South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 26 March 2024 at 9.30
Boardroom, Conference Centre, Kendray Hospital, Barnsley

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**Paper**	2	To receive
3.	**9.33**	**Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal**	5	To receive
4.	**9.38**	**Minutes from previous Trust Board meeting held 30 January 2024**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 30 January 2024 and board action log**	Chair	**Paper**	5	To approve
6.	**9.45**	**Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
7.	**9.55**	**Chair's remarks**	Chair	**Verbal item**	3	To receive
8.	**9.58**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	**10.05**	**Performance**				
	10.05	9.1 Integrated performance report Month 11 2023/24	Executive Directors	**Paper**	30	To receive
	10.35	9.2 Care group performance dashboard (LD,ADHD/ASD)	Chief Operating Officer	**Paper**	15	To receive
	10.50	*Break*			*10*	
10.	**11.00**	**Risk and Assurance**				
	11.00	10.1 Serious incident quarterly report	Chief Nurse and Director of Quality and Professions	**Paper**	10	To receive
	11.10	10.2 Strategic Overview of Business and Associated Risk	Director of Strategy and Change	**Paper**	5	To receive
	11.15	10.3 Review of risk appetite statement	Director of Finance, Estates and Resources	**Paper**	5	To approve
	11.20	10.4 IPC Board Assurance Framework	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
	11.25	10.5 Care Quality Commission (CQC) inspection action plan update	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.30	10.6 Planning update	Director of Finance, Estates and Resources	**Verbal item**	5	To receive
	11.35	10.7 Assurance and receipt of minutes from Trust Board Committees and Members' Council - Collaborative Committee 6 February 2024 - Members Council 23 February 2024 - Mental Health Act Committee 5 March 2024 - Quality and Safety Committee 13 February/12 March 2024 - People and Remuneration Committee 12 March 2024 - Equality, Inclusion and Involvement Committee 13 March 2024 - Finance, Investment and Performance Committee 18 March 2024	Chairs of committees/Members' Council	**Paper**	10	To receive
11.	**11.45**	**Integrated Care Systems and Partnerships**				
	11.45	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	5	To receive
	11.50	11.1.1 South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative revised terms of reference	Chief Executive	**Paper**	3	To approve
	11.53	11.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Director of Provider Development	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.58	11.2.1 West Yorkshire Services Collaborative Committee in Common terms of reference	Director of Provider Development	**Paper**	2	To approve
	12.00	11.3 Provider Collaboratives and Alliances	Director of Finance Estates and Resources	**Paper**	5	To receive
12.	**12.05**	**Governance matters**				
	12.05	12.1 Trust Seal	Director of Finance, Estates and Resources	**Paper**	5	To receive
	12.10	12.2 Internal Governance Framework	Director of Finance, Estates and Resources	**Paper**	5	To approve
13.	**12.15**	**Strategies and Policies**				
	12.15	13.1 Estates Strategy Update	Director of Finance, Estates and Resources	**Paper**	10	To receive
14.	12.25	**Trust Board work programme for 2024/25**	Chair	**Paper**	5	To approve
15.	12.30	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 30 April 2024	Chair	**Paper**	3	To receive
16.	12.33	**Any other business**	Chair	**Verbal item**	7	To note

Item	Approx. Time	Agenda item	Presented by	Time allotted (mins)	Action
	12.40	*Close*			

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 2

Private/Public paper:	**Public**		
Title:	**Trust Board declaration of interests, including fit and proper persons test (FPPT) declaration**		
Paper presented by:	**Marie Burnham - 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, NHS England's Code of Governance for NHS Provider Trusts, the Trust's own Constitution and Fit & Proper Persons Test (FPPT) framework revised standards as reported to Board in September 2023.		
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:	Previous annual declaration of interest papers to the Trust Board. Update to Trust Board in September 2023 on the new FPPT guidance.		
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.		
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the UK Corporate Governance Code and NHS England's Code of Governance for NHS Provider Trusts, 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 declarations 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 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. **Non-Executive Director declaration of independence** NHS England's Code of Governance for NHS Provider Trusts and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. **Fit and proper person requirement** The Kark Review (2019) which was commissioned by the government in July 2018 to review the scope, operation and purpose of the FPPT as it applies under the current regulation 5 of the health and social Care Act 2008 (Regulated Activities) regulations 2014. NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going forward from 30 September 2023. As a direct result of this the Trust constitution and policy were revised to ensure compliance. The Framework has introduced a requirement for and means of retaining certain information relating to testing the requirements of the FPPT for board members, a set of core elements for the FPPT assessment of all board members, and a new way of completing references. The purpose of the new Framework is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The Framework supports board members to build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations. The Framework applies to executive and non-executive directors of integrated care boards (ICBs), NHS trusts and foundation trusts, NHS England and the CQC, interim as well as permanent appointments where greater than six weeks and those who are called "directors" within Regulation 5. 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.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a director's declaration, 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 26 March 2024
Register of interests of the directors (Trust Board)
From 1 April 2024 to 31 March 2025

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 NHS England's Code of Governance for NHS Provider Trusts, 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 declarations of interest have been made by the Trust Board:

Name	Declaration
Chair	
BURNHAM, Marie	Lay member of the Central Lancashire Integrated Care Partnership Chair of NICE Committee for weight management Chair of Pennine Multi Academy Trust of Schools
Non-Executive Directors	
RAYNER, Mandy Non-Executive Director Deputy Chair/Senior Independent Director	Spouse - works for a global not for profit organisation (HIMSS) selling consultancy services to healthcare bodies. Working within the advisory sector as a private consultant for a number of technology organisations who provide technology to the NHS. Any work that may link to the Trust will be declared at the time any future interest arises. Director/Owner of "Opinicus" providing IT consultancy to organisation/suppliers in Healthcare.
FORD, Mike Non-Executive Director	Chair of the Joint Audit Committee for the West Yorkshire Combined Authority and West Yorkshire Police
WEBSTER, David Non-Executive Director	Chief Financial Officer at Red Embedded Consulting Limited (trading as Consultant Red) Director and joint-owner - Tango Residential Ltd Non-executive trustee director - The Mast Academy Trust
MAHMOOD, Erfana Non-Executive Director	Non-Executive Director for Riverside Group. Non-Executive Director for Omega / Plexus part of Mears Group. Sister – Employed by Mind in Bradford.

Name	Declaration
MCMILLAN, Natalie Non-Executive Director	Director/owner of McMillan and Associates Ltd. Associate - NHS Providers Associate - Audit One who conduct audit work across NHS organisations
QUAIL, Kate Non-Executive Director	Director of The Lunniagh Partnership Ltd, Health and Care Consultancy
Associate Non-Executive Directors	
Dr Rachel Lee Associate Non-Executive Director	Director and owner of North Star Psychology Ltd. Consults and provides therapy for Aspire4you commissioned by NHS England. Associate with Healthy You Ltd funded by individual NHS trusts or NHS England.

Name	Declaration
Chief Executive	
BROOKS, Mark Chief Executive	Trustee for Emmaus (Hull & East Riding) Homelessness Charity Partner member of South Yorkshire Integrated Care Board
Executive Directors	
HARRIS, Carol Chief Operating Officer	Spouse works for an engineering consultancy company specialising in healthcare which has involved work with local NHS Trusts including Mid Yorkshire Hospitals NHS Trust Family members work on Trust bank
JENSEN, Lindsay Interim Chief People Officer	Spouse owns small portable appliance testing company who may occasionally undertake NHS work Vice president of Health People Management Association (HPMA) Yorkshire and Humber which is a registered charity and has alignments with the NHS
RAYNER, Sean Director of Provider Development	No interests declared.
SNARR, Adrian Director of Finance, Estates and Resources	No interests declared.
THIYAGESH, Dr Subha Chief Medical Officer	Spouse is a Hospital Consultant & Clinical Director at CHFT. Member of the NHS Clinical entrepreneurship strategic board. Honorary Visiting Professor at Huddersfield University.
THOMPSON, Darryl Chief Nurse and Director of Quality and Professions	Member of the Council of the National Mental Health and Learning Disability Nurse Directors Forum.
LAWSON, Dawn	No interests declared.

Name	Declaration
Director of Strategy and Change	

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Trust Board meeting held on 30 January 2024
Small Conference Room, Learning and Wellbeing Centre, Fieldhead Hospital

Present:	Marie Burnham (MBu)	Chair
	Mandy Rayner (MR)	Deputy Chair/ Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM) (via MS teams)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Prof.Subha Thiyagesh (ST)	Chief Medical Officer
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
Apologies:	Kate Quail (KQ)	Non-Executive Director
In attendance:	Sue Barton (SB)	Deputy Director of Strategy and Change
	Lindsay Jensen (LJ)	Interim Chief People Officer
	Rachel Lee (RL)	Associate Non-Executive Director
	Andy Lister (AL)	Company Secretary (author)
	Estelle Myers (EMy) (Item 9.6 only)	Freedom to Speak Up Guardian
	Sean Rayner (SR)	Director of Provider Development
	Julie Williams (JW)	Deputy Director of Corporate Governance
Apologies:	Dawn Lawson (DL)	Director of Strategy and Change
	Greg Moores (GM)	Chief People Officer
Observers:	Paula Gardner	Insight Candidate
	3 x members of the public	

TB/24/01 Welcome, introduction and apologies (agenda item 1)

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

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

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

TB/24/02 Declarations of interest (agenda item 2)

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

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

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

TB/24/03 Questions from the public (agenda item 3)

No questions were received from the public.

TB/24/04 Minutes from previous Trust Board meeting held 28 November 2023 (agenda item 4)

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

TB/24/05 Matters arising from previous Trust Board meeting held 28 November 2023 and Board action log (agenda item 5)

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

TB/24/06 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Nicola Lang (NL) and Carolyn Storm (CS) from the general community team in Barnsley.

NL reported she works for the Barnsley care group as a service development manager and has been supporting the virtual ward mobilisation in Barnsley. This is a partnership arrangement between the Trust and Barnsley Hospital NHS Foundation Trust. NL reported she also works with CS who is a community matron in the clinical teams supporting the virtual ward.

CS informed the Board she is one of nine community matrons that works in the Barnsley area. Each community matron has an area of Barnsley to cover with a GP attached. Today's story relates to a service user in CS's area and involves one of the GPs that she works closely with in her day-to-day work.

NL reported virtual wards provide consultant led acute level care to a patient in their preferred place of residence, through remote monitoring (telephone and eventually digital monitoring equipment) and face to face support from community clinicians. National guidance was released in 2022 for the roll out of virtual wards across the country.

The virtual ward team is made up of consultants and nurses, employed by Barnsley hospital, and matrons, community nurses, and specialist respiratory nurses who are employed by SWYPFT.

SWYPFT also provide urgent community response / crisis support to virtual ward patients and other wrap around care through its neighbourhood teams e.g. neighbourhood nursing and rehabilitation.

All referrals and patient calls are processed as part of the single point of access service.
NL reported the main aims are to improve patient experience, reduce length of stay in an acute setting, promote earlier supported discharge and/or prevent hospital admission.

NL reported this is important all year round, and particularly during the winter period. This is vital to supporting patients and the health and social care system in terms of patient flow.

Since October 2022 the team have supported 1,180 patients on the virtual ward pathway.

The team continues to learn and develop; working to refine pathways and processes utilising patient and staff feedback along with reviewing outcomes including information on re-admission rates to hospital for example.

NL reported the team is mobilising digital remote monitoring as part of the enhancement of the virtual ward offer to patients. This is a South Yorkshire Integrated Care Board led process. Advanced care planning forms part of the virtual ward pathway and, where needed, the teams will support patients and their families to make informed choices about the care they want.

CS stated Julie's story is about her Aunt Joan and her family's' experience of virtual ward, and it outlines how Joan has been supported to stay at home, with the support she needs. (The family have consented to their story being shared).

CS reported Joan had a recent hospital admission for biliary sepsis (a serious infection of the biliary tract). At the time, a ReSPECT form was completed with Joan, to deliver her wish to avoid future hospital admissions.

The ReSPECT process can be for anyone but has increasing relevance for people who have complex health needs. The ReSPECT process is increasingly being adopted within health and care communities and has recently been rolled out across Barnsley.

Two weeks after her hospital admission, Joan attended accident and emergency (A&E) with new "stroke like" symptoms that were different to the previous time she was admitted for biliary sepsis.

Once a stroke was ruled out in A&E, Joan and her family were offered the option to be supported at home on a virtual ward pathway, which they accepted. Joan was discharged from A&E with oral antibiotics and a plan of care on virtual ward, supported by the Consultant Geriatrician who saw Joan in the department.

Joan was assessed as having high risk of hospital admission, with a clinical frailty score (Rockwood) of 7, meaning that her symptoms / needs are unstable or of high complexity.

At home, Joan has good family support and a package of care in place, including 4 visits per day, from a domiciliary care agency.

Monitoring calls via the virtual ward nurses commenced the day after her A&E attendance and the neighbourhood nursing team were asked to support with blood sampling in line with her plan of care.
Joan's case, presentation and plan was discussed at the Virtual Ward Multi-disciplinary team (MDT) meeting. The team hold MDTs three times a week to discuss new patients, complex patients and agree discharge plans. CS reported Joan was monitored over the next two weeks, with slow but steady improvement.

Unfortunately, Joan took a turn for the worse; and was sick and generally unwell and Julie escalated this to the Virtual Ward team.

The urgent community response team visited Joan within 30 minutes to assess her and take observations.

Following discussion with the Consultant Geriatrician and the wider team, it was recommended that no further intervention would take place at that stage; noting Joan's ReSPECT form and wishes. It was agreed to continue to monitor Joan closely and CS arranged to discuss conservative treatment and future care plans. This was discussed with Julie, who was happy with this plan of care.

CS reviewed Joan at home, with Julie, and her care agency manager. They discussed Joan's increasing frailty and care needs and arranged for social services to increase her package of care.

CS spoke with Joan's GP to arrange an antibiotic to be used for reoccurrence of biliary sepsis, cyclizine for nausea and pre-emptive medication for any pain. They discussed and completed an end-of-life care plan (EPACCS) to support Joan's ReSPECT form to ensure all teams involved in Joan's care are aware of her future care plans and ongoing management of biliary sepsis at home.

CS recommended discharge from virtual ward monitoring and continued to oversee Joan's care and to ensure all plans were in place over the coming weeks. Joan was discharged from CS's care once all best supportive care plans were in place. Julie was made aware of how to escalate any further concerns via RightCare and Single Point of Access (SPA).

NL reported since the end of October, Joan has had two further visits from the community matron team which were treated at home.

NL informed the Board the family were provided with information in hospital about the virtual ward. In their feedback they stated they felt reassured that they had contact details if they were concerned or worried. They found the phone calls from the virtual ward nurses helpful and knew that they were on hand if they had any concerns.

Julie was pleased the team involved her and she stated she felt listened to and involved at all points. She reported the face-to-face visits from all staff were excellent and the family were impressed that the virtual ward nurses escalated concerns and organised a visit quickly when Joan became unwell.

The family now have a clear plan in place now to support Joan at home and avoid repeated hospital admissions. They know how to get in touch if Joan needs any further help and they reported they could not think of anything that could be improved.

CH thanked NL and CS for their story and bringing the virtual ward to life.

MBu thanked NL and CS for the explanation of some the detail in the story. A discussion followed about RESPECT forms and some of the issues involved.

Natalie McMillan (NM) noted how safe the pathway felt from the story provided by the family, knowing they had somewhere to go if they needed help. NM queried if a potential barrier to the success of the virtual ward could be the level of support service users have at home.

NL reported as part of the pathway, the team link in closely with Barnsley Council to look at any requirements for social care to support them discharge from hospital.

CS confirmed these situations do arise, and they are well supported by RightCare Barnsley. There are some situations that can't always be managed but in the main the patients receive the care they need.

MBr noted the story illustrates some of the great teamwork taking place across Barnsley and how we work together effectively as a system. Clearly this service supports Barnsley Hospital in terms of preventing admission or re-admission and also enables discharge. Today we have heard of one case, and MBr recognised there would be many others, and asked if the pathway has the capacity and skills in its workforce to deal with the demand?

NL reported part of the virtual ward initial modelling saw two additional roles created for matrons. This cohort of patients present a certain level of acuity and require a certain level of support. As the pathway and the model develops, we will revisit the skills and capacity required to ensure they are still appropriate for service user needs.

STh asked what proportion of service users were unable to remain on the virtual pathway due to their level of presentation, and what the impact is on the team and Barnsley hospital.

NL reported there is a national dataset that needs to be provided fortnightly, and in addition there is a dashboard that can be used for monitoring performance and outcomes. Included in this is a process to look at re-admission rates for patients on the virtual ward, to identify learning, and re-admission rates seven post discharge from the pathway.

The team benchmark well nationally against other virtual wards. This evaluation continues to develop as virtual wards are still in their infancy. One perception is that while the pathway may not always prevent readmission it does help with patient flow.

Mandy Rayner (MR) noted that digital innovations can be used in addition to digital monitoring such as virtual assessments and is there any scope for a digital package to be implemented to support the pathway?

NL reported a company called “Doccla” have been awarded the digital contract and the package includes vital sign monitoring, a question set to be completed, and alerts that will trigger a phone/video consultation if issues arise.

MBu thanked NL and CS for today’s board story.

I**t was RESOLVED to NOTE the Staff Member Story and the comments made.**

TB/24/07 Chair’s remarks (agenda item 7)

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

- Corporate and organisational risk register
- Collaborative committee minutes
- Integrated Care System updates
- Complex incidents report
- Annual planning process

It was RESOLVED to NOTE the Chair’s remarks.

TB/24/08 Chief Executive’s report (agenda item 8)

Chief Executive’s report

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

- Since the last Board meeting there have been two further periods of industrial action, which have both been well managed.
- MBr had been on a national call recently where it was reported to have been the most challenging winter for mental health services. The Board have just heard a story giving a good example of how the Trust is relieving this pressure from acute colleagues.

- A planning update is on the Board agenda today. Planning guidance is still to be received but we recognise that the national financial position will be very challenging.
- The latest LeDeR (learning disabilities mortality review) report has been published. This will come to Board once it has been reviewed in detail by the quality and safety committee (QSC).

Action: Darryl Thompson

- The Trust strategy refresh is in progress and was discussed at the strategic Board in December. The Trust will now be seeking feedback from partners, staff and service users.
- The Trust's two recent Care Quality Commission (CQC) inpatient ward reports will be presented as part of today's Board agenda.
- The Trust's System Oversight framework classification is 2. All NHS trusts default to 2 unless there is a significant reason why this should not be the case.
- Individual placement support services have achieved strong results in terms of fidelity with the model, and we believe that scores in Calderdale are the best in the country.
- The Horizon Centre, an assessment unit at Fieldhead Hospital for people with a learning disability, has received some positive feedback following a recent independent care and treatment.
- There have been around 270 nominations for the Excellence awards, which MBr believes is the highest number ever received.

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

TB/24/09 Risk and Assurance (agenda item 9)

TB/23/09a Board Assurance Framework (agenda item 9.1)

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

- A revised approach to Board Assurance Framework (BAF) scoring has been scrutinised by the Audit Committee
- The Audit Committee have recommended we proceed with the new scoring methodology and implement it in Q1 24-25.
- 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. The extended management team (EMT) identified that the Trust is better at recording inequalities data but needs to improve the utilisation and analysis of this data.
- 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. EMT recommend this remains at Amber for this quarter and noted the executive trio have engaged in conversations with international nurses about their experience in the Trust.
- 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. AS reported national planning guidance has not yet been received for next year. System financial pressure is building but until the guidance is received EMT are recommending the risk remains yellow.
- 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. EMT are recommending this risk reduces to yellow. As advised recruitment and retention rates are better now than they were this time last year, but some challenges remain in identified areas.

MBr noted that compared to April 2022, the Trust now has 308 more substantive staff. MBr reported international recruits are qualified staff but the increase in staffing is not uniform across all places and services, and experience levels of new staff may be lower than those leaving. We should recognise the progress made and move the risk to yellow.

MR reported recruitment has been discussed at length at the recent people and remuneration committee (PRC) and noted a lot of work has taken place regarding band 5 recruitment, and

although there are still gaps MR was assured by the information presented to the committee which supported that turnover has reduced and growth has increased.

MF agreed with a yellow grading for risk 4.1.

MR queried in relation to Risk 1.4 if the Trust has the analytical capability and capacity to carry out the work required?

AS reported the Trust has the capability, but they are a scarce resource, and therefore capacity is limited.

MBr reported he has given Sue Barton (SB) some work to consider what data the Trust has, needs, and how it is used.

SB reported the mapping of data has started, including capability and where resources are. Some automation will help, and we need to establish what we have, where it is, and how it is used. This work will go into EMT in early March.

EM reported that the yellow rating for workforce feels like the Trust is on a pinnacle and this needs to be monitored. EM suggested there is too much data and there is a need to make sense of what we have, before we start looking at analytics.

SB reported part of the work is looking at the 'SWIFT' dashboard which is a data warehouse for the Trust and identifying which data is being used and which isn't.

MF reported there is a paper coming to audit committee in April to look at benchmarking on Board Assurance Frameworks which will include a PwC report on health sector risks.

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

TB/24/09b Corporate/Organisational Risk Register (agenda item 9.2)

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

- Two new risks have been added this quarter:
  - 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.
  - 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.
- The speaking up risk score is 8, which is an amber grading, as is the sexual safety risk.
- JW reported the risk appetite for both new risks is 1-6 and they fall outside risk appetite which would be expected with new risks.
- Risk 1530 - Risk that demand, through acuity or numbers continues to rise placing further pressure on access to services and waiting lists. The broad nature of this risk has been discussed at EMT, and cross references have now been added to other risks in the ORR, as the nature of this risk is deemed to be appropriate at this time.
- Thie number of risks with a score of 15 or over remains the same.
- Risk 1568 - Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm – there is a live capital scheme to enhance the seclusion suites. This risk needs to remain live until the work is concluded and once the work is completed, the risk score will be reduced and brought back to Board for consideration.
- Risk 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 – EMT are recommending the risk score reduces in line with the conversation just held in relation to the BAF.

MR noted risk 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. MR identified in the actions for this risk it reports cyber security phase 2 enhancements to support the move towards advanced monitoring capabilities was presented as a business case to Executive Management Team and this has been agreed to be put on hold until 2024/25.

AS reported, this is cost benefit decision. Paul Foster has done a lot of work on enhancements that can be made to manage cyber security, but this comes at a cost, and so has to be part of the Trust's prioritisation process.

The Trust carried out this process in 2023/24 and prioritised investment of our resources on front-line patient care. The cyber work will be considered again as part of the prioritisation matrix for 2024/25.

MR noted that information technology is always evolving and so this will need careful consideration. MR also identified the Trust has done a lot of work in this area and consideration of the level of mitigation needs to be included in any change in risk score.

Nat McMillan (NM) noted the executive summary was well written for this report and demonstrates evidence of the dynamic risk management process in the Trust with the level of scrutiny through committees and Board.

MF noted the Trust governance process of Board committees reviewing their allocated risks in detail.

MF confirmed risk 1080 is discussed in detail at audit committee as is risk 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 in line with the committees other allocated risks.

MF noted that audit committee may need an update on the management capacity position on the Trust to fully assess this risk.

MBr stated this will form part of the planning process for 2024/25 as management capacity for priority programmes and change is included.

MF asked for a paper on this risk to come to audit committee to update the position on risk 1217.

Action: Adrian Snarr/Dawn Lawson

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

In addition, it was RESOLVED to:

- **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.**

TB/24/09c Annual Planning (agenda item 9.3)

Sean Rayner (SR) and AS introduced the item and highlighted the following points:

- SR reported that whilst planning national guidance has not been received the Trust needs to develop a plan and the attached papers show how we have been doing this.
- SR reported on page 4 of the report it can be seen how the plan feeds into the integrated care board (ICB) plans, at both district level, and South and West Yorkshire level. On page 5 of the report is the timetable the Trust is working to.
- In addition to the planning templates that are required to be completed, there is also a narrative section required and care groups have been working hard on this narrative.
- Any assumptions we have made prior to national guidance being released will need to be checked once it is available.

MBu noted this a good report. There is not finalised national guidance, but the Trust is doing the work so that it is ready for when it becomes available.

David Webster reported the finance, investment and performance committee (FIP) has been looking at the annual plan and asked the Board to note that he felt the delays to the issuing of the guidance adds pressure to the team.

MF queried if the report needs to go back to FIP and then back to Board.

AS reported, this depends on the planning schedule, there may be a need for an extraordinary meeting or delegated authority.

MBr reported this is a perennial challenge, we will most likely need to have some form of extraordinary committee where necessary. We need to engage with the financially qualified members of the Board and FIP committee members. We might also need Chair and Chief Executives delegated authority, and this will all depend on when the guidance is received.

EF noted the LeDer report from MBr's update and queried if there is any system lead on learning disability?

SR reported the West Yorkshire MHLDA partnership board have a lead project manager on LeDeR. Prof.Subha Thiyagesh is the Trust executive lead on learning disabilities. The region and the Trust are very proactive in their response to the LeDeR data as well as improving lives for people with a learning disability.

DT reported the LeDeR report has been discussed in place quality committees and has a high profile regionally.

It was RESOLVED to NOTE the update on the development of, and timescales for, the Trust operating plan for 2024/25.

TB/24/09e Safer Staffing report (agenda item 9.4)

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

- This is a bi-annual report.
- The report was reviewed by the quality and safety committee (QSC) on 9 January following further work being requested and completed.
- The purpose of the report is to provide assurance to Trust Board regarding the Trust's oversight in response to safer staffing requirements, with a particular focus on three key expectations – the right staff, with the right skills, at the right place and time.
- A fundamental review of this report is to take place to make sure it is providing Board with the assurance required in preparation for its next publication in April.

Action: Darryl Thompson

- There is a national shortage of registered nurses, but the Trust continues to improve its fill rate for registered staff, which demonstrates we have more registered nurses on shift.
- At times there is a need to respond to acuity and staffing pressures and so the skill mix may be adjusted to address the need for higher numbers, i.e. where registered staff aren't available from the bank, health care assistants will be utilised.
- Actions are in place to monitor and mitigate risks, and escalation processes are well embedded seven days a week to monitor staffing levels.
- There is reference in the report to our community teams and there is work planned to understand those needs.

MF noted the integrated performance report there used to have a section on unfilled shifts which was quite helpful. MF believes this is no longer in the IPR, and is not included in this report either?

NM stated this will be discussed through the quality and safety committee as part of the review of this report. NM feels there is a lot of data in the report, and it needs to provide key headlines and explanations to provide the right level of assurance and the committee will look at unfilled shifts and whether these should be in the safer staffing report or the IPR as part of this work. The committee also receives an update from the executive trio which needs to be articulated into this report.

Action: Darryl Thompson

MR reported PRC has received some positive updates about agency spend and recruitment but this needs to triangulate with safer staffing.

Lindsay Jensen (LJ) further noted PRC had looked at the experience of staff and what unfilled shifts mean for them. The Trust is on an improvement journey and is introducing "Safecare" in inpatient wards and we need to see what the impact of this will be, which can then feed into these reports.

EM agreed with NM that there is a lot of information in this report and some clarity in the report on whether the Trust is safely staffed would be helpful.

Action: Darryl Thompson

DT confirmed he is confident the wards are safely staffed, but skill mix can be a challenge.

A discussion followed that identified that the Trust has the lowest turnover rate and highest stability index when compared with similar trusts in the Yorkshire and Humber region.

Dr. Rachel Lee (RL) queried the impact on stress levels of staff and what interventions are available to help? RL asked about Schwartz rounds and if they are well attended?

LJ reported they are well attended and positive for those that attend. The Trust is also looking at local wellbeing champions who will bolster this position further. An audit is to take place in the next quarter which will measure the Trust's position in this area.

MBr suggested that PRC could have an agenda item to look at safer staffing and the impact on staff, stress levels and what interventions are available, and could also include the outcome of the forthcoming audit.

Action: Lindsay Jensen

It was RESOLVED to RECEIVE the report.

TB/24/09e CQC Inspection reports (agenda item 9.5)

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

- This is the public report of the Trust's care quality commission (CQC) inspections in May 2023 in working age adult and psychiatric intensive care units (PICU) and forensic and secure services.
- It is important to note that the ratings issues by the CQC have not changed the overall rating of good.
- The rating for the forensic services reduced from "good" to "requires improvement" and the rating for each of the domains of safe, responsive, and well led is "requires improvement" and for caring the rating is "good".
- For working age adult and PICU, the overall rating remains "requiring improvement, with each domain rated as requires improvement.
- Positive comments were received about the culture on the wards, learning from safeguarding incidents, and people feeling safe to speak up.
- Care planning including family involvement, reducing restrictive physical interventions and the reduction of prone restraint, substantive staffing levels, and appraisal rates were identified as immediate areas of learning.
- There was a challenge in relation to staff training for learning disabilities and autism and DT noted that the current Oliver McGowan e-learning training has been completed by 2,421 staff (54%).

MBr stated it is important that Board have oversight and assurance in relation to the CQC actions. QSC will need to look at these in detail, and progress against the action plans need to come back to Board.

Action: Darryl Thompson

MBu reiterated the reports includes lots of positives including the positive culture on the wards and feeling free to speak up.

It was RESOLVED to RECEIVE and NOTE the report.

TB/24/09f Freedom to speak up (FTSU) annual report six monthly update (agenda item 9.6)

Estelle Myers (EMy) introduced herself to the Board and highlighted the following:

- 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.
- 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 Q3 of 2023/24 there was a small decrease in the total number of concerns raised.
- 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.
- Since April 2023, five cases have been taken through the 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.
- As of November 2023, mandatory training with regards to speaking up was 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 (QMVs) and patient feedback. The output of which will be used to develop targeted work with teams.
- The report provides assurance to Board 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.

Julie Williams (JW) thanked EM for conducting visits across the Trust and supporting teams. In respect of the thematic review, a meeting was held yesterday with the quality team and the information and intelligence is looking to be fed into the new quality oversight monitoring and support system (QOMS).
This will pull together data across the Trust prior to QMVs and will be used to manage actions from QMVs, which should help gather intelligence on teams who may require support.

NM welcomed the progress being made with this report and queried how the information obtained will feed into the Trust's organisational development strategy?

JW reported this work will be taking place with LJ and the people directorate through six weekly meetings being held with the lead non-executive director, Mike Ford.

MF queried on page 17 of the report there are comparisons with national values and peer averages and the Trust looks to be an outlier with some of these.

EMy reported the Trust has maintained its position in the last few years in quartile 2, compared to quartile 1 when FTSU was first introduced.

MF suggested this could be discussed in more detail in one of their six weekly catch-up meetings.

RL reported she liked the report and noted that medics appeared not to be speaking up and queried if any barriers had been identified?

EMy reported there are a number of routes through which people can raise concerns including FTSU. It may be that concerns are picked up and dealt with before getting to the FTSU process.

ST stated the exact same conversation had been held by the executive trio and EMy.
ST reported there are a number of routes through which medics can raise issues. Any complaints or incidents raised by medics are reviewed in detail. In a recent deanery meeting between the Trust and NHS England the Trust was praised for its response to concerns raised by doctors.

A discussion followed noting the FTSU data should be triangulated with the outcome of the forthcoming staff survey report and pulse surveys.

Action: Darryl Thompson

JW added that the FTSU self-assessment tool and action plan was brought to board in November 2023 and this action plan is now embedded in the FTSU steering group and across care groups.

It was RESOLVED to RECEIVE and NOTE this report on Freedom to Speak Up in the Trust.

TB/24/09g Equality and Diversity Annual Report (agenda item 9.7)
Sue Barton (SB) introduced the item and highlighted the following points:

- The report is for the year 2022/23 and represents the views of service users, families, carers, and staff.
- 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.
- Report includes detail on developing systems and processes and forward plans and how the Trust will take things to the next level.
- Equality, Diversity and Inclusion needs to become how the Trust operates on a day-to-day basis and will form part of the Trust strategy refresh and the subsequent refresh of the 'Equality, Involvement, Communication and Membership Strategy'

MBu noted equality, diversity and inclusion needs to be part of the organisational development plan.

A conversation followed noting how the Trust is doing well on actions, but clarity is required in terms of impact.

MBr noted there is work to be done around bullying and harassment and the Trust is working on the development of a programme of inclusive leadership to prepare Trust staff for the changing nature of the workforce.

NM noted it is important to focus on two or three key items in order to make change. As well as the experience of staff we also need to think about service users and their families, which would feed into much broader inequalities work.

RL noted that neurodiversity didn't feature in this report and is that something we are thinking about.

SB noted it is not one of the protected characteristics and so it wouldn't feature in this report, but neurodiversity is a key focus for the Trust.

MBr noted this is a valid point and consideration should be given as to how the Trust reports on neurodiversity.
Action: Dawn Lawson

LJ reported that neurodiversity is included in the Trust's inclusive recruitment plan. The Trust is working with an organisation called Touchstone about how to positivity recruit neurodiverse staff.

It was RESOLVED to APPROVE the final draft report prior to publication.

TB/24/09h Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9.8)

Collaborative Committee 5 December 2023
MF reported on the following:

- The objectives of the original business case for the West Yorkshire Adult Secure Provider Collaborative were reviewed against the collaboratives progress and it was identified that the level of progress made could not have been achieved without collaboration.
- Both West and South Yorkshire adult secure collaboratives are in surplus, but the financial position can be quite sensitive and so the committee takes time to consider the collaboratives' financial position.
- A report was received from the West Yorkshire adult secure surveillance subgroup – they currently have Newton Lodge on focused surveillance. This is a slighter higher level

of surveillance. It was felt this was something being heard through the committee for the first time.

AS reported, there are mechanisms across both provider collaboratives regarding levels of assurance that they seek. It is not necessarily a direct correlation to CQC reports but these do have a bearing on that focus level. The fact that our forensic ward CQC reports were published and provided to the provider collaborative along with the action plans, the decision was to place Newton Lodge under focused surveillance while the action plans are embedded and completed.

CH reported this is going to Quality and Safety Committee (QSC) through the executive trio update paper.

Equality Inclusion and Involvement Committee (EIIC) 13 December 2023
MBu asked to take the report as read.

Audit Committee (AC) 9 January 2023
MF reported on the following:

- There is a need to review which committee has oversight of ligatures.
- AS reported that the Audit Committee had discussed the movement of estates and facilities items from QSC and wanted to check nothing was being missed.

MBr asked for confirmation that there is nothing outstanding in terms of actions and oversight to provide the Board with assurance that the Trust's ligature action plan is being responded to, in a timely manner.

NM confirmed the ligature action plan is coming to QSC, but Audit Committee has oversight of the ligature audit and therefore it actually sits with both committees.

Quality & Safety Committee (QSC) 9 January 2024
Nat McMillan (NM) reported the following:

- Children with a learning disability have not been able to access Barnsley CAMHS. The board are advised (as were committee) that this has been escalated to Barnsley and discussions are taking place.
- The infection prevention and control (IPC) team presented to the committee and the committee was impressed with the work the team carry out.
- The committee is asking Board to support role modelling about bare below the elbow and hand hygiene.
- Reducing restrictive practice and interventions (RRPI) continues to be a committee focus.
- There was an open discussion about the invited review about autism spectrum disorder from the royal college of psychiatry. The report showed candour and transparency and NM noted it takes courage to take part in an invited review.

ST reported the final report has been received, and the royal college has noted the service has taken an open and positive approach to learning. There are twelve identified areas of improvement and four recommendations. A report is being compiled including the context of the invited review and the fact it is quite a niche service. We will share the royal college report and action plan. The quality team are supporting this, and this will go to QSC and will then come to Board.

Action: Prof.Subha Thiyagesh

People and Remuneration Committee 16 January 2024
Mandy Rayner (MR) reported the following:

- Good committee meeting, good topics and the committee gained more assurance from the item presented.

- Appraisals have seen improved performance.
- A detailed organisational development plan was received, and regular updates will be received over the coming months.

Finance, Investment and Performance Committee 23 October 2023
DW highlighted the following:

- Planning guidance has not been issued, as already mentioned.
- Capital spend, there is £6m still to be spent in this financial year and the committee has asked for further assurance regarding this.
- Mental Health Investment Standard – we are behind on investments relating to children and young people.

A discussion took place about the committee workplan and how focused agenda items rotate for finance and performance between meetings.

MR noted agency spend and the amount of effort that gone into improving this and we are almost on target.

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

TB/24/10 Performance (agenda item 10)

TB/24/10a Integrated Performance Report (IPR) Month 9 2023/24 (agenda item 10.1)

AS introduced the item and highlighted the following:

- The IPR this month has a heatmap called "headlines" which is a visual aid at the beginning of the IPR to show where the challenges are, and any improvement or decline.
- Paediatric audiology remains a challenge, this is a small and discreet service in Barnsley. CH and her team are working on an internal action plan this is also being monitored by commissioners.
- The agency use indicator has improved significantly; the trend line is showing gradual improvement, the Trust has achieved target for the past three months.
- People indicators, including appraisals, are improving but there is long way to go. The operational management group (OMG) are looking at supervision rates to see if there is any correlation to identify hotspot teams.
- Out of area (OOA) placements are being maintained, we are currently between 2-4 patients placed OOA and these are all psychiatric intensive care unit (PICU) patients.
- We are seeing increased rates of service users clinically ready for discharge where there is no identified onward placement, which puts pressure on inpatient services.
- There have been four reports of incidents, diseases, and dangerous occurrences regulations (RIDDOR) incidents as a result of violence and aggression against staff by service users, and these have all been reported to the health and safety executive as required.

MBu stated the IPR is getting better, the heat map is an improvement and additional SPC charts would assist further.

MBr highlighted that the heat map in isolation appears to present a lot of red and amber metrics, which is not a balanced reflection of how the Trust is performing. The full depth of the IPR shows many green metrics, and the Board should be cognisant of this.

MBr stated RIDDOR incidents are treated very seriously by the Trust. These are four members of staff who have been assaulted at work and have not been able to return the following day. MBr asked to ensure staff are being appropriately supported and that incidents are being properly reviewed to prevent further occurrences.

Action: Darryl Thompson

MF noted a national metric about virtual ward occupancy and queried how the occupancy of a virtual ward is measured.

CH reported the number represents when people are stepped onto the virtual ward pathway. The virtual ward is provided in partnership with Barnsley Hospital NHS Foundation Trust. CH stated there is some work to be done to ensure patient numbers are being recorded fully.

MBr asked the Board to note that a recent national report identified the use of a virtual ward can be double the cost of having someone in a hospital setting. The virtual ward is of significant benefit to service users and also supports discharge from acute hospitals but does not benefit the Trust financially.

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

TB/24/10b Care Group Dashboards report (agenda item 10.2)

Carol Harris (CH) introduced the item noting the following:

- This month's report is focused on the forensic care group.
- Overall, there has been a decline in appraisals, but a recovery and monitoring plan is in place, and we are seeing improvement. Local records show better performance, so data is being reconciled.
- Clinical supervision in this care group is very positive and is over the target of 85%
- The key issue for the service is sickness. Forensics services are predominantly ward based which reduces the ability to work from home.
- Long term sickness is currently 42% of total sickness in the care group and with support from the business partner in the people directorate we are supporting staff appropriately, with an action plan in place.
- Work continues to manage mandatory training, and in relation to RRPI training, the forensics service is broadly compliant.
- The forensic learning disability (LD) service is an outlier in terms of restraint and prone restraint. Work is taking place around culture within the service and the utilisation of different techniques. The RRPI team is supporting this work.
- Forensic LD have maintained compliance with cardiopulmonary resuscitation (CPR) training, compared to other parts of the service. CPR trained staff are managed so that they are available on every shift.
- Turnover – staff that start their career in forensics wards often then look to move on. We do expect to see a higher turnover as a result.
- In relation to finance the bed base had been working over establishment. This has been reviewed and presented to the provider collaborative and is now funded.
- The community service underspend is mainly due to vacancies across teams.
- Occupancy – all referrals for beds in medium and low secure are gatekept centrally by the West Yorkshire commissioning hub services. We are therefore working with commissioners and the provider collaborative on pathways.
- The friends and family test has been incorporated into a wider patient experience survey. This has increased responses which has in turn improved compliance.
- Activity – 25hrs of activity is recorded at 100% but feedback is that activities need to be more varied. This is being reviewed and a new activities programme is being developed with service users for the end of March.
- CH made the board aware that low occupancy doesn't necessarily correlate to low incidents, these are mainly as a result of acuity. Incidents are within expected levels in forensic services. Given the acuity most incidents are violence and aggression and security related incidents.

- 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
- 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) have been completed and action plans developed. The focus of action plans for 2023 was on 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.

NM noted the huge improvement in appraisals in a short space of time and could any learning to be taken into PRC to look at.

Action: Carol Harris

NM further noted sickness and wellbeing in broad terms, and asked for more understanding about sickness levels, with MR's agreement, to come to PRC. There is a requirement for assurance about the management of sickness.

MR noted there is an audit taking place on sickness in the next quarter and the scope of this may need to be reviewed. MR suggested PRC should see the outcome of the audit before the committee does a deep dive.

CH asked the Board to note that staff sickness is managed with the occupational health unit (OHU) and sometimes, dependent on the staff members condition or illness, staff may be advised not to work on certain wards due to acuity levels and this can affect staffing levels on particular wards at particular times.

RL noted the high supervision rates in forensics and asked is there learning for other wards.

CH reported that learning will be shared through the operational senior leadership team. Ore structured arrangements have been put in place which has ensured improvement.

MBu noted that service users have 25hrs of activities a week and asked if there is a national benchmark?

MBr responded that when we triangulate the CQC report narrative with what patients are saying, comments are about the wrong type of activities along with the variety of food choices. These are longer term service users that need more variation.

It was RESOLVED to RECEIVE the Care Group Dashboards Report and the comments made.

TB/24/11 Integrated Care Systems and Partnerships (agenda item 11)

TB/24/11a South Yorkshire updated including South Yorkshire Integrated Care System (SYBICS) (agenda item 11.1)

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

- The integrated care board meeting had three main agenda items – finance, winter planning and industrial action, and the process for conclusion of the new operating model.

- A health and social care recruitment event has been held in Barnsley which was very successful.
- Barnsley place is developing an autism strategy.
- The emergency preparedness rating given by NHSE was raised at the integrated care board as all providers have had the same issue and concerns.
- The mental health learning disability and autism (MHLDA) provider collaborative has been discussing parity of esteem, and how we can work with acute and primary care colleagues to make sure the needs of those with mental illness are met.
- There has also been some clarity provided about the arrangements for the provider collaborative board and the specialist commissioning arrangements such as adult secure.

Barnsley place:

- There was the first provider collaborative meeting between primary care, Barnsley hospital and SWYPFT and Dawn Lawson has been integral in making sure this comes together.

It was RESOLVED to NOTE the SYB ICS update.

TB/24/11b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism (MHLDA) Collaborative and place-based partnership update (agenda item 11.2)

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

- Similar priorities areas are taking place in West Yorkshire as MBr has described in South Yorkshire.
- Governance arrangements in Kirklees and Wakefield are being reviewed in relation to the integrated care board (ICB) committee meeting frequency.
- The mental health alliances in Kirklees and Wakefield have been taken through the older people's mental health transformation arrangements.
- In Calderdale the neighbourhood teams are a current point of focus.
- In Wakefield health and wellbeing board the Trust has been mentioned and commended regarding smoking cessation services in relation to tobacco control and support towards asylum seekers.

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/24/11c Provider Collaboratives and Alliances (agenda item 11.3)

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

- Through the West Yorkshire provider collaborative, we have been able to invest in inpatient services in all three of the NHS inpatient providers.
- Attention is being given to the community and women's pathway.
- There is now a need for further financial headroom which is intended to be achieved through OOA repatriation.
- There is bed capacity in West Yorkshire of approximately 40-50 beds, but not necessarily where we need it and so a review is going to take place across providers.
- In South Yorkshire the Cheswold Park CQC report has been published.
- South Yorkshire have ambitions for an enhanced community pathway, there is a pilot running in Sheffield which is being expanded across the county. Finances are being checked to ensure the funds are there to make this happen.

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/24/12 Trust Board work programme 2023/24 (agenda item 12)

DW noted the learning from healthcare deaths policy was due this month. AL reported this had been deferred to June and the workplan would be updated accordingly.

It was RESOLVED to NOTE the work programme.

TB/24/13 Any other business (agenda item 13)

ST reported the public consultation for older people's service (OPS) transformation started at the beginning of January. There have been two weeks of face-to-face meetings including Dewsbury, Hemsworth and Wakefield. There have been over 362 completed surveys over the last two weeks, 800 website views, and 467 video animation views.

This information will be shared with the joint oversight and scrutiny committee (JOSC) next week. ST reported the Trust's governors had given tremendous support to consultation.

There have been over 300 attendees across the public meetings and 15,000 letters sent, and 13,00 people reached through social media. ST has taken part in two radio interviews.

The next stage will be regular updates into EMT and the OPS transformation programme board. There is a mid-point review in two weeks' time. We need to provide a report to NHSE to assure them we have complied fully with the public consultation.

RL reported she noted Barnsley speech and language therapy team (SALT) are doing some work with virtual technology and asked if they could be considered for an invite for a Board story.

Action: Andy Lister

DT reported they have been to QSC, and it is a good story.

SB reported this work had taken place with Eyup funding.

TB/24/14 Date of next meeting (agenda item 14)

The next Trust Board meeting in public will be held on 26 March 2024.

Signature: Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 26 March 2024 – ACTION POINTS

= completed actions

Actions from 30 January 2024

Min reference	Action	Lead	Timescale	Progress
TB/24/08	The latest LeDeR (learning disabilities mortality review) report has been published. This will come to Board once it has been reviewed in detail by the quality and safety committee (QSC).	Darryl Thompson	April 2024	
TB/24/09b	MF asked for a paper on this risk to come to Audit Committee to update the position on risk 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 in line with the committees other allocated risks.	Adrian Snarr/Dawn Lawson	April 2024	
TB/24/09d	A fundamental review of the safer staffing report is to take place to make sure it is providing Board with the assurance required in preparation for its next publication in April. Clarity is required around the meaning of unfilled shifts and executive trio oversight needs to be included. The report should stipulate if the Trust is safely staffed or not.	Darryl Thompson	April 2024	
TB/24/09d	PRC should have an agenda item to look at safer staffing and the impact on staff, stress levels and what interventions are available, and the outcome of the forthcoming audit.	Lindsay Jensen	April 2024	
TB/24/09e	CQC inspection action plans to come to Board for assurance	Darryl Thompson	March 2024	On the agenda for March Board.

TB/24/09f	A discussion followed noting FTSU data should be triangulated with the outcome of the forthcoming staff survey report and pulse surveys.	Darryl Thompson	July 2024 (date of next report)	
TB/24/09g	It was noted that neurodiversity is not a protected characteristic and therefore doesn't fall within the scope of the Equality and Diversity Annual Report. Consideration should be given as to how the Trust reports in relation to neurodiversity.	Dawn Lawson	April 2024	
TB/24/09h	ST reported the final report has been received, and the royal college has noted the service has taken an open and positive approach to learning. There are twelve identified areas of improvement and four recommendations. A report is being put together including the context of the invited review and the fact it is quite a niche service, sharing the royal college report and action plan. The quality team are supporting this, and this will go to QSC and will then come to Board.	Subha Thiyagesh	April 2024	
TB/24/10a	MBr stated RIDDOR incidents are treated very seriously by the Trust. These are four members of staff who have been assaulted at work and have not been able to return the following day. MBr asked to ensure staff are being appropriately supported and that incidents are being properly reviewed to prevent further occurrences.	Darryl Thompson	March 2024	RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents relate to physical injury experienced by staff during their work, including where it will result in their absence for more than seven days. In all cases, staff are encouraged to report to the police if required, and the Health and Safety Team links with the managers to ensure that support has been offered throughout their recuperation, suited to their needs. In addition, occupational health referrals are made and debriefs are offered.
TB/24/10b	NM noted the huge improvement in appraisals in the forensic service in a short space of time and asked if any learning could be taken into PRC to review.	Carol Harris	April 2024	

TB/24/13	RL reported she noted Barnsley speech and language therapy team (SALT) are doing some work with virtual technology and asked if they could be considered for an invite for a Board story.	Andy Lister	March 2024	Added to the 24/25 schedule for Board stories.

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	June 2024 (date of next report)	
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	April 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	The metric has been reviewed by the steering group, in line with national expectations. The new metric is "Number of people accessing individual placement and support (IPS) services during the month", to indicate the level of growth and engagement of the service.

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	Reporting of reducing restrictive physical interventions (RRPI) continues to develop and is submitted to each meeting of the Quality and Safety Committee. The annual report presented to committee in October 2023 related to the April 2022 to March 2023 time period. Within adult mental health, psychiatric intensive care and learning disability inpatient settings, the Trust benchmarks as using prone more than other trusts. In low secure and medium secure services, the Trust benchmarks as using prone restraint less than other trusts.
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	To be included in the presentation of the paper at Trust Board.
TB/23/119e	AS to take the detail of the EPRR report back to the Audit Committee for further discussion	Adrian Snarr	April 2024	

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	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	The solving together platform is now closed for new ides but is open for voting on the ideas generated. When voting has closed, consideration will be given for areas to pilot the ideas. There are 5 topics: 1) Ways to maximise clinical time 2) Reducing inequalities in access experience and outcomes 3) Prevention and early intervention 4) Experience of services 5) Transfer of care and wider support Some key themes are emerging relating to admin support, use of data and technology to improve engagement, multi-agency working and colocation, parental support and mental health offers, waiting well and better transition services, service opening times, communities being recognised as part of the support offer and all services being trauma informed. CAMHS will continue to monitor the platform and outcomes and utilise the information shared to inform ways of working. Updates can be provided through the care group quality and safety report to quality and safety committee.

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	Challenges remain in relation to the paediatric audiology performance. Action plans are in place locally and with partners, to understand the increase in demand and agree appropriate actions to manage capacity. This is reported through the care group quality and safety report to quality and safety committee, the waiting list report to the finance investment and performance committee and to Trust Board in the integrated performance report and care group report.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 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.		
	The results of the 2023 NHS staff survey were published on March 7th. A high-level summary has already been shared with Trust Board members. It is encouraging that the Trust's results showed improvement against all nine themes, and in eight of the nine themes our results compare favourably with the average for trusts of our type nationally. It is good to recognise such positive progress, and this is a credit to how our Trust values are truly owned across the organisation in what have been and continue to be challenging times across the NHS. We must also be mindful of areas where further improvement is required and ensuring there is no complacency. There are undoubtedly some areas such as incidents of racial aggression and harassment we need to pay particular attention to. When reviewing the results of all provider trusts in Yorkshire and Humber, SWYPFT's results for the percentage of staff recommending the Trust as a place to work are the highest in any sector. The process for engaging with staff on communicating the results and identifying how further improvement can be made will be overseen by the People & Remuneration Committee. **We often discuss how we can address health inequalities at our Trust Board.** We all know there are inequalities for people who are mentally ill, and for those people with a learning disability. A helpful recent development has been a letter to the Public Accounts Committee from the Department of Health & Social Care (DHSC) which has set out the full definition of "parity of esteem". This established that mental health is valued equally to physical health and that for the NHS this means parity of timely access, evidence-based and therapeutic care, and patient experience for people with mental health needs. Secondly, the letter lists a set of "building blocks" to work towards the achievement of "parity of esteem".		

These are:

- care is patient-centric and therapeutic.
- every part of the NHS recognises mental health on par with physical health.
- data in the mental health sector is on par with physical health. Funding decisions are made to close the gap between mental and physical health.

We will continue to work within our own Trust and with partner organisations in our systems and place, to identify how the use of this definition can support greater equality.

Following the government's Spring budget, it is expected the NHS planning guidance will be published during week commencing March 18th. We have been working closely with colleagues in each place and integrated care system on the development of our plans for 2024/25. Much of the focus has been on finance as well as operational performance requirements. Financially, both of our integrated care systems have submitted deficit plans and it is not expected these will be accepted, with a need to submit a final plan to break even anticipated. The Trust's draft financial plan was for a deficit of £4.1m and we will need to sharpen our focus on our finances and productivity in order to deliver a break-even position, whilst still enabling high quality of care and achievement of our objectives.

Key announcements from the spring budget for health and care include:

- £2.5bn revenue funding in 2024/25 to protect current funding levels in real terms, and support the NHS to continue reducing waiting times and improve performance.
- £3.4bn capital funding over three years for technological and digital transformation in the NHS.

NHS England (NHSE) has launched its board level leadership competency framework (LCF). This is part of a planned suite of management and leadership development training, tools and resources for NHS organisations. The LCF sets out aspirational competencies to support leadership and management development, recognising that not all leaders will meet all competencies at all times. It applies to all board members of NHS provider organisations, integrated care boards (ICBs) and NHSE's board. It applies equally to non-executive directors (NEDs) and executive directors, and applies to them in their role as members of unitary boards. It also recognises the 'extremely demanding' nature of board members' roles and aims to support and help leaders and organisations in this context. The LCF is expected to be used as part of the 2023/24 appraisal process. Clearly this is something we need to understand more fully as a Board and factor into Board development plans.

The LCF is centred around six competency domains which are six domains are:

- Driving high quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Creating a compassionate, just and positive culture
- Building a trusted relationship with partners and communities

Further industrial action by junior doctors took place at the end of February for five days. This was again well planned and managed by our teams, ensuring safe care could continue to be provided with as little disruption as possible in the circumstances.

The nominations for the Trust's excellence awards have now all been reviewed and assessed with a shortlist produced. The standard of entries was again very strong with over 270 nominations submitted. The excellence awards are taking place on May 2nd and will be a great opportunity to recognise the fantastic work being carried out by our staff every day.

NHS Providers has published the results of its annual state of the provider sector survey. The results of this survey are very helpful for understanding the context in which we are operating. Headlines from this report include:

- More than nine in 10 trust leaders (95%) said they were extremely or moderately concerned about the impact of seasonal pressures over winter on their trust and local area.
- Over three quarters of trust leaders (76%) said it was very unlikely or unlikely that their trust will end 2023/24 in a better financial position than it ended 22/23.
- All trust leaders (100%) strongly agreed or agreed that continued industrial action over 23/24 will compromise the NHS's ability to deliver national recovery targets for elective and urgent and emergency care, and nearly all (99%) strongly agreed or agreed that it will compromise the NHS's ability to recover care backlogs including in community and mental health services.
- Most trust leaders were extremely or moderately concerned about the current level of burnout (84%) and morale (83%) across the workforce.
- Most (78%) trust leaders were very worried or worried about whether their trust has capacity to meet demand for services over the next 12 months.
- Trust leaders strongly disagreed or disagreed that their trust will have access to sufficient capital funding.
- Nearly nine in 10 trust leaders (89%) were very worried or worried about whether sufficient national investment is being made in social care.

This Trust Board is focused on performance and monitoring and includes our latest integrated performance report as well as a care group report (ADHD, ASD and Learning Disability). Overall, our performance is holding up well and it is particularly pleasing to see the continued relatively low use of out of area bed placements. This reflects the focus we have on improving flow along with the hard work and commitment of our teams. There has also been a pleasing increased uptake in appraisals. The performance of our community health services in Barnsley also warrants a mention. Although demand continues to be high during winter, the Barnsley Urgent Community Response (UCR) team saw 88% of patients, in a crisis, within 2 hours during February 2024. The team have consistently exceeded the national target of 70% since June 2023. Areas of under-performance are the subject of focus within our operational management group and executive management team.

As a provider of inpatient mental health services, we have been invited to sign up to the national culture of care programme, which we have agreed to do. This includes coaching for inpatient wards and corporate teams to improve the culture of care provided and is intended to help trusts and other providers prepare for the forthcoming NHS England Culture of Care standards.

Each year patient led assessment of the care environment (PLACE) are carried out. **This year we were named in the top five mental health provider trusts in the country for cleanliness**. This is excellent recognition for our housekeeping and domestic staff, whose import work is key to maintaining a clean, safe and hygienic environment.

The consultation on the older people's mental health inpatient services has been well managed and at the time of writing this report over 500 responses have been received. I would like to thank all of those members of staff who have led a very professional consultation and everyone who has responded to it to provide us with such rich feedback. The consultation is due to close at the end of March and at that point the feedback will be fully reviewed and considered to frame the future model of care.

Dawn Lawson, our Director of Strategy & Change, is leading the work to refresh our Trust strategy. Engagement is taking place in many forms including with staff, partners and communities. The Board strategy meeting in May will be used to share some of this feedback and engage with the full Trust Board for input. At the time of writing this report 342 responses to an online survey have been received and over 20 face to face sessions have taken place.

The year-end is fast approaching. We have received the annual guidance for completing our year-end report and accounts, as well as other key governance requirements. Our Audit Committee will be overseeing the process on behalf of the Trust Board.

Our chief people officer, Greg Moores, is leaving the Trust following a period of absence for personal reasons. Greg will be working on secondment in Lancashire until he formally leaves. The recruitment process for a new chief people officer has commenced.

The Trust made a lead provider self-assessment to NHS England NHSE) in December regarding the West Yorkshire Adult Secure Provider Collaborative (including Forensic CAMHS). We have received feedback from NHSE which is positively largely in line with our self-assessment. They have agreed that we have now met all areas of Level 2 of the Quality Management Framework, so we will now move to work towards completion of Level 1. In addition, they have agreed with our self-assessment that we are meeting all our lead provider responsibilities apart from contracting which is rated as amber and reflects some of the national challenges experienced with provider collaborative contracting. There are a number of recommendations of further work outlined in the letter, which will be progressed with support of the Commissioning Hub.

The Trust's submission to showcase improvement work at NHS Providers' annual Quality & Improvement Conference in May has been progressed, which is a real testament to the quality of our submission and our approach to improvement.

The Trust has successfully recruited into substantive roles this year. Whilst there remain challenges in a number of areas, this has been a positive achievement and no doubt in some way has contributed to the results we have seen in our staff survey. There has been a shift in dynamic with more people joining us from a non-NHS background. This does mean we need to consider how we best support and induct our new workforce to give them the best

	experience and enable us to continue to provide the best possible care. This situation is replicated nationally with a recent report by the Kings Fund identifying that although the mental health workforce expanded by 23% between 2010 and 2023, growth varied widely by staff group and is less experienced. The expansion in nursing was only 3%. There is a concerning statistic published recently which show the number of applications to study nursing fell by almost 20% in 2023/24. **Much positive work carried out across our Trust can go unseen**. Some examples of positive achievements in the last month include: • The Trust was re-accredited as Veteran Aware. • The Trust celebrated LGBT+ History Month and Apprenticeship Week. • Julie Metcalf, volunteer and workplace development worker and Creative Minds project worker, was shortlisted and won an award at the 2024 Disability Sport Yorkshire Awards in the 'Services to sport' category. • Volunteer Jolie Evans Duggan was shortlisted for volunteer of the year in the NHS Unsung Hero Awards for her contributions to the stammering training our Trust offers schools. • The Trust officially opened its first ever wudhu facility at Fieldhead. • The Trust launched its first green team newsletter. **In terms of national developments for our sector the following are worthy of Board note:** • Offering the right reasonable adjustments is crucial in reducing health inequalities for people with a learning disability and autistic people, which is why a Reasonable Adjustment Digital Flag is being created on the NHS spine; to ensure that health and care professional can record, share, view and review details of individual needs. • A new clause has been included in the NHS Standard Contract which requires all mental health providers to have implemented the Patient and Carer Race Equality Framework (PCREF) by March 2025. • For Learning Disability and Autism, there is new requirement for staff training added to the NHS Standard Contract. The recommendation is that the Oliver McGowan training programme on learning disability and autism is the "preferred and recommended" training package. 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.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

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The Brief

29 February 2024

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

With **all of us** in mind.

Our mission and values

NHS
South West Yorkshire Partnership
NHS Foundation Trust

It is important we focus on our values.

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

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

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

With the holy month of Ramadan soon approaching, we are delighted to have opened a brand-new wudhu facility at Fieldhead. This is the first of its kind for our Trust. We listened to feedback from our Muslim colleagues about what they need to pray whilst at work, and the new facility will enable our colleagues to perform their prayers comfortably and peacefully. Thank you to everyone involved in bringing this project together.

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

Following a competitive tender process we have been awarded the contract for the provision of the **Doncaster Adult Tobacco Dependency Treatment Service**. Congratulations and thank you to all those who were involved in the bidding process.

The first issue of our green team newsletter is out now.

Find out the latest **social responsibility and sustainability** news from our Trust.

Remember to book onto a lunch and learn session which aims to update staff on what's new with **#allofusimprove**, the Trust's approach to quality improvement. The dates available to book are 14 March, 10 April and 22 April. To book email **allofusimprove@swyt.nhs.uk**

The national, regional and local context

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

A new podcast series which has been created by volunteers with **lived experience of suicide** aims to support staff who work with people in mental health crisis in West Yorkshire. The series, called 'Surviving Crisis: Learning from Lived Experience', consists of five episodes, each 20-30 minutes long and cover different themes. The episodes have been developed using insight from frontline health and care staff who were asked in advance to share their thoughts on what they would like discussed through the series. The volunteers said they hope the podcasts will provide helpful first-person accounts for staff and lead to positive changes for people experiencing mental health crisis in the future.

In November, the West Yorkshire Partnership launched its **'Together We Can' winter campaign**. This is the third regional wide winter campaign that helps people access health and care services at the right time and place. To help prepare a final evaluation report they are seeking feedback on this year's campaign from partners. Share your views here.

Do you or someone you know have an idea that will address health inequalities in the health & care workforce in South Yorkshire? Through this **innovation funding**, the ICB are hoping to fund activities which will develop novel learning and insight about how the NHS can use its role as an employer to improve the health and wellbeing of the workforce.

There is still time to have your say and contribute to the **South Yorkshire Start with People Strategy**. The deadline is 15 March. Find out how to take part here.

The West Yorkshire Health and Care Partnership and the West Yorkshire Violence Reduction Partnership's **adversity, trauma and resilience** fourth annual knowledge exchange is taking place from the 5 to the 7 March 2024. Registration is now available via the website. This event will bring partners together to explore progress to date, share evidence and best practice for ensuring West Yorkshire is a trauma informed and responsive system.

Older people's mental health inpatient services consultation

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The consultation asks people to tell us what they think about our proposal to create specialist inpatient wards for older people with dementia, and other mental health needs (such as anxiety, depression, or psychosis).

Over 500 people have now filled in a survey to tell us what they think.

Help us reach our communities!
The consultation is important for people in Calderdale, Kirklees and Wakefield, in particular people who are living with dementia, a functional mental health need, their families, carers, and health and care staff.

You can help us share information about the consultation with people you may know in your area of work or family, friends and your local communities:

- Share the link to the website and survey, send a quick email or message with a link to - www.southwestyorkshire.nhs.uk/opsconsultation
- Pick up a copy of our consultation document and survey, leaflets or posters from locations across the Trust. Or email opsconsultation@swyt.nhs.uk and we can get some out to you.

Your views are important.

- Visit the consultation website to find out more and fill in the online survey.
- Pick up a copy of the consultation document and a paper survey (return via freepost) in Trust locations across Calderdale, Kirklees and Wakefield.
- Email opsconsultation@swyt.nhs.uk
- Drop in and speak to us – new dates are available, have a look at the events page of our website.

Once the consultation closes on 29 March, we will use what staff, patients, families, carers and the public tell us to inform our decision.

Improving Health
Our performance in January

South West Yorkshire Partnership NHS Foundation Trust

- **50.4%** of people completing Talking Therapies treatment and moving into recovery
- **98.8%** of Talking Therapies referrals beginning treatment within 18 weeks. **100%** within 6 weeks.
- **87.3%** of MH service users followed up within 72 hours of discharge from inpatient care
- **93.4%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **71.8%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **97.4%** of people died in a place of their choosing
- **80.9%** in CAMHS services waiting less than 18 weeks for treatment

Following the successful rollout of electronic prescribing and medicines administration (EPMA) across inpatient wards, the Trust will soon be looking at how we start to use EPMA in our community services. The EPMA system will enable the prescribing, supply, and administration of medicines electronically which has already improved safety and quality in our inpatient services. If you have an interest in being involved in helping shape the rollout of EPMA in community services, please get in touch with Amanda Morris. We are hoping to start rolling out to community teams in the next year. More information will be shared with teams and services over the coming months.

VETERAN AWARE

We have been successfully reaccredited as **'Veteran Aware'** by the national steering group for the NHS Veteran Covenant Healthcare Alliance. This recognises our work in demonstrating the NHS's commitment to the Armed Forces Covenant in identifying and sharing best practice across the NHS, showcasing the best standards of care for the Armed Forces community.

Improving Care
Our performance in January

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- **104** inappropriate out of area bed days
- **1** child / younger person under 18 in adult inpatient wards
- **80.5%** waiting for referral to assessment within 2 weeks
- **4.3%** of service users clinically ready to discharge
- **88.5%** of service users on CPA offered a copy of their care plan
- **96.6%** of our service users have their ethnicity equality data recorded, **46.4%** their disability status, **59.4%** their sexual orientation, and **99.8%** deprivation (postcode)

97% of respondents in the friends and family test rated our general community services either good or very good; **89%** in our mental health services, **90%** CAMHS, **100%** for learning disability services, **60%** for ADHD and **100%** for forensic services.

Our **research and development** team have been successful in winning a £1.3m bid from the National Institute for Health and Care Research (NHIR) to develop and test a stammering app. Our Trust is one of only two sites in the country in the study.

To mark **National Apprenticeship Week** we celebrated our apprentices at an event in Fieldhead**.** Mark Brooks, our chief executive, and Lindsay Jensen, interim chief people officer, met some of our apprentices at the event, heard about their experiences and thanked them for their contribution to the Trust.

Phil McNulty, our Children and Families Service Lead in Barnsley, has had an article published in a national journal about the development of a groundbreaking new web-based app for non-mental health nurses to assess mental health in children and young people. Email Phil for more details.

Improving Care
Incidents in January

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In January we reported:

- **1,212** incidents – **826** rated green (no/low harm)
- **292 were rated yellow and 72 rated amber**
- **22** rated as red (incident severity is reviewed and may be downgraded)
- **96%** of incidents resulted in no or low **actual** harm, or were external to our care
- **15** patient safety incidents that resulted in moderate or severe harm or patient safety related death.

We had **121** restraint interventions in January. **100%** of prone restraints were 3 minutes or less. Actions to support reducing interventions include 4 new support instructors recruited; lots of collaborative work taking place to support reduction in prone restraint; and improving scrutiny and oversight of prone restraint. We are also in the process of revalidation with the Restraint Reduction Network, and are asking all wards to nominate a RRPI champion.

We had **49** falls in January, 7 more than in December. See the falls prevention intranet pages for steps you can take to prevent falls.

We had **32** pressure ulcers which developed under our care in January.
5 of them identified areas for improvement (formerly known as lapse in care)

It's been a year since we started our **tea to improve quality** sessions. As Carmain Gibson-Holmes moves into her new role, the nursing, quality and professions directorate will be continuing to run the sessions. They'd love to hear what you think about the sessions that have been held over the past year. Please send any thoughts to ndadmin@swyt.nhs.uk. Find out how previous sessions have made a difference and read more about the sessions on the intranet.

There were 14 **confidentiality breaches** in January. All of us can reduce the number of patient data or sensitive information breaches. See the intranet for our IG campaign.

All staff must also ensure they complete their **information governance mandatory training**.

Think. Check. Share.

Managing risk

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

Key areas of risk identified in the risk register are:

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

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

Two workshops have been planned to help progress some of the **care planning and risk assessment improvement** work. These will be all day sessions with the aim of completing some of the larger pieces of work in our improvement plan. Any member of staff is welcome to join. More information is on the intranet.

Improving file management on the K drive network. Teams are encouraged to review their files on the K drive network and delete any that are no longer needed. Many teams tend to keep files that haven't been accessed in years, and it's important to remove these files to free up storage space and for data security. Some files will require you to keep them for a certain amount of time but data beyond this point should be considered for deletion.

Improving resources
Our finances in January

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£1m	£0m
Agency Spend	£7.4m	£8.7m
Financial sustainability and efficiencies	£9.7m	£12m
Cash	£72m	£76.9m
Capital	£3.2m	£8.3m
Better Payment Practice Code	98%	

A deficit of £144k has been reported in January 2024. The Trust remains on track to achieve its break even target for 2023/24.

Year to date agency expenditure is £7.4m and the forecast is £8.7m which is in line with target.

The Trust financial plan includes a sustainability programme totalling £12m and is directly linked to the Trust priority of spending money wisely. Year to date we are £0.3m ahead of plan.

The Trust cash position is £72m

Year to date capital expenditure is £3.2m (42% of plan).There is an increase in spend in January with additional significant spend expected in February and March. Our forecast is to achieve our expenditure plan of £8.3m,

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

Use of resources
Digital dictation

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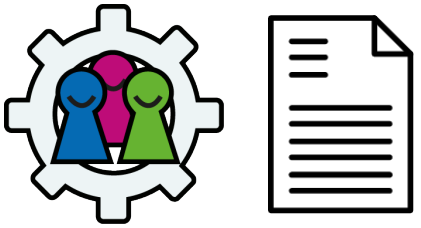
South West Yorkshire Partnership
NHS Foundation Trust



Following a successful pilot at Wakefield digital dictation was agreed as one of the priority programmes for 2023/2024 as part of making digital improvements. There are around 650 current and future users of dictation across the Trust services, with potential for additional areas to adopt it as well.

What is digital dictation? Dictation is used across the Trust by clinicians, secretaries and admin teams. Currently this is mainly in the form of magnetic tapes on dictaphones that are then transported and transcribed. Digital dictation can replace this allowing recording and editing without using analogue tapes. Uploading is almost instantaneous, meaning there is no need to transport and no chance of tapes going missing.

The project is nearing the end of the procurement stage following the tender process to select a supplier for a Trust-wide solution, with representatives from the Trust assessing solutions against a set of requirements gathered from Trust staff and stakeholders.

Digital dictation has many **benefits**, including:

- Improved data security
- Enabling quicker turnaround times for services users
- increased capacity for clinicians and supporting roles
- It can also be useful to people with physical health issues that impact upon typing or writing ability, improving accessibility of workplaces.

In the coming months we will be working with services to agree the approach for providing digital dictation to meet the needs of services across the Trust.

The team will be holding lunch and learn sessions on digital dictation via Microsoft Teams. These sessions will offer an opportunity for people to come along and understand what it is and identify whether they might be interested in getting involved.

The sessions will be on:

- 26 March at 12pm
- 27 March at 12:30pm
- 3 April at 12pm
- 5 April at 12pm

If you would like to join a session, please email kate.ledger@swyt.nhs.uk

A great place to work

Our performance in January

- **5.1%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.1%**
- In December we had new **91** starters to the Trust, and **30** leavers
- We currently have **4,536** substantive members of staff
- **79.6%** of staff have a completed annual appraisal

We want your views as part of our **#allofusconversation**, which will help us to refresh our Trust strategy, develop a new clinical strategy, and set out our plans for the future.

There are many ways for you to do this – we have drop in events, workshops, virtual sessions, and an online survey. Take a look at the intranet for more information.

Thank you to all our staff for their work to make sure we continued to provide safe, high-quality care through recent industrial action by junior doctors. We value all our staff and respect your rights to engage in industrial action. Please look after yourself and one another. Your wellbeing at work matters and our employee wellbeing services are here to help if you need them.

Would you like to become a table host at the Trust's welcome event? Engage with new starters and discuss fresh ideas to help the Trust progress. Read the support guide and view the dates for the 2024 welcome events. Email LandD@swyt.nhs.uk to find out more.

We want all staff to have a high quality **appraisal** and a good conversation with their manager. Our numbers are improving each month. Please continue to make sure they are prioritised.

Our LGBTQ+ staff network has been celebrating **LGBTQ+ history month** by sharing their stories and providing support to colleagues across the Trust. They also developed a Microsoft Teams background so that LGBTQ+ colleagues and allies could show their support. Find out more on the intranet.

Disabled staff network steering group news Congratulations to Cheryl Stott on her new role as communications and membership officer for the staff network. To join or find out more about the network visit the intranet

Do you have any unwanted gifts that would make good tombola/raffle prizes? If so, please email the EyUp! charity team.

With **all of us** in mind.

Take home messages

NHS
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Safety always comes first. Make sure you do everything you can to keep you and those around you safe.

Help us to improve by attending the #allofusimprove lunch and learn sessions.

Share information about our OPS consultation with colleagues, family, friends and in your communities.

Learn more about our digital dictation programme and how it may affect the work of you and your team.

Make sure you are compliant with your information governance mandatory training.

Have your say and help us to be ready for tomorrow by taking part in our #allofusconversation

Make sure you and any direct reports have a high quality, up to date appraisal.

Take a look at the intranet for the support available to help you with your health and wellbeing.

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

NHS
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Trust Board 26 March 2024
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates & Resources**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for February 2024.		
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 insights from the IPR as at the end of February 2024. A new indicator has been included this month for performance against the Oliver McGowan Mandatory Training on Learning Disability and Autism. This is a legal requirement for training on learning disability and autism for CQC regulated service providers, which came into effect from 1 July 2022. The Trust has been following a phased approach in line with the national plan. The Oliver McGowan training was available via e-learning from August 2022 and was attached to all staff as mandatory training		

	requirement from December 2023 and appears in all staffs mandatory training compliance reports. Trust performance against the e-learning module is exceeding the national 10% threshold as at the end of February. Plans are in place to continue the roll out as it becomes available. A piece of work has been undertaken to review appropriate metrics for inclusion in the report for the Trusts individual placement support services. As a result, two new metrics have been added this month: • Number of job start/work retention outcomes during month by individual placement and support service. • Number of new people accessing Individual placement and support service during month These metrics will replace the previously reported metric for Number of people who sustain 26 weeks employment via Trust Individual placement support service. The new metrics, align to the KPI framework set out by Individual Placement Service Grow and will enable us to demonstrate the rate of individuals transitioning from access into employment. The new metrics can be seen on page 12 in the Strategic Objectives & Priorities section of the report. Further developments of the IPR are ongoing in line with the development plan. **Strategic Objectives and priorities** • A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 95.6% against a target of 90%. For the Trust derived indicators, as of February 2024, disability is at 47.4%, sexual orientation 59.7% and postcode is at 99.8%. 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 to ensure that our approach is fair and does not present needless barriers or disadvantage any protected groups of people. No policy is agreed without an equality impact

	assessment in place and therefore we have investigated why the performance is under 100%. **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 reduced use of inappropriate out of area bed days over the last few months with 74 days used in February, this is a significant improvement compared to the 6 months of the year. 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 increased to 69% in February from 56.5% reported in January, 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. This relates to increased demand from due to audiology assessments forming part of other assessments, for example autism and the availability of additional audiologists. An improvement plan is in place and links to work across the Integrated Care System. • Performance against the number of children & younger people with an eating disorder requiring urgent access to treatment dropped in February with 66.7% achieving the 1-week standard for urgent cases. This relates to one case out of a total of three where an appointment within 1 week had been offered to the family but was not attended. **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 February data for care planning shows continued sustained performance above the 80% threshold since April '23, achieving 88.7% for the month. For risk assessments, the February data shows a slight decrease in performance from the previous month within inpatient services (90.1%) this means that 100 service users had a risk assessment within 24 hours, 11 service users had a completed risk assessment but this was outside the 24 hours. For community services, performance for February has increased slightly from the January position of 71.8% to 74.7% - 38 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety. **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. • 'While you wait' offers are in place or in development for children on waiting lists, teams maintain contact with children and families while they wait to ensure appropriate action can be taken in case risks escalate. • Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high. 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 87.5% - (42 out of 48) 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. Improvement work, including recruitment, additional training for staff in specific skills for example dysphagia and pathway development continue. • Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need. As demand is significant the care remains with the referrer until accepted by the service. **Patient Safety Indicators** 96% of incidents reported in February 2024 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 165 (121 in January). Statistical analysis of data since April 2018 shows that the number of

	restraint incidents month on month remain static – all incidents are reviewed, and learning is shared. • Positively, 100% of prone restraint incidents were for a duration of three minutes or less – this related to 7 incidents for the month of February. The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. Use of prone restraint continues to be below the year average of 21, and from now on all incidents of prone restraint will be reviewed for learning in the Patient Safety Oversight Group. • There were 20 information governance personal data breaches during February which is the highest so far during the current financial year. All were caused by human error, twelve incidents related to the Mental Health care group and the data protection officer is undertaking a specific piece of improvement work. An urgent communications campaign is in progress, and items will be issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team will work with them to ensure improvements are made. As yet we can't directly link the incidents to the reduction in training compliance, which is within our normal seasonal variation. • The number of inpatient falls in February was 45 which is similar to the numbers over the last quarter. 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. • Two pressure ulcers identified there was a lapse in care. As per Trust policy, all reported cases are subject to a deep dive and root causes analysis to identify learning which is then shared to prevent future incidents. • The number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%. Improvement work continues. **Our People** • Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for February is 65.86% which is a slight deterioration from the refreshed performance for January which is 67.4%. 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. This is monitored by the operational management group. • The Trust had 22 violence and aggression incidents against staff on mental health wards involving race during February - 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 has increased slightly in February. The number of people joining the Trust outnumbered leavers in February. Year to date, we have had 654.5 new starters and 423 leavers. • As of February 2024, our Trust growth rate has increased further to 6.95% (staff in post). This is already exceeding our initial annual forecasted growth rate of 4%. • Overall, our 12-month turnover rate in February has dropped slightly again this month to 11.2% which is a reflection of the low number of leavers and increase in new starters. • We have recruited a total of 86 international nurses since April 2023. Cohorts in January have been reduced (5 per month) and future international nurse cohort delivery in February and March has been paused. • In February 2024 we have seen a drop in sickness overall to 4.8%. This is seen as a positive as we are still in a seasonal absence period, but this does not appear to have impacted the Trust excessively this winter so far. • Sickness absence year to date in February has now reduced to 5.0% which is above local threshold. However, this is the lowest sickness rate since April 2023. • The Estates and Facilities sickness rate continues to rise, which is now at 8.6%. This staff group have seen a consistent monthly rise since April (Apr 6.15%). Further work is being done with our business partners to help support Estates and Facilities, along with an internal audit. • We have increased our rolling appraisal compliance rate again in February, which saw an increase from 79.6% to 82.9%. This is the first month the compliance of 80% has been reached. Actions remain 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 are taken. • Although our overall mandatory training compliance remains static since last month at 91.8%, we have seen a drop in some areas. Reducing Restrictive Physical Interventions (RRPI) has dropped again this month to 74.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training. • Cardiopulmonary Resuscitation (76.1%) and Information Governance (91.8%) 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). Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning. Weekly e-mail reminders are going out to all staff.

Care Groups

In addition to the care group information found within this report, a separate deep dive into the Learning disability, ASD/ADHD care group can be found under item 9.2 on this board agenda.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of February, and we have also provided 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.
- Although recruitment has been positive, 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, creating additional pressures.
- The Trust currently has higher than usual levels of vacancies in some mental health community teams for qualified practitioners. Work has commenced to review establishments and create proactive and innovative solutions to the workforce.
- Demand into the Single Point of Access (SPA) continues. SPA continues to prioritise 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. February performance data for routine access for assessment within 14 days is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley and specific actions are in place to address.
- Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within the 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 patient under 18 years old remaining in an adult bed during February. Whilst this is measured clearly, other children will wait in other settings, for example acute hospital beds or home, for inpatient care. 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 £398k has been reported in February 2024. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target. This will support the delivery of the

	West Yorkshire Integrated Care System financial target although this remains challenging. • Agency spend has continued to reduce in February 2024 and is now forecast to be under the target of £8.7m spend in year. The Agency scrutiny group continues to monitor both agency spend and impact on operational delivery. Work continues to maintain, and improve, this run rate into 2024/25. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • Overall, the Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure. • Performance against the Better Payment Practice Code is 98%.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**

NHS
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Integrated Performance Report
Strategic Overview

February 2024

With **all of us** in mind.

