Trust is progressing ahead of contract renewal date July 2024. Report scheduled for submission to operational management group in March 2024.	
	Make digital improvements	**Digital Dictation** Tender evaluations are due to be complete 19/01/24. Executive management team approval of the preferred supplier is scheduled for 08/02/24. Change plan and communications plan are in development and Project Board will recommence in February 2024. A benefits realisation workshop is being scheduled for February 2024. Recruitment of two digital graduates to support the project and change management elements is underway	
Great place to work	People Directorate 90-day plan	**Develop the People Directorate (PD) Team** PD development plan covering 7 identified critical pathways is in progress. PD buddying scheme is currently being piloted to support new and existing staff to connect and belong. Interim arrangements in PD structure are in place and communicated across PD and organisation, maintaining a steady state	
		Reduce recruitment time to hire Task & Finish Group set up with strategy directorate support (Commenced Nov 23) Rapid Improvement (RI) mapping and deep dive conducted with recruitment (Nov & Dec 23) 'Time To Hire' action plan in place co-ordinated with strategy lead support. 'Time To Hire' RI Trustwide inclusion event took place on Jan 18th and was positively received. Identified both immediate areas for improvement and some to be taken for wider discussion at different forums. Health care support worker survey sent out to 170 new starters asking about recruitment experience (16% response rate) Appointments to vacant posts in recruitment team. T-Level implemented (Jan 23) Confirmation of recruitment post(s) funding. Recruitment activity reporting under development outside of NHS Jobs Business case for compliance role in development (Dec 23) Values based assessment centre delivery plan for 2024 underway (Complete Jan 24) Re-submitted applicant tracking system and onboarding options appraisal paper completed and submitted to EMT (Dec 23) Onboarding implementation group in place to understand blockages to switch on (Genius/IBM/NHS Jobs) Widened tender process commenced with procurement for system wide learning management system/applicant tracking system (Dec23)	
		80% of Trust staff have received an appraisal in the last 12 months. Dedicated appraisal steering group established Dec 2023 Launch of a personalised appraisal compliance dashboard for manager level – with a weekly data feed Implemented Dec 23 Work is progressing to improve appraisal take up and improve experience for staff and managers - Learning and Development support, through dedicated sessions, messaging, and guidance inc. Frequently Asked Questions in place. Creating a trajectory for completion rates is in progress.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Great place to work	People Directorate 90-day plan	**Improve International Nurse experience and support.** Wrap around support for international nurse recruitment (INR) in the workplace is in development - INR solution focussed group and sessions commenced 13th Nov 2023 and an action plan is progressing to address wrap around support requirements. Implementation of newsletter to INR and preceptor nurses into the Trust (Dec 23) Integration of Practice Learning Facilitator across inpatient wards Work commenced Nurse Recruitment Workforce Plan (Dec 23) To include INR cohort delivery plan and UK preceptorship nurse recruitment plan Jan to Dec 24 Solution focussed workshop held on 14/11/23 with stakeholders from across all care groups aiming to identify improvements to handover etc that will support readiness for entry into role for INR. Action plan identified and aligned with inpatient improvement programme.	
		Improve Quality of Workforce Data Appointment to People & Performance Senior Analyst Role (Dec 23) NHS Jobs data cleanse commenced and completed for End-to-end hire datasets (Dec 23) Review of People integrated performance report workforce production and People Performance Wall metrics – Completed Dec 23. Appraisal business intelligence dashboard development completed and in place. People & Performance Lead developing plan for delivery of key workforce key performance indicators dashboards and care group reporting of workforce key performance indicators.	
		Improve People Experience Completed 'your voice counts' appreciative enquiry sessions in Dec 2023. Inclusive leadership steering group established to work on developing the top-level actions from the themes for inclusive leadership as agreed by executive management team/ operational management team. Delay in receiving evaluation report of the Inclusive Leadership commissioned programme from commissioned consultant, now expected end Jan/early Feb 2024.	
		Improve employee relations support. Business Partner offering in line with the entire employee lifecycle is being well received and is progressing well. Review of the current human resource operations framework including policy and guidance catalogue to address accessibility and user-friendly self-service tools for line managers with clear service level agreements has been delayed.	
		Develop the workforce plan Work has commenced as part of annual planning with care group and corporate services to develop a clear workforce plan to analyse and inform future demand for staff and skills, translated into actions to meet requirements. Nurse recruitment workforce plan commenced Dec 23 Review of existing workforce workshop intelligence and datasets is taking longer than anticipated. Care Group focus group on workforce to be planned (Jan 23). Submitted workforce plan to NHS England (Jan draft – Apr final submission)	

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£1.1m	£0m	A deficit of £66k has been reported in December 2023. The current trend is fluctuating between small surpluses and small deficits. The year to date position is now £1.1m which is £0.3m ahead of plan. On that basis the Trust remains on track to achieve it's breakeven target for 2023 / 24.
2	Agency Spend	£6.8m	£8.8m	The run rate for agency has continued to be maintained at a lower level than the first half of the year. Spend is higher in December than November as this included a one off benefit. Year to date expenditure is £6.8m and the forecast is £8.8m which is £0.1m more than target.
3	Financial sustainability and efficiencies	£8.4m	£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. Year to date is £0.2m ahead of plan.
4	Cash	£75.9m	£76.9m	Overall the Trust cash position is £75.9m. Working capital management actions continue to maximise the Trust cash position.
5	Capital	£2m	£8.3m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £2.0m (32% of plan). Detailed reviews of scheme progress are undertaken and confirm that the forecast expenditure of £8.3m, in line with the current plan, will be delivered.
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 9 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0	Executive Summary / Key Performance Indicators

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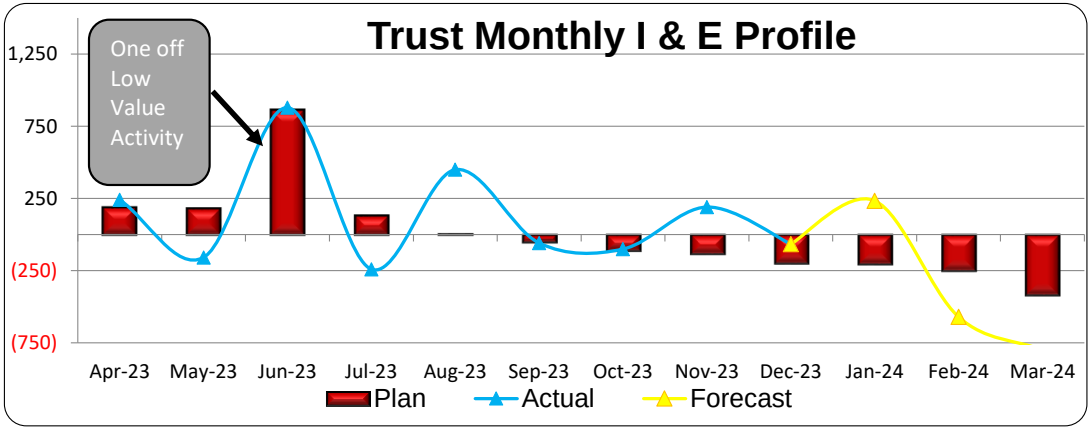
Green	In line, or greater than plan

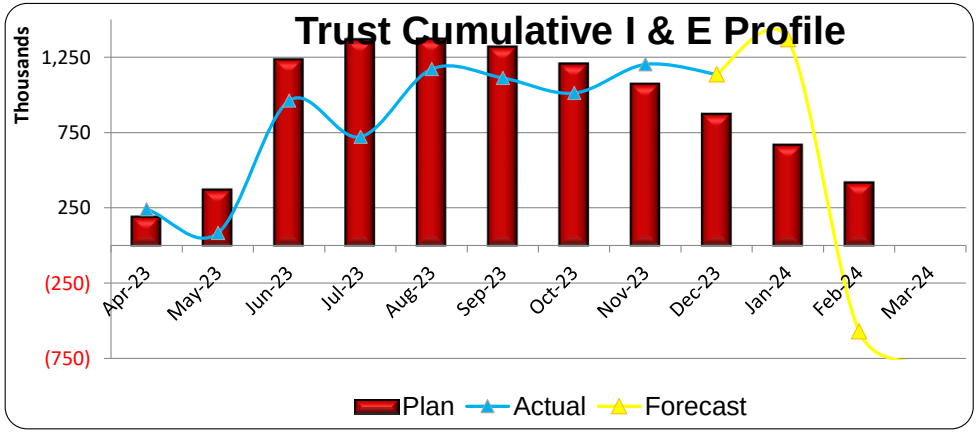
2.0 Income & Expenditure Position 2023 / 24

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					33,405	33,126	(280)	297,265	295,496	(1,769)	398,633	396,813	(1,820)
Other Operating Revenue					1,127	1,300	174	9,477	10,870	1,394	12,637	14,109	1,472
Total Revenue					**34,532**	**34,426**	**(106)**	**306,741**	**306,367**	**(375)**	**411,270**	**410,922**	**(349)**
Pay Costs	4,928	4,970	42	0.9%	(20,746)	(20,665)	82	(183,845)	(182,231)	1,614	(246,845)	(244,416)	2,429
Non Pay Costs					(13,579)	(13,531)	48	(118,222)	(120,066)	(1,843)	(159,398)	(162,551)	(3,152)
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	**4,928**	**4,970**	**42**	**0.9%**	**(34,326)**	**(34,196)**	**130**	**(302,067)**	**(302,292)**	**(224)**	**(406,243)**	**(406,962)**	**(718)**
EBITDA	**4,928**	**4,970**	**42**	**0.9%**	**206**	**230**	**24**	**4,674**	**4,075**	**(599)**	**5,027**	**3,960**	**(1,067)**
Depreciation					(482)	(487)	(5)	(4,506)	(4,535)	(29)	(5,949)	(5,994)	(46)
PDC Paid					(179)	(179)	0	(1,611)	(1,611)	0	(2,148)	(2,148)	0
Interest Received					256	370	114	2,313	3,207	894	3,070	4,182	1,112
Surplus / (Deficit) - ICB performance measure	**4,928**	**4,970**	**42**	**0.9%**	**(198)**	**(66)**	**132**	**870**	**1,136**	**266**	**0**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(174)	(174)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,928**	**4,970**	**42**	**0.9%**	**(198)**	**(86)**	**113**	**870**	**962**	**92**	**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	295,496	50,630	889	27,484	216,494
Other Operating Revenue	10,870				10,870
Total Revenue	**306,367**	**50,630**	**889**	**27,484**	**227,364**
Pay Costs	(182,231)	(1,136)	(81)	(551)	(180,462)
Non Pay Costs	(120,066)	(49,494)	(580)	(26,625)	(43,368)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	**(302,292)**	**(50,630)**	**(662)**	**(27,176)**	**(223,824)**
EBITDA	**4,075**	**0**	**227**	**308**	**3,540**
Depreciation	(4,535)				(4,535)
PDC Paid	(1,611)				(1,611)
Interest Received	3,207				3,207
Surplus / (Deficit) - ICB	**1,136**	**0**	**227**	**308**	**601**
Depn Peppercorn Leases (IFRS16)	(174)				(174)
Revaluation of Assets	0				0
Surplus / (Deficit) - Total	**962**	**0**	**227**	**308**	**427**
Surplus / (Deficit) - Forecast	**(0)**	**0**	**256**	**462**	(718)

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					24,706	24,298	(408)	218,889	216,494	(2,395)	294,158	291,913	(2,245)
Other Operating Revenue					1,127	1,300	174	9,477	10,870	1,394	12,637	14,109	1,472
Total Revenue					**25,833**	**25,598**	**(234)**	**228,366**	**227,364**	**(1,002)**	**306,795**	**306,022**	**(774)**
Pay Costs	4,907	4,937	31	0.6%	(20,602)	(20,475)	127	(182,477)	(180,462)	2,014	(245,043)	(242,063)	2,980
Non Pay Costs					(5,024)	(4,749)	276	(41,215)	(43,368)	(2,153)	(56,726)	(60,722)	(3,996)
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	**4,907**	**4,937**	**31**	**0.6%**	**(25,626)**	**(25,223)**	**403**	**(223,692)**	**(223,824)**	**(133)**	**(301,768)**	**(302,780)**	**(1,011)**
EBITDA	**4,907**	**4,937**	**31**	**0.6%**	**206**	**375**	**169**	**4,674**	**3,540**	**(1,134)**	**5,027**	**3,242**	**(1,785)**
Depreciation					(482)	(487)	(5)	(4,506)	(4,535)	(29)	(5,949)	(5,994)	(46)
PDC Paid					(179)	(179)	0	(1,611)	(1,611)	0	(2,148)	(2,148)	0
Interest Received					256	370	114	2,313	3,207	894	3,070	4,182	1,112
Surplus / (Deficit) - ICB performance measure	**4,907**	**4,937**	**31**	**0.6%**	**(198)**	**79**	**277**	**870**	**601**	**(269)**	**0**	**(718)**	**(718)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(174)	(174)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,907**	**4,937**	**31**	**0.6%**	**(198)**	**59**	**257**	**870**	**427**	**(443)**	**0**	**(949)**	**(949)**

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	4,928	4,970	42	0.9%	(198)	(66)	132	870	1,136	266	0	(0)	(0)
Provider Collaboratives	21	33	12	55.6%	0	(145)	(145)	0	535	535	0	718	718
Total excluding Collaboratives (as shown above)	**4,907**	**4,937**	**31**	**0.6%**	**(198)**	**79**	**277**	**870**	**601**	**(269)**	**0**	**(718)**	**(718)**

Income & Expenditure Position 2022 / 23

The year to date position is a surplus of £1.1m. This is £0.3m better than planned. Excluding the financial impact of the provider collaboratives this reduces to a surplus of £0.6m.

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

2023 / 24 Contracts with commissioners have continued towards signature with financial values, including investments, now being finalised. Income and expenditure have been included in this position. Full Year Effects of these investments have been included in the Trust medium term financial plan; due to the timing of agreement there is slippage in the current year which has been recognised.

Under recovery of income continues in month for those services based on actual costs incurred. As such these are offset by underspends on pay and non-pay within each of the care group positions. The continued development of Patient Level Information and Costing System (PLICS) will enable clearer reporting on the financial contribution from each indiviudal service line.

Pay

December reports another month of overall workforce growth with both substantive and bank staff increases. This has been offset by maintained reductions in agency staffing.

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 sustained low levels of out of area placements which is shown within the purchase of healthcare highlight report. Historically, and earlier in 2023 / 24, this has been highlighted as an area of volatile financial pressure.