NHS
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NHS Foundation Trust

Table of Contents

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for February 2024. 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 where there has been a change in performance or where expected levels are not being achieved. A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

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)	↑	

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	↓	H, F
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)	↑	L, F
% service users clinically ready for discharge	↑	H, ?
% 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	↓	

Metric	Change from last month	Variation/ Assurance
Quality		
Complaints - Number of responses provided within six months of the date a complaint received	↓	
Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	↔	
Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care	↔	
C Diff avoidable cases	↔	

Metric	Change from last month	Variation/ Assurance
People		
Sickness absence - month	↑	
Mandatory training - reducing restrictive physical interventions	↓	

Metric	Change from last month	Variation/ Assurance
National metrics		
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	↔	H, ?

Care Groups

CAMHS

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% 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 physical interventions training compliance	↑	

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 physical interventions training compliance	↑	
Sickness rate (Monthly)	↔	
FIRM Risk Assessments - Staying safe care plan in 7 working days	↑	
% Complaints with staff attitude as an issue	↑	

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)	↓	
Reducing restrictive physical interventions training compliance	↑	

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 physical interventions training compliance	↑	
Sickness rate (Monthly)	↑	

Barnsley General Community Services

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 physical interventions training compliance	↔	

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	↑	
Reducing restrictive physical interventions training compliance	↓	
Sickness rate (Monthly)	↑	

Key

Improvement from last month but up to 5% below threshold	↑
No change from last month and up to 5% below threshold	↔
Deterioration from last month and up to 5% below threshold	↓
Improvement from last month and below threshold	↑
No change from last month and below threshold	↔
Deterioration from last month and 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 95.6% against a target of 90%. For the Trust derived indicators, as of February 2024, disability 47.4%, sexual orientation 59.7% 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 to ensure that our approach is fair and does not present needless barriers or disadvantage any protected groups of people. No policy is agreed without an equality impact assessment in place and therefore we have investigated why the performance is under 100%.

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 reduced use of inappropriate out of area bed days over the last few months with 74 days used in February, this is a significant improvement compared to the 6 months of the year. 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 increased to 69% in February from 56.5% reported in January, 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. This relates to increased demand from due to audiology assessments forming part of other assessments, for example autism and the availability of additional audiologists. An improvement plan is in place and links to work across the Integrated Care System.
• Performance against the number of children & younger people with an eating disorder requiring urgent access to treatment dropped in February with 66.7% achieving the 1-week standard for urgent cases. This relates to one case out of a total of three where an appointment within 1 week had been offered to the family but was not attended.

Quality continued

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 February data for care planning shows continued sustained performance above the 80% threshold since April '23, achieving 88.7% for the month.
• For risk assessments, the February data shows a slight decrease in performance from the previous month within inpatient services (90.1%) this means that 100 service users had a risk assessment within 24 hours, 11 service users had a completed risk assessment but this was outside the 24 hours. For community services, performance for February has increased slightly from the January position of 71.8% to 74.7% - 38 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.

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.
• 'While you wait' offers are in place or in development for children on waiting lists, teams maintain contact with children and families while they wait to ensure appropriate action can be taken in case risks escalate.
• Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high. 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 87.5% - (42 out of 48) 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. Improvement work, including recruitment, additional training for staff in specific skills for example dysphagia and pathway development continue.
• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need. As demand is significant the care remains with the referrer until accepted by the service.

Patient Safety Indicators

96% of incidents reported in February 2024 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 165 (121 in January). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain static – all incidents are reviewed and learning is shared.
• Positively, 100% of prone restraint incidents were for a duration of three minutes or less – this related to 9 incidents for the month of February. The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. Use of prone restraint continues to be below the year average of 21, and from now on all incidents of prone restraint will be reviewed for learning in the Patient Safety Oversight Group.
• There were 20 information governance personal data breaches during February which is the highest so far during the current financial year. All were caused by human error, twelve incidents related to the Mental Health care group and the data protection officer is undertaking a specific piece of improvement work. An urgent communications campaign is in progress, and items will be issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team will work with them to ensure improvements are made. As yet we can't directly link the incidents to the reduction in training compliance, which is within our normal seasonal variation.
• The number of inpatient falls in February was 45 which is similar to the numbers over the last quarter. 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.
• Two pressure ulcers identified there was a lapse in care. As per Trust policy, all reported cases are subject to a deep dive and root causes analysis to identify learning which is then shared to prevent future incidents.
• The number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%. Improvement work continues..

Our People

• Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for February is 65.86% which is a slight deterioration from the refreshed performance for January which is 67.4%. 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. This is monitored by the operational management group.

• The Trust had 22 violence and aggression incidents against staff on mental health wards involving race during February - 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 has increased slightly in February. The number of people joining the Trust outnumbered leavers in February. Year to date, we have had 654.5 new starters and 423 leavers.

• As of February 2024, our Trust growth rate has increased further to 6.95% (staff in post). This is already exceeding our initial annual forecasted growth rate of 4%.

• Overall, our 12-month turnover rate in February has dropped slightly again this month to 11.2% which is a reflection of the low number of leavers and increase in new starters.

• We have recruited a total of 86 international nurses since April 2023. Cohorts in January have been reduced (5 per month) and future international nurse cohort delivery in February and March has been paused.

• In February 2024 we have seen a drop in sickness overall to 4.8%. This is seen as a positive as we are still in a seasonal absence period, but this does not appear to have impacted the Trust excessively this winter so far.

• Sickness absence year to date in February has now reduced to 5.0% which is above local threshold. However this is the lowest sickness rate since April 2023.

• The Estates and Facilities sickness rate continues to rise, which is now at 8.6%. This staff group have seen a consistent monthly rise since April (Apr 6.15%). Further work is being done with our business partners to help support Estates and Facilities, along with an internal audit.

• We have increased our rolling appraisal compliance rate again in February, which saw an increase from 79.6% to 82.9%. This is the first month the compliance of 80% has been reached. Actions remain 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 are taken.

• Although our overall mandatory training compliance remains static since last month at 91.8%, we have seen a drop in some areas. Reducing Restrictive Physical Interventions (RRPI) has dropped again this month to 74.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training.

• Cardiopulmonary Resuscitation (76.1%) and Information Governance (91.8%) 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). Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning. Weekly e-mail reminders are going out to all staff.

Care Groups

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of February, and we have also provided 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.

• Although recruitment has been positive, 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, creating additional pressures.

• The Trust currently has higher than usual levels of vacancies in some mental health community teams for qualified practitioners. Work has commenced to review establishments and create proactive and innovative solutions to the workforce.

• Demand into the Single Point of Access (SPA) continues. SPA continues to prioritise 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. February performance data for routine access for assessment within 14 days is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley and specific actions are in place to address.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within the 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 patient under 18 years old remaining in an adult bed during February. Whilst this is measured clearly, other children will wait in other settings, for example acute hospital beds or home, for inpatient care. 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 £398k has been reported in February 2024. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target. This will support the delivery of the West Yorkshire Integrated Care System financial target although this remains challenging.

• Agency spend has continued to reduce in February 2024 and is now forecast to be under the target of £8.7m spend in year. The Agency scrutiny group continues to monitor both agency spend and impact on operational delivery. Work continues to maintain, and improve, this run rate into 2024/25.

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

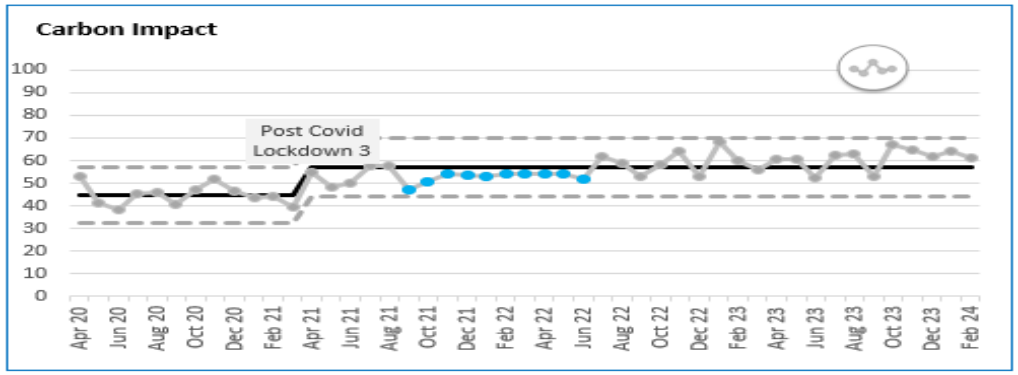
• Overall, the Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure.

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

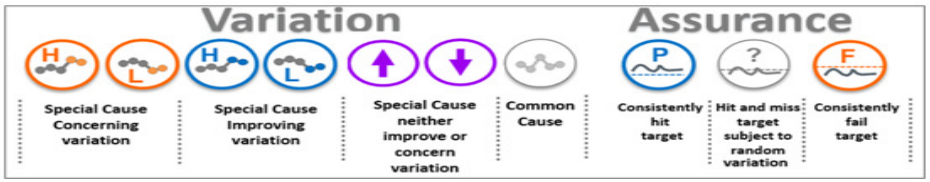
Improving health

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	97.0%	96.6%	95.6%		
Percentage of service users who have had their equality data recorded - disability	50%	47.0%	46.4%	47.4%		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%. Please note that from January 2024 service users under 16 years of age have been excluded from the sexual orientation calculation.
Percentage of service users who have had their equality data recorded - sexual orientation		45.5%	59.4%	59.7%		
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%	88.5% Service	91.7% Service	91.7% 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%	95.8% Policy	95.5% Policy	96.1% Policy		
Completion of equality mandatory training	>=80%	95.6%	95.1%	95.6%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	Reporting commenced Feb '24		7		New metric added March 2024. A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	Reporting commenced Feb '24		50		New metric added March 2024. First contact and work started on vocational profile
Carbon Impact (tonnes CO2e) - business miles	76	62	64	61		Data showing the carbon impact of staff travel / business miles. In February staff travel contributed 61 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%	67.8%		Due May 2024		Q1 - 65.0%, Q2 - 66.0% 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	Dec-23	Jan-24	Feb-24	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%	94.1%	93.4%	90.1%		Focus remains on this area and 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. To support patient safety, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. February data shows a slight decrease in performance from the previous month within inpatient services (90.1%). For community services, performance for February has increased slightly from the January position of 71.8% to 74.7%.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		70.0%	71.8%	74.7%		
% Service users on CPA offered a copy of their care plan	80%	88.0%	88.5%	88.7%		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. The February data for care planning shows continued and sustained performance above the 80% threshold since April '23, achieving 88.7% for the month.
Registered substantive staff in post mental health and learning disabilities services	Establishment	1077	1088	1094		
Registered substantive staff in neighbourhood teams	Establishment	173	171	174		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	19	21	22		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	85	104	74		The Q4 target shown is a National target and whilst we remain above this threshold we have seen a notable improvement in the number of out of area bed days which is down to an average of 86 days in the past 5 months from an average of 447 days in the 5 months prior to that. Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes and to ensure that services users receive care closer to their home. See statistical process chart in National Metrics section for further detail. Please note, this is an in month position and may not reflect the quarterly outturn.
% service users clinically ready for discharge	<=3.5%	5.7%	4.3%	2.9%		Performance in month has improved to 2.9% and below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months. 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.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	702	636	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. Children and young people 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 and there is still a backlog of individuals who will have waited a long time for assessment from referral. The service continues to receive over 50% more referrals than there is capacity to deliver assessments each month. Calderdale - The longest wait for those seen in the month was 714 days, the shortest was 676 days. Number on waiting list at end of February - 167. The longest waiter on the waiting list had waited 730 days. Kirklees - The longest wait for those seen in the month was 783 days, the shortest was 573 days. Number on waiting list at end of December - 1954. The longest waiter on the waiting list had waited 680 days.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	623	633	636		
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	87.5% 42/48	83.8% 62/74	87.5% 42/48		This remains a key concern and actions are underway as part of the improving access priority programme. Where waits breached 18 weeks (6 in total in February) the service understand why and are taking appropriate action. A report in relation to other waits will be discussed in the Executive Management Team meeting.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	91.2%	87.3%	91.0%		
Community health services two hour urgent response standard	70%	85.3%	86.3%	87.8%		
Referral to assessment within 2 weeks (external referrals)	75%	85.1%	80.5%	81.8%		

Improve resources

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£66k)	(£144k)	(£149k)		A deficit of £398k has been reported in February 2024. This is £149k higher than planned. The year to date position is a surplus of £594k which is £177k better than planned.
Capital spend against plan (monthly)	£8.8m	(£789k)	(£16k)	£1,033k		Spend has increased in February with £1m more than originally planned. This is required in both February and March to ensure that the total allocation is utilised in year.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£564k	£581k	£483k		The reduction in run rate, when compared to the first half of the year, continues. The Trust scrutiny group continues to review the detail and the progress made to date to ensure that this is maintained and maximised.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£1,286k	£1,312k	£1,175k		The cumulative savings to date are £10.8m and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	4	Due April 2024			
Estates Urgent Response Times - Service level agreement (SLA)	95%	98.5%	96.9%	96.9%		Service level agreement 1 & 2 are the priorities given to emergency and urgent work which has a two day response time.
Premise Assurance Model (PAM)	Good	Good	Good	Good		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency & Effectiveness
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	100%	100.0%	100.0%	100.0%		Estates senior management have reviewed this metric and from August '23 only jobs screened as category SLA 2 are included due to some inconsistencies in the categorisation of jobs when initially logged.

Make SWYPFT a great place to work

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	12.0%	11.6%	11.2%		
Registered workforce growth	3% (by March 24)	7.0%				
Sickness absence - rolling 12 months	<=4.8%	5.1%	5.1%	5.0%		Absence rate in month dropped slightly to 5%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	May >=78% Overall >=90%	74.3%	79.6%	83.4%		For the month of February, the percentage rate increased 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		70.5%		Results from national staff survey.
% staff recommending the Trust as a place to receive care and treatment	65%	N/A		72.2%		
Staff supervision rate	80%	67.7%	67.0%	64.8%		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. (Band 4 and above, all supervision)
Mandatory training - Cardiopulmonary resuscitation	80%	77.0%	77.5%	76.1%		In order to maintain a safe environment, inpatient services ensure access to appropriately cardiopulmonary resuscitation trained staff on each shift. 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).
Mandatory training - Reducing restrictive physical interventions	80%	81.8%	77.0%	74.0%		Performance has dropped again this month to 74.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training. Sucessful recruitment will improve team capacity.
Mandatory training - Fire	80%	90.8%	90.5%	89.6%		
Mandatory training - Information governance (IG)	95%	94.0%	92.7%	91.8%		Reminders circulated regarding IG training compliance. Further detail included in quality section of the report.

Quality Headlines

Section	KPI	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	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%	80.9%	78.8%	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)	8% (2/24)	14% (1/7)	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)	70.0% 7/10	63% (10/16)	
Service User Experience	Friends and Family Test - Mental Health	84%	82%	85%	91%	90%	90%	95%	89%	88%	94%	89%	92%	1
	Friends and Family Test - Community	95%	94%	97%	96%	93%	97%	96%	95%	97%	98%	97%	97%	1
Quality	Number of compliments received	N/A	50	66	33	35	22	17	18	35	16	2	8	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	26	34	22	24	31	18	24	20	13	12	18	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	0	1	1	0	0	2	2	1	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	2	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%	88.5%	88.7%	1
	Number of Information Governance breaches [3]	<12	12	9	14	13	16	8	9	11	8	14	20	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%	4.3%	2.9%	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%	93.4%	90.1%	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%	70.0%	71.8%	74.7%	2
	Total number of reported incidents	Trend monitor	1198	1327	1257	1156	1204	1150	1315	1320	1183	1278	1275	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	25	34	24	29	34	25	32	24	27	29	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	4	1	2	3	6	
	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	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%	129.6%	127.6%	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%	102.2%	100.8%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	29	42	40	36	43	43	28	33	28	45	49	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	2	1	3	1	2	0	3	6	6	2	2	
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	90%	90.0%	86.6%	89.5%	95.2%	90.0%	90.0%	91.7%	66.6%	100.0%	100.0%	100.0%	1
	Number of Falls (inpatients)	Trend monitor	34	41	43	32	33	36	50	46	42	48	45	
	Number of restraint incidents	Trend monitor	192	186	201	145	146	92	198	153	193	121	165	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting to start from Sept 23					65.8%	66.0%	70.1%	67.8%	67.4%	65.6%	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%	97.4%	88.9%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	1	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	
	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 4 and above clinical staff who have received supervision in the previous 90 days.

Quality Headlines

The following section provides insight into key quality issues identified in the dashbard for the month of February.

• The overall number of restraint incidents increased in February from 121 reported in January to 165. 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 - There were two instances in February, one related to a missed visit and one related to a risk assessment not been carried out, however in both cases the care received was not impacted. All reported cases follow usual Trust policy regarding deep dive and root causes analysis and to identify learning.
• Performance for children's and adolescent mental health service (CAMHS) referral to treatment - a review is being undertaken 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 has decreased slightly at 90.1% from 93.4% for inpatient services. Community services have seen a slight increase from 71.8% reported in January to 74.7% in February.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased to 2.9% and is below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months. 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 February there were 45 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 increased to 20 during the month remains above threshold - further detail is provided in the relevant section of this report.
• 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.
• The C.Difficile case that was reported in December was deemed to be healthcare associated, a case review has been undertaken and was presented at Barnsley post infection review (PIR) meeting for scrutiny. This was deemed to be unavoidable. The case has also been reviewed for action through internal governance processes.

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 Trusts PSIRF plan and policy went live on the 1st December 2023.

Since launching PSIRF we have:
• Reviewed linked policies and procedures
• Refined our guidance for learning responses using PDSA
• Reviewed incidents against our PSIRF Plan
• Supported services with considering if incidents meet the plan and if so what improvement work is already in place
• Developed the format of the Patient safety oversight group (PSOG) (formerly clinical risk panel) to align with PSIRF
• Updated Datix to reflect our processes for PSIRF

Learn from Patient Safety Events (LFPSE)
As reported in the previous IPR, Learn from Patient Safety Events will be a new national system that is being introduced to replace:
• National Reporting and Learning System (where we send our patient safety incidents)
• Strategic Executive Information System (StEIS - where we report Serious Incidents)

Following a further upgrade of the Datix system in January 2024, incident form configuration and thorough testing, the Trust went live with LFPSE on 14th February.

This means that from he 14th February 2024 we no longer report to the National Reporting and Learning System.

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 will became mandatory from November 2023. This is currently progressing well at 95% completed.

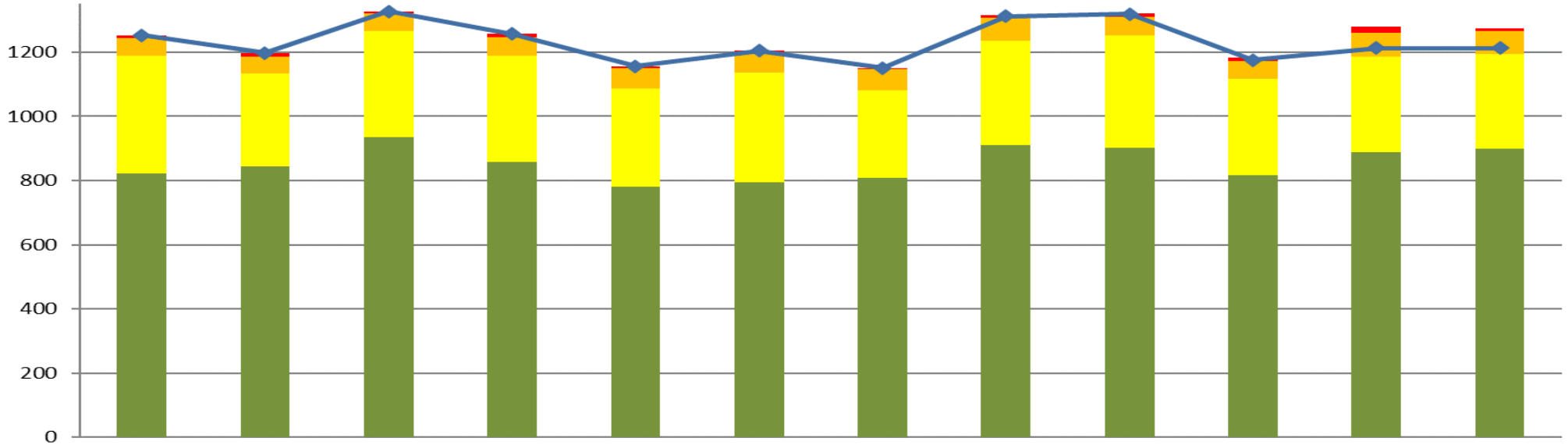
Patient Safety Partners
The three patient safety partners (PSP) (this is a volunteer role) was inducted into the patient safety team in February 2024. The next steps are for the PSP to meet again and discuss work allocations.

Safety First

Summary of Incidents

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

96% of incidents reported in February 2024 resulted in no harm or low harm or were not under the care of SWYPFT. No never events reported in February 2024.



	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Red (should not be compared with SIs)	9	12	7	11	7	9	3	8	10	12	19	9
Amber	57	51	55	58	63	60	66	72	57	55	74	72
Yellow	364	291	330	330	306	342	273	324	352	300	298	294
Green	823	843	935	858	780	793	808	911	901	816	887	900
Total	1253	1197	1327	1257	1156	1204	1150	1311	1318	1175	1212	1213

Safety First cont…

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

Breakdown of incidents in February 2024 -

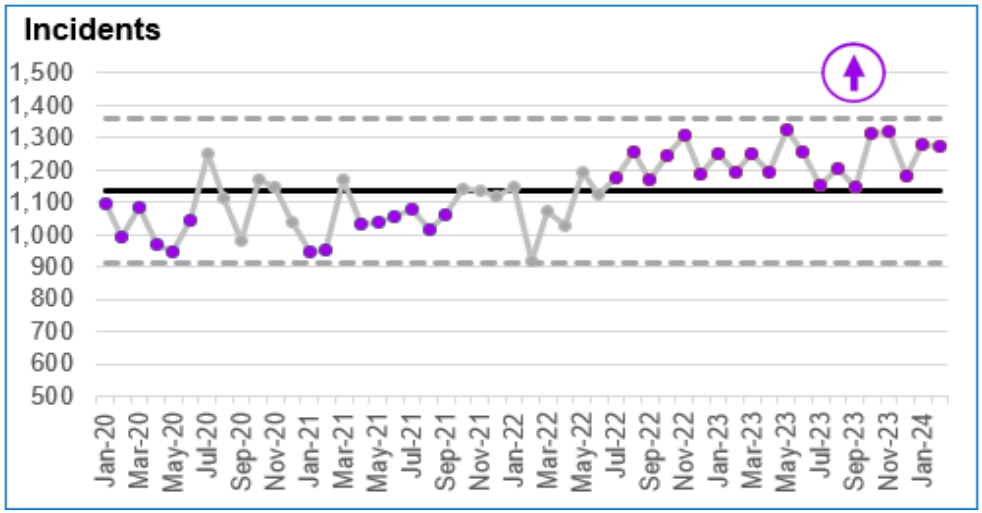
31 moderate harm incidents:

17 Pressure ulcer category 3 incidents across Barnsley neighbourhood teams
6 Self harm (actual harm) - (2x Nostell Ward, Ward 18, Bronte Ward, Clark Ward, Intensive Home Based Treatment Team / Crisis Team - Calderdale)
2 Tissue viability other - (across Barnsley neighbourhood teams)
2 Administration/ supply of medication from a clinical areal (e.g. documentation) - (CAMHS- Calderdale, Intensive Home Based Treatment Team (IHBTT) - Wakefield)
1 Self harm (actual harm) with suicidal intent - (Older Peoples service)
1 Bed Management issues (not including Single Sex accommodation incidents) - (Willow Ward)
1 Unwell/Illness - (Nostell Ward)
1 Diabetic foot ulcer (Neighbourhood Team - Central)

6 Severe harm incidents:

6 Pressure ulcer category 4 incidents across Barnsley neighbourhood teams

Incidents



We remain in a period of special cause variation (something is happening and this should be investigated) in February due a sustained 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).

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':

If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

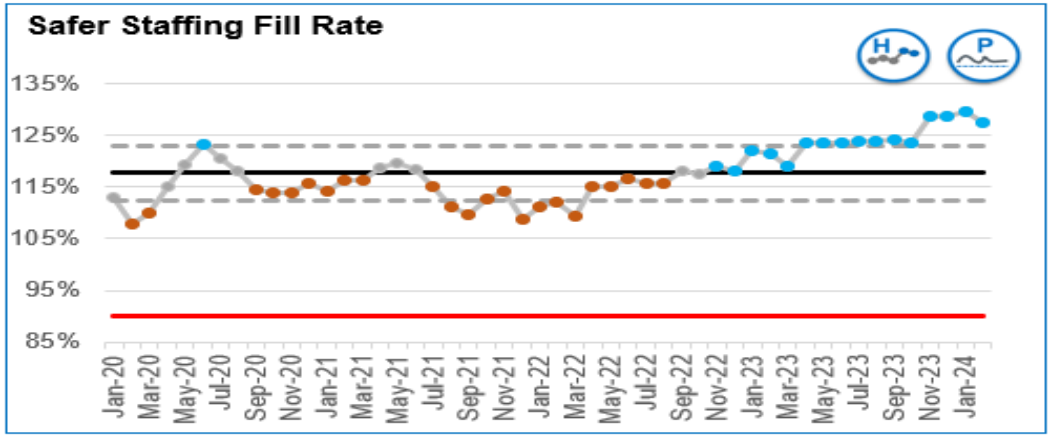
Patient Safety Alerts

Patient safety alerts issued in February 2024

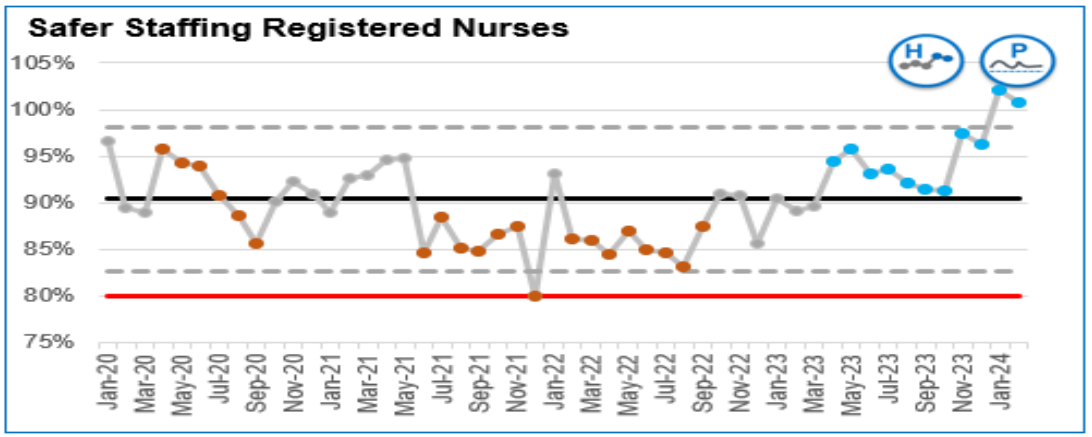
Patient Safety alerts not completed by deadline of February 2024 - zero.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2024/003/DHSC.MVA	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	26/02/2024	Yes - circulated for information	08/03/2024	07/03/2024

Safer Staffing Inpatients



The chart above shows that as at February 2024 due to the continued increasing staffing fill rate, we remain in a period of special cause improving variation.



The chart above shows that in February 2024, due to the continued increase in the registered nurses fill rate, we remain in a period of special cause improving variation.

- There was a further significant decrease in February on demand, mainly due to decreased vacancies and less annual leave being taken by substantive staff, of the flexible staffing pool with a total of 435 less shift requests with the overall fill rate remaining high.
- All figures indicate a slight decrease in overall demand to deal with acuity given the reduction in requests correlating with the reduction in fill rates and we will closely monitor this trend.
- All international educated nurses have been assigned.
- The centralised assessment centres have also been stopped to allow for more targeted recruitment and the last successful band 2 and band 5 candidates will be placed shortly.
- Having looked at the staff bank resource, we are targeting support in the community, both adult and mental health, to increase the bank resource in these areas.
- The safer staffing meeting is being reconfigured to increase attendance and improve outcomes to be more supportive of the operational colleagues.
- The collaborative bank launch and enrolment is ongoing with issues around training and smart cards being resolved in our working groups.
- SafeCare lessons within Calderdale are being supported and solutions being supported.
- The roll out of the health roster system is ongoing at a slower than expected pace due to several operational issues that we are currently looking at.
- The overall fill rate has reduced by 2% to 127.6% however the day fill rate for registered nurses continues to improve. This has meant that 13 wards (a decrease of three) have fallen below the 90% registered nurse day fill rate with six wards below 80%, two less than the previous month.
- In February one ward fell below the 90% overall fill rate threshold, this was Enfield Down in Kirklees with 89.1%

Safer Staffing Inpatients cont…

Registered Nurses Days
Overall registered Day fill rates have increased by 1.1% to 92.7% in February compared with the previous month.

Registered Nurses Nights
Overall registered Night fill rates have decreased by 3.9% in February to 108.9% compared with the previous month.

Overall Registered Rate: 100.8% (decreased by 1.4% on the previous month)
Overall Fill Rate: 127.6% (decreased by 2.0% on the previous month)

Fill Rate	Dec-23	Jan-24	Feb-24
Adults and Older People	136%	136%	136%
Barnsley Integrated Services	104%	111%	110%
Forensic and LD	120%	122%	117%
Grand total	**129%**	**130%**	**128%**

Registered day rate	Dec-23	Jan-24	Feb-24
Adults and Older People	86%	89%	91%
Barnsley Integrated Services	96%	103%	105%
Forensic and LD	85%	94%	93%
Overall shift fill rate	**86%**	**92%**	**93%**

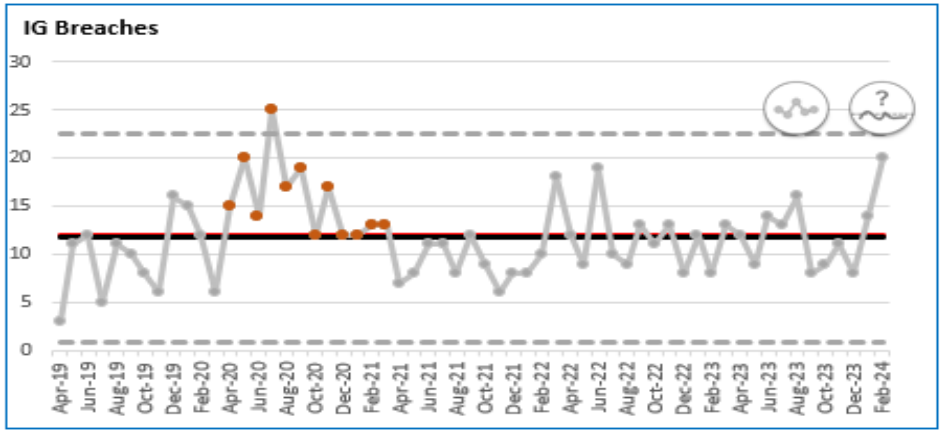
Registered night rate	Dec-23	Jan-24	Feb-24
Adults and Older People	104%	113%	108%
Barnsley Integrated Services	82%	90%	80%
Forensic and LD	113%	116%	114%
Overall shift fill rate	**106%**	**113%**	**109%**

- Bank staff filled 62.61% (increased by 2.29% on the previous month) of RN requests for flexible staffing and 86.22% (increased by 4.05% on the previous month) of healthcare assistant requests.
- Agency staff filled 13.29% (a decrease of 4.69% on the previous month) of RN requests for flexible staffing and 10.33% (a decrease of 3.56% on the previous month) of healthcare assistant requests.
- Health care assistants showed a decrease in the day fill rate for February of 2.6% to 152.4% and the night fill rate decreased by 4.95% to 150.35%.

Information Governance (IG)

There were 20 information governance personal data breaches during February which is the highest so far during the current financial year. All were caused by human error, twelve incidents related to the Mental Health care group and the data protection officer is undertaking a specific piece of improvement work. An urgent communications campaign is in progress, and items will be issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team will work with them to ensure improvements are made. As yet we can't directly link the incidents to the reduction in training compliance, which is within our normal seasonal variation.

This SPC chart shows that as at February 2024 we remain in a period of common cause variation, though we are above the threshold with 20 data breaches.



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

- Failure to bcc parties on email so addresses are shared widely,
- Letters sent to the wrong address due to incorrect recording or erroneously addressing letters/ envelopes,
- Other individuals' data included in envelopes,
- Emails/ texts sent to wrong recipients.
- Data shared with party who service user had not given consent for,
- Staff member sharing information about a service user with another service user.

Other incidents were reported for the following reasons:

- Information added to incorrect record and later used to generate a letter to a school,
- Paperwork left in a public area.

Appropriate remedial action and, where applicable, duty of candour have been undertaken in respect of all reported breaches. No complaints have been received in respect of these to date. No incidents were reported to the Information Commissioner's Office (ICO) and the Trust has not been informed of any complaints to the ICO.

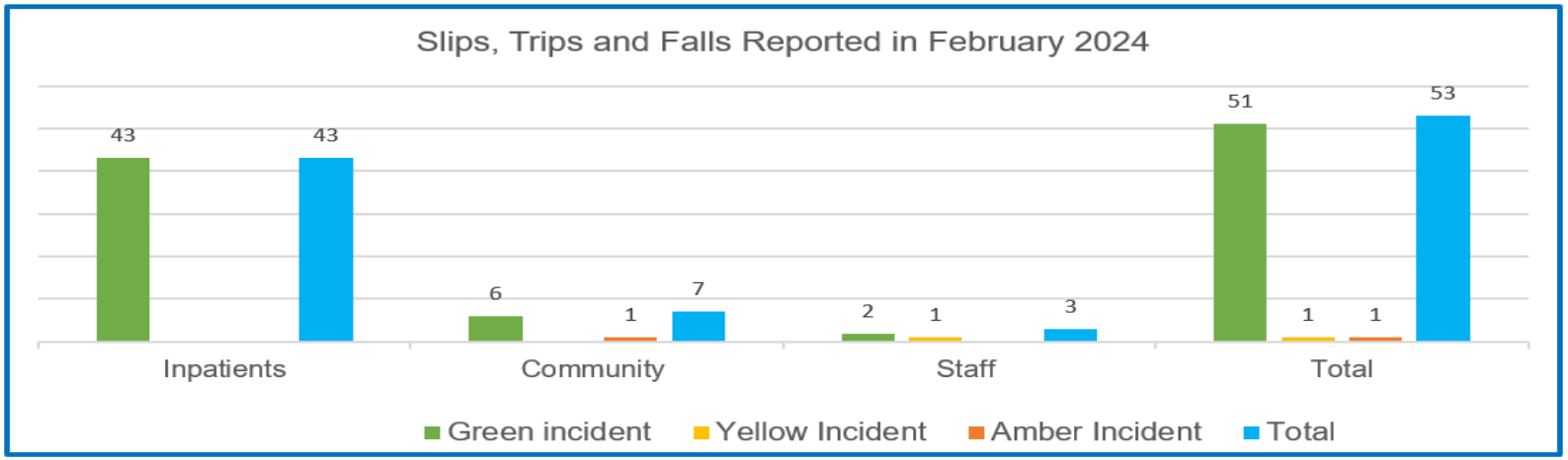
Commissioning for Quality and Innovation (CQUIN)

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. The quarter 3 submission was undertaken at the end of February 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 February 2024 there were 53 Datix reported slips, trips and falls. Below is a breakdown of falls and where they occurred in the community, inpatients, or staff group.
• The current rate of falls is 3.74 per 1000 bed days. We remain within the National average of 3 - 5 falls per 1000 bed days.

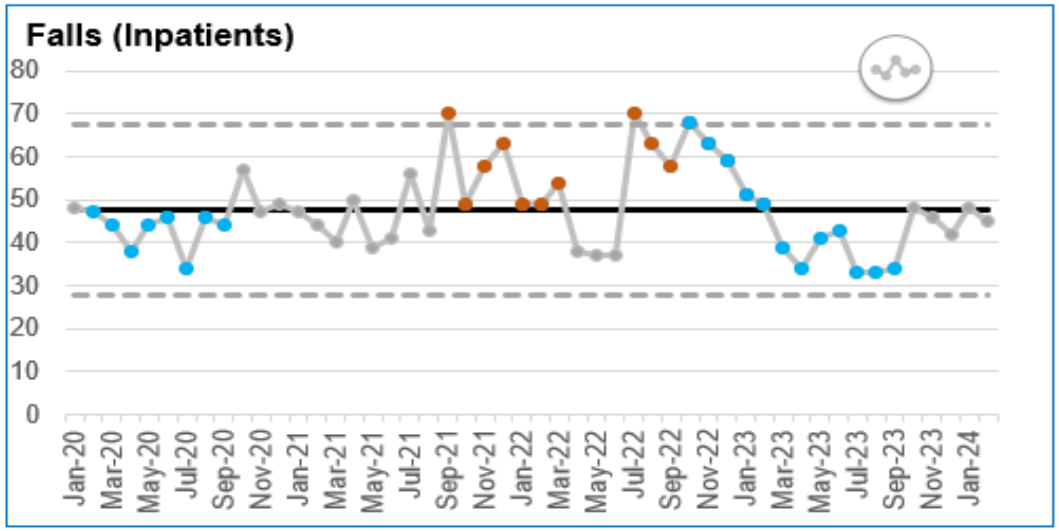


Incident Grading
Amber: 1 (2%) reported incident, patient had a fall at home
Yellow: 1 (2%) reported incident, for a member of staff
Green: 51 (96%) reported incidents had low or no harm recorded

Falls by location
• 25 falls (54%) have been reported within bedroom areas, this remains consistent with previous months. A 'Focus on Falls' staff education newsletter has been produced highlighting bedroom falls and recommendations for falls reduction.
• A meeting is being arranged with key inpatient staff to review, and benchmark interventions and quality improvement activity.

Falls (Inpatient)

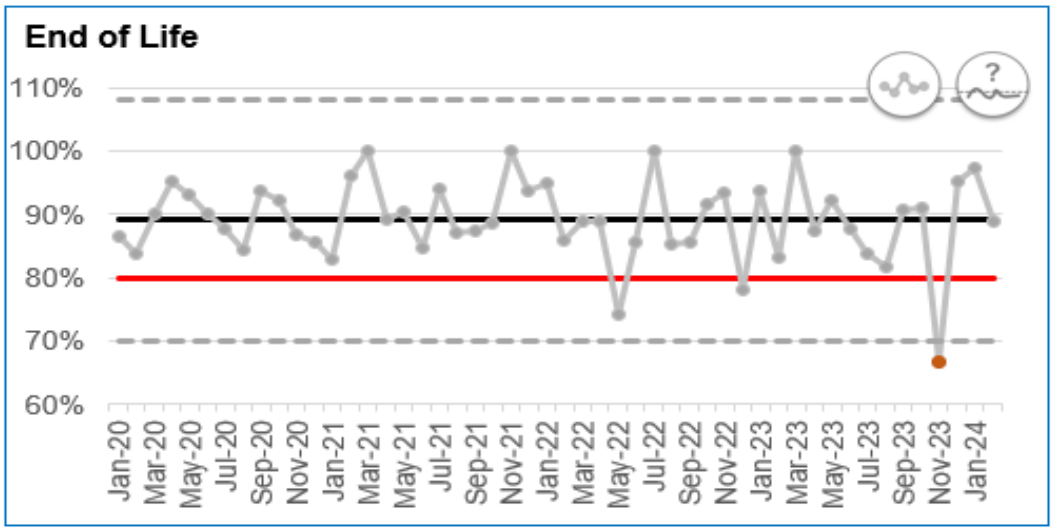
• The total number of inpatient falls was 45 in February.
• 15 inpatient falls occurred for people under the age of 65 years, there has been 2 younger people having repeated falls.
• 28 inpatient falls occurred for older adults.



The SPC chart above shows that in February 2024 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 88.9% in February. As is noted in the Quality Headlines Dashboard, performance against this metric remains increased above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in February 2024 the performance against this metric remains in 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 (FFT) shows

- 97% would recommend community services
- 92% would recommend mental health services

	Target	December	January	February
Mental health community	85%	96%	90%	94%
Mental health inpatient	85%	97%	87%	89%
Learning Disabilities	85%	100%	100%	100%
ASD/ ADHD	85%	67%	60%	67%
CAMHS	75%	89%	90%	86%
Forensic	60%	75%	100%	67%
Mental health overall	84%*	**94%**	**89%**	**92%**
Barnsley Gen ops	95%	**98%**	**97%**	**97%**
Trustwide	**85%**	**96%**	**93%**	**94%**

** weighted for 2023/24*

- Satisfaction across all service lines has increased except for Child and Adolescent Mental Health Services (CAMHS) and Forensics, but they remain above target.
- Satisfaction in Barnsley physical health (Barnsley Gen ops) has remined the same.
- 48/72 FFT responses received for mental health inpatients were completed as part of the larger patient experience survey.
- The backlog of FFT cards will be completed by the end of March

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

Safeguarding

Safeguarding Adults:
In February 2024, there were 43 Datix categorised as safeguarding adults. Nineteen of these were graded as green, 21 were graded as yellow, three were amber and there were no red Datix. The most common subcategories were neglect concerns, emotional/psychological abuse, self neglect and physical abuse.

In addition to the Safeguarding Adults Datix, there were 18 regarding sexual safety of which there were two graded amber, 11 graded green and five graded yellow. The amber incidents involved a fact find where there was no evidence to suggest that the allegation was substantiated. The second amber incident was in relation to a community incident (not related to care and treatment the individual was receiving). In all cases reviewed appropriate actions were taken, including Police, local authority safeguarding referrals and support from specialist services where required.

Safeguarding Children:
In February 2024 there were 12 Datix categorised as safeguarding children; seven of these were graded as low risk, four were graded as moderate risk and one was graded as high risk. The most common subcategory of these Datix was physical abuse. In all of the Datix submitted, SWYPFT safeguarding advice was sought as appropriate.

The Datix that was categorised as high risk was submitted by a practitioner working with an adult service. The police and children social care were informed, and appropriate safety plan was put in place.

Complaints

- Acknowledgement and receipt of the complaint within three working days – 7/7 (100% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 10/16 (63%)
- Number of complaints waiting to be allocated to a customer service officer – 4 (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 – 21/02/2024
- There were 7 new formal complaints in February 2024
- 8 compliments were received.
- 16 formal complaints were closed in February 2024.
- Number of concerns (informal issues) raised and closed in February 2024 – 43
- Number of enquiries responded to in February 2024 - 73
- Number of complaints referred to the Parliamentary Health Service Ombudsman and upheld this financial year to date and how many upheld = 2

Infection Prevention Control (IPC)

Mandatory training: figures for Hand hygiene and, Infection, prevention and control remain healthy and above Trust 80% threshold.

Outbreaks
- One Covid-19 outbreak on inpatient ward
- Three inpatient areas monitored for increase in prevalence of Covid-19
- One diarrhoea and vomiting, no causative organism outbreak on inpatient ward
- One inpatient area monitored for increase in patients with gastroenteritis 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.

Two patients have died within 28 days of a positive Covid-19 result in January 2024. Both patients were part of the outbreak on ward 19 in December 2023, each case has been reviewed and deaths not linked to Covid-19.

There has been a national increase in respiratory viruses.

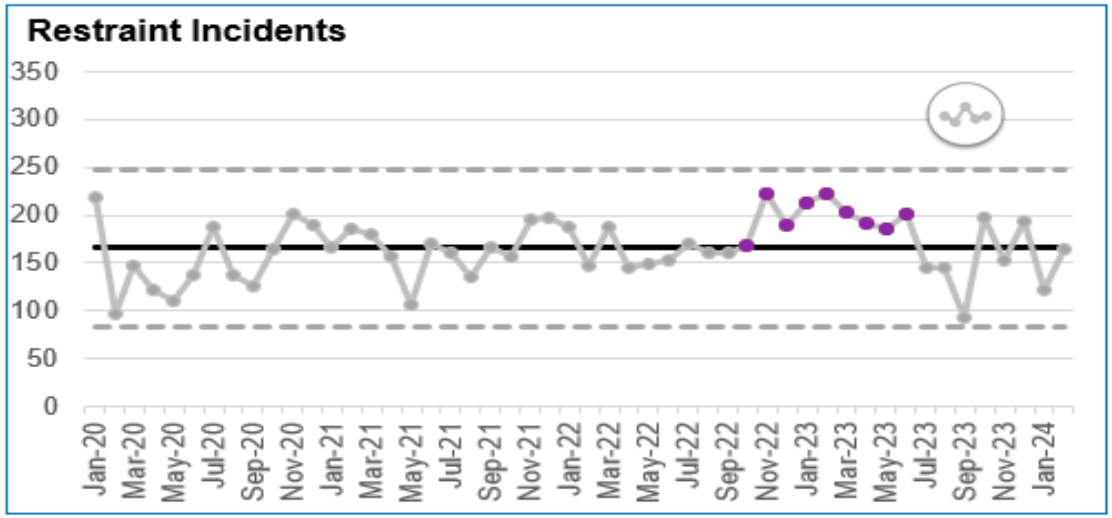
Reducing Restrictive Physical Intervention (RRPI)

• There was an increase in the number of physical restraints in February 2024 from the previous month. However this remains under the mean average of 180 incidents. The increases were seen across four wards due to due to increase in acuity in presentation of service users. Despite the increase in physical restraint, data reflects that when proactive and preventative interventions have not been successful least restrictive restraint positions and holds were most used.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	92	36.5%
Seated	57	22.6%
Safety Pod	33	13.1%
Supine - held on their back, regardless of surface	26	10.3%
Restricted escort	11	4.4%
Side	11	4.4%
Prone descent then immediately rolled to other position side/back	11	4.4%
Prone descent then remained in chest down position	6	2.4%
Kneeling	5	2.0%

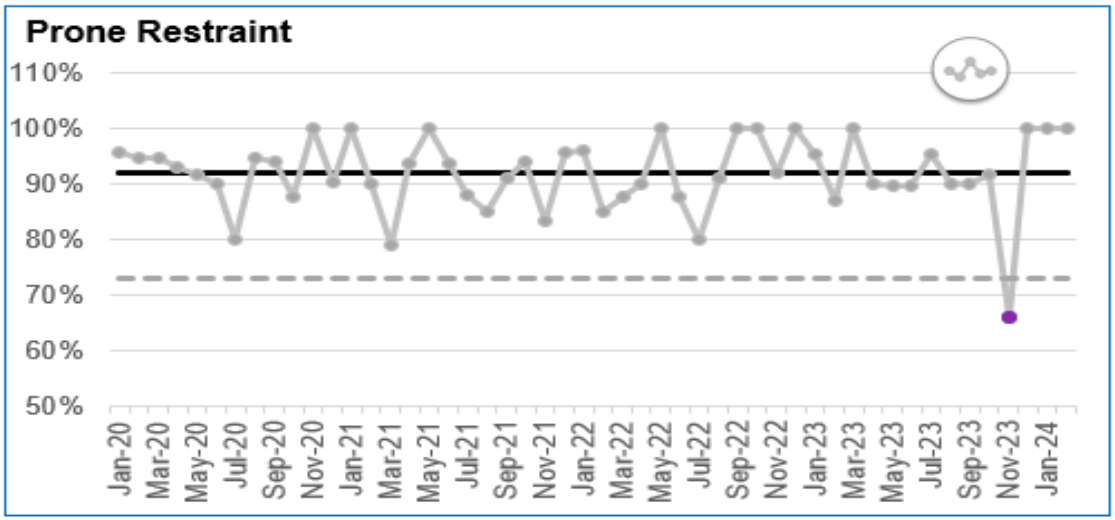
Team Using Prone Restraint February 2024	Total
Appleton, Newton Lodge, Forensic	2
Stanley Ward, Wakefield	2
Walton PICU	1
Clarke, Barnsley	1
Elmdale Ward	1
Nostell Ward	1
136 Unity Centre	1

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in February 2024 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.



The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. Use of prone restraint continues to be below the year average of 21, and from now on all incidents of prone restraint will be reviewed for learning in the Patient Safety Oversight Group.

People - Performance Wall

Trust Performance Wall

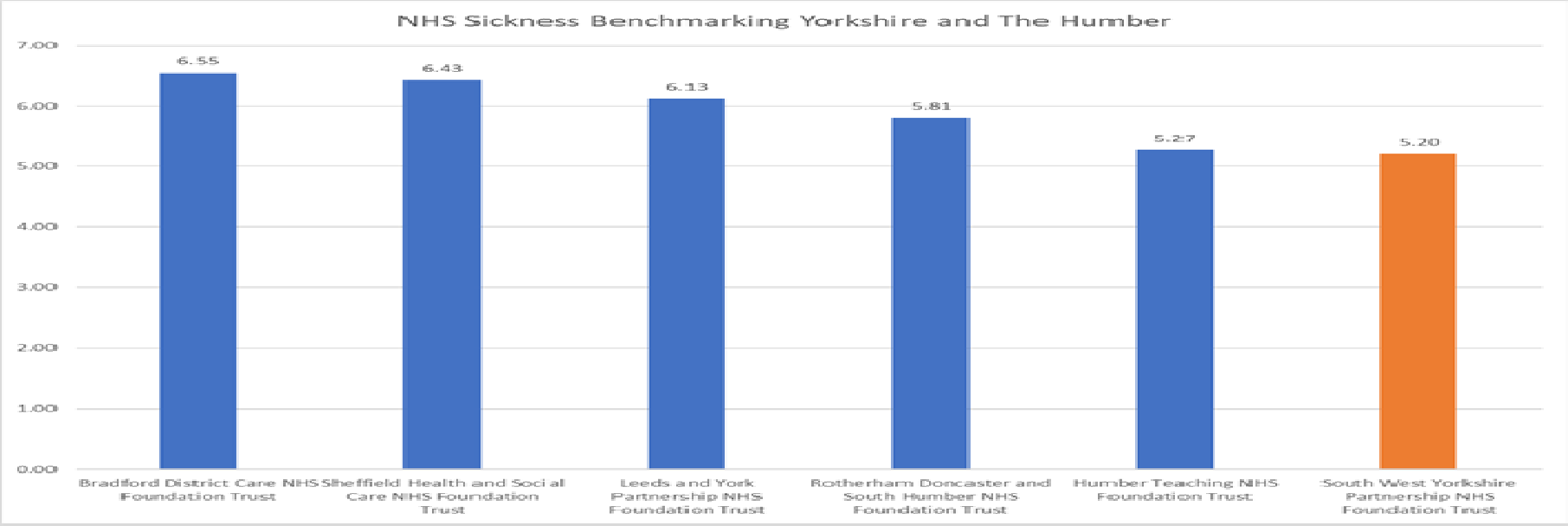
	Objective	CQC Domain	Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Establishment	Improving Resources	Well Led	-	5,157.4	5,174.0	5,193.8	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4	5412.1	5415.1
Contracted Staff In Post (Ledger)			-	4,338.5	4,352.0	4,375.4	4,400.5	4,432.7	4453.2	4425.9	4442.5	4471.3	4535.6	4574.5
Vacancies			-	818.9	822.0	818.4	796.1	772.1	867.8	897.4	887.0	870.1	876.6	840.6
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%	11.6%	11.2%
Starters			-	45.8	54.9	57.5	53.9	64.0	63.3	69.4	61.6	42.8	91.4	49.8
Leavers			-	39.4	36.5	41.1	51.3	45.2	35.2	51.8	31.9	27.6	30.3	32.8
International Nurse Starters in Month			-	0	0	0	0	9	10	10	10	5	5	0
% Bank Fill Rates - Registered Nurses			-	Reporting commenced August 23				47.8%	49.6%	52.0%	59.1%	52.3%	60.3%	62.6%
% Bank Fill Rates - Health Care Assistants			-					69.8%	70.2%	75.9%	80.3%	80.8%	82.2%	86.2%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)								90.9%	90.3%	90.6%	93.4%	91.6%	92.2%	92.2%
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%)	217 - All staff (15.9%) 89 - excl medics (7.6%)	220 - All staff (16.2%) 92 - excl medics (7.9%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-					931 (69.8%)	942 (69.3%)	962 (69.5%)	963 (69.7%)	946 (69.8%)	947 (69.8%)	952 (69.9%)
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%	5.1%	5.0%
Sickness absence - Month			<=4.8%	5.0%	4.6%	4.6%	5.1%	4.7%	4.9%	5.2%	4.9%	5.1%	5.1%	4.8%
Employees with long term sickness over 12 months			-	1	0	0	0	0	2	2	0	1	1	0
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%	79.6%	82.9%
Employee Relations - Suspensions (over 90 days)			-	0	0	0	3	3	3	4	2	2	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%	91.9%	91.8%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	76.7%	76.2%	82.6%	82.8%	82.9%	85.0%	81.8%	77.0%	74.0%
Mandatory Training - Cardiopulmonary Resuscitation				75.5%	79.2%	81.3%	81.0%	79.9%	80.0%	79.7%	78.5%	77.0%	77.5%	76.1%
Mandatory Training - Clinical Risk				95.6%	95.4%	95.4%	95.2%	94.8%	94.0%	92.6%	91.3%	91.0%	90.6%	91.8%
Mandatory Training - Display Screen Equipment				96.5%	96.8%	97.0%	97.1%	97.4%	97.4%	97.4%	97.1%	97.0%	95.2%	96.1%
Mandatory Training - Equality & Diversity				96.0%	96.2%	96.2%	96.0%	95.9%	96.1%	95.4%	94.9%	94.9%	95.1%	95.3%
Mandatory Training - Fire Safety				90.2%	91.2%	92.8%	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%	90.5%	89.6%
Mandatory Training - Food Safety				78.0%	83.4%	86.4%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%	90.0%	90.4%
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%	95.2%	95.2%
Mandatory Training - Infection Control & Hand Hygiene				91.5%	92.4%	94.1%	94.3%	94.3%	95.6%	94.2%	93.6%	93.1%	93.7%	93.7%
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%	92.7%	91.8%
Mandatory Training - Moving & Handling			>=80%	95.5%	94.9%	95.2%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%	97.3%	97.5%
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%	93.5%	93.6%
Mandatory Training - Mental Capacity Act/Dols				91.6%	93.6%	93.7%	93.4%	94.0%	96.7%	99.6%	99.2%	99.0%	99.1%	99.2%
Mandatory Training - Mental Health Act				91.6%	91.3%	91.2%	91.1%	92.2%	99.8%	91.2%	90.5%	90.2%	90.7%	89.6%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism			10%	Reporting commenced February 2024										66.6%
Mandatory Training - Prevent			>=80%	95.4%	95.5%	92.1%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%	92.9%	91.9%
Mandatory Training - Safeguarding Adults				90.0%	89.7%	89.3%	89.5%	89.7%	93.9%	90.7%	89.6%	89.4%	88.4%	88.3%
Mandatory Training - Safeguarding Children				90.0%	90.7%	91.1%	91.2%	91.7%	89.7%	95.1%	94.4%	94.0%	92.9%	93.6%

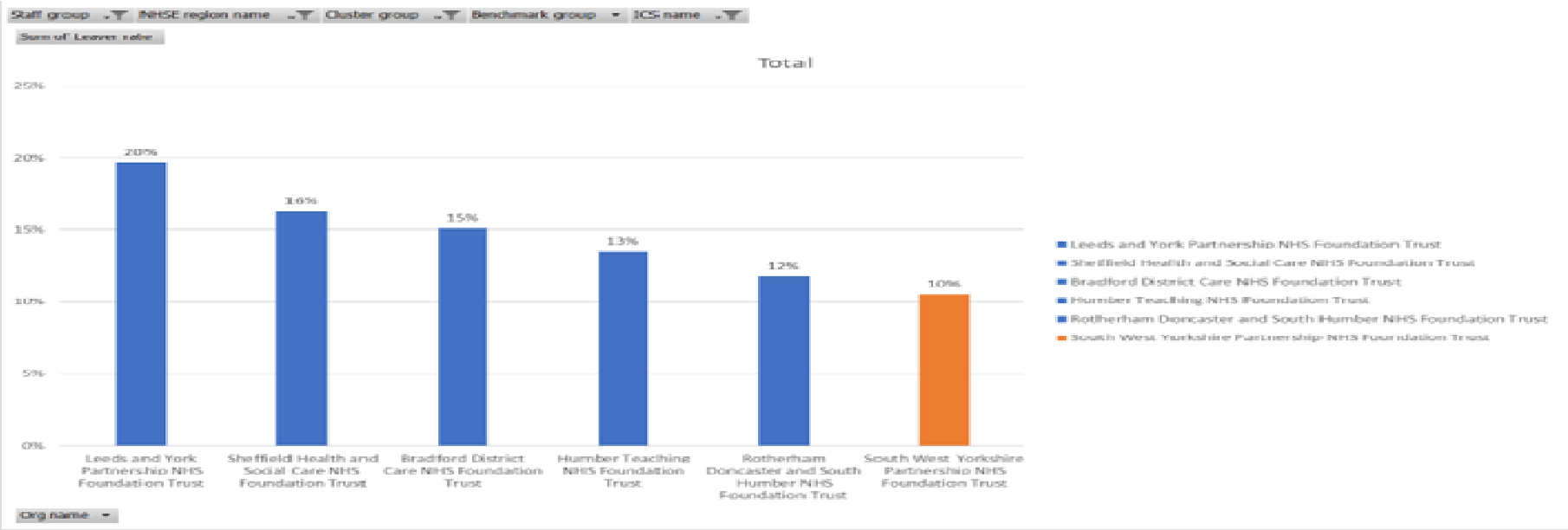
Notes:

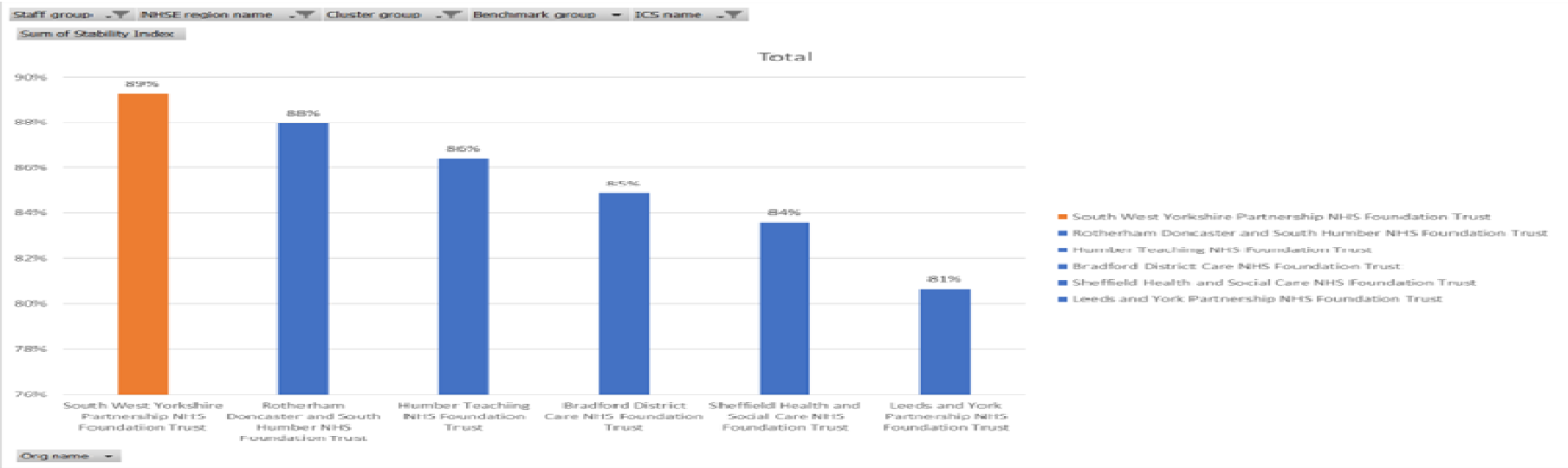
- Contracted Staff In Post (Ledger) - this has replaced the previously reported Staff in Post (ESR Last Day of the month)
- The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not 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.

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.
• The staff in post has increased again this month. Although the number of people joining the Trust has dropped this month (49.8 WTE) this still outnumbered leavers (32.8 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 654.4 new starters and 423.0 leavers.
• As of February 24, our Trust growth rate has grown further to 7.0% (staff in post). This is already exceeding our initial annual forecasted growth rate of 4%.
• Overall, our 12 month turnover rate in January has dropped slightly again this month to 11.2% which is a reflection of the low number of leavers and increase in new starters.
• In February 24 our stability has reached 90.1%. This is a great achievement as it shows our staff are keen to stay within SWYFT. This is the first time the stability rate has been above 90%.
• For the fourth consecutive month we have seen a steady decrease in our vacancies taking us to a vacancy rate of 15.5% (in October 23 this was 16.9%).
• We have recruited a total of 86 International Nurses since April 23. Cohorts in December and January have been reduced (5 per month) and future international nurse recruitment cohort delivery in February and March has been paused.
• 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%
85%
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

• Sickness absence year to date in February has now reduced to 5.0% which is above local threshold. However this is the lowest sickness rate since April '23.

• The Estates and Facilities sickness rate continues to rise, which is now at 8.6%. This staff group have seen a consistent monthly rise since April (Apr 6.15%). Further work is being done with our Business partners to help support Estates and Facilities, along with an internal audit.

• 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).

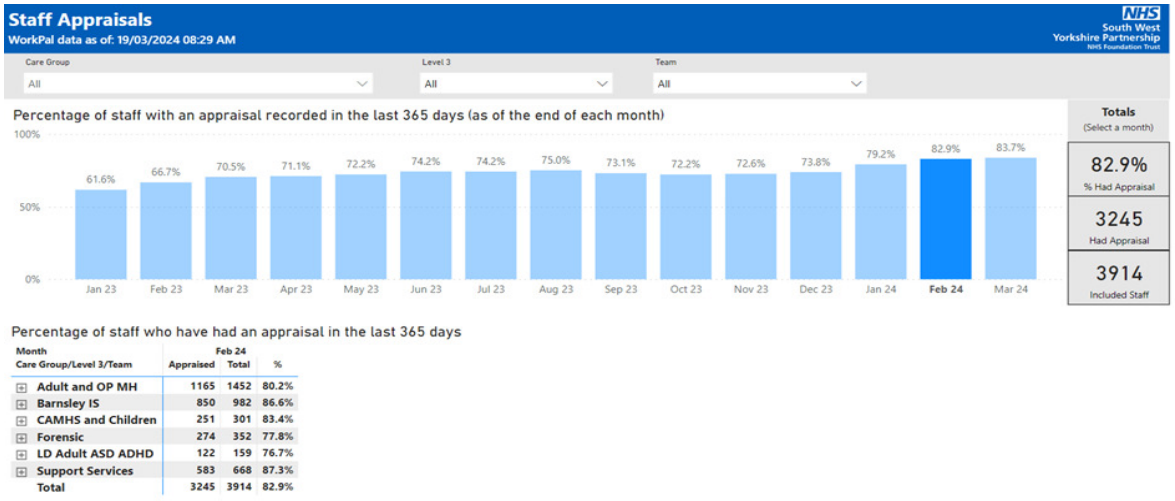
Supportive Teams

Appraisals

• The new online reporting system for appraisals has been very positive and has reflected in the appraisal compliance.

• Although there were some queries regarding data quality this month, assurance has been given at operational management group, with a full explanation of how the data is populated into the report. This was well received and has allowed the operational team to have confidence in the information available.

• We have increased our rolling appraisal compliance rate again in February 24, which saw an increase, from 79.6% to 82.9%. This is the first month the compliance of 80% has been reached.



Training

• Although our overall mandatory training compliance remains static since last month at 91.8% we have seen a drop in some areas.

• Reducing restrictive physical interventions (RRPI) has dropped again this month to 74.0% however our learning and development team and RRPI team are working together to maximise the training places available for RRPI training and are taking a targeted approach to booking staff onto refresher training. Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning

• Information Governance (IG) training compliance has also dropped from 92.7% to 91.8%. This is the fourth consecutive month where IG has been below target. Although cardio pulmonary resuscitation continues to be below target, this has increased since last month to 76.1%.

• A new indicator has been included this month for performance against the Oliver McGowan Mandatory Training on Learning Disability and Autism. This is a legal requirement for training on learning disability and autism for CQC regulated service providers, which came into effect from 1 July 2022. The Trust has been following a phased approach in line with the national plan. The Oliver McGowan training was available via e-learning from August 2022 and was attached to all staff as mandatory training requirement from December 2023 and appears in all staffs mandatory training compliance reports. Trust performance against the e-learning module is exceeding the national 10% threshold as at the end of February. Plans are in place to continue the roll out as it becomes available.

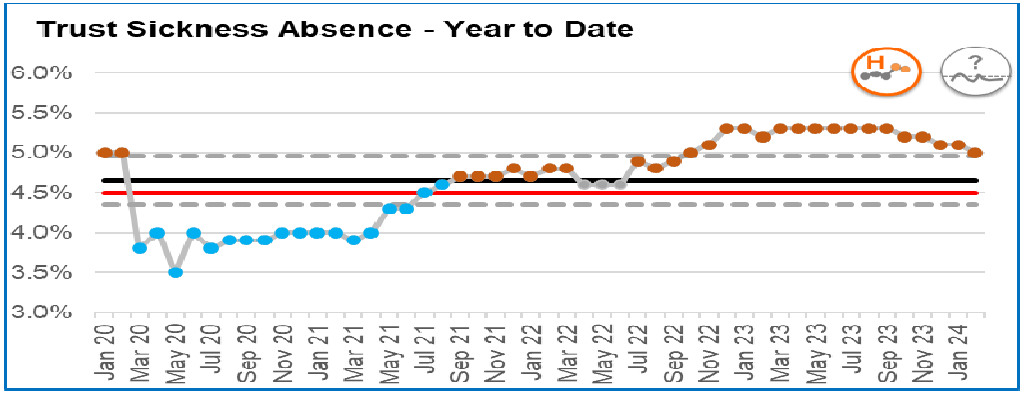
Staff Survey

• The total response rate for the 2023 NHS staff survey is 51%. This is a 1% increase from last year.

• The Trust has improved in many areas this year. Some examples of these are below:
  • 70% of our employees think the Trust is a great place to work in 2023. This is a 5% improvement from last year (65%)
  • We have also seen a decrease in the amount of bullying and harassment within the Trust. This has dropped to 6% (last year 7%)
  • Our staff feel safer in their workplace with a reduction in violence and aggression. This is now at 13% (Last year 15%)

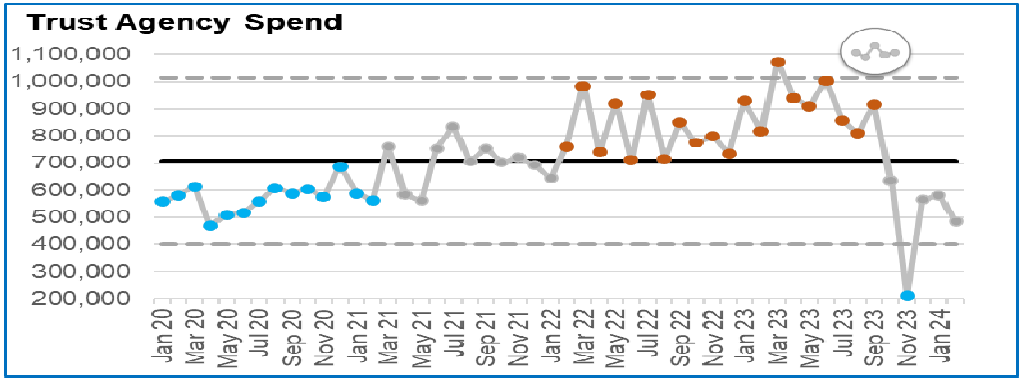
• Further analysis is currently underway between the People Experience team and the People Performance team to further examine the output of the staff survey results, it is also in the plan to share this with operational teams to see where improvements can be made or achievements can be celebrated and learnings can be applied.

Statistical process control charts



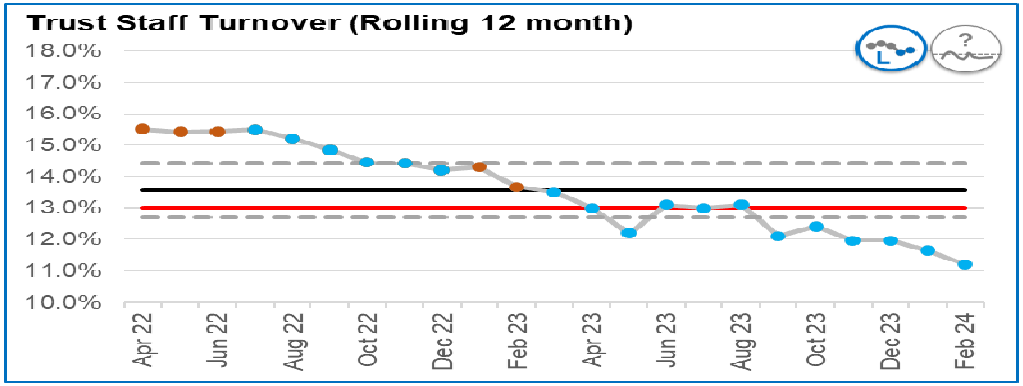
The SPC chart shows that in February 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

From July 2022 this data also includes absence due to Covid-19.



The SPC chart shows that in February 2024, as anticipated after the VAT savings incorporated in November 2023, we remain a period of common cause variation (no concern).

Please see finance appendix for further detail on agency spend.



The SPC chart shows that in February 2024, we remain 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.

National Metrics

Data as of : 22/03/2024 13:06:06

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.

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
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	480	434	545	435	589	400	187	66	75	85	104	74
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		74.4%	87.1%	87.8%	88.6%	90.3%	93.1%	70%	81.8%	83.8%	83.3%	81.1%	87.0%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		53.8%	52.5%	53.4%	53.2%	50.4%	51.5%	51.6%	52.7%	51.6%	54.6%	50.3%	53.9%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	97.5%	97.9%	99.0%	99.6%	99.0%	99.5%	99.9%	100%	100%	99.7%	99.8%	99.9%
M6	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	79.8%	59.7%	53.6%	83.1%	67.1%	64.4%	74.9%	74.2%	63.0%	64.4%	56.0%	69.0%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		87.2%	92.5%	90.6%	92.6%	87.7%	90.7%	88.6%	90.8%	89.0%	91.2%	88.7%	91%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		43	15	11	29	9	18	8	2	9	23	30	28
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		2	3	1	1	1	2	2	1	1	1	1	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	98.1%	97.8%	98.6%	99.4%	99.2%	98.3%	98.3%	99.0%	98.8%	98.6%	98.8%	98.7%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.8%	99.8%	99.8%	100%	99.8%	99.8%	100%	99.9%	99.8%	99.8%	100%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		87.5%	50%	80%	100%	70%	66.7%	100%	100%	100%	75%	100%	66.7%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	95.8%	77.8%	95.8%	100%	92%	91.3%	96.6%	91.7%	93.5%	88.6%	97.1%	97.1%
M15	Data Quality Maturity Index		95%	P	H	98.2%	99.4%	99.2%	99.5%	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%	99.5%	99.4%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1532	1306	1603	1578	1470	1403	1477	1745	1713	1315	1621	1416
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		98.9%	98.9%	98.4%	99.0%	99.2%	99.7%	99.0%	99.1%	99.4%	99.2%	99.7%	99.4%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	31	23	33	26	37	38	34	35	38	25	48	50
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					81	51	67	53	64	61	70	68	45	38	82	61
M30	Number of detentions under the Mental Health Act (MHA)					86	93	101	93	101	100	97	97	86	98	92	81
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority					20.9%	20.4%	17.8%	12.9%	24.8%	19%	23.7%	23.7%	19.8%	18.4%	18.5%	19.8%

National Metrics

Data as of : 22/03/2024 13:06:06

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%	?		98.0%	97.7%	97.7%	98.0%	98.5%	98.5%	97.2%	97.8%	98.2%	97.7%	97.7%	97.0%
M34	% Clients in settled accommodation	⚠	60%	P	L	84.6%	84.2%	84%	84.3%	83.8%	84.3%	84.3%	84.8%	85%	84.5%	84.6%	84.2%
M35	% Clients in employment	⚠	10%	P	H	11.2%	11.2%	11.5%	11.7%	12.0%	12.3%	12.6%	12.2%	12.3%	12.6%	13.2%	13.0%
M41	Completion of a valid NHS number		99%	P	L	100%	100%	100.0%	100.0 %	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%	P	L	99.4%	99.4%	99.5%	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%	99.4%	99.4%	96.9%
M43	Community health services two hour urgent response standard		70%	P		83.7%	87.3%	86.6%	86.1%	88.0%	89.5%	88.6%	88.1%	87.4%	85.3%	86.3%	87.8%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500				1523	1719	2335	1509	1667	1656	1726	1844	1303	1700	1559
M45	The number of incomplete Referral to Treatment (RTT) pathways		2100														2216
			2200													2285	
			2300										2009	2289	2019		
			2400							1782	1982	2168					
			2500				1933	1835	1592								
M46	Count of 2-hour urgent community response first care contacts delivered				↗	761	826	953	910	935	1019	1003	929	862	929	1102	1005
M47	Virtual ward occupancy		80%				82.9%	44.3%	92.9%	51.4%	57.1%	60%	57.5%	78.8%	64.3%	81.4%	95.7%
M48	Community services waiting list		5198													4767	5068
			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						3943	3957	3956	3947	3931	3911	3907	3901	3876	3859	3842
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact						10990	11130	11133	11152	10968	11070	11169	11235	11059	11140	11070
M171	% Admissions gate kept by crisis resolution teams		95%	P		98.2%	100%	99%	100%	96.6%	100%	99.1%	100%	97.9%	100%	98.1%	98.8%

National Metrics

Data as of : 22/03/2024 13:06:06

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 99.9%

• 72 hour follow up remains above the threshold at 91%.

• The percentage of service users waiting for a diagnostic appointment for less than 6 weeks in the paediatric audiology service remains below threshold at 69% in February however this has improved from 56.5% in January. 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 4.2 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 February to 66.7% though low number do impact these figures. The routine access to treatment measure has dipped under the 95% threshold at 91.9%. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

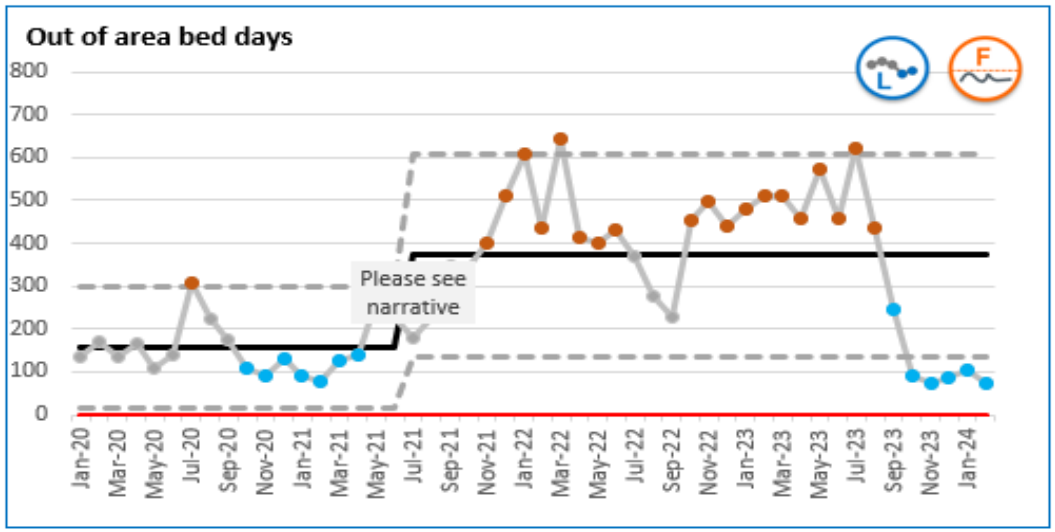
• During February, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 28 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews.

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

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

• NHS Talking Therapies - proportion of people completing treatment who move to recovery remains above the 50% target at 53.9% for February. 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 February. 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 there has been a marginal decrease in the number of inappropriate out of area bed days in February 2024 and 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.

The process limits were recalculated in June 2021 due to a conscious increase in out of area bed usage which in turn was due to staffing pressures across the wards, increased acuity, Covid-19 outbreaks and challenges to discharging people in a timely way.

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.

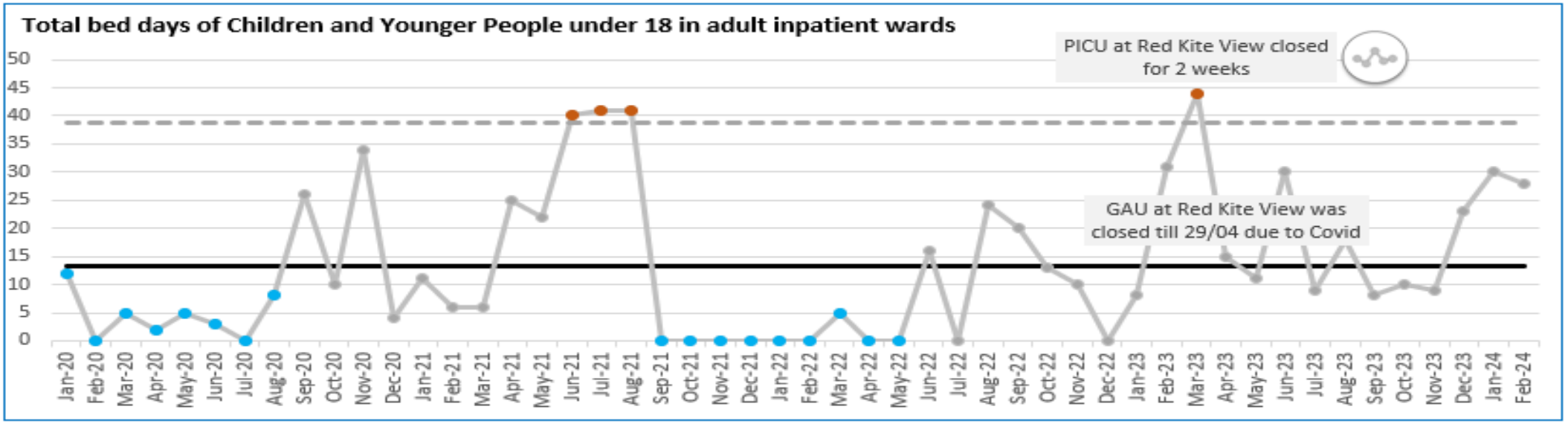
Summary	Actions	Assurance
The Trust remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people 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 metrics 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 February the following data quality issue has been identified in the reporting:

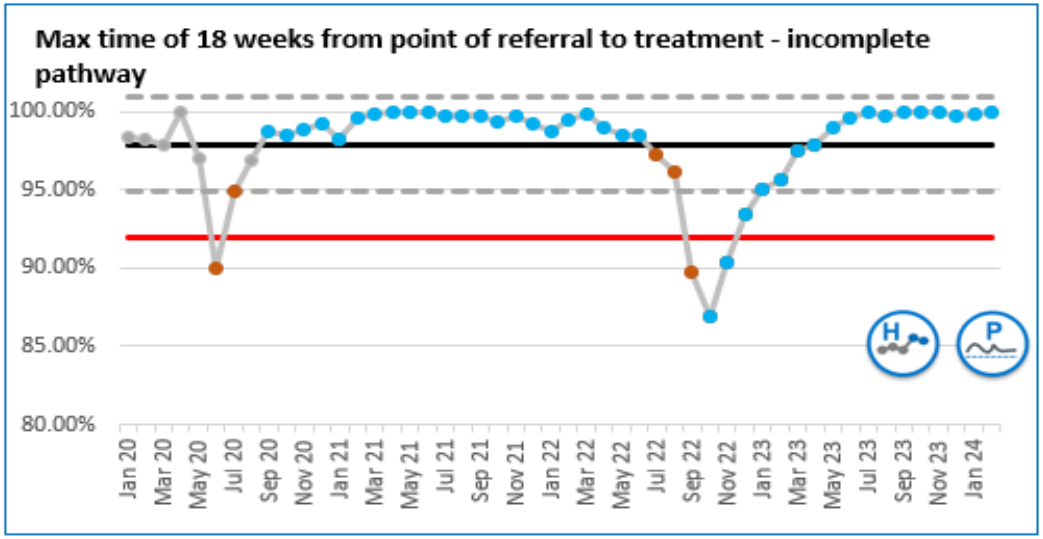
- The reporting for employment and accommodation shows 17.5% of records have missing employment and/or accommodation status with a further 1.1% that have an unknown employment status and 1.0% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

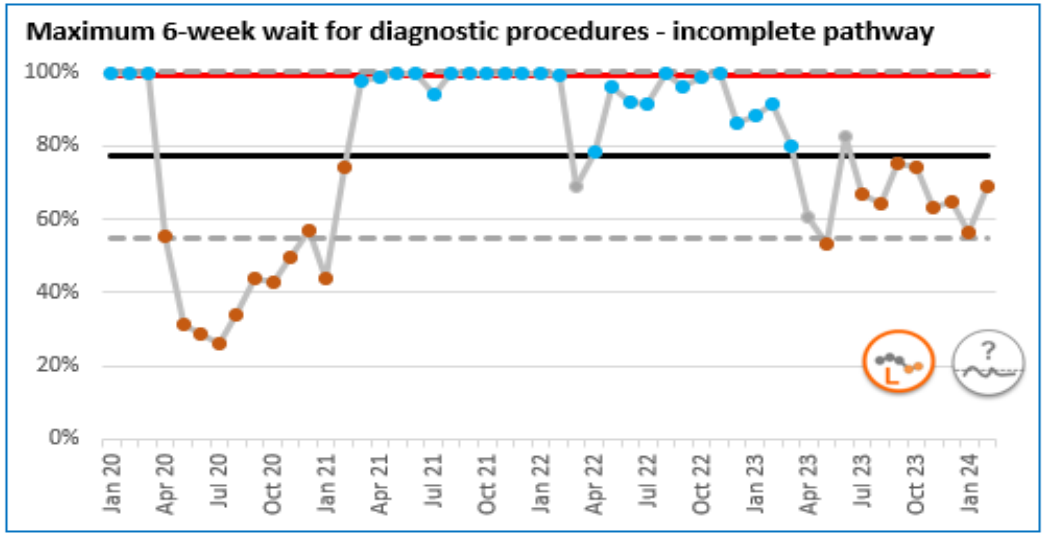
Analysis



The statistical process control chart (SPC) above shows that in February 2024 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

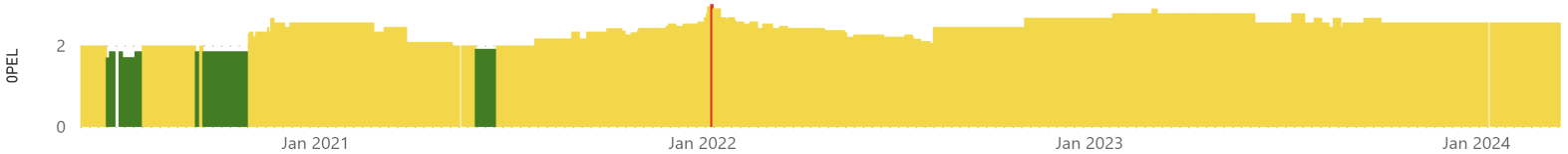




The SPC charts above show that in February 2024 we remain in a period of special cause improving variation (something is happening and this should be investigated) for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. As we have seen a continued and sustained achievement of the target and indeed over 10 months over the mean, a recalculation of the process limits should be considered. 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

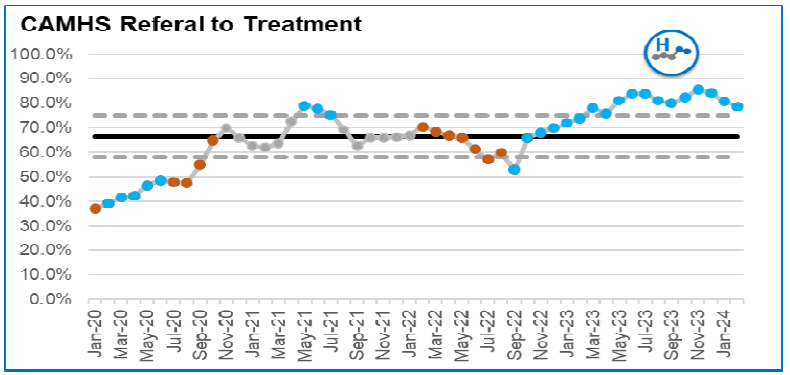
Key
Level 1
Level 2
Level 3
Level 4

Child and adolescent mental health services (CAMHS)

Headlines
Neurodevelopment waits remain a concern particularly in Kirklees particularly as the additional capacity ends in March 2024.
Access to specialist provision for inpatient care is challenging. This has been escalated within the provider collaborative

CAMHS

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	76.7%	84.1%	84.6%	
% Complaints with staff attitude as an issue	< 20%	0% 0/1	0% 0/4	0% 0/1	
% of staff receiving supervision within policy guidance	80%	76.6%	74.3%	73.6%	
CAMHS - Crisis Response 4 hours	N/A	100.0%	98.3%	95.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	74.0%	75.2%	
Eating Disorder - Routine clock stops	95%	88.2%	97.1%	97.3%	
Eating Disorder - Urgent/Emergency clock stops	95%	75.0%	100.0%	66.7%	
Information Governance training compliance	>=95%	93.2%	92.6%	92.6%	
Reducing restrictive physical interventions training compliance	>=80%	67.5%	68.6%	70.6%	
Sickness rate (Monthly)	4.5%	3.6%	4.5%	4.0%	
% rosters locked down in 6 weeks					



As you can see in February 2024, we remain in a period of special cause improving variation (something is happening and this should be investigated).

Alert/Action

• Waiting time and 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. Action underway to ensure all children seen outside of the service are removed from the waiting list. Pathway changes have been implemented locally to maximise capacity and consideration of further actions continues.
• Access to specialist provision for inpatient care is limited due to bed closures locally and bed pressures nationally. Local escalation meetings are in place and executive trio to trio escalation meetings have been put in place.

Advise

• The risk that related to the core children's pathways in Kirklees has been mitigated with support from the healthcare commissioner. This is now being managed through the usual contracting routes.
Appraisals are being prioritised in each team, a plan is in place to ensure we reach the expected threshold.
• Waiting times continue to be closely monitored and the teams are developing the 'while you wait' supports on offer.
• There is a plan in place to increase the training compliance for reducing restrictive practice interventions, cardiopulmonary resuscitation and Information governance. Availability of courses can impact on uptake – however the management team recognise the need for proactive bookings.

Assure

• Staff wellbeing remains a focus. Localised wellbeing plans are in place and sessions are being held to address wellbeing issues in live time to positively impact on wellbeing overall.
• Offers of support to parents are siblings are being explored through group work – feedback from this will shape the longer term offer.
• Recent recruitment has been positive and new starters are bringing skills and experience to the teams.

Adults and Older People Mental Health

Headlines

Out of area usage decreased slightly in February and there has been a decrease in the number of people who are clinically ready for discharge although there remains some hotspot areas across adults and older peoples wards and the detail of this can be seen in the ward level detail in the next section of the report. 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	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	74.1%	77.2%	79.9%	
% Assessed within 14 days of referral (Routine)	75%	85.1%	80.5%	81.8%	
% Assessed within 4 hours (Crisis)	90%	90.4%	93.4%	99.0%	
% Complaints with staff attitude as an issue	< 20%	37.5% (3/8)	9% (1/11)	0% 0/2	
% of staff receiving supervision within policy guidance	80%	69.3%	67.6%	61.5%	
% service users followed up within 72 hours of discharge from inpatient care	80%	91.2%	87.3%	91.0%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.5%	97.1%	96.8%	
% Treated within 6 weeks of assessment (routine)	70%	98.9%	96.3%	97.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.0%	77.9%	77.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	71.3%	73.5%	74.7%	
Information Governance training compliance	>=95%	93.7%	91.2%	91.1%	
Reducing restrictive physical interventions training compliance	>=80%	66.1%	70.1%	72.8%	
Sickness rate (Monthly)	4.5%	4.6%	5.0%	5.0%	
% rosters locked down in 6 weeks					

Mental Health Inpatient

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	56.7%	77.7%	89.0%	
% bed occupancy	85%	82.9%	87.1%	87.8%	
% Complaints with staff attitude as an issue	< 20%	17% (1/6)	33% (1/3)	0% 0/2	
% of staff receiving supervision within policy guidance	80%	91.2%	89.8%	90.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.6%	78.9%	76.3%	
% of clients clinically ready for discharge	3.5%	7.6%	5.6%	3.6%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	94.1%	93.4%	90.1%	
Inappropriate Out of Area Bed days	92	85	104	74	
Information Governance training compliance	>=95%	93.0%	89.6%	91.0%	
Physical Violence (Patient on Patient)	Trend Monitor	12	18	22	
Physical Violence (Patient on Staff)	Trend Monitor	52	55	62	
Reducing restrictive physical interventions training compliance	>=80%	82.3%	77.9%	78.3%	
Restraint incidents	Trend Monitor	85	65	***75***	
Safer staffing (Overall)	90%	136.1%	135.7%	135.5%	
Safer staffing (Registered)	80%	92.3%	97.3%	97.1%	
Sickness rate (Monthly)	4.5%	6.3%	6.2%	6.4%	
% 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, Intensive Home Based Treatment Teams, and community teams.
- 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 new national guidance on Discharge from mental health inpatient settings. 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, creating additional pressures. 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. In February performance data indicates that the routine access for assessment target is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley. Barnsley performance has fallen again in February which requires specific measures for improvement in addition to current business continuity plans and improvement work. This will include further consideration of systems and processes within the team, workforce modelling, pathways with core and enhanced, improving pathways with primary care and talking therapies to provide timely assessment and the most appropriate intervention to meet individual need.
- The Talking Therapies recovery rate for February is 55.76% for Kirklees and 50.45% 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. There has been some improvement 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 and bed occupancy. 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, Elmdale have had a number of band 6 vacancies impacting on supervision capacity.
• 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.
• 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 level of reporting for restraint interventions within the care group. There is a higher incidence of restraint on Walton which is attributable to the PICU setting not unusual in a PICU (Psychiatric Intensive Care Unit) environment. All restraint incidents are reviewed by the RRPI (Reducing Restrictive Physical Interventions) team and no areas of concern have been identified.
• Work continues towards meeting required concordance levels for Cardiopulmonary 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 CP 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.
• The use of out of area beds remains low 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:
Referral rates remain high across both pathways and the service try and minimise waiting times as far as possible.

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 6 breaches out of 48 people. Work is underway as part of the Improving Access priority program. Each locality has an action plan and there have been some demonstrable improvements to date and waiting lists will be monitored on a weekly basis. A high proportion of inpatients within the Horizon centre remain clinically ready for discharge and awaiting a suitable placement - work continues with partners to encourage flow.

LD, ADHD & ASD

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	74.7%	77.8%	76.3%	
% Complaints with staff attitude as an issue	< 20%	0% (0/5)	0% (0/2)	100% (1/1)	
% of staff receiving supervision within policy guidance	80%	74.7%	72.3%	74.7%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	56.9%	56.5%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.5%	74.9%	75.8%	
% of clients clinically ready for discharge	3.5%	66.0%	57.8%	50.0%	
Information Governance (IG) training compliance	>=95%	93.3%	94.7%	97.2%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	87.5%	83.8%	87.5%	

LD, ADHD & ASD

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	19	38	30	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	75.4%	75.6%	76.5%	
Safer staffing (Overall)	90%	156.2%	166.6%	164.2%	
Safer staffing (Registered)	80%	112.3%	123.2%	108.5%	
Sickness rate (Monthly)	4.5%	4.9%	3.1%	2.5%	
Restraint incidents	Trend Monitor	10	27	***32***	
% 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 this metric. Service is looking to use chat pads to aim to improve engagement with service users.
• West Yorkshire Integrated Care Board Neurodiversity Project – Work ongoing across West Yorkshire with the further summit being held in February.
• Appraisal 89%↓. It is unusual for the service to dip below 90%. Work is in place to understand and address this. Trust staff transferred into the service without an existing appraisal have also impacted the data.
• ADHD Pathway - Referral rates remain high and waiting lists continue to grow. There are currently over 4000 people waiting for an ADHD assessment. This is a national challenge.
Autism Pathway
• Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. There are approximately 20 people currently waiting from these areas and the longest wait for assessment is 16 weeks from referral.
• Calderdale continues to progress the Any Qualified provider Model.

Advise

• The service have had discussions with commissioners to find the best solutions to challenges in their Places until the work taking place across West Yorkshire can offer a sustainable solution within budget.
• Wakefield Place has already invested in a pilot project to implement ADHD screening and triage from April 2024.
• Kirklees Place has invested in an all-age neurodiversity referral unit, submitted jointly with Kirklees CAMHS. This clinical unit will determine appropriateness for ADHD and autism assessments.
• These developments have also created an opportunity to review the referral process for adults and an electronic referral process is being explored.

Assure

• All key performance indicator targets met.
• Work is underway to address the training not above target (reducing restrictive physical interventions and information governance)
• Relationship with Bradford working very well.
• Excellent levels of supervision (100%) and appraisal (93%).
• Excellent staff survey results.

Learning disability services:

Alert/Action

LD (Learning Disability)

• Appraisal performance remains a focus. Plans are in place to ensure compliance across the care group. Current compliance is 80%%. The service is working with the people directorate to reconcile the Trust figure.
• Supervision 69.5%↑ Further work is taking place to embed supervision in practice.
• Plans are in place to address mandatory training hotspots in cardiopulmonary resuscitation, information governance and reducing restrictive physical interventions.

Community Services

• Waiting Lists - Following system changes and training, team managers have improved oversight of waiting lists. This identified the need for further improvement work as waits beyond 18 weeks were held by senior clinical staff. The service is currently working to understand this in more detail and monitoring improvement through weekly meetings.
• Business cases for additional ADHD resource now submitted to commissioners (West Yorkshire Transforming Care Programme Board and Barnsley 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.
• Progress on improvement actions continues and the service is now assessing itself against QNLD standards (Quality Network for Inpatient Learning Disability standards) internally and are sharing with the Bradford ward and seeking support from national peers.

Advise

Greenlight Toolkit

• Work continues to progress.

Community

• Challenges continue with the recruitment of specialist in Speech and Language, Psychology 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 (Assessment & Treatment Unit)

• 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.
• Service users clinically ready for discharge continues to be at 50% which is recognised as a system wide pressure.

Assure

• Benchmarking community teams against Senate standards is underway. Community improvement plan continues to progress.
• Sickness on target and well being plans have good levels of engagement from staff.
• Data Quality on target.
• Staff survey results demonstrate improvements.
• 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 and recovery plans are in place for the waiting times for diagnostic procedures and an audit action plan is in place and agreed by integrated care board (ICB).
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	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	77.8%	81.5%	85.8%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/3)	0% (0/1)	
% people dying in a place of their choosing	80%	95.1%	97.4%	88.9%	
% of staff receiving supervision within policy guidance	80%	44.2%	48.5%	53.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.6%	77.6%	79.1%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	>=95%	94.0%	93.6%	94.0%	

Barnsley General Community Services

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.9%	99.8%	99.9%	
Maximum 6 week wait for diagnostic procedures	99%	64.3%	56.5%	69.0%	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	100.0%	75.0%	100.0%	
Safer staffing (Overall)	90%	104.4%	110.6%	110.1%	
Safer staffing (Registered)	80%	91.5%	98.7%	96.9%	
Sickness rate (Monthly)	4.5%	3.9%	3.8%	4.2%	
% rosters locked down in 6 weeks					

Alert/Action

- Appraisals - many of our 32 service lines are at 100% and we continue to work on data cleansing linked to ESR. Overall figure as at end Feb has increased to 85.8%.
- NRU (Neurological Rehabilitation Unit) Safer staffing figures continue to show green however, noting the ongoing challenge to fill trained staff shifts. We continue to supplement with untrained staff. Work ongoing with Finance and Contracting colleagues. This issue has been logged on Datix and is also on the local risk register.
- Pressure ulcers - Lapse in care – two incidents in February related to clinical documentation and a missed visit. We are hoping to cease using 'lapse in care' terminology as it is not aligned to PSIRF and misrepresents the clinical care provided.

Advise

- Clinical supervision is receiving focused attention with the development of an improvement plan giving support to specific areas with lowest rates of clinical supervision. Supervision compliance is improving with a drive on recording data. Associate Director of Nursing and Professions recently met with the clinical leads in the care group to discuss barriers to clinical supervision and the majority is around the ease of recording. Overall the compliance rate is improving even though it remains below target.
- Children's Speech and Language Therapy and Adult Community Speech and Language Therapy - Active working party across regional integrated care board on FASD (Foetal Alcohol Syndrome Disorder) - Now part of NICE guidelines for medical identification. May lead to an increase in referrals – specific speech and language profile.
- Barnsley School Aged Immunisation Service (SAIS) – recently notified of a confirmed measles case in Barnsley. Working with BMBC Public Health colleagues around outbreak scenarios as SAIS likely to be involved in any response.
- Barnsley SAIS – are providing primary school clinics to target those schools with highest number of children with zero doses of MMR. Also providing MMR vaccines alongside routine adolescent vaccinations at school sessions and clinics.
- Children's Speech and Language Therapy (SLT) - Waiting times are long and likely to increase due to significant staffing issues in the next few months, equating to 7.1 wte clinical staff. As several are maternity leaves, there will be no budget for backfill and recruitment is challenging already due to national shortages/temporary contracts. Staff within the team able to work additional hours are already doing so.

Assure

• Smoking Quit rates as at Quarter 3 (Oct – Dec '23) for all five services is at 68% quit rate against a threshold of 55%.
• Yorkshire Smoke Free (YSF) - Latest statistics show prevalence in priority groups from Stop Smoking has dramatically reduced. The information below shows how all five services have impacted on the outcomes from 2014 – 2023:

Smoking Prevalence:	Adults		Pregnancy - smoking at time of delivery		Routine & Manual Workers		Adults With a Long Term Mental Health Condition	
	2014	2023	2014	2023	2014	2023	2014	2023
Barnsley	22.5	15.8	20.5	13.9	32.6	19.6	33.7	24.1
Calderdale	19.9	11.5	13.9	8.3	37.3	19.7	40.9	26.5
Doncaster	21.5	12.4	20.7	13.2	31.9	19.2	26.8	33.8
Sheffield	17.2	12.0	15.1	9.9	29.7	20.3	37.2	28.0
Wakefield	22.4	12.5	19.7	14.2	35.00	23.0	34.3	29.8

• Paediatric Audiology - The percentage of service users waiting for a diagnostic appointment (paediatric audiology) within 6 weeks increased to 69% in February from 56.5% reported in January, 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. This relates to increased demand from due to audiology assessments forming part of other assessments, for example autism and the availability of additional audiologists. An improvement plan is in place and links to work across the Integrated Care System.
• Urgent Community Response Service 2-hour target is 88% as at February 2024 which is well above the 70% threshold. The team are also working on data quality in order to improve statistical information further.
• Musculo-Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 99.9% as at February 2024 - which is excellent given the continued increase in referral rate.
• Friends and Family Test (FFT) 97% of people would recommend community services.
• 88.9% of people dying in their place of choosing as at February 2024.
• Achieving all care group CQUIN targets.
• Staff Survey Results are looking positive for the Care Group.

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. There has been some improvement in February with the overall performance.

Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.

Supervision performance remains above threshold and learning is being shared with other areas.

Forensic

Metrics	Threshold	Dec-23	Jan-24	Feb-24	Variation/ Assurance
% Appraisal rate	>=90%	74.4%	76.5%	79.1%	
% Bed occupancy	90%	82.6%	83.2%	81.2%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	94.5%	91.8%	83.9%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.2%	97.3%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.7%	71.8%	75.6%	
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	N/A	
Information Governance (IG) training compliance	>=95%	92.6%	91.2%	92.2%	
Physical Violence (Patient on Patient)	Trend Monitor	3	1	3	
Physical Violence (Patient on Staff)	Trend Monitor	14	15	10	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	80.3%	77.8%	76.1%	
Restraint incidents	Trend Monitor	29	29	***29***	
Safer staffing (Overall)	90%	114.6%	115.7%	105.8%	
Safer staffing (Registered)	80%	91.8%	99.2%	97.4%	
Sickness rate (Monthly)	5.4%	8.1%	6.5%	5.3%	
% rosters locked down in 6 weeks					

Alert/Action

• **Bed Occupancy** – Newton Lodge 85.79%↑, Bretton 77.95%↓, Newhaven 63.36%. Waiting list for medium secure has increased significantly. Available beds are not admission beds, so will not help to reduce the number of people placed out of area. The service is undertaking work on the pathway to maximise efficiencies.
• **Sickness absence** – continues to be a concern across the service with year to date data indicating Newton Lodge 6.8%↓ (3.9% in month), Bretton Centre 11.9%↓ (8.3% in month) and Newhaven 7.5% ↓(5.8% in month).
• **Vacancies & Turnover** –Service continues to focus on recruitment and retention. Band 5 vacancies have reduced but this has not led to a commensurate increase in registered nurse capacity as recruits are still working through preceptorship / induction. 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.
• The West Yorkshire Provider Collaborative have circulated the 5 year commissioning intentions to providers for comment. Concerns regarding the plans for community forensic services in the Trust have been shared back with the collaborative.
• Mandatory training overall compliance:
  Newton Lodge – 92.1%
  Bretton – 90.5%
  Newhaven –90.6%
• Whilst the figures represent an overall positive position, hotspots in reducing restrictive practice, cardiopulmonary resuscitation and information governance training are being managed and monitored closely.
• Improvement work is being undertaken in Clinically Ready for Discharge, pathway development and improving sickness absence rates.
• Appraisal performance – local records indicate 93%. Work is being undertaken with people directorate to reconcile this data with Trust data.
• The well-being of staff remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying 3 key areas to focus on. There is a strong level of engagement within the Care Group.

Assure

• High levels of data quality across the Care Group (100%).
• 100% compliance for HCR20 risk assessments being completed within 3 months of admission.
• 25 Hours of meaningful activity is 100%.
• CPA 100%
• All Equality Impact Assessments across Forensic Services have been completed for 23/24 and are scheduled to be reviewed shortly.

Inpatients - Mental Health - Working Age Adults

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

Sickness
• Significant improvement on Melton due to return of staff from long term sickness absence.
• Increase on Clarke, Ward 18, Stanley and Ashdale due to a combination of long term sickness absence and unrelated short term absence including pregnancy related illness and seasonal illness.
• Specific challenges on Elmdale relate to recent serious incidents. Occupational Health are involved and support is in place.

Supervision
• Supervision capacity has been impacted on some wards, including Elmdale, by staffing pressures particularly Band 6/7 vacancies and sickness absence.
• Ward specific improvement plans in place where required, for example on Ward 18 and Lyndhurst.

Mandatory Training
• CPR (Cardiopulmonary Resuscitation) course cancellations and changes in course times not aligning with shift patterns have impacted on compliance. This has been a particular issue for staff on Beamshaw, Elmdale and Ward 19 Female.
• RRPI (Reducing Restrictive physical Interventions) compliance has been impacted by course cancellations and exacerbated by staff then needing to attend the full 4 day course as they have missed the timeframe for the refresher due to course cancellation. This has been the case for Beamshaw, Walton, Ashdale, Ward 19, Enfield Down and Lyndhurst.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
• IG is a particular area of focus and staff are having protected time on shift to complete. Absences on Clarke and Elmdale are impacting on compliance.

Bed Occupancy
• All WAA 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.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Safer Staffing
• Elmdale did not meet the safer staffing (registered) target in February due to the sickness absence of 5 registered staff. There was a minimum of 1 registered member of staff with additional Health Care Assistants to ensure overall safe staffing.

Clinically Ready For Discharge (CRFD)
• High percentage affect due to small numbers of patients on the ward.
• CRFD categorisation includes more individuals than previous DTOC (Delayed Transfer of Care), however the threshold of 3.5% for DTOC has remained for CRFD. The threshold is under review.
• Work is ongoing to ensure the categorisation of CRFD is applied consistently.
• CRFD has reduced on all wards with the exception of Nostell where there has been a slight increase. CRFD remains high on some wards which reflects the complexities of the service user population and is impacted by availability of specialist placements for people with complex needs.

FIRM Risk assessments
• Percentage compliance is significantly impacted by small number of admissions. Enfield Down have not had any direct admissions in February therefore the 0% reported is a data quality issue.
• Compliance on some wards (Clarke and Ward 19- Male) has been impacted by recent staffing pressures, particularly registered nurse deficits.
• 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
• Higher incidence of restraint on Nostell, Stanley and Crofton is reflective of current patient population & presentation and risk profile of service users.
• All restraint incidents are reviewed by the RRPI (Reducing Restrictive physical Interventions) team and no areas of concern have been identified.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	82.6%	95.8%
Sickness	4.5%	9.6%	7.5%	4.8%
Supervision	80%	90.1%	91.7%	100.0%
Information Governance training compliance	>=95%	96.2%	92.9%	90.0%
Reducing restrictive physical interventions training compliance	>=80%	73.1%	67.9%	70.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.3%	82.1%	56.7%
Bed occupancy	85%	109.2%	109.0%	106.2%
Safer staffing (Overall)	90%	131.8%	153.0%	132.7%
Safer staffing (Registered)	80%	134.9%	126.9%	136.6%
% of clients clinically ready for discharge	3.5%	5.8%	6.6%	4.2%
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	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	6	1	***1***
Prone Restraint incidents	Trend Monitor	1	0	***1***

Clark Suite

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	88.9%	87.5%
Sickness	4.5%	3.5%	7.1%	12.7%
Supervision	80%	85.7%	100.0%	83.3%
Information Governance training compliance	>=95%	95.0%	90.0%	84.2%
Reducing restrictive physical interventions training compliance	>=80%	94.7%	95.0%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.0%	85.0%	73.7%
Bed occupancy	85%	82.7%	92.2%	92.1%
Safer staffing (Overall)	90%	129.7%	129.3%	159.7%
Safer staffing (Registered)	80%	97.2%	99.8%	100.5%
% of clients clinically ready for discharge	3.5%	16.3%	15.5%	7.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	91.7%	77.8%	66.7%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	1
Physical Violence (Patient on Staff)	Trend Monitor	3	4	5
Restraint incidents	Trend Monitor	2	7	***8***
Prone Restraint incidents	Trend Monitor	0	0	***1***

Melton Suite

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	68.2%	87.0%
Sickness	4.5%	6.0%	6.5%	3.6%
Supervision	80%	100.0%	91.7%	90.0%
Information Governance training compliance	>=95%	87.0%	92.0%	96.2%
Reducing restrictive physical interventions training compliance	>=80%	82.6%	80.0%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.6%	80.0%	73.1%
Bed occupancy	85%	100.0%	103.8%	110.3%
Safer staffing (Overall)	90%	153.2%	165.9%	160.8%
Safer staffing (Registered)	80%	74.1%	89.3%	98.3%
% 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	0	2
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	1	2	***8***
Prone Restraint incidents	Trend Monitor	0	1	***0***

Nostell

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	92.6%	96.3%
Sickness	4.5%	2.1%	2.7%	0.8%
Supervision	80%	92.3%	87.5%	92.9%
Information Governance training compliance	>=95%	93.3%	93.5%	96.8%
Reducing restrictive physical interventions training compliance	>=80%	96.6%	80.0%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.7%	83.3%	90.0%
Bed occupancy	85%	87.8%	97.1%	94.4%
Safer staffing (Overall)	90%	122.0%	118.5%	139.3%
Safer staffing (Registered)	80%	98.5%	102.5%	100.8%
% of clients clinically ready for discharge	3.5%	18.7%	13.1%	13.4%
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	1	2
Physical Violence (Patient on Staff)	Trend Monitor	1	1	6
Restraint incidents	Trend Monitor	6	3	***11***
Prone Restraint incidents	Trend Monitor	2	2	***1***

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	84.0%	84.6%
Sickness	4.5%	7.5%	4.6%	8.6%
Supervision	80%	100.0%	100.0%	92.9%
Information Governance training compliance	>=95%	100.0%	92.3%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	88.0%	84.6%	83.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	80.8%	77.4%
Bed occupancy	85%	88.6%	97.1%	97.8%
Safer staffing (Overall)	90%	163.3%	162.5%	158.4%
Safer staffing (Registered)	80%	109.5%	114.5%	118.4%
% of clients clinically ready for discharge	3.5%	10.0%	8.0%	3.8%
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	0	3
Physical Violence (Patient on Staff)	Trend Monitor	0	2	1
Restraint incidents	Trend Monitor	2	8	***3***
Prone Restraint incidents	Trend Monitor	0	3	***1***

Walton

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	88.9%	97.1%
Sickness	4.5%	6.2%	6.3%	4.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	94.6%	97.4%	88.6%
Reducing restrictive physical interventions training compliance	>=80%	83.3%	73.7%	79.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.4%	81.6%	88.2%
Bed occupancy	85%	93.5%	93.1%	98.3%
Safer staffing (Overall)	90%	140.9%	127.9%	125.4%
Safer staffing (Registered)	80%	90.4%	92.7%	101.0%
% 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%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	1	3
Physical Violence (Patient on Staff)	Trend Monitor	3	2	1
Restraint incidents	Trend Monitor	3	13	***11***
Prone Restraint incidents	Trend Monitor	0	5	***2***

Ashdale

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	84.6%	92.9%
Sickness	4.5%	12.1%	9.9%	10.2%
Supervision	80%	72.7%	84.6%	92.9%
Information Governance training compliance	>=95%	96.6%	90.0%	93.9%
Reducing restrictive physical interventions training compliance	>=80%	82.8%	80.0%	69.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.0%	80.0%	78.8%
Bed occupancy	85%	96.5%	99.7%	99.0%
Safer staffing (Overall)	90%	133.3%	115.9%	125.3%
Safer staffing (Registered)	80%	91.1%	92.9%	82.8%
% of clients clinically ready for discharge	3.5%	0.0%	4.2%	3.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	3	1
Physical Violence (Patient on Staff)	Trend Monitor	2	0	2
Restraint incidents	Trend Monitor	8	1	***3***
Prone Restraint incidents	Trend Monitor	1	1	***0***

Ward 18

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	63.0%	89.3%
Sickness	4.5%	4.9%	3.4%	5.6%
Supervision	80%	35.7%	38.5%	66.7%
Information Governance training compliance	>=95%	91.2%	88.2%	85.7%
Reducing restrictive physical interventions training compliance	>=80%	82.4%	79.4%	82.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.4%	76.5%	74.3%
Bed occupancy	85%	93.8%	95.9%	99.4%
Safer staffing (Overall)	90%	119.4%	125.3%	125.3%
Safer staffing (Registered)	80%	74.8%	84.2%	87.5%
% of clients clinically ready for discharge	3.5%	2.6%	8.3%	5.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	88.2%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	1	0
Physical Violence (Patient on Staff)	Trend Monitor	9	4	0
Restraint incidents	Trend Monitor	11	5	***5***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Mental Health - Working Age Adults

Elmdale

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	85.7%	94.4%
Sickness	4.5%	6.6%	9.3%	17.0%
Supervision	80%	37.5%	62.5%	60.0%
Information Governance training compliance	>=95%	82.6%	78.3%	75.0%
Reducing restrictive physical interventions training compliance	>=80%	87.0%	87.0%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	54.5%	63.6%	68.4%
Bed occupancy	85%	90.6%	100.3%	96.6%
Safer staffing (Overall)	90%	139.4%	137.2%	144.5%
Safer staffing (Registered)	80%	72.7%	81.6%	70.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	1.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	80.0%	88.9%	93.3%
Physical Violence (Patient on Patient)	Trend Monitor	1	4	5
Physical Violence (Patient on Staff)	Trend Monitor	3	9	10
Restraint incidents	Trend Monitor	9	14	***7***
Prone Restraint incidents	Trend Monitor	2	2	***1***

Inpatients - Mental Health - Older People Services

Crofton

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	73.7%	95.7%
Sickness	4.5%	0.7%	6.5%	5.8%
Supervision	80%	100.0%	90.0%	100.0%
Information Governance training compliance	>=95%	96.2%	96.2%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	79.2%	76.0%	80.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.7%	92.0%	92.3%
Bed occupancy	85%	81.7%	82.5%	80.0%
Safer staffing (Overall)	90%	183.9%	185.9%	166.2%
Safer staffing (Registered)	80%	140.2%	161.2%	147.1%
% 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%	85.7%	100.0%	90.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	7	4	1
Restraint incidents	Trend Monitor	13	1	***2***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Poplars CUE

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	91.7%	88.0%
Sickness	4.5%	2.9%	2.4%	1.1%
Supervision	80%	100.0%	81.8%	81.8%
Information Governance training compliance	>=95%	100.0%	96.4%	96.4%
Reducing restrictive physical interventions training compliance	>=80%	88.0%	84.6%	84.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	88.5%	84.6%
Bed occupancy	85%	67.3%	72.0%	68.5%
Safer staffing (Overall)	90%	207.1%	210.2%	205.2%
Safer staffing (Registered)	80%	105.6%	115.2%	111.4%
% of clients clinically ready for discharge	3.5%	30.4%	14.6%	9.7%
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	2	2
Physical Violence (Patient on Staff)	Trend Monitor	12	10	16
Restraint incidents	Trend Monitor	10	8	***13***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	85.0%	100.0%
Sickness	4.5%	4.2%	1.1%	0.3%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	96.0%
Reducing restrictive physical interventions training compliance	>=80%	81.0%	78.3%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	42.9%	65.2%	76.0%
Bed occupancy	85%	77.7%	47.4%	45.5%
Safer staffing (Overall)	90%	154.0%	136.3%	119.9%
Safer staffing (Registered)	80%	95.4%	98.7%	86.1%
% of clients clinically ready for discharge	3.5%	41.1%	34.7%	22.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	66.7%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	3	0	0
Restraint incidents	Trend Monitor	4	0	***2***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Beechdale

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	100.0%	91.3%
Sickness	4.5%	9.0%	10.3%	7.5%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	95.8%	91.7%	91.7%
Reducing restrictive physical interventions training compliance	>=80%	87.5%	83.3%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.6%	83.3%	91.7%
Bed occupancy	85%	84.9%	97.8%	96.3%
Safer staffing (Overall)	90%	130.1%	139.8%	138.3%
Safer staffing (Registered)	80%	88.5%	93.4%	97.0%
% of clients clinically ready for discharge	3.5%	9.5%	0.4%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	83.3%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	2	0
Physical Violence (Patient on Staff)	Trend Monitor	3	5	4
Restraint incidents	Trend Monitor	4	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Ward 19 - Male

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	93.8%	93.8%
Sickness	4.5%	3.4%	2.2%	5.8%
Supervision	80%	100.0%	87.5%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	95.2%
Reducing restrictive physical interventions training compliance	>=80%	75.0%	69.6%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	87.0%	90.0%
Bed occupancy	85%	83.0%	91.8%	94.0%
Safer staffing (Overall)	90%	107.3%	117.6%	126.3%
Safer staffing (Registered)	80%	82.4%	76.5%	70.7%
% 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%	100.0%	80.0%	50.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	3	2
Physical Violence (Patient on Staff)	Trend Monitor	3	5	8
Restraint incidents	Trend Monitor	5	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Ward 19 - Female

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	81.3%	94.1%
Sickness	4.5%	12.9%	7.0%	8.4%
Supervision	80%	100.0%	89.9%	100.0%
Information Governance training compliance	>=95%	94.7%	89.5%	94.4%
Reducing restrictive physical interventions training compliance	>=80%	77.8%	66.7%	72.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	44.4%	55.6%	52.9%
Bed occupancy	85%	81.5%	94.8%	95.9%
Safer staffing (Overall)	90%	111.5%	108.7%	111.9%
Safer staffing (Registered)	80%	72.1%	77.4%	85.9%
% of clients clinically ready for discharge	3.5%	7.3%	7.0%	1.1%
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	3	2
Physical Violence (Patient on Staff)	Trend Monitor	3	5	8
Restraint incidents	Trend Monitor	5	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Mental Health - Rehab

Enfield Down

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	69.6%	72.7%
Sickness	4.5%	3.6%	5.5%	6.4%
Supervision	80%	84.2%	93.3%	92.9%
Information Governance training compliance	>=95%	96.1%	82.7%	91.8%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	76.5%	72.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.5%	73.9%	79.5%
Bed occupancy	85%	48.1%	49.3%	57.2%
Safer staffing (Overall)	90%	92.9%	87.8%	89.1%
Safer staffing (Registered)	80%	70.6%	70.6%	76.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.4%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	2	0
Restraint incidents	Trend Monitor	1	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Lyndhurst

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	95.2%	95.5%
Sickness	4.5%	6.0%	4.7%	5.8%
Supervision	80%	87.5%	68.8%	75.0%
Information Governance training compliance	>=95%	92.6%	85.2%	92.6%
Reducing restrictive physical interventions training compliance	>=80%	60.7%	59.3%	59.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.8%	70.4%	70.4%
Bed occupancy	85%	64.7%	64.1%	69.0%
Safer staffing (Overall)	90%	124.3%	127.6%	95.7%
Safer staffing (Registered)	80%	93.2%	108.4%	102.4%
% of clients clinically ready for discharge	3.5%	10.0%	5.8%	0.0%
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	1
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 - Forensic - Medium Secure

Ward Level Headlines - Forensics

Performance for all wards is being addressed through regular meetings with Ward Managers and the General Manager. Remedial work continues on appraisals and the service is confident that compliance is just above 90% further work is now being undertaken to update the Trust system so this is reflected more accurately.

Medium Secure

- Supervision remains a focus for the service performance has reduced on Waterton, Appleton and Chippendale. For Appleton and Chippendale this could be attributed to acuity on the wards areas.
- Waterton's performance has been affected by sickness/absence and vacancies in the Band 6 group. Additional support is being offered to the ward.
- 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. Sickness for Medium secure had reduced to 3.9% in month.
- Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service with particular challenges accessing courses.
- Bed occupancy in Appleton is lower due to an overall reduction in referrals for learning disability beds in medium secure. Bed occupancy in general remains under constant review with work on flow and pathways progressing.
- Cardio pulmonary rehabilitation compliance is the focus of targeted improvement work. All wards with the exception of Bronte have made some improvement. The service is currently booking staff on available courses and monitoring closely.
-Priestley is currently experiencing challenges with overall performance due to high sickness rates and high levels of staff on amended duties (40%). The service is working closely with the People Directorate to address ongoing issues.

Low Secure

- Sickness across all wards monitored closely significant improvement in Thornhill and Newhaven's position. Sandals sickness has reduced but remains higher than target. Sickness levels on Ryburn are currently 36.8% due to long term sickness. The service is currently being supported by the People Directorate to address these issues.
- Cardio pulmonary rehabilitation compliance on all 4 Low Secure wards remains a focus with all staff now either completed or booked on courses.
- 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 excellent across all 3 wards at the Bretton Centre but has dropped significantly in Newhaven for February, acuity on the ward is affecting performance.
- The number of prone restraints on Newhaven has fallen this has been supported by quality improvement work undertaken by the service and supported by the reducing restrictive physical interventions team.

Appleton

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	90.5%	85.7%
Sickness	5.4%	5.9%	3.1%	4.4%
Supervision	80%	100.0%	83.3%	72.7%
Information Governance training compliance	>=95%	87.0%	95.7%	95.7%
Reducing restrictive physical interventions training compliance	>=80%	82.6%	82.6%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.2%	83.3%	79.2%
Bed occupancy	90%	62.5%	56.5%	62.5%
Safer staffing (Overall)	90%	97.2%	96.7%	97.3%
Safer staffing (Registered)	80%	105.5%	108.7%	104.3%
% 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	1
Physical Violence (Patient on Staff)	Trend Monitor	1	1	2
Restraint incidents	Trend Monitor	0	1	***16***
Prone Restraint incidents	Trend Monitor	0	0	***2***

Bronte

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	100.0%	100.0%
Sickness	5.4%	0.0%	0.4%	0.3%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	95.7%	91.3%	87.0%
Reducing restrictive physical interventions training compliance	>=80%	78.3%	78.3%	78.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	73.9%	65.2%
Bed occupancy	90%	95.9%	99.5%	98.0%
Safer staffing (Overall)	90%	99.6%	99.7%	99.2%
Safer staffing (Registered)	80%	103.6%	101.1%	94.6%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	3	0
Restraint incidents	Trend Monitor	1	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Chippendale				
Metrics	**Threshold**	**Dec-23**	**Jan-24**	**Feb-24**
Appraisal rate	>=90%	Reporti	90.9%	90.9%
Sickness	5.4%	7.2%	3.7%	3.8%
Supervision	80%	88.9%	90.9%	50.0%
Information Governance training compliance	>=95%	89.5%	87.5%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	89.5%	79.2%	81.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.2%	75.0%	90.9%
Bed occupancy	90%	91.7%	91.7%	91.7%
Safer staffing (Overall)	90%	128.5%	145.3%	147.1%
Safer staffing (Registered)	80%	101.9%	117.8%	119.6%
% 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	2	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	5	4
Restraint incidents	Trend Monitor	4	4	***7***
Prone Restraint incidents	Trend Monitor	1	0	***0***

Hepworth				
Metrics	**Threshold**	**Dec-23**	**Jan-24**	**Feb-24**
Appraisal rate	>=90%	Reportin	92.0%	92.0%
Sickness	5.4%	8.5%	7.9%	4.1%
Supervision	80%	84.6%	90.9%	100.0%
Information Governance training compliance	>=95%	96.6%	93.1%	89.3%
Reducing restrictive physical interventions training compliance	>=80%	72.4%	75.9%	82.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.4%	78.6%	74.1%
Bed occupancy	90%	83.2%	98.1%	94.7%
Safer staffing (Overall)	90%	96.7%	96.3%	94.2%
Safer staffing (Registered)	80%	89.2%	86.2%	86.0%
% 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	1	0
Restraint incidents	Trend Monitor	1	7	***1***
Prone Restraint incidents	Trend Monitor	0	5	***0***

Inpatients - Forensic - Medium Secure

Johnson				
Metrics	**Threshold**	**Dec-23**	**Jan-24**	**Feb-24**
Appraisal rate	>=90%	Reporti	89.3%	82.8%
Sickness	5.4%	7.4%	6.4%	2.5%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	93.5%	93.8%	87.5%
Reducing restrictive physical interventions training compliance	>=80%	87.1%	87.5%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	67.7%	78.1%	87.5%
Bed occupancy	90%	86.7%	80.4%	79.3%
Safer staffing (Overall)	90%	137.8%	140.2%	136.5%
Safer staffing (Registered)	80%	92.2%	105.8%	116.1%
% 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	0	1
Restraint incidents	Trend Monitor	1	0	***0***
Prone Restraint incidents	Trend Monitor	1	0	***0***

Priestley				
Metrics	**Threshold**	**Dec-23**	**Jan-24**	**Feb-24**
Appraisal rate	>=90%	Reportin	50.0%	73.7%
Sickness	5.4%	8.4%	15.5%	10.1%
Supervision	80%	87.5%	80.0%	80.0%
Information Governance training compliance	>=95%	91.3%	90.5%	95.2%
Reducing restrictive physical interventions training compliance	>=80%	77.3%	70.0%	50.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.7%	70.0%	75.0%
Bed occupancy	90%	93.5%	89.8%	90.7%
Safer staffing (Overall)	90%	97.3%	94.1%	97.9%
Safer staffing (Registered)	80%	73.5%	69.1%	96.0%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Waterton

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	45.0%	42.1%
Sickness	5.4%	5.6%	4.6%	4.9%
Supervision	80%	91.7%	83.3%	54.5%
Information Governance training compliance	>=95%	85.7%	90.5%	91.3%
Reducing restrictive physical interventions training compliance	>=80%	100.0%	85.7%	69.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	57.1%	61.9%	69.6%
Bed occupancy	90%	85.3%	75.0%	80.2%
Safer staffing (Overall)	90%	121.3%	122.1%	121.6%
Safer staffing (Registered)	80%	85.5%	98.5%	92.0%
% 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	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	1	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Forensic - Low Secure

Thornhill

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	86.4%	83.3%
Sickness	5.4%	9.8%	1.0%	0.8%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	91.3%	95.8%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	91.3%	83.3%	70.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	56.5%	62.5%	70.8%
Bed occupancy	85%	56.3%	59.8%	57.9%
Safer staffing (Overall)	90%	109.3%	106.9%	99.1%
Safer staffing (Registered)	80%	101.3%	106.3%	92.4%
% 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	1
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Sandal

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	66.7%	70.8%
Sickness	5.4%	14.0%	8.0%	6.1%
Supervision	80%	90.0%	100.0%	90.0%
Information Governance training compliance	>=95%	82.6%	76.0%	92.3%
Reducing restrictive physical interventions training compliance	>=80%	82.6%	80.0%	65.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	52.2%	52.0%	73.1%
Bed occupancy	85%	85.9%	87.3%	88.8%
Safer staffing (Overall)	90%	128.0%	127.4%	103.0%
Safer staffing (Registered)	80%	95.0%	101.1%	105.7%
% 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	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1
Restraint incidents	Trend Monitor	6	3	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***

Inpatients - Forensic - Low Secure

Ryburn

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	100.0%	100.0%
Sickness	5.4%	37.8%	36.8%	26.1%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	90.0%
Reducing restrictive physical interventions training compliance	>=80%	71.4%	62.5%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	57.1%	50.0%	55.6%
Bed occupancy	85%	100.0%	100.0%	96.1%
Safer staffing (Overall)	90%	102.8%	104.7%	98.6%
Safer staffing (Registered)	80%	100.3%	109.7%	96.0%
% 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	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***

Newhaven

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	76.2%	81.8%
Sickness	5.4%	6.1%	6.3%	3.9%
Supervision	80%	100.0%	100.0%	66.7%
Information Governance training compliance	>=95%	92.3%	89.3%	92.9%
Reducing restrictive physical interventions training compliance	>=80%	80.8%	78.6%	71.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	78.6%	67.9%
Bed occupancy	85%	75.0%	73.0%	63.4%
Safer staffing (Overall)	90%	124.9%	126.3%	112.0%
Safer staffing (Registered)	80%	96.3%	112.0%	101.5%
% 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	1	1
Physical Violence (Patient on Staff)	Trend Monitor	6	4	0
Restraint incidents	Trend Monitor	15	11	***5***
Prone Restraint incidents	Trend Monitor	6	0	***0***

Inpatients - Non-Mental Health

Headlines

Appraisal rate:

• NRU rate has dropped to 29.2% - all appraisals are booked to take place during March and April. A number of appraisals are overdue as of February – critical staffing levels mean that it has been difficult to release staff from clinical duties.

• SRU rate has reduced slightly to 85.5%. This ward has been impacted by long term sickness in terms of management/senior staff.

Supervision:

• NRU figures have significantly increased from 66.7% and the unit is now compliant at 81.8%

• SRU figures have also increased significantly from 54.8% to 69.2% despite this ward being impacted by long term sickness in terms of management /senior staff.

Cardiopulmonary resuscitation CPR:

• NRU – 76.7% as at February 2024. This is still below compliance, however, critical staffing levels are contributing to this position. 6 further staff booked on during March.

• SRU – 74.6% as at February 2024. This is an increase. 4 further staff booked on during March. This should increase compliance and achieve target by end of financial year.

Information Governance (IG):

• NRU – 96.8% as at February 2024 – now compliant

• SRU – 93.5% as at February 2024 with the following increase to 94.8% noted as at 15.3.24. This is very slightly below target.

• Recovery improvement plan has been in place for IG and CPR within NRU and SRU.

Sickness:

• NRU – increase to 10.3% during February. This is being managed via HR processes and sickness reviews and a number of these staff have returned to work during March.

• SRU – reduction to 5.9% from 8.3% during February. The unit continues to have some long term sickness which is likely to continue for an extended period due to nature of illness.

Neuro Rehabilitation Unit (NRU)

Metrics	Threshold	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	50.0%	29.2%
Sickness	4.5%	7.3%	6.6%	10.3%
Supervision	80%	45.5%	66.7%	81.8%
Information Governance training compliance	>=95%	89.3%	87.1%	96.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.1%	76.7%	76.7%
Bed occupancy (Barnsley Commissioned beds only)	80%	100.0%	109.7%	107.8%
Safer staffing (Overall)	90%	99.4%	114.2%	113.2%
Safer staffing (Registered)	80%	75.1%	87.0%	84.7%
% 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	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reportin	92.3%	85.5%
Sickness	4.5%	6.9%	8.3%	5.9%
Supervision	80%	44.8%	54.8%	69.2%
Information Governance training compliance	>=95%	96.7%	98.3%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	67.2%	69.6%	74.6%
Bed occupancy	80%	82.5%	77.7%	96.8%
Safer staffing (Overall)	90%	108.1%	107.9%	107.8%
Safer staffing (Registered)	80%	106.1%	108.7%	107.4%
% 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

Inpatients - Mental Health - Learning Disability

Headlines
- Improvements to supervision levels have been made with supervision now being rostered in for all staff. Appraisal is being monitored locally and is 80% but further work needs to be undertaken to align that on the Trust system.
- Cardiopulmonary resuscitation training is currently a hotspot with remedial actions in place and staff being booked on available courses.
- Focused attention on information governance training and reducing restrictive physical interventions have been successful in achieving 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	Dec-23	Jan-24	Feb-24
Appraisal rate	>=90%	Reporti	73.1%	71.4%
Sickness	4.5%	6.1%	4.2%	3.3%
Supervision	80%	80.0%	50.0%	80.0%
Information Governance training compliance	>=95%	97.3%	100.0%	97.4%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	80.0%	80.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	60.6%	60.0%	61.1%
Bed occupancy	N/A	56.9%	56.5%	50.0%
Safer staffing (Overall)	90%	156.2%	166.6%	164.2%
Safer staffing (Registered)	80%	112.3%	123.2%	108.5%
% of clients clinically ready for discharge	3.5%	66.0%	60.7%	50.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	30
Physical Violence (Patient on Staff)	Trend Monitor	18	38	0
Restraint incidents	Trend Monitor	10	27	**32**
Prone Restraint incidents	Trend Monitor	0	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. Examples include our work on physical health checks for people with a Learning Disability and work to improve understanding of the people who are waiting for services Internal work on data and metrics is supporting this work and developing our understanding of the impact of services on different cohorts of people. We are exploring a piece of work with the alliance and the acute hospital in Barnsley to see how we can collectively support people who are waiting for orthopaedic procedures or MSK services	
Improving care	Transform our Older People inpatient services	Public consultation is progressing well and includes: 805 digital survey responses and 400 (approx.) paper surveys. 3069 website homepage views (between 12.01 and 07.03), 683 video/animation views, 43,000 people reached across the Trust social media accounts with many more across partner social media. Further engagement activity now nearing completion, and these have included stands in 5 general hospitals and 5 town markets, further digital meeting, Sikh temple visit, further meetings with interested public groups, Memory Lane, Halifax, St Swithuns Wakefield. Voluntary community and social enterprise (VCSE) work ongoing across the Trust footprint and advocacy work now also happening to ensure current inpatients have a say. A work plan is now being established for next phase which includes: Travel, Transport and Parking working group, tasked with making recommendations on solutions for those that travel to visit. Finance working group tasked with establishing a clear medium-term financial plan which demonstrates affordability from both a Trust and Integrated Care Board (ICB) perspective. Task and finish groups to refresh and update impact assessments (including Equality, Quality and Sustainability). Options review group tasked with reviewing findings and recommending an option to implement. Estates activity and estates business case development to be planned for time period to compliment programme activity.	
	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: Wait time to complete the referral appointment in Kirklees remains at 4 weeks (4 months at outset of project); on track to reduce further going forward. Two Whole Time Equivalent (WTE) Band 4 Assistant Psychologists to commence March/April. Two WTE Band 6s out to advert. Overtime commenced to provide additional assessments to end of March. Shortlisting undertaken for 1 WTE substantive Band 3, for pre and post diagnosis support and resources for professionals and families; interviews March 2024. There continues to be a stabilisation of the caseload size since February '23, suggesting the current level of clinical capacity is ensuring assessment flow, though the level of commissioned clinical capacity (43 assessments per month), may not be sufficient to contribute to a significant reduction across the metrics. The Trust continues to be involved in discussions with the Integrated care board and West Yorkshire collaborative on implementation of Choice agenda in Calderdale for Adult ADHD and neurodevelopment services. Impact of backlog and waiting lists of right to choose providers is being monitored for impact on the Trust's waiting lists in Calderdale. Integrated care board agreed additional funding for neurodevelopmental screening post to be taken from first point of contact into SWYPFT- 1 WTE Band 7 to be recruited. 1 WTE Assistant psychologist recruited on 24 month contract. Commissioners confirmed no funding for second post which may impact ability to complete additional assessments in a timely manner – currently reviewing. Transition work with Adult ADHD services in both localities continues to be sustained, providing greater equity for others on the waiting list. **2. Waits for Community LD (CLD) services:** The improvement work has provided greater oversight to the waiting times and has highlighted the full scale of the issue. Update report to the Executive Management Team is currently being worked on and have set up a Task & Finish group to improve the position. Each locality has an action plan and there have been some demonstrable improvements although there is still a long way to go. Waiting lists will be monitored on a weekly basis. **3. Improving Access to Core Psychological Therapies:** Work has been undertaken to get project back on track, estimated one month behind schedule. In February the following work has been undertaken: • Clearer understanding of demand for both assessment and therapy which will inform next steps of improvement. • A narrative detailing the longest wait times has been provided to enhance comprehension regarding why certain individuals are experiencing extended delays. This has also given insight into variations across localities. • Process mapping has commenced in some localities with Lead Psychologist and Admin team manager to understand the current 'as is' position and understand variations in the ways of working across different localities. **4. Mental Health Single Point of Access (SPA) Review:** February 2024: Reviewed staff survey and findings to be considered as part of recommendations – complete. February 2024: Review SystmOne processes in SPA service with IM&T team. Time arranged – on track. February 2024: Substance misuse – currently mapping substance misuse/ dual diagnosis offer across the Trust – on track. March 2024: Draft and agree SPA core principles and recommendations for improvement work as part of the review report – on track. April 2024: Review completed, and improvement plan developed – on track. May 2024: Report submitted to EMT for approval of recommendations to move into improvement implementation – on track.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving Care	Improve our mental health services so they are more responsive, inclusive, and timely	**Care Closer to Home (CC2H) Programme** • Work continuing to sustain the reduction in out of area admissions during a challenging January and February • Pre-workshop survey reviewed • Successful engagement workshop in Wakefield • Meeting to look at the feedback from the events • Calderdale under represented so a further event being planned • Intensive Home Based Treatment Team Standard Operating Procedure (SOP) work progressing **Inpatient Priority Programme** • Discharge Initiatives are being progressed in alignment with NHSE principles • New standards relaunch for the Barriers to Discharge meeting have been rolled out in Calderdale/Kirklees • Workforce - Preceptorship support package in development – to be implemented from April 24 • Data - Outcome and measures dashboard drop-in training sessions have been sent out to staff **Community Transformation (MH)** High level mapping of service processes across Trust services completed and analysis completed. Pathway review task and finish group has commenced. Currently holding fortnightly meetings to identify commonality and address issues of difference within Pathways. Three Task and Finish groups have commenced working on reviewing Care Pathways; Core Services SOP and Enhanced Services SOP. Review of SOPs scheduled for completion by 30/04/24 A sub-group of the Interoperability Operational severe mental illness (SMI)/physical health check (PHC) Steering Group is currently reviewing SMI/PHC Templates and SNOMED coding on templates within SWYPFT and Ardens templates used in Primary Care. On track 30/03/24 Two pilots undertaking review of Cardiometabolic Guidance at Trinity (Wakefield) and Calder Valley (Calderdale) PCN's are on track 30/4/24. Installation of Client Activation Tool on SWYPFT laptops for the Community Mental Health Pharmacy Team across Localities so real time information and changes can be made by the service has been agreed. Analysis of the impact of the Client Activation Tool for EMIS GP Practices in other SWYPFT Services on track 31/03/24. Working together with Integrated care board locality programme leads across localities to maintain alignment, sharing communications and learning as the transformation programmes develop. Sign off higher level communications intranet page delayed as await information from Integrated care board locality programme leads to form the links for localities pages. Rescheduled to 28/02/24, this will be signed off at the Steering group 19.03.2024. All General Managers and key staff have been involved with the NICHE West Yorkshire Community Mental Health Team (CMHT) Evaluation. The review period has now finished, and we will await the second report due for July 2024.	
Improving care	Improve safety and quality	**Care planning and risk assessment** Work is progressing in line with the improvement plan. Improvement workshops to co-design the good practice guide, training package, the new look care plan and a quality dashboard with front line staff have been scheduled with the first one held in March. The next workshop is scheduled for 26th April. **Personalised care (moving on from Care Programme Approach)** The steering group continue to engage with the Avon and Wiltshire National Network Meeting, now joint chaired by NHSE, The Regional Community of Practice for North East Yorkshire and the Local West Yorkshire Network meetings. A joint Task and Finish Group with the Care Planning & Risk Assessment Improvement Group (CPRAIG) has been created and commenced working on the development of the PROMS (patient recorded outcome measures) and co-production of a Care Plan. Currently mapping where PROMS are being used within the Trust for discussion at the next steering group. Focus has been agreed on the use of Dialog including Dialog+ and the use of Reqol-10. Engagement session has been held with VCSE in Calderdale. Now working with Integrated care board to review the development of a group to continue the discussion specifically focused on the named keyworker and multi-disciplinary team role within this programme. Learning will be used in other localities. On track 31/03/24. Preliminary draft principles for key worker and multi-disciplinary team (MDT) functions in preparation for engagement have been signed off by main steering group 20/02/24. Members of the steering group will subsequently attend service line meetings across the Trust (April 2024) to roll out the discussion to staff by end of May 2024. Feedback is being fed back into the #allofusconversation. Higher level communications have been produced for use on SWYPFTS internet page. These have been displayed on the internet in March 2024.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving use of resources	Spend money wisely and increase value	**Value for money** Concerns remain about our ability to deliver the value for money sustainability target for 2024/25. Non pay schemes are progressing but identified financial savings realised to date have been limited. Challenges remain around pace and capacity, and this continues to be escalated to both the operational management group (OMG) and EMT. Value for money templates are being received via the operational management group, acknowledged further work is required to realise efficiencies/savings.	
	Make digital improvements	**Digital Dictation** The tender exercise has been completed and a new supplier (Lexacom) appointed to supply a Trustwide single digital dictation solution. Contract documentation will be completed by end of March. The first benefits realisation workshop has been held, with others scheduled for April 2024. The recruitment of a digital graduate has been completed with their start date confirmed for April 2024. Mobilisation meetings to be held with the new supplier to develop an implementation plan for roll out starting from April 2024 onwards.	
Great place to work	People Directorate 90-day plan	**Develop the People Directorate (PD) Team** Continuing with staff engagement activities and gaining commitment to critical pathways work with people leadership team (PLT) and wider in the directorate with recognition of longer-term programme of culture change and directorate stability work. This ongoing work includes watchful waiting and building the capacity, competence, and confidence across the directorate in getting the basics right (90-day plan) and building individual and team cohesion across the teams in the directorate. Monthly updates in senior leadership team (SLT) prior to updates for Trust board will support governance and introduction of deeper dives.	
		Reduce recruitment time to hire: Six task & finish groups in place following Recruitment Development Day Following initial work to cleanse systems and obtain first draft data overall time to hire is approximately 60 days. This does not include candidates working notice periods in current/previous roles. This dataset is being identified from ESR.	
		80% of Trust staff have received an appraisal in the last 12 months: Having achieved the 80% threshold, the focus is to aim to 95%	
Great place to work	People Directorate 90-day plan	**Improve International Nurse experience and support:** Outstanding 17 nurses now allocated to a ward: 10 into Wakefield, 7 into Forensics. Agreement for over recruitment in these areas. • 8 nurses OSCE passed and awaiting start on ward. • 11 nurses awaiting OSCE exam, all booked in for next 4 weeks. No further cohorts planned. International nurse recruitment removed from 2024/25 workforce plan to focus on support. Temporary pastoral support officer role extended to end of June for existing support/handover.	
		Improve Quality of Workforce Data: Capacity to deliver and re-instate online suite of required workforce information in People Directorate Delays in project implementation due to delays in sign off, however progress is being made.	
		Improve People Experience Some progress in the work streams but retaining amber status due to the scale of the culture work and multiple dependencies to embed including: Delay in receiving the draft inclusive leadership report Effective and accurate data as a baseline (Although request now scoped and lodged for the design and creation of a workforce equalities dashboard in PowerBI to support analysis and monitoring of data. The current RED status for workforce data on the plan presents a risk Willingness from leaders and their teams to engage in process.	
		Improve employee relations support: Service propositions for the People Partners and People Operations Teams completed. Staff side have agreed proposals however timescales for completion of entire project is dependent on multiple stakeholders hence to retain amber status for this action at this point. Completion of new formatted policy suites via legal advisors (date has already been scheduled for completion end April pending signoff to proceed with resource allocated.	
		Develop the workforce plan The first draft plans have been completed and submitted. Work continues final triangulation of workforce/activity/finance plans toward April 2024 sign off and final submission to NHSe/Integrated care boards First draft of the NHSE/Integrated care board mental health non-functional workforce plan complete submission in February pending Trustwide sign off. First draft consolidated workforce plan complete. First draft submission agreed EMT February March 2024 - Trust is an outlier regionally for first draft plan regarding workforce growth. Review of final plan and workforce growth rate to EMT timeout 14/05/24. To be revised for triangulation with finance.	

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

Performance Indicator		Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£0.6m	£0.5m	A deficit of £398k has been reported in February 2024. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target. This will support the delivery of the West Yorkshire Integrated Care System financial target although this remains challenging.
2	Agency Spend	£7.9m	£8.5m	Agency spend has continued to reduce in February 2024 and is now forecast to be under the target of £8.7m spend in year. Work continues to maintain, and improve, this run rate into 2024 / 25.
3	Financial sustainability and efficiencies	£10.8m	£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	£74.5m	£71.4m	Overall the Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure.
5	Capital	£5.1m	£8.3m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £5.1m (61% of plan). Spend in February was £1.9m. Progress on all schemes has been reviewed and the team are confident that the total allocation of £8.3m will be utilised in full.
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 11 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0	Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to Date	Forecast 2023 / 24	Narrative
1	Surplus / (Deficit)	£0.6m	£0.5m	A deficit of £398k has been reported in February 2024. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target. This will support the delivery of the West Yorkshire Integrated Care System financial target although this remains challenging.
2	Agency Spend	£7.9m	£8.5m	Agency spend has continued to reduce in Febuary 2024 and is now forecast to be under the target of £8.7m spend in year. Work continues to maintain, and improve, this run rate into 2024 / 25.
3	Financial sustainability and efficiencies	£10.8m	£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	£74.5m	£71.4m	Overall the Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure.
5	Capital	£5.1m	£8.3m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £5.1m (61% of plan). Spend in February was £1.9m. Progress on all schemes has been reviewed and the team are confident that the total allocation of £8.3m will be utilised in full.
6	Better Payment Practice Code	98%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

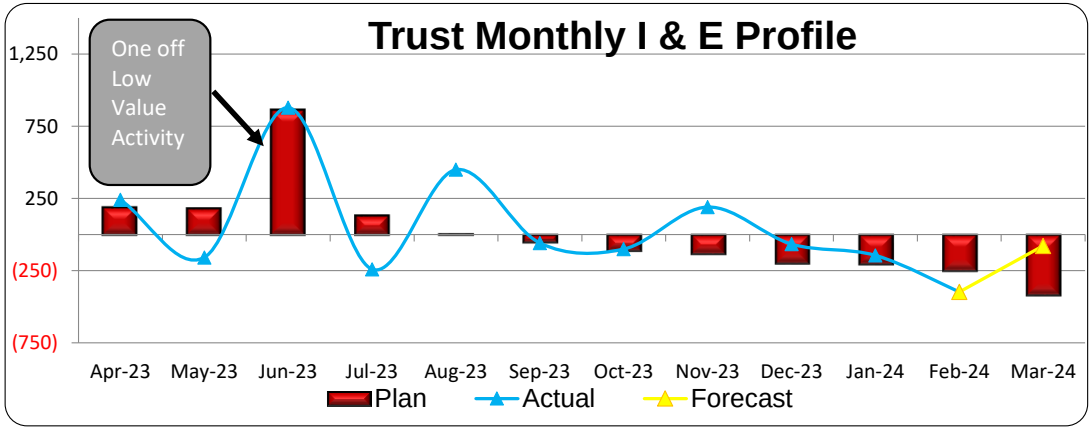
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

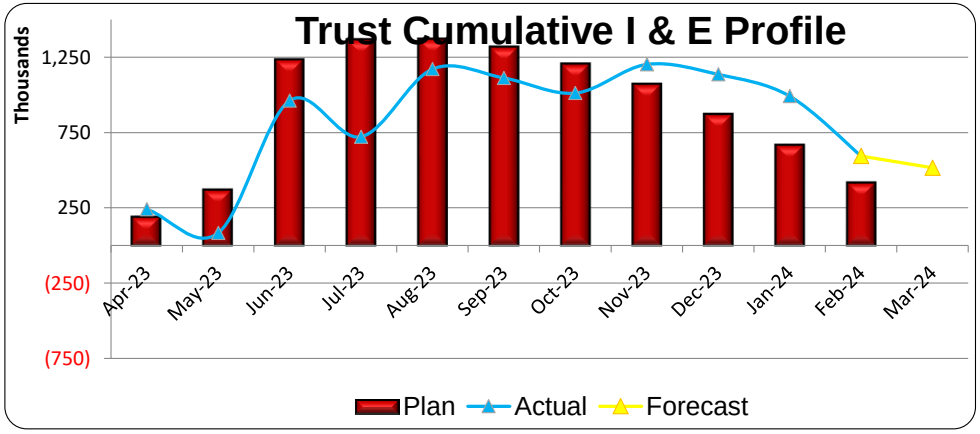
2.0 Income & Expenditure Position 2023 / 24

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					34,066	34,468	402	365,035	363,840	(1,194)	399,221	397,282	(1,938)
Other Operating Revenue					1,073	1,612	539	11,875	14,057	2,181	12,976	15,421	2,445
Total Revenue					**35,138**	**36,079**	**941**	**376,910**	**377,897**	**987**	**412,197**	**412,703**	**507**
Pay Costs	5,022	5,079	57	1.1%	(21,127)	(21,929)	(802)	(226,411)	(222,206)	4,205	(247,604)	(243,266)	4,338
Non Pay Costs					(13,852)	(14,257)	(405)	(145,459)	(151,577)	(6,119)	(159,566)	(165,057)	(5,490)
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	**5,022**	**5,079**	**57**	**1.1%**	**(34,979)**	**(36,186)**	**(1,207)**	**(371,870)**	**(373,778)**	**(1,908)**	**(407,170)**	**(408,317)**	**(1,147)**
EBITDA	**5,022**	**5,079**	**57**	**1.1%**	**160**	**(106)**	**(266)**	**5,040**	**4,119**	**(921)**	**5,027**	**4,386**	**(641)**
Depreciation					(481)	(489)	(8)	(5,468)	(5,517)	(49)	(5,949)	(6,007)	(59)
PDC Paid					(179)	(179)	0	(1,969)	(1,969)	0	(2,148)	(2,148)	0
Interest Received					251	377	126	2,813	3,960	1,147	3,070	4,285	1,215
Surplus / (Deficit) - ICB performance measure	**5,022**	**5,079**	**57**	**1.1%**	**(249)**	**(398)**	**(149)**	**416**	**594**	**177**	**0**	**516**	**516**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(212)	(212)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	870	870	0	870	870
Surplus / (Deficit) - Total	**5,022**	**5,079**	**57**	**1.1%**	**(249)**	**(417)**	**(168)**	**416**	**1,251**	**835**	**0**	**1,154**	**1,154**





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	363,840	61,844	1,086	33,676	267,234
Other Operating Revenue	14,057				14,057
Total Revenue	**377,897**	**61,844**	**1,086**	**33,676**	**281,291**
Pay Costs	(222,206)	(1,390)	(101)	(681)	(220,033)
Non Pay Costs	(151,577)	(60,454)	(720)	(32,995)	(57,409)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	**(373,778)**	**(61,844)**	**(821)**	**(33,676)**	**(277,437)**
EBITDA	**4,119**	**0**	**265**	**0**	**3,854**
Depreciation	(5,517)				(5,517)
PDC Paid	(1,969)				(1,969)
Interest Received	3,960				3,960
Surplus / (Deficit) - ICB	**594**	**0**	**265**	**0**	**328**
Depn Peppercorn Leases (IFRS16)	(212)				(212)
Revaluation of Assets	870				870
Surplus / (Deficit) - Total	**1,251**	**0**	**265**	**0**	**986**
Surplus / (Deficit) - Forecast	**516**	**(38)**	**280**	**0**	274

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.

There has been significant movement in the South Yorkshire Adult Secure collaborative in month. The increase in expenditure recognises the risk associated with ongoing contract negotiations with one independent sector provider.

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					25,366	25,583	217	269,259	267,234	(2,025)	294,746	292,020	(2,725)
Other Operating Revenue					1,073	1,612	539	11,875	14,057	2,181	12,976	15,421	2,445
Total Revenue					**26,439**	**27,195**	**756**	**281,135**	**281,291**	**156**	**307,721**	**307,441**	**(280)**
Pay Costs	5,001	5,046	45	0.9%	(20,982)	(21,734)	(751)	(224,754)	(220,033)	4,720	(245,801)	(240,892)	4,909
Non Pay Costs					(5,297)	(4,382)	915	(51,341)	(57,409)	(6,068)	(56,893)	(62,448)	(5,554)
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	**5,001**	**5,046**	**45**	**0.9%**	**(26,279)**	**(26,116)**	**163**	**(276,095)**	**(277,437)**	**(1,342)**	**(302,695)**	**(303,335)**	**(640)**
EBITDA	**5,001**	**5,046**	**45**	**0.9%**	**160**	**1,079**	**920**	**5,040**	**3,854**	**(1,186)**	**5,027**	**4,106**	**(921)**
Depreciation					(481)	(489)	(8)	(5,468)	(5,517)	(49)	(5,949)	(6,007)	(59)
PDC Paid					(179)	(179)	0	(1,969)	(1,969)	0	(2,148)	(2,148)	0
Interest Received					251	377	126	2,813	3,960	1,147	3,070	4,285	1,215
Surplus / (Deficit) - ICB performance measure	**5,001**	**5,046**	**45**	**0.9%**	**(249)**	**788**	**1,037**	**416**	**328**	**(88)**	**(0)**	**236**	**236**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(212)	(212)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	870	870	0	870	870
Surplus / (Deficit) - Total	**5,001**	**5,046**	**45**	**0.9%**	**(249)**	**768**	**1,018**	**416**	**986**	**569**	**(0)**	**874**	**874**

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	5,022	5,079	57	1.1%	(249)	(398)	(149)	416	594	177	0	516	516
Provider Collaboratives	21	33	12	55.6%	0	(1,185)	(1,185)	0	265	265	0	280	280
Total excluding Collaboratives (as shown above)	**5,001**	**5,046**	**45**	**0.9%**	**(249)**	**788**	**1,037**	**416**	**328**	**(88)**	**0**	**236**	**236**

Income & Expenditure Position 2022 / 23

The year to date position is a surplus of £0.6m. This is £0.2m better than planned.
Excluding the financial impact of the provider collaboratives the core Trust is a surplus of £0.3m.

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

There has been an increase in income in February, as forecast, due to the agreed investments from commissioners. This has been phased later in the year to reflect best estimates of recruitment. Due to delays £1m of slippage, agreed with, and payable to, commissioners has been included in the March 2024 position. This had been included in previous Trust forecast modelling.

Pay

Expenditure in January 2024 was lower than the previous run rate due to a number of one off benefits recognised in month. In Feburary this has increased by £1m relating to an accrual.

There has also been continued workforce growth, substantive and bank, in month. This is a continued trend of growth which has been throughout the whole financial year. This growth has been experienced across a wide range of services and localities.

Non Pay

The non pay analysis highlights a reduction in spend compared to January. This includes a reversal of the provision previously accounted for in January. There has also been a number of additional one off spends in month as described on page 11.

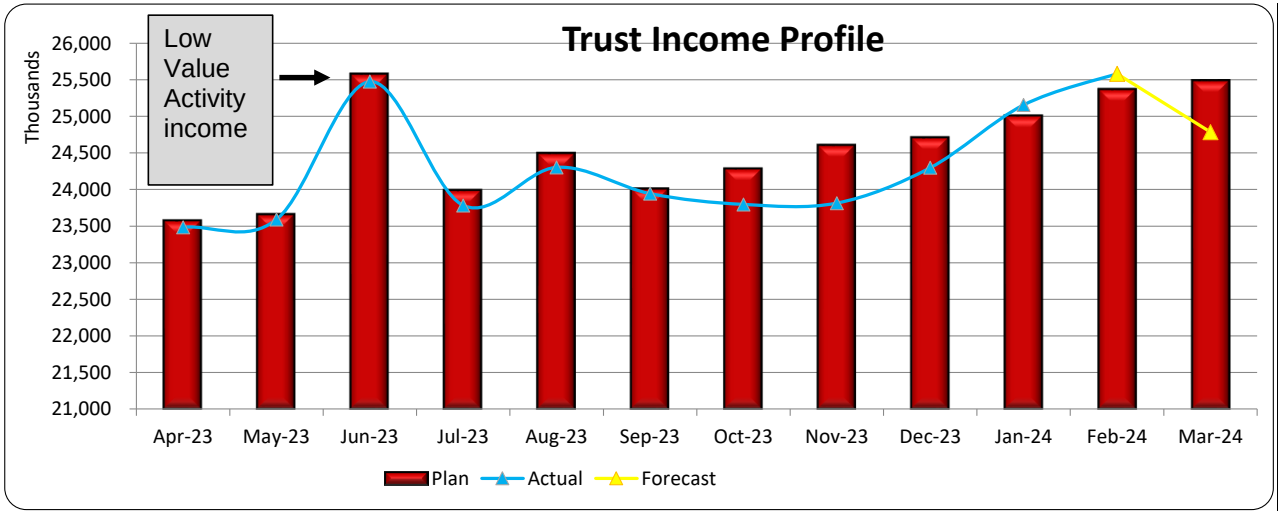
2.1 Income Information

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	21,444	20,865	20,837	**244,925**	**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	2,740	3,172	2,785	**33,429**	**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	466	702	500	**5,838**	**5,311**
Partnerships	514	584	546	591	472	608	377	493	504	376	755	522	**6,341**	**5,052**
Other Contract Income	197	96	144	102	144	138	140	67	98	130	89	143	**1,487**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,783**	**24,304**	**23,945**	**23,797**	**23,815**	**24,298**	**25,157**	**25,583**	**24,786**	**292,020**	**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**	



As previously noted the income profile increases in Quarter 4 to recognise additional investment (both Mental Health Standard Investment (MHIS) and other) agreed with commissioners. This is offset by additional costs.

The full year effects of this investment have been included in the Trust financial model for 2024 / 25.

The reduction in March 2024 relates to slippage against investment agreed with commissioners.

2.2 Pay Information

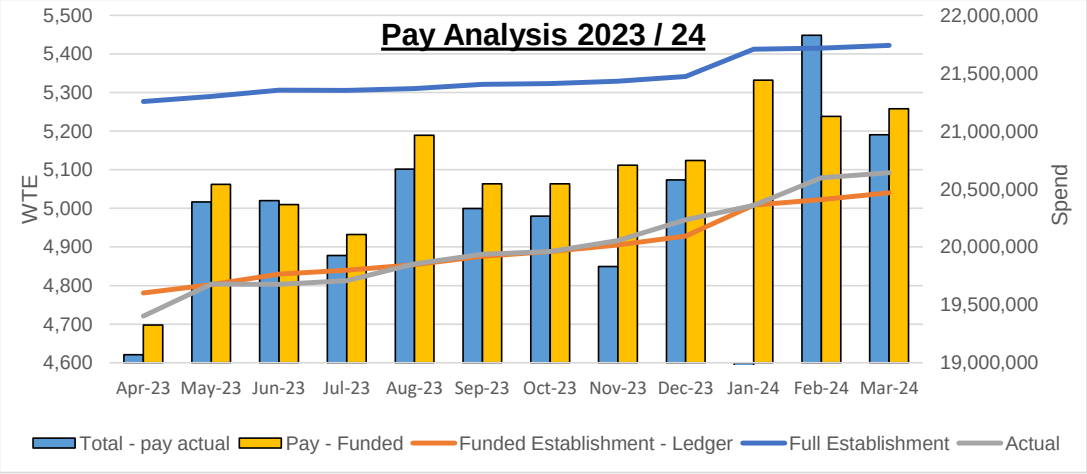
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	16,462	19,522	18,644	**215,879**
Bank & Locum	849	1,355	1,337	1,360	1,481	1,454	1,442	1,511	1,587	795	1,729	1,619	**16,518**
Agency	939	908	1,002	855	810	915	635	209	564	581	483	596	**8,496**
Total	**18,936**	**20,296**	**20,278**	**19,819**	**20,540**	**20,195**	**20,200**	**19,722**	**20,475**	**17,837**	**21,734**	**20,859**	**240,892**
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%	4.5%	8.0%	7.8%	6.9%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.5%	3.1%	1.1%	2.8%	3.3%	2.2%	2.9%	3.5%

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	4,490	4,558	4,588	**4,412**
Bank & Locum	222	314	326	321	356	369	363	387	408	415	438	406	**360**
Agency	157	161	164	163	144	145	126	113	108	103	84	98	**130**
Total	**4,721**	**4,804**	**4,803**	**4,812**	**4,856**	**4,881**	**4,888**	**4,917**	**4,970**	**5,008**	**5,079**	**5,092**	**4,903**
22/23	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



Pay expenditure was low in January due to release of a number of one off adjustments. It is higher, than the underlying run rate, in Feburary due to an additional £1m estimate of potential staff claims.