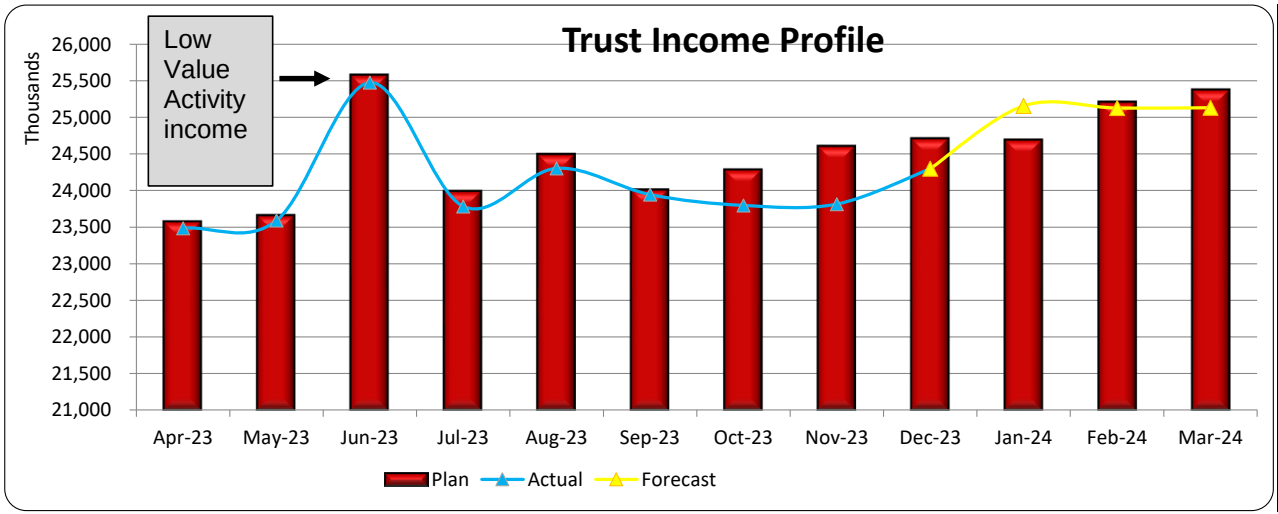
2.1 Income Information

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

This excludes the income received for the commissioning role as co-ordinating provider 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	20,116	20,482	21,293	21,268	21,268	**245,609**	**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	2,737	2,746	2,745	2,746	2,746	**32,969**	**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	402	468	503	503	503	**5,680**	**5,311**
Partnerships	514	584	546	591	472	608	377	493	504	500	493	497	**6,178**	**5,052**
Other Contract Income	197	96	144	102	144	138	140	67	98	117	117	117	**1,477**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,783**	**24,304**	**23,945**	**23,797**	**23,815**	**24,298**	**25,159**	**25,128**	**25,133**	**291,913**	**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, both budget and actuals / forecast, have been increased to recognise additional investment (both Mental Health Standard Investment (MHIS) and other) agreed with commissioners.

Part year effects have been included to recognise expected recruitment and expenditure profiles hence the increase forecast in

As in previous months actual income remains behind plan due to known shortfalls as highlighted below:
* 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

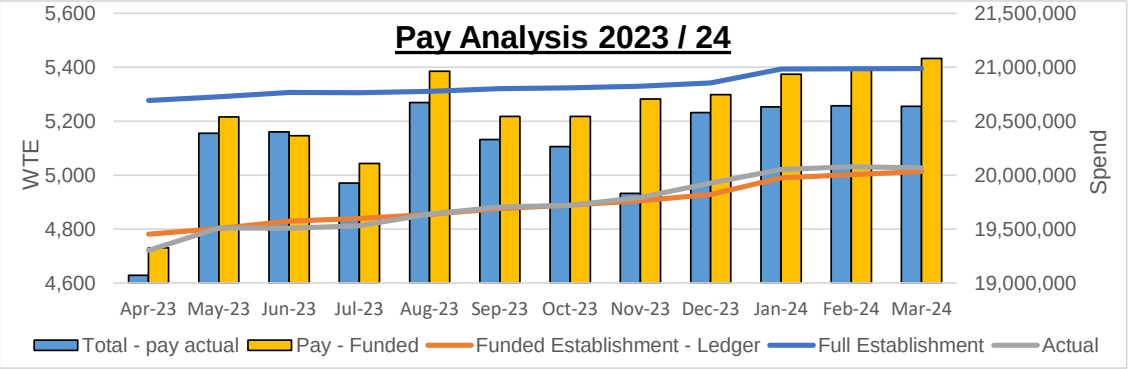
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	17,940	17,603	18,250	17,827	18,124	18,001	18,324	18,356	18,406	18,384	**216,397**
Bank & Locum	849	1,355	1,337	1,360	1,481	1,454	1,442	1,511	1,587	1,522	1,491	1,497	**16,885**
Agency	939	908	1,002	855	810	915	635	209	564	651	642	652	**8,781**
Total	**18,936**	**20,296**	**20,278**	**19,819**	**20,540**	**20,195**	**20,200**	**19,722**	**20,475**	**20,529**	**20,538**	**20,533**	**242,063**
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%	7.7%	7.7%	7.4%	7.3%	7.3%	7.0%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.5%	3.1%	1.1%	2.8%	3.2%	3.1%	3.2%	3.6%

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	4,400	4,417	4,454	4,515	4,537	4,532	**4,408**
Bank & Locum	222	314	326	321	356	369	363	387	408	389	381	383	**352**
Agency	157	161	164	163	144	145	126	113	108	117	113	112	**135**
Total	**4,721**	**4,804**	**4,803**	**4,812**	**4,856**	**4,881**	**4,888**	**4,917**	**4,970**	**5,021**	**5,031**	**5,027**	**4,894**
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**



As shown above, and in the graph on the left (grey line) the Trust has seen sustained growth of worked WTE with further increases in December. Overall this equates to an additional 509 WTE since April 2022.

December 2023 highlights a further 37 WTE increase of substantive worked and 21 WTE in bank. This has helped to support the reduction of agency WTE utilised.

The largest increase is in inpatient areas (adult secure) but there has been an increase across all care groups in month through continued recruitment

Budgeted WTE has been increased in Q4 to reflect the recently agreed additional investment for 2023 / 24.

2.2 Agency Expenditure Focus

Agency spend is £564k in December.

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.

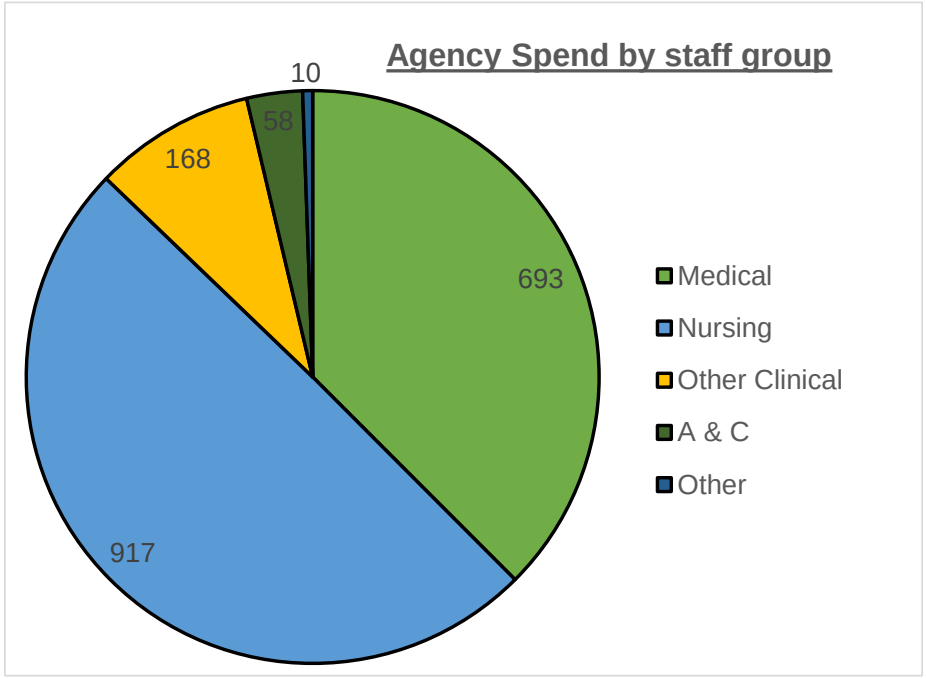
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

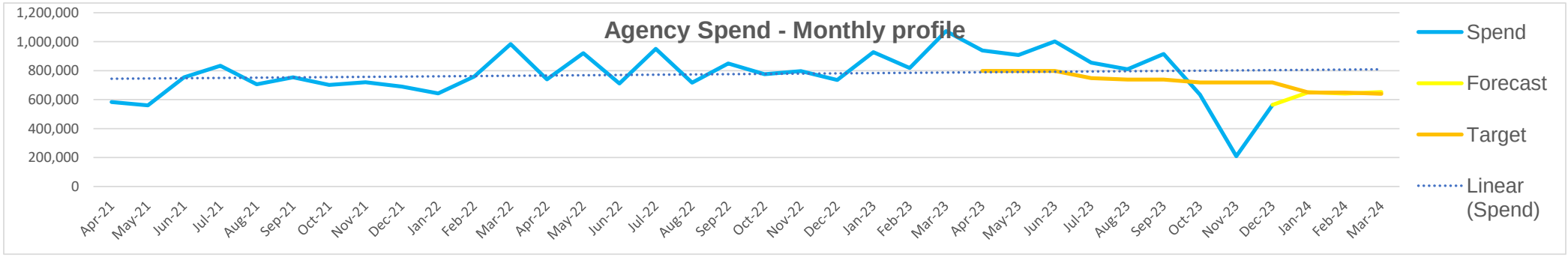
Under the NHS Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23 and the target trajectory is outlined in the graph below.

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.

December 2023 spend is £564k which, whilst higher than November as this included a one off benefit, is a reduced run rate from the first half of the year. As highlighted on the previous pay page the increase in substantive and bank staff has meant a reduced requirement for agency staff to provide safe staffing levels.

Overall the forecast spend for 2023 / 24 is £8.8m which is £0.1m higher than plan. The run rate, and impact on planning for 2024 / 25, continues to be assessed as part of the planning process.



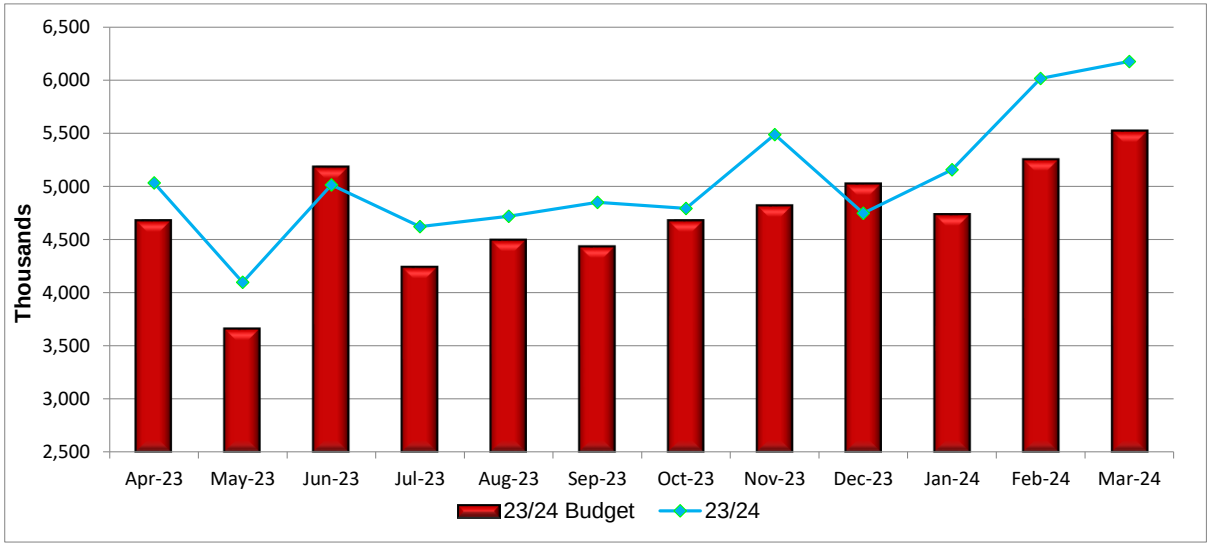


2.3 Non Pay Expenditure

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	5,015	4,621	4,719	4,851	4,793	5,489	4,749	5,158	6,018	6,178	**60,722**
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	3,100	2,952	(148)
Establishment	7,151	7,012	(140)
Lease & Property Rental	6,536	6,407	(129)
Premises (inc. rates)	4,225	4,134	(91)
Utilities	1,631	1,770	139
Purchase of Healthcare	6,570	8,417	1,847
Travel & vehicles	3,818	3,766	(51)
Supplies & Services	5,064	5,643	579
Training & Education	1,548	1,228	(320)
Clinical Negligence & Insurance	795	798	3
Other non pay	776	1,240	464
Total	**41,215**	**43,368**	**2,153**
Total Excl OOA and Drugs	**31,545**	**31,998**	**453**



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.

Expenditure has rreverted to the normal current run rate in December. There was an increase in November following a single agreed one off payment.

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.

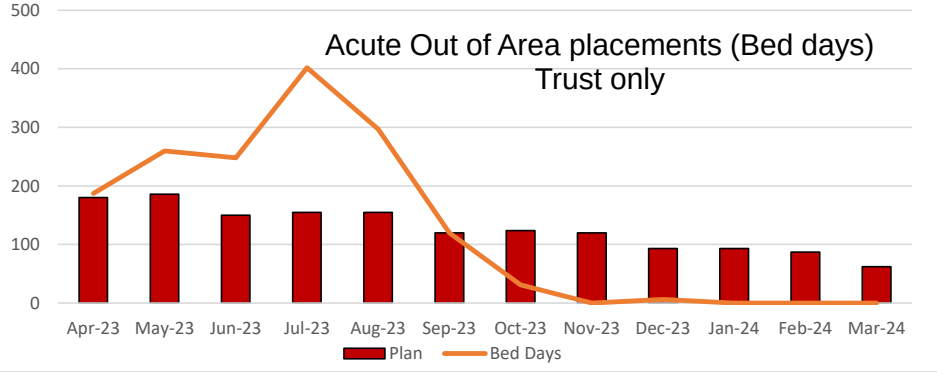
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

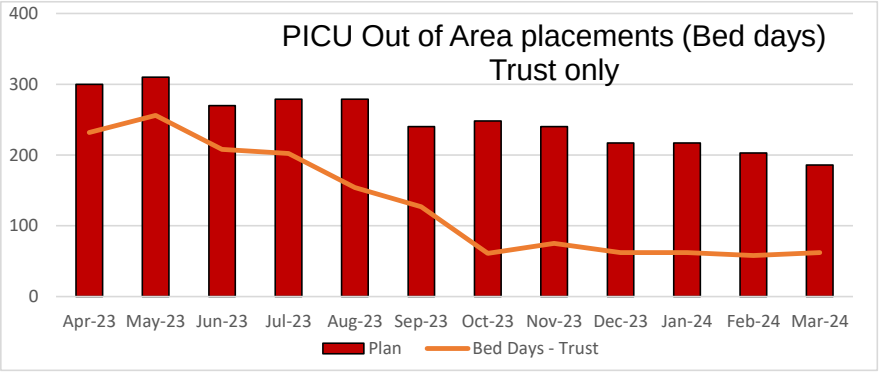
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

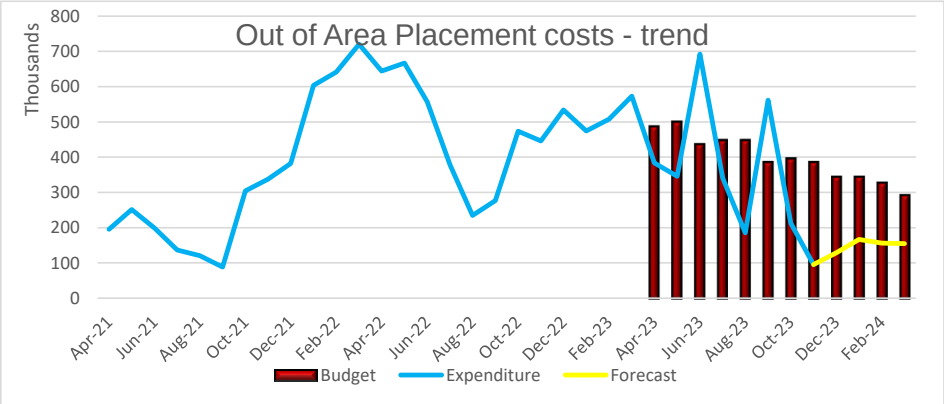
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	980	1,240	260
PICU	2,741	1,627	(1,114)
Locked Rehab	1,712	1,969	256
Services - NHS	295	2,237	1,941
IAPT	132	336	204
Yorkshire Smokefree	58	25	(34)
Other	651	985	334
Total	**6,570**	**8,417**	**1,847**







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

Current activity levels remain low. There was 1 acute placement in December totalling 6 bed days. There has been an increase in PCU placements at the end of December, from 2 to 3. This continues to be managed as part of overall operational management.