None of these adjustments had associated WTE so the graph on the left highlights the underlying rate with continued workforce growth.

February 2024 highlights a further 67 WTE increase of substantive worked and 23 WTE in bank. This has helped to support the reduction of agency WTE utilised (19 less in month). Overall this is an increase of 71 worked

The increase is spread across a wide range of services and localities. In February there has been no significant movement in inpatient areas.

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 £483k in February.

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.

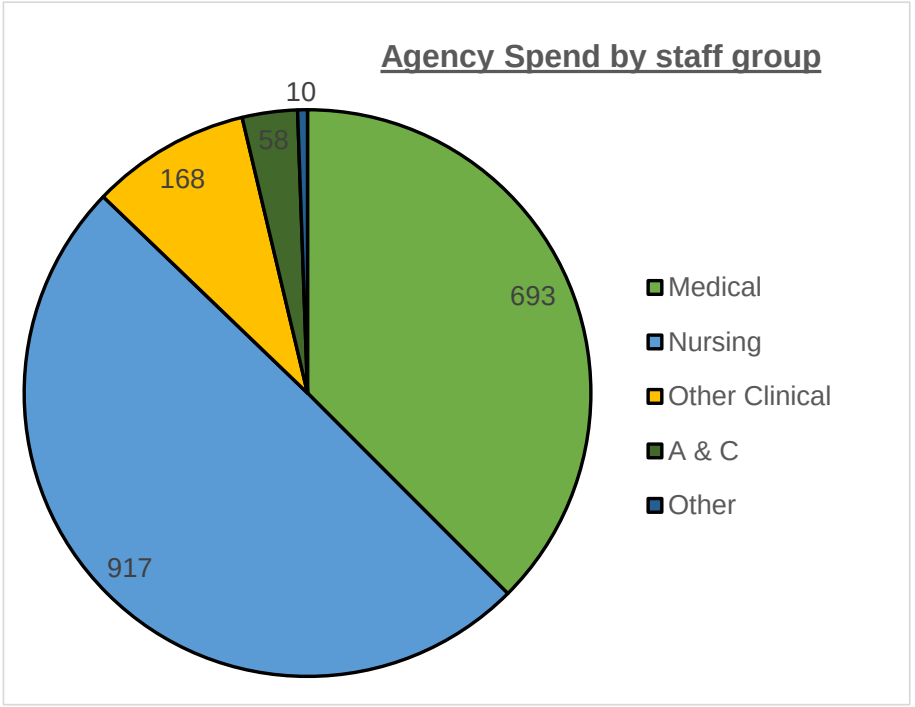
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

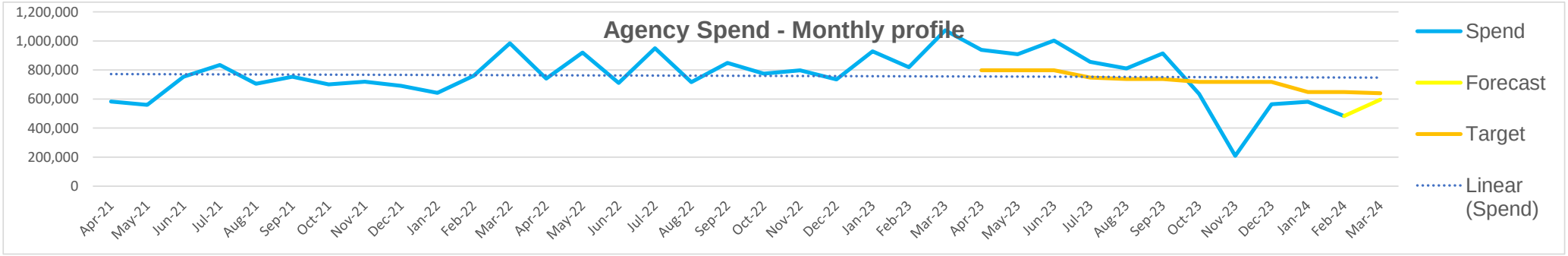
Under the NHS Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23 and the target trajectory is outlined in the graph below.

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.

February 2024 spend is £483k which is c. £100k lower than last month. This improves on the quarter 3 run rate, which in itself was an improvement from the first half of the year, although it should be noted that February is normally less than the average run rate due to less days in the month and less annual leave taken resulting in less backfill requirements. Further work continues to triangulate the growth in substantive and bank staff against the reduction in agency staff.

Overall the forecast spend for 2023 / 24 is £8.5m which is £0.2m less than the target value. The run rate, and impact on planning for 2024 / 25, continues to be assessed as part of the planning process.



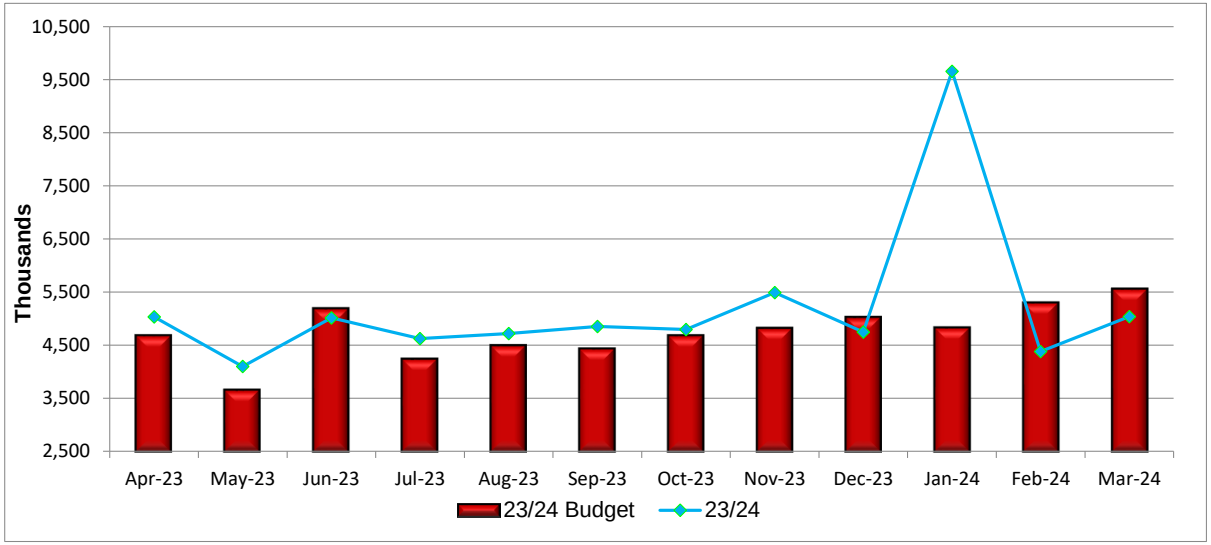


2.3 Non Pay Expenditure

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	9,659	4,382	5,039	**62,448**
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	3,789	3,632	(157)
Establishment	9,270	9,467	197
Lease & Property Rental	7,988	7,844	(144)
Premises (inc. rates)	5,185	5,629	444
Utilities	2,108	2,248	140
Purchase of Healthcare	8,333	12,255	3,923
Travel & vehicles	4,688	4,524	(164)
Supplies & Services	6,105	7,049	944
Training & Education	1,924	1,638	(286)
Clinical Negligence & Insurance	972	975	3
Other non pay	980	2,148	1,168
Total	**51,341**	**57,409**	**6,068**
Total Excl OOA and Drugs	**39,219**	**41,521**	**2,302**



Key Messages

There has been a number of significant non pay movements in February including:

* £2m reversal of previous legal provision. This has been resolved.
* A further £1m additional purchase of healthcare with a local NHS provider relating to mental health activity within an acute setting

Excluding these the non pay expenditure run rate is in line with previous months.

The purchase of healthcare, highlighted as a cost pressure above, is reported in detail on page 12. This is shown as £5m overspent which relates to the mental health activity in acute hospitals as previously reported.

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.

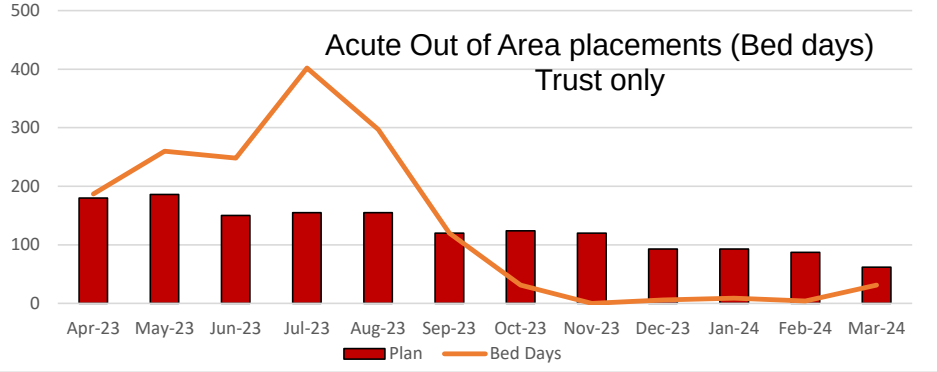
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

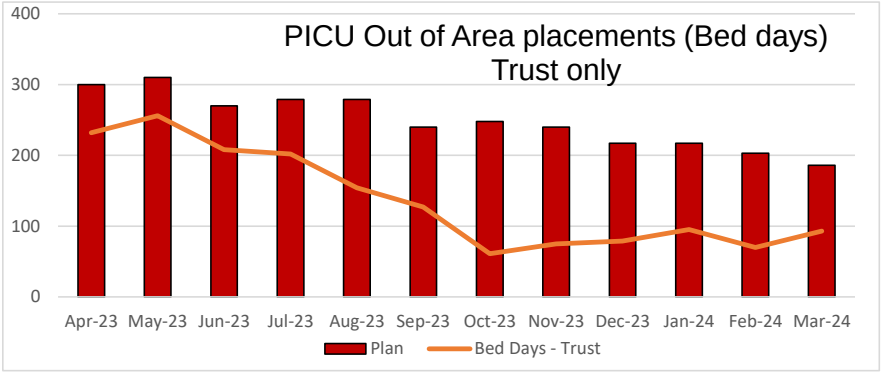
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

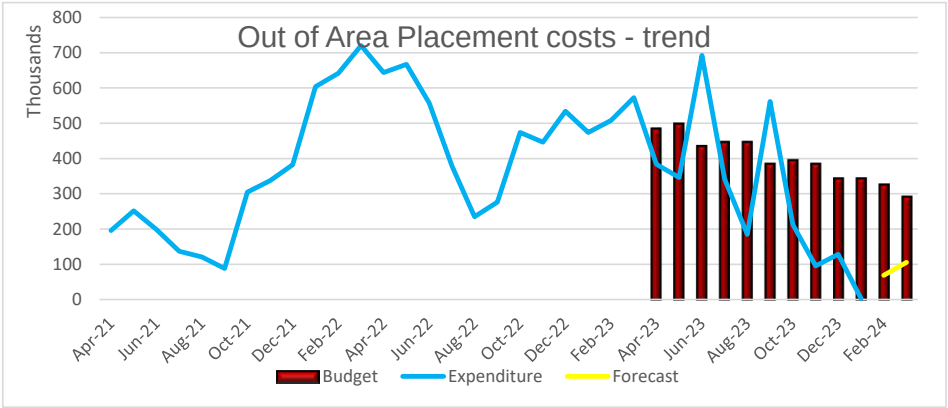
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	1,121	1,168	47
PICU	3,257	1,759	(1,498)
Locked Rehab	2,093	2,318	225
Services - NHS	361	5,319	4,958
IAPT	162	393	232
Yorkshire Smokefree	71	30	(41)
Other	1,268	1,268	(0)
Total	**8,333**	**12,255**	**3,923**







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 has been minimal acute placements, 4 days in February, and 70 in PICU (3 individuals). 2 of the PICU placements are due to specific gender requirements. This continues to be managed as part of overall operational management.

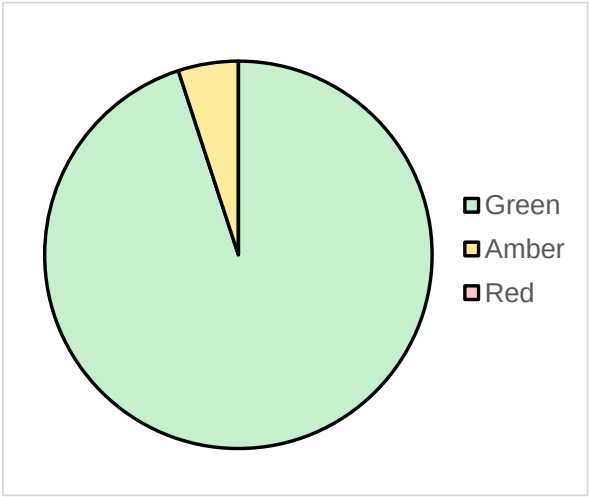
This remains volatile and increases in both areas have been included in the baseline forecast scenario. Other West Yorkshire mental health providers have seen rapidly escalating usage of placements over this period.

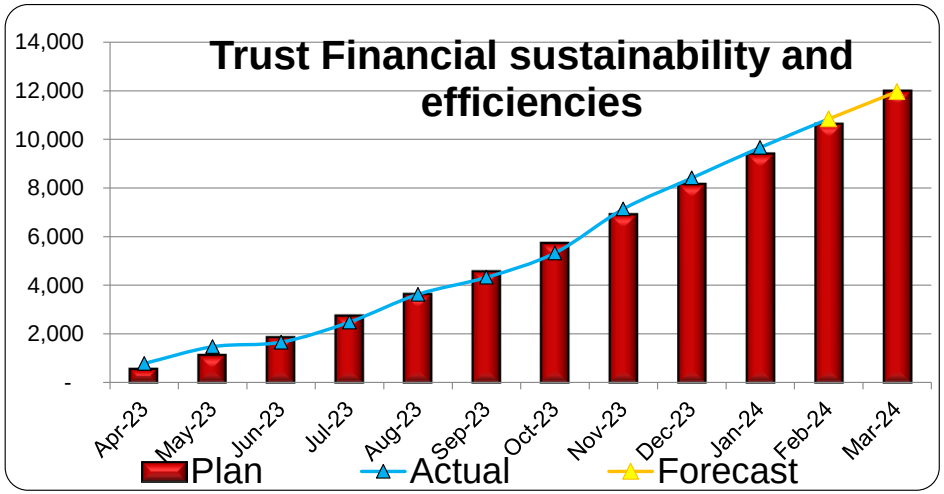
2.4 Value for Money, Financial sustainability and efficiency

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	2,780	4,250		3,197	4,250	600	
Agency & Workforce	Pg. 10	3,830	718	1,602	4,380	2,387	0	
Medicines optimisation		367	188		400	188		
Non Pay Review		938	0		1,048		0	0
Income contributions		462	703		500	885		
Interest Receivable	Pg. 4	1,283	2,430		1,400	2,615		
Provider Collaborative	Pg. 5	952	952		1,044	1,044		
Total		**10,611**	**9,241**	**1,602**	**11,969**	**11,369**	**600**	**0**
Recurrent		9,697	9,241		10,943	9,767	2,202	
Non Recurrent		913		1,602	1,026			0





The year to date value for money programme is currently £232k ahead of plan which is helping to support the overall financial position of the Trust. For 2023 / 24 the forecast is that the target of £11,969k will be achieved in full.

In year performance has been better than planned for:

* Out of area placements
* Interest receivable

This has offset under delivery on schemes relating to workforce and non pay efficiencies.

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	165,948	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,166	
Non NHS Trade Receivables (Debtors)	2,853	962	
Prepayments	3,482	2,823	
Accrued Income	9,372	1,002	2
Cash and Cash Equivalents	74,585	74,490	Pg 15
Total Current Assets	**92,097**	**80,675**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(5,435)	3
Capital Payables (Creditors)	(739)	(2,388)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,511)	4
Accruals	(32,952)	(21,767)	4
Deferred Income	(4,172)	(1,748)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(51,577)	1
Total Current Liabilities	**(104,062)**	**(91,426)**	
Net Current Assets/Liabilities	**(11,965)**	**(10,751)**	
Total Assets less Current Liabilities	**153,210**	**155,197**	
Provisions for Liabilities	(4,319)	(3,620)	
Total Net Assets/(Liabilities)	**148,891**	**151,577**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,657	
Revaluation Reserve	14,026	15,460	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	85,239	
Total Taxpayers' Equity	**148,891**	**151,577**	

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.

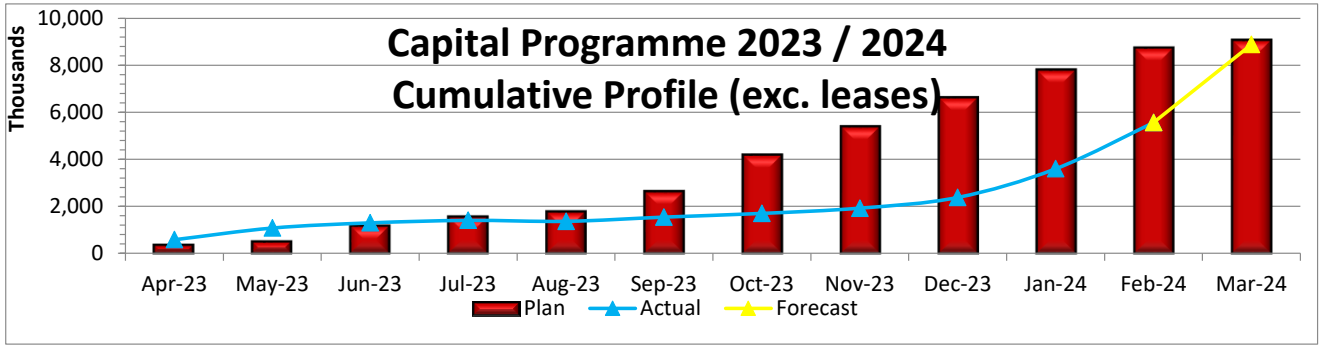
2. Accrued income, and maintaining at a low level, remains a focus in order to reduce risk and maximise cash balances. Invoices will be continued to be raised timely ahead of Month 12.

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, 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	1,475	71	(1,404)	100	(1,375)
Seclusion rooms	750	750	426	(324)	700	(50)
Maintenance (Minor) Capital						
Clinical Improvement	285	285	638	353	783	498
Safety inc. ligature & IPC	990	890	1,694	804	2,357	1,367
Compliance	430	430	59	(371)	193	(237)
Backlog maintenance	510	510	28	(482)	148	(362)
Sustainability	300	300	58	(242)	224	(76)
Plant & Equipment	40	40	115	75	260	220
Other	1,223	1,025	1,009	(16)	992	(231)
IM & T						
Digital Infrastructure	1,100	1,100	602	(498)	1,440	340
Digital Care Records	180	160	41	(119)	46	(134)
Digitally Enabled Workforce	815	816	151	(665)	706	(109)
Digitally Enabling Service Users & Carers	400	390	175	(215)	268	(132)
IM&T Other	270	270	83	(187)	84	(186)
TOTALS	**8,768**	**8,441**	**5,148**	**(3,292)**	**8,300**	**(468)**
Lease Impact (IFRS 16)	5,203	5,203	6,085	882	6,096	893
New lease	303	303	417	114	587	284
TOTALS	**14,274**	**13,947**	**11,650**	**(2,296)**	**14,983**	**710**



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%.

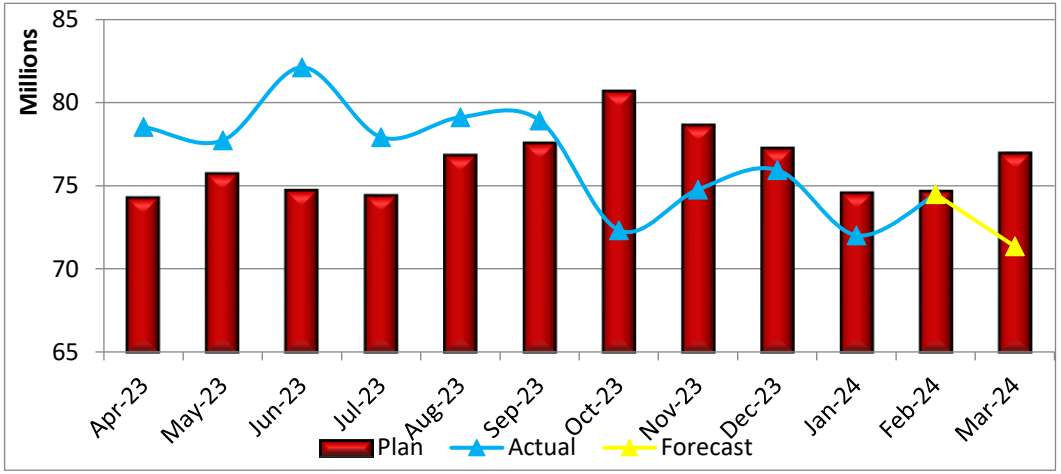
In November 2023 the ICB agreed for all Trusts to revert to plan. For the Trust the revised target is £8,300k.

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 2023 / 2024

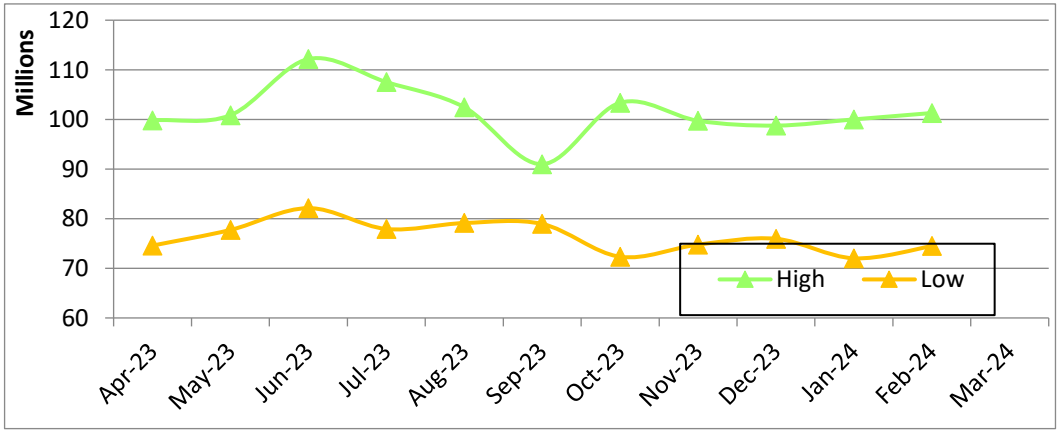


The Trust cash position remains positive.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	74,649	74,490	(158)

Cash has increased in month but is expected to reduce in Month 12, as one off payments are made including PDC.

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



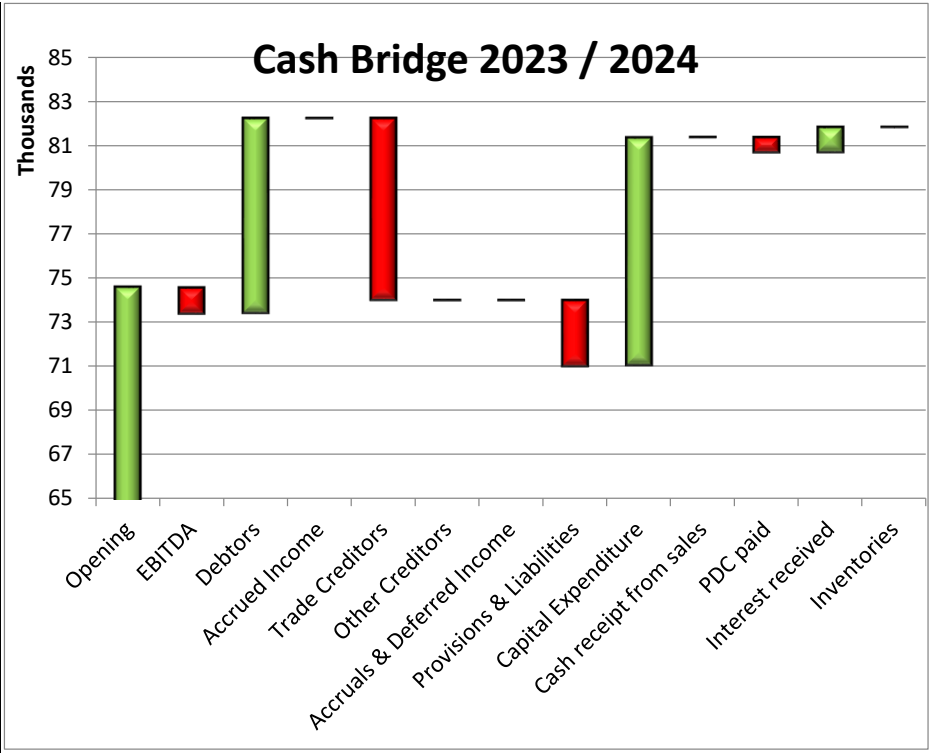
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £101.3m
The lowest balance is: £74.5m

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)	13,245	12,054	(1,191)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	2,113	10,939	8,826	
Trade Payables (Creditors)	(2,504)	(10,705)	(8,201)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(128)	(3,123)	(2,995)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(15,476)	(5,148)	10,327	
Cash receipts from asset sales	0	5	5	
Leases	0	(7,386)	(7,386)	
PDC Dividends paid	0	(691)	(691)	
PDC Dividends received	0		0	
Interest (paid)/ received	2,813	3,960	1,147	
Closing Balances	**74,649**	**74,490**	**(158)**	



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 £0.2m lower than plan, the high value of creditors paid is offset by the delay in capital expenditure.

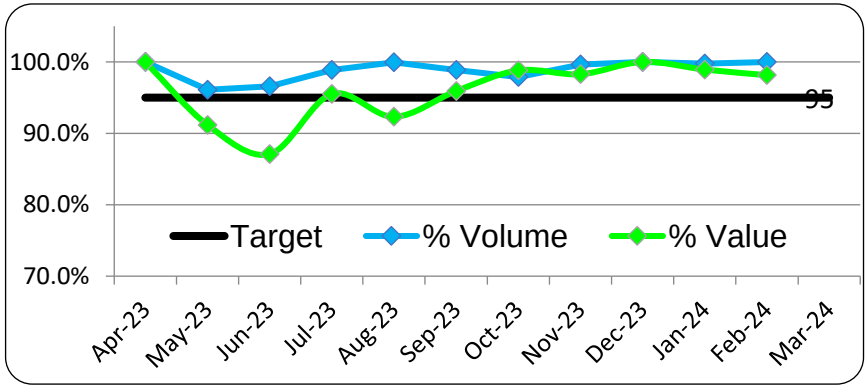
4.0 Better Payment Practice Code

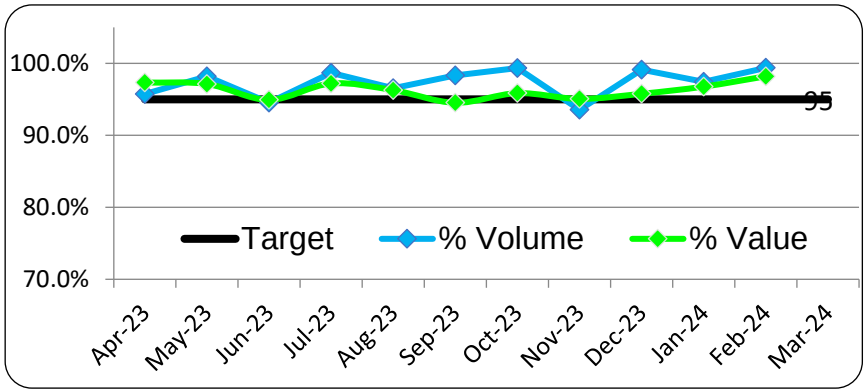
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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%	98%
Cumulative Year to Date	99%	97%

Non NHS	Number %	Value %
In Month	99%	98%
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 (£)
05-Feb-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5401	800,000
18-Feb-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000057778	740,183
14-Feb-24	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1001081	680,394
27-Feb-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	204132	620,647
29-Feb-24	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59894475	477,784
27-Feb-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS43	450,000
01-Feb-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D200007195	342,087
22-Feb-24	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000519	319,139
01-Feb-24	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0129115	287,415
24-Feb-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	-	270,000
05-Feb-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 281	235,196
14-Feb-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foun	4400001063	232,254
27-Feb-24	Purchase of Healthcare	AS Collaborative	Mid Yorkshire Hospitals NHS Trust	1600025928	202,992
22-Feb-24	Purchase of Healthcare	AS Collaborative	Softcat Plc	INVUK1194464	178,890
09-Feb-24	Purchase of Healthcare	AS Collaborative	My Happy Mind Ltd	1610	162,050
01-Feb-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5399	129,526
01-Feb-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D200007194	119,775
22-Feb-24	Research	Trustwide	Durham University	200007	104,326
12-Feb-24	IT Services	Trustwide	Daisy Corporate Services	3I522086	90,250
23-Feb-24	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	326008	77,036
18-Feb-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC020BINV	70,330
13-Feb-24	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1001079	66,273
08-Feb-24	Purchase of Healthcare	AS Collaborative	Kirklees Council	8608573533	56,500
22-Feb-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000007553	56,000
15-Feb-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS041INV	54,818
14-Feb-24	Continence products	Barnsley	Supply Chain Coordination Limited	1124279547	54,201
14-Feb-24	Drugs	Barnsley	NHS Business Services Authority	1000079731	53,366
15-Feb-24	Purchase of Healthcare	AS Collaborative	Edf Energy Customers Ltd	000018118518	51,803
16-Feb-24	Software Licence	Trustwide	Softcat Plc	INVUK1190154	51,216
09-Feb-24	Purchase of Healthcare	Forensics	Spectrum Community Health Cic	SINV7048	48,868

06-Feb-24	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72486758	47,313
07-Feb-24	Purchase of Healthcare	AS Collaborative	Family Lives	2537	39,709
05-Feb-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001129EPC	37,587
01-Feb-24	Purchase of Healthcare	Barnsley	Touchstone-Leeds	SINV20230260	35,365
15-Feb-24	Mobiles	Trustwide	Vodafone Ltd	105249011	35,241
27-Feb-24	Purchase of Healthcare	Kirklees	Nouvita Ltd	11334	35,190
26-Feb-24	Utilities	Trustwide	Totalenergies Gas & Power Ltd	33079507424	33,168
06-Feb-24	Continence products	Barnsley	Supply Chain Coordination Limited	1124285803	32,662
18-Feb-24	Purchase of Healthcare	AS Collaborative	Cloverleaf Advocacy 2000 Ltd	12866	31,397
13-Feb-24	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	1001077	30,853
08-Feb-24	MFDs	Trustwide	Annodata Ltd	1346268	30,591
21-Feb-24	Purchase of Healthcare	AS Collaborative	Capsticks Solicitors Llp	INVDP134	30,000
06-Feb-24	Legal Fees	Trustwide	Bevan Brittan Llp	10262605	28,721
28-Feb-24	Staff Recharge	Trustwide	Sheffield Health & Social Care NHS Foundation Tr	0000000500	28,291
15-Feb-24	Utilities	Trustwide	Edf Energy Customers Ltd	000018098785	28,286
12-Feb-24	Staff Recharge	Calderdale	Calderdale Metropolitan Borough Council	IN23173908	28,123
28-Feb-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB05699	27,586
29-Feb-24	Service Recharge	Barnsley	Barnsley Metropolitan Borough Council	9000319513	25,000

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

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

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

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

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

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

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

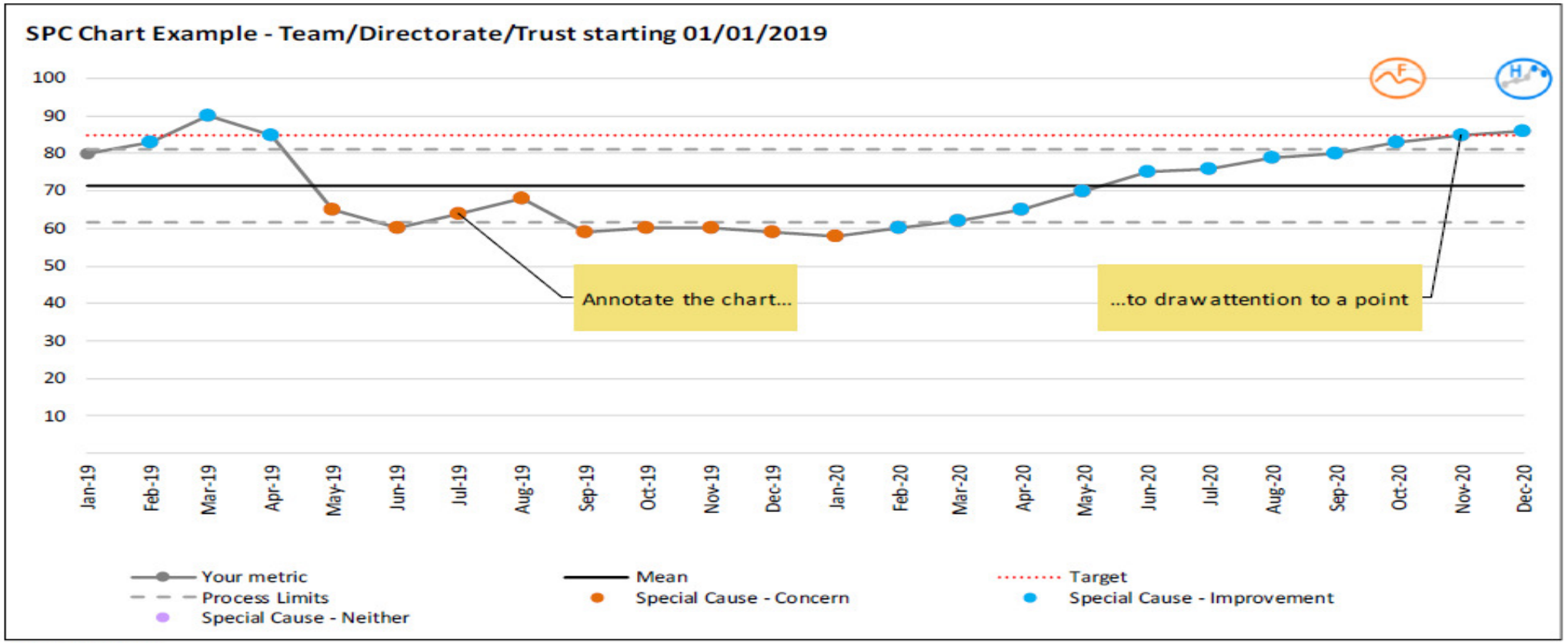
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

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

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Care Group Dashboards**		
Paper presented by:	**Carol Harris - Chief Operating Officer**		
Paper prepared by:	Sue Threadgold - Director of Services		
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in services for adults with attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) and learning disability (LD) 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 adult ADHD/ASD and LD 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 adult ADHD/ASD and LD 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	ADHD /ASD services contribute to the wider work underway in both integrated care systems to understand the significant national, regional and local rise in demand and to try to find solutions. The Trust provides ASD services to people in Bradford in partnership with Bradford District Care Trust. The performance of this service is not included in this report. Regarding LD, Bradford District Care Trust are the coordinating provider of the assessment and treatment units (ATU) and the Horizon unit, along with the ATU in Bradford, provide inpatient assessment and treatment for people with a learning disability for West Yorkshire.
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. Specific performance detail for Horizon ATU is set out in the inpatient section of the integrated performance report and performance is reviewed in the operational management group.
Executive summary:	Trust Board members are asked to note specifically: Working through the report the care group identified that future reports will include a further breakdown of learning disability services by place or service line and provide ADHD/ASD data separately, to provide Board with more in-depth information. Plans are in place to achieve the 90% target for appraisals in LD services by 31 March 2024. Regular monitoring and focused actions are in place. Work is underway to align local reporting and Trust wide data. Mid-March local reports are showing 84.8% with 12 outstanding appraisals booked in diaries between now and the end of April 2024. ADHD/ASD services have maintained a robust system of monitoring and consistently perform well with appraisals with January data at 92.9% and consistency between Trust wide and local data. Spikes in sickness in LD services have been related to a mixture of COVID /seasonal illnesses alongside long term sickness. Overall, sickness is well managed and in January is at 3.8%. The professional mix of LD services causes challenges when sickness absence impacts the availability of a specific profession due to the distribution of specialist professions across the service

	and existing vacancies. For example, if a speech and language professional is unwell, this will impact on waiting lists immediately. ADHD and ASD services sickness absence is managed well, with January sickness at 0.3%. It must be noted that the small team size will impact the overall percentage and a spike is noted when one or two members of the team are ill. The ADHD/ASD service has a very strong embedded culture of prioritising supervision with January performance at 95.5.%. Recognising the positive impact this has on staff and recognising the strong appraisal performance also, the correlation with the low sickness in the team is notable. Uptake of clinical supervision in LD services has been consistently below target. The service is reviewing the uptake and the recording of supervision and introduced closer monitoring through team manager meetings, shared a 'how to' guide in relation to reporting and strengthened messages with staff about prioritising supervision. The current actions are expected to create an upwards trajectory by June 2024 and the date for compliance against the target will be confirmed. Compliance with the reducing restrictive practice interventions (RRPI) training is in part impacted by the availability of training which is now being resolved. The majority of staff in LD and ADHD/ASD services work in the community and are required to complete breakaway and personal safety training. Managers are monitoring compliance and ensuring staff are booked onto the training. The Horizon Unit, as a reporter of high incidents of violence and aggression, takes proactive action with staff rosters to ensure appropriate numbers of trained staff are on duty. Horizon's performance is currently 81% with staff booked into future training. Recognising that people with a learning disability are also at a higher risk of physical health conditions, the LD team are taking action to improve performance in cardiopulmonary resuscitation (CPR) training and managers are working with staff to book courses. The LD team have engaged with the resus team to improve access to the courses for staff who work shifts. Staff rostering ensures that appropriately trained staff are available on all shifts. Waiting times for both ADHD/ASD and LD services are captured in detail in the waiting list report that is presented to the Finance, Investment and Performance Committee and the impact of waits are reported through the care group report to the Quality and Safety Committee. Key issues relating to ADHD waits include: • People referred to ADHD services are initially prioritised based on their clinical needs relating to ADHD and the MDT review of a request from a referrer to expedite the referral. • Referral rates are approximately 7 times higher than commissioned capacity in Barnsley and Kirklees, and 11 times higher in Wakefield. • There are approximately 3,900 people waiting for their first appointment from these localities, plus 960 people waiting in Calderdale. This

	number is expected to grow by approximately 250 each month which also impacts on waiting times. • Kirklees and Wakefield commissioners have invested in a pilot project that will be in place from April 2024, new referrals are to be offered a face to face appointment with an ADHD expert to ensure clinical appropriateness for an ADHD assessment. This new and innovative step will ensure people are not added to the waiting list inappropriately, they can be signposted to other services if appropriate. Key issues relating to ASD waits include: • Barnsley, Kirklees and Calderdale referrals are almost 2.5 times greater than in 2019/20. • A triage step is in place. This is compliant with NHS England guidance. • Although referrals have increased, there has not been a corresponding increase in clinically appropriate referrals so this has not negatively impacted waiting times. • The triage step was taken out of the new commissioning arrangements for Calderdale in April 2024 which, although a small reduction in referrals has been noted, has led to a 2 year wait as all referrals determined by a GP will need to be seen. Discussions are ongoing with the commissioners. Key issues relating to LD waits include: • Good performance for referrals being screened within 2 weeks. • Challenges in meeting the 18 week face to face contact remain and relate predominantly to profession specific vacancies. • Improvement work is underway to revise pathways and create alternative solutions including training other professions to manage dysphagia to create speech and language therapist capacity. • Drill down to understand why the 18 week waits have not improved has highlighted an emerging issue relating to 'hidden' waits. These are waits that have breached 18 weeks and therefore are not flagged by the current waiting list reporting. The executive management team will receive a detailed report on 21 March 2024 and both the Finance Investment and Performance Committee and the Quality and Safety Committee will be updated following this. Safer staffing data relates to the Horizon unit only and staffing above establishment is to support the needs of individual service users. The staffing model is under review. Ongoing challenges with the provision of suitable community placements for people with a learning disability result in people being clinically ready for discharge on the Horizon unit. Discussions with commissioners are underway on how to address this. A direct corelation with staffing levels on Horizon cannot be easily made as people who are ready for discharge may still need a high level of support on Horizon. Low numbers impact the Family and Friends Test results. Work is underway with volunteers to improve the ways that feedback is gathered in the ADHD/ASD service.

	Incident levels are within expected range within the services. Inpatient falls are low, screening and risk assessments are in place and the service took proactive action to replace slippery flooring. Further work is required to understand the inequity data in both services. Although LD data shows a good corelation between the population data and service user data, the impact of Leeds and Bradford residents accessing the Horizon unit has not been fully considered. The ADHD/ASD service has noted a marked underrepresentation in referrals of people from Asian communities. Work with partners is in place to understand how this can be addressed. Recognising that people with a learning disability experience health inequalities strategic health facilitators are working closely with GPs to increase take up of annual health check ups and supporting additional health screening. Performance is on track to meet or exceed the 75% target. The learning disability service has introduced a reducing health inequalities group that shares tools and information on preventing early death, using learning from the LeDeR reports.
Recommendation:	**Trust Board members are asked to RECEIVE and note the report.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Care Group Summary

January 2024

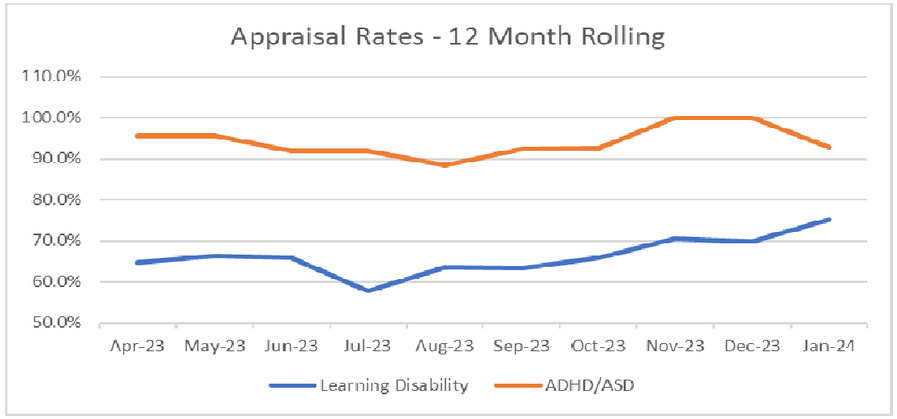
With **all of us** in mind.

Adult Attention Deficit Hyperactivity Disorder (ADHD) Autism Spectrum Disorder (ASD) and Learning Disability (LD) Services

LD- Comprises of four locality teams Wakefield, Barnsley, Calderdale and Kirklees. Each Team includes psychiatry, psychology, specialist learning disability nursing, therapists and an intensive support team with many different skills. The teams provide specialised support to people with learning disabilities who are unable to access mainstream health services and aims to improve their overall health and wellbeing. The team works with adults of all ages and many other agencies. The teams are also supported by a Strategic Health Facilitator in each area and a newly developed Out of Hours service. In addition to this the Trust works with Bradford District Care Trust as the coordinating provider to provide inpatient assessment and treatment to people with a learning disability across West Yorkshire. The Trust's assessment & treatment service is provided at the Horizon Unit .
ADHD/ASD- The service provides a person-centred service that enables an individual with Adult ADHD and/or Autism to reach their full potential and live well in their community. The service provides 'a comprehensive assessment and interventions service' for adults aged 18+ with ADHD or autism, operating as part of a range of integrated services with the local authority, including access to appropriate psychological interventions, information covering diagnosis, assessment, and support provided to patients, and carers.

Workforce

Appraisals



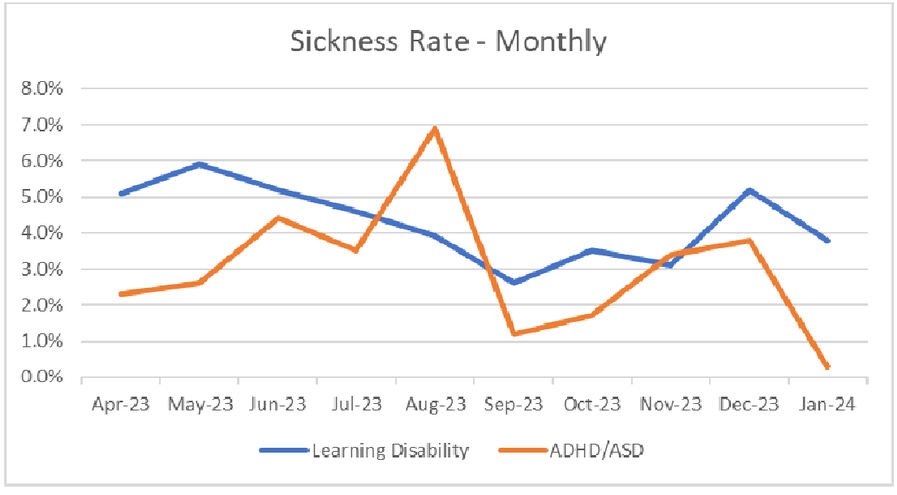
Insights

LD - Targeted actions with individual teams remain in place to continue improve appraisal performance. Monitoring is carried out on a weekly basis and has been in place since October 2023. January performance is 75.2% and on an upward trajectory with full performance expected by 31 March 2024. All outstanding appraisals are booked in diaries. In addition, the service has agreed a process for a conversation with new starters to include mandatory training, Trust values and behaviours.

The service is working hard to ensure WorkPal and service performance data reflect actual appraisal activity. The new pivot appraisal report is providing services with more accurate feedback.

ADHD/ASD - has a strong history of compliance rarely dropping below 90%. The service has a robust system of monitoring compliance and is currently achieving 92.9%. This figure has dipped recently because the service recruited 2 internal members of staff who had not previously received an appraisal in 2023.

Sickness



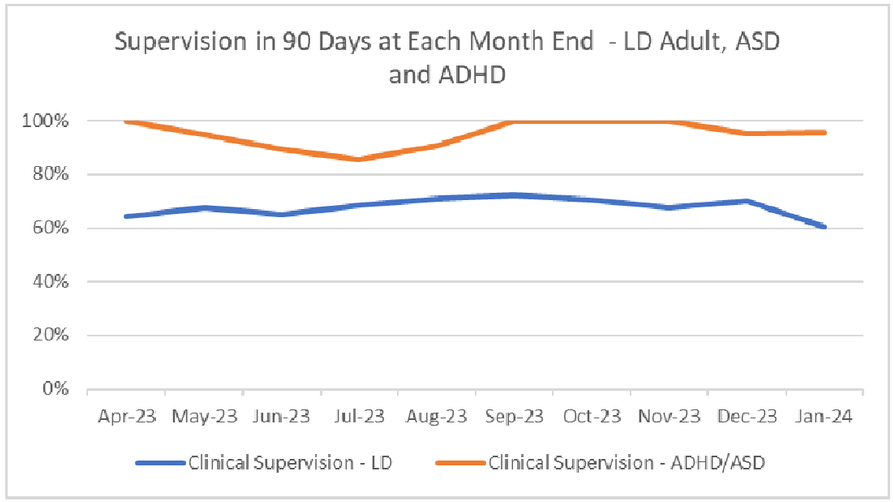
Insights

LD - The January position for sickness absence is 3.8%
All sickness absence is managed by line managers in line with policy. The spike in sickness in May 2023 was a combination of long term sickness and COVID/viruses and December 2023, short term absences related to seasonal illnesses. Managers have recently supported people who were on long term absences successfully back into work.

ADHD/ASD - The January position for sickness absence is 0.3%. The team overall comprises of less than 35 WTE staff. The dramatic spikes within the data are usually attributable to one or two individuals. The spike in November/ December 2023 is short term sickness absence and was resolved quickly as the January data shows. The correlation with low sickness and positive performance in appraisal and supervision uptake must be noted in this team.

Both services recognise the impact sickness absence has on service delivery and both services have a strong focus on staff well being with support and well being events being an integral part of staff support.

Supervision



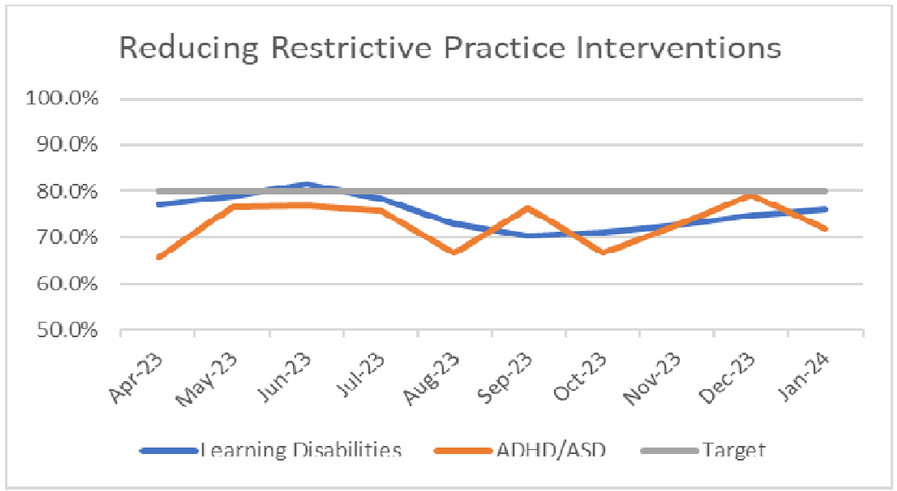
Insights

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 target is 80% compliance.

LD - Uptake of clinical supervision has been consistently below target. January is 60.4%. The service is undertaking a review of compliance and has adopted closer monitoring to ensure remedial actions are successful in improving the current position. Supervision will be more closely monitored through team manager meetings and supervision sessions for staff will be scheduled. Staff have informally reported that they prioritise other activities often to meet either acute clinical need or cover existing vacancies. This is exacerbated by staff covering wide geographical areas for community services and therefore not returning to staff base frequently throughout the day. Messages from the wellbeing group are supporting the message to staff about the positive impact of supervision on wellbeing and patient care and safety. Some staff were unclear on correct process for recording supervision. Guidance has been shared with all staff and supervision is supported and monitored by team managers.
Current remedial actions are expected to shift performance to an upward trajectory by June 2024 where the date for full compliance will be reviewed.

ADHD/ASD - The service has a very strong embedded culture of prioritising supervision. The January position is 95.5% and the data demonstrates strong compliance throughout the last year. Recognising the positive impact on staff, the

Mandatory Training

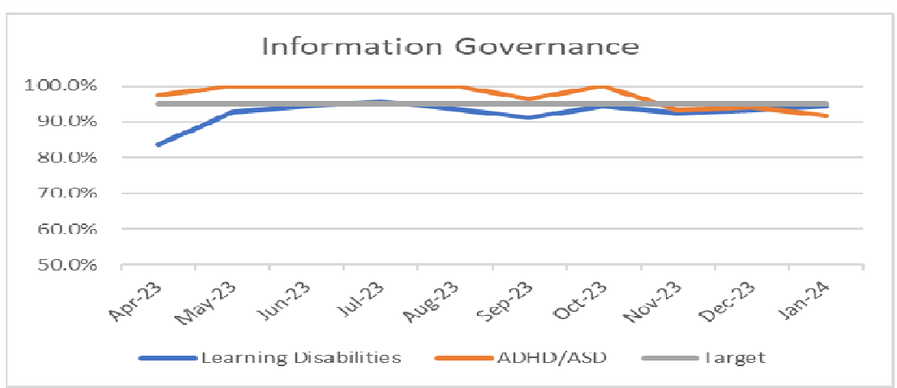


Insights

LD - January performance 76.1% which is below the Trust Target of 80%.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 resources are in place to support increased training provision. In addition to this, the service has been proactive in ensuring that staff members who require training are all booked on available courses. This will ensure an improvement in performance.

The Horizon unit reports a high number of incidents relating to violence and aggression and therefore RRPI training is essential to support effective de-escalation and safe management of care. New staff are booked onto the training when they commence in post and staff are prioritised for the updates. There is a wait for training which means there are staff who are not yet trained. Staff rotas are managed to ensure a sufficient number of RRPI trained staff are available. Current performance for Horizon is 81%.

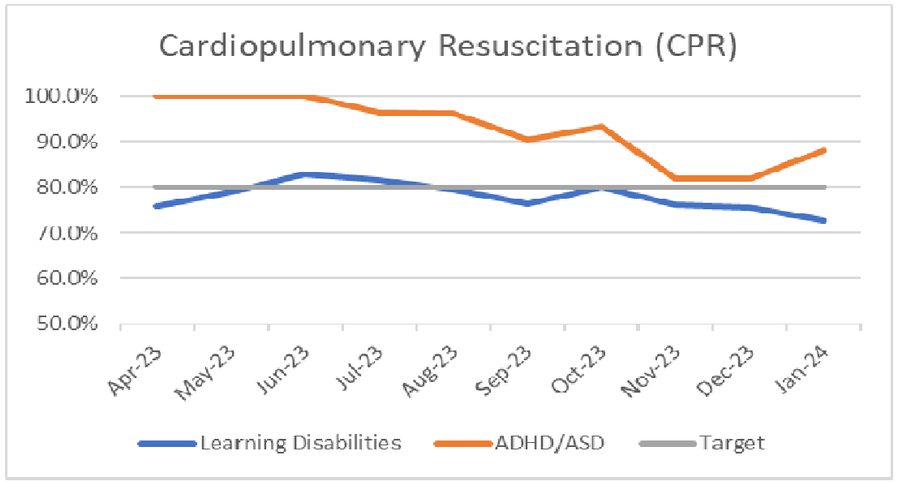
ADHD/ASD - January performance is 72.0%. Performance has been impacted by the availability of training. The team is community based and not expected to be engaged in the physical restraint of service users so is required to complete Breakaway and Personal Safety training. Despite not achieving compliance there have been no incidents within this team that have compromised the safety of staff or service users. Managers within the service are closely



LD - January compliance with this target is 94.2% which is just below the 95% target. Compliance with target was achieved in July and October 2023 and has since remained just under , Staff have been reminded to complete the training with the importance of service user data being kept secure emphasised.

Compliance is being monitored on a regular basis by team managers.

ADHD/ASD - January compliance is 91.7% and therefore below the Trust target of 95%. On closer scrutiny the majority of staff within this service are required to update their training in the latter months of the financial year and performance has captured a slight lag in this being completed. Service managers are currently monitoring this closely to achieve compliance. The slight dip in performance has no associated information governance incidents.



LD - CPR compliance remains below the 80% target at 72.7%. Barnsley and Kirklees community teams are meeting the target, with other services currently under target. The Horizon unit compliance is currently 70%. Staff rostering ensures the availability of that staff who are trained on each shift.

Recognising that people with a LD are also at a higher risk of physical health conditions, the LD team are taking action to improve performance. Although challenges with the availability of reports to monitor progress against training remain, team managers are working with individual staff members to ensure they are booked onto the training

Engagement with the Resus team is underway to make training more accessible to staff who work across 24 hours 7 days a week.

ADHD/ASD - Compliance remains above the target of 80% and is currently at 88%.

Finance

Agency Spend

Agency Spend YTD

£524k

Variance to Budget YTD

£493k Underspent

Insights

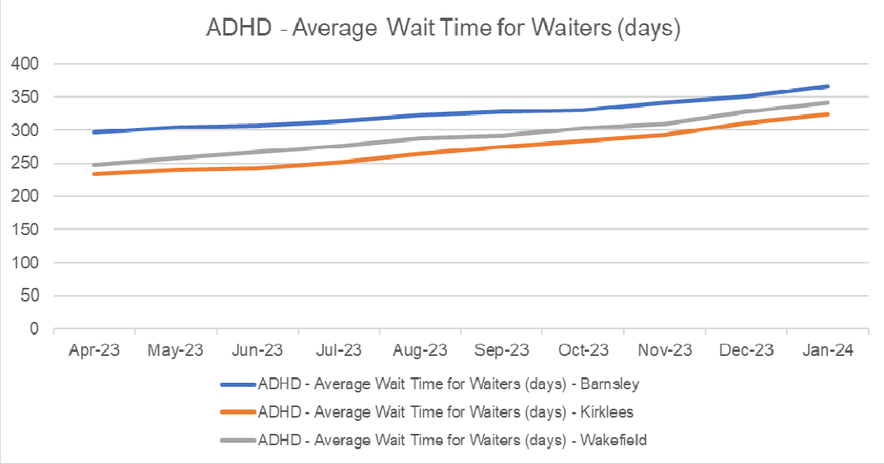
LD - the agency spend is mainly attributed to Horizon where in the past year service users admitted have required specialist nursing care in high numbers i.e. 1:1,2:1,3:1 this has been benchmarked with other Assessment and treatment units and is consistent with their experience and demonstrates that admissions to the ATU an acuity and complexity. The service is currently reviewing staffing levels to ensure efficient use of resources.

There has been some additional agency spend in the community which reflects the inability to recruit in highly specialist posts e.g. Psychology, OT etc.
The underspend is entirely due to the inability to recruit to vacancies which the service is addressing by working with the People Directorate to recruit to all vacancies.

ADHD/ASD
There has been no agency spend within the service.

Access

ADHD - Average waiting time (days)



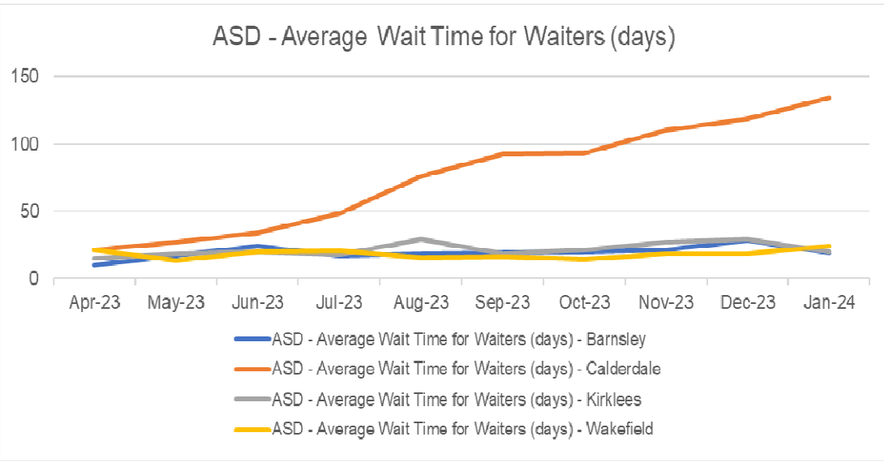
Insights

People are not necessarily seen based on chronological receipt of the referral. In order to manage the waiting list safely, people are initially prioritised based on clinical needs related to ADHD and also, MDT may agree to expedite an assessment should it be requested by the referrer. In practice, this means that since April 2023, 78 people (15%) were offered appointments within 12 weeks of referral date.

The service is commissioned to assess 360 new cases each year. In 23/24, the service is on track to assess over 500 new people. The maximum capacity for assessment (when all posts are filled) is 560 per annum. The 200 cases (=560-360) are available to Calderdale or to other commissioners who are able to invest.

Referral rates are approx. 7 times higher than commissioned capacity in Barnsley and Kirklees, and 11 times higher in Wakefield. There are approximately 3,900 people waiting for their first appointment from these localities, plus 960 people waiting in Calderdale. This number is expected to grow by approx. 250 each month which also impacts on waiting times. Long waits are typical across the country. Kirklees and Wakefield commissioners have invested in a pilot project that will be in place from April 2024, new referrals are to be offered a face to face appointment with an ADHD expert to ensure clinical appropriateness for an ADHD assessment. This new and innovative step will ensure people are not added to the waiting list inappropriately, they can be signposted to other services if appropriate and it will also bring a benefit to primary care as referrers will not need to provide as much information or determine if the referral is appropriate.

ASD - Average waiting time (days)



Insights

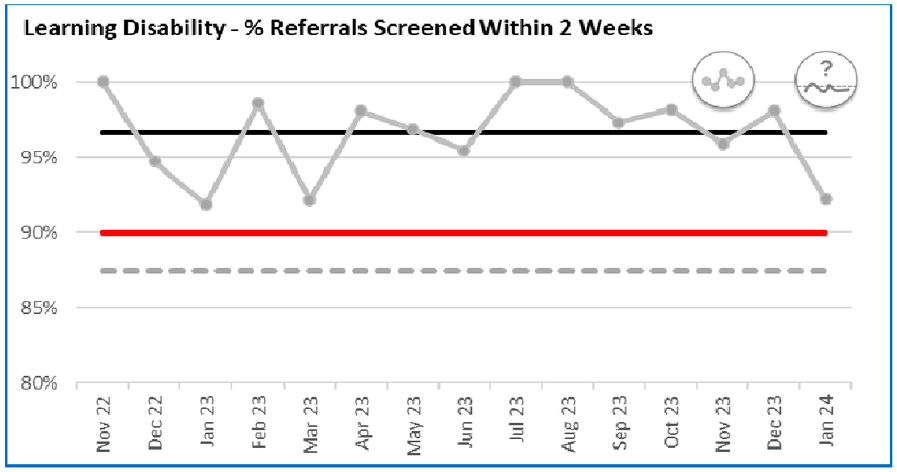
The Autism pathways in Barnsley, Kirklees and Calderdale have also seen an increase in referrals, the referral rate is almost 2.5 times higher than in 2019/20. 1,400 referrals are expected in 2023/24.

Each of these pathways is commissioned to provide a triage step for every referral where the referral information and other available health records are reviewed by a panel of autism experts to determine if it is clinically appropriate for the person to have an assessment for autism. Although controversial with some patient groups, this step is compliant with the guidance NHS England » Operational guidance to deliver improved outcomes in all-age autism assessment pathways: Guidance for integrated care boards issued in April 2023. Despite the increase in referrals, there has not been a corresponding increase in clinically appropriate referrals for these areas, and so the waiting time for assessment remains relatively low.

Calderdale Place commissioned this step as part of their pathway until the end of April 2023. On 1st May 2023, they launched an Any Qualified Provider (AQP) model with other providers accepting referrals for all-age neurodiversity. The other providers were unable/unwilling to undertake this step and it was agreed that clinical appropriateness for all Calderdale referrals would be determined by the GP and only invalid referrals would not be accepted for assessment. This change has resulted in a waiting list for Calderdale residents and a waiting time of approximately 2 years. This is being discussed with commissioners.

Referrals from Calderdale have slightly reduced since the launch of the AQP model. The service received approx. 15 referrals each month from August 2023 to January 2024 compared to 18 per month in the same period the year before.

LD - Referrals screened within 2 weeks



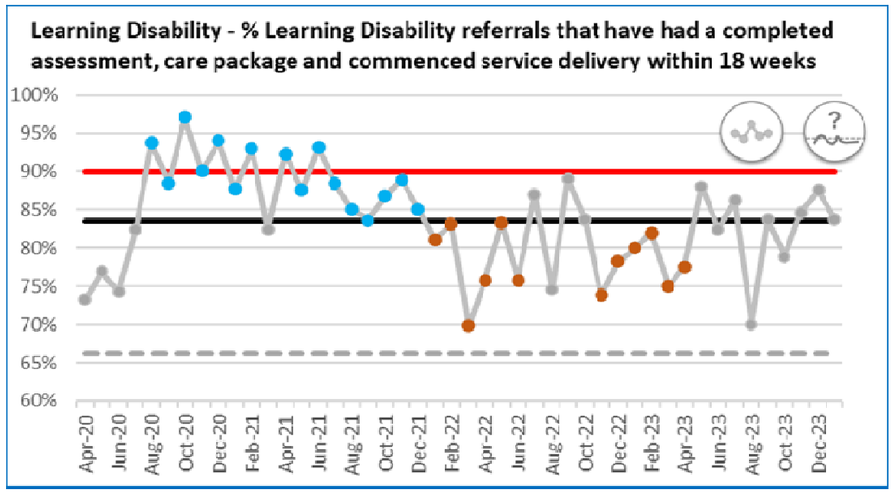
Insights

All areas are consistently exceeding the 90% target.

In January, Barnsley is at 95.2%, Kirklees at 92.6% and Wakefield at 100%. Calderdale is performance is showing 81.3%, but a data quality review identified that 2 out of the 5 cases that breached are as a result of recording errors. Once corrected accurately the target of 90% will be met in Calderdale also.

Training has been targeted to recording processes and mitigate future occurrences.

LD - Face to Face Contact within 18 Weeks



Insights

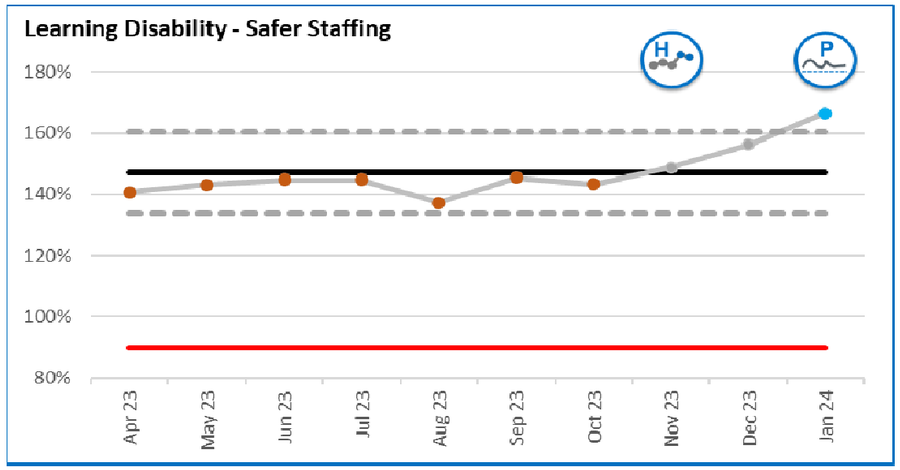
January - Barnsley - 75.0%, Calderdale - 75.0%, Kirklees - 90.9%, Wakefield - 93.8%

Following the improvement work supported by the change team to address the 18 week standard, the service now has greater oversight of waiting times. This change in the overview of data has highlighted some 'hidden' waits, i.e. waits that are not reported through this data, that the teams are now working on. Further work is currently underway to identify remedial actions required to reduce the waiting list times. The service will continue to provide enhanced monitoring of waiting lists with team managers. A full update report regarding this will be submitted to EMT on 21st March and updates will be provided to quality and safety and finance, investment and performance committees.

Breaches in Barnsley are largely attributed to the inability to recruit to a speech and language therapist (SLT) post. In the locality, one SLT is on maternity leave and this post is fully covered by a combination of bank and agency but a second post has remained vacant for over 12 months. Longer term plans are being expedited to increase dysphagia skills in community teams by training other disciplines and this will in turn, free up some capacity in SLT teams to focus more time on communication assessments. Recruitment continues. Calderdale breaches are largely impacted by a psychology vacancy and recruitment is taking place. Capacity in the team has been reviewed to free up some time of the intensive support team (IST) psychology lead to support the reduction of the psychology waiting list.

Quality and Safety

Safer Staffing



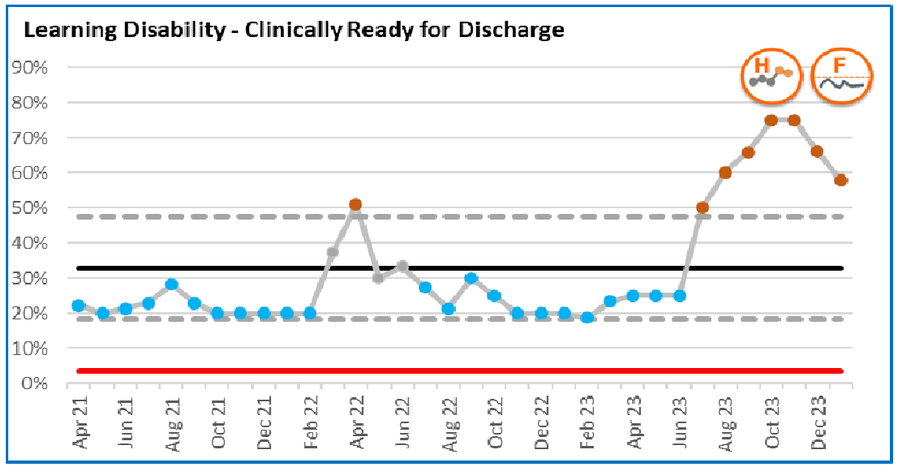
Insights

This indicator relates only the Horizon inpatient ATU.

Increased staffing levels are in place to support a small number of service users who require a high level of engagement and observation. The increase is in relation people who are newly admitted to the service, who require a high level of support.

The service has recognised that the staffing model requires a thorough review. This is now underway across the partnership with Bradford District Care Trust. A revised model to improve effectiveness and efficiency will be in place from 1st April.

Clinically Ready for Discharge



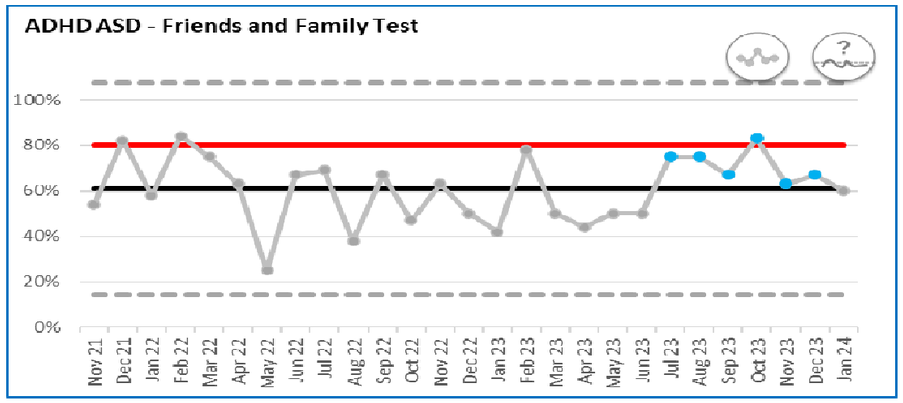
Insights

There are ongoing challenges with the provision of suitable community placements for people with a learning disability to be discharged. Small bespoke specialist placements have long waiting lists.

This has caused significant delays in discharge for people who are clinically ready for discharge (CRFD) - with performance currently at 50%. Conversations regarding this continue with commissioners and partners.

It should be noted that although people may be clinically ready for discharge from Horizon, this does not necessarily relate to a reduction in their need for support and reduced staffing levels. For example, a person requiring observation and engagement from 2 staff may continue to need this in their community placement. Staying on Horizon once they are clinically ready for discharge will not impact this and potentially increase their support needs if they are someone who has been assessed as needing their own private space.

Friends and Family Test



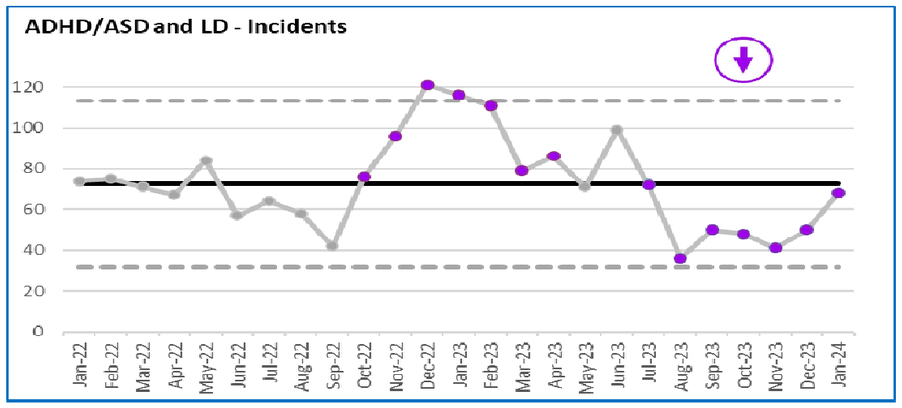
Insights

Friends & Family Test feedback remains within normal variation. The service is committed to increasing feedback into the service. Low scores tend to be a result of long waiting times for ADHD or individuals not receiving the diagnosis they were expecting. Despite the service having typically 460 contacts per month, there are typically approx. 10 responses and such a low response rate can adversely distort the results.

The service has been working with volunteers to gather feedback and is also exploring the use of Chatpads to enable clinicians to gather real time feed back.

Both positive and negative feedback is acted upon and leads to service improvement, for example, lighting has been changed in the waiting area/clinic space and medication clinics are now planned so that the cycle of clinic space/clinician coincides with the prescribing cycle to offer continuity for the Service user.

Incidents



Insights

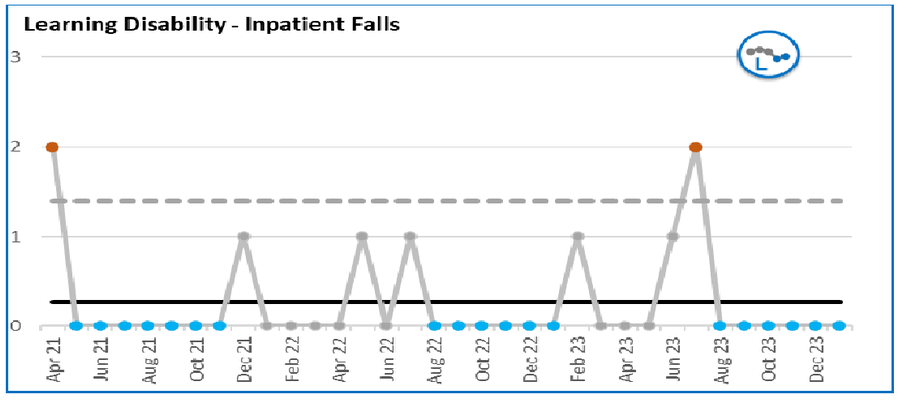
The SPC chart indicates that the number of incidents remains within common cause variation. The majority of the incidents were within the inpatient service (72.3%), with the remainder in community LD services (26.3%) and the ADHD/ASD service (1%). The increase since August 2023 is attributed to new admissions to the inpatient service.

94.7% of the incidents were no / low harm. High reporting of low / no harm incidents indicates a positive safety culture.

Three incidents were amber (4%) and the issues are being managed in relation to safeguarding and violence and aggression. .

Information about a single red incident has been removed from the report support anonymity,

Falls



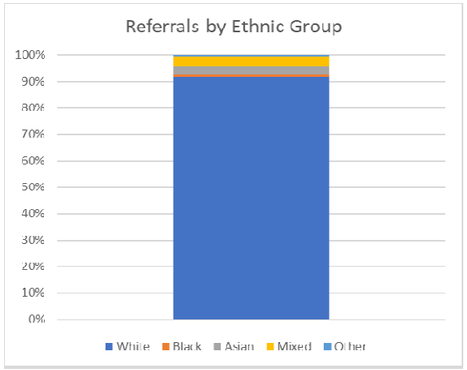
Insights

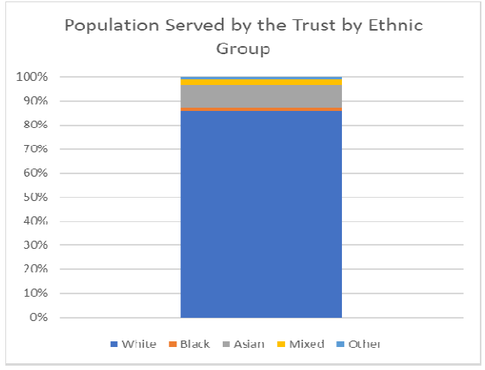
Inpatient falls in the service are low in number. All service users have a falls screening assessment and risk assessments/care plans are in place for individuals who require them. As some of the service users are unsteady with mobility, falls tend to be trips.

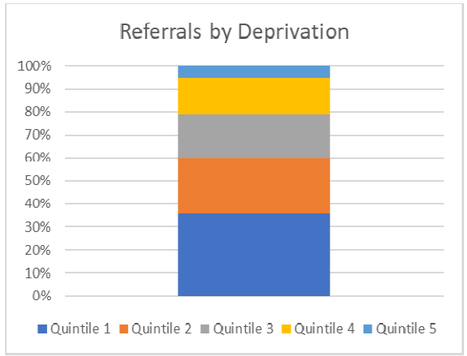
There were some issues with the resin floors in bathroom areas that became very slippy when wet but these issues have now been addressed with support from the estates department and the flooring has been changed to a different resin in those areas. Fall numbers are too low to draw a direct comparison, but staff are confident that a safer environment has been achieved.

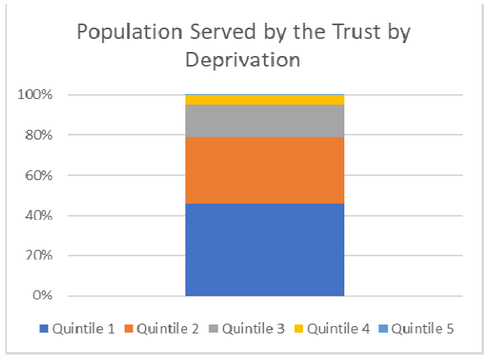
Inequalities

ADHD and ASD Referrals









Insights

Based on YTD Referrals (Apr23-Jan24)

There is a marked underrepresentation in referrals from the Asian community compared to other ethnic groups.

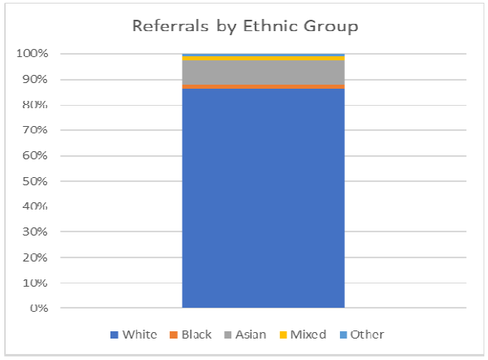
This year's data is typical of previous years. Pre-pandemic, there was active engagement with community groups to promote the service offer. Although the service does not currently have capacity to engage at this level it is working with local partnership groups who recognise this as an issue across healthcare in general. Additionally the West Yorkshire ICB Neurodiversity work has recognised this and its co-production partner (Touchstone) is working to raise awareness and support service redesign.

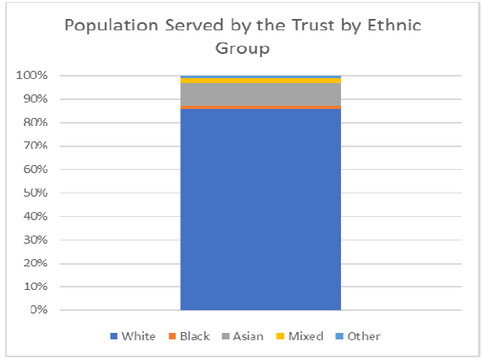
Based on YTD Referrals (Apr23-Jan24)

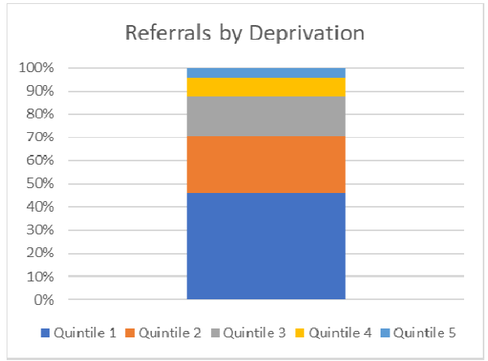
There is some correlation between quintiles 1-3, quintiles 4-5 appear to be over-represented. This over - representation is more recent and is typical of referral activity in other parts of the country.

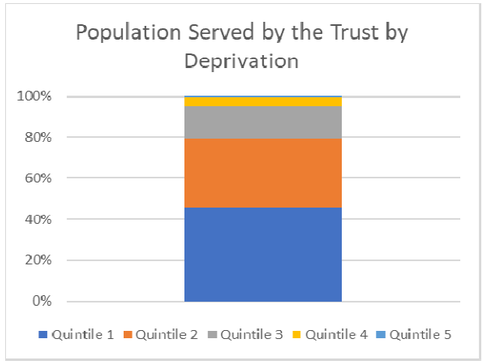
Further work is required to understand this.

LD Referrals









Insights

Based on YTD Referrals (Apr23-Dec23)

The data supports that there is good correlation for ethnicity between the population the Trust serves and the referrals into the service.

It should however be noted that the ATU provides a wider service remit, across West Yorkshire and further drill down will be undertaken to understand the impact on the data by people from Leeds and Bradford.

The service has ensured prioritisation of equality impact assessments (EIAs) over the last 12 months with the matron team taking a lead to facilitate their completion and to ensure that action plans are meaningful.

Based on YTD Referrals (Apr23-Dec23)

There is some correlation between quintiles 1-3, quintiles 4-5 appear to be over-represented. This over - representation is not yet understood and further work is required.

Additional data for LD: Community locality teams / Strategic Health Facilitators have worked closely with General Practitioners to increase annual health check take up for people with a learning disability. Barnsley, Calderdale and Wakefield are on track for meeting//exceeding the target (75%) and currently Kirklees are projected to achieve 73% and are prioritising targeting some additional this month to take this figure to 75%. All localities have also been focussing on quality of health action plans and supporting access to relevant regular screenings for people with a learning disability e.g. bowel cancer.

The STOMP (stopping over-medication of people) project is progressing in all four localities enabling some service users to be discharged to GPs following reductions in medication.

The service has now introduced a Reducing Health Inequalities Group that share tools and information on preventing early death. The LeDeR reports that are published are for the year before and this group look at deaths happening now to ensure our interventions and support are timely and up to date.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 March 2024
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Trust wide Incident Management Report - Quarter 3 2023/24**		
Paper presented by:	Darryl Thompson, Chief Nurse / Director of Quality and Professions		
Paper prepared by:	Chloe Dexter, Patient Safety Portfolio Manager Helen Roberts, Patient Safety Specialist		
Mission/values:	The report demonstrates the Trust's commitment to all the Trust's values, which are fundamental to delivering safe and high quality 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:	This report provides information in relation to incidents recorded in Quarter 3 2023/24 and more detailed information regarding serious incidents. It also provides assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2023/24 deaths. The learning from healthcare deaths section of this report will be published on the Trust website.		
Strategic objectives:	Improve Health	✓	Please remove as appropriate
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2 – Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust continues to have a robust governance system of reporting and investigating incidents including serious incidents and of reporting, analysing, and investigating healthcare deaths. The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed. This aligns with the West Yorkshire integrated care system's ambition to reduce suicide, and the South Yorkshire integrated care system's ambition of proactively enabling early intervention to prevent more serious difficulties and preventing suicide.		
Any background papers / previously considered by:	Previous quarterly reports have been submitted to the Quality & Safety Committee and Trust Board, along with annual incident reports. The Quality and safety Committee has also received papers in relation to learning from healthcare deaths policy requirements. The Quality and Safety Committee		

	reviewed this report in detail on 13 February 2024. At committee, a question was asked as to if we are reducing the serious incidents as a direct result of the learning. This is being explored by the patient safety support team for a response in time for Trust Board.
Executive summary:	This report was produced by the patient safety support team and shows the data for incidents. Data is also available at service line/team level via Datix. All managers have access to Datix dashboards to interrogate data further. Key headlines are as follows: **Incident Management Trust-wide report** • The number of incidents reported in Q3 2023/24 was 3,766. 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. • Physical violence from patient to staff (contact made) has reduced for the fourth consecutive quarter. • All serious incident investigations currently underway are within agreed timescales. **Learning from experience** We incorporate learning from experience into the report (section 3). This shares the learning from incidents in Q3 2023/24 and examples of learning in practice. New learning responses linking to the patient safety incident response framework (PSIRF) will be updated in the Quarter 4 learning journey. **Serious Incidents** • Patient Safety Incident Response Framework (PSIRF) - replaces the Serious Incident Framework. We transitioned to PSIRF from 1 December 2023. • There was one serious incident reported in Q3 2023/24. This was the apparent suicide of a service user on Ashdale Ward in Halifax. • Serious incidents account for 0.02% of all incidents. • We have continued to strengthen our initial review process to ensure we are using our resources to investigate the right incidents, as this will be the approach in the future under Patient Safety Incident Response Framework (PSIRF). • During Q3 2023/24 there were no 'Never Events'. **Learning from Healthcare Deaths** • 89 deaths were reported in Q3 2023. • 70 of the 89 deaths were in scope for mortality review. • There are no areas of special cause variation that require further exploration. • Quarterly data on deaths is published on the internet page. Colleagues from the Trust are attending the regional mortality meetings hosted by the Improvement Academy; the Northern alliance of mental health Trusts and West Yorkshire ICB (Kirklees) to share best practice in relation to the scrutiny/review/learning from deaths. **Summary** Trust Board can take assurance that there are robust systems and processes in place to oversee and capture learning from incidents and deaths that occur

	for people using our services. Our implementation of PSIRF will further enhance this focus on learning, in line with national developments. This report includes assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite – low and the risk target 1-6. The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/ Moderate 4-6.
Recommendation:	**Trust Board are asked to NOTE the quarterly report on incident management.**

South West Yorkshire Partnership NHS Foundation Trust

Trust-wide Incident Management Report

Quarter 3 2023/24

Incorporating Learning from Healthcare Deaths reporting for the period 1 April 2023 to 31 December 2023

Report prepared by Patient Safety Support Team

January 2024

Contents

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust-wide information on incident activity during Quarter 3 2023/24 (01/10/2023 to 31/12/2023) including reported serious incidents, learning from healthcare deaths and learning from experience.

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

2. Incident Reporting Analysis

This report has overall figures for incident reporting. In Quarter 3 2023/24 there were 3766 incidents reported. Incident reporting rates remain within normal variation.

96% of all incidents reported on Datix in Quarter 3 are classed as “low” or “no harm”. This shows a positive culture of risk management; low or no harm incidents reported indicates action taken proactively at an early stage before harm occurs[1].

Headlines

Quarter 3 2023/2024 Headlines

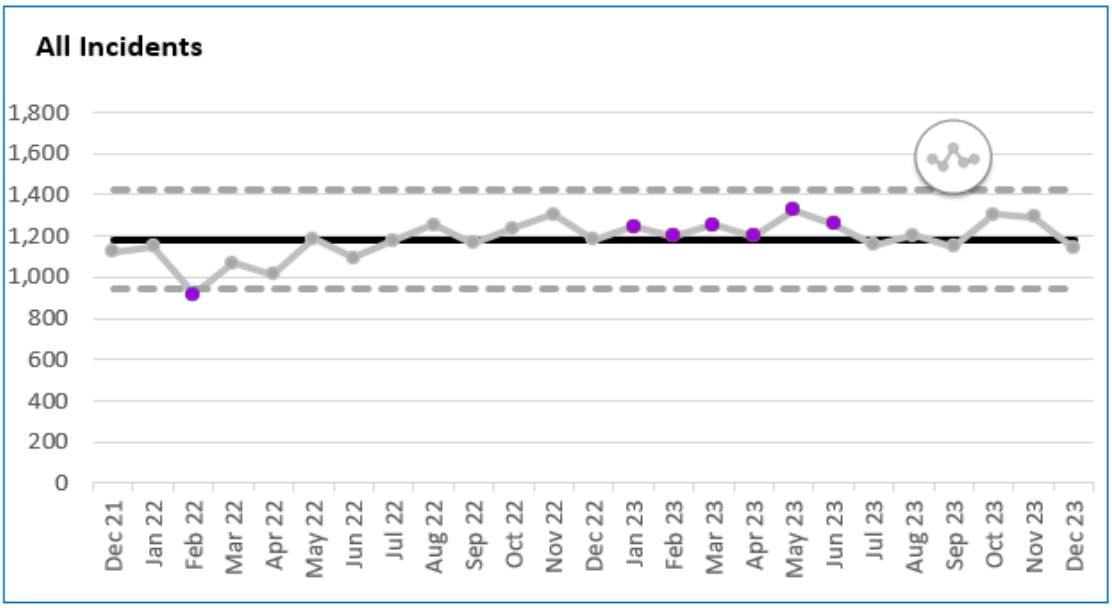
- **3766** incidents reported
- **Reporting rates remain within normal variation**
- **96%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no / low harm is indicative of a positive safety culture

Figure 1 below shows the pattern and number of incidents reported between 01/12/2021 to 31/12/2023 in a SPC chart. This shows that reporting remains within normal variation but rates in more recent months are consistently above the average (mean) for the Trust. Increased reporting of incidents does not in itself bring cause for concern whilst our overall proportion of no harm / low harm sustains and could be attributable to continuing work on

[1] NaPSIR NHS England 2022

raising awareness regarding the importance of reporting incidents. We continue to monitor data on a monthly basis.

Figure 1 Statistical Process Control chart of all incidents reported 01/12/2021 to 31/12/2023



Severity

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

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

Figure 2 All incidents reported Trust wide between 01/01/2023 – 31/12/2023 by severity and financial quarter.

	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24
Green	2439	2637	2381	2579
Yellow	1061	951	921	972
Amber	171	164	187	187
Red	26	30	19	28
Total	**3697**	**3782**	**3510**	**3766**

In Figure 2, Quarter 3 has seen a slight increase in the number of yellow and green incidents reported. Analysis of the data shows that on average, we usually see around 28% of all incidents in a quarter graded as yellow, and 5% as amber. In Quarter 3 the figure was 26% yellow and 5% amber. The percentage of each severity against the total for the quarter remains relatively consistent but may appear higher where the total for the quarter is higher. The number of red incidents varies each quarter. We ask staff to report a higher severity where the impact could be significant, or where we are waiting a cause of death.

As described above, severity relates to potential risk and actual harm. These incidents may be re-graded once more information is known about the cause of death.

Data in figure 2 is refreshed to reflect current severity.

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

An additional piece of work has been requested to understand the numbers after regrading. Comparative data is seen in figure 3. This compares data when the number of red incidents was provided in the integrated performance report (IPR) against the revised number after regrading has taken place (date of this report). There can be a delay in re-grading due to delays in receiving updates, particularly regarding causes of death. In some cases, lower graded incidents are subsequently upgraded to red.

Figure 3 Break down of the number of incidents graded red at point of preparing data for IPR and date of this report.

	Number of incidents originally graded Red at time of producing IPR data	Number of incidents currently graded red
Apr-23	14	12
May-23	10	7
Jun-23	13	11
Jul-23	13	7
Aug-23	11	9
Sep-23	11	3
Oct-23	12	8
Nov-23	10	10
Dec-23	10	10

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

Please see Appendix 1 for the breakdown of all incidents reported Trust-wide between 01/12/2021 – 31/12/2023 by severity, using statistical process control (SPC) charts to give a context to any variance. The time period that data is reviewed in can affect how it appears, for example quarterly may not reveal a rise in one month's data.

Figure 4 shows the severity breakdown for Quarter 3 by Care Group.

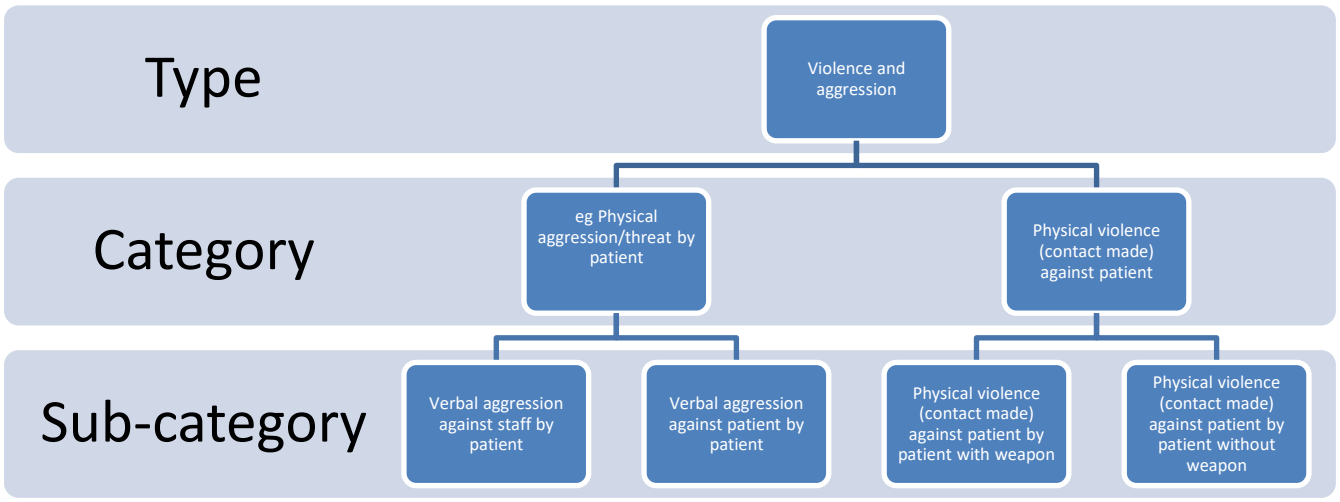
Direct comparisons between Care Group data should be viewed with caution as it does not provide a like for like comparison.

Figure 4 All incidents reported Trust wide between 01/10/2023 – 31/12/2023 by severity and care group.

Care Group	Green	Yellow	Amber	Red	Total
Adults and Older People Mental Health Care Group (Inpatient)	1243	619	48	5	1915
Barnsley Integrated Care Group (includes mental health community)	560	88	85	14	747
Forensic Services Care Group	436	158	32	0	626
Adults and Older People Mental Health Care Group (Community)	154	45	13	9	221
Learning Disability and ASD/ADHD Care Group	110	26	1	0	137
CAMHS and Childrens Care Group	61	28	7	0	96
Trust wide (Corporate support services)	15	8	1	0	24
Provider Collaboratives	0	1	0	0	1
Total	**2579**	**972**	**187**	**28**	**3766**

Type and Category of incidents

All incidents are coded using a three-tier method to enable detailed analysis. Type is the broadest and highest grouping (17 options), with each Type breaking into its own multiple categories, and then onwards into its own multiple subcategories. This has been illustrated below with a small group of incidents.



This report provides two levels of this data:

- Number of incidents per each type of incident (figure 5)
- Top 10 categories of incidents overall (from all types of incidents) (figure 6)

The Patient Safety Support Team review incident data monthly through the production of the Integrated Performance Report (IPR) and clinical risk report for Operational Management Group (OMG). Where any potential changes in incident reporting patterns are identified,

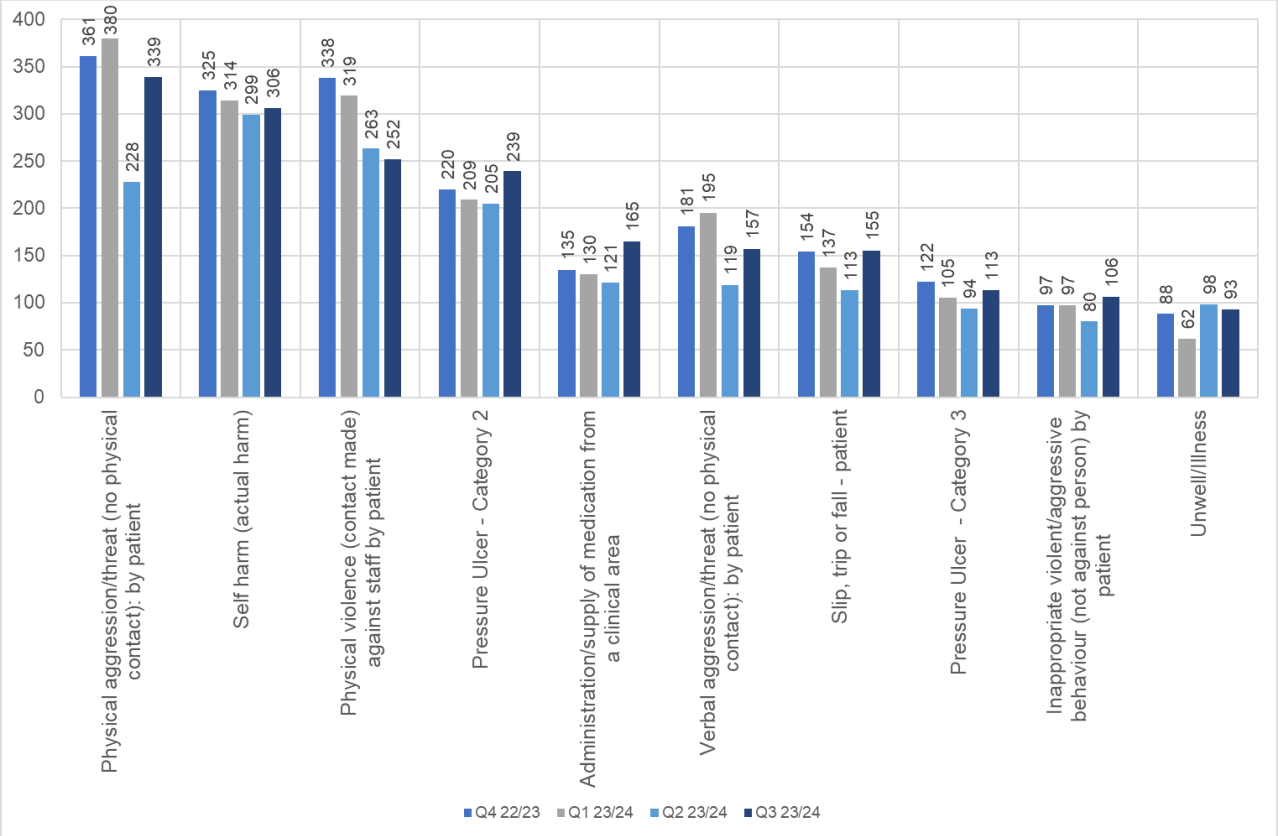
these are raised with the relevant specialist advisor for investigation and/or explanation, as they also review patterns and trends. The team has dedicated time to review incident types using statistical process control to look for changes in data.

Figure 5 Type of incident reported in Quarter 3 by Care Group.

Care Group	Adults and Older People Mental Health Care Group (Community)	Adults and Older People Mental Health Care Group (Inpatient)	Barnsley Integrated Care Group	CAMHS and Childrens Care Group	Forensic Services Care Group	Learning Disability and ASD/ADHD Care Group	Trust wide (Corporate support services)	Grand Total
Violence and Aggression	22	601	15	14	247	71	4	974
Care Pathway, Clinical and Pressure Ulcer Incidents	9	76	481	20	7	6	0	599
Self-Harm	24	296	20	4	43	2	0	389
Medication	43	206	51	1	49	7	4	361
Health and Safety (including fire)	9	130	27	3	70	8	4	251
All Other Incidents	8	126	15	6	46	4	2	207
Slips, Trips and Falls	2	127	21	2	11	1	1	165
Legislation and Policy	0	136	1	1	22	3	0	163
Security Breaches	7	44	10	6	68	2	3	140
Safeguarding Adults	15	21	34	0	17	13	1	101
Death (including suspected suicide)	57	5	19	0	0	8	0	89
Missing/absent service users	1	59	1	1	14	0	0	76
Information Governance Incidents	7	4	26	10	12	7	3	69
Safeguarding Children	13	3	12	24	2	0	0	54
Sexual Safety incident	2	41	2	1	8	0	0	54
Infection Prevention/Control	0	31	5	0	3	0	1	40
IT Related Issues	2	9	7	3	7	5	1	34
Grand Total	**221**	**1915**	**747**	**96**	**626**	**137**	**24**	**3766**

Figure 6 shows the top 10 categories of incidents overall. These are the second tier of incident reporting. In Quarter 3 2023/24, this can be affected by individual patient presentation and clinical acuity.

Figure 6 Trust-wide Top 10 most frequently reported incident categories (01/12/2022 – 31/12/2023)



The second highest category is 'self-harm (actual harm) 53% of the self-harm (actual harm) incidents reported in Q3 were spread across three inpatient wards. Self-harm data has been explored through the Patient Safety Incident Response Framework (PSIRF) Implementation Groups to identify where we need to identify new learning, and what improvement work may be required going forward.

The third highest category of incident is physical violence (contact made) against staff by patient. This is the fourth quarter in a row where this has reduced.

Category 2 and Category 3 pressure ulcers appear in the top 10 categories of incidents.

Analysis of Category 2 pressure ulcers shows that 44 of the 239 incidents developed under the care of the Trust (18%). Of the remaining 195 incidents, 164 incidents developed under other providers' care (care home/acute hospital) or in the patient's own home. 31 were pending further information at the time of reporting. These are reported on Datix to enable thorough review of our care, capturing our actions taken and escalation to the responsible organisation where required.

This is similar with Category 3 pressure ulcers; of the 113 incidents, 28 developed under the care of the Trust (24%), and 73 under other providers/own home. There are a further 12 pressure ulcer incidents currently pending updates.

Please note, all pressure ulcers that develop whilst the person is in the care of the Trust are reviewed using a root cause analysis tool and are overseen by the Tissue viability nursing team, to ensure any lapses in care (areas for improvement) are identified. The processing of

pressure ulcers is changing with the introduction of PSIRF from 1 December 2023 where we will introduce new tools to help screen for system issues and new learning opportunities.

Patient falls has had a slight increase in Quarter 3, which is reviewed by the falls coordinator and remains in the national average of 3-5 falls per 1000 bed days. The falls coordinator continues to horizon scan all falls related patient safety reports. They have quickly seen repeat fallers and themes emerging and offered support and advice. They have been supporting staff in forensic services with weekly meetings regarding a patient with complex physical and mental health needs.

Reporting to National Reporting and Learning System

The Trust uploads patient safety incidents[2] (which are a subset of all incidents reported) from Datix to the National Reporting and Learning System (NRLS) on a weekly basis and has done since 2004. All Patient Safety Incidents go through an internal management review and governance processes before being uploaded to NRLS. Data can also be refreshed if details change.

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

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

As reported previously, Learn From Patient Safety Events (LFPSE) is a new national system that is being introduced to replace:

- National Reporting and Learning System (where we send our patient safety incidents)
- Strategic Executive Information System [StEIS] (where we report serious incidents)

We are working towards transitioning to LFPSE by the end of March 2024.

As part of our transition to LFPSE, all patient safety incidents that remain in Datix that have not been reported to NRLS by the transition date, will be uploaded in a final batch, whether or not they have been approved. This will avoid having to manually transfer data into LFPSE.

In Quarter 3, 1752 incidents were reported to the National Reporting and Learning System compared to 1839 in Quarter 2 2023/24.

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

3. Learning from incidents

This section of the report provides links to our summary of learning examples in Quarter 3 2023/2024.

Learning from incidents presentation

Appendix 3 gives an illustration of our learning presentation that brings together some of the learning from Quarter 3 2023/2024. New learning responses linking to PSIRF will be updated in Quarter 4 learning journey. The full set of slides are available for staff on the Trust's intranet. Previous reports are also available on this page.

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

The Trust transitioned to working under the new Patient Safety Incident Response Framework (PSIRF) from 1 December 2023. From this date, the Serious Incident Framework no longer applies for new incidents and serious incident (SI) reporting ceased. This section of the report focusses on serious incidents reported in Quarter 3 to the end of November 2023.

In future, we will have Patient Safety Incident Investigations (PSII) under the new framework. PSIIs do not directly replace SIs. There are currently no PSIIs. In future these will be reported on separately.

Background context

Serious incidents (up to 30/11/23) are defined by NHS England as:

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [4]

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

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

- the unexpected or avoidable death of one or more patients, staff, visitors, or members of the public
- serious harm to one or more patients, staff, visitors, or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation, or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS
- one of the core sets of *Never Events*[5].

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

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

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

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

National Update

The NHS Patient Safety Strategy[6] was published in July 2019. This sets out how the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

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

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

- Learn from Patient Safety Events (LFPSE) – this will be a new section of Datix incident reporting system and will replace NRLS and StEIS systems. Please see information in this report in the section Reporting to National Reporting and Learning System for further information.
- Patient Safety Incident Response Framework (PSIRF) - replaces the Serious Incident Framework. We transitioned to PSIRF from 1 December 2023.
- Patient Safety training – Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 became mandatory from 1 November 2023. This is currently at 93% compliant. Level 3 training (investigation and oversight) has been received. Training on engagement and involvement of those affected by patient safety incidents will be concluded in January 2024.

Investigations

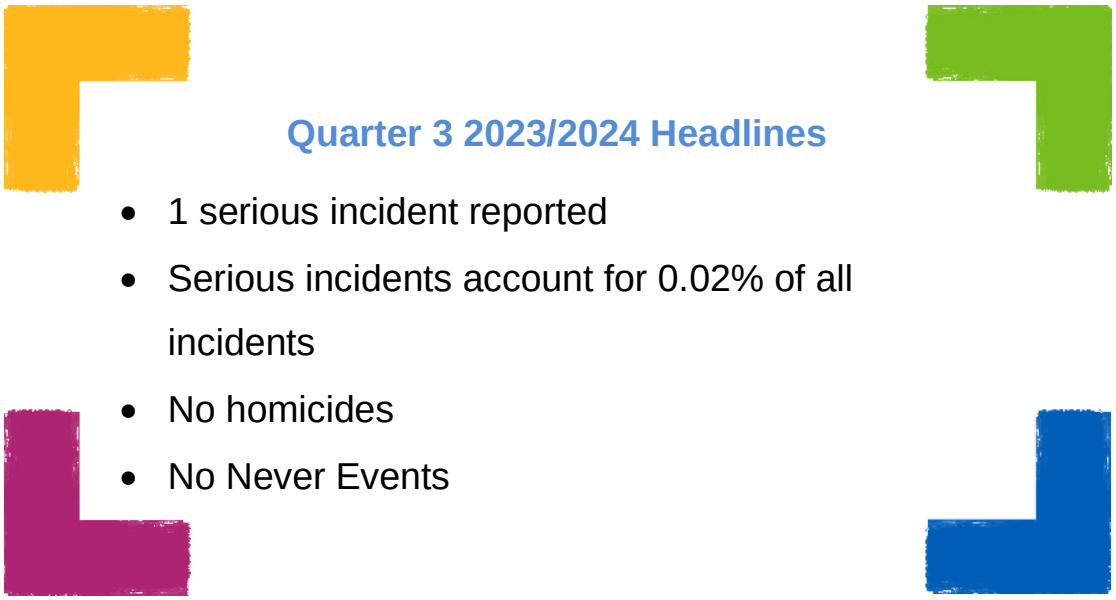
Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as serious incidents on StEIS after local investigation such as where significant care and service delivery issues are identified.

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

Serious Incidents reported during Quarter 3 2023/2024

Headlines

During Quarter 3 2023/24, there was **one serious incident reported** to the relevant commissioning body (e.g. integrated care boards (ICB), provider collaborative) via the NHS England Strategic Executive Information System (StEIS) as shown in figure 6. See comments above regarding implementation of PSIRF during Quarter 3.



Never Events[7] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no 'never event' incidents reported by the Trust in Quarter 3 2023/2024. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 01/02/2018. This is available on the Trust intranet.

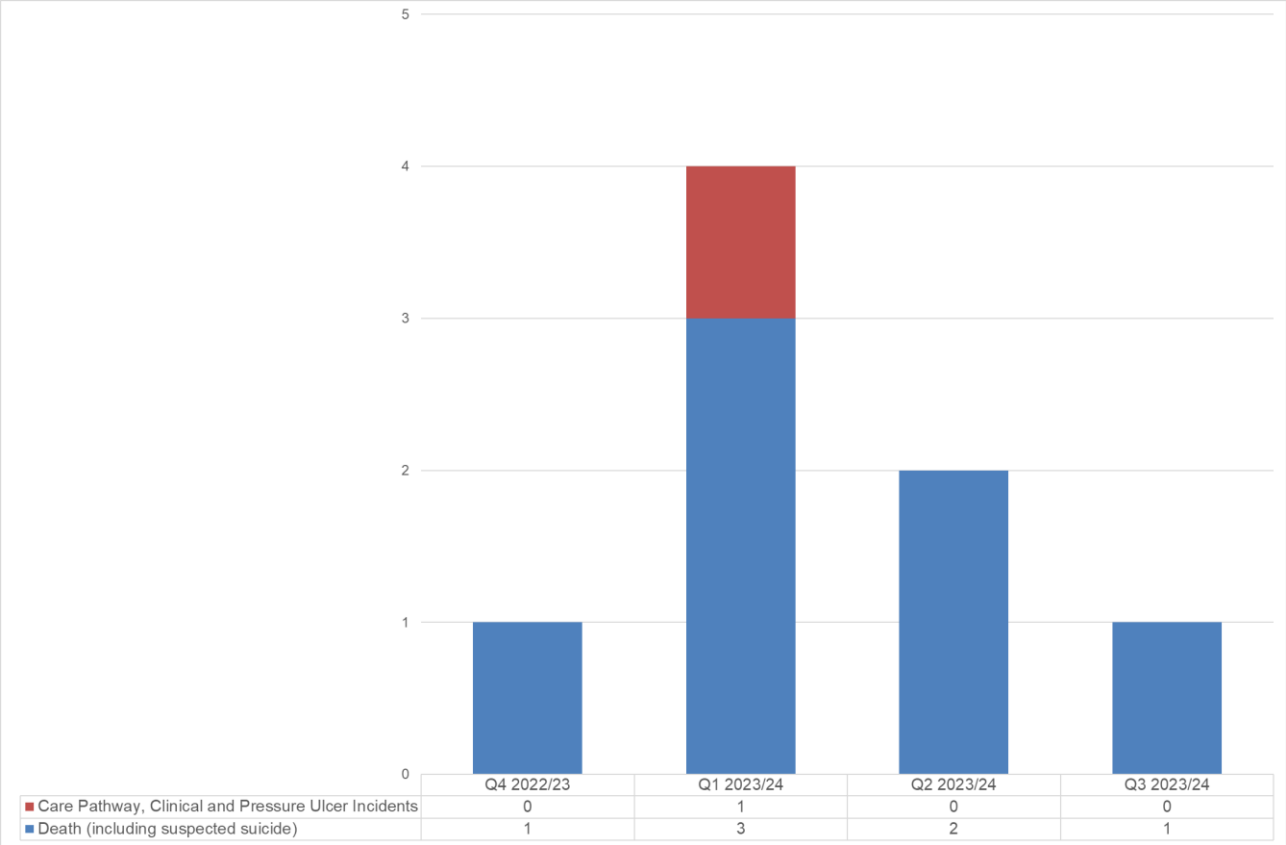
Figure 7 Serious incidents (StEIS) reported to commissioners by financial year and quarter up to 31/12/2023 (2019/20 – 2023/2024)

Financial Quarter	19/20	20/21	21/22	22/23	23/24
Quarter 1	12	8	8	6	4
Quarter 2	12	10	5	4	2
Quarter 3	8	8	8	4	1
Quarter 4	15	6	1	1	N/A
Total	47	32	22	15	7

Figure 8 shows a breakdown of the eight serious incidents in a rolling 12-month period (01/01/2023 to 31/12/2023) by the type of incident and the quarter reported. The number of SIs reported in any given period can vary and given the relatively small numbers involved and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However, it is important that any underlying trends or concerns are identified through analysis.

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

Figure 8 Types of All Serious incidents reported on STEIS in the 12-month period (01/01/2023 – 31/12/2023)



	Q4 2022/23	Q1 2023/24	Q2 2023/24	Q3 2023/24
Care Pathway, Clinical and Pressure Ulcer Incidents	0	1	0	0
Death (including suspected suicide)	1	3	2	1

All serious incidents are subject to a manager's review within 48 hours of reporting. This is to enable any themes/trends /issues to be identified early and as close to services as possible.

The serious incident reported in Quarter 3 2023/24 was on Ashdale Ward, Adult and Older People's Mental health care group (inpatient). It involved the apparent suicide of a service user on the ward.

Serious Incident Investigations completed during Quarter 3 2023/2024

This section of the report focusses on the serious incident investigation reports that were completed and submitted to the relevant commissioners during Quarter 3 2023/2024. Please note this is not the same data as those incidents reported in this period as investigations take several months to complete. The term 'completed' is used in this section to describe this.

Headlines

- **3** SI Investigation reports have been completed
- **3** SI investigations closed by the commissioners
- **6** SI investigations remained under investigation (as at 02/01/2024)
- From the completed investigations, the top action themes were:
  1 Staff education, training & supervision
  2 Joint 2nd
  Record keeping
  Organisational systems, management issues
  Risk assessment
  Care Delivery
  Carers/ family

Up until the end of November 2023, the Trust worked to the national guidance on serious incident reporting and management (Serious Incident Framework 2015, NHS England). From 1 December 2023, we transitioned to the Patient Safety Incident Response Framework.

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

In preparation for this transition and to Patient Safety Incident Investigations (PSIIs), we now capture if an investigation is within the timeframe agreed with the patient/family.

Of the six investigations that are underway (as at 02/02/2024), these are at different stages of progress. This is reported weekly into Patient Safety Oversight Group (formerly Clinical Risk Panel) and progress is monitored at the weekly investigator meeting. All are within agreed timeframes (either agreed with the ICB or with the patient/family).

There are a number of reasons why delays can occur, including family engagement in the SI process, including listening to the family's voice to defer discussions about investigation process until after anniversary dates, and ensuring families have sight of the draft report before organisational approval; and sign off process. Families are kept informed of any delay.

Staff support

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

Our staff support arrangements have been reviewed as part of our preparations for the Patient Safety Incident Response Framework and this will continue to evolve as we progress.

Serious Incident learning and themes

During Quarter 3 2023/24, three investigations were completed and sent to commissioners. A further SI action plan was also submitted from Quarter 2 that had been omitted in error. This resulted in seven actions which are included within the 25 actions in the data below.

There were 25 separate actions made to improve the system or process to prevent recurrence.

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

In line with the new approaches within PSIRF, we have aligned some areas for improvement identified in investigations with existing improvement work.

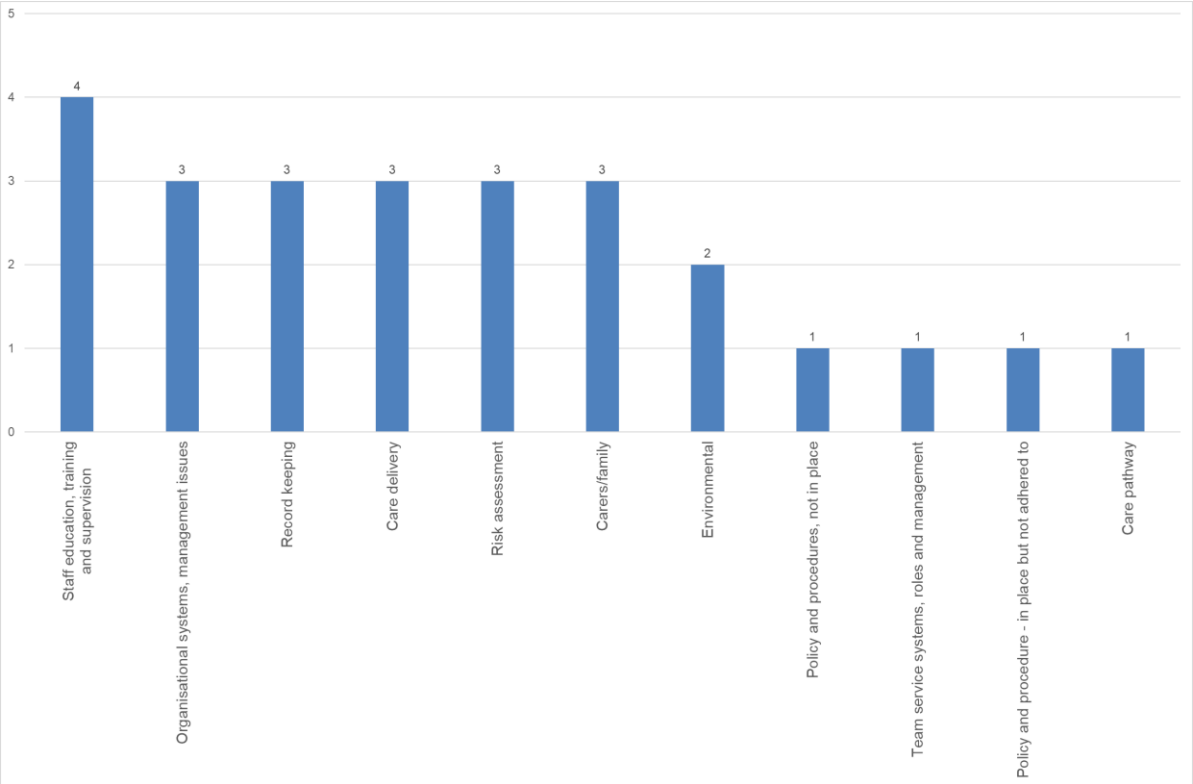
Categorisation of recommendations/actions

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

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

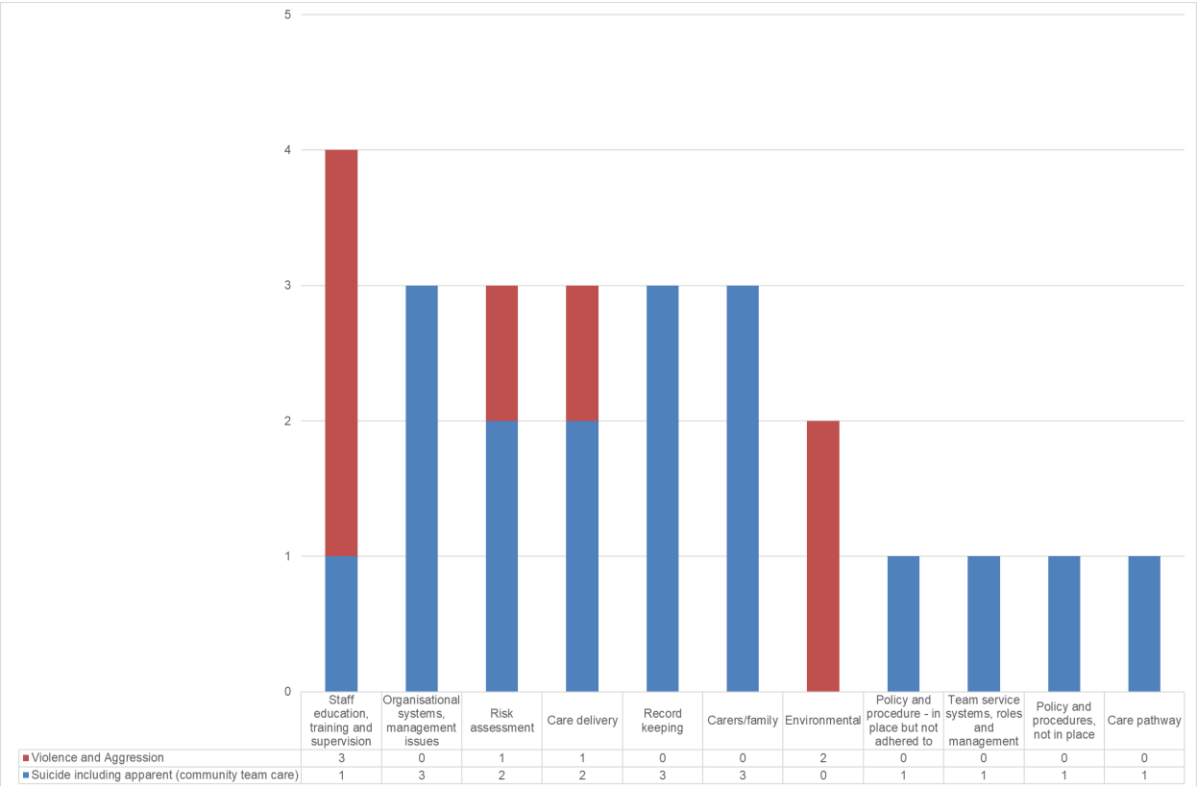
Figure 11 shows the action themes arising from the completed serious incidents.

Figure 9 Quarter 3 2023/2024 completed Serious Incident investigations, by action theme.



As shown in Figure 12, 18 of the actions came from investigations into apparent suicides (three cases). The themes from these are shown in the graph.

Figure 10 Comparison of action themes from completed Serious Incident investigations in Quarter 3 2023/2024, by action theme and serious incident type.



Top themes this quarter:
An overview of recommendations from serious incident investigations completed in Q3, are detailed below by action theme:

Staff education, training and supervision	
Risk assessment	It is recommended that there is information and learning within the induction process around the likelihood of risks posed and the overall nature of those service users within the Forensic Inpatient settings.
	It is recommended that the Forensic Service and Estates and Facilities ensure staff awareness of potential weapons or assault is maintained through regular reminders of potential weapons or aggression/assaults through team meetings, posters, and toolbox talks.
Various Training (Violence and Aggression)	It is recommended that ward orderly staff undertake situational awareness training. Discussions have taken place between the Reducing Restrictive Physical Intervention Team (RRPI), Estates team and the investigator to facilitate the foundations for this work and this will be continued going forwards, including roll out across the Trusts other inpatient services. A collaborative approach to safety and training between the services and directorates is recommended.
Supervision	The supervision process of all staff within the Psychiatric Liaison Team should ensure that the requirement for Team Practitioners to lead on communicating information across services for key clinical detail on care decisions is embedded in practice. This learning and that of the earlier 2019 incident investigation action plan for the Psychiatric Liaison Team in Wakefield should be reviewed and re-distributed, to embed learning and understanding on how and why this part of the care pathway process is essential. Learning should be shared Trust wide.
Organisational systems, management issues	
Standard Operating Procedures	The Trust should review the comprehensive health and social care assessment template to ensure that the question 'has the patient had a baby within the last 12 months' is altered to ensure this asks within the last 24 months/two years. Learning should be shared to ensure staff are aware of this change and that all relevant documents that help guide staff in primary and secondary care mental health services are updated to reflect this change.
Inadequate liaison/information sharing procedures between the service - other	A) The changes that had been instigated noted in Appendix 7 of the report by the Patient Flow service require an evaluation with support from the Quality Improvement and Assurance team. This should include a survey from front line staff across Intensive Home Based Treatment Team workforce professionals as a part of the process. Measure for success are required along with monitoring outcomes to ensure that the actions in place and already taken are productive and effective and understood by all teams across the Trust. B) The operational policies should be updated to reflect the current and future aims for the patient flow/bed management pathways and process, this should include the expected roles and responsibilities of staff within the Intensive Home Based Treatment Team.
Care delivery	It is recommended that the Trust consider a retrospective review on the 2019 Royal College Psychiatrist report for internal insights that can help shape the Trust's progressions for accessible inpatient care and treatment,

	consideration should be given to a systems wide analysis to explore any additional blocks or barriers across the whole care system.
Record keeping	
Monitoring Compliance of the Clinical Record Keeping	A) The Intensive Home Based Treatment Team should consult with the Quality Improvement and Assurance team for additional input on improvements that can be made to the current audit process in place so that the process of mapping against gaps in clinical record completion can be improved and knowledge and learning shared across the team to further enhance insights. This information should be utilised to inform future thinking on the need for consistency across the Trust in record keeping practice across all Intensive Home Based Treatment Teams. Variance should be considered alongside best practice and evidence based insights. B) The Intensive Home Based Treatment Team Dashboards or other alert systems utilised to help inform staff on record keeping completion should be reviewed. Any barriers to application across the team ought to be considered and used to inform changes that represent best practice and organisational standards in record keeping. Consideration should also be given to the quality of the completion and insights mapped for future actions.
Communication with other agencies	Discussions should be held between the Local Authority Information Technology (IT) services and the NHS IT services for any electronic solutions that can aid record keeping in the community when completing Mental Health Act assessments and read or read/write access to neighbouring electronic records care first and system One for those requiring it.
Medical plan	The learning from this investigation should be shared across the Doctors and medical community for South West Yorkshire Partnership NHS Foundation Trust on the importance of progress note entries when completing Mental Health Act assessments and ensuring clarity on who will make the entry, what access the Doctor has to the electronic system and to ensure when recommendations are made days apart that where possible additional entries are made
Care delivery	
Care planning	It is recommended that the observation and engagement plan clearly articulates instructions for enhanced observations which are clearly understood and implemented. In the case of the service user, he was to be nursed on a 2:1 basis, and yet ward orderly staff were alone around him when conducting their tasks on the ward. The investigator is aware that the service are currently updating their clinical record review and will factor this recommendation into governance processes.
Service provision	Adult & Older People's Mental Health Care Group continue to develop local waiting list management procedures in relation to SystmOne developments, national waiting list guidance. Developments should include reference to the NICE guidance for the management of depression (NG222).
MDT working and meetings	When a discussion has taken place during the MDT regarding a service user this should be recorded including where there is a potential change of risk/concern and a rationale provided of the decisions made.
Risk assessment	
Other	2.The Enhanced team should be reminded of Section 6 of the best practice standards of the Clinical Risk assessment, Management, and Training Policy,

	which states that 'Service users and carers are involved whenever possible at all stages of the CPA, risk assessment, and risk management process and Team managers should discuss practitioners understanding of and involvement with families as part of supervision.
	As part of the ongoing quality assurance monitoring processes the service should provide assurance that when the FIRM risk assessment is being reviewed, the risk assessment formulation has also been reviewed. If it is not, to establish what the barriers to completing it is and this information be used to help shape improvements.
Inadequate exploration of risk - Harm to others	It is recommended that when Risk Assessments are being formulated, consideration is given to the risks to other staff within the setting, including maintenance staff and ward orderlies and that this information is clearly communicated to all staff. The instructions for observations should be easy to articulate and implement.
Carers/family	
Other	The Intensive Home Based Treatment Team led by the Quality and Governance Leads in the Care Groups should explore the use of innovation and technology to create ease of access to information that can be shared with families. A review should be conducted on the present use of any information packs that are specifically prepared for information sharing.
	The development work should also include a specific family information leaflet of supporting loved ones with suicidal ideation/at risk of suicide, the leaflet development should align with the Trust Suicide prevention strategy and adaptable for Trust Wide use, consideration to the inclusion of the Trust Communications Team should be given.
Communication with family and carers	A) The Intensive Home Based Treatment Team led by the Quality and Governance Leads in the Care Groups should explore the use of innovation and technology to create ease of access to information that can be shared with families. A review should be conducted on the present use of any information packs that are specifically prepared for information sharing. B) The development work should also include a specific family information leaflet of supporting loved ones with suicidal ideation/at risk of suicide, the leaflet development should align with the Trust Suicide Prevention Strategy and adaptable for Trust wide use, consideration to the inclusion of the Trust Communications Team should be given.
Environmental	
Operational policy	It is recommended that there is a review of the staffing and tasks, and environmental factors for the ward orderly team to ensure there is sufficient staffing in pairs when carrying out certain duties, such as cleaning bedrooms and at other points where risks might be identified.
	It is recommended that the closing down of communal areas for cleaning is continued in order to retain safety of the ward orderly staff whilst they are cleaning large areas and may have their back turned to the service users.
Policy and procedures, not in place	
Other	The operational policies should be updated to reflect the current and future aims for the patient flow/bed management pathways and process, this should include the expected roles and responsibilities of staff within the Intensive Home Based Treatment Team.

Team service systems, roles and management	
Allocation of tasks	A flow process should be created and kept visible within the Psychiatric Liaison Team/Mental Health Liaison Teams on the importance of communicating alerts to the Intensive Home-Based Treatment Teams when admissions to hospital under the Mental Health Act are identified and document what the involvement will be.
Policy and procedure - in place but not adhered to	
Operational policy	The team should be reminded of section 5.2, When to assess risk, of the Clinical Risk Assessment, Management and Training Policy and Team managers should revisit this with practitioners as part of supervision.
Care pathway	
Care planning	Practitioners should complete a Staying Well Plan as part of the FIRM risk assessment and not develop an alternative care plan around crisis response.

Future direction

The Patient Safety Incident Response Framework (PSIRF) implementation from 1 December 2024 includes a Trust improvement plan with workstreams around agreed areas. The Trust improvement plan is available here.

Where we identify areas for improvement in the future, we will move from creating new individual/team actions to moving learning into improvement work. Themes from our historic SIs including those above has been and will be considered in improvement workstreams.

We will also have three thematic patient safety incident investigation (PSII) analysis projects around three main themes:

- Suicide prevention
- Clinical risk assessment (Formulation Informed Risk Management [FIRM])
- Clinical documentation of pressure ulcers

5. Learning from Healthcare Deaths Report - Annual Cumulative Report 2023/2024 (covering the period 1/4/2023 – 31/12/2023)

5.1 Background context

5.1.1. Introduction

In line with the National Quality Board report published in 2017, the Trust has a Learning from Healthcare Deaths policy which sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Nationally, most people will be in receipt of care from the NHS in the weeks, months or years leading up to their death. However, for some people, their experience is of poor quality care for a number of reasons including system failure.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services.

The Trust has a representative from the Patient Safety Support Team who attends the Regional Mortality Meeting which are held quarterly. This meeting facilitates the dissemination of good practice around learning from deaths with sharing of processes that other trusts have in place to review deaths and improve care.

5.1.2. Scope

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

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

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
1	Death Certification	Details of the cause of death as certified by the attending doctor.
2	Case record review	Includes: (1) Manager's 48-hour review (2) Structured Judgement Review (3) Case note review
3	Investigation	**Up to 30/11/2023 included**: Service Level Investigation Serious Incident Investigation (reported on STEIS) Other reviews e.g. LeDeR, safeguarding. **From 1/12/2023 (Patient Safety Incident Response Framework start date**) includes a range of Learning responses

5.2 Annual Cumulative Dashboard Report[8] 2023/2024 covering the period 1/4/2023 – 31/12/2023

Figure 11 Summary of 2023/2024 Annual Death reporting by financial quarter to 31/12/2023

Reporting criteria		2022/ 2023 total	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	2023/ 2024 Total (to date)
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[9]	2918	542	491	464		1497
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	379	94	98	89		281
3	Total Number of deaths which were in scope	253	71	75	70		216
4	Total Number of deaths reported on Datix that were not in the Trust's scope	126	23	23	19		65

As shown in Figure 13, row 2 shows that 89 deaths were reported on Datix during Q3 2023/2024. Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the 3 levels as described earlier.

Figure 14 below shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/4/2022-31/12/2023. Reporting rates have been checked and remain within the normal variation, within an SPC chart. This demonstrates there has been no increase

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

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

outside of the anticipated parameters. There are no areas of special cause variation that require further exploration at this time.

Figure 12 Statistical Process Control Report of all deaths reported 1/4/2021 – 31/12/2023 by date reported.

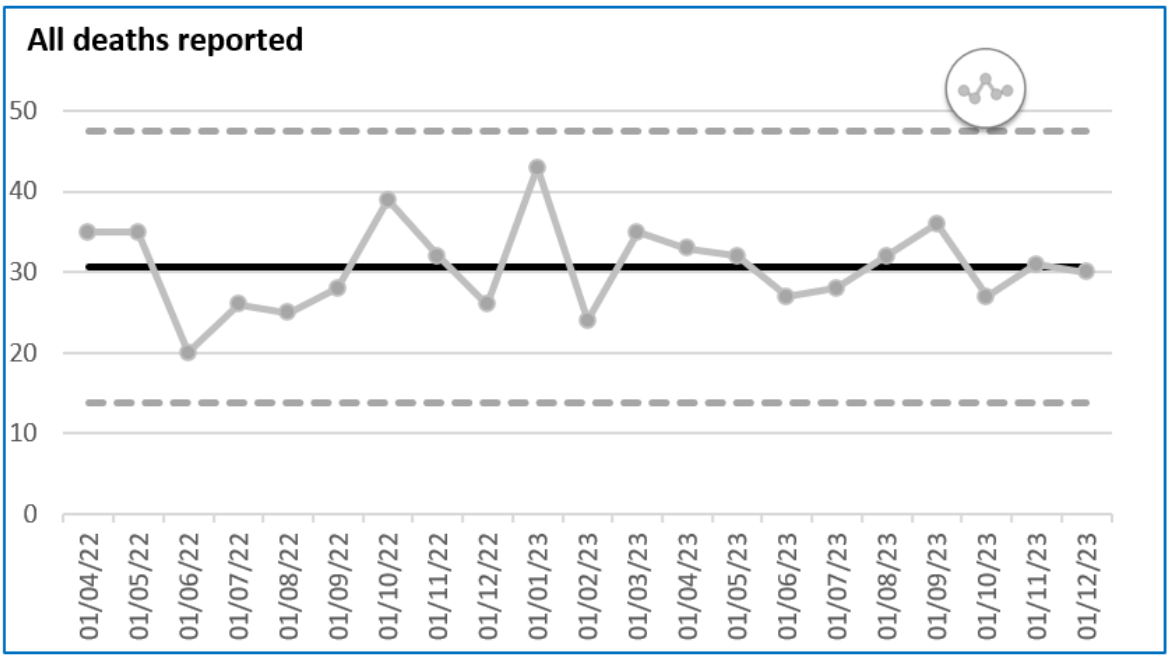


Figure 13 Breakdown of the total number of in scope deaths reviewed in 2023/2024 by care group by financial quarter.

Financial quarter - date reported	Barnsley Integrated Care Group	Adults and Older People Mental Health Care Group (community)	Adults and Older People Mental Health Care Group (inpatients)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	CAMHS and Children services	Total
2023/2024 Q1	19	40	3	8	1	0	**71**
2023/2024 Q2	9	53	2	10	0	1	**75**
2023/2024 Q3	10	46	5	9	0	0	**70**
2023/2024 Q4							
Total	**38**	**139**	**10**	**27**	**1**	**1**	**216**

Figure 14 Summary of total number of all in scope deaths in 2023/2024 to the end of Quarter 3 by the respective mortality review process

Financial quarter reported	Level 1: Certified	Level 2: Case note review			Level 3: Investigation			Total
	Death certified	Manager's 48-hour review	Structured Judgment Review	Case Note review - enhanced	Serious Incident Investigation	Safeguarding Review	Learning Disability Death process (LeDeR[3])	
2023/2024 Q1	27	25	8	0	3	0	8	71
2023/2024 Q2	26	31	4	2	1	1	10	75
2023/2024 Q3	24	32	3	0	1	0	10	70
2023/2024 Q4								
Total	**77**	**88**	**15**	**2**	**5**	**1**	**28***	**216**

*One Structured judgement review (SJR) was also reported to LeDeR[10] but is counted under SJR figures.

Figure 16 above shows the total number of all in scope deaths in 2023/2024 to date. The number of deaths in scope for Q3 (n=70).

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

Learning Disability deaths

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

The death of any patient with a Learning Disability has to be reported to LeDeR. It should be noted that the figures may not tally with the figures above by care group. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for.

Figure 17 below shows number of learning disability deaths and their status of being reported to the Learning Disability Review Programme (LeDeR).

[10] Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

Figure 15 Summary of total number of in scope deaths in 2023/2024 by the Review process (excluding Learning Disability deaths)

	Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Total
2023/2024 Q1	8	1	9
2023/2024 Q2	10	0	10
2023/2024 Q3	10	0	10
2023/2024 Q4			
Total	**28**	**1**	**29**

Of the 10 Learning Disability deaths which were reported to LeDeR during Quarter 3, all had the Manager's 48 hour review completed.

Other deaths

Figure 18 below shows all deaths where the patient is recorded as not have a learning disability and what level of review was completed. All deaths reported have the Manager's 48 hour review completed to ensure we have considered the care and treatment we have provided leading up to a death, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 16 Summary of total number of in scope deaths in 2023/2024 to the end of Quarter 3 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Investigation		
	Death certified	Manager's 48-hour review	Structured Judgment Review	Case Note Review	Serious Incident Investigation	Safeguarding Review	Total
2023/2024 Q1	27	25	7	0	3	0	**62**
2023/2024 Q2	26	31	4	2	1	1	**65**
2023/2024 Q3	24	32	3	0	1	0	**60**
2023/2024 Q4							
Total	**77**	**88**	**14**	**2**	**5**	**1**	**187**

Inpatient deaths

Figure 19 below shows that over the year 2023/2024 to the end of Quarter 3, there were seven inpatient deaths reported. There were no inpatient deaths relating to Learning Disability Services.

Figure 17 Trust wide Inpatient deaths in 2023/2024 by date reported.

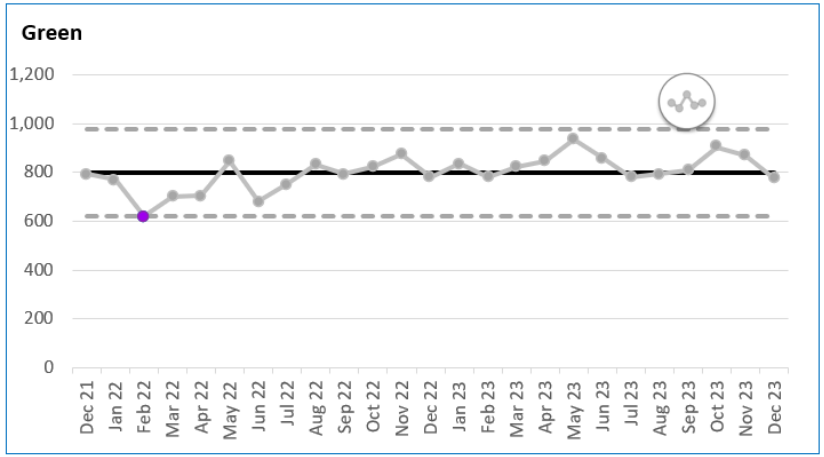
Care Group	Ward	Financial quarter - date reported				Total
		2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	
Adults and Older People Mental Health Care Group (Inpatient)	Beechdale Ward, The Dales Unit	1	1	0		**2**
	Ward 19 (OPS)	1	0	2		**3**
	Ashdale Ward	1	0	2		**3**
	Poplars Unit	0	1	1		**2**
Forensic Services Care Group	Johnson Ward	1	0	0		**1**
Barnsley Integrated Care Services Group	Stroke Unit	1	0	0		**1**
Total		**5**	**2**	**5**		**12**

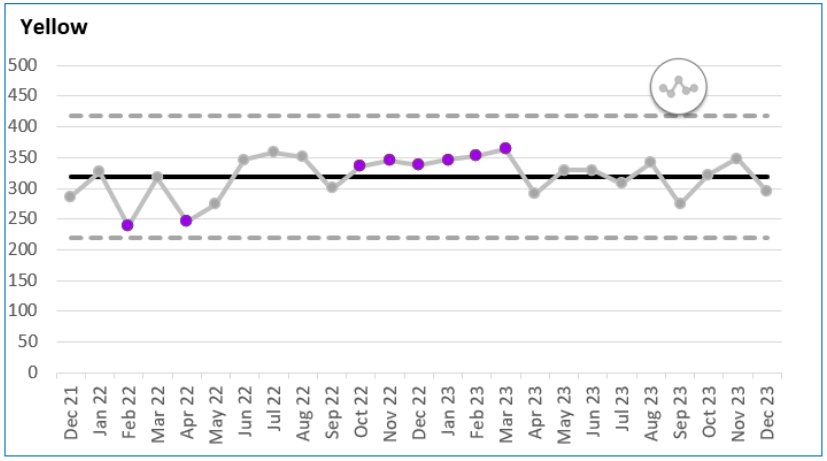
5.3 Next Steps

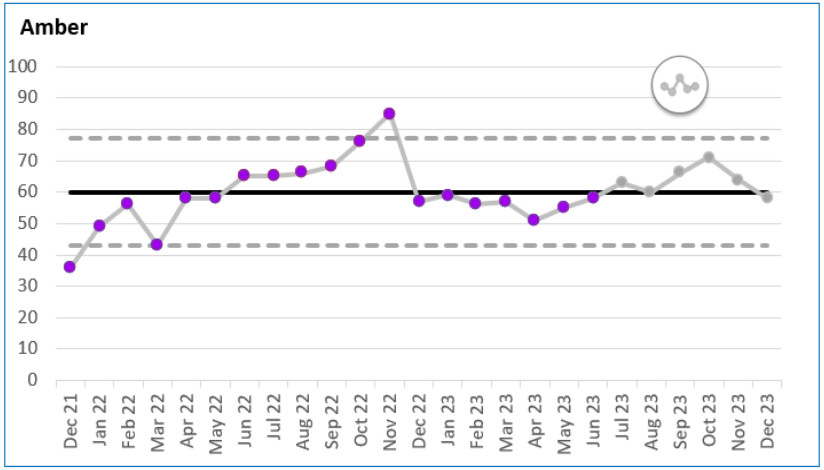
Our work to support learning from deaths continues, and includes:

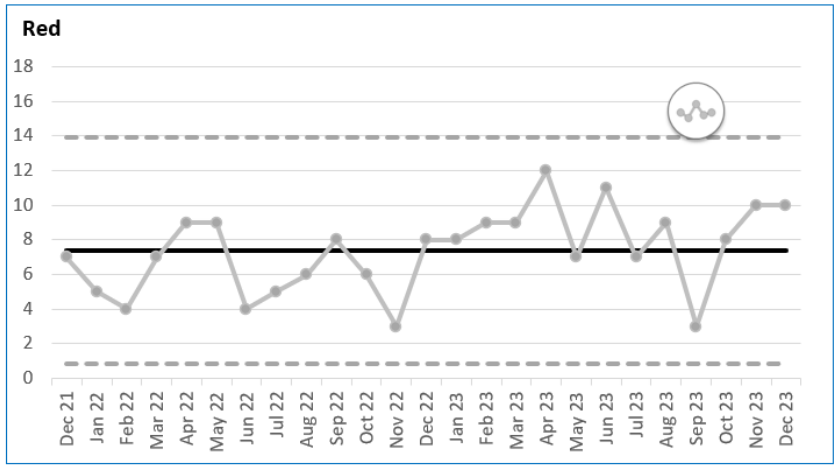
- The Family Liaison Officer (FLO) commenced in post in August 2023. This role will focus on engaging, involving and supporting bereaved families through the incident learning response and investigation process and ensuring families are linked into the support of the coroner's court. The FLO is also working closely with Care Groups and the Lead SI Investigators from the Patient Safety Support Team in response to this new way of working.
- We are attending Regional Mortality Meetings hosted by the Improvement Academy; the Northern alliance of mental health Trusts and West Yorkshire ICB (Kirklees) to share best practice in relation to the scrutiny/review/learning from deaths.
- We are reviewing our Learning from Deaths policy to reflect the implementation of the Patient Safety Incident Response Framework.
- We have re-established the Mortality Review Group from 23 October 2023, which will meet quarterly.
- From 1 April 2024 the Trust is required to work with the Medical Examiner's Office. Guidance on the Medical Examiner's process is currently being drafted.
- SJR training is due to be made available, both internally and externally through the Y&H Improvement Academy.
- We are now receiving LeDeR reports from cases within South Yorkshire; this learning is being reviewed through Learning Disability and ASD/ADHD Care Group and are being added to the corresponding Datix incident. We continue to work with West Yorkshire to mimic this development (or equivalent) for shared learning from deaths.
- Learning Disability and ASD/ADHD Care Group are developing a service learning group to promote and share learning from LeDeR reviews.

Appendix 1 – Statistical Process Control charts for all incidents reported Trust wide between 01/12/2021 – 31/12/2023 by severity









Graph 4 (red incidents) shows that there has been an upwards trend in recent months, this is expected. We usually see a higher number before incidents are re-graded as more information comes to light and are reflected in grading changes in the live Datix system.

Appendix 2 – Learning Library summaries Quarter 3 2023/2024

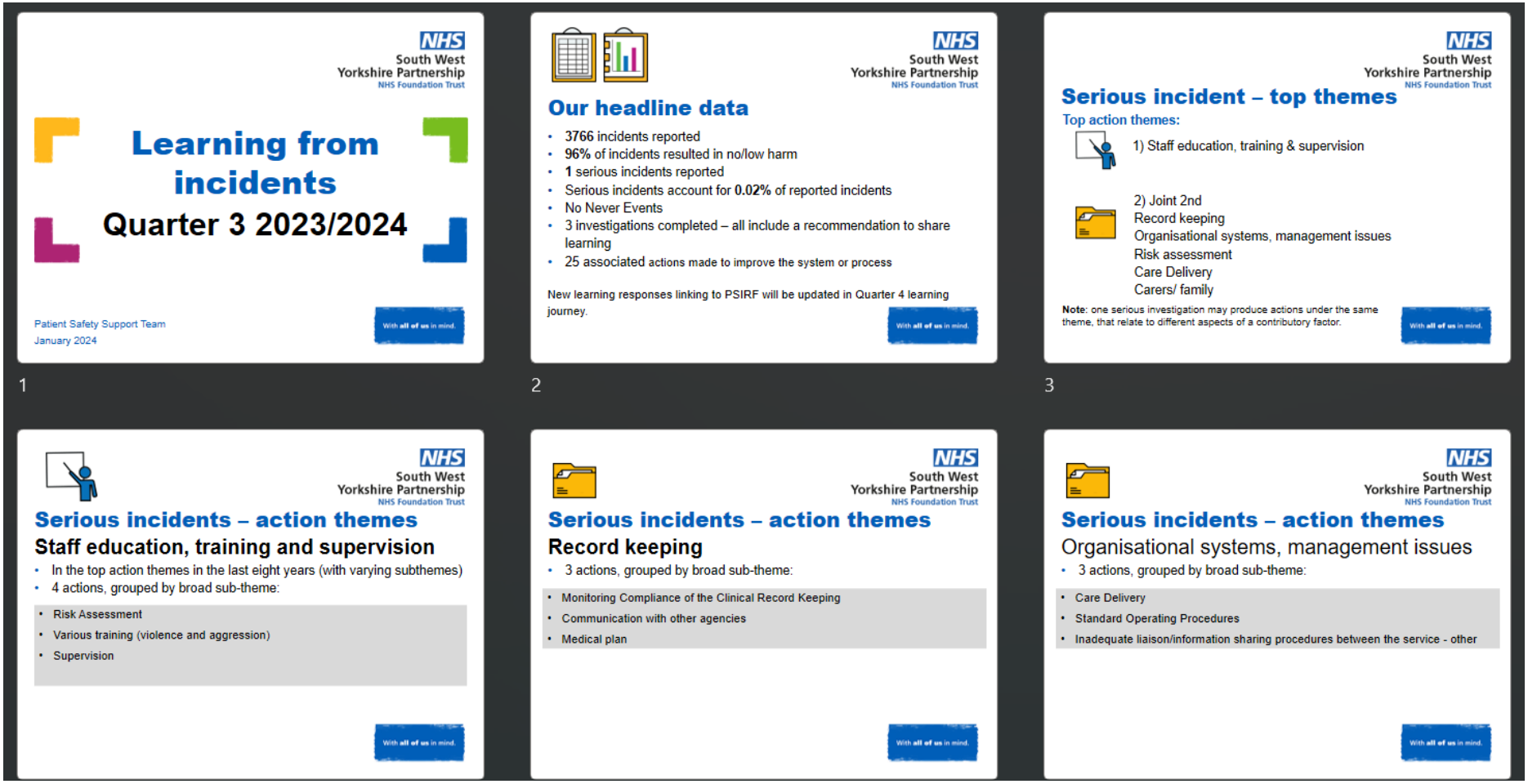
To review any of the SBARs please see the learning library page on the intranet:
Learning library (sharepoint.com)

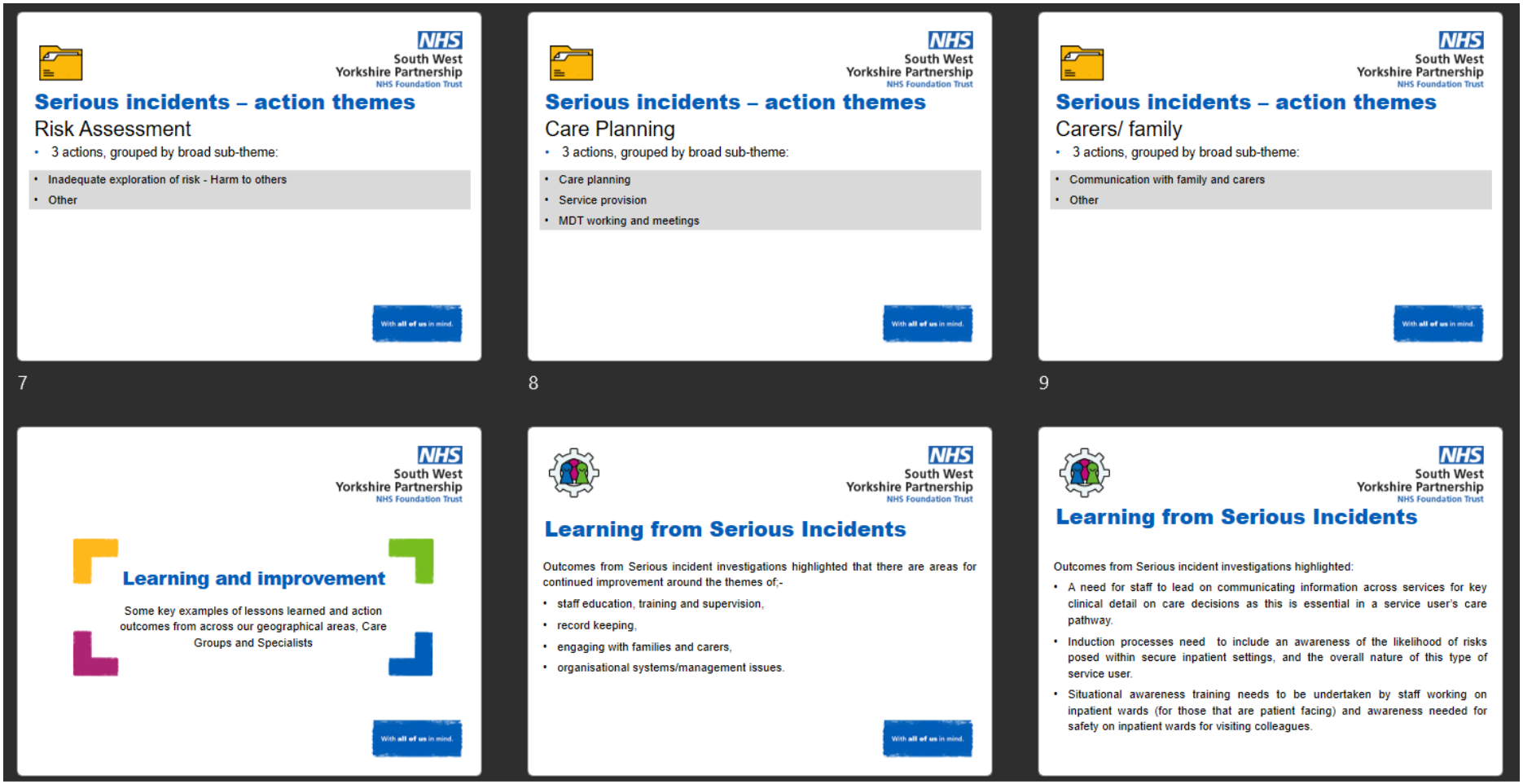
Title	Summary
Professional Curiosity for Staff visiting Care Homes	This briefing has been produced as a prompt to staff who may visit Care Homes through their working responsibilities. It is important that when practitioners visit other premises, such as Care Homes, that they are professionally curios to the environment and the impact on the persons within that environment.
ICON strategy and ICON week	The ICON awareness week is starting week commencing 25.9.23. ICON is a national strategy aimed at parents and carers of young babies and children which aims to reduce the incidence of abusive head trauma through parental education and support. All staff, trust wide regardless of role will encounter parents and carers both professionally and personally, the strategy promotes professional curiosity through supportive questioning and provides tools and direction for referral if concerns are raised.
Neglect Matters	The impact of neglect on children and young people is well documented. Neglect causes great distress to children. It can lead to poor; health, education and social outcomes. In some cases, it can lead to a child's death. Even where this is not the case, the effects can be serious and long lasting. Children's abilities to form relationships and to attend and do well at school may be affected. These things will influence their success in adulthood and their ability to parent in the future. The cumulative impact on children of both persistent and intermittent neglect is a central concern when considering the most effective ways of protecting them.
Death by insulin: management of self-harm and suicide in diabetes management	Those with diabetes can cause self-harm and potentially kill themselves by purposeful poor management of their illness. This poor management can be accomplished in several ways, such as manipulations of food and/ or diabetic medications. Some people feel that they would rather die than give themselves insulin due to needle phobia or psychological resistance (a feeling of failure, lack of time for multiple injections, fear of hypoglycaemia). Despite having poorly controlled diabetes managed by multiple oral agents, some persons with diabetes will refuse to use insulin and prefer to die. Medication underuse by persons who require insulin is also an issue. It has been employed in self-harm or suicide attempts for those with diabetes. Overdosing of insulin can be fatal. Often, it is not apparent if an overdose is accidental or an actual suicide attempt.
Summary for using Seclusion in Secure Services	Seclusion refers to the supervised confinement and isolation of a service user, away from other service users, in an area from which the service user is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. At times when a seclusion room is occupied or out of use it may be necessary to utilise another unit's facility.

	This presents a number of logistical issues particularly when a non-forensic service need to utilise the seclusion suite in secure services.
learning from a service user death in the community	a service user tied a dressing gown cord around her neck and placed a plastic bag over her head at home. She had also taken a significant overdose of propranolol and bleach prior to the hanging. The service user was admitted to Barnsley District General Hospital however passed away in the Intensive Care Unit a few days later. The service user was under the care of a community CORE team at the time of her death. A case note review following the service users death highlighted both areas of good practice in the overall care and treatment and identified some areas for improvement. This learning is being shared in the form of this learning template to influence future practice across services.
The importance of following guidance and supervision of visits to prevent Illicit substances being accessed by service users.	A service user received a family visit. The visit was hosted and supervised as per protocol; however, the visitor was allowed to utilise a non-designated staff only bathroom facility during the visit. This was observed by another member of staff and the senior nurse was alerted. The bathroom was searched, and a suspected illicit substance was found along with a lighter in the soap dispenser. The service user also requested to utilise this bathroom facility during the visit a short time later, and this was prevented.
Counter Allegations of Domestic Abuse	One of the more common challenges for those coming into contact with domestic abuse is counter allegations, where both parties allege that the other is abusive. It can be easy to fall into the trap of believing this to be a common aspect of domestic abuse, i.e. there will be two perpetrators and two victims in one relationship.
The National Paediatric Early Warning System: PEWS	In 2020 The NHS England Children and Young People's Transformation team led a system wide paediatric observation tracking (SPOT) programme, which incorporated research into what was used nationally to monitor paediatric observations for inpatient care. The process included the development of a standardised system for inpatient Paediatric Early Warning Systems and an e-learning package to support the implementation.

Appendix 3 – Learning from incidents slides

Below is an illustration of our Learning presentation that brings together some of the learning from Quarter 3 2023/2024. The full set of slides are available here along with previous years learning.




NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Serious incidents – action themes
Risk Assessment
3 actions, grouped by broad sub-theme:
Inadequate exploration of risk - Harm to others
Other
With all of us in mind.
7
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Serious incidents – action themes
Care Planning
3 actions, grouped by broad sub-theme:
Care planning
Service provision
MDT working and meetings
With all of us in mind.
8
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Serious incidents – action themes
Carers/ family
3 actions, grouped by broad sub-theme:
Communication with family and carers
Other
With all of us in mind.
9
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning and improvement
Some key examples of lessons learned and action outcomes from across our geographical areas, Care Groups and Specialists
With all of us in mind.
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
Outcomes from Serious incident investigations highlighted that there are areas for continued improvement around the themes of;-
staff education, training and supervision,
record keeping,
engaging with families and carers,
organisational systems/management issues.
With all of us in mind.
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Learning from Serious Incidents
Outcomes from Serious incident investigations highlighted:
A need for staff to lead on communicating information across services for key clinical detail on care decisions as this is essential in a service user's care pathway.
Induction processes need to include an awareness of the likelihood of risks posed within secure inpatient settings, and the overall nature of this type of service user.
Situational awareness training needs to be undertaken by staff working on inpatient wards (for those that are patient facing) and awareness needed for safety on inpatient wards for visiting colleagues.

Learning from Serious Incidents

- A need for more education and increased communication on the use of potential weapons or aggression/assaults.
- A need for additional input for improvements to audit processes to map against gaps in clinical record completion.
- Alert systems/dashboards utilised to help inform staff on record keeping should be reviewed, with barriers to application reviewed against best practice and organisational standards in record keeping.

13

Learning from Serious Incidents

- Reinforcement is needed with record keeping practice standards for medics involvement in a Mental Health Act assessment, particularly the importance of progress note entries and clarity about who should make an entry, medical accessibility on SystmOne and where recommendations are made days apart additional entries should be made in progress notes
- Information governance arrangements/requirements and local agreements for shared access to electronic records with other partner agencies (read/write access to those that require it) should be determined. This will aid record keeping in the community services when completing Mental Health Act assessments.

14

Learning from Serious Incidents

- There is a need to explore the use of information packs accessible to family/carers.
- Collaboration with service users/carers is needed to involve them whenever possible at all stages of the CPA, risk assessment and management process.
- When updating FIRM risk assessments, risk formulation needs to be reviewed. Ongoing monitoring processes need to identify the barriers as to why, where it is not completed.
- Consideration of risks to staff within the service setting is needed whilst reviewing / updating patient specific risk assessments.

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Learning from Service Level Investigations (SLI)

Outcomes from Service Level Investigations (SLI) highlighted:

Family and carer engagement and involvement

- There was learning identified that early information sharing on accessible information for families is best practice.
- All families and carers should have access to a carers passport which they can complete for themselves in respect to their role in supporting the family member. Community teams are recommended to ensure that current information shared is up to date and reflective of the family and carers matter values that the Trust subscribes too.
- Learning identified that guidance shared with families on the sharing of information should be explicit in advising that families are encouraged to share their concerns, even if the Trust are unable to share information back due to a service users removal of consent.

Learning from Service Level Investigations (SLI)

Communication and joint working across teams and organisations

- Learning identified that there could be improved visibility of support available to families and children where substance misuse is an issue, Trust community mental health and inpatient teams covering the Kirklees district would benefit from being able to share this information in the form of a leaflet or a link to the details.
- Learning acknowledged developments in the past 12 months in community specialist substance misuse services that the Trust community mental health teams in Kirklees would benefit from being alert to.
- Learning identified by a partner organisation the Trust services are recommended to actively engage in any community developments in respect to dual diagnosis and future development. The community specialist substance misuse service plan to join the reviews learning event with the community team to share what the developments of the service are and what the ambitions are for the future.

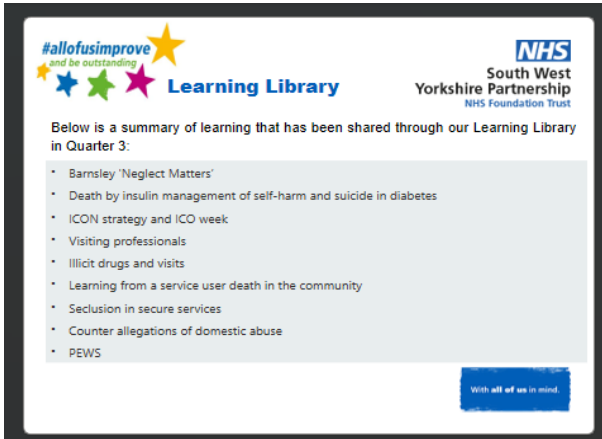
Learning from Service Level Investigations (SLI)

Documentation

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

Training

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


#allofusimprove
and be outstanding
Learning Library
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Below is a summary of learning that has been shared through our Learning Library in Quarter 3:
Barnsley 'Neglect Matters'
Death by insulin management of self-harm and suicide in diabetes
ICON strategy and ICO week
Visiting professionals
Illicit drugs and visits
Learning from a service user death in the community
Seclusion in secure services
Counter allegations of domestic abuse
PEWS
With all of us in mind.