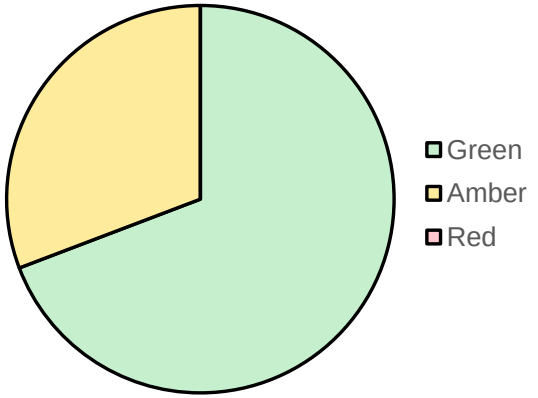
This remains volatile and increases in both areas have been included in the baseline forecast scenario.

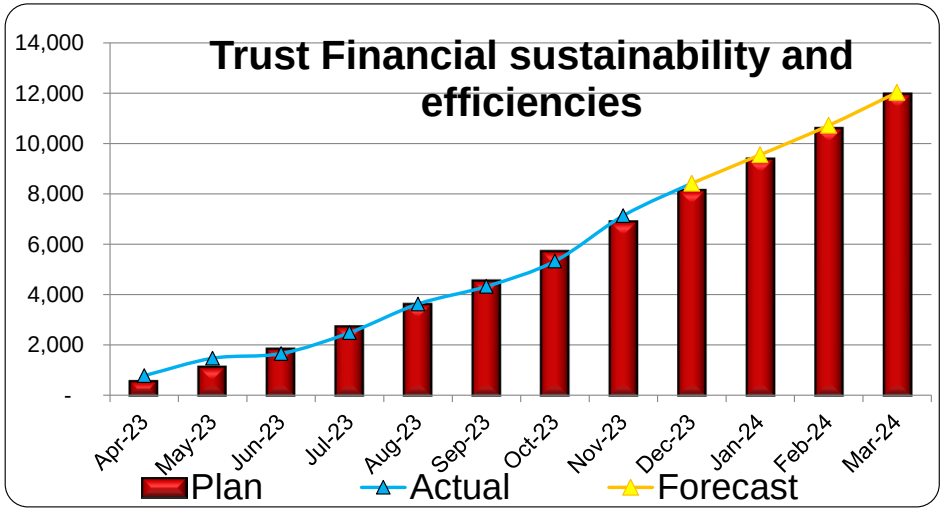
2.4 Value for Money, Financial sustainability and efficiency

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	2,071	2,936		3,197	2,936	1,615	
Agency & Workforce	Pg. 10	2,860	560	1,614	4,380	785	2,088	
Medicines optimisation		300	188		400	188		
Non Pay Review		713	0		1,048		0	0
Income contributions		378	404		500	864		
Interest Receivable	Pg. 4	1,050	1,944		1,400	2,512		
Provider Collaborative	Pg. 5	779	779		1,044	1,044		
Total		**8,150**	**6,809**	**1,614**	**11,969**	**8,328**	**3,703**	**0**
Recurrent		7,440	6,809		10,943	8,328	3,703	
Non Recurrent		710		1,614	1,026			0





The year to date value for money programme is currently £227k ahead of plan which is helping to support the overall financial position of the Trust. This is an improvement of £28k from last month due to:

* Continued low levels of out of area placement; being better than planned.
* Reduction in agency spend
* Contributions to fixed costs and overheads from recently agreed investments actioned in month.

These improvements now highlight that the full programme is forecast to be delivered in year. Elements of delivery remain assessed as amber and these will continue to be monitored.

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	162,835	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,413	
Non NHS Trade Receivables (Debtors)	2,853	1,788	
Prepayments	3,482	3,244	
Accrued Income	9,372	1,096	2
Cash and Cash Equivalents	74,585	75,949	Pg 15
Total Current Assets	**92,097**	**83,721**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(4,768)	3
Capital Payables (Creditors)	(739)	(445)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,597)	4
Accruals	(32,952)	(23,942)	4
Deferred Income	(4,172)	(1,939)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(53,090)	1
Total Current Liabilities	**(104,062)**	**(92,781)**	
Net Current Assets/Liabilities	**(11,965)**	**(9,060)**	
Total Assets less Current Liabilities	**153,210**	**153,775**	
Provisions for Liabilities	(4,319)	(3,921)	
Total Net Assets/(Liabilities)	**148,891**	**149,853**	
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	84,950	
Total Taxpayers' Equity	**148,891**	**149,853**	

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.

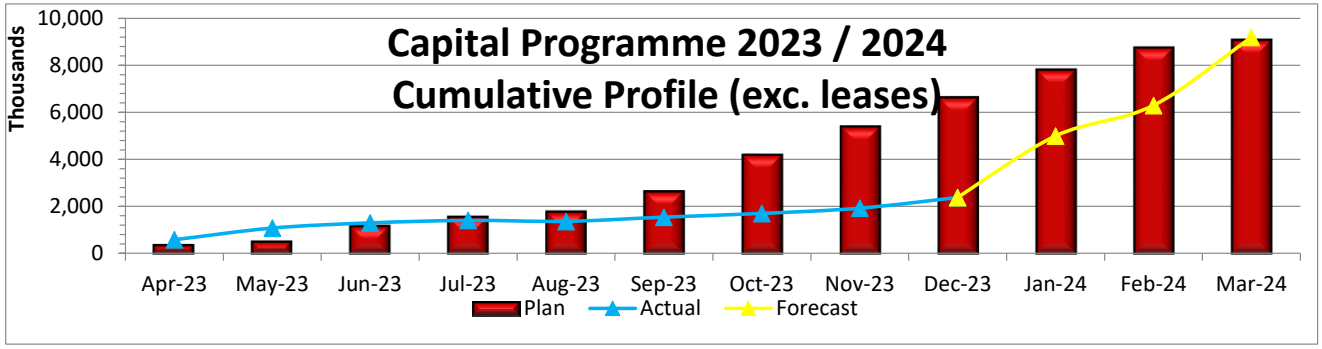
2. Accrued income, and maintaining at a low level, remains a focus in order to reduce risk and maximise cash balances. NHS Invoices were raised ahead of the month 9 Agreement of balances exercise.

3. Trade payables remain at a lower level than previous, work is ongoing to identify any old invoices so as to resolve issues and pay suppliers.

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	575	65	(510)	150	(1,325)
Seclusion rooms	750	750	140	(610)	725	(25)
Maintenance (Minor) Capital						
Clinical Improvement	285	185	29	(156)	871	586
Safety inc. ligature & IPC	990	665	728	63	2,265	1,275
Compliance	430	430	1	(429)	313	(117)
Backlog maintenance	510	510	28	(482)	147	(363)
Sustainability	300	200	8	(192)	189	(111)
Plant & Equipment	40	40	41	1	148	108
Other	1,223	573	791	218	961	(262)
IM & T						
Digital Infrastructure	1,100	1,050	124	(926)	1,200	100
Digital Care Records	180	160	30	(130)	70	(110)
Digitally Enabled Workforce	815	710	0	(710)	755	(59)
Digitally Enabling Service Users & Carers	400	325	44	(281)	300	(100)
IM&T Other	270	170	5	(165)	206	(64)
TOTALS	**8,768**	**6,343**	**2,034**	**(4,309)**	**8,300**	**(468)**
Lease Impact (IFRS 16)	5,203	5,203	6,085	882	6,117	914
New lease	303	293	342	49	893	590
TOTALS	**14,274**	**11,839**	**8,461**	**(3,378)**	**15,310**	**1,037**



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 was originally set at £8,768k which represented the capital allocation plus 5%.

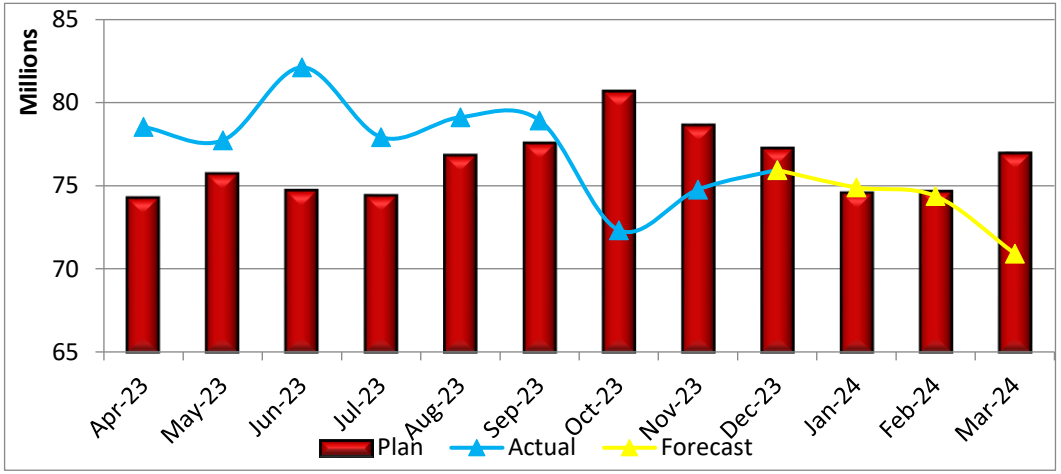
In November 2023 the ICB agreed for all Trusts to revert to plan. For the Trust the revised target is £8,300k.

The forecast has been risk assessed and revalidated in order to achieve this.

Spend to date is significantly behind plan although each scheme has been assessed for deliverability in 2023 / 24.

The accounting treatment of IFRS 16 leases will be managed at an ICB level for 2023 / 24. As such expenditure is shown as below the line (outside the scope of capital limits). For 2024 / 25 this will be included in the Trust capital allocation and will need to form part of the overall capital programme.

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

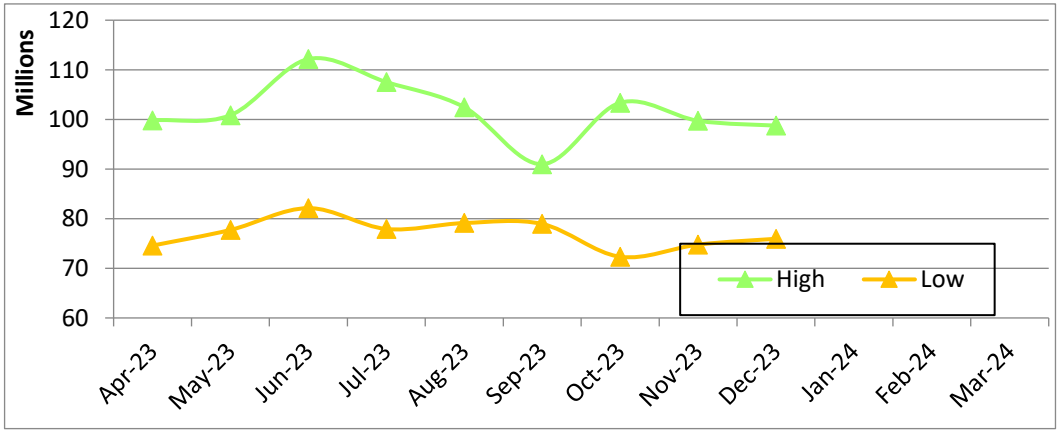


The Trust cash position remains positive.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	77,229	75,949	(1,280)

Cash has increased slightly in month but is expected to reduce in the last quarter as more capital is spent.

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



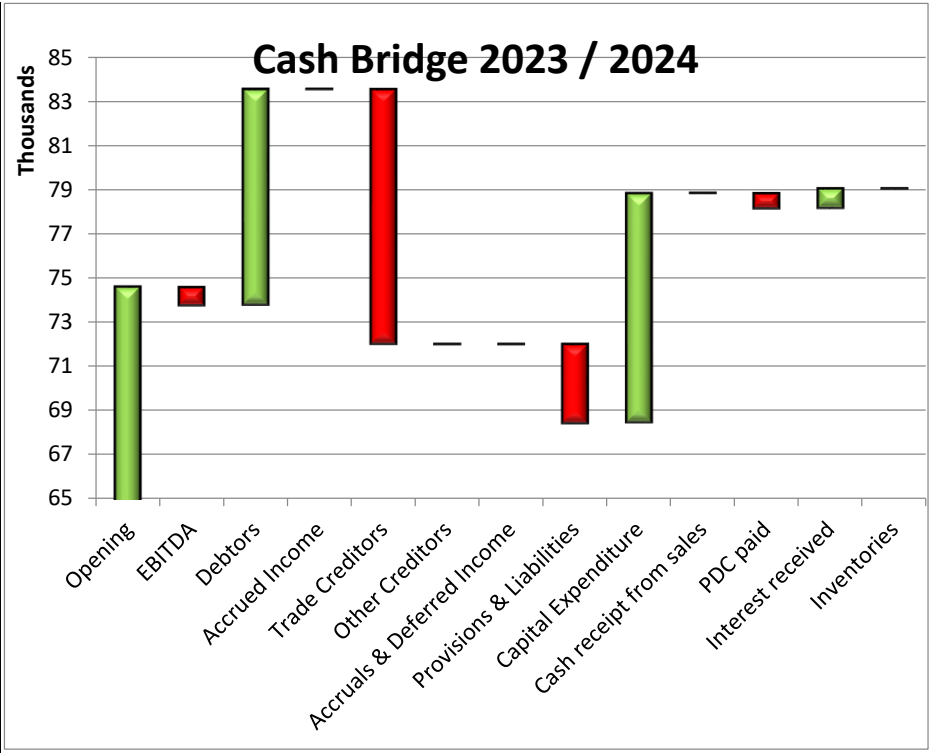
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £98.8m
The lowest balance is: £75.9m

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)	11,393	10,567	(826)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(416)	9,353	9,769	
Trade Payables (Creditors)	817	(10,696)	(11,512)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	949	(2,630)	(3,579)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(12,412)	(2,034)	10,378	
Cash receipts from asset sales	0	5	5	
Leases	0	(5,716)	(5,716)	
PDC Dividends paid	0	(691)	(691)	
PDC Dividends received	0		0	
Interest (paid)/ received	2,313	3,207	894	
Closing Balances	**77,229**	**75,949**	**(1,280)**	



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 £1.3m lower than plan, the high value of creditors paid is offset by the delay in capital expenditure.