19


#allofusimprove
and be outstanding
Learning Network
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Below is a summary of learning that has been shared at our Learning Network forum: (24th October)
Falls improvement work
Propranolol in overdose
Below is a summary of learning that has been shared at our Learning Network forum: (12th December)
Barnsley CAMHS (Discharge letter)
Customer Services Improvements
Learning from an inpatient covid related death
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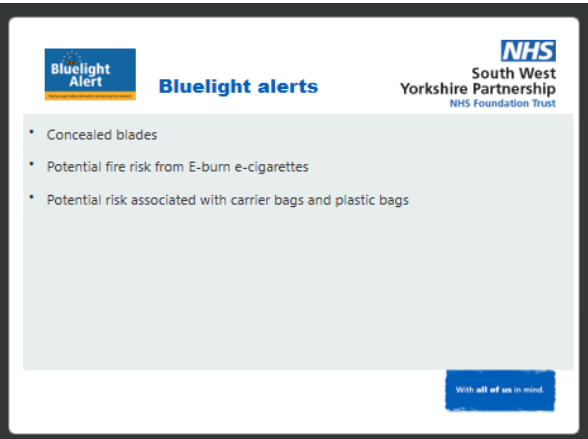
20


Bluelight Alert
Bluelight alerts
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Concealed blades
Potential fire risk from E-burn e-cigarettes
Potential risk associated with carrier bags and plastic bags
With all of us in mind.

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NHS
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NHS Foundation Trust
Thank you for supporting a patient safety culture
Contact the patient safety team: patientsafety@swyt.nhs.uk
With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 10.2

Private/Public paper:	Public		
Title:	**Trust Strategic Overview: PESTLE & SWOT** **(Previous title Strategic Overview of Business and Associated Risks)**		
Paper presented by:	Dawn Lawson, Director of Strategy & Change		
Paper prepared by:	Sue Barton – Deputy Director of Strategy & Change		
Purpose:	This report provides an analysis of the current business and associated risks for the Trust. It is based on a review of the PESTLE (political, economic, socio-cultural, technological, legal and environmental factors) and SWOT (strengths, weaknesses, opportunities and threats), organisational risk register (ORR), Board Assurance Framework (BAF).		
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:	The analysis was discussed in EMT during January and February 2024.This document indicates connections with the ORR, and BAF.		
Executive summary:	The document contains a full copy of the Trust's PESTLE and SWOT, together with a summary on a slide set for ease of reference of the key issues that will inform our strategy refresh. There is strong alignment with the PESTLE register and the BAF and ORR suggesting that these key processes are identifying the same issues in the environment. This analysis will be further tested through the engagement process for the strategic review in order to inform our future strategy and priorities		
Recommendation:	**Trust Board is asked to RECEIVE the report.**		

South West Yorkshire Partnership NHS Foundation Trust

Trust Strategic Overview: PESTLE & SWOT

(Previous title Strategic Overview of Business and Associated Risks)

January 2024

Dawn Lawson, Executive Director of Strategy and Change

Improve health

Improve care

Improve resources

Make this a great place to work

With **all of us** in mind.

1. Purpose of the Report

This report provides an analysis of the current business and associated risks for the Trust. The analysis was last presented to the Trust Board in February 2023. This report provides an update since February 2023 which is based on a review of the PESTLE (political, economic, socio-cultural, technological, legal, and environmental factors), and SWOT (strengths, weaknesses, opportunities and threats), organisational risk register (ORR), and Board Assurance Framework (BAF).
The main body of the document references the current key issues identified within the PESTLE and SWOT and considers the implications of these for the Trust. The full PESTLE and SWOT registers are presented in Appendix A for reference. Appendix B contains those items which were in the version considered in February 2023 and which it is proposed to remove.
This report will provide the basis for the strategic analysis to underpin the Trust strategy refresh and to set our strategic priorities

2. Information and Analysis

There is a natural and coherent alignment between and across the content of the Trust's SWOT and PESTLE analyses, ORR, BAF and priority programmes. This report identifies the indicative connections between these however, strict alignment and correlation of content is not practical due to the complex and non-linear nature of our external environment.

Our PESTLE and SWOT registers are attached at Appendix A. The registers gather information including:

- **The date when the entry was first added to the register.**
  This is referenced to help indicate where long term issues may require additional and specific attention.
- **The date the record was last updated** to ensure register entry is current and valid
- **Cross-reference to the Trust organisational level risk register (ORR)** through identification of the number of the relevant risk to enable alignment between the ORR and this document
- **Cross reference to the BAF** through identification of the relevant section of the BAF to enable alignment between the BAF and this document
- **Cross reference to the Trust's strategy and strategic objectives** using colour coding for the relevant strategic objective to indicate how this issue links into the current strategy and priority areas of work

All items on the registers have been reviewed and updates and additions made since the last report to Trust Board are indicated in blue text and are indicated with a blue 'tick' (✓) in the relevant 'updated this time' field. Any parts of entries that are no longer applicable are indicated with text crossed out, for example, ~~like so~~. Any entries that are considered no longer applicable are included in Appendix B with the rationale for this decision indicated.

3. PESTLE Key current issues

Our PESTLE register contains an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate.

The main current issues are set out in the table below. The reference number relates to the reference in the full PESTLE in Appendix A

Table one Key current PESTLE issues

Category	Ref.	Description
Political	1.4*	Continued emphasis on collaborative place-based approaches to improvement and associated changes in organisational form such as integrated care systems and partnerships indicate a shift away from market-based drivers of improvement. The Trust is playing a key role in each of the partnerships that are emerging and developing for the places in which we provide services to mitigate the risk on quality and sustainability of services. Our mental health offer is well regarded with the establishment of Mental Health Provider Alliance in Wakefield and strengthened partnership arrangements in Calderdale, Kirklees and provider alliance in Barnsley.
Political	1.16*	General election due in 2024.Opinion Polls suggest strong likelihood of change in government with subsequent potential change in health and care policy and approach. However, this is unlikely to result in significant increases in national allocations for health and social care services (or general Council spending) for several years.
Political	1.17*	The NHS is now under more extreme pressure than it was as the height of the pandemic, this is having consequences on patient experience and outcomes. Demand and acuity have increased, investment in the NHS has been flat over consecutive years and a lack of long term workforce planning, has had a significant impact on waiting times across the NHS. Public satisfaction with the NHS is at an all time low and political pressure to reduce waiting times is increasing.
Economic	2.5*	Major Cost Improvement Programme requirements, for the Trust which are greater than we have recently delivered coupled with financially challenged health and social care providers. This could lead to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing and risk of deterioration in quality of care provided.
Economic	2.12*	Economic impact of the Covid 19 pandemic, Brexit, Russian/Ukrainian and Middle East conflict leading to recession and pressure on public sector finances in UK. Rising inflation, cost of energy and disruption to supplies as well as longer term impact of funding for public services. This has an impact on the spending available for the NHS and on individuals across our communities. The increasing cost of living including the increased risk of fuel poverty in some of our communities and the tightening of funding, contributing to widening inequalities and impact on people in lower income communities including some of our staff. The impact of poverty is already evident in the increased acuity of patients, some patients unable to attend appointments due to travel costs and less resilience in communities impacting upon acuity and readmission.
Socio-Cultural	3.1*	The longer term effects of the pandemic on people's health e.g., mental health and long covid as well as societal attitudes towards mental health increasing recognition of widespread prevalence and relevance in the lives of all and potentially removing the societal stigma of mental health conditions. Together with the NHS long term plan for services for young people, the uptake and demand for MH services and the whole system response has the potential to increase the likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention. This is all exacerbated by the increase in cost of living
Socio-Cultural	3.6*	The benefits of new health approaches – social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health. This has been acknowledged in our Involvement and equality strategy and the Social Responsibility and Sustainability strategy and annual plans for our charities that enable us to deliver this aspect.
Socio-Cultural	3.7*	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy. Equality, Involvement, Communication and Membership Strategy revised with insight from extensive involvement and engagement. Associated action plans detail work to be undertaken to further strengthen the Trust approach
Socio-Cultural	3.10*	The population of people accessing our services is changing. There is greater societal awareness of ASD/ADHD, leading to surging demand for diagnosis and increasing pressure on already stretched services. There are high expectations from a new group of people who do not have the other co-determinants that many of our service users have
Technological	4.3*	Inequalities in technology access, literacy, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. Technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to deliver the Trust mission and objectives. Inequality in access to technology is impacting on service user choice of assessment and treatment. The Trust is actively working across the health and care ecosystem with partners to reduce the digital divide.
Technological	4.10*	Rapid developments in the use of Artificial Intelligence have the potential to transform the way we work
Legal/ Regulatory	5.10*	Increasing scrutiny from the regulators, coroners and other legal bodies. There is a hardening of approach due to high profile examples of incidents within the NHS and subsequent impact on public confidence

Environmental	6.3*	Climate change is something that affects us all, both now and in the future. Several local authorities across the Trust footprint have declared a climate emergency and have prioritised environmental sustainability. The Trust is a partner in these activities to support local improvements to be more environmentally sustainable. Work has commenced on environmental sustainability across the ICS which we are a part of. Sustainability continues as part of the Board approved green plan to address the Net Zero agenda at the Trust.

4. SWOT Key current issues

Our SWOT register contains an analysis of the internal capability of the Trust as well as opportunities and threats that the external environment poses for the organisation. These are presented under the headings of:

- Strengths: characteristics of the Trust that gives it an advantage over others
- Weaknesses: characteristics of the Trust that places the Trust at a disadvantage relative to others
- Opportunities: elements in the environment that the Trust could exploit to its advantage
- Threats: elements in the environment that could cause challenge for the Trust

The main **current issues** are set out in the table below. The reference number relates to the reference in the full SWOT in Appendix A.

Table two Key current issues in SWOT

Category	Ref.	Description
Strength	1.1*	Compelling model for alternative capacity – Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing and Altogether Better is well aligned to LTP direction and offers opportunities for partnership in local place-based solutions such as ICS. The Trust's linked charity Creative Minds has been announced as a winner in a Europe-wide 'challenge' focused on different ways to empower communities to improve their health. Creative Minds is one of eight winners in the Reimagining Community Health Challenge
Strength	1.3*	Partnership relationships and track record of collaborative working, providing leadership where appropriate and moving arrangements forward are a key strength. and place-based delivery structure underpinned by clear FT governance arrangements for system leadership and place based integrated care partnerships. A range of executive and board arrangements with trusts, commissioners, and other stakeholders in each of the place we operate
Strength	1.34*	Developing expertise and experience in provider collaboratives and alliances as either a host or a partner. This means we can be a strong and influential partner and take forward potential strategic opportunities for leading Collaboratives/Partnerships.
Strength	1.6*	Clear commitment to the Trust's mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust Staff 'living the values' as evidenced through values into excellence awards.
Weakness	2.1*	There are some Trust services where access to help can be too slow and needs to improve and there is a risk that people will be adversely affected because of waiting for treatment - in particular child neuro-developmental waits. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.
Weakness	2.3*	Our most recent CQC Report in 2023 highlights that there is a requirement to improve our adult acute inpatient and PICU services and forensic services We do not yet have a comprehensive plan to respond to a well led review
Weakness	2.14*	Whilst some investment in analytical capability has been made, there has been very limited and there is an increasing need to expand the ability of the organisation to provide analytical data that is usable for front line colleagues.
Opportunity	3.1*	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional ~~lead~~ coordinating provider in forensics in both West Yorkshire and South Yorkshire.
Opportunity	3.7*	We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches e.g., Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing and Altogether Better. We have commenced work to embed these approaches as an integral part of our offer in inpatient and community services and could be a national exemplar. This is a unique ability and would enable SWYPFT to lead the conversations about the role of creativity in routine service planning and delivery and support the conversations about mental health services of the future.
Opportunity	3.37*	Opportunity to gain Teaching Trust status to demonstrate our commitment to supporting training and development of the workforce, being a great place to work and ensuring quality care. Alongside this there is a broader opportunity for strategic relationships with universities in our localities to support and enable

		us to engage with our communities, improve our ability to evaluate the impact on our programs and to participate in bids we wouldn't otherwise have the ability or capacity to consider.
Opportunity	3.41*	Opportunity to use the publication of the NHS long term workforce plan as a framework to drive the agenda for the Trust to be a great place to work, research and train
Threat	4.3*	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g., because of benefit restrictions). The financial position of Councils is challenged; this could impact on support for vulnerable people who are service users (or potential service users) of our services.
Threat	4.22*	Impact on financial performance. of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs, out of area placements, reductions in cash, and regulator intervention, could impact on our ability to improve services and meet our objectives.
Threat	4.34*	Concern that national priorities will focus on acute and primary care due to pressures within these systems and therefore there will be less attention paid to Mental health, Learning disability and general community services

5. Analysis and Implications – So what?

There is strong alignment with the PESTLE register and the BAF and ORR suggesting that these key processes are identifying the same issues in the environment. In addition, there is strong alignment between the SWOT and the strategic objectives. We will use this analysis to underpin the development of the refreshed Trust strategy and indicate what our priority programmes of work should be. These will be areas where we are building on the Trust strengths to capitalise on opportunities and address the weaknesses whilst minimising the threats.

The purpose of undertaking this detailed work is to ensure that the current environment is understood and responded to via analysis of the external environment and the internal capability of the Trust. This is an important foundation for our strategy refresh and this analysis will therefore be used in this work. This is particularly important for the key issues which have been identified in sections three and four above. Consequently, the areas identified as key in tables two and three will be fed as key issues into the strategy refresh to make sure that these are given consideration and actions identified in response. This will mean that the Board can be assured that there are actions in hand to address the issues identified within our analysis.

6. Summary and recommendations

This document provides an analysis of the current business and associated risks for the Trust, in January 2024. It has been produced as part of the strategic analysis in preparation for the Trust strategy refresh

Trust Board is asked to:

- Receive the strategic overview, note the contents and that this will be used as the basis for the strategic review

Appendix A – Full PESTLE and SWOT

Key: Link to strategic objectives colour coding

Improve Health | Improve Care | Improve Resources | Great place to work

To note, items from the full PESTLE and SWOT registers presented in this Appendix which also feature in Section three or Section four of the main body of the report are indicated with a * following the reference number

PESTLE

Below is an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate:

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross ref with ORR	Cross ref with BAF	Link to Strategic Objectives
Political	1.1	The NHS Long Term Plan (LTP) was introduced in January 2019. It builds on the vision and ambition set out in the five year forward view (5YFV) with greater emphasis on better access to mental health services to help achieve the government's commitment to parity of esteem between mental and physical health; better integration of health and social care so that care does not suffer when patients are moved between systems; greater emphasis on collaboration through Integrated Care Systems (ICS) place based intervention; greater role for primary care and community services focusing on the prevention of ill-health so people live longer, healthier lives; and with a strong focus on workforce and technology. SWYPFT have a strong position given SWYPFT engaged well in the production of the LTP and used our membership of both the mental health network of NHS Confed and NHS Providers to engage. We also used our roles in our ICSs to influence messages and engagement with systems which was very relevant.	Mar 19	Jan 21		695	1.1, 1.2	

Political	1.4*	Continued emphasis on collaborative place-based approaches to improvement and associated changes in organisational form such as integrated care systems and partnerships indicate a shift away from market-based drivers of improvement. The Trust is playing a key role in each of the partnerships that are emerging and developing for the places in which we provide services to mitigate the risk on quality and sustainability of services. Our mental health offer is well regarded with the establishment of Mental Health Provider Alliance in Wakefield and strengthened partnership arrangements in Calderdale, Kirklees and provider alliance in Barnsley.	Pre Apr 16	Jan 23		812	1.1 1.2	
Political	1.7	The NHS Long Term Plan requires commissioners 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. Ongoing contractual growth is in line with mental health investment standard, recognises demographic growth and some specific service pressures. Mental health investment standard funding provided by each commissioner in line with national requirements.	Jan 21	Jan 23		275	3.1	
Political	1.8	Assessment of place-based plans in each Integrated Care System (ICS) will take place as part of the annual planning process. The Trust inputs into the development of place based plans in all four places	Jan 21	Jan 23		812	1.1,1.2	
Political & Economic	1.9	Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place-based developments and transition to system working at operational and clinical level Ongoing engagement through place based Integrated Care Partnerships to agree capacity and resources to deliver on agreed change programmes. The impact of the reduction on ICB costs has yet to work through but could have an impact on SWYT.	Jan 21	Jan 24	✓	1511	3.1	
Political	1.10	Further development of the ICBs and changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint. The Trust is involved in each place response, the development of provider collaboratives and shared governance arrangements.	Jan 21	Jan 23		812	1.1 1.2	
Political	1.11	The NHS Long Term Plan includes ambitious targets and developing transformation plans for Community Mental Health services .	Jan 22	Jan 23		522	1.4	
Political	1.13	Unrest in response to pay awards across several unions leading to strike action which will impact on service delivery and staff morale	Jan 23	Jan 23		1758	4.3	

Political & Economic	1.14	Inflation and volatility in the building sector means that Capital planning is difficult and costs are increasing. The capital regime and approach mean that we are not always able to adapt to this volatile environment	Jan 23	Jan 23		1585	3.1	
Political	1.15	Increased scrutiny and high profile media reporting on the NHS system and its delivery. This includes regular highlighting of pressures and impacts related to access, waiting times, capacity to deliver, and reports of system failures	Jan 23	Jan 23			4.2	
Political	1.16 *	General election due in 2024.Opinion Polls suggest strong likelihood of change in government with subsequent potential change in health and care policy and approach. However, this is unlikely to result in significant increases in national allocations for health and social care services (or general Council spending) for several years.	Jan 24	Jan 24	✓		1.1	
Political	1.17 *	The NHS is now under more extreme pressure than it was as the height of the pandemic, this is having consequences on patient experience and outcomes. Demand and acuity have increased, investment in the NHS has been flat over consecutive years and a lack of long term workforce planning, has had a significant impact on waiting times across the NHS. Public satisfaction with the NHS is at an all time low and political pressure to reduce waiting times is increasing.	Jan 24	Jan 24	✓	1530	2.3 3.1	
Political	1.18	The NHS long term workforce plan has been developed which sets out the long-term strategic direction for the NHS workforce in England.	Jan 24	Jan 24	✓	1151	4.1	
Political	1.19	The political environment is volatile and can change very quickly. The NHS is therefore required to be flexible and respond to these changes	Jan 24	Jan 24	✓		1.1	
Economic	2.1	Changes in funding outlined in the NHS Long Term Plan supports collaboration and parity of esteem between Mental Health, Learning Disabilities, and Physical Health with a strong emphasis on tackling inequalities and prevention.	Jan-17	Oct-19		522	3.1	
Economic	2.3	The impact of NHS financial control measures ~~on both commissioners and providers – particularly around control totals, agency caps, etc. There~~ means there is stronger financial interdependence across health systems through integrated care systems-level control totals, as underlined in the FYFV and in the NHS long term plan.	Oct-16	Jan 24	✓	522	3.1	
Economic	2.4	Impact of current employment market for many staff groups, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans ~~and 'cap'~~. Risk that wards are not adequately staffed, leading to increased temporary staffing and potential negative impact on quality of care provided. Potential threat of losing staff (more specifically lower graded staff) to other sectors for higher pay.	Oct-16	Jan 24	✓	1151	4.1	

Economic	2.5*	Major Cost Improvement Programme requirements, for the Trust which are greater than we have recently delivered coupled with financially challenged health and social care providers. This could lead to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing and risk of deterioration in quality of care provided.	Jul-16	Jan 24	✓	275	3.1 1.1	
Economic	2.6	The planned increase in funding to support the LTP, particularly with a 'guarantee' that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget. There is a risk that the Trust's financial viability will be affected because of changes to national funding ~~and additional recurrent costs as a result of the Covid-19 pandemic which are being mitigated through the annual planning process and continued external engagement and communications with stakeholders.~~	Jul-16	Jan 24	✓	522	3.1	
Economic	2.7	~~All NHS staff groups are experiencing the pressures of high inflation and are demanding significant pay uplifts~~ Due to higher inflation, pay awards are also increasing, from a financial planning perspective for 23/24 the trust was instructed to plan for a 2% uplift to pay costs ~~whilst negotiations continue with Government~~, any agreed pay award above 2% would result in additional funding for the trust. ~~It should be noted that due to the high pay to non-pay ratio this trust has, which is typical of community and MH trusts, it is likely there would still be a local funding shortfall to the trust.~~ It is now evident that created a funding shortfall for the trust as it was not fully funded, this may well repeat in 24/25	Sep-17	Jan 24	✓	522	3.1	
Economic	2.8	The viability and maturity of the third sector to operate fully in the competitive market place impacts on the degree of flexibility that the Trust can partner to provide flexible and diverse services within health enabling us to reach into and benefiting communities .The third sector is particularly affected by financial constraints making it more vulnerable	Apr-18	Jan 23		275	1.1 1.2 1.3	
Economic	2.11	At present, demand and capacity issues across West Yorkshire and nationally have meant that children and young people requiring a CAMHs bed are, on occasions, temporarily located in a bed assigned for adults. ~~Development of a new CAMHs inpatient facility in Leeds for West Yorkshire has now been completed and Red Kite View opened in January 2022~~. Planned investment outlined in the Long-Term Plan can support improvements to services. Transformation funding through the ICSs to support MH community services and children and young people's services have been secured.	Mar-19	Jan 24	✓	1368	3.3	
Economic	2.12 *	Economic impact of the Covid 19 pandemic, Brexit, Russian/Ukrainian and Middle East conflict leading to recession and pressure on public sector finances in UK. Rising inflation, cost of energy and disruption to supplies as well as longer term impact of funding for public services. This has an impact on the spending available	Jan 21	Jan 24	✓	522	3.2	

		for the NHS and on individuals across our communities. The increasing cost of living including the increased risk of fuel poverty in some of our communities and the tightening of funding, contributing to widening inequalities and impact on people in lower income communities including some of our staff. The impact of poverty is already evident in the increased acuity of patients, some patients unable to attend appointments due to travel costs and less resilience in communities impacting upon acuity and readmission.						
Economic	2.14	The financial context we are operating within is challenging. The economic growth is poor and the treasury are reluctant to provide additional funding	Jan 24	Jan 24	✓	1114	3.1	
Socio-Cultural	3.1*	The longer term effects of the pandemic on people's health e.g., mental health and long covid as well as societal attitudes towards mental health increasing recognition of widespread prevalence and relevance in the lives of all and potentially removing the societal stigma of mental health conditions. Together with the NHS long term plan for services for young people, the uptake and demand for MH services and the whole system response has the potential to increase the likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention. This is all exacerbated by the increase in cost of living	Jan-17	Jan 24	✓	1530	2.3	
Socio-Cultural	3.2	Impact of demographic change on the demand for services and on workforce age profiles.	Pre Apr 16	Mar-19		1132	2.3	
Socio-Cultural	3.3	Changing expectations of services, greater expectation of personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention all supported by the NHS long term plan. This requires changes in workforce requirements with new skills, new roles, and new psychological contracts at work. Risk of not being able to recruit qualified clinical staff and impact of medical workforce retention / turnover in certain specialities and assessment is being mitigated through recruitment and retention strategy. This includes safer staffing review, development of new roles such as Advanced Nurse Practitioner, and an international recruitment campaign.	Pre Apr 16	Mar-19		1151	4.3	
Socio-Cultural	3.4	The national shortages of clinical staff ~~is affecting~~ has affected the Trust's ability to recruit suitably qualified clinical staff which impacts on: the safety and quality of our services and the effective delivery of the Trust strategy, particularly in the ability for future development in services and increases our expenditure on bank and agency staff to fill the shortage gap. This position is slowly changing and we are seeing an early increase in headcount and downturn in agency use	Feb-18	Jan 24	✓	1151	4.1	
Socio-Cultural	3.6*	The benefits of new health approaches – social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and	Apr-18	Jan 23		695	1.2 1.3 1.4	

		community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health. This has been acknowledged in our Involvement and equality strategy and the Social Responsibility and Sustainability strategy and annual plans for our charities that enable us to deliver this aspect.						
Socio-Cultural	3.7*	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy. Equality, Involvement, Communication and Membership Strategy revised with insight from extensive involvement and engagement. Associated action plans detail work to be undertaken to further strengthen the Trust approach	Jan 21	Jan 21		1157 1531 695	1.3 1.4	
Socio-Cultural	3.8	Social and community impact of ~~pandemic on~~ poverty, domestic violence, safeguarding, employment which will have an impact on the complexity and number of people requiring help from our services, particularly mental health.	Jan 21	Jan 24	✓	1132 695	2.3	
Socio-Cultural	3.9	Increasing evidence of, and focus on, the health inequalities across the country ~~The global pandemic~~ has exposed significant challenges to the way we think about and design our service offers. health inequalities which require work with partners across all our systems to address. This requires us to work effectively and in a coordinated way with partners across all our systems to address inequity in a sustainable way.	Jan 21	Jan 21		1132 695 1689	1.2 1.3 1.4	
Socio-Cultural	3.10 *	The population of people accessing our services is changing. There is greater societal awareness of ASD/ADHD, leading to surging demand for diagnosis and increasing pressure on already stretched services. There are high expectations from a new group of people who do not have the other co-determinants that many of our service users have	Jan 24	Jan 24	✓	1530	2.3	
Socio-Cultural	3.11	Recent examples of political decisions and media presentations suggest a hardening of views against some vulnerable groups which has a potential impact on communities and staff.	Jan 24	Jan 24	✓		1.3	
Socio-Cultural	3.12	Changing attitude to work. Evidence that people entering the workforce are not considering the NHS as a lifetime career opportunity but are expecting portfolio careers with opportunities to develop in different ways	Jan 24	Jan 24	✓	1157	4.2	
Technological	4.1	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional continuous cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. (mitigated by business continuity plans). Russian/Ukrainian conflict increased potential threat levels.	Jan-17	Mar 22		1080	2.4	
Technological	4.2	Digital technologies, and the continued direction of travel in public service towards "digital by choice" are a key enabler for change. In addition, "political will", individuals and communities drive demand for health and care providers to keep pace with their use of technology as in other aspects of their lives. This increasing demand and expectation for digitally enabled services requires significant focus and emphasis on expanding sustainable digital transformation and change capabilities This has been	Pre Apr 16	Jan 23		1585	3.3	

		adopted by the Trust and is central to the digital strategy The Trust has established a modern and resilient infrastructure to support agile working. The use of NHS apps and digital technology is emphasised in the NHS LT Plan and the What Good Looks Like (WGLL) framework. The Trust is also working with partners at place and, at wider ICS system level as part of the WY&H and SY&B ICSs. The Trust is also implementing the Patient Knows Best solution for people to access their own records. The pandemic has led to a step change in the use of digital approaches across the whole organisation.						
Technological	4.3*	Inequalities in technology access, literacy, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. Technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to deliver the Trust mission and objectives. Inequality in access to technology is impacting on service user choice of assessment and treatment. The Trust is actively working across the health and care ecosystem with partners to reduce the digital divide.	Jul-16	Jan 22		695 1689	1.4	
Technological	4.4	Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable Technology is also supporting the speed in which we receive friends and family feedback, as we use text messages and handheld devices.	Pre Apr 16	Jan 23		695	1.3	
Technological	4.5	Technology enables improved access and use of data – telehealth/remote monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, education, self-care, and movement towards coaching approaches. As supported in the long term plan.	Pre Apr 16	Mar-19		695	1.2 1.3	
Technological	4.6	Interoperability of clinical systems, and enhanced analytical functions (population health management, data warehouses, big data etc.) support evidence-based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. The LTP and success measures within the WGLL framework accelerates opportunities to integrate and standardise health care information across care systems and actively supports collaborative digital opportunities across the regions. Following the work undertaken to implement and optimise the Trust's clinical record system, Systmone, the Trust is now able to share service user's records to other health organisations via Systmone.	Pre Apr 16	Jan 22		1530	2.1	
Technological	4.7	Platform technology potentially allows Trust's to widen the range of offers available to service users e.g., digitally held personal records from which to access correspondence, complete assessments and access care plans etc., mobile apps, enables more peer to peer support, promotes innovation and provides data on	Jul-16	Jan 23		1530	2.1	

		choice. The Trust is utilising digital innovations such as Chat Pads on ward areas,						
Technological	4.8	Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc. Investment in technology has enabled an increase in clinical activity with service users ~~to continue in a remote/agile manner during the pandemic via video consultation solutions. Support for service users via schemes such as virtual visitors and recovery college online activities have been set up using digital technology.~~	Pre Apr 16	Jan 24	✓	1530	2.1	
Technological	4.9	The provision of agile/hybrid working (using communications and information technologies to enable staff to work in ways which best suit their needs) offers the capacity to help the Trust become a more responsive, efficient and effective organisation, improving performance. Covid-19 pandemic ~~and the need for social distancing required significant investment in technology to enable remote working by a large proportion of the workforce. This has~~ led to a step change increase in agile working and opportunities in support of the sustainability agenda	Apr-18	Jan 24	✓	695 522	3.3	
Technological	4.10 *	Rapid developments in the use of Artificial Intelligence have the potential to transform the way we work	Jan 24	Jan 24	✓	1585	3.3	
Legal/ Regulatory	5.1	Increased pace of movement towards new organisational forms and partnership vehicles suitable for place-based solutions (e.g., Integrated Care System, Multi-specialty Community Provider), and for service line specific collaboration (e.g., mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place-based care provision	Jan-17	Mar-18		812	1.1 1.2	
Legal/ Regulatory	5.2	The NHS LTP places greater emphasis on choice and parity of esteem between mental health and physical health.	Mar-18	Mar-19		695	1.1, 1.2	
Legal/ Regulatory	5.3	A new Draft Mental Health Act was published 27th June 2022 which has since passed through the Pre-Legislative Scrutiny stage with the Joint Committee publishing their report on 19th January 2023. The Bill suggests the requirement for expansion of the mental health and social care workforces, infrastructure to support the roll out of these reforms, and work to promote practical and cultural change across the system, through such initiatives as the Quality Improvement Programme and the Patient and Carer Race Equality Framework. In November 2023 the progression of the Draft has not been included in the Kings Speech. It is being suggested that there will be little or no progress until after the next General Election. As a Trust we continue to include best practice from the Draft in new pieces of work when considering risk management and care planning for our service users.	Mar-18	Jan 24	✓	695 1545	1.1 1.2 1.4	

Legal/ Regulatory	5.4	The amended Mental Capacity Act (deprivation of Liberty safeguards) received Royal Assent on the 16th of May 2019. The implementation date has been delayed due to the Covid 19 pandemic and concerns as to the content of the Draft code of Practice and associated Regulations. We are awaiting the Code of Practice and Regulations on the understanding that the Government aims to lay these before Parliament some time before the end of Spring. No implementation timetable has been set at this time. Work has begun on a gap and impact analysis for the Trust to support an implementation plan. There has been no progress on the new code of practice and no implementation date. The Trust continue to implement elements of the new Act in practice as the opportunity arises through a quality improvement cycle.	Apr-18	Jan 24	✓	773 1545	2.3	
Legal/ Regulatory	5.5	The national view to develop an NHS estates strategy to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the LTP and enable clinical transformation to deliver world class care have brought changes to the Trusts estate strategy. We have been asked to develop an ics level infrastructure plan. Our new estates strategy has very little in with regards disposals as most have already been delivered.	Apr-18	Jan 24	✓	522	3.3	
Legal/ Regulatory	5.6	There is a legal regulatory framework provided through health and safety legislation for employers to provide employees with a safe and secure workplace in which to work. The legal remedies to provide appropriate management specifically on aggression and violence and on manual handling for the Trust are considerable.	Jan-17	Jan 23		1545	4.3	
Legal/ Regulatory	5.7	In May 2021 a new CQC strategy and approach was introduced which also looks at how the care provided in a local system is improving outcomes for people and reducing inequalities in their care. This means looking at how services are working together within an integrated system, as well as how systems are performing as a whole.	Mar 22	Mar 22		695	1.1	
Legal/ Regulatory	5.9	The Trust is to provide evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services. In line with our Public Sector Equality Duty, Equality Duty, NHS constitution and the Health and Social Care Act. ~~The revision of EDS2 will be implemented over the coming year and require a more systemic approach to evidencing statutory duties~~	Jan 22	Jan 24	✓	1689	1.1, 1.2,1.4	
Legal/ Regulatory	5.10 *	Increasing scrutiny from the regulators, coroners and other legal bodies. There is a hardening of approach due to high profile examples of incidents within the NHS and subsequent impact on public confidence	Jan 24	Jan 24	✓		2.1	

Legal/ Regulatory	5.11	introduction of the Provider Selection Regime Commissioning Process which will have implications for the Trust	Jan 24	Jan 24	✓		1.1	
Environmental	6.1	Change in travel patterns as part of new service models and technological change – e.g., more home-based care but fewer trips back to base. More support staff using video conferencing. ~~Travel has been further reduced due to changes in working because of the pandemic~~	Pre Apr 16	Jan 24	✓	522	3.2	
Environmental	6.2	Opportunities around renewable energy are emerging. The Trust has built this into the revised Green Plan. COP 26, COP 27 and a range of climate change networks and guidance have raised awareness of the climate agenda. NHS Trusts have carbon reduction targets and reporting requirements.	Pre Apr 16	Jan 23		522	3.2	
Environmental	6.3*	Climate change is something that affects us all, both now and in the future. Several local authorities across the Trust footprint have declared a climate emergency and have prioritised environmental sustainability. The Trust is a partner in these activities to support local improvements to be more environmentally sustainable. Work has commenced on environmental sustainability across the ICS which we are a part of. Sustainability continues as part of the Board approved green plan to address the Net Zero agenda at the Trust.	Oct-19	Jan 23		522	3.2	
Environmental	6.4	Work has commenced across the ICSs to look at the wider determinants of sustainability. The Trust has a Board approved green plan and a Social Responsibility and Sustainability Strategy with supporting action plans. Five headline initiatives have been developed as areas of focus for this work. There are increasing expectations and opportunities for the Trust to use its role as an anchor institution	Jan 22	Jan 24	✓	695	3.2	
Environmental	6.5	Recent examples of resources being unavailable due to environmental issues impacting on supply of essential items such as drugs and electronica equipment	Jan 24	Jan 24	✓	275	3.2	

SWOT

In the context of an analysis of the external environment and the Trust's strategic objectives and priorities, the following strengths, weaknesses, opportunities and threats are highlighted:

Please note, the cross-reference columns for the ORR and BAF have been blanked out for the strengths and opportunities sections as they are not relevant

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Link to Strategic Objectives
Strength	1.1*	Compelling model for alternative capacity – Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing and Altogether Better is well aligned to LTP direction and offers opportunities for partnership in local place-based solutions such as ICS. The Trust's linked charity Creative Minds has been announced as a winner in a Europe-wide 'challenge' focused on different ways to empower communities to improve their health. Creative Minds is one of eight winners in the Reimagining Community Health Challenge	Pre Apr 16	Jan 23		
Strength	1.3*	Partnership relationships and track record of collaborative working, providing leadership where appropriate and moving arrangements forward are a key strength. and place-based delivery structure underpinned by clear FT governance arrangements ~~including plans to fully engage and mobilise an active public membership – all key~~ for system leadership and place based integrated care partnerships. A range of executive and board arrangements with trusts, commissioners, and other stakeholders in each of the place we operate	Oct-16	Jan 24	✓	
Strength	1.4	Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of ICS aims. For example, The Trust has worked with partners in West Yorkshire to agree lead provider collaboratives for eating disorders, CAMHS and secure care. The Trust is Lead Provider for secure care in West Yorkshire and South Yorkshire. Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract.	Oct-16	Jan 23		
Strength	1.5	'Centres of excellence' within services recognised internally and externally examples include: Our adult attention deficit hyperactivity disorder (ADHD) and autism service received the prestigious ACOMHS accreditation awarded by the Royal College of Psychiatrists. Our Calderdale memory assessment service being accredited by the Royal College of Psychiatrists for the care they provide to local people with memory problems or dementia and their families. The Trust was accredited as a Veteran Aware NHS organisation by the Veterans Covenant Healthcare Alliance (VCHA).	Jan-17	Jan 22		

Strength	1.6*	Clear commitment to the Trust's mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust Staff 'living the values' as evidenced through values into excellence awards.	Jul-17	Jan 21		
Strength	1.8	The Care Quality Commission report confirmed that staff treat people with kindness, care and compassion, and that we are respectful and warm. Our inspection in 2023 confirmed that "We observed positive and caring interactions between staff and patients on all the acute/PICU wards we visited"	Jul-16	Jan 24	✓	
Strength	1.12	Our partnership relationships and the way in which we conduct ourselves when working collaboratively and co-producing with others demonstrates a real focus on the needs of the people who use our services and on partnerships~~., and this was noted as a strength in the recent CQC report. Care Quality Commission (CQC) visit overall rating of good including well-led review, Partnership working acknowledged to be strong~~. This has been further enhanced through the ~~refresh~~ delivery of the of the Equality, Involvement, Communication and Membership Strategy and action plans that deliver the objectives of the strategy. Audit undertaken in 2021 by internal auditors and found the Trust could demonstrate significant assurance ~~with some low risk areas identified for improvement. All of which were achieved by December 2021.~~	Jul-16	Jan 24	✓	
Strength	1.14	~~Recognition of our services through local, regional, and national awards raises the profile of the trust and celebrates outstanding achievements. In 2022: our Barnsley tissue viability service won Gold at the Journal of Wound Care World Union of Wound Healing Societies Awards in the 'Cost-effective Wound Management' category. The Trust's serious incident review process was accredited by the Royal College of Psychiatrists.~~ ~~Figures revealed that the top five locations in Yorkshire and the Humber with the highest success rates for quitting smoking are all areas supported by the Trust's Yorkshire Smokefree service. The Trust's early intervention in psychosis teams were named as some of the best performing in the country by the National Clinical Audit of Psychosis (NCAP). We were awarded the Carer Confident benchmark of Level 2 Accomplished. We achieved Level 3 (Leader) Disability Confident status~~ Recognition of our services through local, regional, and national awards raises the profile of the trust and celebrates outstanding achievements. In 2023 the Trust was awarded at the 2023 Eventeer Awards for its successful virtual recruitment fair held in collaboration with local NHS partners. 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. David Yockney, a Registered Nurse Professional Lead (Adult Nursing) for the Barnsley Integrated Care Group received the Queens Nurse Award. And the 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. The Trust was also awarded Future-	May-18	Jan 24	✓	

		Focused Finance Towards Excellence Accreditation level 2; and we achieved Level 3 (Leader) Disability Confident status.				
Strength	1.15	Partnership working by the Trust with the 3rd sector VCS (voluntary and community sector) and faith sector aiming to improve access to services and ensure those from our most deprived neighbourhoods have equal access to pathways of care for example, partnership working with Nova and Living Well Service in Wakefield. Additional work to identify key partners in VCS and faith sector has taken place resulting in 200+ groups and individuals organisations identified as partners. Work to strengthen these relationships continues.	Jan-19	Jan 22		
Strength	1.16	The occupational health team have introduced a proactive process to support staff to manage distress caused by work and was noted as best practice in the recent CQC report. Staff health and wellbeing support has been further strengthened throughout the pandemic.	Aug-19	Jan 22		
Strength	1.17	There are positive indicators that SWYPFT is a great place to work. WRES data indicates improvements in some areas; we have a diverse Trust board; staff networks established such as BaME, LQBTQ+, Disability and Staff carers network; excellent staff side relations; agile and flexible working; and established leader and manager development pathways.	Aug-19	Oct-19		
Strength	1.18	The Trust has made significant investment in modern and high-quality estates and digital infrastructure, evidenced by hubs such as Drury Lane and the development of the Unity Centre; agile working; and the Trust-wide Systmone implementation. ~~Digital infrastructure has been further developed during the pandemic.~~ Our digital journey and approach has been recognised in an NHS confederation publication titled Integration and Innovation in action: virtual care. The forthcoming refresh of the Digital Strategy will enable to us amplify the strong underpinning infrastructure investment	Aug-19	Jan 24	✓	
Strength	1.19	The Trust is taking active steps to support local improvements to be more environmentally sustainable. For example, to reduce waste and help the environment by reducing the use of single use plastics across all catering, encouraging use of electric cars and electric car charging points added to Fieldhead site. The Social Responsibility and Sustainability strategy builds on this foundation with key actions in place to take this forward	Aug-19	Jan 23		
Strength	1.20	Range of integrated services now delivered through an Alliance Contract. The service provides an integrated pathway for patients in Barnsley delivered by SWYPFT, Barnsley CCG, Barnsley Hospital NHS Foundation Trust, Barnsley Healthcare Federation, and the Local Authority. Pulmonary Rehab pathways, and Stroke provision, are also both provided via integrated pathways.	Aug-19	Jan 23		
Strength	1.21	The Trust has supported a reduction in smoking prevalence. We have worked in partnership to develop a proposal for implementation of QUIT across the ICS	Aug-19	Jan 21		
Strength	1.22	SWYPFT have continued delivery of the schools' flu programme in Barnsley We have also helped deliver a successful vaccination programme through the alliance in Barnsley	Aug-19	Jan 23		

Strength	1.23	The Trust is viewed as a trusted provider for services by our commissioners. Most of the feedback on our Friends and Family Test is positive and this has been maintained over several years	Jan 21	Jan 24	✓	
Strength	1.24	The Trust has delivered its Equality, Involvement, Communication and Membership strategy and supporting annual action plans to ensure an integrated approach to delivering on the strategic objectives. The approach is insight driven and offers a joined-up approach to delivering equality and involvement in its broadest sense. Our Approach has been showcased at regional and national learning events and we have continued to place level approaches that are aligned to ours. Building on these systems and processes and demonstrating impact will be a key component of our strategy refresh	Jan 21	Jan 24	✓	
Strength	1.26	Quality Improvement culture becoming embedded and good examples have emerged on safety huddles, reducing restricted practices, flu vaccination programme, out of area bed, edischarge and patient flow .	Jan 21	Jan 23		
Strength	1.27	Strength in our work on Creativity and arts in health. Lead on the development of a system wide approach in Calderdale. Working with the National Centre for Creativity and Health and supporting the establishment of the WY ICS Creative Health hub aligned to the WY mayoral priorities West Yorkshire has been identified as the first Creative Health System	Jan 21	Jan 24	✓	
Strength	1.28	Using data and insight in place and within the Trust to understand the population we serve. This includes working with our communities to capture voice and ensure greater involvement. Working with partners to align our approaches, use the data and insight we already have to plan collaborative activities to increase reach into our grassroots communities.	Jan 22	Jan 22		
Strength	1.29	Developing a framework to support the Trust wide equalities dashboard using the core 20 plus 5 approach and Kings fund framework, aligned to our partners in WY and SY ICS, and using the internally developed interactive equalities tool to drive targeted reduction in health inequalities.	Jan 22	Jan 22		
Strength	1.30	Equality Impact Assessments (EIA) processes which ensure our services are culturally sensitive, appropriate and relevant. Acting against impacts and co-designing improvements. Also capturing and monitoring equality data using Systmone, ESR to inform person centred care by a reflective work force and capturing experience.	Jan 22	Jan 22		
Strength	1.31	Strong approach to capturing insight and building capacity for involvement. For example, engaging with our communities using volunteering, ~~TWOCAN to create pathways into our Trust for employment~~, developing carers passports, increasing peer support workers, and building capacity and capability through development sessions and diversity training. Inclusive employment is a key priority for the Trust	Jan 22	Jan 24	✓	
Strength	1.32	In Barnsley we are part of a formal Health and Care Alliance with the GP federation which is providing a vehicle for increased integration of primary and community care services It is a unique approach that brings primary and secondary care services together to create a seamless package of care for local people. This means local GPs, nurses, healthcare staff and other professionals bringing community and mental health services together to ensure	Jan 23	Jan 23		

		that everyone receives the highest possible quality of care This is being shared as best practice regionally and nationally				
Strength	1.33	. Established governance in place in order to ensure separation of the Trust's commissioning responsibilities from its role as a provider of services where appropriate. To be kept under regular review as commissioning role of Trust develops.	Jan 23	Jan 24	✓	
Strength	1.34*	Developing expertise and experience in provider collaboratives and alliances as either a host or a partner. This means we can be a strong and influential partner and take forward potential strategic opportunities for leading Collaboratives/Partnerships.	Jan 23	Jan 24	✓	
Strength	1.35	Significant progress made on developing Trust wide approach to equalities and inequalities including data and insight including BI interactive tool, EQIA, and community reports There has been some investment in business intelligence which is helping to target hotspot for intervention	Jan 23	Jan 24	✓	
Strength	1.36	The mental health museum in Wakefield provides information and artifacts that detail the history of mental health, dating back over 200 years since the Stanley Royd Asylum was first established in the same grounds as the museum is based. The museum also reaches out to local schools, community groups and individuals and runs events and courses to highlight the changing approach to mental health through the ages.	Jan 23	Jan 23		
Strength	1.37	Our Trust recognises the importance of maintaining good physical health as well as positive mental wellbeing. Our Unity Centre in Wakefield and Dales wards in Halifax have gyms and exercise equipment, funded through our EyUp Charity which supports service users to stay well. We also run physical health programmes, including Watsu water therapy in Wakefield. In addition, our Move More SWYPFTly programme supports staff to exercise and live healthily. We have improved accessibility of physical health checks for people with sever mental illness	Jan 23	Jan 24	✓	
Strength	1.38	The Trust is the regional co-ordinating provider for forensic CAMHs services and is able to use this position of strength to influence this area of provision	Jan 24	Jan 24	✓	
Weakness	2.1*	There are some Trust services where access to help can be too slow and needs to improve and there is a risk that people will be adversely affected because of waiting for treatment - in particular child neuro-developmental waits. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.	Pre Apr 16	Jan 23		
Weakness	2.2	~~In common with other trusts~~ We experience difficulties in ensuring that we have the right workforce across many disciplines. e.g., staff grade doctors, ward-based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies.	Pre Apr 16	Jan 24	✓	

Weakness	2.3*	Our most recent CQC Report ~~from August 2019~~ in 2023 highlights that there is a requirement to improve our adult acute inpatient and PICU services and forensic services ~~CAMHS service~~. ~~And overall, we need to improve our 'Safety' from requires improvement.~~ We do not yet have a comprehensive plan to respond to a well led review	Jul-16	Jan 24	✓	
Weakness	2.6	In some of our place based/integrated care system discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community. Being a partner in two ICSs and four places requires significant resources	Apr-17	Jan 24	✓	
Weakness	2.7	The Trust has a number of contracts with Local Authorities and a small number with ICB places that may still be subject to competitive market testing upon expiry of current contracts. The majority of "core" trust services are now considered as part of a system approach and so the risk posed by competitive testing is present, but diminished	Feb-18	Jan 23		
Weakness	2.8	The CQC report 2019 identified that Children and young people were waiting over 18 weeks to receive treatment in some areas. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service. Improvement has been noted from waiting list initiatives in Wakefield and Barnsley. Calderdale and Kirklees neurodevelopmental pathways still have excessive waits and are now included in the CAMHS improvement work. Impact of covid on waiting lists is evident	Aug-19	Jan 22		
Weakness	2.10	Whilst there has been some progress made in developing model hospital and data warehouse tool with roll-out of dashboards covering additional services and metrics being completed in March 2020. There is limited actual use of benchmarking information in the Trust.	Jan 21	Jan 21		
Weakness	2.12	Workforce challenges are manifesting in difficulties achieving mandatory training targets e.g., RRPI, appraisal compliance and leading to a reliance on agency staff	Jan 23	Jan 23		
Weakness	2.13	Out of area bed use usage ~~has~~ increased during the pandemic. An improvement plan is in place which has resulted in significant improvement however it remains an area that we are monitoring closely ~~and will need systemic focus going forward. This leads to both quality of care and financial impacts~~	Jan 23	Jan 24	✓	
Weakness	2.14*	Whilst some investment in analytical capability has been made, there has been very limited and there is an increasing need to expand the ability of the organisation to provide analytical data that is usable for front line colleagues.	Jan 24	Jan 24	✓	
Opportunity	3.1*	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional ~~lead~~ coordinating provider in forensics in both West Yorkshire and South Yorkshire.	Jan-17	Jan 24	✓	

Opportunity	3.2	The integrated nature of our organisation, with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature. We are leading and partners in a number of alliances which will further support integration	Pre Apr 16	Jan 23		
Opportunity	3.4	We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place-based care systems. Our connections into Primary Care Networks provides a vehicle to do this	Jan-17	Jan 21		
Opportunity	3.5	The Trust's priority programme to make the Trust a better place to work has the opportunity to understand the key challenges faced by the services regarding workforce and the changes in workforce required to meet increasing service demands and acuity levels through maximising productivity and new ways of working. We can use our skills in health and wellbeing and health coaching to support our revised workforce strategy with a focus on retention and wellbeing. This will enable us to focus on actions to address staffing shortfalls that lead to agency use.	Jan-17	Jan 21		
Opportunity	3.7*	We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches e.g., Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing and Altogether Better. We have commenced work to embed these approaches as an integral part of our offer in inpatient and community services and could be a national exemplar. This is a unique ability and would enable SWYPFT to lead the conversations about the role of creativity in routine service planning and delivery and support the conversations about mental health services of the future.	Jan-17	Jan 24	✓	
Opportunity	3.8	The result of our Care Quality Commission inspection provides opportunities to improve from 'good to outstanding' with a collective and coordinated plan to achieve this.	Apr-17	Jan 24	✓	
Opportunity	3.9	We can use our strategic aim of co-production to explore arts and health, sports, and health and wellbeing tender and bid opportunities.	Mar-18	Mar-18		
Opportunity	3.10	There is an opportunity for the Trust to implement the NHS long term plan and help shape the ambitions for improvement in the NHS.	Aug-18	Jan21		
Opportunity	3.11	We continue to pursue collaborative partnership working by the Trust with 3rd sector organisations such as 'Live Well Wakefield', and the opportunities presented through the development of primary care networks, aligning our services to be well placed to meet changing population and workforce requirements.	Mar-19	Oct-19		
Opportunity	3.13	Opportunity to build capability to enhance capacity for change within the organisation to meet strategic objectives through programme such as IHI and Board development programmes	Mar-19	Oct-19		
Opportunity	3.14	Opportunity to be leader/exemplar in equality and inclusion and employer of choice in region. Ensuring our Staff equality networks have significant involvement in developing measures to ensure we comply with the Workforce Race Equality Standard, Workforce Disability Equality	Oct-19	Oct-19		

		Standard and to improve diversity.				
Opportunity	3.17	Through the ICS's digital strategies, there is the opportunity to actively support and participate in collaborative digital opportunities across the regions and places as appropriate. This provides an opportunity to collaboratively address cyber security.	Oct-19	Jan 23		
Opportunity	3.20	There is the opportunity for greater involvement in regional networks and peer mentoring relationships in our local areas as they implement personal health budgets (PHBs)	Oct-19	Oct-19		
Opportunity	3.21	There is an opportunity to work with staff from the 'hot spot' areas identified through staff survey, to improve staff health and wellbeing at work.	Jan 21	Jan 21		
Opportunity	3.24	Opportunity to develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. With potential to review staffing mix and safer staffing levels following new ways of working implemented during covid 19 pandemic. Opportunity to re-think models of care and develop new roles.	Jan 21	Jan 21		
Opportunity	3.25	Opportunity to explore new ways of working which can reduce waiting lists delaying treatment and recovery, and activity to reduce admissions and plans to reduce length of stay, following new ways of working implemented during covid 19 pandemic.	Jan 21	Jan 21		
Opportunity	3.26	Opportunity with the confirmation of continuation of the Mental Health Investment Standard and the subsequent continued investment in Mental Health services and a basis for working with Primary Care Networks	Jan 21	Jan 21		
Opportunity	3.27	Opportunity with developments in Integrating Care to explore new arrangements in each place e.g. Building on what we are already achieving in 'hosting' Alliances and provider collaboratives to strengthen joined up care and support to individuals, families and communities Our expertise gives us the opportunity to share our impact and be seen as a leading organisation for working in this way.	Jan 21	Jan 24	✓	
Opportunity	3.29	Opportunity to enable working effectively, improved estate utilisation and application of digital technology by adopting the enabling working effectively framework, underpinned by learning from covid pandemic, the hybrid working policy and corporate service help available to support changes in practice.	Jan 22	Jan 22		
Opportunity	3.30	Opportunity to ensure organisational leaders develop and embed clear leadership standards, strengthen race forward and equality guardian roles and further develop an inclusive culture, to help sustain an equality competent organisation that demonstrates inclusive and diverse leadership.	Jan 22	Jan 22		
Opportunity	3.31	We have established partnership with universities and opportunity to strengthen these through innovation and research links as well as through training and development opportunities. There is a specific opportunity to work with Huddersfield University with regard to the development of a Health Innovation campus	Jan 22	Jan 23		

Opportunity	3.32	Opportunity through the new social responsibility and sustainability strategy to add greater social value in places working with partners and to reduce inequalities.	Jan 22	Jan 22		
Opportunity	3.33	Opportunity to improve data quality, including equality data for anyone who works in or uses our services, collection and use of data and insight to improve services and reduce inequalities with a more focused approach to addressing health inequalities.	Jan 22	Jan 24	✓	
Opportunity	3.34	Opportunity to become a ~~regional~~ national leader in shaping the future provision of Forensic CAMHS provision, through SWYPFT as regional ~~lead~~ co-ordinating provider of these services.	Jan 23	Jan 24	✓	
Opportunity	3.35	~~Opportunity to further expand our role in Wakefield place, and to take on further responsibilities for commissioning of adult mental health services through the Mental Health Alliance. .~~ Opportunity to further expand our role at place and our commissioning role, and to take on further responsibilities for commissioning of adult mental health services through Mental Health Alliance arrangements (particularly Wakefield and Kirklees).	Jan 23	Jan 24	✓	
Opportunity	3.36	Opportunity to further develop and deliver an integrated community services offer in Barnsley.	Jan 23	Jan 23		
Opportunity	3.37*	Opportunity to gain Teaching Trust status to demonstrate our commitment to supporting training and development of the workforce, being a great place to work and ensuring quality care. Alongside this there is a broader opportunity for strategic relationships with universities in our localities to support and enable us to engage with our communities, improve our ability to evaluate the impact on our programs and to participate in bids we wouldn't otherwise have the ability or capacity to consider.	Jan 23	Jan 24	✓	
Opportunity	3.38	Using data and insight in place and within the Trust to understand the population we serve. This includes working with our communities to capture voice and ensure greater involvement. Working with partners to align our approaches, use the data and insight we already have to plan collaborative activities to increase reach into our grassroots communities.	Jan 23	Jan 23		
Opportunity	3.39	We have opportunity to become a national leader in Maternal Mental Health provision through SWYPFT's role as Coordinating Provider.	Jan 24	Jan 24	✓	
Opportunity	3.40	Expansion of service delivery to new areas e.g., prison healthcare.	Jan 24	Jan 24	✓	
Opportunity	3.41*	Opportunity to use the publication of the NHS long term workforce plan as a framework to drive the agenda for the Trust to be a great place to work, research and train	Jan 24	Jan 24	✓	
Opportunity	3.42	Opportunity for genomics to transform the way the NHS supports health and delivers care We are already involved in studies with public health and ones looking at genetic mapping and depression/anxiety. We have plans to get involved in commercial studies and therapeutic studies.	Jan 24	Jan 24	✓	

Opportunity	3.43	Opportunity for the Trust to contracting directly more with the Third Sector, in line with other local Trust. This could support our own services (demand alleviation) and the VCSE sustainability.	Jan 24	Jan 24	✓	
Opportunity	3.43	Opportunity to use PSIRF (patient safety incident response framework) to improve out patient safety . We have analysed learning from our former processes to inform and shape our PSIRF plan and associated improvement plans for major patient safety system quality improvement projects which draw learning from our former and current learning.	Jan 24	Jan 24	✓	
Threat	4.1	Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, increased ICB scrutiny and diversion of effort away from progressive activities.	Jan 22	Jan 23		
Threat	4.2	Place based 'integrated care' systems and changes to contracting could be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability. Risk of loss of business impacting on financial, operational, and clinical sustainability	Jan 22	Jan 23		
Threat	4.3*	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g., because of benefit restrictions). The financial position of Councils is challenged; this could impact on support for vulnerable people who are service users (or potential service users) of our services.	Pre Apr 16	Jan 23		
Threat	4.5	Data quality and information governance issues may lead to regulatory action and reputational damage.	Pre Apr 16	Sep-17		
Threat	4.6	Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T	Jan-17	Sep-17		
Threat	4.7	Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action	Apr-17	Oct-17		
Threat	4.8	Threat of cyber-attack impacting on operational continuity and stakeholder confidence. Increased threat from cyber-crime impacting on NHS bodies – resulting in additional continuous cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. Russian/Ukrainian conflict has increased potential threat levels.	Apr-17	Mar 22		
Threat	4.9	The Trust's control total is set as part of the WY&H ICS. A change in system performance across the ICS may impact the shared control total which in turn may then have an impact on the Trust.	Apr-17	Oct-19		
Threat	4.10	Trusts reputation could be adversely affected by long waiting lists delaying treatment and recovery	Feb-18	Feb-18		

Threat	4.12	There is a threat to the safety and quality of current services, ability for future development in services, and the effective delivery of the Trust strategy due to recruitment challenges, retention concerns and national shortages of staff, especially clinical staff.	Feb-18	Jan 22		
Threat	4.14	Non, or late, submission of statutory returns could result in non-compliance with constitution and licence	Feb-18	Oct-18		
Threat	4.15	The ageing workforce who can retire in the next five years brings a potential loss of knowledge, skills, and experience	Mar-18	Mar-18		
Threat	4.16	The impact of universal credit has the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits may have an increased negative affect on people's mental health and therefore an increased pressure on Trust resources. This places greater emphasis on the need to continue to work with partners and Health and Wellbeing Boards to address the wider determinants of health and social care. ~~This threat has increased due to the pandemic~~	Mar-18	Jan 24	✓	
Threat	4.17	Cuts to Citizens Advice (CAB) funding is reducing the numbers of people that CAB can help with problems such as debt, benefits, housing and employment worries therefore potentially increasing people's mental health problems, the knock on affect to mental health services.	Mar-18	Mar-18		
Threat	4.18	Cuts in local authority budgets, and social care budgets specifically, could adversely affect health services, particularly in delays in discharges from hospital, due to problems accessing social care services. Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource.	Mar-18	Jan 21		
Threat	4.19	The development of integrated care and services and the development of Primary Care Networks aligned to neighbourhoods will require the Trust to realign its services in each place and clarify and strengthening the Trusts role within primary care networks and partnerships. There is a threat of a lack of capacity to support partnership working across a wide geography.	Jul-18	Jan 21		
Threat	4.21	Significant progress that has been made in response to the CQC action plan does not improve CQC ratings	Apr-19	Oct-19		
Threat	4.22*	Impact on financial performance. of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs, out of area placements, reductions in cash, and regulator intervention, could impact on our ability to improve services and meet our objectives.	Apr-19	Jan 21		
Threat	4.23	WRES/WDES data worsens; staff survey data worsens; widening gender and ethnicity pay gaps occur which have a negative impact on making this a great place to work.	Oct-19	Oct-19		

Threat	4.24	Failure to reduce CO2 emissions and use of single-use plastics results in the Trust not achieving its environment sustainability targets.	Oct-19	Oct-19		
Threat	4.25	There is an increased demand for services after the Covid-19 pandemic. This is both an increase in numbers of people referred and an increase in acuity and represents a threat to our ability to meet this demand	Jan 21	Jan 23		
Threat	4.26	There is a threat to the wellbeing of staff during the sustained and prolonged period ~~of~~ pressure through Covid-19 and now due to workforce challenges. Increased risk in the number of staff experiencing burnout.	Jan 21	Jan 23		
Threat	4.28	The integrated nature of our organisation, with reach into several localities across many different services, means we. are sometimes viewed as not fully belonging to a particular place	Jan 21	Jan 21		
Threat	4.29	There is a threat that Primary Care Networks will pursue different service models in each place, creating uncertainty & impacting on Mental Health in-patient demand adversely	Jan 21	Jan 21		
Threat	4.30	There is a threat that with the Mental Health Investment standard and the subsequent increase in posts that we will not be able to recruit into some posts. There is an inadequate ~~I~~ workforce pipeline to support recruitment in the Trust, the ICSs and nationally. This means that we are competing for the same scarce resource	Jan 21	Jan 23		
Threat	4.31	Threat of increased staff fatigue due to dealing with increased demand and acuity. ~~requirements placed on staff during the pandemic and with the continuing vacancies.~~ This will have an impact on current and future staff wellbeing and affect service delivery and performance. It could also limit our capacity to innovate our service offer and think creatively about future models of care.	Jan 21	Jan 24	✓	
Threat	4.32	Threat of losing staff (more specifically lower graded staff) to other sectors for higher pay.	Jan 22	Jan 22		
Threat	4.33	Restrictions on Trust ability to spend our cash reserves on capital projects means we may be unable to meet our capital plans	Jan 23	Jan 23		
Threat	4.34*	Concern that national priorities will focus on acute and primary care due to pressures within these systems and therefore there will be less attention paid to Mental health, Learning disability and general community services	Jan 23	Jan 23		
Threat	4.3	Rapid political policy changes which mean the Trust need to be flexible to respond, but also have an underlying consistent approach about certain key principles e.g. addressing health inequalities	Jan 24	Jan 24	✓	

Appendix B Items from PESTLE and SWOT February 2023 to be removed

PESTLE

Category	Ref.	Description	Date First Added	Rationale for removal
Political	1.6	The impact of the global Covid 19 pandemic has altered the quantum and focus of public spending, which underpin NHS budget projections. Demand for services is increasing and inability to meet the competing demand of responding to the impact of the pandemic and restoration drives will need to remain a focus	Jan 21	Public spending no longer impacted by the global pandemic
Political	1.12	In February 2022, the government published The Levelling Up White Paper: Health and social care integration: joining up care for people, places and populations which sets out how the government will spread opportunity more equally across the UK giving everyone, in all parts of the UK, the same opportunities to make the most of their lives. Tackling the wider determinants of health will be crucial for levelling up to be a success. this will impact on place priorities and demonstrably on Trust priorities to ensure we are considering the levelling up and inequalities agendas in our work.	Mar 22	No longer relevant
Economic	2.2	Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. NHSE and HMRC interventions continue to impact.	Oct-16	No longer relevant
Economic	2.13	In Sept 2021 Build Back Better plans announced to increase funding for health and social care over next 3 years by a new tax, the Health and Social Care Levy. Concerns raised regarding the challenges associated with transferring revenue to social care and whether or not the funding will be sufficient to address wider issues in the care sector.	Jan 22	Reversed in a subsequent budget so no longer relevant
Socio-Cultural	3.10	The Build Back Better policy paper sets out a number of proposed changes to how people pay for social care and the social care charging framework, including the introduction of a cap and changes to capital limits.	Jan 22	No longer relevant

SWOT

Category	Ref.	Description	Date First Added	Rationale for removal
Strength	1.2	Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint delivery, is a strength in formation of integrated care systems.	Jul-16	Integrated care systems now fully formed and subsequent strength already described in 1.3
Strength	1.7	Integrated approach to quality improvement ensures quality drives everything we do. The Trusts integrated change framework supports innovation, change and improvement and programmes to develop capability and capacity are in place with 'allofusimprove'. This has enabled us to deliver change with 250 trained improvement facilitators.	Jul-17	Unsure we currently have evidence that this is a strength. It is likely to be a key thread in the new strategy
Strength	1.9	Our Care Quality Commission report in 2016, and again in 2019, highlights the outstanding features of end of life care services provided by the Trust. It also highlights consistent good ratings in most services.	Jul-16	The length of time since this inspection
Strength	1.10	Our Care Quality Commission report (2019) highlights that more than 87% of the individual ratings are good or outstanding and 12 of our 14 core services are rated Good The overall rating for the Trust improved to GOOD. CQC rated effective, caring, responsive and well-led as good.	Jul-16	The length of time since this inspection
Strength	1.11	The Trust has a Board agreed workforce strategy and action plan which is in line with the NHS People Plan governed by the Workforce and Remuneration Committee (WaRC) of the Board has strong partnership links to the WY&H ICS Local Workforce Action Board, LWAB and South Yorkshire and Bassetlaw workforce group. Workforce planning is an integral part of the Trust's service line and financial planning process and is developed through a robust engagement process with clinical, operational, professional staff and staff side. Our culture of supporting those with which we work, Trust's commitment to staff health and wellbeing, our work with and supporting service users and carers and volunteers and the activities of 'allofusimprove'- all contributes to the Trust being a great place to work.	Jul-16	Up to date workforce strategy and action plan in development rather than a strength at the current time
Weakness	2.9	The clinical record system, Systmone, requires further focused work, through an optimisation work programme, to ensure the system is used consistently to support reduction in clinical variation and the full benefits are enabled to be realised across the Trust. E.g., there are some residual data quality issues about how Systmone is used. Plans are in place and progress can be evidenced	Oct-19	Systmone is now fully embedded
Weakness	2.11	Persistent reoccurring issues from serious incidents such as record keeping, risk management and co-production of care plans with service users requires a systematic approach to improvement.	Jan 22	Patient Safety Incident response framework (PSIRF) now in place three major patient safety system quality improvement projects

Opportunity	3.3	By fully rolling out our devolved approach to leadership we can empower and inspire more people and continue becoming an employer of choice and delivering great results in partnership with our service users.	Jan-17	General statement rather than specific opportunity
Opportunity	3.19	There is an opportunity to explore the way we offer care and support to people living with mental health, learning disabilities and autism so we can identify opportunities to improve physical health and to increase the number of physical checks for people living with learning disabilities and autism.	Oct-19	Opportunity realised therefore moved to strength
Opportunity	3.22	There is an opportunity to capture the learning from new ways of working adopted throughout the covid19 pandemic and incorporate the learning into recovery and long-term planning.	Jan 21	Learning captured and incorporated so no longer an opportunity
Opportunity	3.23	There is an opportunity to review use of Trust infrastructure such as estates and technology, and support adoption of new ways of working following changes resulting from covid 19 pandemic and ensure these are reflected in refreshed strategies	Jan 21	Learning captured and incorporated so no longer an opportunity
Opportunity	3.28	Opportunity to support operational services to reset inclusively using the codesigned recovery toolkit and the insight gained from staff and service users surveys.	Jan 22	Reset taken place following the pandemic so no longer an opportunity
Threat	4.20	Continuing numbers of people being placed out of area leading to financial pressures for the Trust. The position with PICU out of area beds remains an issue. All financial risk for out of area bed costs currently sits with the Trust.	Jul-18	Reduction to numbers means that this is no longer an active threat
Threat	4.27	There is a threat of serious harm occurring to service users from Covid-19.	Jan 21	Covid 19 now no more significant threat than other infectious diseases such as flu

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 10.3

Private/Public paper:	**Public**		
Title:	**Review of the Risk Appetite Statement**		
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**		
Purpose:	To review the risk appetite statement which outlines the level of risk Trust Board is prepared to tolerate.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The risk appetite statement provides a structure through which the Trust assessed and controls risk in order to meet statutory and regulatory requirements and deliver its strategic objectives.		
Any background papers / previously considered by:	Risk Management Governance Framework (including Risk Appetite Statement) was approved by Trust Board in April 2022. The Corporate/Organisational Risk Register is received quarterly by Trust Board. EMT on 7 March 2024 and e-mail consultation with Non-Executive Directors.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trusts risk appetite statement demonstrates the Trust's effective management of risk to ensure it delivers quality healthcare over the long term and contributes to the objectives of the integrated care partnerships (ICP), integrated care boards (ICB), and place-based partnerships, through robust governance arrangements.		
Executive summary:	**Background** Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time. Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Governance Framework. The Director of		

	Finance, Estates and Resources is the responsible director for the Risk Appetite Statement. Trust Board is committed to reviewing the risk appetite statement annually. Bi-annually this process is undertaken by the Trust internal auditors 360 Assurance. (last conducted 9 January 2023) **Review** On 7 March 2024 the executive management team considered the Trust risk appetite statement and agreed that risk appetites remained the same for all risks. Following this review opinion was sought from non-executive director colleagues on the proposal, and presentational changes have been made as a result of feedback. The key changes are: • Separation of risk appetite scores and good governance matrix titles • Identification of examples of risk by category • Update of the narrative introduction to the risk appetite statement, including reference to the Trusts strategic objectives The attached paper provides an updated Risk Appetite Statement for approval which continues to be aligned to the *'Good Governance Institute risk appetite for NHS Organisations'* matrix last updated in May 2020. In summary the recommended material changes following consultation are: <u>Clinical Quality and Safety Risks</u> • Amendment of title from "clinical risks" to "clinical, quality and safety risk" • Amendment of the description to include "the inability to recruit or retain an appropriately skilled workforce", previously included in business risks. • Separation of the mandatory and statutory training risks. The mandatory training risk is to remain in clinical quality and safety risk. The statutory training risk has been moved into the compliance risk category. <u>Business Risks</u> • Remain as previously stated. <u>Compliance Risks</u> • Addition of "Risks to meeting statutory training requirements e.g. information governance, Oliver McGowen training." <u>Financial Risks</u> • Remain as previously stated. <u>Strategic Risks</u> • Remain as previously stated. The next review which will be led by 360 Assurance session with Trust Board will take place in January 2025.

Recommendation:	**Trust Board is asked to REVIEW and APPROVE the updates to the Trust's Risk Appetite Statement.**

Risk appetite statement

Risk Appetite, definition, and purpose

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

The Trust recognises that its long-term sustainability depends upon optimising risk in relation to the delivery of its strategic objectives, and also that the relationship with patients, staff, contractors, the general public and other stakeholders is key to the Trust's success.

As such, SWYPT upholds a duty of care to ensure that Health and Safety is not compromised and therefore, taking into consideration that most risks cannot be completely eliminated, the Trust will have a low tolerance to risks that could result in a negative impact on the Health and Safety of patients, staff, contractors, the general public and other stakeholders.

However, within the boundaries of regulatory constraints, the Trust has an open appetite to take well-considered and balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted.

The Trust will review its risk appetite at least annually as part of the review of its Risk Management Strategy.

A risk appetite enables Trust Board to formally communicate to the organisation the level and type of risks it is willing to accept to achieve the Trust's mission, strategic objectives and organisational priorities. It will assist decision-makers in understanding the degree of risk to which they are permitted to expose the Trust whilst encouraging enterprise and innovation. The Public Accounts Committee (PAC) supports well managed risk-taking, recognising that innovation and opportunities to improve public services often requires risk taking, providing the organisation has the ability, skills, knowledge, and training to manage those risks well. The statement of risk appetite is by its nature dynamic, and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS.

Process

It is recognised that the Trust may have limited influence on external factors that can impact on the Trust's ability to manage a risk down to the risk target. A risk target is just that: a target the Trust is trying to manage down to; however, on occasions the Trust may have to revise that target to the least worst option. The Executive Management Team (EMT), through its regular review of the Organisational Risk Register. and the Operational Management Group through its review of care group risk registers, will consider if there is a likelihood of a risk not being managed down to the right level. A risk exception report will go to the relevant committee or forum of Trust Board (as set out in their Terms of Reference) setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Through EMT, a scan across care group and directorate registers of risks scoring below 15 and above 15 (before mitigation) will allow any themes / hot spots to be identified, mitigating actions agreed and referral to the appropriate committee / forum of the Board as applicable.

Trust Board will review its activities at the quarterly Business and Risk meeting, ensuring any risks, emerging risks, changes in activities or key risk indicators are reviewed in accordance with the risk appetite of Trust Board. This may involve taking considered risks into account where the long-term benefits outweigh any short-term losses. The impact of these risks will be reflected through the Board Assurance Framework.

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 show below:

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

The Trust's Risk Management Strategy sets out the Trust's risk scoring approach, which is based on the likelihood of an event happening multiplied by the consequence of the action. When considering risk appetite and areas of risk the Trust will take into consideration any potential impact on inequalities, maintaining a low threshold in this regard.

Risk appetite target scores

We have reviewed and defined our risk appetite in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix update published in May 2020 and aligned to the Trust's own risk assessment matrix as shown in the table below.

Note: The target score is that after the risk has been mitigated through relevant action plans.

Good Governance Institute matrix	**Risk appetite Level**	**Risk target score (range)**
None: Avoidance of risk and uncertainty is a key organisational objective	**None**	**Nil**
Minimal: (ALARP: As low as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and value for money (VFM))	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**

Good Governance Institute matrix	Risk appetite Level	Risk target score (range)
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Application

Within our Risk Management Governance Framework, we have defined the following five broad areas of risk which have been used to frame the Trust's risk appetite statement. *Note: The risk appetite and risk targets noted are indicative and for discussion at Trust Board.*

Clinical Safety and Quality risks: Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce i.e. the inability to recruit or retain an appropriately skilled workforce	**Good governance matrix:** **Minimal – Cautious**	**Risk target** **1-6**
	Risk appetite: **Low-Moderate**	
• Examples of clinical safety and quality risk are:		
• Risks to service user/public safety. • Risks to meeting recognised clinical and/or environmental standards e.g FIRM (Formulation informed risk management) , record keeping, infection prevention and control, and NICE guidance • Risks to staff safety • Risks to meeting mandatory training requirements, within limits set by the Board.		

Business risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	**Good governance matrix:** **Open**	**Risk target** **8-12**
	Risk appetite: **High**	
• Examples of business risks are:		
• Reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public • Workforce risk, inability to attract and retain appropriately qualified staff to deliver Trust plans. • Environmental risk, not having appropriate Estates and Facilities structures and systems to deliver high quality, modern safe services		

- Missed opportunities, the Trust fails to identify opportunities for growth impacting on business sustainability and development.

<u>Compliance risks:</u> Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	**Good Governance matrix:** **Minimal-Cautious** **Risk appetite:** **Low - Moderate**	**Risk target** **1-6**

- Examples of compliance risks are:

- Risk of failing to comply with NHS England requirements impacting on the Trust's license
- Risk of failing to comply with CQC standards and potential of compliance action.
- Risk of failing to comply with health and safety legislation
- Risk of failing to comply with Fire Safety (England) Regulations 2022
- Risk of failing to comply with data security protection toolkit standards, including meeting cyber essentials standards
- Risk of failing to comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED) and the Health and Social Care Act 2022.
- Risks to meeting statutory training requirements e.g. information governance, Oliver McGowen training.

<u>Financial risks:</u> Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	**Good Governance Matrix:** **Minimal-Cautious** **Risk appetite:** **Low-Moderate**	**Risk target** **1-6**

- Examples of financial risks are:

- 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.
- Risk of impact of wider financial system pressures on the Trust's ability to deliver its own operational and financial plan

<u>Strategic risks:</u> 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.	**Good Governance Matrix:** **Open** **Risk appetite:**	**Risk target** **8-12**

	High	
• Examples of strategic risk are:		
• Delivering transformational change ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance the Trust's 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		

Approved by Trust Board:

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 March 2024
Agenda item 10.4

Private/Public paper:	Public		
Title:	Infection Prevention and Control Board Assurance Framework (IPC BAF)		
Paper presented by:	Darryl Thompson, Chief nurse / director of quality and professions		
Paper prepared by:	Alison Thomas, Assistant director of nursing quality and professions		
Mission/values:	**Our values** • We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of the National Infection Prevention and Control Manual (NIPCM) Board Assurance Framework (BAF) enables the Trust to self-assess compliance with the measures set out in the National Infection Prevention and Control manual, the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures. The outcomes can be used to provide evidence to support improvement and patient safety.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
BAF Risk(s):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	As a provider within both integrated care systems, the Trust's self-assessment via the IPC BAF is a core part what is expected of us with regards to core governance.		

Any background papers / previously considered by:	The IPC BAF: • was previously presented at Quality and Safety Committee on 12 March 2024 and approved to be recommended to Trust Board. • was presented and reviewed at the Trust IPC Trust Action Group meeting, where monitoring, action and governance is applied.
Executive summary:	The IPC BAF worksheet contains the ten criteria of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded. The compliance rating column allows for the selection of a red-amber-green (RAG) rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant, compliant. In May 2023 the Trust rated compliant with nine and partially compliant with one criteria. As of January 2024, the Trust rated, compliant with eight and partially compliant with in two criteria. Noting that criteria 6 and 8 are partially compliant, these have been identified and actioned. These two criteria are as follows: • Criteria 6.5 - That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept [to ensure the Trust has a process for fit testing masks for use during aerosol generating procedures]. • Criteria 8.2 - Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary [ensuring that all staff who require access to ICE desktop (the pathology electronic system) have access]. Clear recommendations and next steps include: • The IPC BAF will be reviewed and updated 6 monthly and earlier if required, reporting to the IPC Trust Action Group and the executive management team. • Identified key lines of enquiry requiring improvement will be actioned by the IPC team and in cooperation with respective services / teams. • Gain compliance in criteria 6 and 8, acknowledging that there are processes and mitigations in place currently. • Ensure that the IPC annual plan and quality improvement programme are aligned to criteria for improvements and to reach and maintain compliance in all criteria. **Risk Appetite** This meets the clinical risk appetite – low and the risk target score 1-6.
Recommendation:	**Trust Board are asked to RECEIVE this report**

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations

Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by

Links

Section 1	
1.4	NIPCM
1.6	NICPM
	Primary care, community care and outpatient settings,
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07:01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
9	UKHSA
	NIPCM

Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

January 2024

The National Infection Prevention and Control (IPC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format. Current compliance ratings are in the below table;

Key;
- Compliant
- Partially compliant
- Non-compliant

Number	Criterion	Key Lines	Compliance
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.	8	**100%** (8/8)
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	9	**100%** (9/9)
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.	6	**100%** (6/6)
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.	5	**100%** (5/5)
5	Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.	5	**100%** (5/5)
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	6	**83%** (5/6)
7	Provide or secure adequate isolation precautions and facilities.	4	**100%** (4/4)
8	Provide secure and adequate access to laboratory/diagnostic support as appropriate.	7	**86%** (6/7)
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	1	**100%** (1/1)
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	3	**100%** (3/3)
Total;		**54**	96% (52/54) Compliant
			4% (2/54) Partially compliant

Infection Prevention and Control board assurance framework v0.1 January 2024

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	• DIPC, Chief Nurse / Director of Quality and Professions who is reportable to Chief Executive • DIPC has delegated the Infection Prevention and Control (IPC) function to the Assistant Director of Nursing, Quality and Professions • Non-executive Director chairs the Trust's Quality and Safety Committee where IPC reports into ensuring overview of IPC arrangements • Assistant Director of Nursing, Quality and Professions chairs the IPC Trust Action Group (IPC TAG) • IPC TAG reports to Quality and Safety Committee - escalate to appropriate groups as appropriate • Lead Nurse for IPC is responsible for the operational management of the IPC team and for ensuring that the IPC quality assurance programme is embedded • There is a strong, clear line of accountability from the IPC team to the DIPC, Chief Nurse / Director of Quality and Professions and vice versa • Expansive IPC programme and part of this is to deliver the Code of Practice (Health and Social Care Act) core principles. The IPC team provide clinical infection prevention and control specialist advice, and supports the Trust's staff in the delivery of the programme • There is a formal structure of the IPC team with clear, defined roles and responsibilities within job descriptions				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	• IPC team have robust monitoring and reporting systems and processes in place • There are established links and communication links with all acute Trust's IPC teams. There is a notification surveillance system operational in Barnsley which IPC check on a regular basis, an electronic weekly surveillance system with Mid Yorkshire Teaching NHS Trust microbiology for any alert organisms and additionally, a support system for Calderdale and Kirklees with IPC team for any alert organisms • Post Infection Review (PIR) Group in place at Barnsley and a HCAI operational group for Wakefield, Calderdale and Kirklees which IPC are active members • Mandatory infection control, outbreaks and any emerging organisms are reported through DATIX (a web-based incident reporting and risk management information system), follow up, investigation, action planning, shared learning • Receive daily emails from UKHSA on outbreaks, alert organisms and epidemiological data • Local daily reports from local healthcare partners • Active member on local Public Health Boards where agenda items include outbreaks, surveillance and any emerging organisms **Governance;** **Internal reporting** eg Integrated Performance Report (IPR), annual reports, quarterly reports, Advise, Alert, Assure (AAA) reports and other matters arising by exception, ensuring inter-communication, through IPC TAG, Quality and Safety Committee, Trustwide Clinical Governance Group, and Care Group Clinical Governance Groups and other Trust Action Groups (TAGS) as appropriate. Any learning is shared and actioned through internal governance **External reporting** as appropriate to UK Health Security Agency (UKHSA), Public Health and Integrated Care Boards (ICB's)				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	• DATIX system is used Trustwide to report, collect and manage data on adverse events (as well as data on complaints, risk, action and learning) with IPC specialist advice follow up with any escalation actioned with appropriate service • Action and feedback take place through relative groups eg IPC TAG, Trustwide Clinical Governance Group, and Care Group Clinical Governance Groups, Water Safety, Estates TAG, Safety and Resilience TAG and other relevant governance and safety groups • Presenting at Clinical Safety Overview Group • Presenting at learning events • IPC have a section on Chief Medical Officer webinar, Trust Brief, Nursing, Quality and Professions directorate webinar • Post infection review (PIR) process for alert organisms with partner healthcare organisations • Outbreaks are reported to UKHSA, NHS England (NHSE) as required • IPC peer support forums are used for learning and development • Situation, Background, Assessment, Recommendation (SBAR) produced as an improvement tool to reduce the number of outbreaks, breaches and incidents, Blue/Green light alerts circulated Trustwide • Learning library available to all staff to share improvements and developments • Work place and operational risk assessments are undertaken to mitigate occurrence and reduce risk of cross transmission • The Trust is adopting Patient Safety Incident Response Framework (PSIRF) and IPC annual plan is the IPC improvement plan • Numerous tools adopted for improvement learning such as case reviews, deep dives and after action events review				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	• Existing policies and procedures in place and working on integrating the National Infection Prevention and Control Manual (NIPCM) into these • Work plan and implementation plan produced to ensure NIPCM is functional on or before national deadline of March 2024				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	•IPC Operational Arrangement Policy and the Surveillance Management and Reporting of Infections Standard Operating Procedure (SOP) • Structures in place for the continued ongoing surveillance of infection rates, through various governance groups and board level meetings • Internal surveillance of infection rates, outbreaks and incidents is undertaken by the Trusts IPC team • IPC surveillance and monitoring data is reported through Integrated Performance Report (IPR) monthly which is part of the Trusts dashboard and data is reviewed by ICB's • IPC team implement actions identified through PIR's using (PSIRF) methodology with co-production and collaboration with operational colleagues and others as required • Outbreaks and mandatory infections are reported through appropriate internal and external governance such as Integrated Care Boards (ICB's), UKHSA, Public Health and through DATIX, follow up, investigation, action planning • Incident Management Team (IMT) is co-ordinated with the appropriate membership for the outbreak, to attend meeting(s) with a focussed agenda, defined clear roles and responsibilities, safety and mitigating actions formulated in an action plan which is reported through internal governance structures and external partners. Meetings are documented and an outbreak report is produced and circulated appropriately for shared learning • Outbreaks, single cases/clusters are reported through senior leadership communication route • Trust has senior leadership oversight of ongoing outbreaks and action plans • IPC surveillance data is reported in annual IPC report **Governance;** Internal reporting eg Integrated Performance Report (IPR), annual reports, quarterly reports, Advise, Alert, Assure (AAA) reports and other matters arising by exception, ensuring inter-communication, through IPC TAG, Quality and Safety Committee, Trustwide Clinical Governance Group, and Care Group Clinical Governance Groups and other Trust Action Groups (TAGS) as appropriate. Any learning is shared and actioned through internal governance External reporting as appropriate to UK Health Security Agency (UKHSA), Public Health and Integrated Care Boards (ICB's)				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	• IPC Annual Programme outlines the IPC priorities, objectives and quality improvement actions and sits alongside the day to day preventative and reactive workings of the IPC service. The plan is monitored through IPC TAG and other internal governance processes • IPC operational arrangement policy • DIPC statement on the intranet, aligns with Trust mission, values and behaviours • Role of the IPC Team is supported by senior management within the Trust and monitoring of service provision/staffing levels takes place routinely • IPC Team have robust monitoring and reporting systems and processes in place that are underpinned by Trustwide policies and procedures • IPC annual Quality Improvement plan is an integral part of the IPC Annual Programme with quarterly monitoring and reporting arrangements • Trust staff have a professional accountability eg job description, appraisal, values and behaviours				3. Compliant

1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	• Competent IPC team with specialist training and knowledge • Trustwide IPC and hand hygiene mandatory training programme for all staff is in place with adhoc/ additional training as necessary • Completes a training needs analysis in collaboration with Centre for Learning and Development (CFLD) for every staff member and competency attached to their Electronic Staff Record (ESR) profile **the IPC Team;** • Identifies and targets hotspot areas of non-compliance by emailing identified staff • Provide ad-hoc training sessions, themed toolbox training and any additional education programmes as required/requested across the Trust • Provide ongoing education to support standard IPC and transmission base precautions application • Provides health promotion and awareness sessions such as IPC week, antimicrobial awareness, hand hygiene week, Sepsis awareness • Continue to support link staff personal development and additional educational training				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	• Transmission based risk assessment using hierarchy of controls put in place and coproduced by clinical services for individual patients/service users, outbreaks, different scenario's to reduce transmission • Control measures are considered and applied in order from most to least effective (categories of elimination, substitution, engineering controls, administrative controls, and personal protective equipment (PPE), respectively) • IPC liaise with Trustwide areas to advise on the requirement, development and implementation of local risk assessments as required • Workplace risk assessments undertaken to minimise and mitigate workplace risks • Patient/service user centred approach risk assessment, utilising the least restrictive process, maintain safety for all • Operational risk assessments are undertaken across operational areas with review by IPC, Safety and Resilience Manager (or equivalent) Operations and sign off by Care Group Clinical Governance Groups with outcomes communicated to relevant staff • Isolation SOP, in line with NIPCM, and Guidance On Isolation On Inpatient Mental Health, Learning Disability and Autism, Specialised Commissioning Services, and for physical health units (Stroke Rehabilitation Unit and Neurological Rehabilitation Unit) consistent principles will be applied for infected patients/service users not compliant with isolation this includes isolation decision making tool, risk assessment, escalation and cohort nursing				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	• Annual review of the frequency risk ratings undertaken by the Trust's Facilities team • Monitoring audits that comply with the frequency rating risk schedules are carried out in all Trust premises and electronic records are kept. Each monitoring audit is distributed to operational Service Leads, IPC and any actions are promptly rectified. Any lapse in standards are highlighted and actioned, signed off and returned to the Monitoring team to mark as complete on the audit • Learning is actioned through IPC TAG, Safety and Resilience TAG, the Trustwide Clinical Governance Group and Care Group Clinical Governance Groups meetings and a report on cleanliness standards is compiled and sent to Estates TAG • IPC receive a monthly overview of the star ratings this enables triangulated intelligence • Efficacy audits are undertaken to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. These audits inform the Trust that correct training, IPC, health and safety, and safe systems of work are being used • An integral part of the efficacy audit is observing cleaning to check that staff use the colour coding correctly, follow cleaning methodologies, wear the correct uniform and PPE, use chemicals appropriately and adhere to safe ways of working. These audits are to provide assurance that cleaning standards are met using good practice • Each patient-facing area is audited at least once each year. If an area falls below 80%, it will be re-audited within a reasonable timeframe to check that following remedial action it is achieving an audit score of over 80% • Efficacy audits are conducted by multidisciplinary teams that include staff responsible for cleanliness, nursing staff, IPC and other Estates and Facilities colleagues to give a rounded view of the cleaning process • All areas display latest cleaning star ratings and cleaning schedules				3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	• PLACE visits are carried out annually and incorporate representatives from IPC, matrons, ward managers, domestic services managers, patient/service user public representatives and non-executive directors (NEDs) • Reports are published nationally and actioned through IPC TAG, Safety and Resilience TAG, the Trustwide Clinical Governance Group and Care Group Clinical Governance Groups meetings, escalated from Estates TAG to the Executive Management Team (EMT) and benchmarked against national standards • Trust report is benchmarked alongside national average • Any learning is identified, actioned and monitored through through IPC TAG, Estates TAG, Safety and Resilience TAG, the Trustwide Clinical Governance Group and Care Group Clinical Governance Groups meetings				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	**Cleaning** • Trust has a nominated executive lead and a Head of facilities for environmental cleanliness • National cleanliness standards compliance is monitored through Estates TAG and IPC TAG • Deep clean team works to an annual plan, with frequencies determined by use of area as per national cleanliness standards. The deep clean team also provide deep clean for outbreak situations • Access to Domestic Supervisor out of hours • Accountable Leads designate responsibilities to appropriate qualified personnel • Assessment of the environment occurs during walk rounds by accountable lead • Quarterly monitoring reports actioned by responsible person / team • IPC Environment Report, monitored quarterly and actioned by responsible person / team. Reported regularly and will be governed through the IPC TAG • Ward Managers display results of monitoring audits, the cleanliness scores **Decontamination** • Guideline and process detailed within the Trusts Decontamination policy and Medical Devices policy • Trust only uses single use cleaning items of equipment • Trust has a service level agreement with Barnsley Facilities services ltd, central sterile services department (CSSD), to provide decontamination for our Podiatry services and some of the Neighbourhood Nursing Teams • Barnsley Integrated Community Equipment Store (BICES) is a dedicated and sustainable decontamination unit for Barnsley people with a lead for the service. IPC undertake an annual environment audit • Following decontamination, Iam clean labels are used on high risk equipment ie commodes • Decontamination certificates used on equipment that has been serviced, repaired, condemned • Treatment room checklist and standards poster implemented throughout the Trust				3. Compliant

2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	**Ventilation** • Ventilation is picked up in the Estates TAG • The Trust has reviewed and ensured good ventilation in admission and waiting areas to minimise opportunistic airborne transmission • Dedicated personnel working on ventilation projects and these are on going through the Estates team • Two inpatient areas have had remedial work undertaken to increase ventilation **Water** • Water management policy and procedures in place • The Trust has a Water Safety Group that meets quarterly, more frequently if need arises • Water safety plan which includes risk management of Pseudomonas and Legionella • Planned maintenance and flushing ongoing • Annual Water Safety Audits, reviewed at the Trust's Water Safety group and any concerns are escalated and actioned by Estates TAG and supported through IPC TAG • Water hygiene risk assessments are at least annually updated reviewed at the Trust's Water Safety group and any concerns are escalated and actioned by Estates TAG and supported through IPC TAG • For Barnsley, annual reassurance community leg ulcer clinic risk assessment				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	• Pre-planned maintenance schedules can be viewed on the Estates PLANET facilities management system and are monitored on a weekly report to ensure compliance and emergency works are completed in relevant time frames • IPC team are part of stakeholder meeting for any new builds, new re-furbishments etc				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	• Robust system in place and a Laundry standard operating procedure • Laundry contract in place Trustwide which is reviewed and monitored through Facilities governance arrangements • Facilities undertake regular audits and results are reported with actions to remedy any issues • Trustwide procedure for Managing Laundering on Wards and Departments that all wards (who have washing machines and dryers) should have in place • Areas tailor procedures to reflect what occurs on local wards/units • IPC environment audit and Toolbox themed talks				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	• Waste contract is held, monitored and reviewed by Facilities • Waste Policy and Waste segregation posters are in place • Waste audits monitor the waste process from beginning to end, received by Estates TAG, Safety and Resilience TAG and any actions are followed up by the waste compliance team • Healthcare waste audits are undertaken, which outline how the Trust aims to demonstrate compliance	Numerous audits were cancelled at short notice due to nursing staff/ward managers not being available to participate in the audits.	Clinical waste segregation was internally audited on all wards and most departments in 2023, corrective actions were taken where required until all areas scored over 85%.	In 2024 the focus of waste audits will continue to be on clinical waste.	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	• The Trust has a service level agreement with Barnsley Facilities services ltd, which is an accredited service, central sterile services department (CSSD), to provide decontamination for Barnsley place based services ie Podiatry services and some of the Neighbourhood Nursing Teams • All other areas use sterile at point of use, single use equipment				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	• Trust wide Food Hygiene policy • Trust wide Food Safety training programme in place for all staff who handle food. Trust has a training needs analysis undertaken for staff • Level 1 Food Safety Awareness undertaken by staff who undertake minimal food handling duties • Foundation Certificate in Food Safety undertaken by all staff who are involved in food handling duties. • Food Safety Management system in place that states the procedures to be followed for the storage of food brought in by staff, service users, relatives or visitors • Regular kitchen audits undertaken by monitoring staff				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	• DIPC, Chief Nurse / Director of Quality and Professions who is reportable to Chief Executive is the formal lead • Lead Nurse for IPC undertaking a population health fellowship AMR mentoring role • Lead Pharmacist who undertakes the AMR role • For antimicrobial prescribing the Trust use the NICE AMS guideline • Antimicrobial prescribing in inpatient wards is audited annually and report goes to Drugs and Therapeutic TAG and IPC TAG • Antimicrobial prescribing is in line with local partner organisations				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	• Formal quarterly IPC report goes to the Trust's Quality and Safety Committee (Trust Board) for oversight • Annual IPC report which includes antimicrobial stewardship which goes through the IPC TAG, Quality and Safety committee, Trustwide Clinical Governance Group, and Care Group Clinical Governance Groups • Antimicrobial prescribing audit reported to the Trust's Drugs and Therapeutic TAG and the IPC TAG • Electronic Prescribing and Medication Administration (EPMA) is a key development for the Trust; designed to improve patient/service user safety, efficiency in service delivery, improve quality of data, deliver financial benefits for the organisation and will replace the current paper medication chart with an electronic medication chart within SystmOne			Barnsley place based services who prescribe IV antibiotics - consideration for audit 2024/25	3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	• DIPC, Chief Nurse/Director of Quality and Professions who is reportable to Chief Executive • AMR is discussed at the IPC TAG with a Lead Pharmacist				3. Compliant

3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, Then Focus are followed.	• Trust are active members of the West Yorkshire ICB AMR sub-group which focus on the methods and ideas of reducing antimicrobial prescribing for example regular meetings, workshops, task and finish groups • Every inpatient ward has a Clinical pharmacist who reviews prescriptions / pathways to treatment for antibiotics and adherence to guidance, eg correct antibiotics, right treatment, right dose, right length of time and IV to oral switch and consider antimicrobial resistance eg MRSA and organisms that cause healthcare-associated infections, for example, C. difficile • The IPC team monitor results obtained and give advice on sampling, management, treatment alternatives and antimicrobial resistance • There are national MHRA Patient safety updates which are received and actioned through internal governance processes • To optimise patient/service user outcomes, patient/service user reviews in line with PSIRF are undertaken and any antimicrobial stewardship issues are addressed • South West Yorkshire Area Prescribing Committee and Barnsley Area Prescribing Committee have a medicines safety network which shares learning from patient/service user safety incidents • Any samples on management and treatment identified by clinical staff can be reviewed by IPC team who will give advice on sampling, management, treatment alternatives and antimicrobial resistance • Antimicrobial prescribing contra-indications with other medicines or any food and drink is considered • Any drug allergies (these should be documented in the patient/service user's record) consider de-labelling of allergy statuses • Document reason for antibiotic use • When prescribing any antimicrobial, a clinical assessment is undertaken and document the clinical diagnosis (including symptoms) in the patient/service user's record and clinical management plan • Regular correspondence sent out to Senior health professionals through emails and Comms to raise awareness and promote antimicrobial guardianship				3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing • Broad-spectrum prescribing • Intravenous route prescribing • Treatment course length	• Annual antimicrobial prescribing audit which reports on: total number of antimicrobial prescriptions in inpatient services, specification of course indication and treatment length, reporting to the Trust's Drugs and Therapeutics TAG and IPC TAG where improvements are actioned • The Trust delivers Intravenous antibiotic treatment for patients/service users in community by shared place based system in Barnsley eg Acute Trust, Primary care and SWYFPT working together. The prescribing of intravenous antibiotics is reviewed eg choice of antibiotic, route and treatment length on a case by case basis by the Consultant Microbiologist, and support the intravenous to oral switch initiative			System wide prescribing data is being investigated by the Trust's Pharmacy team for reporting into Trust governance forums The Trust does not have contractual reporting incentives and performance improvement schemes relating to AMR as we are not classed as an Acute Trust,	3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	• For antimicrobial prescribing the Trust use the NICE AMS guideline • Annual antimicrobial prescribing audit and action plan report goes to the Trust's Drugs and Therapeutic TAG and IPC TAG • Non-medical prescribers have competencies reviewed and revalidate every three years • Regular correspondence sent out to Senior health professionals through emails and Comms to raise awareness and promote antimicrobial guardianship			Antimicrobial audit plan under review, these areas to be considered for inclusion Focus group with Integrated Care Boards (ICBS) to influence practice	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	• Trust has an integrated approach to equality, equitability, involvement, communication and membership; person, people and communities at the centre to understand and map audience • IPC annual plan (improvement plan) policies, procedures, initiatives and comms are developed using Equality Impact Assessment information and IPC work closely with equality and inclusion team • Patient/service user experience information is used to identify hotspots or areas for improvement that require solutions • Friends and Family paper/electronic surveys. You Said We Did posters/leaflets. Quarterly Trustwide results and managers receive monthly reports with specific team results • Customer Services team provides information, advice and support for people who use Trust services, their families, carers and the public • NHS England; Integrated Care Services, the plan for Health and Care Services to work with people and communities aims to give people who use services more choice, more information and control of their own health • Trust works in partnership with Trustwide Healthwatch groups • Patient/service user representatives included in the annual PLACE audit • IPC are part of quality monitoring visits				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	• A wide range of leaflets and posters have been created to help patients/service users and staff ensure they are following effective infection prevention and control practices and these are updated as guidance changes • Patient/service user information leaflets on specific organisms in easy to read format with different languages available upon request • Accessible information standard in place to make sure that people who have a disability, impairment or sensory loss are given information in a way that they can access and understand, and any communication support that they need is identified and provided such as easy to read formats • Patient Knows Best (PKB) is an app platform where patients/service users can access 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. Patients/service users will see their Trust appointments, allergies and demographic information. They will also be able to access resources created or shared by Trust clinicians as part of their recovery and care • Trust uses multiple ways to display information				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	• Trust information is in line with IPC and AMR policies, procedures and guidelines eg standard operating procedures • There is an intranet link to the National Infection Prevention and Control Manual (NIPCM) for England and all policies. Local standard operating procedures have been developed to support implementation of the manual • Information leaflets for patients/service users, families, carers and public information are available and accessible electronically/paper copies on Clostridioides difficile, MRSA, Respiratory virus, Viral gastroenteritis, Scabies, Reducing risk of infection and a Guide to multi-resistant organisms • IPC posters Trustwide such as hand hygiene information above each sink, diarrhoea and vomiting visitors poster not to visit until 48 hours clear, Catch it, bin it, kill it posters and respiratory posters displayed • Verbal communication available from service leads, managers, ward staff, IPC specialist advice • IPC noticeboards across the Trust with up to date and relevant information				3. Compliant

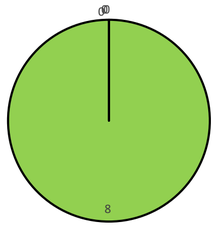
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	• Medical/nursing staff communicate with service user(s), specific individuals, carers, visitors, advocates as appropriate • Utilise Carers passport • Display posters and signage to notify restricted access where appropriate e.g outbreaks, ward isolation, hand hygiene • Provide appropriate PPE including face masks re-iterating appropriate use, verbally by staff and posters • IPC posters and signage are displayed on the ward areas, • IPC information is available on the internet and intranet and there are specific updates circulated using Twitter, Facebook • Patient/service user leaflets and guidance available on wards and on the Trust intranet website and can be available in easy read format and other languages on request • IPC good standards and cleanliness is in the Trustwide inpatient welcome pack • Trustwide outbreak guidance in place, outbreak pack for staff and patient/service users and an outbreak pack for IPC Team on arrangement, notification and surveillance • Trustwide pandemic policy • Localised business continuity plans • Procedure in place for access to hydrogen peroxide vapour cleaning technology as and when required • Deep clean team • Vaccination programmes for inpatients in place for seasonal respiratory infections and other missed childhood vaccines including measles • Influenza vaccination programme in place for staff annually and signposting to COVID-19 vaccine • Lessons learned from outbreaks go through quality improvement and use SBAR tool to capture these • Utilise internal and external communications during increase incidence and/or outbreaks • Display cleaning scores • IPC visit for alert organisms, conversation and support • Measles vaccination recovery programme • IPR data is available on the internet and intranet				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	• Infection status is on the intra-healthcare transfer form held within the IPC Risk Assessment Policy for Admission, discharge, transfer, handover, admission and transfer documentation. Any other form of handover documentation eg Stroke pathway • Electronically stored and paper copy in case notes • COVID-19 Patient/service user assessment and infection prevention and control guidance, agreed triage questions of clinical, competent staff to use when assessing patient/service user • Screening questions are in risk assessments for services • Trust has a Caldicott Guardian • Trustwide Information Governance policy in place • Staff adhere to information governance standards, Data Protection Act and Caldicott guardian principles • Information is given on a 'needs to know' purpose • Trust General Data Protection Regulation (GDPR) policy and requirements	Invasive devices passport			3. Compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	• Pre-admission patient/service user flow pathway and agreed triage questions in place for any infection eg MRSA, C.diff, diarrhoea and vomiting and Carbapenemase-Producing Enterobacteriaceae (CPE) and Candida auris in specific areas • For admission, transfers and discharges the intra-healthcare transfer form or similar documentation in place • Risk assessment undertaken and patients/service users are put on the appropriate care pathway utilising infection prevention and control guidance such as PPE, IPC precautions, isolation • Those who have or are at risk of infection, screening is offered eg COVID-19 symptomatic patients/service users are offered a test and are isolated in line with guidance • Individuals medically reviewed for possible treatment for example antivirals • Patients/service users are isolated on suspicion of infectious illness, the isolation decision making tool is utilised for patients/service users who are not fully compliant with isolation				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	• Patients/service users are regularly monitored and assessed for ill health throughout stay • Systems in place for the management of patients/service users that display symptoms of infectious illness • For any infection the patient/service user has a personalised plan • All inpatient areas are single room occupancy that supports isolation, however, not all rooms are ensuite. Escalation cohort plan in place for outbreak ensuring patient/service user placement is paramount to reduce transmission • Internal Test and Trace takes place for patients/service users and staff to reduce exposure risks • If there are any key areas for improvement these are communicated using shared learning system e.g. SBAR and through the learning events by presentation • Least restrictive approach used for all patients/service users • All communication regarding patient/service user placement and precautions is documented in SystmOne and also whilst waiting any results	Patient/service user bedrooms that are identified as not ensuite are discussed and assessed for action in the Estates TAG and are on the Trusts improvement plan	Hierarchy of controls are used to mitigate the risk during patient/service user specific infections or outbreak The Trust is aware of areas that do not have hand hygiene sinks, and these are considered during patient/service user placement		3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	• Infection status is on the intra-healthcare transfer form held within the IPC Risk Assessment Policy for Admission, discharge, transfer, handover, admission and transfer documentation • Electronically recorded and paper copy in case notes • Documented on SystmOne • Patient/service user flow communication • Service to service communication by IPC ie to other IPC teams				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	• Public health messaging throughout the Trust eg Catch it, Bin it, Kill it posters, hand hygiene posters, waste management posters • Posters and signage are used to notify restricted access where appropriate in COVID-19/Influenza/D+V etc situations e.g outbreaks, ward isolation				3. Compliant

5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	• The Trust has a Pandemic policy and linked to all health and social care local partners • The Trust has an Outbreak SOP for the identification of and management of outbreaks of infection • All infectious positive cases are reviewed by IPC team, medical staff and in some cases the Microbiologist. If there are two or more linked cases the outbreak procedure is triggered and outbreak pack of resources is distributed to area to support outbreak management. The outbreak pack is available on the Trust intranet • Incident Management Team (IMT) is co-ordinated with the appropriate membership for the outbreak, to attend meeting(s) with a focussed agenda, defined clear roles and responsibilities, safety and mitigating actions formulated in an action plan which is reported through internal governance structures and external partners. Meetings are documented • Outbreak sitrep internally and externally reported through governance structures. IIMARCH is completed and outbreak report is produced and circulated for shared learning appropriately e.g. SBAR and through the learning events by presentation. Learning is also addressed in the Trust IPC improvement plan				3. Compliant
6.5	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	• All staff (clinical and non-clinical including bank/agency and volunteers) have appropriate IPC training to ensure their personal safety and working environment is safe. Contractors adhere to the Trusts Control of Contractors policy and abide by the Trusts policies and procedures whilst on Trust premises • Trustwide induction for new employees including a staff induction workbook • Staff are made aware to abide by and adhere to Trust wide policies and procedures and this monitored via annual appraisals and one:ones • Mandatory training identified through a training needs analysis for the staff role eg hand hygiene and IPC training • Care Certificate training • IPC team provide support, advice and targeted specific training				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	• DIPC, Chief Nurse / Director of Quality and Professions who is reportable to Chief Executive • DIPC has delegated the IPC function to the Assistant Director of Nursing, Quality and Professions • Non-executive Director chairs the Trust's Quality and Safety Committee where IPC reports into ensuring overview of IPC arrangements • Assistant Director of Nursing, Quality and Professions chairs the Infection prevention and control Trust action group (IPC TAG) • Dedicated competent IPC team ie Lead Nurse, Specialist Nurses, Surveillance and administrative roles with IPC specific job descriptions and training and continuous personal and professional development. There is membership of Infection Prevention and Control professional bodies and collaborative work, peer support, clinical supervision with other IPC professionals • Individual job descriptions indicate that 'all staff employed by the Trust must comply with the Trusts policies and commitment to comply with Trust Policies and Procedures at all times particularly those concerning mandatory training..... and the prevention, control of infection and information governance'. • IPC Link professionals •The Trust has good IPC measures in place demonstrable by well managed outbreaks causing minimal disruption to service delivery				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	• Mandatory training performance data is reviewed by the EMT, displayed and utilised through the Board performance reports • Trustwide IPC mandatory training threshold is 80% • IPC team undertake monthly review of mandatory IPC and hand hygiene competency figures and training statistics are reported monthly in the IPR, monthly Operational Management Group (OMG) report, quarterly to IPC TAG and Care Group Clinical Governance Groups • Hotspots are identified by IPC team and escalated to the individual, the Care Group and service leads for action • The training programmes are up to date as we use the national training programme				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	• All staff (clinical and non-clinical including bank/agency) providing patient/service user care are trained in IPC training which includes the selection and use of PPE appropriate for the clinical situation • Trust coronavirus guidance page on the intranet includes information on how to safely don and doff PPE, and posters • Staff have access to online resources and posters are displayed in service areas in outbreak situation • IPC compliance with PPE is undertaken and action plans produced and followed up from findings such as Appropriate Use of Gloves audit • Inappropriate use of gloves is challenged on IPC walkarounds • IPC support operational managers and matrons to monitor PPE compliance, to embed practice				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	• Process in place for identifying staff requiring FFP3 training, this is through staffs job appraisal and outlined in Learning and development brochure • Re-active system in place to deliver training for staff at point of need to maintain patient/service user and staff safety, and records kept • Risk assessment for staff that fail fit testing eg considered alternative respiratory protection equipment (RPE) • Staff that fail to be adequately fit tested are referred to Occupational health and discussion and process around redeployment are employed using a nationally agreed algorithm	There is no substantive process and provision for FFP3 mask fit testing Training is recorded and type of mask however this is not on a central database	Current Training and recording is picked up within IPC team who are trained to fit tested Area of required need have been risk assessed Discussion are taking place with learning and development team and ESR about accurate recording of testing	Options appraisal for the delivery of FFP3 training was reviewed by OMG 1st November 2023 and is being considered by finance colleagues as part of required unfunded posts.	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	• The Trust provides competency based training and all staff have individual competency assessments prior to being allowed to undertake the procedures independently. This is supported by Trustwide policies and procedures eg manual catheterisation, venepuncture, any invasive medical devices				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	• Isolation standard operating procedure, in line with NIPCM, and Guidance On Isolation On Inpatient Mental Health, Learning Disability and Autism, Specialised Commissioning Services, and for physical health units (Stroke Rehabilitation Unit and Neurological Rehabilitation Unit) consistent principles will be applied for infected patients/service users not compliant with isolation this includes isolation decision making tool, risk assessment, escalation and cohort nursing • Protocols and support for isolation- least restrictive practices advised and review of patient/service user well being in response to restrictions • All inpatient areas are single room occupancy that supports isolation, (not all rooms are ensuite). Escalation cohort plan in place for outbreak ensuring patient/service user placement is paramount to reduce transmission • Medical review and assessment and regular clinical observations (NEWS2) • No delay in care or treatments these are discussed with care facility to ensure mitigations are in place •Individual care planning and risk assessments				3. Compliant

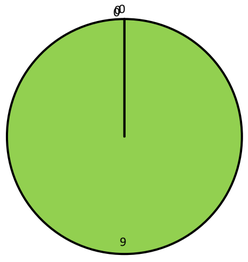
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	• All inpatient areas are single room occupancy that supports isolation, (not all rooms are ensuite). Escalation cohort plan in place for outbreak ensuring patient/service user placement is paramount to reduce transmission • Operational separation, isolation, cohort, restricted access in the Outbreak Policy • IPC regularly review cohort areas • Procedure in place for patients/service users that refuse or have difficulty isolating eg admission criteria, symptomatic or contacts • Mitigation systems in place to provide separation for patients/service users, if there is a patient/service user with a respiratory infection, reviewed scheduling of appointments to avoid mixing and have reduced waiting times in reception areas • Personal plans for source/isolation				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	• Transmission based precautions are in place where possible - risk assessment undertaken and seek to lower risk at every stage - a patient/service user may require isolation but this may not be appropriate for that person at that time. This is documented in the patients/service users care plan/notes • Posters and signage are used to notify restricted access where appropriate e.g outbreaks, ward isolation, donning and doffing PPE • Ward staff have access to IPC outbreak packs				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	• Infection status is on the intra-healthcare transfer form held within the IPC Risk Assessment Policy for Admission, discharge, transfer, handover, admission and transfer documentation • Communication with received area is also done verbally, hand over sheet, discharge letter				3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	• Trust has a service level agreement in place with Barnsley Hospital NHS Foundation Trust and Mid Yorkshire Teaching NHS Trust for laboratory support • These laboratory's operate according to relevant national accreditation bodies standards • The microbiology laboratory at Mid Yorkshire Teaching NHS Trust is currently CPA accredited and is transitioning to ISO15189 standards • Notification surveillance system operational in Barnsley which IPC check on a regular basis, an electronic weekly surveillance system with Mid Yorkshire Teaching NHS Trust microbiology for any alert organisms and additionally support system for Calderdale and Kirklees with IPC team for any alert organisms • Testing is only undertaken by competent and trained staff • Trust has a Screening Standard Operating Procedure eg COVID-19, PCR • Staff are trained to perform samples through videos, face to face and signage				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	**IPC** • Process in place with local laboratories that results are received in a timely manner to wards who escalate infectious organisms to IPC • Process in place that IPC team review results in a timely manner • Working with wards and Information Management and Technology team (IM+T) to get access to ICE desktop (pathology) system • Weekly review of results from Mid Yorkshire Teaching NHS Trust (inpatients Wakefield and Dewsbury) and daily review in Barnsley, notifications from Calderdale as required from IPC team under service agreement **Wards/services** • Review results through ICE in a timely manner and escalate infectious organisms to IPC • Microbiology advice as required	Not all staff that require access to ICE desktop have access (pathology system)	This has been escalated to IM+T for action. There is a Trustwide piece of work actioning this. Mechanisms are in place to ensure that updated staff lists for those staff requiring access to ICE are provided to our acute partners and any staff no longer requiring access are removed. Integration activities are progressing with our respective acute partners (in order of activities CHFT, Mid-Yorks and Brnsley) to integrate their separate instances of ICE with SystmOne. This will present results within SystmOne.		2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored, with relevant service users as part of contract monitoring and laboratory accreditation systems.	• All laboratory's operate according to relevant national accreditation bodies standards UKAS ISO15189 standards				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	• The Trust has specific SOPs, guidance and flowcharts for the testing for admission, transfer and discharge of patients/service users in line with national guidance and this is communicated as required to any receiving organisation eg MRSA, CPE				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	• The Trust has specific SOPs, guidance and flowcharts for the testing for admission, transfer and discharge of patients/service users in line with national guidance and this is communicated as required to any receiving organisation eg MRSA, CPE				3. Compliant

8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	• Local place based (Public Health-led) resilience agreements for outbreak management this includes resources, testing, PPE, resource allocation etc • IT Surveillance system operational in Barnsley, an electronic weekly surveillance system with Mid Yorkshire Teaching NHS Trust microbiology for any alert organisms and additionally support system for Calderdale and Kirklees with IPC team for any alert organisms • Calderdale and Kirklees can contact Consultant in communicable disease control for West Yorkshire • There is adequate lab capacity for testing for admission, discharges, additions pathway and symptomatic patients/service users • There is adequate lab capacity for outbreaks or hotspot				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	• Transportation contract with local transportation services and procedure in place for transportation of specimens this includes equipment • Specialist specimen transport boxes are used to transport specimens from the ward environment to the labs • Clinical community staff are issued with specimen transportation boxes which meet the standard UN3373 • Compliance is regularly checked through themes / environment walk arounds • Standard Operating Procedure for transportation and sample management which can be modified to new and emerging pathogens as required				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA and the NIPCM) (UKHSA and NHSE A to Z pathogens list to be added once published). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	• Trust has multiple forms of IPC information and guidance around specific organism which are available on the Trusts intranet for staff reference • Trust has an Outbreak policy, an outbreak pack for staff and patient/service user use and an outbreak pack for IPC Team on arrangement, notification and surveillance • IPC ratifying matrix and procedure is completed for all IPC policies • All policies are up to date and a review date is clearly marked • All policies are evidence based with references made to relevant evidence used in the production of the policy this is listed towards the back of the policy • During policy development and prior to final approval consultation with managers/practitioners takes place. This would include a Consultant Microbiologist • An annual audit programme is in place to establish an acceptable level of compliance with the infection prevention and control policies • Internal processes in place for reporting and escalating to regulatory bodies eg UKHSA, and all relevant stakeholders				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	• Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment undertaken by Manager/Team leader and any concerns or risk identified would be referred to OH for additional support. Risk assessment would be reviewed regularly				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	• Initial risk assessment completed for exposure • OH procedure in place for managing occupational exposure based on latest national guidance				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	• All checks undertaken at pre-employment stage and reminders for any updates are flagged on individuals record and appointment sent for immunisation update on commencement of employment • Individuals electronic staff record are regularly reviewed and updated with current medical history • Ability to adapt to staff screening guidance				3. Compliant

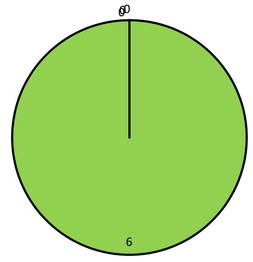
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



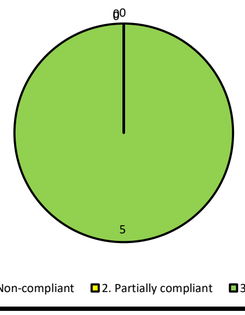
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



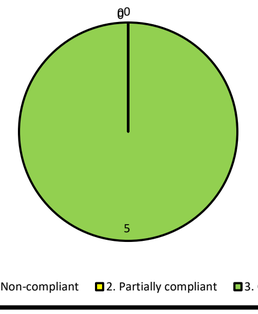
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



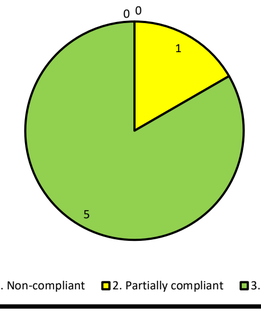
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



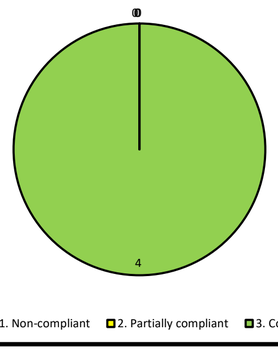
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



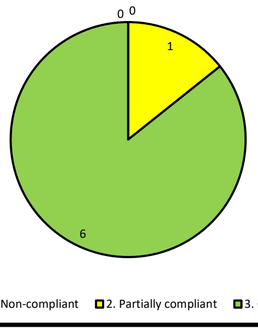
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



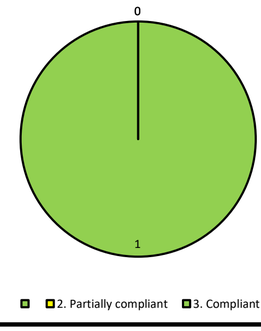
7. Provide or secure adequate isolation precautions and facilities



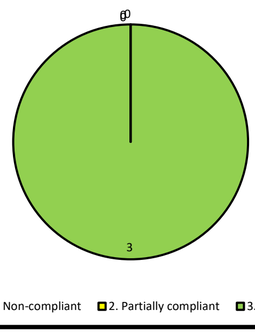
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

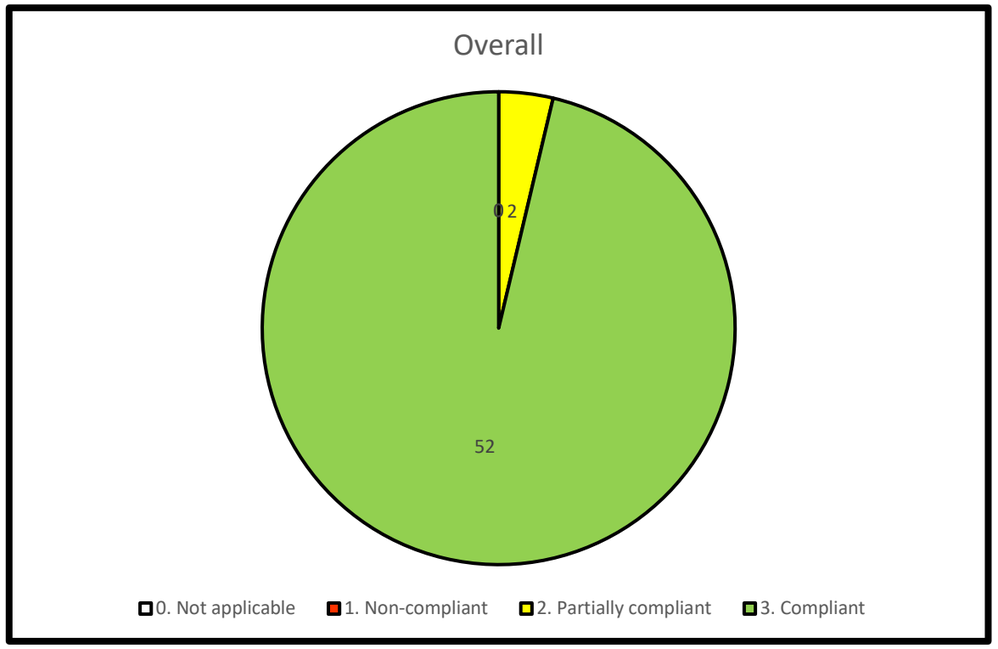


9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections



10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection




Overall
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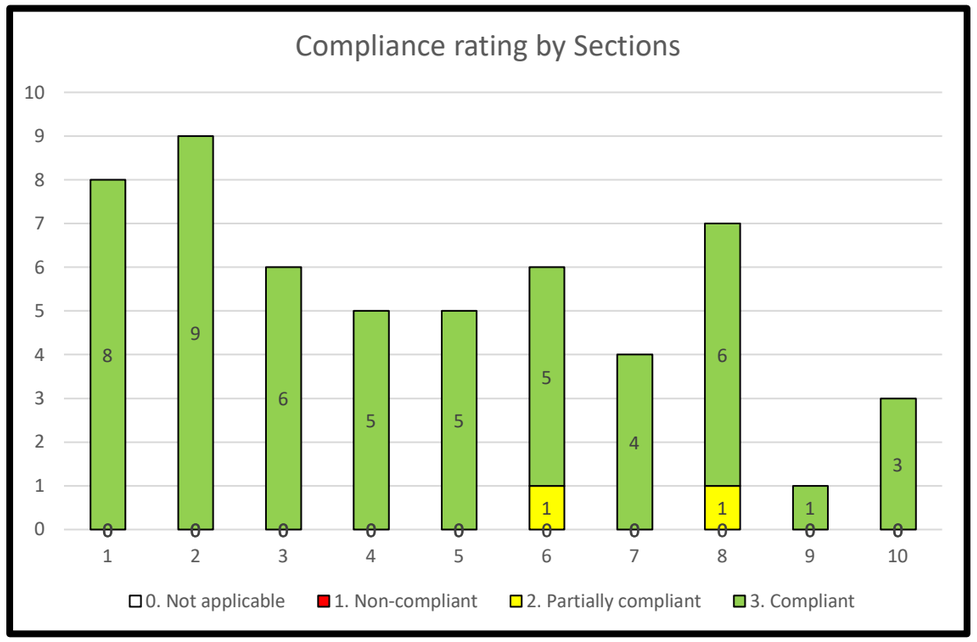
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
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0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 March 2024
Agenda item 10.5

Private/Public paper:	**Public**		
Title:	**Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions**		
Paper presented by:	Darryl Thompson, Chief Nurse / Director of Quality and Professions		
Paper prepared by:	Sarah Whiterod – Associate Director of Nursing, Quality and Professions Liam Redican – Quality Governance Manager		
Mission/values:	The report demonstrates the Trust's commitment to all the Trust's values, which are fundamental to delivering safe and high quality 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 the paper is to provide the committee with an update and assurance regarding the Trust approach to CQC concerns, inspections and our own internal process for assuring ourselves of the quality of our services.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve. 2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents. 2.3 Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care. 4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Each provider Trust within the Integrated Care System will be governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from feedback and action is taken to remedy any findings. Regulatory bodies also identify areas of strength and good practice. Being part of the Integrated Care System allows for opportunity to share learning, findings and best practice to ensure services are delivered to the highest standard. Understanding our current position, areas of strength and areas for improvement supports us to be an engaged member of the integrated care systems support and consider opportunities for economies of scale.
Any background papers / previously considered by:	The executive management team reviewed the content of this report on 7 March 2024. The Quality and Safety Committee reviewed this content on 12 March 2024. Trust Board previously received a summary paper of the inspection reports in January 2024.
Executive summary:	On Wednesday 6 December 2023 the reports were published for the Care Quality Commission (CQC) inspections into the core services of acute wards for working age adults and psychiatric intensive care units (PICU), and forensic inpatient and secure wards. These inspection reports were presented to Trust Board in January 2024. This report contains an update on the Trust's progress with regards to the action plans against the MUST DO and SHOULD DO actions within the CQC inspection reports. The Care Groups have identified that some 'should do' actions are being approached not purely as opportunities to consider them, but with a clear expectation of completion (therefore responding to them in effect as a must do action). Actions are signed off as completed at Care Group level before final sign off by the Chief Nurse / Director of Quality and Professions, where the evidence of assurance is reviewed. There will be a further stage of sign off by the Chief Nurse / Director of Quality and Professions that will be in future versions of this report, to indicate when there is confidence via agreed metrics that an action is embedded, and when an oversight process is in place that will alert should performance deteriorate at any point in the future. Quality improvement approaches are being used wherever possible, either with individual actions or where actions are part of broader improvement work. **Current progress** **Forensic service MUST DO actions:** • One of the seven must do actions has been completed • Six of the seven actions are in progress and on track **Forensic service SHOULD DO actions:** The Forensic Care Group received seven should do actions, alongside the must do actions. The Care Group are considering all seven should do actions as must do actions and are progressing these as detailed below. • One action is complete • Four actions are on track • Two actions are being progressed with input from other areas of the Trust

	Acute and PICU MUST DO actions: • Of the 16 must do actions all are in progress and on track **Acute and PICU SHOULD DO actions:** The Care Group are considering a six of the 12 should do actions as must do actions and are progressing these as detailed below. • Two actions are complete • Ten actions are in progress and on track Going forward, progress will continue to be presented to the executive management team, the Quality and Safety Committee, Trust Board and the CQC. 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 is asked to RECEIVE the Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions**

South West Yorkshire Partnership NHS Foundation Trust

Care Quality Commission Inspection Reports
Action plan update for Must and Should Do Actions
Trust Board
26 March 2024

1. Purpose of the paper

Following receipt of the initial feedback from the Care Quality Commission (CQC) inspections in May 2023 and on receipt of the draft reports in September 2023, the core services (acute wards for working age adults and psychiatric intensive care units (PICU) and forensic inpatient and secure wards) put in place a number of improvement actions. Some of these actions were already in progress in existing improvement work and others were added to plans. This paper is intended to provide an updated position on progress against the Must and Should Do actions that were highlighted within the two inspection reports, published on 6 December 2024.

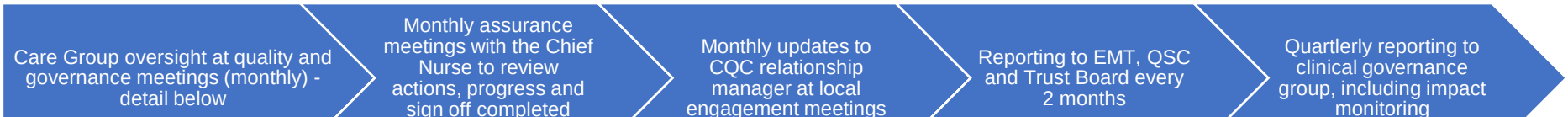
2. Action plan update following the Care Quality Commission reports into Forensic inpatients and Acute inpatient/psychiatric intensive care units (PICU)

On 21 December 2023 two action plans were submitted to the CQC, one for each of the inspection reports. These action plans detailed how each core service aims to address the must do actions / regulatory breaches, along with timescales and action owners. Within the inspection reports are the following:

	MUST DO actions	SHOULD DO actions
Forensic service	7	7
Acute and PICU service	16	12

3. Action plans, oversight and assurance

There is an overarching Trust-wide action plan. Full detail relating to the actions is contained within this and it is held by the quality improvement and assurance team. This action plan will be updated during monthly update and assurance meetings and will be used to provide oversight and assurance to newly established monthly CQC Update and Assurance meetings (chaired by the Chief Nurse / Director of Quality



and Professions), the Trust-wide clinical governance group, executive management team (EMT), Quality and Safety Committee (QSC), Trust Board, and the Trust's CQC inspector at the monthly local engagement meetings. This is summarised below:

Sign off of actions at a Care Group level is completed before final sign off by the Chief Nurse / Director of Quality and Professions at a monthly meeting.

4. Trust-wide actions

There are some CQC actions which are being progressed on a Trust-wide basis. Whilst there are specific actions for each Care Group, detailed in the table below, some actions will be developed on a larger scale. These actions cover a number of the MUST DO actions and include:

- Regulation 12 – safe care and treatment
    - Reduction in prone restraint, use of alternative injection sites, strategies for exit from seclusion and use of safety pods
- Regulation 9 – person centred care
    - Care plan and risk assessment improvement group
- Regulation 17 – good governance
    - Use of e-seclusion

Reporting of progress of these larger scale improvement plans occurs regularly through quality and safety committee, operational management group and executive management team.

5. Forensic action plan details and updates

MUST DO actions:

- One of the seven must do actions has been completed
- Six of the seven are in progress and on trac.

Forensic service SHOULD DO actions:

The Forensic Care Group received seven should do actions, alongside the MUST DO actions. The Care Group are considering all seven should do actions as must do actions and are progressing these as detailed below.

- One action is complete
- Four actions are on track
- Two actions are being progressed with input from other areas of the Trust

6. Acute and PICU action plan details and updates

Acute and PICU MUST DO actions:

Of the 16 must do actions all are in progress and on track.

Acute and PICU SHOULD DO actions:

The Acute and PICU service received 12 SHOULD DO actions, alongside the MUST DO actions needed. The Care Group are considering a six of the 12 should do actions as must do actions and are progressing these as detailed below.

- Two actions are complete
- Ten actions are in progress and on track

7. Understanding the impact of actions

A number of the actions are part of ongoing improvement work across Care Groups and Trust-wide. The impact of changes made as a result of these improvement programmes is reviewed on an ongoing basis and using the following data and intelligence:

- Complaints/concerns raised – for example this is being monitored as the triangle of care work progresses and through the dashboard that is reviewing the impact of this work on carers experience
- Friends and family test, service line patient experience surveys and carers feedback
- A reduction in the use of prone restraint through the improvement work on exit strategies from seclusion, safety pods and alternative injection sites. This is reported on a monthly basis through RRPI trust action group and within the integrated performance report
- The number of ligature related incidents monitored and reviewed through clinical environment safety group
- Staff culture and retention of staff, reported through Care group quality and governance meetings, annual staff survey, leavers surveys and oversight of supervision recording, mandatory training compliance and appraisal completion are monitored through Care Group dashboards reviewed at operational management group
- Improvement in the quality of care plans, monitored through audit processes within the service

- Reduction of the use of out of area beds and the provision of care closer to home. Monitoring and reporting of this will include understanding how this reduction has impacted on the holistic care, pathway and journey of the individual patients. This programme monitored and reported on through mental health inpatient performance and quality oversight group
- Improved seclusion experience for patients through the development of and improvement to the use of e-seclusion, monitored through audits of seclusion records, patient experience information and reduction in Datix incidents

8. Summary

The CQC actions are progressing across the two Care Groups and on a Trust-wide basis (where applicable). These actions vary in complexity, and the timescale for completion also varies depending on this complexity. There are systems in place for the Chief Nurse / Director of Quality and Professions to maintain oversight and be provided with assurance and updates on progress, which in turn will allow assurance to be provided to the Board as this report develops. Monthly meetings with the Care Group leads have been established and challenge will be provided where required. Monitoring of the sustainability of improvements will be monitored through Care Group processes and through the Trust-wide clinical governance group on a six-monthly basis. This will be reported to EMT and QSC. The embedded by dates will allow for monitoring of how the actions have impacted and supported change across each Care Group and across the Trust.

9. Care Group action plan details and updates

The progress of actions is measured using a blue, red, amber, green (BRAG) key. These are defined as the following:

Blue	Action complete
Red	Action not started
Amber	In progress but off track from expected
Green	On track for completion by date

Forensic service MUST DO actions:

Regulation	How the regulation was not being met	Current position as at end February 2024	Person responsible	Action to be taken	Action Completion date	Evidence	Current status (BRAG)	Embedded by date
09 - person-	The Trust must ensure patients, who require them, have relevant	Quality improvement action plan describes details of steps to raise awareness	Clinical manager, lead matron and NQ&P directorate	Continue with QI action plan working towards	April 2024	The QI project has 19 actions. Two of these have been		TBC

centred care	behavioural support plans that enable staff to meet their needs and provide person centred care. Regulation 9 (3)(a)(b)	around PBS plans, training, monitoring and reduction in restraint, prone restraint and improvement in restrictive practices. This also incorporates must do actions for regulation 13 and 17. Goal to have PBS plans suitable for each service users individual need. Training provider identified and reflective practice and formulation sessions have been provided to staff.		April completion date		completed and signed off. A further three are ready for sign off.		
10 – dignity and respect	The Trust must ensure confidential spaces where service users share sensitive information are private and that conversations cannot be overheard by others. Regulation 10(1)(2)(a)	The noise reduction product has been delivered, however there is an issue for installation due to the anti-barricade mechanism	Senior estates manager Forensic care group managers	The facilities department are reviewing other approaches to add additional noise reducing products which will be compatible with the door and its associated mechanisms	January 2024	The noise reduction product has been fitted to door P35 and this has muffled the sound from the room. Staff have stood in the corridor and are no longer able to overhear conversations in the room. This product if approved will be added to the other confidential space on Priestley.		This is already in place on one area and once satisfied will be added to further area by end March 2024.
12 – safe care and treatment	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	Actions taken around ligature assessments and the visibility of ligature audits following the inspection in May 23, with the introduction of yellow folders. A local summary sheet has been developed to raise	Clinical lead for security Ward managers/governance team Clinical environment safety group	To monitor compliance with complete actions and to incorporate into assurance processes within the new quality oversight	March 2024	Ligature risk assessments are discussed in all new starter, student, bank, agency inductions. Existing staff have been made aware through security induction		March 2024 At the last induction staff were asked if they were aware of the ligature

	use. Regulation12(d)(e)	awareness of the highest risks, including photographs. All ligature audits are now up to date. Staff knowledge is being monitored through supervision. QI plan in place for assuring the checking of emergency equipment.		and support system (relacing QMVs)		and updates. The governance team have raised awareness in primary nursing days, meetings and away days. A prompt has been added to the risk handover sheet to remind staff and a prompt has been added to the bank and agency leaflet. A summary has been sent to Colin Hill to share with bank and agency staff and a dummy ligature folder has been sent to the RRPI team to raise awareness during their training sessions.		folder and all staff were already aware of the contents and location. The process will be repeated at the next induction which is in March 24.
13 – safeguarding service users from abuse and improper treatment	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	Trust has established a task and finish group for alternative injection sites to support reduction in prone restraint. Use of safety pods and exit strategies will also support reducing the use of prone restraint. Learning is being obtained from Mersey Care. A restraint reduction collaborative group is being	Care Group leadership team and NQ&P directorate	This is a Trust wide action. Extra safety pods have been ordered for the LD ward. The PBS quality improvement work continues. Bespoke seclusion exit training has	Septembe r 2024 – with interim updates to submit progress against specific actions	From Jan 2024 prone restraint has been included in the incident data within the Forensic inpatient security committee for oversight and discussion. This meeting is held monthly.		Dec 24

	restraint. The Trust must also ensure prone restraint is only used as a last resort and is carried out safely. Regulation 13 (4)(b)	established and e-learning for the mental health use of force act training is also being established.		been carried out on our LD ward		The forensic governance team are represented within the task and finish groups.		
17 – good governance	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. Regulation 17(1)	Monthly performance clinics have commenced. The Care group management structure, supported by a framework of key meetings form the governance framework in the Forensic Care Group. Meeting structures include quality and performance reviews. Quality and performance are further supported in the care group by a governance team under the leadership of a Lead Matron. For other actions – see regulation 9	Senior managers NQ&P directorate	To further enhance this, the general manager has reviewed the structure of a management highlight report and will be hosting individual performance clinics with ward managers, which will give additional management oversight and improvement activity.	Septembe r 2024, with interim dates to submit progress against specific actions	From Jan 2024 prone restraint has been included in the incident data within the Forensic inpatient security committee for oversight and discussion. This meeting is held monthly.		Dec 24
20 – duty of candour	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. Regulation 20	All staff have been reminded of their responsibilities to ensure a verbal apology is followed up in writing and a copy will be uploaded to Datix. The Datix system issues a prompt to remind staff to send a written duty of candour letter.	Lead Matron	The Datix team are exploring if the prompt can be strengthened or re-worded to support this action. Continue to work as part of the T&F group.	December 2023 – complete	Monitoring through datix reporting		December 2024

		A task and finish group has been established with all care groups to look at duty of candour. Case studies provided by Care group to support Trust T&F group.		Care Group specific action is now complete. This will be monitored through the Care Group and through quality oversight process.				
18 – staffing	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. 18(2)a	Oliver McGowan training is at 87.16% and reported through the management highlight report. The new performance clinics will further strengthen oversight.	Senior management team NQ&P directorate	To continue to identify and monitor hot spot areas within a quality clinic	March 2024	The new performance clinics have commenced. The ward managers complete a highlight report in advance. This includes supervision, appraisals and mandatory training.		June 2024

Forensic service SHOULD DO actions:

The Forensic Care Group received seven should do actions, alongside the MUST DO actions. The Care Group are considering all seven should do actions as must do actions and are progressing these as detailed below.

- One action is complete
- Four actions are on track
- Two actions are being progressed with input from other areas of the Trust

The Should Do action	Current position as at end February 2024	Person responsible	Action to be taken	Completion date	Status (BRAG)	Considering as a MUST DO (Y/N)
The Trust should ensure that patients are able to engage in a range of activities across all wards	Activity boards have been refreshed across the care group. Activities are offered daily and recorded. Feedback is sought from service users via paper format. Cancelled activities are recorded with reason. The care group have developed a process for the monitoring of all activity (therapeutic intervention/ward led) activities which are being reported into the management team for oversight.	Care group leadership team	All wards are aiming to improve the provision of activities. Activities provision will also be monitored as part of the individual performance review with ward managers and senior managers.	July 2024		Yes
The Trust should ensure patients are supported to take section 17 leave, particularly when this involves patients attending medical appointments	Recording of cancellation of leave is an embedded practice. The additional metric relating to medical appointments is now being collected each month.	Care group leadership team	Teams have started to use the new template and data outputs will be reviewed to gauge the level of completed medical appointments and cancelled leave.	July 2024		Yes
The Trust should consider its options for improving the provision of food for patients	Building into current workstreams around catering provision	Care group leadership team and Catering Team	Require a view from Nick Phillips / Paul Ayres / Elaine Lane	October 2024		Yes
The Trust should ensure patients privacy and dignity is considered when staff accompany them on section 17 leave in relation to wearing of scrubs	A refreshed communication has been made to all staff to remind them of the importance of changing out of scrubs to undertake escorted leave outside of the hospital grounds. The service has identified a need for additional storage for staff for personal items including changes of clothing. (This was not an issue pre covid as staff wore their own clothes). Work is underway on the Trust uniform policy which will support this action.	Care group leadership team	The service is ordering lockers which are bigger to enable staff to store the additional items they may need during the course of the working day. An observation exercise has also been requested in order to assess how often this issue continues in order that management	In line with uniform policy review – October 2024		Yes

			colleagues can address this with individuals.			
The Trust should ensure that all patient's one-page profiles are easily accessible for all staff	The provision of one page profile information is not relevant for all service user groups and will be implemented locally as required, principally on Newhaven who developed this local approach to provide temporary workforce with additional helpful information around service user behaviour and social communication approaches.	Care group leadership team	All service users on Newhaven have a current one-page profile information sheet available. Link with Must Do (Reg 9)	April 2024		Yes
The Trust should ensure where appropriate carers have opportunities to be involved in their loved one's support	Timescale in line with Trust wide rollout of triangle of care	Care group leadership team	Continue to engage with triangle of care programme	September 2024		Yes
The Trust should ensure that restrictions are individually assessed and blanket restrictions are a proportionate response to risks posed	All ward blanket risk assessments have been updated and this has been added to the agenda for the security committee to retain oversight and a level of consistency across the care group. The service user involvement meeting agenda includes update and discussion around ward risks. Now displayed on wards.	Care group leadership team	Unrestricted access to courtyards remains an issue. Consider how the care group demonstrate this is not a blanket restriction	September 2024		Yes

Acute and PICU MUST DO actions:

Of the 16 must do actions all are in progress and on track. Detailed updated provided in the table below:

Regulation	How the regulation was not being met	Current position as at end February 2024	Person responsible	Action to be taken	Action completion date	Evidence	Status (BRAG)	Embedded by date
09 - Person centred care	9.1 The Trust must ensure that people have care plans in place to meet their needs and minimise any risks relating to	Matron quality checks incorporate presence and quality of care plans. This includes	Care group senior leadership team NQ&P directorate	Update to Tendable for clinical record keeping checks. Bite-sized training on care planning is being developed in the service and will be	In line with Care plan and risk assessment group	Record keeping audits – performance criteria, metrics including protected characteristics to be agreed. Compliance with NICE guidance through NICE oversight group.		31/03/2025

	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))	meeting the needs of people with protected characteristics. Part of clinical and management supervision, with actions taken where gaps are identified. Review of the re-introduction of care plan documentation training, overseen by the care planning and risk assessment group.		delivered by the matrons to individuals where gaps are identified.				
09 - Person centred care	9.2 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	Inpatient areas benchmarking of practice against triangle of care completed by 11th March, Self assessments to be reviewed at the triangle of care steering group on 12th March. Introduction of	Care Group senior leadership team and NQ&P directorate	Action plan to be developed following self-assessment against triangle of care standards, with support from the Carers Project Manager. Improvement actions will be recorded on individual ward quality priority plans and matrons will lead improvement actions with their teams.	In line with care plan and risk assessment group	Tenable to be updated with revised clinical record keeping audit. Dip samples with each ward to be completed. Carer feedback via compliments/complaints/FFT. Capturing where care plans have been offered to service users and carers (as appropriate) (to be developed). Absence/reduction of complaints.		31/03/2025

	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))	bite-sized sessions to remind staff about best practice when care planning, offering advocacy and copies of care plans. Discussed during clinical and management supervision. Tendable to be updated with a revised clinical record keeping audit and complete regular dip samples on each ward.		To further explore how we are able to capture that care plans are being offered to service users as changes to SystmOne mean that inpatient areas are not able to do this				
12 - Safe care and treatment	12.1 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	Trust is establishing a task and finish group for alternative injection sites to reduce the use of prone restraint. The RRPI team are introducing specialist safety pods and exit strategies to	Care Group senior team and NQ&P directorate	Care group is engaged in Trust wide actions	September 2024 with interim dates to submit progress against specific actions	Data on use of restrictive practice and ongoing monitoring through RRPI TAG. Evidence of culture shift where prone restraint is a notable exception (to be developed)		Aligned with Trust wide work

	best practice guidance (Regulation 12(2)(b))	support reducing the use of prone restraint. The RRPI team are gathering learning from Mersey Care and establishing a restraint reduction collaboration to implement quality improvement changes.						
12 - Safe care and treatment	12.2 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))	Reinforcement of requirement for appropriate monitoring checks following the administration of rapid tranquillisation. Monitoring checks will be carried out in line with national guidance and when patients are secluded, using the Tendable audit system.	Care Group senior team and NQ&P directorate	Work with care groups, NQP and pharmacy to update guidance and develop a small working group to outline governance around this practice. Care group engaged with Trust wide e-seclusion work.	September 2024 with interim dates to submit progress against specific actions	Matron weekly Tendable checks as a baseline and to monitor against moving forwards. Changes to paperwork. Monitoring checks initiated and completed.		31/12/2024

		A booklet is being co-designed across care groups (MH, LD, Forensic) overseen by NQP regarding monitoring checks after rapid tranquillisation.						
12 - Safe care and treatment	12.3 The Trust must ensure that staff receive regularly updated training on cardiopulmonary resuscitation and responding to violence and aggression (Regulation 12(2)(c))	The Care Group Service Manager is working with Ward Managers on ensuring staff receive mandatory training as a priority. Reducing Restrictive Physical Intervention Training is now above target at, and the service will continue to increase compliance further. Some challenges remain regarding CPR training which	Care Group senior team and NQ&P directorate	Meeting to be held with leads for CPR and RRPI training and Care Group to explore alternative solutions to ensure that training is available and completed as required.	September 2024 with interim dates to submit progress against specific actions	CPR and RRPI training figures. Care group performance dashboards for monitoring.		31/12/2024

		has been escalated, with actions in place to address						
15 - Premises and equipment	15.1 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 Care Groups, Care Closer to Home priority programme is in progress to improve patient flow, capacity and demand across the inpatient services, this includes a focus on the purpose of admissions and a focus on timely discharge. Admissions to non-bedroom areas continue to be reported via Datix to ensure senior leadership oversight and all decisions to admit to a non-bedroom area require approval from	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)	Update the local operating procedure to include regulation 15 requirements. Awaiting feedback from CQC inspector on further detail and clarity around this MUST DO action. Work remains ongoing to improve pathways and flow through inpatient services via the Care Closer to Home Priority Programme.	In line with Care Closer to Home priority programme	Monitoring through care closer to home programme, reporting through mental health oversight group.		In line with CCTH programme

		a senior manager						
15 - Premises and equipment	15.2 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))	Work at the Dales is now complete. Ward 18 bathroom improvements will be costed and explored. Clark Ward social island and flooring work to be completed next financial year due to capital money allocations.	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)	Care planning if required for service user from ward 18 to use the accessible bath on ward 19 if required. Ward 18 bathroom _ works have been costed and estates colleagues are progressing the work. Clark works are being submitted through capital bid process and this has been moved to 24/25 General manager to liaise with estates colleagues to establish timescales for completion	In line with Care Closer to Home priority programme	Clear dates for work completion to be determined and monitored until completion		N/A
15 - Premises and equipment	15.3 The Trust must ensure that the care environment on all wards supports patients' privacy and	New windows to be installed at The Dales with integrated blinds, with a phased rollout	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)	Work on the windows to commence W/C 22nd April with the programme duration estimated at 6 weeks.	June 2024	Completion of works		N/A

	dignity, particularly when wards are overlooked by areas accessed by patients of another gender or the general public (Regulation 15(1)(c))							
17 - Good governance	17.1 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 Medical Clinical Lead will ensure that colleagues are aware of their responsibilities to record fully in the clinical record their assessment of the service user's capacity and understanding in relation to consent to treatment processes. The MHA Office have established a process, which commenced on the 1st April 2023 where all capacity assessments	Care Group Senior Leadership Team, MHA Team, Directorate of Nursing, Quality and Professions	Monitoring in progress and care group lead will link in with legal services on this to ensure care group input into trust wide work.	April 2024	Data collected by MHA office around capacity assessment completion		301/03/25

		for those treated under either a T2 or T3 will be reviewed, and if not completed reminders will be sent to the approved clinician until a comprehensive assessment of capacity is completed and recorded in full in the patient's clinical record. The Medical Clinical Lead will oversee that this is implemented and establish a process for reviewing the quality of medical entries to ensure records are in line with the code of practice requirements						
17 - Good governance	17.2 The Trust must ensure that record keeping in relation to environmental	Action has been taken in regard to access to ligature audits.	Care Group Senior Leadership Team, MHA Team, Directorate of	Monitoring in progress. To be added to matron Tendable checks to check for the presence of the yellow folder	March 2024	Tendable reporting on both substantive and temporary (bank and agency) workforce		30/09/24

	risks is kept up to date and is available for ward staff to refer to when needed. (Regulation 17(2)(b))	Yellow folders in place on all wards. Ligature audit system reviewed and improved to ensure they are kept up to date and reviewed in a timely manner. Each folder contains photos and narrative to inform all staff working on the ward of the highest scoring ligature risks	Nursing, Quality and Professions	and staff awareness of risks				
17 - Good governance	17.3 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))	Update to e-seclusion went live 12/2/24 and positive feedback received from staff. Enhanced monitoring of seclusion episodes is in progress. Ward leadership teams are reviewing episodes of seclusion daily	Care Group Senior Leadership Team, MHA Team, Directorate of Nursing, Quality and Professions	Enhanced monitoring of seclusion episodes is in progress. To identify baseline and agree metrics for reporting. Gather and share learning on quality improvement work to reduce seclusion.	April 2024	Metrics and reporting to be determined		In line with Trust wide work on e-seclusion including automated audit reporting

		and any identified issues are addressed at the time. Continue the roll-out of the new e-seclusion module which will enhance the oversight and monitoring of seclusion episodes						
18 - Staffing	18.1 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))	Registered nurse vacancies have reduced significantly since May 2023. Work on preceptorship support for staff and introduction of the legacy nurses within the Care Group. Continue with care group retention and wellbeing plans. The service is now achieving an 85% fill rate for	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	Implementation of the actions from workforce workstream initiatives from the Inpatient Improvement Programme continue, for example preceptorship support framework. Introduction of recording of section 17 leave which is in place in Forensics, including identifying what is reasonable/defensible.	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	Monitoring of leave through new process for recording being implemented. Feedback from community meetings. Rates of bank and agency staff – trajectory and reduction over time. Staff and patient experience feedback. Quality and safety walkaround. Supervision data		31/03/2025

	18.2 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)) 18.3 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))	substantive registered staff following successful recruitment to substantive roles. The service has introduced a new temporary matron role to support internationally educated learners in the service, Professional Lead for Mental Health Nursing is focusing on support for newly registered nurses. The service is rolling the occupational health CRISP model to support staff well-being. This enhances supervision structures already in place in addition to increased						

		visibility from the senior leadership teams across the inpatient service						
18 - Staffing	18.4 The Trust must ensure that staff receive regular appraisals in line with the requirements of the trust's appraisal policy (Regulation 18(2)(a))	Appraisals have been completed. System changes are now complete which will allow information to be recorded on Workpal to reflect the accurate position on each ward. The Care Group 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	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	Ongoing monitoring of appraisal data by care group via inpatient quality and performance meeting.	March 2024	Ward level data through Care group dashboards		30/09/2024

		the WorkPAL appraisal system. The Care Group continue to review the appraisal data weekly to ensure that performance remains above the trust target.						
18 - Staffing	18.5 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 will rollout Oliver McGowan LD and Autism training. Over 2,000 staff now completed the e-learning of level 1, with plans to promote the webinar aspect of that training once it is available across the ICB.	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	Team managers are instructing staff to complete Part 1 of this training. Trust to roll out Part 2 of training and care group will oversee completion of this.	March 2024	Training data and staff awareness		To be aligned with Trust wide work

Acute and PICU SHOULD DO actions:

The Acute and PICU service received 12 SHOULD DO actions, alongside the MUST DO actions needed. The Care Group are considering a six of the 12 should do actions as must do actions and are progressing these as detailed below.

- Two actions are complete

- Ten actions are in progress and on track

The Should Do action	Current position as at January 2024	Person responsible	Action to be taken	Completion date	Status (BRAG)	Considering as must do action
The Trust should ensure that staff complete their training on door top alarms so these can be implemented across all acute and PICU wards as soon as possible	All substantive staff have completed training. Query over bank and agency staff. Training covered within local inductions.	Care group leadership team	To locate training log for substantive ward staff and to liaise with Safer Staffing Manager to understand figures for non-substantive bank and agency staff.	May 2024		Yes
The Trust should ensure that written information for agency workers at Kendray Hospital is reviewed and updated to include accurate information on the Trust's medicines management system	Updated at the time of inspection and assurance sent to CQC in data submission	Care group leadership team		Action complete		n/a
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	Initial conversations have taken place	Care group leadership team, Directorate of NQ&P, Pharmacy	Carmain and Kate having conversations moving forward. Needs someone from the service too. To pick up with Carmain. Need to assure compliance as a service/understand current compliance and put a system in place for monitoring	TBC		Yes
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	Aligns with must do action for regulation 18	Directorate of NQ&P	Working group to be established to develop SOP and	TBC		Yes

that action is taken to address any concerns identified from this data			benchmarking across inpatient services. Care group are engaged in this work			
The Trust should ensure that patients are able to access medical care as quickly as possible when this is needed, including out of hours	To monitor Datix entries and complaints to identify any gaps. Robust systems already in place.	Care group leadership team	Develop simple flowchart for escalation process - to liaise with medics	Ongoing process of monitoring incidents.		Yes
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	Processes already in place - need assurance that they are robust.	Care group leadership team, Pharmacy	Require pharmacy input/guidance to support. Challenge for staff to identify who is applicable. Discuss with wards to understand further - is it a training issue, one-off occurrence etc. A list of medication from pharmacy that require enhanced physical health monitoring would be useful Ongoing assurance check could be included in matron monthly quality visit (recorded via tendable)	Dec 2024		Yes
The Trust should ensure that the restrictions on patients' access to certain areas of the wards at Kendray Hospital are kept under review and	Reviewed regularly through blanket restrictions register.	Care group leadership team	Plans in place regarding garden	Completion will be determined		No

kept to the minimum level of restriction necessary to keep people safe from avoidable harm	The room in question had the lock removed the following day.		fence - asking for service user feedback.	by estates team securing a contract to complete the work.		
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	Aligns with and will be picked up as part of the must do action related to care planning	Care group leadership team	Baseline audit on care plans - self-harm, then look at improvements to be made. Follow up/regular checks via Tendable	May 2024		Yes as aligns with a must do action
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	Ongoing conversations	Catering Team	To raise with the catering department - how service user feedback is being used when planning menus.	TBC		No
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	Melton - reintroduced immediately	Care group leadership team		Action complete		n/a
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		Estates and Facilities	Narrative required from Estates - Nick Phillips. Contract with external agency	TBC		
The Trust should consider reviewing the seclusion policy to make this more accessible for staff to use in practice	Flowcharts in place across wards	Care group leadership team,	E-seclusion work as outlined in must do action	TBC		No – but aligns with must do

		Directorate of NQ&P				action around e-seclusion

Report prepared by:
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Liam Redican – Quality Governance Manager

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 9.8 – Assurance from Trust Board Committees

Collaborative Committee

Date	6 February 2024
Presented by	Mike Ford (Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	**Alert**
	• The Committee approved the commissioning intentions for West Yorkshire for 24/25; South Yorkshire to be covered at future meeting
	• We are still awaiting more detailed reporting on the Phase 2 collaboratives in line with that received for the Adult Secure
	• Monitoring of key SY independent provide continues with specific focus on incident reporting and impact on overall risk level of the collaborative and the Trust
	• Future discussions to be held regarding structure/TOR/membership of Collaborative Committee in the light of developments re Wakefield place collaborative and understanding re collaboratives where SWYFT is not a provider
	
	Advise
	• The Committee received a paper reviewing the progress of the South Yorkshire Adult Secure collaborative against the objectives set out in the original business case along the lines previously received for the West Yorkshire collaborative. A similar conclusion was reported that progress has been made which would not have been possible without collaboration
	• Contracting for 22/23 broadly in place by Dec 23 with similar target requested for 24/25 contracts
	
	Assure
	• The Committee continues to receive reporting across the following areas from both collaboratives
	  ○ Finance
	  ○ General performance (occupancy/discharges/delayed discharges/length of stay)
	  ○ Contracting
	  ○ Quality
	  ○ Risk

Approved Minutes of previous meeting for receiving	Minutes of 5 December 2023 presented to private board due to being commercial in confidence.

Equality, Involvement and Inclusion Committee

Date	13 March 2024
Presented by	Marie Burnham (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • **The Patient and Carer Race Equality Framework (PCREF)** paper setting out the approach to delivering on the assurance framework following the national Mental Health Act Review in 2018. This

framework will now be rolled out by the Trust through a working group and embedded in the 2024/2025 equality action plan.

- **Annual action plans for equality and involvement** have now been agreed by the committee for 2024-2025. The plans include a focus on delivering Trust approaches, national actions, and key programmes of work. The key areas of focus are:
  - Equality delivery System EDS2022
  - PCREF
  - EDI Improvement plan for workforce as part of our people plan.
  - NHS Health Inequalities Duty
  - Developing a new strategy for Equality, Involvement, Communication and Membership
  - Building on 'Connecting people' and our community asset approach to involving communities.
- Priority programmes – with equality and involvement as a golden thread.

Advise

- Care Group update: Adult inpatient Mental Health Service presented by Catherine Musegedi highlighted the positive progress on service EIAs which are all up to date and how the service is involving people. Highlights included usage of reports and dashboards on Health Inequalities, leading to positive work on the admission rates of people from BAME backgrounds into Older People Service wards. The formal consultation on the change to older people services to create a dementia specific ward and dedicated functional wards. Tackling racial abuse using the microaggression guide and working with the police. Improvements to physical health checks for people using services and a specific focus on armed forces and veterans. Access for people with a disability, in our estates and parking and a focus on improving access to faith services.
- EDS2022: The committee received the final grading report for all domains:
  Doman 1: commissioned or provided services.
  Domain 2: Workforce health and well-being
  Domain 3: Inclusive leadership.
  All the domains have gone through an evaluation process, with evidence collated and presented at a peer review and stakeholder event. The evidence for each of the service themes perinatal mental health, Accessible Information Standard (AIS) and Children and Adolescent Mental Health Service (CAMHS). was presented by service leads. The overall Trust grading for all the evidence combined was **'Achieving'**. The final Trust grading was be agreed by a small group of EIIC members. The information on all domains has now been submitted to NHS England and published on our website.
- **A** focus on the LGBT staff network achievements and progress was presented by new chair - Michaela Kenworthy. The vice chair is now Chris Kelly. The achievements include a new intranet site which has been launched along with a new training offer from the network. This training provides a real push on lived experience and includes topics such as LGBTQ+ history, Trans-awareness, and use of pronouns. The network continues to deliver a space which is safe and allows for supportive and confidential conversations. Monthly drop in for network members, monthly steering group meeting and full network meeting are going ahead as planned. Finally, a change of name from LGBT+ to LGBTQ+ is now official, the network has 154 members. For all staff networks the following new ways of working will improve each

	network, this was updated as part of the new approach to supporting networks and includes: o Protected time policy (draft) for steering group members o Protected budget for each staff network group o Executive sponsor per network • Development budget for steering group members **Assure** • **All of you: Race Forward** annual update highlighted our significant progress on this agenda. Race Forward was set up as an implementation group to provide focused strategic action, to facilitate a collaborative approach to respond to harrassment, abuse and racism from service users towards our frontline colleagues. The work programme for this year 2023-2024 was to develop a platform to promote the work which is now 'All of You' and consists of a dedicated intranet page for Race Forward. In addition, there were four strands of work, these are: o To develop a micro-aggression guide, which is now published. o To create an animation for people who use services and work in our Trust, which is due to be completed in April 2024 o To develop an escalation protocol, where work will finalise a guide for May 2024 o To roll out restorative practice and bystander training which is in progress. • The **EII exception and highlight report provides assurance** that the Trust has delivered on over 192 Trust wide actions for both equality and involvement. The committee were also assured that the Trust had delivered the required metrics for equality data and equality impact assessments as well as maintaining compliance for equality and diversity mandatory training. • **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. • **The Trust wide insight report for quarter 3 and 4** was received by the committee. The report highlights the emerging themes from involvement approaches, Healthwatch insight and governors. • **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 **Sexual Orientation and shows an overall improvement** in staff representing LGBT+, this is above the population figures in the census data, making us reflective of our communities (current baseline for the Trust is 4.2%) our population data where the average across all 4 places is just under 3%. • A **case study focusing on the importance of religion and faith highlighted the improvements.** The case study reported on the development of a faith calendar, more faith celebrations, reaching out to faith groups and improving our estates with WUDHU facility, introduction of Friday prayers and fasting guidance. • **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. • **Committee annual report and annual review of effectiveness** as well as the Terms of Reference and work plan were also discussed

	and provided assurance that the committee had delivered against the terms of reference for the previous year 2023-2024.
Approved Minutes of previous meeting for receiving	13 December 2023

Mental Health Act Committee

Date	5 March 2024
Presented by	Kate Quail (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Continued issue around overrepresented groups in terms of detained populations - remains an area of focus for the Mental Health Act Committee (MHAC) and Mental Health Care Group, and is outlined in the equality action plan. How we address inequalities remains a priority. • The length in detentions is a challenge with pathways into community for people who are admitted to hospital and lengthening detentions arising from difficulties with specialised placements or appropriate accommodation in the community. • 136 suites continue to be a challenging area of service. The usage over the last quarter has fallen slightly, though from a baseline of consolidated increase. Still seeing the same number of people detained, admitted or informally admitted following 136. I.e. a very low number of formal admissions for those people who are brought to the suite. Raised questions about people's experience and is it 'least restrictive' and how the rest of the system is working. We will continue to challenge e.g. through our Multi Agency Partnership Group, whether people who are brought in actually need to be in the suite, and are the systems, practice and partnership working in place to ensure that all alternatives are considered. Assurance that a standard operating procedure and protocol ensures all arrangements are in place for medical input and all aspects of care. MHA office support practitioners about how they can ensure that person is cared for safely and legally. • The rate of internal transfers has increased quite significantly this month, though no clear explanation. Further evaluation work will take place to understand if the trend continues for the next quarter. **Advise:** **Legal briefing – CTO Remote Renewals: Judgement 14 December** • The Devon Judgement (January 2021) declared that detentions and associated renewals founded on remote examinations of the patient (e.g. due to Covid restrictions) were deemed unsafe and must be based on face to face examination. Following the judgement, a review of SWYPFT patient's sections confirmed that every section was safe. This was held on the MHAC Risk Register for the relevant time period. • Following a recent legal challenge, the court determined that the same standard (i.e. face to face) applied for the setting up or extension of a Community Treatment Order (CTO). • Assurance that the MHA Office had already identified in 2021 that remote CTOs were also potentially challengeable and therefore included these in their review and scrutiny process at that time. They were found to be safe and remain part of the ongoing scrutiny of records.