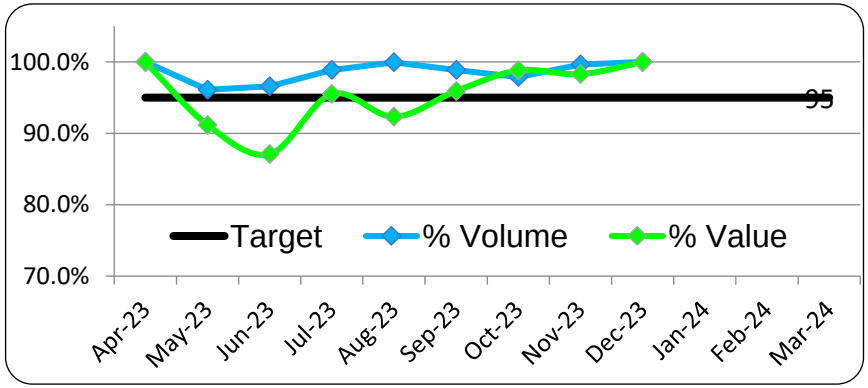
4.0 Better Payment Practice Code

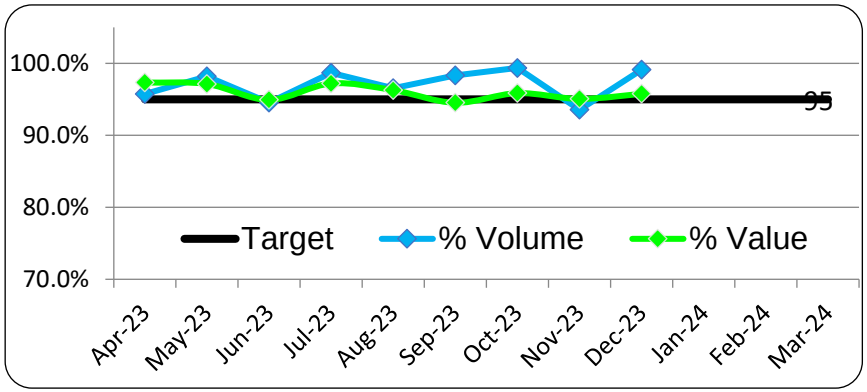
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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

NHS	Number %	Value %
In Month	100%	100%
Cumulative Year to Date	98%	96%

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 (£)
12-Dec-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5246	850,000
13-Dec-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000057603	740,183
19-Dec-23	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	203863	708,565
12-Dec-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1000712	680,394
19-Dec-23	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	203862	620,647
12-Dec-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS41	544,330
01-Dec-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D200007045	342,974
12-Dec-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS18	270,000
08-Dec-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 279	245,869
12-Dec-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Nhs Foun	4400000818	232,254
02-Dec-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5243	138,458
01-Dec-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D200007044	128,035
18-Dec-23	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	325492	93,156
11-Dec-23	IT Services	Trustwide	Daisy Corporate Services	3I519360	90,250
05-Dec-23	NHS Recharge	Calderdale	Calderdale & Huddersfield Nhs Foundation Trust	4710178727	87,514
19-Dec-23	Purchase of Healthcare	AS Collaborative	Oxford Health Nhs Foundation Trust	A0128848	75,835
04-Dec-23	Drugs	Trustwide	Lp Hcs Ltd	HCSLP513	69,355
13-Dec-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1000765	66,273
13-Dec-23	Software Licence	Barnsley	American Well Corporation Ireland Ltd	INV66416	61,427
01-Dec-23	Purchase of Healthcare	Barnsley	Elysium Healthcare Ltd	FDN01010	57,798
01-Dec-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000006821	56,000
29-Dec-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000007038	56,000
11-Dec-23	Drugs	Trustwide	Nhs Business Services Authority	1000079093	52,333
15-Dec-23	Utilities	Trustwide	Edf Energy Customers Ltd	000017471373	50,328
14-Dec-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	UPLIFT APR DEC 23	49,211
06-Dec-23	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72486359	47,313

20-Dec-23	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	126	45,000
06-Dec-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB05371	41,106
08-Dec-23	Purchase of Healthcare	Wakefield	St Matthews North Ltd Ta Broomhill	BHSWYORFT6000	37,120
06-Dec-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB05372	31,949
13-Dec-23	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1000764	30,853
12-Dec-23	Purchase of Healthcare	Forensics	Humber Teaching Nhs Foundation Trust	59893974	30,255
15-Dec-23	Utilities	Trustwide	Edf Energy Customers Ltd	000017451428	26,963
06-Dec-23	Recruitment Fees	Trustwide	Neu Professionals Ltd	SWYFT071	26,106
11-Dec-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5269	25,877
05-Dec-23	Rent	Kirklees	Bradbury Investments Ltd	1832	25,530

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

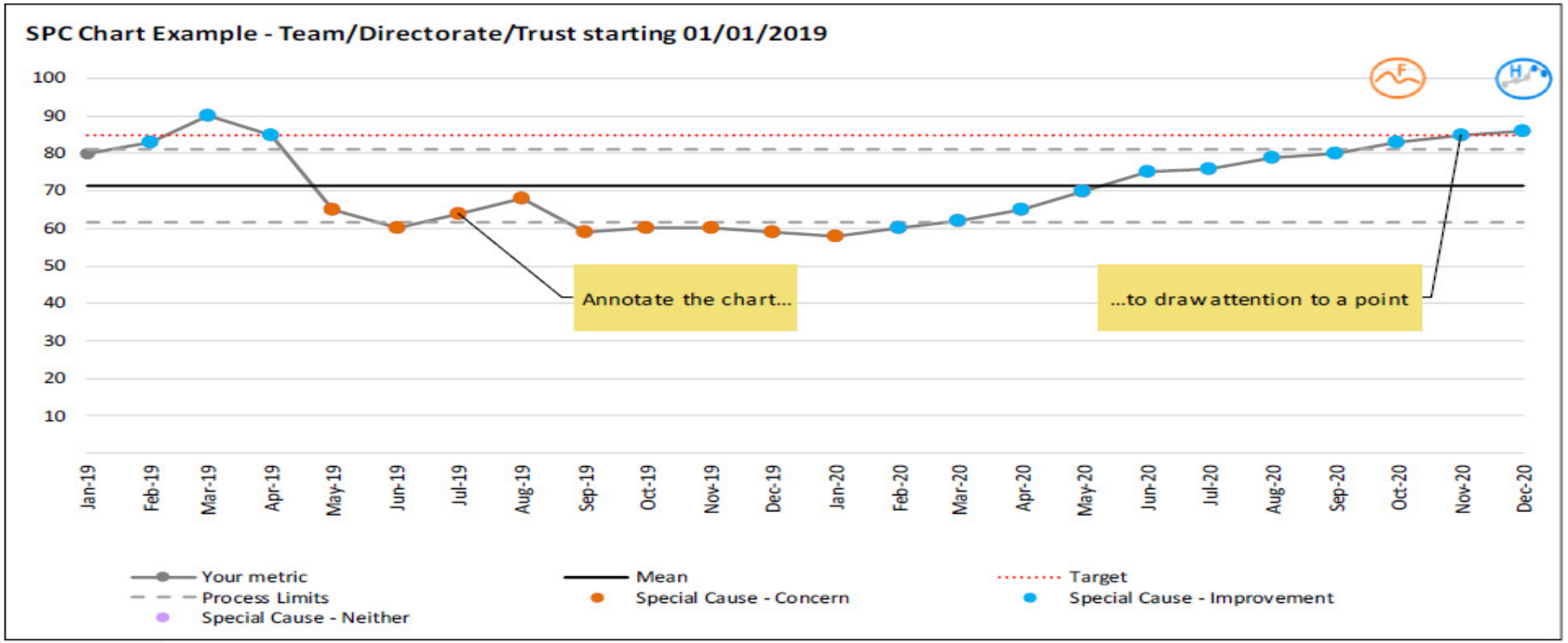
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

Appendix 3 - Guardian of Safe Working

Quarterly Report Q3

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 and December rotations have left us with gaps especially affecting Calderdale (2 CTs and 2 FY2s) but also another in Barnsley GP vocational training scheme. The Trust has recruited LAS doctors which have filled the core trainee gaps and GP gaps, in addition to the International Fellows supporting some of these services. The trust continues to support a number of less than full-time (LTFT) Trainees and many of the barriers to less than full-time training have now been removed. Although we now have 70 training posts, the whole-time equivalents in post are less than 60 due to a combination of vacancies and less than full-time 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 whole-time equivalents (WTE).

Exception Reports (ERs - with regard to working hours)

There have been few exception reports completed in the Trust since the introduction of the new contract. There were seven in this quarter, although an additional one was added to the system during this quarter related to work at the end of September. The majority have been completed by Foundation year 1 trainees, who have stayed late or missed educational opportunities due to a combination of acuity and staffing issues on the wards (Calderdale and Wakefield). TOIL (Time off in Lieu) was agreed for some with payment agreed where this was not possible. The remaining exception reports related to increased hours of work on the non-resident Kirklees 1st on-call rota and payment for the additional hours was agreed. The doctors were all happy with the outcomes.

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 been slightly reduced in comparison to the last quarter, with Calderdale and Barnsley continuing to have the highest proportion of gaps this quarter. The commonest factors included Illness and Occupational Health recommendations for trainees to come off the rota (39), Vacancies (30) and trainees being less than full-time (21). Covid-19 was not reported to be a factor. 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.

Appendix 3 - Guardian of Safe Working

Quarterly Report Q3

Gaps by rota October/November/December '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	45 (24%)	45 (100%)	0	0	0
Calderdale 1st	33 (18%)	33 (100%)	0	0	0
Kirklees 1st	13 (14%)	13 (100%)	0	0	0
Wakefield 1st	18 (10%)	17 (94%)	0	0	1 (6%)
Total 1st	109 (17%)	108 (99%)	0	0	1(1%)
Wakefield 2nd	21 (23%)	0	0	21 (100%)	0

Costs of Rota Cover October/November/December '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	45 (445)	£17,905	£0	0
Calderdale	33 (308.75)	£13,893.75	£0	0
Kirklees	13 (232)	£8,120	£0	0
Wakefield	17 (152.5)	£6,851.25	£0	0
Total	108 (1138.25)	£46,770	£0	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. Once again, the importance of using exception reports was stressed, especially as evidence, if there has been an increase in workload. We await a resolution to concerns raised previously about the failure of promised changes to the Barnsley F1 on-call rota in the acute trust and there are ongoing discussions with the acute trust and training programme director. A number of other issues relating to on-call were discussed and where possible, actions put in place to make things easier for trainees. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the AMD for Postgraduate Medical Education. Problems with the flow of information between the acute trusts and SWYFT, necessary for safe patient care, remains a concern for trainees and Postgraduate Medical Education staff are looking into options to improve this.

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. The use of the Allocate software system has come under scrutiny due, especially to its inflexibility when staff are creating rotas and work schedules for less than full time trainees. As a trust we may need to invest in more administrative staff to be able to manage these issues or changes to the system. There have been a couple of complaints by trainees recently about the process. Another area of concern for trainees is that the rota coordinators do not having time to address leave requests in the preparation of rotas, which can make it hard for trainees to plan.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024
Agenda item 10.2

Private/Public paper:	**Public**		
Title:	**Care Group Dashboards**		
Paper presented by:	**Carol Harris - Chief Operating Officer**		
Paper prepared by:	Sue Threadgold - Director of Services, Forensics		
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in forensic services contributes towards the Trust's vision to provide outstanding physical, mental and social care in a modern health and care system. The key performance indicators link to all the Trust's values which are: We put the person first and in the centre. We know that families and carers matter. We are respectful, honest, open and transparent. We improve and aim to be outstanding. We are relevant today and ready for tomorrow.		
Purpose:	To provide Trust Board members with a summary of the performance in forensic services and the action being taken to deliver high quality care. The report provides assurance to Trust Board members on compliance with key performance indicators. It identifies emerging issues and actions being taken to address risks to operational delivery and therefore achievement of strategic intent.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Monitoring and managing performance in forensic services contributes to managing all the risks on the Board Framework and makes a specific contribution to actions to address the following risks: Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 2.3 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.		

	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. Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce, leading to poor service user and staff experience and the inability to sustain safer staffing levels. Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience, meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Forensic services work as part of the West Yorkshire Secure Provider Collaborative and as such, this report to Trust Board, to assure delivery against key performance objectives, forms part of the broader assurance of delivery against the West Yorkshire Integrated Care Board's 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. This report has been reviewed by the Executive Management Team. Reporting is one month retrospective to allow sufficient time for the report preparation.
Executive summary:	Trust Board members are asked to note specifically: The data shows there was an overall decline in appraisal performance for both Newton Lodge and the Bretton Centre, with Newton Lodge more recently demonstrating improvements. The care group implemented a recovery plan to weekly monitor improvements. Where local records and the Trust database differ, data quality actions are in place. The care group is on trajectory to achieve appraisal compliance at the end of February 2024. The overall care group appraisal compliance in November is recorded as 69.1%. Local care group records for mid-January 2024 show 89.7%. Whilst not a reason to accept high sickness, it must be noted that forensic services are predominantly ward based and as such do not offer staff flexibility to change their diary, to an admin day for example, if they feel unwell but able to work. Sickness absence has remained high for a long time and is a concern, most significantly the proportion of staff off sick on long term sick, 42% in November is typical of recent months. Learning from the health and wellbeing work in medium secure is being used to embed actions in low secure. Deep dive work includes an audit on compliance with the arrangements in the sickness absence policy and actions to support people with non-work related, long-term conditions. This will positively impact long term sickness. Benchmarking data with similar services at other trusts will be considered for future reports.

	Clinical supervision uptake is very positive. The service works to the commissioner target for clinical supervision, of 85%. This is monitored carefully to ensure compliance is maintained. The dip in September 2023 coincided with high levels of sickness absence of registered staff in low secure. Performance was returned through focused actions. Work is underway to improve reporting to support managers to better monitor and manage mandatory training. Forensic services overall are broadly compliant with reducing restrictive physical interventions (RRPI) training. Low secure were slightly under target but have demonstrated improvement and actions are in place to address the recent dip in forensic learning disability (LD). The service welcomes the actions being taken by the RRPI team to increase training capacity. Forensic LD have maintained compliance with cardiopulmonary resuscitation (CPR) training when other areas have slipped below target. Focused actions are in place to address this in medium and low secure services. Access to trained staff on each shift is managed through the staffing rotas. Staff undertake information governance training at a similar time each year and therefore the drop off occurs at a similar time. Plans are in place to improve compliance and address performance more proactively. Like acute inpatient services, forensic services often see staff at the start of their career who then move on to a community position. The development of community forensic services has also drawn resources from the more experienced inpatient staff group. Whilst this may not impact the turnover figure it adds to the feeling of movement within the services. All inpatient areas continue to work above establishment, leading to an overspend on direct budgets. This relates to high acuity and staffing requirements to keep the wards safe. Additional investment has been agreed in principle by the adult secure collaborative to address the staffing overspend. Community services within forensics continue to deliver an underspend position, mainly due to vacancies across all teams. All referrals for secure beds are managed and gatekept by the West Yorkshire services single point of access (SPA). The service has engaged with commissioners and committed to support quality improvement work in relation to patient pathways that improve patient flow and occupancy.

	As part of a quality improvement initiative the Friends and Family Test has been incorporated into an overall Patient Experience Survey which has resulted in improved compliance. This forms one part of a range of feedback activities. The number of incidents remains within common cause variation. The current lower occupancy within the inpatient service will have an impact on this data and the number of incidents, but a direct correlation is not possible due to the variable aspects of acuity and clinical need. As expected, when increased acuity is reported, themes of violence of aggression and security incidents remain the most reported incident categories. The security incidents relate to systems failures and do not reflect a material shift in security practice. To ensure safe staffing levels, staff are reallocated to areas with the greatest clinical need where it has not proven possible to cover that shift with temporary staffing or when there is absence that has occurred close to commencement of the shift. Despite low occupancy levels the safer staffing data reflects high levels of acuity and complexity. Significant quality improvement work was undertaken within the care group to reach and maintain the excellent care programme approach (CPA) performance. Despite compliance with the 25-hour meaningful activity target, recent feedback from service users suggests a more diverse range of activities should be offered. The service is reviewing this and plans to develop an improved offer, which will commence following the completion of the review at the end of March 2024. Forensic LD is an outlier in relation to restraint and prone restraint and quality improvement work has commenced that has a focus on the culture within the service and involves the introduction of positive behaviour support planning. The RRPI team are supporting the ward team. Hotspots in prone restraint have been identified and include the exiting of seclusion, service user choice and intramuscular injection administration. A task and finish group has been established within the Trust to support staff to use alternative injection sites, to avoid prone restraint for gluteal muscle injections and work is underway in forensic LD to pilot different methods of seclusion exit. Admissions to secure services of people from Black, Asian and Mixed ethnicity backgrounds are overrepresented in relation to local population representation.

	Equality Impact Assessments (EIAs) are completed and action plans developed (with 1 EIA rated as excelling). The focus of action plans for 2023 has been on the cultural awareness and celebration events, carers, and improvement of access to services to meet the needs of all populations. There is a marked variation between population and admissions in relation to the index of multiple deprivation. More detailed analysis is required to better understand this data.
Recommendation:	**Trust Board members are asked to RECEIVE and note the report.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Care Group Summary

November 2023

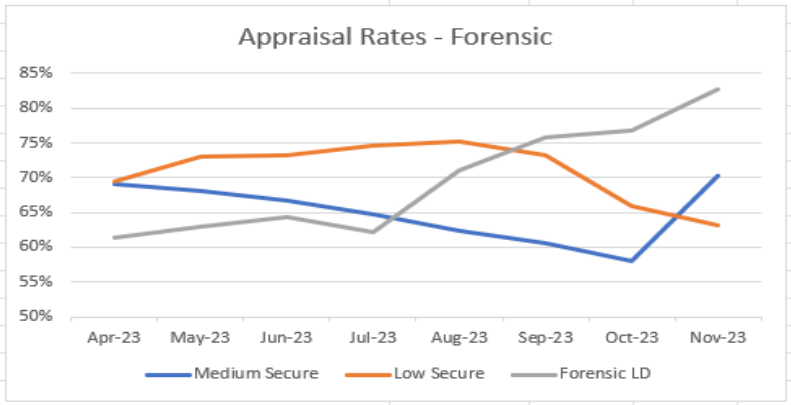
With **all of us** in mind.

Forensic Services

Forensic Services relates to Medium Secure (Newton Lodge), Low Secure (Bretton Centre) and Low secure Learning Disabilities (Forensic LD). There are 7 wards in medium secure comprising of a male pathway across Bronte, Hepworth, Waterton, Chippendale and Priestley. There is also a Learning Disability male ward on Appleton and a female ward on Johnson. In the Bretton Centre there are 3 wards Sandal, Thornhill and Ryburn which provide a male low secure pathway, there are no female low secure beds. Forensic LD is a stand alone male low secure learning disability service. In addition to the inpatient services there are 4 community teams. The Forensic Community Transition Team (FCTT) supports service users transitioning from low secure into generic services within the community. The Specialist Community Forensic Team (SCFT) supports those service users who require additional and/or more robust support and supervision within the community. The service also provides similar support to service users with a learning disability through a Forensic Outreach and Liaison Service (LD FOLS). The Forensic Child and Adolescent Mental Health Service (FCAMHS) is a Yorkshire and Humber service providing a consultation and specialist intervention model. With the exception of LD FOLS which is commissioned by the ICB all other services are commissioned but the West Yorkshire Adult secure Provider Collaborative (WYASPC). The collaborative went live on 1st October 2021 and is led by South West Yorkshire Partnership NHS Foundation Trust in partnership with Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Cygnet Health Care, and In Mind Healthcare Group for the provision of low and medium adult secure services. It covers the areas of Leeds, Calderdale, Kirklees, Wakefield and Bradford.

Workforce

Appraisals



Insights

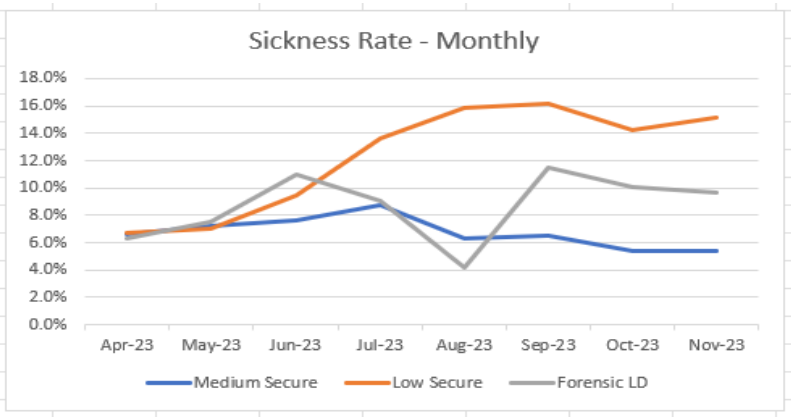
With the exception of Forensic LD the data shows a decline in performance overall for both Newton Lodge and the Bretton Centre with a recent upturn in performance in medium secure . In part the decline in performance is due to cohorts of new starters in September and October 2022 and who now need their first appraisal.

Given appraisal compliance provides assurance that individuals are in receipt of appropriate feedback, support and development a recovery plan was implemented to closely monitor the position on a weekly basis until compliance is reached. The trajectory to reach compliance is the end of February 2024. (Local data at the time of report in mid January 2024 shows 89.7%).

The data shows the November position as forensic LD 82.8%, Medium Secure 70.2% and Low Secure as 63.2%. Low secure experienced high levels of sickness throughout August and September which also impacted on the services ability to undertake appraisals. Appraisals were booked in as staff returned to work and the local data from December and early January is demonstrating improvements

Data cleansing is also underway to ensure WorkPal and service performance data reflect actual appraisal activity. The new pivot reporting is already providing services with more accurate feedback on performance.

Sickness

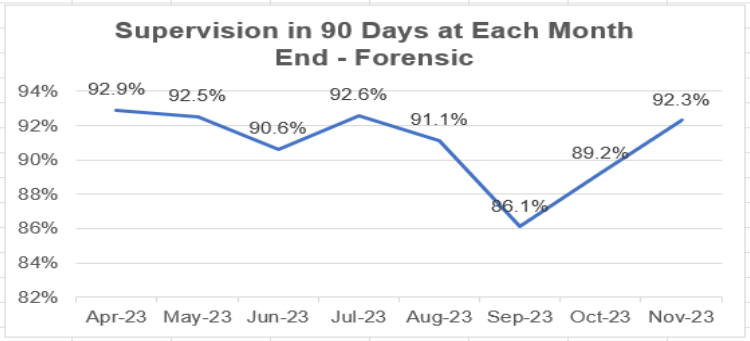


Insights

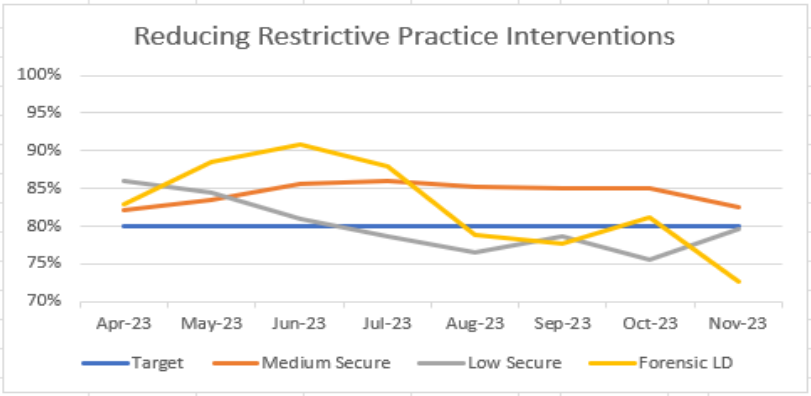
Sickness absence remains above the Trust target and the data includes both short term and long term absence from work. November split between long term (42% of all sickness) and short term (58 %) is typical of recent months.
The care group has a strong focus on wellbeing, it is noted that this is embedded more strongly within medium secure than in low secure and forensic LD. Managers from low secure and forensic LD are using the learning from medium secure to embed wellbeing champions and improve engagement with the action plan.
We are conscious sickness is high and we are seeking to understand how this compares nationally and regionally.
The rise in low secure across the summer is long term sickness with a strong prominence on stress, anxiety and depression, this also coincided increased acuity and complexity within the service and high levels of cancellation of bank, agency and overtime shifts. There are also several cases of staff with serious physical health issues not related to work.
The service is currently being supported by the People Directorate who are undertaking an audit on compliance with trust policy to provide assurance that the policy is being applied robustly. This will support the reduction in long term sickness.
Impact due to absence on care is managed through a flexible approach to staffing and the use of temporary staff. Further work is required to understand impact through qualitative measures, such as continuity through named nurse sessions.
Focus over the last 3 months has been on management of the long term sickness cases with robust plans in place to support a return to work for many and some have progressed to the final stage of the process.

Forensic Services

Supervision



Mandatory Training



Insights

Clinical supervision is a form of reflective practice that aims to enhance the delivery of safe and effective care, by using the process of professional support and learning to develop an individual both professionally and personally.
The Trust has a target of 80% compliance for clinical supervision, however, NHS England (NHSE) and subsequently the West Yorkshire Provider Collaborative have set the same target of 85%.

The service recognises the benefits and potential negative impacts on falling below compliance targets, and supervision is monitored closely through performance meetings within the care group. The data shows compliance with both targets throughout this year, dipping significantly in September 2023 which coincides with high levels of sickness absence in registered staff within low secure, and focussed activity to increase appraisal rates across the care group.

The chart informs of medium secure services remaining above target. Improvements in performance are noted for low secure , however performance dipped for Forensic LD.

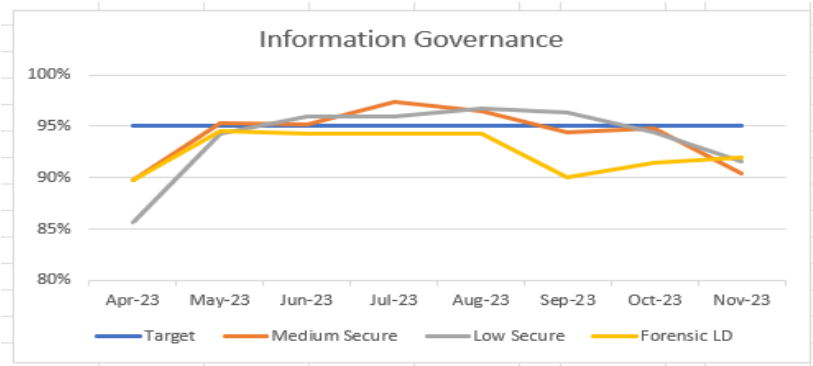
Medium Secure remains above target at 82.6%.Low Secure and Forensic LD are under target at 79.6% and 72.7% retrospectively.

The low secure data includes low secure and adult forensic community teams. Community staff are not expected to undertake the full physical intervention training as they do not engage in restraint, but they are required to undertake Breakaway and Personal Safety. Analysis has been undertaken and a piece of work to ensure that the right level of training is identified and reported for all staff.

In part performance has been impacted by the capacity of reducing restrictive practice interventions (RRPI) training. This has been acknowledged as a trust wide issue and additional resource approved to support an increase in training provision.

Actions are in place to address the shortfall in performance. Managers are rostering staff onto training and asking staff to change shifts to take up places that become available at short notice. This is monitored through management supervision.

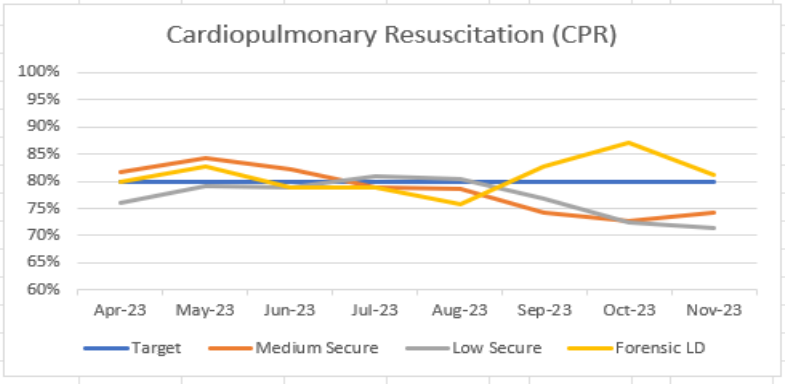
Forensic Services



There has been a small reduction in compliance across all service lines in November with medium secure at 90.4%, low secure at 91.6% and forensic LD at 91.9%.

A large number of staff require update training in the later months of the year. Improved reporting is being developed to support managers to better monitor and manage training compliance.

Proactive plans are in place to improve compliance. Ward managers regularly review compliance data.



Improvements in cardipulmonary resucitation (CPR) training performance are evident for Forensic LD from August 2023, remaining above compliance at 81.3%.

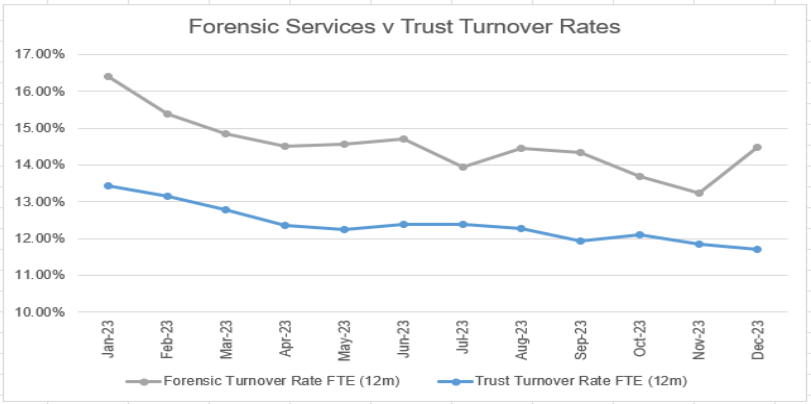
Medium secure and low secure remain below expected compliance at 74.3% and 71.4% retrospectively. The low secure data includes the adult forensic community teams. Community staff are not expected to undertake the same level of training as the registered inpatient staff. Analysis has been undertaken and a piece of work to ensure staff have the appropriate level of training for their role has started and remains ongoing.

As above, the team level and service level access to data impact on the service performance. The People Directorate are working on reports which will support operational delivery.

Staff who require this training have been identified and ward managers are currently booking staff on available courses. A trajectory for compliance will be completed before the end of January and progress will be monitored through the performance operational management group (OMG)
Staffing rosters ensure access to appropriately trained staff at all times.

Forensic Services

Turnover



Insights

Following a focus on recruitment and retention across the Trust the overall turnover for the service has reduced compared to last year. This is in part due to supporting Trustwide recruitment, undertaking bespoke recruitment within the care group and welcoming a substantial number of international colleagues. The recent slight increase will be further investigated.

Over the last 4-5 years the care group has experienced an ongoing challenge as community services have developed, with approximately 70% of community staffing being provided by SWYPFT forensic wards.

Within the inpatient service there continues to be a large number of Band 5 nurses in preceptorship or undertaking the development required for international nurses to work as a Band 5. The care group now has a robust mechanism for being alerted when nurses do not reach expected milestones in terms of completing preceptorship and sign off to work as an independent Band 5 nurse.

The care group has a focus on wellbeing and professional development as part of its retention strategy.

Finance

Agency Spend

Agency Spend YTD
£780k

Variance to Budget YTD
£160k Overspent

Insights

All inpatient areas continue to overspend on direct budgets due to high acuity and staffing requirements to keep the wards safe. Additional investment has been agreed in principle to increase the substantive staffing in inpatient area, and therefore reduce the demand required for temporary staffing. The West Yorkshire Provider Collaborative recognises there has been a historical deficit in funding.

Community services within forensics continues to deliver an underspend position. The prime reason for this is the number of vacancies.

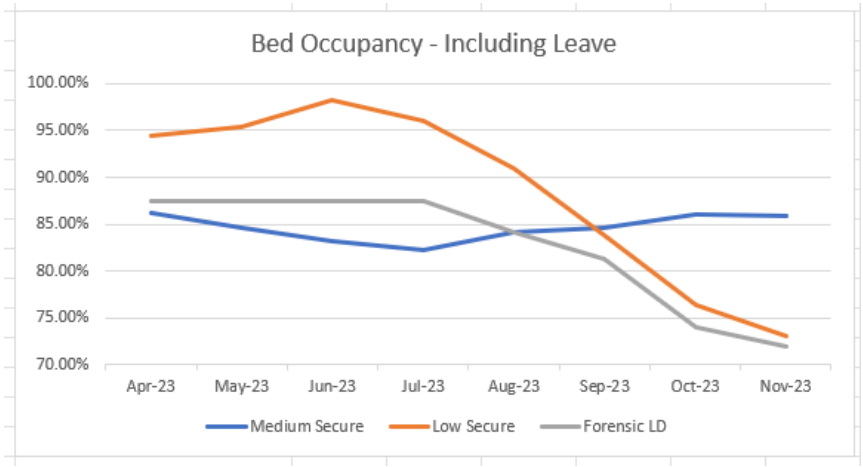
Over the last few months since August 2023 there has been a decline in the number of agency shifts worked and an increase in the number of bank shifts worked. Once newly registered and international recruits complete preceptorship bank and agency should reduce further.

It is noted that there has been significant non-pay costs to replace curtains and furniture. The care group will work with colleagues from Estates and Finance to develop a sustainable spending programme for replacement of such items.

Forensic Services

Access

Bed Occupancy - Including Leave



Insights

All referrals for secure beds are managed by the WYASPC Forensic single point of access (SPA). The SPA provides a gatekeeping function for all West Yorkshire secure beds. All appropriate referrals are sent from the SPA to the relevant clinical service for access assessment. Access assessment determines if admission to secure care is necessary.

Within secure services a significant proportion of people will need Ministry of Justice (MOJ) sign off to support transfer. This can create delays in the process.

Lower occupancy means that there are beds available in the service but these are not in wards that accept direct admissions, so people could still be placed out of area. The service has engaged with commissioners and committed to support quality improvement work in relation to patient pathways that improve patient flow and occupancy. Further meetings with the West Yorkshire Provider Commissioning hub are scheduled.

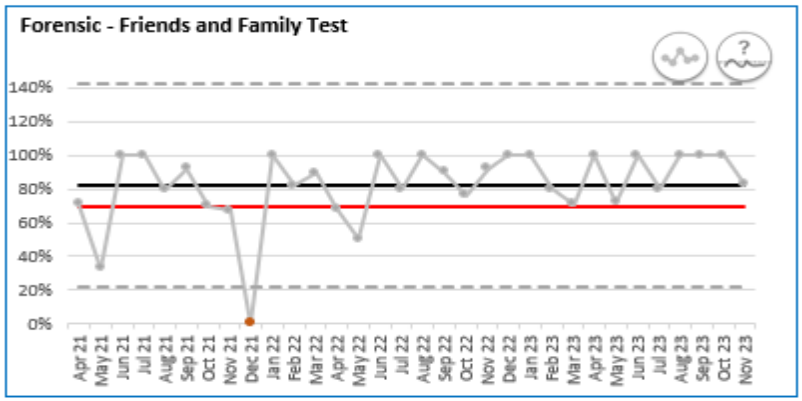
Forensic LD's underoccupancy is as predicted due to national changes within LD, transforming care.
Proactive monitoring with commissioners is underway.

Lower occupancy levels increase the opportunity for therapeutic activity. However, a direct correlation with reduced incidents and restraints cannot be assumed and is not clearly evident in the data over this period as acuity and clinical need are significant influencing factors.

Forensic Services

Quality and Safety

Friends and Family Test



Insights

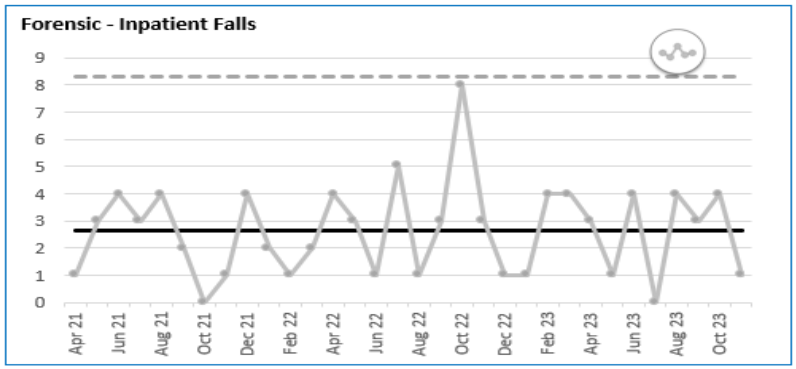
The statistical process control (SPC) chart indicates a period of common cause variation with no concerns in relation to performance.

Quality Improvement work was undertaken following low uptake and results in December 2021. Service users in medium and low secure services have medium to long lengths of stay and are asked to complete lots of survey activity as part of their inpatient stay. This impacted on the number of survey results received. To ensure compliance the Friends and Family Test was incorporated into an overall Patient Experience Survey which has resulted in improved engagement.

The results from the patient experience survey are provided in a narrative report to commissioners on a quarterly basis with actions taken in response to the feedback provided.

The care group use many different ways to capture and use the views of service users, learning from surveys is backed up by ward events and activities and specific service user meetings. Service user meetings/forums within Forensic services have received regional recognition and service users within the service are noted as being very active within the Yorkshire and Humber Involvement network. Food forms one of the key themes and service users have opportunity to directly feedback to the catering team and influence menus and choices.

Falls



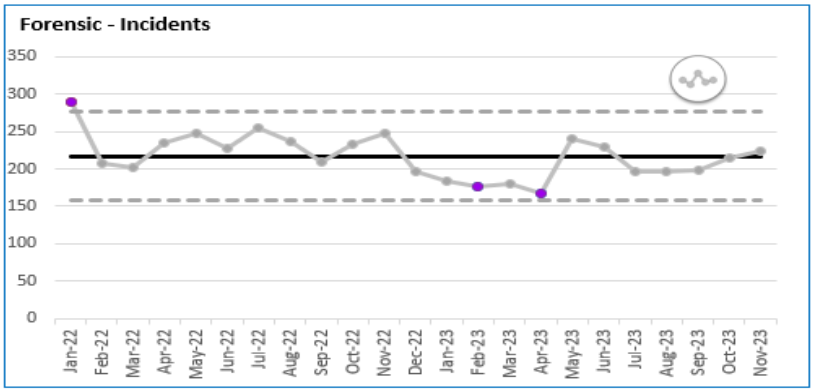
Insights

Inpatient Falls incidents remain within usual variation.

There were two falls in November, with no correlation between incidents. Both no apparent or minor injury

Forensic Services

Incidents



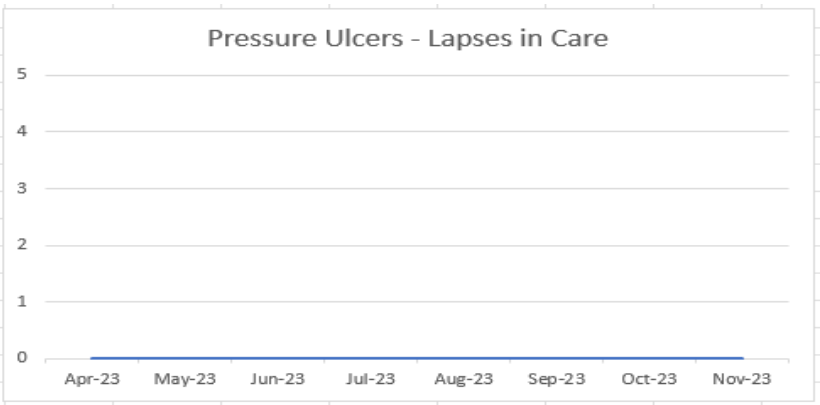
Insights

The SPC Chart informs that the number of incidents remains within common cause variation. The current lower occupancy within the inpatient service will have an impact on this data and the number of incidents although acuity and clinical need are significant variable factors, so a direct correlation is not evident.

The majority of incidents occur in the bed base of low secure and medium secure (93 and 113 respectively for November) with the remainder (17) split between forensic LD and the community.

There were no serious incidents. 97% of incidents were low / no harm and this provides assurance of a good reporting culture and a positive safety culture. As expected where acuity is high, themes of violence of aggression and security incidents remain the most reported incident categories. The security incidents relate to systems failures and does not reflect a material shift in security practice. Staff are encouraged to report incidents and these are reviewed through the care group and Trust processes.

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

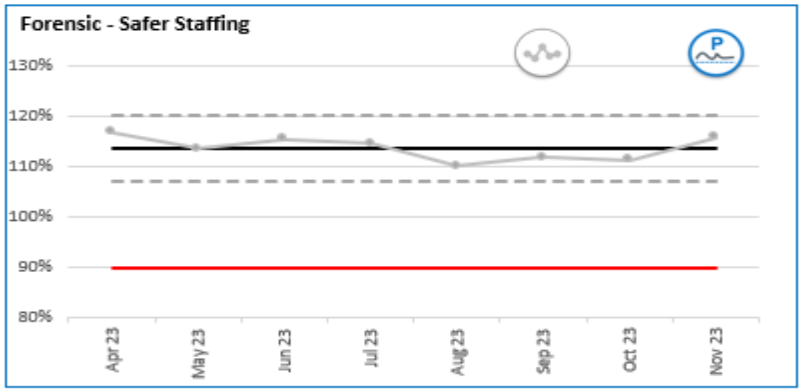


Insights

There were no pressure ulcer incidents within the service.

Forensic Services

Safer Staffing



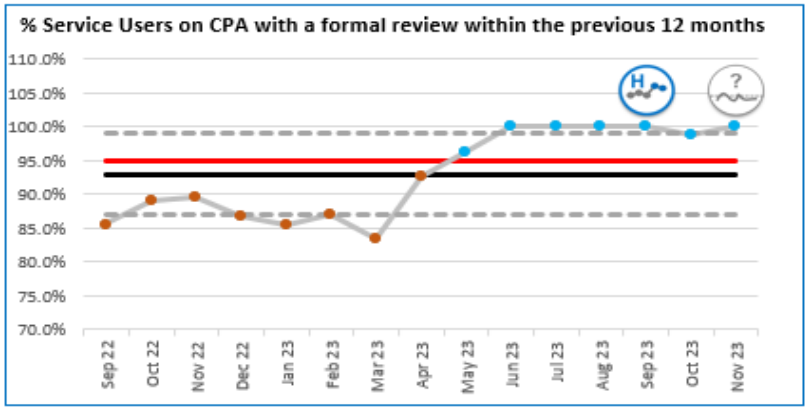
Insights

Actual and planned staffing hours is published monthly and the Trust completes exception reports for staffing below 80% fill rate for registered staff, and below 90% fill rate for overall staffing. The exception reports provide context and explanation.

Within the care group it is routine that staff are reallocated to areas with the greatest clinical need where it has been impossible to cover that shift with temporary staffing or when there is absence that has occurred close to commencement of the shift.

In November 2023 there were only two wards that dropped below 100% fill rate, these were Appleton and Priestley, and this relates to staff being reallocated to other wards with greater clinical need. Ryburn and Bronte operated close to establishment levels. These wards are at opposite, but specialist, ends of the pathway (rehabilitation and PICU) and establishments have remained better aligned with their needs. Chippendale, Hepworth, Johnson, Waterton, Thornhill, Sandal and Forensic LD operated above establishment levels and this related to higher levels of acuity. Overall establishments have since been reviewed, funded by the collaborative and will be amended.
Despite low occupancy levels this data reflects high levels of acuity and complexity.

CPA Reviews



Insights

Significant quality improvement work was undertaken within the care group to ensure care programme approach (CPA) compliance, which the care group has achieved over the last few months.

Most breaches of the target are due to a small number of historical cases attached to the Forensic community transition team where individuals are placed out of area in long term independent sector providers. The service continues to focus on transitioning these individuals safely to the responsible providers, but will continue to monitor CPA compliance very closely.

NHS
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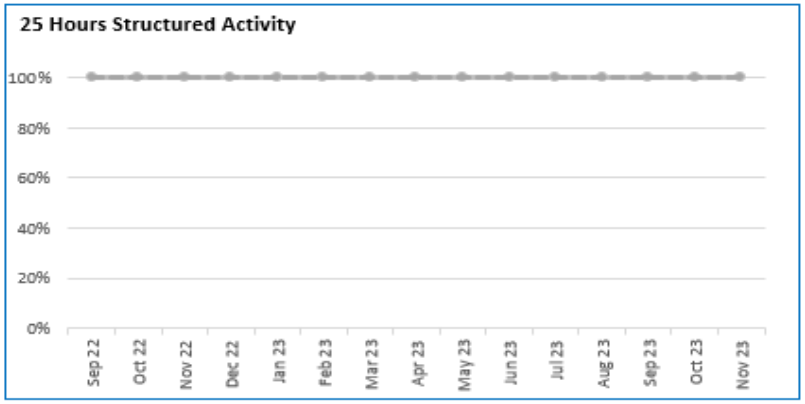
Forensic Services

25 Hours



Insights

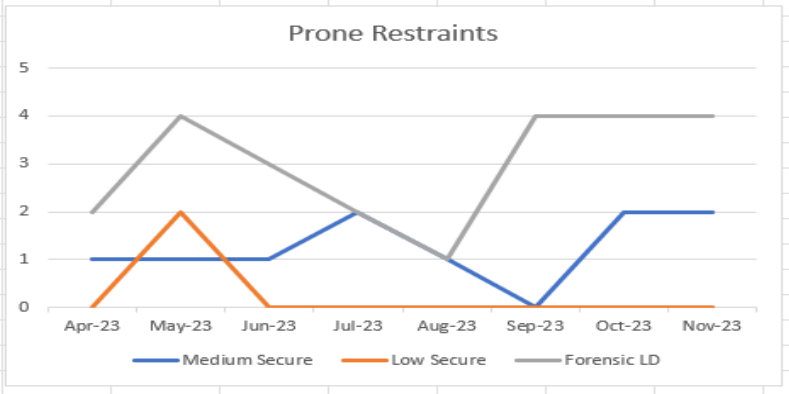
The achievement of 25 hours meaningful activity was a CQUIN (Commissioning for quality and innovation) prior to it becoming a key performance indictator (KPI) nationally for Adult Secure Services. In the past the service worked with other providers and commissioners across Yorkshire and Humber to identify activities which are essential to promoting wellbeing and recovery. The service has maintained 100% compliance with this target over a sustained period.

Despite compliance with the 25 hour meaningful activity target, recent feedback from service users, which was also articulated in the latest care quality commission (CQC) report would suggest that service users within the forensic care group would like a more diverse range of activities offered. The service is currently undertaking a review of this by 31 March 2024 and this will inform development work led by the associate director.

Forensic Services

Quality and Safety

Restraint Incidents/Prone Restraint



Insights

November data is provisional.

Incident numbers are impacted by acuity and occupancy in services.

Forensic LD is an outlier in relation to restraint and quality improvement work has commenced that has a focus on the culture within the service and involves the introduction of positive behaviour support planning. The reducing restrictive physical interventions (RRPI) team are engaged with this work and are supporting the ward team.

November data is provisional.

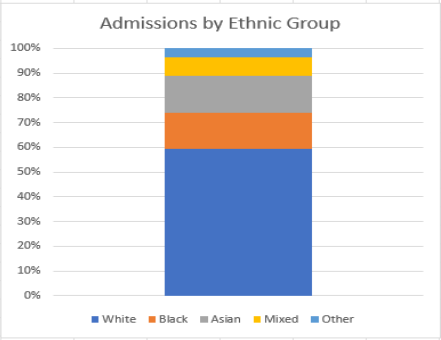
Forensic LD is an outlier in relation to prone restraint and quality improvement work has been commenced and includes the planning and implementation of positive behaviour support plans to better support people to make changes to manage their behaviour and reduce the need for restraint. Hotspots have been identified that include the exiting of seclusion and service users who place themselves in a prone position. The RRPI team are engaged with supporting the ward team.

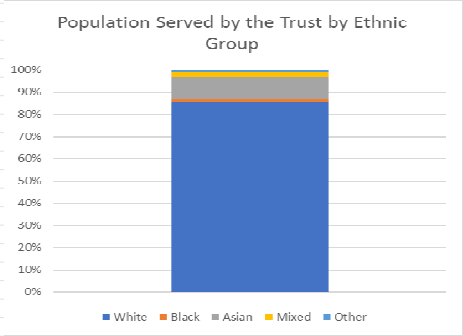
Both incidents in medium secure were to administration of intramuscular (IM) injections into the gluteal muscle. A task and finish group has been established within the Trust to establish if alternative injection sites could be used.
6/7 incidents relate to a very small number of service users.

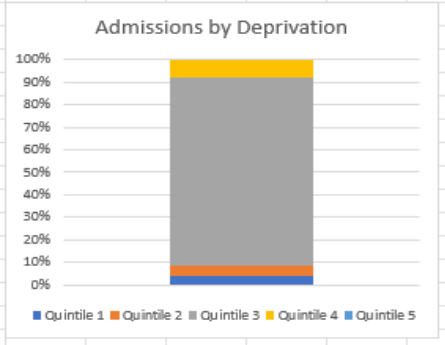
Forensic Services

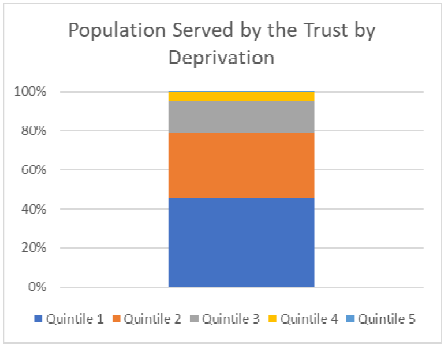
Inequalities

Admissions









Insights

Based on year to date (YTD) Admissions (Apr23-Nov23)
The data informs us that admissions to secure services of people from Black, Asian and Mixed ethnicity backgrounds are overrepresented in relation to local population representation. To make the data meaningful, a more detailed breakdown in required and services considered individually with the populations they serve. The low secure service provides a service across the Trust footprint however medium secure provides a West Yorkshire service. Forensic LD provides a service across an extended geography across Yorkshire and Humber.

The NICHE (Nov 2020) investigation into inequalities within West Yorkshire adult secure forensic services supports an improved understanding of our inequalities. WYASPC are leading on actions to support reducing targeted inequalities (over representation of males of Mixed, Asian, Black or other ethnicities, over representation and prolonged length of stay for women, length of stay disparities).

Equality Impact Assessments (EIAs) are completed and action plans developed (with 1 EIA rated as excelling). The focus of action plans for 2023 has been on the cultural awareness and celebration events, carers and improvement of access to services to meet the needs of all populations (i.e. hairdressers).

Based on YTD Admissions (Apr23-Nov23)

There is a marked variation between population and admissions in relation to the index of multiple deprivation. More detailed analysis is required to better understand this data. Again, to make this data more meaningful it would need to represent the same localities and geographies that are served by secure services.

The majority of admissions to services align with quintile 3 with a small number within quintile 1, 2 and 4. The population serviced by the Trust has over 40% within quintile 1, and further detail in relation to the West Yorkshire population would needed to understand if this also reflected across this geography.

NHS
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NHS Foundation Trust

Trust Board 30 January 2024
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 30 January 2024

Agenda item – 11.1 South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Collaborative (SY MHLDA) and linked programmes, and also on partnership developments in Barnsley.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Partnership

South Yorkshire Integrated Care Board

Member	Chief Executive

Items discussed	Update from meeting of 3rd January 2024
	
	Key items discussed were:
	
	• Story telling- this item focused on Urgent and Emergency Care.
	• Chair's update.
	• Chief Executive report- key updates included:
	  ○ Integrated Care Partnership Board- the November meeting focussed on work to reduce smoking in South Yorkshire.
	  ○ Financial position- in November, NHS England wrote to all trusts and ICBs requesting that for the remainder of 2023/24 organisations work to improve the financial position whilst maintaining safe patient services, prioritising emergency care and other time critical work such as cancer treatment. The South Yorkshire Integrated Care Board (ICB) has submitted an updated deficit forecast of £54.5m.
	  ○ Industrial action.
	  ○ Covid-19 and vaccinations.
	  ○ Winter planning.
	  ○ Patient choice for planned treatments.
	  ○ NHS England ICB Running Costs Allowance.
	  ○ NHS Research Engagement Network Development programme.
	  ○ NHS Maternity and Neonatal Independent Senior Advocate pilot- South Yorkshire has been chosen as one of 21 ICBs to take part in the NHS Maternity and Neonatal Independent Senior Advocate pilot.
	• Place reports. Key updates included:

	○ Barnsley – a health and social care careers event was held attended by circa 600 school pupils. An alliance of 70 bodies is promoting increased activity for older people. Barnsley Mental Health, Learning Disabilities, Dementia and Autism partnership are developing an All-Age Autism Strategy. In November, a 'big conversation' event was held with the voluntary, community and social enterprise sector. In November, the Barnsley Stroke campaign was launched. ○ Doncaster- CEOs have met to have a conclusive conversation on priorities. Co-production of the 1 Doncaster Plan 2024-29 is underway. Work is taking place to raise awareness of challenges faced by gypsy roma traveller communities. Work is taking place with the Deaf Society to improve service provision. ○ Rotherham – innovative work is taking place to reduce health inequalities in respiratory. Rotherham Place partners have developed the 'Say Yes' campaign to engage local people with positive, preventative messaging. Rotherham's integrated service for smoking cessation and tier 2 weight management was recommissioned in 2023. The new service, Rotherham Healthwave, launched in October. ○ Sheffield – community learning disability (LD) pathway redesign has had a positive impact. There is a focus on neurodiversity due to significant increase in referrals. • 2023/24 NHS South Yorkshire Financial Plan. • Emergency Preparedness Resilience and Response (EPRR) Framework. • Local Maternity and Neonatal System. • Right Care Right Person (RCRP) – a joint report from South Yorkshire Police and ICB which recognised the positive partnership approach being taken. • South Yorkshire ICB Outcomes Framework. • 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 6th March 2024.
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 5th December 2023

	Key items discussed included: • Parity of esteem- this was discussed and will come back for agreement at the March 2024 meeting. It was emphasised that there are some strategic opportunities through the National Institute of Health Research to support this work. • Collaborative Contribution to the System Efficiency Programme- there was recognition of the pressure regarding finances and that a collaborative understanding of what can be achieved and when is important. There was discussion about the implications that reconfiguration of services into one place will generate savings. It was acknowledged that ideas re reconfiguration often come from the acute sector which can't necessarily translate across to other areas. • Specialist commissioning update- a paper was received. There was discussion around the role of the group in service redesign and retendering going forward.
Date of next meeting	The next meeting is scheduled for 23rd January 2024.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair

Items discussed	<u>Update from meeting on 30th November 2023</u>
	
	Key items discussed included:
	• Story from our Communities – Supporting Young People into Employment in Health and Care Roles in Barnsley.
	• Reflection from the Story from our Communities,' Eating Disorders'.
	• Questions from the public.
	• Place Director update and Place achievements. Updates included:
	  o Running cost allowance- it was updated that the consultation had closed and final changes to the operating model were being made, which was due to be shared with NHS South Yorkshire staff on 20th December 2023.
	  o A #WeCareIntotheFuture careers event was held on 22nd November, bringing 600 students from across Barnsley together with a range of services and careers to better understand the professions.
	• Feedback from South Yorkshire Integrated Care Partnership Board.
	• Primary Care Access Recovery Plan- NHS England asked ICBs to develop their own system level access improvement plans, including actions. Primary Care Networks (PCN)s and practices have committed to confirmation of funding and offers each wanted to take up and outcomes expected. Barnsley PCN Capacity and Access Improvement Plan identified making improvement

	in three key areas: patient experience of contact, ease of access and demand management, and accuracy of recording in appointment books. • Strategic Winter Plan. • Health Protection Plans. • Quality and safety report. • Board Assurance Framework, risk register and issues log. • Finance update. • Performance dashboard (including SY ICB Performance Report).
Date of next meeting	Next meeting scheduled for 25th January 2024.
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 9th January 2024 Key items discussed included: • SEND (arrangements for children and young people with special educational needs and/or disabilities) inspection preparedness- an update was provided on the Local Area's preparedness for the Ofsted and CQC inspection of SEND services in Barnsley under the new inspection framework which was launched in January 2023. An inspection notification is anticipated in early 2024. • Cancer Programme- an overview of the cancer programme delivery was given and opportunity to provide recommendations and feedback on the priorities and consider how the Place Partnership Delivery Group (PPDG) can support this work. It was agreed that further discussion of priorities would take place at Barnsley Cancer Steering Group, and reported back to the PPDG. • Strategic Workforce Group- a Barnsley Strategic Workforce Group has been established to develop the Place Partnership Workforce Strategy and oversee the delivery of priority activities which met for the first time in December 2023. • Strategic Information and Digital Group. • Escalations from other subgroups. • Escalations for Partnership Board. •
Date of next meeting	Next meeting scheduled for 13th February 2024.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy and Change
Items discussed	Update from meeting of 20th December 2023

	This was a shortened meeting. The discussion focused on key elements of the NHS Joint Forward Plan for South Yorkshire, in order to consider where the Alliance can contribute further to Place strategy and objectives, including potential areas for collaboration.
Date of next meeting	Next meeting scheduled for 31st January 2024.

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 30 January 2024
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:	**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 30 January 2024

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	<u>Update from meeting of 16th January 2024</u> Key agenda items included: • Public Questions. • Chair's report- key updates included: o The ICB is reviewing its governance cycle for 2024/25, reflecting on learning from the first 18 months of operation as a statutory organisation. o Further guidance for the development of ICB Joint Forward Plans (JFP) was issued by NHSE on 22 December 2023. This reaffirms the requirement of ICBs to develop JFPs which act as a shared delivery plan for the Integrated Care Strategy as well as the requirement to refresh this annually. There is also a requirement to ensure closer alignment with the 2024/25 ICB capital plan. o The ICB's Freedom to Speak Up Guardian (FTSUG) annual report will be presented to the Board at the next meeting in March 2024. o The West Yorkshire Partnership Board of NHS, local authority and voluntary, community and social enterprise (VCSE) health and care leaders, met on 5 December 2023 at Halifax Town Hall. The meeting in public included a deep dive into the progress to date and further plans for two of the 10 big ambitions, - reducing the gap in healthy life expectancy and preventing suicide. • Chief Executive's report. Key updates included: o COVID-19 Inquiry- on 12 December 2023, the UK Covid-19 Inquiry opened its sixth investigation: the Care Sector across the UK (Module 6). Module 6 will investigate the impact of the pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland. o Latest position on COVID-19 and respiratory diseases. o Update on industrial action. o Confirmation of NHS plans for 2023/24. o Update on NHS Planning Guidance for 2024/25- on 22 December 2023, NHSE wrote to ICBs and Trusts to advise that discussions with Government were not yet concluded on expectations and priorities for 2024/25 and that it would therefore not be possible to publish the 2024/25 priorities and planning guidance until January 2024. o Long term financial modelling and Council finances. o Reflections on current performance. o Innovation and improvements. o Update on Provider Collaboratives. o Our people.

	• Board Assurance Framework. • Winter planning 2023/24. • Integrated Performance Report including financial performance. • Corporate Risk Register. • Committee 'AAA' reports. • System performance. • Annual assurance of Emergency Preparedness, Resilience and Response Core Standards.
Date of next meeting	Next meeting scheduled for 19th March 2024.
Further information:	https://www.westyorkshire.icb.nhs.uk/meetings/integrated-care-board/nhs-west-yorkshire-icb-board-meeting-16-january-2024

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 5th December 2023 Agenda items included: • Update from the Partnership Chief Executive Lead. This outlined three key areas of focus: ○ Short term actions to ensure safe delivery of services over winter. ○ Planning for 2024/25, in advance of planning guidance and in line with council budget setting processes to ensure an annual plan that is deliverable. ○ Creating the conditions for the medium-term delivery of the partnership's 10 big ambitions and the relevant Mayoral priorities on workforce, infrastructure and services, including through a medium-term financial plan and associated strategies. • Our ambition to increase the years of life that people live in good health in West Yorkshire- an overview was provided on progress as an Integrated Care Partnership to address inequalities. • Patient and public voice- our ambition to reduce suicide by 10% across West Yorkshire. ○ The age-adjusted suicide rates in WY are higher than the national average and have been rising between 2015 and 2021. ○ Work taking place in each of our Places to prevent suicide was outlined, a presentation was given by Leeds MIND, and lived experience stories shared. ○ The need to share good practice in suicide prevention, raise awareness and make it everyone's business was highlighted. • Narrowing Inequalities through inclusive recruitment- an update was provided on key work programmes and interventions led by

	Leeds Health and Care Academy (LHCA) and by partners to tackle health inequalities now and for the future.
Date of next meeting	Next meeting scheduled for 5th March 2024.
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-december-2023

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Member	Director of Provider Development, Chief Operating Officer and Medical Director.

Items discussed	Update from meeting of 11th January 2024
	
	Agenda items included:
	• Chair's update.
	• Learning Disabilities.
	  ○ Children and Young People's Keyworker update.
	  ○ Dynamic Support Register update.
	• Physical health care (PHC) of adults living with severe mental illness (SMI).
	• Community Mental Health transformation.
	  ○ Assurance.
	  ○ Care Programme Approach (CPA).
	  ○ Eating Disorders.
	• Neurodiversity.
	• Suicide prevention.
	• Children and Young People Self-harm report.
	• Escalation from AAA reports.

Date of next meeting	Next meeting scheduled for 22nd February 2024.

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 9th January 2024 Key items discussed included:

	• Mental Health Alliance Video
	• Report of the Place Lead. Key updates included:
	  ○ Health and Care Act New powers- there are further policy changes to scrutiny as a result of the Health and Social Care Act, and this will be further discussed at the next meeting.
	  ○ Infrastructure Strategy for West Yorkshire- there is a national and local requirement to develop an Infrastructure Strategy for West Yorkshire. This responsibility is currently part of the remit of the WY ICS Capital & Estates Strategy Board (CESB). Two groups will be established to support this work: an Infrastructure Strategy Oversight Group and an Infrastructure Strategy Development Group.
	  ○ NHS England Locality Team for West Yorkshire- from 1st December, the NHS England Locality Team for West Yorkshire formally transferred into NHS West Yorkshire ICB to become the ICB Planning and Performance Directorate.
	  ○ Finance Re-forecast Position- in November NHS England asked systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year. An allocation of £800 million was available to systems sourced from a combination of reprioritisation of national budgets and new funding. On 17 November the WDHCP Chair, Wakefield Accountable Officer and the Wakefield Place Finance lead met to agree the Wakefield Place submission.
	  ○ Operating Model.
	  ○ Frailty Virtual Ward Update- Adult Community Services have recently marked their one-year anniversary of the Frailty Virtual Ward.
	  ○ New District Nurses Diabetes Champion Model.
	  ○ YAS Pathways Roadshow.
	  ○ Integrated Neighbourhood Model.
	  ○ NHS Confederation Report.
	• Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative). Key updates included:
	  ○ King Street Walk-in Centre- a further three-year lease has been agreed for the Walk-in Centre to remain in King Street.
	  ○ Housing, Health and Social Care Partnership- it was updated that highlights of how the work of the Housing, Health and Social Care Partnership is enabling priority programmes were presented to the November meeting.
	  ○ Children's Observation Hub- this is operating as a pilot from October 2023 – February 2024, run by Conexus (on behalf of Wakefield Council & Mid Yorks). Early indications are that the service is having

	a positive impact, with very good feedback from primary care and families. ○ Hospices supporting discharge. ○ Review of Individual Placement and Support Service- following the Fidelity Review of the Individual Placement and Support Service, Wakefield scored 118 out of a possible 125 achieving exemplary status. ○ Outcomes framework. ○ People Alliance. • Public health profile-Health Determinants Research Collaborations (HDRC) Update- Wakefield is one of 11 applicants to be awarded funding (£5m) to establish a Health Determinants Research Collaboration (HDRC), from the National Institute for Health and Care Research (NIHR). With a long-term aim of tackling health inequalities, the grant will help build capacity, infrastructure and skills so we can be leaders in research. • Future Selph Overview (16-25 Years Mental and Emotional Wellbeing Service). A presentation was given by Conexus, as co-ordinating provider with 4 VCSE provider partners. The service is now funded recurrently by the Mental Health Alliance. It has been planned and developed by the PCNs working with local communities. Positive feedback has been received and good evidence of feedback and outcomes for young people. A formal evaluation brief is being prepared for a longitudinal study (3 years) to start in April. • Pontefract Midwife Led Unit the committee approved the proposal that the temporary suspension of the birthing facility should be made permanent and that the maternity service at Pontefract Hospital should continue to focus on the provision of ante-natal and post-natal care and family support complemented by community midwifery services and home births. • Operational Planning update. • Quality Update report. • Finance Update Month 8- the ICB in Wakefield reported £4m adverse variance to its planned surplus of £5.9m in line with the agreed reporting position of the WY ICS with NHS England. There are a number of risks to the achievement of the NHS Financial Plan across all the Wakefield Place. The ICB is in receipt of additional funding from NHS England to cover some of these costs, which should improve this position but we are awaiting distribution of funding at place level. • Wakefield Place Risk Register. • Issues escalated/for escalation.
Date of next meeting	Next meeting scheduled for 7th March 2024.
Further information	Meeting papers are available here:

	Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk) WDHCP-Committee-Combined-Meeting-Pack-9-January-2024-1.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	Update from meeting of 16th January 2024
	
	Key items discussed included:
	• Programme highlight reporting.
	• Outcomes Framework- Performance and Activity Report.
	• Integrated community services model.
	• West Yorkshire integrated working for Children and Young People.
	• Older People's Mental Health Transformation.
	• NHS Planning Guidance.
	• Items for escalation to Wakefield District Health and Care Partnership Committee.
	• Papers for information
	  ○ Embedding Quality – Monthly Report
	  ○ Performance – Monthly Report
	  ○ Notes of the Professional Collaborative Forum.

Date of next meeting	Next meeting scheduled for 20 February 2024.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	Update from meeting on 17th January 2024
	
	Key agenda items included:
	
	• Mental Health Alliance performance dashboard.
	• SWYPFT Older People's Inpatient Transformation public consultation.
	• 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.

	• Development session- 29th February 2024. • Planning and financial update 2024/25. • 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 21st February 2024.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)

Items discussed	Update from meeting of 18th January:
	
	Key agenda items included:
	• Migrant health.
	• Health Protection - 6-month Review.
	• Stopping the start: our new plan to create a smokefree
	• generation- consultation update.
	• For information:
	  ○ Overview and Scrutiny Committee papers.
	  ○ Connecting Care Executive Papers.

Date of next meeting	Next meeting scheduled for 21st March 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 30th November 2023 Agenda items included: • Public questions. • Place Lead Report • Delivering hospital reconfiguration – future model of care in Calderdale • Report of the Primary Care Strategy Group • Quality and safety report. • Place finance report.

	• Place Committee Work Plan and Board Review.
	• Clinical & Professional Forum Terms of Reference.
	• Papers received for information:
	  ○ Winter planning.
	  ○ Minutes CCPQG.
	  ○ Minutes Clinical and Professional Forum.

Date of next meeting	Next meeting scheduled for 25th January 2024.
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 11th January 2024 (Development Session)
	
	• The key priorities of the Calderdale Cares Community Programme Board are:
	  ○ Development of neighbourhood teams.
	  ○ An integrated health and care point of access.
	  ○ Integrated urgent community response.
	• The session focused on challenges and barriers to delivering the priority of developing Neighbourhood Teams, and the development of potential solutions.

Date of next meeting	Next meeting is scheduled for 8th February 2024.
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 14th December 2024 Items discussed included: • Progress with the Living and Working Well Goal in Calderdale's Wellbeing Strategy. • Update on the local implementation of the National Drug Strategy • Key Issues impacting on people's health. • Health and Wellbeing Board Forward Programme.
Date of next meeting	Next meeting is scheduled for 15th February 2024.
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 10th January 2024 Items discussed included: • People story- this focused on carers. In conjunction with Healthwatch, lanyards have been procured for carers in Kirklees with the aim of carers being recognisable in any healthcare setting, without having to explain who they are. • Kirklees Community Services – update on actions. • An update on progress on next steps identified within the 'Direct Award of Contract for Kirklees Community Services (KCS)' Committee paper supported and approved by the Place Committee on 13th September 2023 was given. The direct award process required the publication of a Voluntary Ex-Ante Transparency Notice (VEAT) to advise the market of the ICB's intention to award the contract and allow for any challenge to that action. The VEAT was published on 31st October 2023 and closed on 10th November 2023, there were no challenges or • representations. • Accountable Officer's Report. Key updates included: NHS West Yorkshire ICB – Operating Model Review. NHS West Yorkshire ICB Board- it was updated that the ICB Board met on 21 November and had a detailed discussion on primary care, taking into account the strategic direction set out in the Fuller Stocktake, and the requirements of the Primary Care Access Recovery Plan. • Kirklees Place Quality Report. • Kirklees Financial Update – Month 8. • Contract Report. • Performance Report against Key Performance Indicators for 2022/23. • High Level Risk Report: Cycle 5 2023/24 (November 2023 – January 2024). • Urgent Decision Notices • Items for the Attention of the ICB Board

	• Committee Work Plan. • Receipt of minutes.
Date of next meeting	Next meeting scheduled for 14th March 2024.
Further information	Further information and papers are available at: Kirklees ICB Committee papers - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)

Kirklees Integrated Health and Care Partnership Forum

Member	Director of Provider Development
Items discussed	Update from meeting of 7th December 2023 Items discussed included: • Update on Kirklees System Leadership offers 2023 and future plans. • Kirklees Health and Care Communications and Engagement Network: update on ongoing work and outputs from recent partnership development session. • Work plan.
Date of next meeting	Next meeting scheduled for 1st February 2024.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	Update from meeting of 18th January 2024 Key agenda items included: • Special Educational Needs and Disability (SEND) Programmes- the Board will received information on The Big Plan – SEND Strategy Refresh, SEND Governance arrangements, and an update on the Written Statement of Action. • Kirklees Health and Care Partnership - Starting Well Programme- the Board received information on Starting Well specifically on the refreshed governance and accountability arrangements including the role and scope of the new Board and groups reporting to it, the Health and Wellbeing role in governance, and Children and Young People Partnership updates.
Date of next meeting	The next meeting is scheduled for 4th April 2024.
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 8th January 2024 Key agenda items included: • Health and Care Plan Priority- Crisis Response. • Provider Selection Regime Commissioning Process. • The Big Plan (SEND Transformation). • Starting Well Programme Update. • Living Well Programme Update. • Ageing Well Programme Update. • Dying Well Programme Update.
Date of next meeting	Next meeting scheduled for 5th February 2024.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 22nd January 2024. Agenda items included: • Health and Care Plan refresh. • The relational practice movement. • Older Peoples Mental Health Transformation update (followed by break out group discussion).
Date of next meeting	Next meeting scheduled for 4th March 2024.

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 30 January 2024
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. National and regional work has been undertaken by NHS England (NHSE) to develop a new oversight and assurance approach to Provider Collaboratives. In November 2023, all Phase 1 Provider Collaboratives 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 were rated as Level 2 'Normalising' on the Quality Maturity Framework. The Adult Secure Provider Collaborative submitted a response to this request on 8th December 2023. Feedback is awaited from NHSE. All Phase 1 Provider Collaboratives in West Yorkshire have Lead Provider contracts in place up until end of March 2024. New contracts will be issued from 1st April 2024, for 2 years. Updated business cases are required to outline Provider Collaborative ambitions for 2024-26 in advance of a new contract being issued. The Adult Secure Provider Collaborative Board has continued to meet, and the collaborative have progressed among a range of items: • Review of the Provider Collaborative Business Case, and ambitions for 2024-26 in response to the request from NHSE outlined above. • Review of investment proposals, to utilise the collaborative 'Investment Fund'. • Development of a West Yorkshire- wide community model. The final 'Gateway 3' report was received by the Provider Collaborative Board in December, and associated investment proposal. Implementation of the new model, and support for the proposal cannot be progressed until further savings have been made by the collaborative. • The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives. A national transformation programme is being established by NHSE following a review of women's secure services. Much of the work initiated in West Yorkshire is aligned to the proposed programme. • A proposal is being developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements.

- Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network.
- A project is underway to improve patient experience. This includes standardising the approach across West Yorkshire adult secure services to patient reported experience measures, development of expert by experience roles, peer reviews, and a West Yorkshire- wide patient AGM, and greater focus on quality and oversight of 'You said we did', strengthening our validation of patient experience and action.
- 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, 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 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 9 months to December 2023 the collaborative operated with a financial surplus of £1,237k. A surplus position of £969k is forecast.

The Adult Eating Disorders Provider Collaborative reported a deficit at month 9. A year end deficit position is forecast.

The Children and Young People Mental Health Provider Collaborative reported a deficit position at month 9. 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.

	A specialist community services business case was approved by the Provider Collaborative Oversight Group in November, and by the Collaborative Committee at its December meeting. The CQC report for Cheswold Park Hospital, one of the providers within the provider collaborative, was published in December 2023- the Commissioning Hub have been supporting the provider to implement improvement plans, working closely with CQC and NHSE. The month 9 forecast position for the collaborative is £462k surplus. **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. An options paper as to how commissioning oversight will be managed going forward was developed and considered by EMT and Collaborative Committee. The option supported was to bring FCAMHS in line with Phase 1 Provider Collaboratives with commissioning oversight of the FCAMHS service by the West Yorkshire Specialised Provider Collaboratives Commissioning Hub, whilst maintaining as much of the current partnership arrangements as possible. NHSE agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023. Commissioning oversight of Yorkshire and Humber FCAMHS has now transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub. To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, despite oversight being via the West Yorkshire hub, a Yorkshire and Humber Provider Collaborative Oversight Meeting will meet for the first time in January 2024, between the three Yorkshire and Humber Commissioning Hubs. If successful, this arrangement could be considered for other Yorkshire and Humber wide collaboratives going forward. 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 had been confirmed for the PMH Provider Collaborative of 1st April 2024, but there are ongoing discussions as to whether this should be delayed. This will be confirmed over the next few weeks and support for any decision to delay sought from Committees in Common. A mobilisation group has been established. A Clinical Director for the PMH Provider Collaborative

	is in post, and Provider Collaborative Programme Lead, due to start in post in February 2024. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to: Receive and note the Specialised NHS-Led Provider Collaboratives update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 January 2024

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

National and regional work has been undertaken by NHS England (NHSE) to develop a new oversight and assurance approach to Provider Collaboratives. In November 2023, all Phase 1 Provider Collaboratives 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 were rated as Level 2 'Normalising' on the Quality Maturity Framework.

The Adult Secure Provider Collaborative submitted a response to this request on 8th December 2023. Feedback is awaited from NHSE.

All Phase 1 Provider Collaboratives in West Yorkshire have Lead Provider contracts in place up until end of March 2024. New contracts will be issued from 1st April 2024, for 2 years. Updated business cases are required to outline Provider Collaborative ambitions for 2024-26 in advance of a new contract being issued.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative have progressed among a range of items:

- Review of the Provider Collaborative Business Case, and ambitions for 2024-26 in response to the request from NHSE outlined above.
- Review of investment proposals, to utilise the collaborative 'Investment Fund'.
- Development of a West Yorkshire- wide community model. The final 'Gateway 3' report was received by the Provider Collaborative Board in December, and associated investment proposal. Implementation of the new model cannot be progressed until further savings have been made by the collaborative.
- The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives. A national transformation programme is being established by NHSE following a review of women's secure services. Much of the work initiated in West Yorkshire is aligned to the proposed programme.
- A proposal is being developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements.
- Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network.
- A project is underway to improve patient experience. This includes standardising the approach across West Yorkshire adult secure services to patient reported experience measures, development of expert by experience roles, peer reviews, and a West Yorkshire- wide patient AGM, and greater focus on quality and oversight of 'You said we did', strengthening our validation of patient experience and action.
- 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 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 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 9 months to December 2023 the collaborative operated with a financial surplus of £1,237k. However, this is expected to reduce in the later part of the financial year due reduced activity from other Provider Collaboratives using West Yorkshire beds, and increased costs and complexity of Exceptional Packages of Care (EPCs). A surplus position of £969k is forecast.

Following review of the 2023/24 Lead Provider Contract Variation, this has now been signed by the Trust and NHSE.

2023/24 contract variations for in area providers have been prepared. 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 5th December 2023, with a further meeting planned for 6th February 2024.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

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 9, a deficit position of £378k is reported. This is a deterioration against a break-even plan and can be attributed to deficits against the out of area (OOA) budget (£245k) and the cross flows income target (£223k).

The forecast position for the 2023/24 financial year is a £637k 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 £234k is reported for the 2023/24 financial year to December 2023 against a balanced plan**.** High-cost Exceptional Packages of Care (EPC's) are primarily driving this position. There is one ongoing high-cost EPC which is forecast to continue throughout the 2023/24 financial year. The forecast position for 2023/24 is a £347k deficit.

The provider collaborative financial envelope currently includes £1.1m non-recurrent funding from NHSE that was allocated to support the development of Red Kite View. This funding will end in March 2024, which poses a further risk to the collaborative financial position.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Collaborative went 'live' on 1st May 2022, with the Trust as 'Co-ordinating Provider'.

Key areas of focus have included the following:

- Governance structures are in place, with attendance from SWYPFT as Co-ordinating Provider. The Commissioning Hub is fully established.
- The Provider Collaborative Oversight Group for the collaborative provides oversight of the Trust's commissioning responsibilities. This reports into the Trust's Collaborative Committee.
- The draft 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 specialist community services business case was approved by the Provider Collaborative Oversight Group in November, and by the Collaborative Committee at its December meeting.
- The CQC report for Cheswold Park Hospital, one of the providers within the provider collaborative, was published in December 2023- the Commissioning Hub have been supporting the provider to implement improvement plans, working closely with CQC and NHSE.

The month 9 forecast position is £462k surplus. This is due to delay in timing of the community forensic service expansion.

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 was developed and considered by EMT and Collaborative Committee. The option supported was to bring FCAMHS in line with Phase 1 Provider Collaboratives with commissioning oversight of the FCAMHS service by the West Yorkshire Specialised Provider Collaboratives Commissioning Hub, whilst maintaining as much of the current partnership arrangements as possible.

NHSE agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023. Commissioning oversight of Yorkshire and Humber FCAMHS has now transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub. To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, despite oversight being via the West Yorkshire hub, a Yorkshire and Humber Provider Collaborative Oversight Meeting will meet for the first time in January, between the three Yorkshire and Humber Commissioning Hubs. If successful, this arrangement could be considered for other Yorkshire and Humber wide collaboratives going forward.

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 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 had been confirmed for the PMH Provider Collaborative of 1st April 2024, but there are ongoing discussions as to whether this should be delayed. This will be confirmed over the next few weeks and support for any decision to delay sought from Committees in Common. A mobilisation group has been established. A Clinical Director for the PMH Provider Collaborative is in post, and Provider Collaborative Programme Lead, due to start in post in February 2024.

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 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	✘		✘	✘		✘	✘	✘		✘		✘
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)								✘				
Finance updates for longer term planning					✘						✘	
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												✘

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
Strategies and Policies												
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 *(June 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)*