	Assurance: • Learning Disability Service - seclusion and long-term segregation - The team have demonstrated improvements and are retaining good governance oversight on Horizon. Compliance overall is good, though some areas need further support which the management team are looking into. The Learning Disability quality governance team carry out regular audits for long term segregation and seclusion, the last one a few weeks ago identified actions for ward managers to address. • Annual governance - Reviewed MHAC self-assessment of effectiveness, considered and approved MHAC Annual Report, Annual MHAC Workplan and MHAC Terms of Reference, with minor amendments agreed and noted. • Consent to Treatment Review and Record of SOAD Outcome being given by the RC to the patient. Phase one QI complete - An increase of 55% of patients who have had a capacity assessment now recorded in the clinical record. Hotspots on 5 wards now addresses. Phase 2 underway – ie sharing the SOAD's report outcomes with the service user concerned. • S17 Leave Review - Over the last year the Forensic services have had a 54% increase of patients who are getting their escorted leave. Mental Health Care Group had not been reporting the cancellation of planned section 17 escorted leave in the same way as forensic services - this is now taking place. Quality work will also outline the impact of the cancellations, and will also be reported through Datix. The findings will be brought to next MHAC. • Performance Monitoring information Q4 - Overall, good assurance of compliance. • Mandatory Training compliance MHA and MCA/DoLS high compliance rates. Compliance (standard 80%) Trust-wide for clinical staff 91. 74%; non clinical 100%. Assurance gained that any service /team 'hotspots' of non-compliance are identified and addressed promptly. • Code of Practice Oversight Group – assurance on ongoing activity relating to the implementation of the current Code of Practice and the development and preparatory work related to pending legislation. • Care Quality Commission MHA visits – Visit activity has greatly increased, leading to a large number of actions. Assurance that all actions and recurring themes have an action plan or quality improvement workstream taking place. All actions are managed through the nursing quality and professions directorate or though the MHA team. Care Group. Some themes and required actions are recurring - Quality Leads to be invited in turn to attend a future meeting, for MHAC to gain further assurance around completion and embedding of actions. • Second Opinion Appointed Doctors (SOAD) are appointed by the CQC. The waiting list has reduced though we have six patients still waiting from last year. Assurance that these will be allocated soon and that the very late case had now been allocated.
Approved Minutes of previous meeting for receiving	17 November 2023

Quality and Safety Committee

Date	13 February 2024 and 12 March 2024
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert** • Risk 1624: The committee had previously discussed the possibility of closing this risk on the Operational Risk Register and managing the risk operationally. The COO advised that the scoring around this risk will not be changed and will remain. This is the risk related to being unable to access referral to a 136 suite due to service demands. • Paediatric audiology diagnosis performance remains a concern. The committee was advised that wait times are around 5 weeks with a maximum of 12 weeks. Although the performance aspect will be discussed and reported further at Finance, Investment and Performance Committee there is the quality aspect in terms of those waiting and the outcome of the national audit leading to ongoing improvement work around processes and protocols. • Issues around LD waits (deep dive ADHD report for Board will not have the details as discussed above as an emerging risk) • Recovery college funding for Calderdale: the committee were made aware that Calderdale has indicated an intention to reduce funding. • The committee was advised that mental health performance is achieved consistently in all areas although there is a recognition that small numbers of people are having an extended wait for a bed which has an impact on acute providers. • The committee was made aware of ongoing concerns around the experience of our international nurses and the actions of the trio to meet with individuals, review the action plan and form a steering group to ensure the voices of internationally educated colleagues are listened to as part of the improvement work. It was noted that this is a focus in the People and Remuneration Committee. **Advise** • The committee was advised that the Independent Review of Greater Manchester Mental Health NHS Foundation Trust (including Edenfield) have been published in January and requested the headlines and key issues to be shared at Trust Board ahead of a more detailed report back to committee in April. • As part of the updated received on Patient Safety training, the board is reminded of the need for compliance with e-learning (Level 1b) • The committee was advised that the trust has been reaccredited 'Veteran Aware' by the national steering group for the NHS Veteran Covenant Healthcare Alliance. **Assure** • The Patient Safety Strategy update was noted and received by the committee. This includes an update on the adoption of Patient Safety Incident Response Framework (PSIRF). • The committee was assured by the ongoing performance on out of area beds. • The committee received the annual effectiveness report and annual governance statement, approved the updated Terms of Reference and the Workplan for 24/25. • The committee received the Annual Nurse revalidation report and recommended approval at trust board.

	• The committee were assured that there was ongoing work around a previous concern raised with the CQC regarding racism in forensics in October 2023 and the ongoing review with an independent expert. • The committee received the Infection Prevention Control (IPC) Business Assurance Framework (BAF) and recommended for approval at trust board. • The committee noted the work of the Reducing Restrictive Physical Interventions (RRPI) with the improving trends around restraints and alternative sites for medication. This provided assurance that the ongoing focus is leading to improvements and furthermore, noted the open culture of learning with staff feeling able to share their need for more training to gain greater confidence, which is being acted upon.
Approved Minutes of previous meetings for receiving	9 January 2024 and 13 February 2024

People and Remuneration Committee

Date	12 March 2024
Presented by	Mandy Rayner (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • The committee was made aware of a number of international nurses that have yet to be placed. Some were still working through their "ready for work" plans however some were ready but have yet to be assigned a role. • There was an in-depth discussion on workforce planning and how this is currently managed. It was concluded that an experience workforce planner should be recruited/put in place as a matter of urgency. • There are still ongoing concerns on e-rostering for junior Doctors it still doesn't seem fit for purpose. **Advise** • The committee now receive a written report on Disciplinary and ET cases this has initiated a more thorough discussion about decisions made around outcomes/settlement. The committee welcomed this. • Uptake of the flu vaccine concluded at 54% of frontline staff. • CPO reported that EMT have supported protected time for network chairs and a budget to support activities. • The committee received a student placement update. Concerns were raised around some of the placement numbers that are not yet back to pre-covid levels. Further information was requested on conversion rates as a return on our investment as well as the trusts capacity to support the students. • The committee received the first draft of the workforce plan. The trust is awaiting planning guidance from NHSE. There is an assumption that the agency target will be reduced by 23%. SWYPFT also appears to be an outlier for workforce growth against other organisations across the ICB. • An update on the 90day plan was given. It was acknowledged that some actions were ongoing and will exceed 90 days. Good progress is being made. **Assure** • The agency and scrutiny group reported continued progress on agency spend and will deliver target of £8.7m • Appraisal compliance is now over 80% working now towards 90/95%

	• Committee members only received the annual report, committee self-assessment, 24/25 workplan and updates to the terms of reference. All were approved with an agreement that the workforce plan should be reviewed and reflect a more timely review of the staff Survey results in 2025.
Approved Minutes of previous meeting for receiving	16 January 2024

Finance, Investment and Performance Committee

Date	18 March 2024
Presented by	David Webster (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • Full & final planning guidance has still not been issued • 24/25 plan assumed no workforce growth until a workforce plan is developed • Paediatric audiology wait times worsen vs national trend **Advise** • Regarding IPR, request that the Board set aside time in a future agenda to align on level of detail & needs in IPR • Patient Level Information & Costing System has not been developed, although remains manual, it is now being used in part to assess opportunities. An offer is being made to the Board for a session on this. • Updated year end position of an expected £0.5m surplus has been shared with the ICB (+£0.5m from last position) • In terms of financial risk, this has not moved still (remains 3x3 – High), but will be reviewed against full planning guidance, and kept under discussion • MHIS is primarily behind in Kirklees, where there were delays in agreeing activity **Assure** • Deficit in month greater than planned, but still on track for a small surplus as shared with the ICB • Agency and Out Of Area spend now in line with target thanks to a huge effort on this. Thanks should be given to the team for the hard work and focus on improving this which gives both a financial and service user benefit.
Approved Minutes of previous meeting for receiving	22 January 2024

Members' Council

Date	13 March 2024
Presented by	Marie Burnham (Chair (Chair of Committee)
Key items to raise at Trust Board	• Members' Council approved the re-appointment of one Non-Executive Director • Members' Council received an update on the Chair and Non-Executive Director remuneration • Members' Council received the Freedom To Speak Up annual survey results and planning tool • Members' Council received the process for the Chair's appraisal • Members' Council received an update on the Members' Council election - 2024

	• Members' Council received a presentation on the Members' Council Biennial evaluation Members' Council received an update on the Trust strategy refresh
Approved Minutes of previous meeting for receiving	Minutes of 17 November 2023.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Minutes of the Members' Council meeting
17 November 2023, 10.00 – 12.12

Hybrid meeting
Large Conference Room, Learning and Development Centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP and Microsoft Teams

Present:	**Marie Burnham (MBu)**	**Chair**
	Cllr Sue Bellamy (SB)	Appointed – Barnsley Council
	Keith Stuart-Clarke (KSC)	Public – Barnsley
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Emma Hall (EH)	Appointed – Mid Yorkshire NHS Teaching Hospital
	Sara Javid (SJ)	Public - Kirklees
	Rosie King (RK)	Public – Wakefield
	John Laville (JLa)	Public – Kirklees (Lead Governor)
	John Lycett (JLy)	Public – Barnsley
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Helen Morgan (HM)	Staff – Allied Health Professionals
	Bob Morse (BM)	Public – Kirklees
	Reini Schühle (RS)	Public – Wakefield
	Phil Shire (PS)	Public – Calderdale
	Susan Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
In attendance:	Mark Brooks (MBr)	Chief Executive
	Mike Ford (MF)	Non-executive director
	Carol Harris (CH)	Chief Operating Officer
	Dawn Lawson (DL)	Executive director of strategy and change
	Mandy Rayner (MR)	Deputy Chair and Senior Independent Director
	Adrian Snarr (ASn)	Executive Director of finance, estates and resources
	Darryl Thompson (DT)	Chief Nurse and Director of quality and professions
	Natalie McMillan (NMc)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Julie Williams	Deputy director of corporate governance, performance and risk
	Andrew Lister (AL)	Company Secretary/ Head of Corporate Governance
	Asma Sacha (AS)	Corporate Governance Manager (author)
Apologies: Members' Council	Jacob Agoro (JA)	Staff – Nursing
	Tanisha Bramwell (TB)	Public – Kirklees
	Cllr Howard Blagbrough (HB)	Appointed – Calderdale Council
	Bob Clayden (BC)	Public - Wakefield
	Daz Dooler (DD)	Public – Wakefield
	Rumaysah Farooq (RF)	Public – Kirklees

	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Leonie Gleadall (LG)	Staff – non clinical support
	Daniel Goff (DG)	Public – Barnsley
	Claire Den Burger-Green (CDBG)	Public – Kirklees (Deputy Lead Governor)
	Laura Habib (LH)	Staff – Nursing support
	Adam Jhugroo (AJh)	Public – Calderdale
	Anne Magee	Appointed – staff side
	Christopher Matejak (CM)	Public – Calderdale
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Fatima Shahzad (FS)	Public – Rest of Yorkshire and Humber
	Nik Vlissides (NV)	Staff – psychological support
Apologies:	Dr Rachel Lee (RL)	Associate Non-Executive Director
Attendees		
	Greg Moores (GM)	Chief People Officer
	Sean Rayner (SR)	Director of provider development
	Erfana Mahmood (EM)	Non-Executive Director
	Lindsay Jensen (LJ)	Acting Chief People Officer
	Professor Subha Thiyagesh	Chief Medical Officer
	Kate Quail (KQ)	Non-Executive Director

MC/23/47 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) formally welcomed everyone to the meeting, apologies were noted as above. The meeting was quorate and could proceed.

MBu reported that the meeting is being recorded to support minute taking. The recording will be deleted once the minutes have been approved (it was noted that attendees of the meeting should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place). Attendees who were joining virtually were kindly requested to remain on mute, unless speaking.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC/23/48 Declarations of interest (agenda item 2)

No further updates. There are some declarations that are outstanding which will be updated in due course.

It was RESOLVED to NOTE the individual declarations from governors.

MC/23/49 Minutes of the meeting dated 16 August 2023 and the Extraordinary Members' Council meeting dated 11 September 2023 (agenda item 3)

Approved and no amendments noted.

Extraordinary Members' Council minutes dated 11 September 2023

Page 3, Mike Ford (MF) highlighted a typing error at the bottom of page 3, where Bob Morse (BM) asked about misstatements, the minutes state “unconnected” and should say “uncorrected”.

Andy Lister (AL) informed the Members’ Council that Bob Clayden (BC) has sent his apologies for the meeting today, but he has sent some comments through by email which need to be addressed;

BC has informed that the first item on the action log, MC/23/31 (item 7.1) is not complete, and he has asked that this item remains open.

Action: Corporate governance team

It was RESOLVED to AGREE the minutes of the Members’ Council meeting held on 16 August 2023 and 11 September 2023 as a true and accurate record with the noted amendments.

MC/23/50 Matters arising from the previous meeting held on 16 August 2023 and 11 September 2023 and action log (agenda item 4)

No further updates were received, and any actions shown as closed for 16 August 2023 and 11 September 2023 meeting were approved.

It was RESOLVED to NOTE the action log of the Members’ Council.

MC/23/51 Chair’s report and feedback from Trust Board (agenda item 5)

MBu provided highlights from her report which she asked to be taken as read. She explained the purpose of the report was to highlight the Chair’s and Non-Executive Director’s activity since the last meeting.

Phil Shire (PS) noted everyone was really busy but noted there seems to be a lack of service visits.

Mandy Rayner (MR) said she was aware Non-Executive Directors have attended and are booked on for Quality Monitoring Visits (QMVs), in addition to which there were on site visits to the recovery college.

MBu noted there were less QMVs in the summer months. Trust activities are now collated onto a spreadsheet where the Non-Executive Directors are invited to events and services throughout the Trust.

MBu explained apart from QMVs, there are also other visits such as Patient Led Assessments of the Care Environment (PLACE) and the Chairing of Committees and NEDs are only meant to work 2.5 – 3 days per month.

It was resolved to NOTE the Chairs’ report.

MC/23/52 Chief Executive’s Comments on the operating context (agenda item 6)

Mark Brooks (MB) provided the following highlights;

- There is continued industrial action, but this has been well managed. In October 2023, both Consultants and Junior doctors took part in industrial action at the same time. Although well managed, cover arrangements meant that there were some unintended consequences, such as the delay in the completion of mandatory training, appraisal completion and supervision.

- MBr said one of key Trust challenges is out of area (OOA) bed placements. There are currently 3 OOA beds being utilised, this has reduced from 25, and has made a big difference to service users and carers.
- The Lucy Letby case has concluded, and this has put an emphasis on speaking up and ensuring staff have the confidence to speak up. The Trust wants to foster a strong ethos where people feel they are comfortable and confident in speaking up and will be listened to. There are three new part-time freedom to speak up guardians, who are performing this role in addition to their normal work duties.
- MBr reported in respect of the Trusts financial position, there is a cost inflation and higher than expected non-funded pay awards. This is having an impact on the Trust and neighbouring acute Trusts, and discussions are taking place with our places through the Integrated Care Board.
- MBr welcomed Dawn Lawson (DL) to the Trust and reported she will be speaking later today in the joint Members' Council and Trust Board meeting.
- MBr noted the older people's inpatient transformation programme. The Trust will be going out to public consultation in the New Year. The Trust will be engaging with governors before this takes place.
- MBr reported Integrated Care Systems (ICSs) have had to cut their costs by 30% and there will be an impact on staff being at risk.
- MBr reported the Chief People Officer is currently on long term sick leave and the role is being covered through management arrangements.
- MBr noted the Trust is involved in winter planning arrangements and is working with partners. MBr reported the Trust is encouraging all staff to have annual flu and the Covid-19 booster vaccinations. 44% of staff have received the flu vaccination currently.
- MBr reported the staff survey is live and so far, 48% of staff have completed the survey.

It was resolved to RECEIVE the update from the Chief Executive on the operating context.

Members' Council business items

MC/23/53 Governor feedback and appointment to Members' Council groups (to be taken as read and submit questions in advance) (agenda item 7.1)

John Laville (JLa) explained an email was sent to all governors inviting self-nominations for the vacancies in the Members' Council Co-ordination (MCCG) group, Members' Council Quality Group (MCQG), Nominations Committee (NC) and the Equality, Involvement and Inclusion Committee (EIIC).

One uncontested nomination was received from Bob Morse (BM) to become a member of the Members' Council Quality Group (MCQG) and one uncontested nomination was received from Sara Javid (SJ) to become a member of the Equality, Involvement and Inclusion Committee (EIIC). The nominations were discussed at the last Members' Council Co-ordination Group on the 4 October 2023, and the MCCG recommends to the Members' Council that BM becomes a member of the MCQG and Sara Javid becomes a member of the EIIC. Members' Council approved the recommendation.

JLa thanked BM and SJ.

JLa said there remain two vacancies on the Members' Council Co-ordination Group.

JLa said he has received feedback from governors, and he spoke to governors about PLACE visits to Kendray, Priestley Unit and the Dales Unit.

JLa said there have been staff challenges, he explained Ian Grace (IG) reported one of our student nurses wants to work for the Trust, which was positive.

JLa said he has been notified by a staff governor that there is a shortage of personal alarms in the Priestley Unit and staff must share alarms.

MBu and MBr said this was a serious matter and there are a large number of alarms available. Ian Grace (IG) explained there are agency staff on the ward, and it looks like the system of leaving alarms after work was not being effective. IG said he has personally had issues with access to an alarm recently.

Action: Carol Harris

JLa said the governor publicity video has been sent to governors and he will review this.

JLa said he was speaking to constituents in Kirklees and there was good feedback in terms of a mother and her daughters experience of counselling at Northorpe Hall in Kirklees. Jla has spoken to a carer in Kirklees whose husband has been on Ward 19 for 16 weeks., She raised that there is nothing for her husband to do on the male side of the ward JLa said he has seen this in the patient experience report as well. There is also a lack of visiting facilities at the Priestley Unit which is a concern.

JLa reported at the Dales Unit, visitors can go into bedrooms, and asked why this was not possible at the Priestley Unit. JLa said many years ago he raised the issue with the then Chief Executive, Rob Webster, in relation to ensuite facilities at the Dales and Priestley Unit.

Carol Harris (CH) thanked JLa for raising this and she apologised that people have not had a good experience. She said there are individual circumstances where carers can go into patient bedrooms but this was an exception rather than a rule. CH explained bedrooms are private spaces and this is not encouraged but was determined by individual circumstances. CH will speak to the leadership team to review the improvements to the experience of visitors. CH said the Trust is challenged in relation to space at the Dales and the Priestley Unit.

Action: Carol Harris

IG said his office was still a temporary office space since the Covid-19 pandemic and explained there have been some good experiences of people visiting

IG explained there are rooms available, but these are not suitable for our visitors.

MBu suggested this was reviewed within the care groups.

MBr said there are challenges as the Trust doesn't own the Priestley Unit or the Dales and it is difficult to determine how much can be achieved in terms of time and current financial constraints, but the Trust may be able to review a creative use of space.

JLa acknowledged what CH had said about the rules at the Dales but on visiting during a PLACE visit, staff said visitors could go into bedrooms and no other explanation was provided. Carol Harris (CH) said she will clarify the visiting space for Kirklees and the Dales.

Action: Carol Harris

Sara Javid (SJ) explained that she has a gentle request for staff in Single Point of Access (SPA) to be empathetic to families and carers who call them to speak to them about patients.

SJ said they need to listen to families and explained this was feedback from a conversation she had with a member of staff from SPA. SJ had explained she was aware of consent to

share information, but this was not the conversation she was trying to have, and felt she was not being heard.

SJ explained this was a personal experience and a one off so it not reflective on the whole service, but she wouldn't want anyone else to have a similar experience. She asked for staff to be reminded to be patient, and not interrupt and continue reminding the carer in relation to consent. SJ said she has had a good experience with SPA in the past.

Darryl Thompson (DT) thanked SJ for her feedback and apologised for her recent experience, he said the Trust has become a member of an organisation called Triangle of Care and that is part of the broader ambition to help carers and family members feel part of the care team, he said he will feed this back to the teams. He explained staff are also self-assessing against those Triangle of Care expectations and he asked for that to be taken in the SPA team and even when staff can't share information, they can always listen to a family member.

Action: Darryl Thompson

It was resolved to RECEIVE the governor feedback and APPROVE the appointment of governors to Members' Council groups.

MC/23/54 Assurance from Members' Council groups and Nominations Committee including (to be taken as read and submit questions in advance) (agenda item 7.2)

Members' Council present confirmed they had read the paper, and they had no questions.

Andy Lister (AL) explained he had received a question from Bob Clayden (BC) in relation to the Members' Council Quality Group minutes of 1 August 2023 under heading 8. Care Quality Commission (CQC) Inspections – initial feedback. BC asked about the concerns raised in relation to medicine fridge temperatures and recalled this has been documented in a previous report and asked why the Trust has not resolved this issue.

Darryl Thompson (DT) said he doesn't know what the previous identification was and provided assurance that prior to CQC inspection the leadership team worked alongside pharmacy colleagues to resolve this issue and this piece of work continues.

DT reported there is an improvement focused approach.

Ian Grace (IG) explained from a pharmaceutical perspective, the technician team have led a piece of work on room temperature and fridges and one of the issues they need to look at again in terms of nurses using the thermometer correctly and resetting them correctly. IG explained the technicians check this when they are on the ward, and this is standard practice.

It was resolved to RECEIVE the assurance from Members' Council groups and Nominations Committee

MC/23/55 Constitution review (agenda item 7.3)

Andy Lister (AL) reported the Trust undertook a detailed review of the Trust's constitution in readiness for compliance with the revised Code of Governance for NHS provider Trusts, which came into effect on 1 April 2023. The annual review has also been completed in October 2023. Following this the Trust consulted with the Members' Council with a proposal to alter the staff constituency to include all Trust social workers in the Members' Council elections from January 2024. This motion was supported by Trust Board on 31 October 2024 and is recommended to Members' Council for approval.

DT explained there are 111 social workers in the organisation, and they are not in an integrated team, and it would open up access to those colleagues.

It was resolved to APPROVE the change of the staff governor constituency from "social workers in integrated teams" to "social workers."

MC/23/56 Patient Experience annual report (agenda item 7.4)

Darryl Thompson (DT) noted that the report was reviewed in detail in the Quality and Safety Committee, and it was approved by Trust Board on 26 September 2023.

DT provided the following key highlights;

- During 2022/23 the customer services team received and processed 758 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 2.5% decrease compared to the previous year (2021/22) when 777 items of feedback were received.
- There is no longer a backlog of complaints awaiting an allocation to an investigator.
- The friends and family test has seen an increase in responses over the previous 12 months and an increase in the number of people who rate our services as 'good' or 'very good'.
- Performance in response to closure of a complaint within 6 months of receipt has deteriorated over 2022/23, with a range of factors impacting on this situation. The improvement approach currently underway to address this is referred to in the report.
- A backlog of complaints awaiting allocation to a complaints case handler has reduced from a peak of 61 in autumn 2022, to 40 at the end of 2022/23, with further and sustained reduction since.
- A full review of this annual report is planned for February 2024 to ensure that the experience of patients and carers is reflected in it for 2023/24. This will be held and developed through the Patient Experience Group and will include:
  Customer Services feedback
  Insight data and information
  Friends and Family test and other patient experience surveys
  A proposal for the new report will be shared with Quality and Safety Committee in March 2024.

Natalie McMillan (NMc) said the Trust is working on an improvement programme and strengthening this.

Andy Lister (AL) said he has received a comment from governor, Bob Clayden (BC) who, referring to Section 3.4, the bottom of bullet points 1 and 2, reports this isn't clear to him and whether this was due to editing. DT agreed to review this.

Action: Darryl Thompson.

Emma Hall (EH) commented on the triangulation between complaints and feedback from friends and family. EH asked whether this can be presented by service area which shows all the feedback and the triangulation. DT said this was really positive feedback which he will take to the improvement programme.

Action: Darryl Thompson

Phil Shire (PS) said the Members' Council Quality Group have reviewed this report in the last meeting. He explained that what EH described is already at the back of the report under

appendices under “services”. He said this was useful and summarised by service. PS said the executive summary helps and it was really well written.

JLa thanked DT for the executive summary, and he also read the report in full. He said it is a national metric for complaints to be responded to within 6 months, but 6 months seems a long time. He said the graphs only go up to 2022/23.

DT explained it was a year report.

JLa said he can see an improvement, and this is good to see.

It was resolved to RECEIVE the annual report on Patient Experience (including complaints).

MC/23/57 Incident Management annual report (agenda item 7.5)

Darryl Thompson (DT) reported the Quality and Safety Committee (QSC)and Trust Board have received the quarterly and annual Incident Management reports. The committee recommended this report to Trust Board for approval on 13 June 2023. Some minor amendments were made to the report after the committee in response to further review prior to submission to Board. It was approved at Trust Board on 27 June 2023.

DT said the report has also been presented to the Members’ Council Quality Group meeting. DT highlighted the following points;

- The Trust continues to have a robust incident management process, maintained through a high level of scrutiny and governance.
- The Trust continues to focus on improving the quality of incident recording, and to strengthen our data quality processes for incident data to ensure accuracy.
- Datix has been updated to capture abuse/hate related to any protected characteristic and this is reported into Clinical Risk Panel each week.
- The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed. We publish our quarterly data on deaths on the internet page.
- The report includes achievements in the past year, and a summary of our work plan which aligns with the Quality Account areas for improvement and primarily focusses on work related to implementation of the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events.
- The Trust has appointed three patient safety partners who are people with lived experience, and they will work on the development plans.

JLa explained the executive summary doesn’t highlight some of the issues in the report and gave the following examples:

- self-harm incidents have increased by 50% but this is not on the summary.
- pressure ulcers have increased by 85% and this is not on the summary.
- JLa said 95% of incidents resulting in low or no harm, but that number doesn’t correlate with the 50% in self-harm.

Natalie McMillan (NMc) said QSC had a deep dive on pressure ulcers meeting and provided with assurance.

NMc said one of the reasons is there is a correlation between the social factors and quality of life.

DT reported the consultant nurse for tissue viability attended the Committee and is an expert in this field. and several deep dives have taken place.

DT said in relation to self-harm as being low or no harm, this means around 4000 incidents are being reported over the year, but there is still learning from these incidents and some self-harming incidents may be graded within the no or low harm criteria.

EH said pressure ulcer increase is also a concern for Mid Yorkshire Teaching NHS Trust, she asked whether there was more of an opportunity to share learning between organisations about the work that the Trust was doing.

DT agreed and explained the Trust pressure ulcer focus is primarily in Barnsley where there are community nurses so the Trust is part of a system wide approach and looking at a Barnsley place policy and approach to pressure ulcers.

DT said the Barnsley nursing team have also shared learning and there is resource which supports and provides advice to inpatient areas across the organisation, which is one of the reasons why there is an increase in reporting, as people are identifying issues much earlier.

Phil Shire (PS) said in the appendix there is a presentation to staff and asked what happens to the presentation.

DT reported it was a team's/face to face presentation and focused on colleagues working in those areas, but it is an open invitation to all colleagues. The sharing of the information is in the action plan, and this is monitored in the governance groups.

It was resolved to RECEIVE the annual report on incident management.

MBu Chair and all executive directors left the meeting.

MC/23/58 Review of Chair remuneration (subject to NHSE guidance and appraisal) (agenda item 7.6)

Julie Williams (JW) explained the Members' Council undertake regular reviews of the remuneration rates for the Chair to ensure they are fair and justifiable.

JW explained the structure on the summary sets out the pay range for Chair's based on the size of the organisation and the Trust is a medium sized organisation with an annual turnover of 201m – 400m.MBu was appointed in 2021 at a remuneration £47,100 per annum which is the second point on the Trust's incremental scale. Progression up the scale is determined by the Members Council based on her annual appraisal.

In 2022, the Chair was subject to an initial interim appraisal based on her performance between 1 December 2021 and 30 March 2022.

In 2023, the Chair was subject to a full appraisal based on her performance from 1 April 2022 – 31 March 2023, following which it was agreed the Nominations Committee would review the Chairs remuneration and a make a recommendation to the Members' Council.

She explained the Nominations Committee reviewed the Chair's remuneration on 11 October 2023 and is recommending an increase to the Chair's remuneration to £50,000, the top of the NHSE pay range, with effect from 1 December 2023.

It was resolved to APPROVE the increase in the Chairs remuneration to £50,000pa from 1 December 2023.

Marie Burnham, Darryl Thompson, Adrian Snarr, Carol Harris and Dawn Lawson re-joined members' council meeting.

MC/23/59 Members' Council elections – process (agenda item 7.7)

Andy Lister (AL) explained the election process will be managed by Civica on behalf of the Trust. This is to make sure that the elections are managed impartially and fairly so that the process is independent and transparent. Elections are held in accordance with the Model Election Rules which are included as an appendix within the Trust's Constitution. He explained due to the success of elections in 2023, there are limited seats for 2024.

He highlighted the following vacancies;

Public:
Wakefield: 2 seats
Kirklees: 1 seat

Staff:
Allied health professional: 1 seat
Psychological therapies: 1 seat
Social care staff working in integrated teams (will change to social workers if approved on 17 November 2023): 1 seat

AL explained MBu will write out to governors regarding the election process and vacancies and the nominations will open in January 2024, it will close in February 2024 and voting will open in early March 2024 and it will close in April 2024.

It was resolved to RECEIVE the update to the election process.

MC/23/60 Integrated Performance Report (IPR) (to be taken as read and submit questions in advance) (agenda item 7.8)

MBu explained the IPR was to be taken as read and governors were requested to submit questions in advance.

Phil Shire asked about the cash or reserves available to the Trust.

Adrian Snarr (AS) explained the surplus generates cash, but it is not easily accessible, there are restrictions, it can only be invested at West Yorkshire level. The Trust has the benefit of the interest and there is enough money to pay our creditors, but this is the same for all Foundation Trusts.

John Laville (JLa) asked whether the Trust benefits from interest, which is generated from the cash.

AS confirmed, this to be the case and in the current economic climate it is a healthy amount.

Mike Ford (MF) reported the use of these funds is also reviewed at the Audit Committee.

MF said he has received some questions from Bob Clayden (BC);

BC referred back to the Minutes of the last meeting in August 2023 in relation to the comments made by MBr on reporting injuries, diseases and dangerous occurrences (RIDDOR) and states that MBr commented that four people had fractures. BC commented that he believes RIDDOR requires reporting of any fracture except hand or foot, he asked about any discrepancies.

MF confirmed MBr's comments related to the incidents reported in June 2023.

In Q2 (July, Aug, Sept) there were 3 incidents in total and all three reported incidents relate to violence and aggression.

In all three reports, staff have been supported through their recuperation. There were no enquiries from either the Health and Safety Executive or Care Quality Commission related to any RIDDOR notifications during Q2.

MF said BC also noted that in p217 of the members' council papers, there is reference to smoking quit rates which will be available in November 2023. He asked if these figures were now available as we are in November 2023.

The performance team gave feedback that the report is data until the end of September 2023. The October report which is produced for the November 2023 Trust Board will contain the Q2 figures for this metrics.

MF stated BC commented on p224 in relation to community health services 2-hour response threshold of 70%. He asked whether the threshold was too low as the Trust has been on the 80% mark.

MF reported the performance team have provided feedback that the 70% threshold is a national threshold that the Trust is monitored against, whilst it is acknowledged the Trust is over performing and this may be something the Trust considers locally (a local stretch target) however, it is unlikely the Trust would include this in the Integrated Performance Report.

JLa asked about the capital spend as it is currently in red, but the forecast is £8.8m.

AS reported the red indicator shows that the Trust is not spending enough, and it is underspending which still makes this a red indicator as capital is "within a year" allocation, so the Trust has to spend the money within the year.

It was resolved to RECEIVE the Integrated Performance Report (IPR).

Chief Executive and Executive Directors left the meeting

MC/23/61 Focus on item – How can we make your contribution to Members' Council easier? (agenda item 12)

(Presentation)

John Laville (JLa) highlighted this item follows on from a discussion he has had with governors at the Calderdale virtual governors meeting where a few governors discussed different ways of working and to review how we can make it easier for everyone to contribute to the members' council.

JLa explained the first two slides are in relation to governor population by age (slide 1), there are two governors on the council who are under the age of 18 which is the first time which is positive and there are governors from 18 – 64 and the over 65. He explained people who work and who are attending school and college have got commitments.

JLa then explained how the governors are represented by ethnicity (slide 2). He explained we have a diverse members' council.

JLa informed the members' council that a survey was sent out to all governors and out of 31 governors, 19 governors responded, 10 public, 3 staff and 6 appointed governors. The majority of new governors answered the survey who have been there less than a year.

He highlighted that from 19 governors, 18 responded to state they were involved in community groups and governors provided some examples,

- School governance
- Working in an inpatient setting so have access to different forums to explore nursing staff concerns

JLa said it was noted that the majority of governors are communicating the views of the groups to the members' council.

JLa explained that governors have provided a list of community groups which they were involved in and some of these are;

- Grassroots in Batley
- St Georges community centre
- Positive Mental Health Network
- Nova Wakefield
- The S.M.A.S.H society
- CIC across the Wakefield district
- Foodbank
- Kirklees Mental Health Carers Forum
- Brookroyd patient reference group
- Spen primary care network patient reference group
- Kirklees patient care reference group
- Patient participation group
- Hive community
- Doctors and pharmacy forums
- Kirklees co-production board
- Kirklees disability network
- Kirklees mental health carers forum
- West Yorkshire neurodiversity partnership
- GP patient partnership group
- EDS Leeds support group

There were around 50% of governors who explained they share information from the community groups back to the Trust and some of the reasons were;

- Share relevant information
- Communicate both ways where relevant
- When necessary

When governors were asked if they wished to participate in community groups then over 50% said yes.

JLa said when he started with a governor, he had access to a list of community groups pre-Covid-19 pandemic. He said most governors were already participating in community groups but there were some governors who commented that they had other commitments and would struggle with time.

JLa said governors were asked what the key barriers for them to attending the members' council meetings. Key points;

- Caring responsibilities

- Diary clashes
- Working full time and having the capacity/ time to attend
- Time
- Length of meetings
- Disability
- Ill health
- Difficulty accessing online meetings
- Documentation being too small to see on paper and online
- Having more variety for meeting days, rather than set days of the week e.g. Fridays

Most governors said the members' council meetings were accessible and governors highlighted the following ways the meetings could be more accessible;

- To hold meetings in different venues, i.e. Kendray Hospital
- Views of governors translated into policy
- Hybrid meetings
- Newsletter to explain items in plain language
- Consulting governors prior to setting up the members' council meetings
- Summaries and easy read information
- Shorter meetings or meetings with more breaks
- A reduction in the amount of reading material
- Name badges for governors
- More time for governors' discussion
- A clearer outline of the items to be discussed

Governors were asked whether they found the buddy system useful, and a majority of governors said yes. A few comments were received;

- Not aware of the buddy system
- Not used it yet
- Somewhat aware of the system
- A governor had not heard from the person who was supporting them

JLa recommended to set up guidance for the buddy system.

Action: Corporate governance team

Governors were asked whether their training needs were being met by the Trust. More than 50% of governors responded yes and the following comments were received;

- I am not sure what I need.
- Need help to identify my training needs.
- Unsure
- Sometimes

Governors were asked what further training they required to fulfil their role as a governor and the following responses was received;

- Better access to Trust policies

- Governor roles training
- Visits to various departments within the Trust to inform us what the Trust is responsible for
- Not sure but something about the expansion of current skills
- Good training is available, it would be useful to have guideline for minimum training for governors to achieve the basic standard, then a second level of training and third level which is approved at each level
- Training regarding “whose who” in the Trust and their status within the Trust

Phil Shire (PS) it is a commitment of time to become a governor and he would have struggled if he worked full time. He said some governors would also find evening commitments as difficult as the day. He explained the Members’ Council Quality Group have decided to hold the meetings as hybrid and to visit a location/service and talk to staff. PS said this took place in October and he was the only governor sitting in the room and two governors joined virtually. He explained he visited Newton Lodge as part of the meeting with Darryl Thompson (DT). He said there must be compromises.

John Lycett (JLy) asked about the training needs of individual governors and whether his skills are meeting the needs of being a governor. MBu said this was a self-assessment and JLy agreed.

MBu asked about face-to-face meetings and whether there is a need to look at a “getting to know you session”.

Andrea McCourt (AMc) explained the Trust she works for also face the same issues and it is difficult in relation to arranging service visits and training. AMc said they have also done development sessions between the Board and governors, and this was helpful.

JLy explained he would like guidance and support with his training to enable him to provide a service as a governor.

Julie Williams (JW) said she is an appointed governor at Calderdale and Huddersfield NHS Foundation Trust, and she commented that the session with governors and staff was helpful, and it would be helpful to arrange a session like this in the New Year.

Reini S (RS) said she is a full-time carer and she can only join virtually.

MBu said it was important to remember that the online contribution is also valuable, hybrid meetings work.

AL reported the Trust would always facilitate hybrid meetings.

JL said there are other governors who cannot attend in person because of disabilities. JL explained there are many reasons people cannot attend whether they are at college or work, and it was about gathering their contribution to the meetings.

It was recommended and agreed by governors to set up a training needs analysis/ guidance.

Action: Corporate governance team

JLa said the outcome of today’s discussions will be formulated into an action plan to be monitored through the Members’ Council Co-ordination Group.

JLa highlighted the outcome will also be aligned to the Members’ Council Biennial evaluation survey.

Action: Corporate governance team

Keith Stuart-Clarke (KSC) explained he attends Andy's man club, and this has a big membership, and he has mentioned to members that he was a governor at this Trust.

He said he has also joined the Hoyland community choir, and he informs them of the Trust.

MBu said this his community engagement was very positive and she thanked him. MBu asked governors to communicate with the corporate governance team if they had any further ideas.

JLa thanked Andy Lister (AL) and Asma Sacha (AS) for creating the survey and pulling the information together.

KSC thanked MBu and said she was a fantastic Chair and has made some very positive changes, governors agreed with this comment.

MC/23/62 Annual work programme 2023/24 (agenda item 11)

No changes were noted, governors agreed with the work programme.

It was resolved to RECEIVE the work programme for 2023/24.

MC/23/63 Members' Council meetings (agenda item 12)

Friday 23 February 2024 (hybrid) timings to be agreed.

It was resolved to RECEIVE the date of the next Members' Council meeting.

MC/23/64 Any Other Business (agenda item 13)

None.

It was resolved to NOTE any other business.

Close of public meeting

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Mental Health Act Committee Meeting
Tuesday 7 November 2023
Microsoft Teams Meeting

Present:	Erfana Mahmood (EM) Kate Quail (KQ) Mandy Rayner (MR) Subha Thiyagesh (STh) Darryl Thompson (DT)	Non-Executive Director Non-Executive Director (Chair of the Committee) Non-Executive Director Chief Medical Officer (Lead Director) Chief Nurse / Director of Quality and Professions
Apologies:		
In attendance:	Chris Lennox (CL) Mark Brooks (MB) Carmain Gibson-Holmes (CGH) Julie Carr (JC) Yvonne French (YF) Carly Thimm (CT) Gordon Walker (GW) Sarah Burns (SB)	Director of Services Chief Executive Deputy Director of Nursing, Quality and Professions Clinical Legislation Manager Assistant Director of Legal Services Mental Health Act/MCA Manager Chair of the Hospital Manager Forum PA to Chief Medical Officer (Author)
Observing	John Laville (JL)	Lead Governor

MHAC/23/42 - Welcome, Introduction and Apologies (Agenda item 1)
The Chair, Kate Quail (KQ) welcomed everyone to the meeting.
No apologies were received.

KQ made the committee aware that this was GW's last meeting.

KQ informed the committee that Nancy Cartwright will be the new Chair of the Independent Hospital Managers' Forum from January 2024 and therefore attending MHAC meetings.

The meeting was deemed to be quorate.

KQ outlined the Microsoft Teams meeting protocols and etiquette. The meeting would be recorded for transcription purpose and would be deleted once minutes had been agreed.

MHAC/23/43 - Declarations of Interest (Agenda item 2)
The Committee noted that there were no further Declarations of Interest over and above those made in the annual return to Trust Board in October 2023 or subsequently.

MHAC/23/44 – Right Care, Right Person presentation (Agenda item 3)
KQ explained that this section is about using the Mental Health Act in practice, and helps to triangulate with data received and gives assurance that we are compliant with the Mental Health Act (MHA)

.

What does Right Care Right Person mean in relation to the MHA.

Carly Thimm explained that this is an operating model for police and partners to ensure that calls for services are responded to by the right people with the right skills and expertise.

The Trust's footprint covers South Yorkshire and West Yorkshire Police The forces are implementing the protocol differently.

South Yorkshire Police have set out three phases and the specific dates on which these will go live. West Yorkshire Police have a more relaxed approach to the RCRP rollout, engaging with the Trust from the start and have been making these changes since 2018.The Trust is well represented at the Justice and Mental Health Forum within West Yorkshire and attend a similar group in South Yorkshire

Both forces have been very clear that they will work alongside the Trust if someone is assessed as high risk, a risk to themselves or property. The police view these situations as being part of core police duties.
In all other circumstances the police would be reluctant to support the Trust.

The Trust are actively working with this new process but specifically noting the impact on the following areas:

- Reduction in the use of Section 136 MHA
- Request for Police assistance when a patient goes AWOL
- Increase in detention rates within inpatient settings

The RCRP response by the police to our Forensic services is acknowledged by the police as requiring an alternative response to that of a person from our Acute wards or for persons in the community.

Prior to RCRP, where a person was an inpatient but had either gone on leave or absconded, the Trust would have contacted the police to undertake a welfare check. In regard to RCRP, the police are no longer required to undertake the welfare check if there is no immediate threat to self or property. It will now be the responsibility of the Trust to locate and return the service user to the ward, subject to legal powers being available to the Trust.

The following action is being undertaken by the Trust: reviewing policy and guidance, development of an internal working group for RCRP, working with partners to ensure the safety of our patients, attending the tactical and strategic meetings with the police forces and their partners, attending the criminal justice and mental health forums.

MR enquired how we balance the need for support either for a patient or for staff, where a possible volatile reaction could happen. KQ also noted that an Approved Mental Health Professional may refuse to attend a MHA assessment if the police are not present. CT confirmed that these issues will arise, and this is why a robust escalation process needs to be in place and we need to identify that where there is a high risk, this evidence is very clearly and concisely shown to the police; the police have confirmed a presence in such situations. The police recognise that they themselves are not always the right people to respond as they may not have the best skill set to deal with a particular situation.

STh agreed that analysing data relating to RCRP is required to consider the impact, either in terms of response from the police or inadvertent harm caused to our service users and families as a result of missed opportunities - in particular for vulnerable populations such as people with learning disabilities and older patients. A review of the risk register needs to be undertaken to see if the RCRP agenda may have an impact on our current risks. DT confirmed that questions have been asked whether incidents have been influenced by RCRP, and queried how much difference in practice would this be, how it could be tracked and how this would be triangulated . DT advised the importance of learning from incidents and the impact on service user's experiences.

In regard to multi agency training in West Yorkshire. STh enquired whether this was being shared across South Yorkshire. CT confirmed that this area was not included as the initiative was with West Yorkshire Police. The Trust is linking with South Yorkshire, though not to the degree of doing training. CGH explained that the current work is being shared across both areas for information and then it is a choice whether this is adopted. It has been useful having links into both networks as we have been able to influence some of the decision making as we sit across two police forces. There is appetite from both police forces to be engaged with each other to understand where there are differences or similarities.

KQ stated that there is a role for the Mental Health Committee in collecting this data as one of the areas that the committee collates, monitors and reports on is section 136 assessments, as this helps give an indication of any changes that helps us triangulate what is occurring.

CT confirmed that anyone that is subject to MAPPA (Multi-agency public protection arrangements) will not be affected and DT commented that we are connecting with the people who are conditionally discharged who are not subject to MAPPA - this group of people perhaps, invite a different response.

KQ has requested an Alert, Advise Assure (AAA) report comes into the committee from the multi-agency group that the police sit on, which will now be ongoing, so that MHAC can understand the issues and risks of these RCRP changes and the impact on the trust and our partners. This AAA report will come to every MHAC meeting.

KQ stated that whenever new legislation arises, the Trust has a tried and tested approach for reviewing policies guidance and practice, including internal working groups, working with external partners, and developing multi agency training, and consultation with service users, carers and staff to inform the new agenda.

MHAC/23/45 - Minutes from previous Mental Health Act Committee meeting held 15th August 2023 (Agenda item 4)

KQ confirmed that MHAC/23/19b in relation to linking in with Susan Bains regarding accessing Charitable funds for toiletries and access to drop in services such as hairdressers had been closed. SB to amend minutes from 15th August accordingly.

No further amendments or corrections to the minutes from 15th August 2023. Minutes agreed as a true and accurate record by the Committee.

MHAC/23/46 - Matters arising from previous Mental Health Act Committee meeting held 15th August 2023 (Agenda item 5)

Agreed that there were no matters arising from the previous meeting, other than those on the Matters Arising action log.

MHAC/23/30 - Challenges and opportunities in Older People's Mental Health services (Act in Practice)
This action was completed and now closed.

MHAC/23/30a - Challenges and opportunities in Older People's Mental Health services (Act in Practice)
This action was completed and closed.

MHAC/23/32 – Matters arising from May 16 meeting: (Performance report 4).
CL explained that the experience of young people is built into the in-patient priority improvement programming and part of the quality improvement work overall. Specific work is being carried out around the well-being of all young people in those exceptional circumstances where they are admitted. The Trust has a Standard Operating Procedure in place which deals with the admission of young people to adult wards.

DT felt that the experience of the young person is at the heart of person-centred care planning and agreed to contact Suzie Barton, who is developing work around capturing young people's experience in the community to ensure their voices are heard within Child and Adolescent Mental Health Services (CAMHS), to see if there is some transferable learning.

Action: Darryl Thompson

KQ suggested also engaging with young people's families and carers about their experience, including what it was like for them to have staff attend their home and, in some cases take the young person away, what was their experience of our 136 suite or ward. KQ also noted the findings of national reports that young people report feeling very frightened on adult wards and that their experiences are often very difficult.

STh suggested having a bespoke approach for the young person and family experience, advising that data collection would require some ongoing work as there would not be enough numbers for it to be meaningful or less identifiable. This could be sent out as a Survey Monkey or using ChatPads.

EM felt that it was important to communicate with the young people/ children in a language that they might be familiar with and how Equality & Inclusion work is really important to address the child or young person's needs including if they have a protected characteristic. CL confirmed that the Trust has developed a person-centred plan for each young person who may be on an adult ward and would hope that the protected characteristics were well reflected and responded to. There is a very stringent plan of care around their individual needs in all cases.

KQ felt that it is important to engage with staff to understand whether they feel adequately trained and supported to support young people and their families.

MR commented that the Trust has the friends and family test and other tools already in place and need to ensure that these are used and not create another industry if the information is already there.

MHAC/23/34 & MHAC/23/34a - Feedback from Local Partners. Local Authorities and Acute Trusts

The actions were completed and closed.

MHAC/23/47 - Legal Briefings (Agenda item 6)
MHAC/23/47a - Liberty Protection Safeguards (Agenda item 6.1)

JC explained that since the briefing was written there has been a court appeal and the judgment has been upheld. This has had far-reaching consequences and this briefing outlines the impact on clinical decision making.

Over the last few weeks there have been enquires from services within the Trust who were in the process of renewing a Section 3 MHA. There had been discussions about the criteria for Section 3 and should the detention be renewed when the treatment does not need to be provided in hospital but for the fact there is no identified accommodation in the community for the patient to be discharged to.

A summary of the Judgement states the treatment can only be given in hospital due to the patient not having accommodation in the community , therefore treatment is being given in hospital and it is treatment for the mental disorder as set out by the court at section 145(1) MHA; which states that treatment includes nursing, psychological interventions, specialist mental health treatment and rehabilitation and pertinently includes care, which is the level of care that is given to a patient to support them with their mental disorder.

This ruling is in effect reducing the threshold for the use of the MHA. The courts found it was the government's intention when implementing the Deprivation of Liberty (DoLS) safeguard, that it should not be used to address care and treatment for mental disorder. In fact it is essentially stating that DoLS cannot be used within a mental health setting.

One regime may be regarded as more restrictive than the other, though in reality the care plan is exactly the same and no different from one legal framework to the other. However using the MHA provides far more safeguards for the patient than a DoLS authorisation.

GW asked that this briefing is taken to the next Hospital Managers' Forum as this issue is debated on several panels, around discharge, what treatment in hospital means and can it be delivered in any other setting.

Action: Julie Carr

EM reiterated the level of responsibility and capacity that is being put onto the Trust, there is an ever increasing expectation that we have to do more and more and how do we manage this.

KQ explained that this is case law, it is judgement about patients with learning disability and other patients who lack capacity, who are clinically fit for discharge but there is nowhere for them to go in the community, there is no service or provision, so they stay with the trust - this has been a dilemma for the trust creating issues on the Horizon unit, rehabilitation units and low secure wards.

The committee were asked for the legal briefing to be received and next steps approved. Next steps are sharing with the Clinical Governance Group, Medical Officer webinar, Hospital Managers' Forum and developing a guidance note to put on the MHA intranet to support clinical staff. This was approved by the committee.

MHAC/23/48 - Feedback from Local Partners (Agenda item 7)
MHAC/23/48a – Multi Agency Group Feedback (Agenda item 7.1)

YF presented the triple AAA report from the Multi Agency Group (MAG) . The meeting is chaired by CGH who will, going forward, write this report.
The meeting is attended by SWYPFT, Police, Local Authority, Acute Partners, ICB representatives and YAS.

Alert:

- The RCRP meeting reporting the local authority may refuse to attend MHA assessments if the police refuse to support when risks to staff have been identified. From a trust point of view, we are mindful of this, and it will be incorporated into the planned training. Conversations are taking place with local authority partners in regard to the impact on frontline staff and service users if they are unable to undertake a MHA assessment.

- Section 136 assessments - Cross Border Arrangements:
  The trust operates across a large geographical area and our service users are admitted to different localities - recent confusion was discussed regarding which local authority should attend to undertake the MHA assessment. The local authorities at the meeting have agreed to take the issue to the regional forum to see whether they can collectively have a consensus on the application of the law.

  A secondary issue was highlighted during the above relating to the need for re assessment and confusion about local authority responsibilities. Have agreed MHA will progress some work before a secondary MHA assessment is requested, to avoid delays.

- The Local Authority are working with Mid Yorkshire Hospitals Trust to clarify the position relating to their hospital being used as a place of safety. Although the Act states under 136 “a hospital-based place of safety can be any hospital” the actual hospital management have to agree to be that place of safety. At the moment Mid Yorkshire hospitals are saying that they will not act as a place of safety, and they never have done.

MHAC/23/48b - Independent Hospital Managers feedback (Agenda item 7.2)
GW confirmed that the minutes and the papers clearly describe the situation with regards to hospital managers.

MHAC/23/49 - Risk Registers (Agenda item 8)
MHAC/23/49a - Consideration of the Items from the Organisational Risk Register (Agenda item 8.1)
MHAC/23/49b - MHA Committee Risk Register (Agenda item 8.2)
KQ explained that all committee members receive the full organisational risk register (ORR) including the grading matrix etc. This paper was introduced to this committee with the idea of reviewing the organisational risks which are relevant and may have an impact on compliance with the MHA. Impact on Mental Health Act implementation or compliance are escalated to the Executive Management Team (EMT) by STh.

JC confirmed that there are no new risks for this quarter.
There are 2 existing risks to highlight:

- the first risk is 275 which has been upgraded from amber to red .

- 1151 has been moved from outside risk appetite to within, which has reduced the grading.

No other grading has resulted in a movement in terms of risk appetite.

The risks tend to be about staffing issues , staffing pressures, impacting on the ability to comply with the MHA.

MR commented on MB point in regard to the RCRP and whether this is something that the committee does own because of the process around this and its impact. MR felt that the committee needs to be aware and have as a risk.

EM felt that it was more of a strategic risk around capacity and the expectation of what the trust have got to do and needs to be fitted around patient care because the police are not going to come or attend as quickly as needed and also looking at more delayed risk assessments, it is about how the patient care is being managed. Not sure on how this can be filtered or factor into the risk maps though felt that both capacity and in patient care sit together.

DT felt that it could sit under Quality and Safety Committee(QSC) around all the reasons being mentioned in relation to the impact on patient experience, safety, and quality. Whether or not it sits within this area and has a link into this committee due to the legal context whether it is being particularly driven by the legal context and therefore sits in this committee and is then overseen by QSC.

MB commented whether the key issue here is whether there is a risk or not. There is an emerging piece of work around RCRP across the country, and a need to have assurance ultimately at Board, though whether it is at the MHAC or QSC, is to be determined and to understand what the risk is and have the right actions in place to mitigate this risk. There is a need to go through a process to understand the risk and whether the actions are comprehensive.

STh suggested that this is a discussion for outside of the MHAC and taken to EMT with all of these aspects in terms of what the current gaps are, the assurances and logging the different aspects in regard to the strategic element, the legal side, and the clinical side. To then determine which committee would be best placed. Need to understand what the impact is on the services and patient care.

Action: Subha Thiyagesh/Darryl Thompson/Chris Lennox

EM commented that the risk is not about the introduction of the legal power, the trust is a statutory organisation and is expected to meet all the legal requirements, the risk is round the capacity and the impact of those legal issues. The risk assessments have to be dynamic; staff are already under pressure and then new regulations come in to place and they have not got the tools to manage this. EM suggested that there is a need to have systems in place before they become an issue.

DT identified several of risks that go through QSC, though felt it would be helpful noting in this paper which other committees are the primary owners of the risk.

Action: Julie Carr

KQ asked those present to confirm that no risks had been identified for addition to the MHAC Risk Register.

MHAC/23/50 - Statistical information use of the MHA 1983 and MCA 2005 (Agenda item 9)
MHAC/23/50a - Performance report – monitoring information April – June 2023 (Agenda item 9.1)

- Acute admissions under the MHA, are lower than the national average though not significantly lower.
- Proportion of admissions are higher than the last quarter, 60% of admissions in Calderdale are formal. Looking into whether this is a trend as does seem slightly higher than other areas.
- 1 Admission of a under 18 patient this quarter
- In terms of ethnicity, there is over representation of detained patients from particular ethnic minority groups. This is an ongoing concern and it's part of the equalities work across care groups and a focus for the organisation, continuing to seek improvement.
- Use of section 2 and 3 of MHA are in a steady state trend. Increase in use of Section 2 corresponding with a slight decreased use of Section 3
- Section 5(2), slightly higher conversion rate in some areas. .
  Monitoring section 5(2) and the conversion into section 2 or 3, does not necessarily mean a misapplication of section 5(2).

- 136 suite activity, a decrease of 18 from quarter1, there were 126 assessments. 52% were admitted to hospital, 17% of all assessments resulted in formal admissions under the MHA. A low proportion of patients assessed in the 136 suites are subsequently detained under the MHA This emphasis the need to reduce the use of 136 suites, to continue working with partners and police liaison staff.

- 4 conditional discharges have been applied this quarter and 1 patient was recalled to hospital in this quarter.

- Internal transfer, Calderdale remains as the highest source of transfer activity. This is attributable to the way the trust provides older people's services in bringing people back to their local areas for preparation for discharge. We are building that intelligence into the work around older people's transformation in terms of working with partners and looking at local practices with the councils. No appeal or renewal hearings were affected by these transfers.

- The use of Community Treatment Orders, 44 open at the close of the quarter, an increase of 2. There were 9 discharges.

- Hospital Manager activity, , 9 appeals received in quarter 2 which is a decrease on quarter 1. 2 were heard with no discharges ordered 7 were cancelled either by the patient or their solicitor.

- 1 nearest relative applied for discharge in quarter 2 and the outcome was that the patient should remain on the section.

- 25 hearings following the extension of a CTO were heard.

- No discharge was made by the hospital managers.

- Tribunals are not showing any trend in terms of applications. There was an increase on the previous quarter on the rate of tribunal applications achieving a Hearing, with Quarter 2 showing 59% compared with 44% last quarter.

- 74 Tribunal hearings were held, resulting in 11 discharges.

- MCA, 8 new approaches were made to the trust this quarter, 37 open and active Court of Protection cases are held by the trust, there are a further 36 dormant cases, no further action is required by the trust at this time. Due to continued pressure full responses are still taking between 12 to 16 weeks to complete.

- DOLS, 8 new applications were made in quarter 2, all from the stroke and neuro rehab wards at Barnsley and none of those have been refused, 4 are waiting an outcome from the local authority and all applications are progressed and monitored by MHA.

- There were sadly 2 notifiable deaths of detained patients in this quarter. A 48-year-old man, on a Community Treatment Order (CTO), died at home and the cause of death is still being established. An 88-year-old woman subject to a CTO, acquired sepsis following food aspiration. the cause of death was pneumonia.

- The were 5 exception reports in relation to Section 2 and Section 3. All were investigated and ensured each detention was safe.

- Consent to treatment, 28 exception reports, a decrease from quarter 1. The main reason for delays being the allocation of the Second Opinion Approved Doctor, 14 of these referrals remain outstanding with the longest dating back to July. All patients where required are being treated under section 63.

- 136 suites - There were 9 occasions when the suite was unavailable. The service is looking in more detail as to why they were unavailable and also considering the duration of the non-availability.

- Section 17 leave compliance is showing a positive position in terms of escorted leave being granted and taken. Services are considering different ways of measuring the leave, pre-planned in adults and older people's mental health, more in line with how the forensic services operate. The forensic and specialist services had an improvement plan and have exceeded the 90% from the plan with 92% of granted leave being taken.

- Statutory notification of Absent with Leave (AWOL), 5 patients from Forensic services were reported to the Care Quality Commission. This is a statutory notification where a person is AWOL past midnight on the day of non-return.

- Consent to treatment compliance monitoring, shows continued improvement and the Mental Health Act office continue to work closely with the design team for System1 to take full opportunity to record within the system.

- Compliments and concerns to the Hospital Managers, generated 5 compliments and 4 concerns with appropriate action being taken.

- MHA complaints, 1 raised a concern about the care and treatment and the use of the MHA. 1 was around discharge but consent was not provided by the service user, therefore this did not proceed.

- Mental health advocacy shows a positive position, with good working relationships, and service users and carers being supported appropriately and people working well in partnership.

- Section 132 (patient's rights) shows a positive position, with compliance for detained patients being 99% held from quarter one. 93% for informal patients, this being a slight decrease. Community 84%, being a slight decrease.

- MHA, MCA and DoLS training; Compliance target of 80%. For MCA/DoLS training trustwide compliance rates are reported as being non-clinical staff 100%, clinical staff - 91.27%. For MHA training: trust wide compliance rates are 91.74%

- Receipt and Scrutiny training is delivered locally by the MHA office managers across the Trust geographical areas including the acute trusts.

DT commented on the reduction of the CTOs: the number of people that have been discharged is a really healthy indicator.

MR felt that the trust is making good progress particularly around advocacy because of the support and the processes that have been put in place, though questioned what CL's areas of most concern are.

CL felt the potential impact on patient experience with staffing levels and cancelled pre planned leave and the way of measuring this and how to improve this across the broader wards.

CL also felt re the low conversion rates of patients in the 136 suites with formal admission, a very low proportion of those patient who actually need to be detained, means a lot of patients are having a restrictive experience of being detained under 136 and are there other alternatives prior to this, as not many of these patients need to be detained into hospital. Also, the ongoing challenges of patients' experience from some ethnic minority groups or neighbourhoods. the more information collected, the better the understanding and how we can influence positive change.

MR suggested highlighting these on the summary, as it is important to pull these points out, so as a non-executive director we can look at offering support or an action and have further discussion on the concerns, to see what help is needed.

Action: Chris Lennox/Julie Carr

GW felt that they need to be made aware if there was a change to the Second Opinion requests, as this is something that Hospital Managers rely on in their decision making. KQ explained that the issues are around the escalation process due to the delays, not a change in the request process - the CQC appoints the SOAD (Second Opinion Appointed Doctor), a request for this is submitted by the Trust, but the CQC is not always providing SOADs on time. The trust has therefore developed an escalation process with the CQC to address such delays.

GW pointed out that one of the clearest indicators they have about a patient's capacity to remain as an informal patient is whether they are taking their medicines on either a T2 or a T3. .

CT explained that with the work done through the escalation with the CQC, a full-time administrator in the CQC has been appointed for the trust and this is assisting with the reduction and will further improve.

MHAC/23/51 - Audit and compliance (Agenda item 10)
MHAC/23/51a - CTO Review (Agenda item 10.1)

Patients subject to Community Treatment Orders (CTOs) have been read their rights- the Trust compliance rate is currently held at 84%, this is a 29% increase since introducing the reminder system.

Nationally, CTO's are most frequently used in the age group 35 to 49 whereas in the Trust the age group CTO's are most frequently applied to is 50 to 59 years.

The Trust rate of application of CTO's remains at a much lower rate than the national picture with the national rates for males being twice that of the Trusts and females being 75% higher than the Trust.

Nationally people from a Black/Black British ethnicity are eleven times more likely to be subject to a CTO. Whereas, at the time of the data extract for this report, the Trust had 44 patients subject to a CTO. Of those 44, 19 patients were recorded as being from a BAME community. KQ noted that whilst the relationship between CTO's and ethnicity will be explored in more detail in the Annual Inequalities report to MHAC, an interim AAA report will be presented to the March Committee to provide an initial scoping report to better understand the impact of ethnicity on application for a CTO.

Action: Carly Thimm

In respect of following up on the giving of patient rights ,CT confirmed that the MHA team are now sending patient rights leaflets out so it can be recorded as attempted to be read, for it to be followed up at the next face to face appointment.

CT explained that in regard to embedding all the information, that there is always an action that arises from these reports; what has been learnt, what is working well, what is not working well, to reflect on this and how can we help ward colleagues to take the work back from the MHA office.

STh explained there is a lot of work ongoing with the MHA Office team and they are on site in each of our inpatient sites. Looking at how we embed the information within the operational role is a challenge and also having to balance the work and provide hands on patient care.

MHAC/23/51b - Annual Review of Hospital Managers Arrangements (Agenda item 10.2)

KQ noted that this is GW's last attendance at a MHAC meeting as Chair of the Hospital Managers' Forum. KQ appreciated GW's enormous skill and expertise and thanked him for his commitment and dedication to the role for the last two years and prior to that two years as Vice Chair.

The Trust have recruited new Hospital Managers over the past 12 months; we currently have 15 Hospital Managers therefore an annual recruitment programme has been introduced. In order to increase the diversity of the Hospital Managers we are working with Dawn Pearson's team to access communities and local equality and inclusion networks.

At the last Forum there was a pilot hybrid format (online and face to face), this will continue in the future to enable more people to participate and meet the minimum standards for the training requirements to retain the role as Hospital Manager.

KQ spoke about Lorraine Jeffrey who very sadly passed away in September following a short illness. KQ reflected that Lorraine had been a Hospital Manager for many years and had chaired the Hospital Managers' Forum. Lorraine worked tirelessly and diligently for service users and families, and she always put them at the centre of everything she did. MB has sent a card to her husband and family on behalf of the Committee and the Trust. Lorraine was universally liked and admired, and a large number of Trust staff attended her funeral.

KQ also explained that June Stokes, who has been a Hospital Manager for many years, is retiring and will be presented with thanks at the December Forum. KQ wished to send June huge thanks for all her tireless hard work on behalf of our service users and families and to wish her well in her retirement.

MHAC/23/52 - Care Quality Commission MHA visits (Agenda item 11)
MHAC/23/52a - Visits and summary actions quarter 2 including Care Group actions (Agenda item 11.1)

- By the end of quarter 2 the Trust has had 12 of the 29 wards visited. Pre pandemic the Trust would have approximately 17 visits per year. It is estimated that there will be a further 5 to 10 visits, so it is anticipated that we will exceed the usual rate over this year.

- 62 open actions over quarter 2. Themes emerging from these recent visits include patients' rights, section 17 leave, blanket restrictions, recording of capacity and consent to treatment, care planning and risk assessments. All of these actions have been put into a quality improvement process and are either being managed by CGH though the Nursing Quality and Professions directorate or though the MHA team under YF within the Medical Directorate.

- Environmental issues are being picked up and addressed by Estates which includes the female only areas, courtyard, general maintenance.

- All reports when received are circulated to Care Groups and all heads of services, so there is general learning

- Emerging points in respect of people's understanding of Autistic Spectrum Disorders, currently using Oliver McGowan training through ESR, and EMT have now made this mandatory training.

- KQ commented on the open and overdue actions, though noted these will be completed by the end of quarter 3. Any recurring actions and recurring themes all have an action plan or a work stream.

DT asked that it be noted that the quality aspects of MHA visits are also reviewed in Quality and Safety Committee.

KQ referred to the CQC inspections carried out in May 2023 to the acute wards for working age adults and psychiatric intensive care units (PICU) and forensic inpatient and secure wards (i.e. not MHA visits), and asked for a paper to come to the March MHAC meeting to provide assurance regarding any findings and actions relating to the MHA committee, MHA, Code of Practice, MCA, as well as any good practice and evidence of improvement work on these in the CQC Reports.

Action: Yvonne French/Julie Carr

MHAC/23/53 - MHA/MCA Code of Practice Oversight Group (Agenda item 12)

The 136 policy has been written in collaboration with partners and has been signed off by the Trust for quite some time, however it is still being held up through delays with partner agencies' sign-off, though this may need to be reviewed in relation to RCRP.

STh noted the 136 policy had been taking some time, and asked is there any risk to the Trust and something may need to be discussed in more detail and included in the MHAC agenda setting meeting.

Action: Yvonne French/Julie Carr

YF confirmed now that the Multi Agency Group (MAG) had been re-established, this has been discussed with CGH to be added back on the agenda as this is where it would normally sit.

MR queried whether the partner organisations have not given the Trust the opportunity to finish the policy, is there an escalation process due to the length of time it is taking, though depends on what kind of risk is exposed. YF confirmed that the Trust has its own policy and has an internal Standard Operating Procedure that the Trust works from, though we are all working to this policy it has not gone through partners' governance processes. YF noted we will need to review this in light of RCRP.

The joint policy for admission to hospital is not a Trust policy, it is owned by the ICB and CL is working closely with the ICB though Roland Miller.

The committee were asked to accept the paper and note the ongoing activity relating to the implementation of the current Code of Practice and the development and preparatory work related to pending legislation. This was agreed.

MHAC/23/40 - Key messages to Trust Board and other Committees (Agenda item 13)

No messages for other Committees.
Messages for Trust Board:

Alert

- **'Right Care Right Person'** – risks and mitigations – agreed to go through the risk process to determine whether our controls, assurances and actions are sufficient to mitigate any risks, noting some risks will be Mental Health Act related.

- **Ethnicity** - continued picture of underrepresentation of preventative, least restrictive services and over representation of detained patients from certain minority groups. This is an ongoing concern and area of focus for MHAC and is part of the equalities work across care groups.

Advise

- **Briefing – 'Mental Health Act or Deprivation of Liberty Safeguards (DoLS).** Case law confirms that people who lack capacity and are clinically fit for discharge but have no community placement to be discharged to, can still be detained under the Mental Health Act, not the Mental Capacity Act (MCA). Legal briefings for governance groups, staff and Hospital Managers' Forum, and update on Trust MCA intranet page.

Assure

- **Performance Monitoring information Q2 -** Overall, good assurance of compliance:
    1. **Section 17 leave compliance**, positive position of leave being granted and taken. Exploring different ways of measuring pre-planned leave in Adults' and Older people's mental health services, in line with Forensics. Forensics and Specialist services had an improvement plan and exceeded the 90% plan, with 92% of granted leave being taken.
    2. **Mental health advocacy -** positive position, good partnership working and relationships between Advocacy services and Trust staff. Service users and carers supported appropriately.
    3. **Section 132 Patients' Rights**, positive position - compliance for detained patients 99% held from quarter one. 93% for informal patients. Community 84%.
    4. **Mandatory Training compliance** MHA and MCA/DoLS have some of the highest compliance rates of all mandatory training across the Trust - Compliance (standard 80%) Trust-wide for clinical staff 91. 74%; non clinical 100%. Assurance gained that any service /team 'hotspots' of non-compliance are identified and addressed promptly.

- **Code of Practice Oversight Group** – assurance on ongoing activity relating to the implementation of the current Code of Practice and the development and preparatory work related to pending legislation.

- **Care Quality Commission MHA visits** – Assurance that actions and recurring themes have an action plan or quality improvement workstream taking place. Visit activity has increased with the number exceeding previous years.
- **Community Treatment Order (CTO) Annual Report -** Assurance on the use of CTOs, patient rights, and access to advocacy services for those subject to a CTO. Of note, nationally, CTO use on Black people are over 11 times that of White people. (CQC national reports on longstanding inequalities state "urgent action is needed to tackle the over-representation of Black people on Community Treatment Orders & that progress too slow"). However in this Trust, only 45% of people on a CTO are from a Black Asian Minority Ethnic background. The MHA Team is working with Performance Monitoring & Informatics team to build a report on the use of CTOs by the Trust.

- **Independent Hospital Managers' Annual Review –** MHAC acknowledged and thanked Gordon Walker in his last meeting as Chair of the Hospital Managers' Forum for his hard work and dedication. Committee also fondly remembered Lorraine Jeffrey who sadly died in September. Committee also thanked June Stokes who is standing down after many years dedication and service to the Trust and to patients and families.

MHAC/23/41 - Work Programme (Agenda item 14)
The Work Programme was noted.

Date and Time of Next Meeting
The next meeting will be held on 5th March 2024 at 14:00 – 16:30 via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Quality & Safety Committee meeting
Tuesday 9 January 2024
9.00am – 11.15am
Microsoft Teams

Present:	Nat McMillan (NM) Darryl Thompson (DT) Marie Burnham (MB) Dr Subha Thiyagesh (STh) Carol Harris (CH)	Non-Executive Director (Chair of the Committee) Chief Nurse / Director of Quality and Professions (Lead Director) Chair of the Trust Chief Medical Officer Chief Operating Officer
Apologies:	Kate Quail (KQ)	Non-Executive Director
In attendance:	Sarah Harrison (SLH) Yvonne French (YF) Carmain Gibson-Holmes (CGH Julie Williams (JW) Rachel Lee (RL) Mike Ford (MF) Alison Thomas (AT) Susan Burns Dr Marios Adamou	PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Legal Services Deputy Director of Nursing, Quality and Professions Assistant Director of Corporate Governance & Risk Associate Non- Executive Director (observing) Non-Executive Director (observing) Assistant Director of Nursing Quality & Professions (item 6) Infection, Prevention & Control Nurse (item 6) Consultant Psychiatrist Adult ADHD

QS/23/249 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 Mike Ford and Rachel Lee were observing the meeting today and Alison Thomas, Susan Burns and Dr Marios Adamou would be in attendance for their relevant items.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed.

NM outlined the Microsoft Teams meeting protocols and etiquette.

QS/23/250 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/23/251 Minutes from previous Quality and Safety Committee meeting held 14 November 2023 (agenda item 3)

The minutes were approved as an accurate record. A typing error on page 13 will be rectified.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 14 November 2023 as a true and accurate record.

QS/23/252 Matters arising from previous Quality & Safety Committee meeting held 14 November 2023 and action log (agenda item 4)

The action log was reviewed and updated as follows:

- QS/23/229 Committee Related Risks.
  Darryl Thompson (DT) informed the Committee that this action was included in the risks update on today's agenda. Closed.
- QS/23/229 Committee Related Risks
  Mike Ford had previously raised a query around seclusion and medical device risks in Trust Board. Marie Burnham (MB) advised that this had been dealt with and could now be closed.
- QS/23/231 Chief Nurse Update.
  Kate Quail requested to see a full programme of the cost improvement programmes. NM suggested that this should this be discussed through the Finance, Investment and Performance Committee unless there was a quality aspect that needed to be discussed. The committee agreed.
- QS/23/233 Quality, Regulatory & Oversight paper.
  Quality monitoring visits. Carmain Gibson-Holmes (CGH) advised that this has been factored into the paper today and the action can be closed.
- QS/23/236 Safer Staffing Update.
  NM confirmed that this action could be closed as it was included on the agenda today.
- QS/23/209 CQC Inpatient and Community Surveys
  This will be included within the Chief Nurse updates going forward.
  Closed.
- QS/23/211 Care Group Quality & Safety Report
  Update on risk relating to demand. Carol Harris (CH) advised that this was a dynamic risk and was included on the risk register. The work is being undertaken through the improvement group and the risks are reviewed regularly. Closed.
- QS/23175 – Review of Committee related risks.
  This relates to risks where multiple people have been named. Julie Williams (JW) confirmed that both the risk triangulation report and the ORR both state who would be holding the risk and which Committees would be involved. This would then follow through to Audit Committee. Closed.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates.

QS/23/253 Committee related risks were reviewed in accordance with the terms of reference. Including:

NM advised the Committee the need to agree the proposed risks scores for:

- 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 (risk score of nine) and

- 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.(risk score of eight).

DT advised that EMT had discussed the speaking up risk in terms of whether it was people not feeling able to speak up or whether patients would come to harm should people not speak up. The outcome was that it would be seen in the spirit of what the risk was intending, implying the outcome of harm. Therefore, the risk would be owned by this Committee with a link to People and Remuneration Committee around organisational culture and speaking up.

NM asked the Committee if they agreed with the risk scores that had been suggested in the paper. NM confirmed that she was happy to agree the scores.

NM also advised that there were two risks 1624 and 1319 that the Committee were being asked to reduce following a review. RISK ID 1624 is relating to the Section 136 suites. CH advised that there has been an improvement with patient flow therefore reducing the likelihood of this risk. NM asked for some assurance around this and CH informed that a report provided by Vic Humble showed that there had been no adverse impact on caseload sizes or patient safety incidents from reduced use of out of area beds. CH also confirmed that out of area use has been used by only three people during the Christmas holidays, including during two significant doctors strikes.

The Committee confirmed that they were happy with the proposed reduction in risk for both risks.

NM wanted to discuss RISK ID 1650 which relates to access to gardens. NM acknowledged the detail and updates contained in the paper and was aware that this was still being looked at in terms of the ongoing works taking place.

DT advised the Trust was working in partnership with the new CQC inspector around this issue and he is keen to work alongside the Trust to ensure that changes will meet the CQC standards. This remains a risk in terms of ongoing monitoring.

It was RESOLVED to RECEIVE the update.

QS/23/254 Staff / Team Story (agenda item 6)

Alison Thomas (AT) Assistant Director of Nursing, Quality and Professions and lead for physical health in the Trust, and Susan Burns (SB) Infection, Prevention & Control Nurse joined the Committee to provide a presentation in relation to infection, prevention & control and the challenges the team face, both old and new, and the key priorities within the Trust. The presentation will be shared with the group after the meeting.
Action: SLH

NM thanked both AT and SB for the presentation and the work that has been undertaken by the team and the tremendous efforts of all the team who were the unsung heroes of the Trust.

MB noted that the problems and solutions were explained wonderfully and couldn't ask for more from the team and the great work they are achieving.

Subha Thiyagesh (STHi) thanked both AT and SB for the really helpful summary and acknowledged how incredible the team were and wondered if the acute trusts have similar issues and what else could the Committee do to support the team. SB would like support and encouragement with bare below the elbow and hygiene measures being reaffirmed wherever possible, and role modelled by senior leaders.

DT noted the unwavering commitment of the team and acknowledged the huge level of assurance that they provide which was invaluable.

NM asked that they take these comments back to the team and that they in turn be thanked.

QS/23/255 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:

- National best practice guidance has been developed by the Mental Health Nurse and Learning Disability Director Forum and published by the CQC around ligature management. This is being reviewed within the Trust for learning.
- DT is the new Co-Lead for the development of new national guidance around supportive observations.
- The QIA structure is established and ready to implement in preparation for any cost improvement plans.
- DT noted feedback from two recent Place Quality Committees.
- The Trust's CQC inspection results were discussed in the Place Quality Committee,
- Partnership work is planned to continue improvement focused work across providers in West and South Yorkshire.

NM was pleased to see the work around reducing harm from ligatures on mental health wards and people with a learning disability and was pleased that this has been recognised.

QS/23/256 Quality and Regulatory Oversight Paper (agenda item 8)

The paper had been circulated to all members prior to the meeting.
DT gave a brief update to the Committee.

The report for January 2024 contained the following information:

- A summary of the outcome of the CQC inspections which took place in May 2023, following publication of the inspection reports in December 2023, and the actions taken in response.
- Notification of quality monitoring visits undertaken with Barnsley enhanced team west, Barnsley core team and Newhaven Ward.
- The quality monitoring visit schedule up to March 2024.
- Updated data on the new enquiries received into the Trust from the CQC. This is broken down by Care Group.
- Information about the CQC's single assessment framework.
- An overview of the process for CQC mental health act inspections within the Trust, including the receipt of reports and action plans.
- An update on the implementation of the Triangle of Care across the Trust, to support a consistent offer to unpaid carers.

NM noted the detail that was included in the report, however commented how do we make sure through this Committee, and continue to be assured with regards to the progress of actions from service quality visits. This is overseen within Care Group governance groups and further reference will be included in future versions of this report.

MB stated that monitoring the report and actions was ok however in 2024 there will be a need to see the metrics change to be more on top of things at a ward level and that the operational teams get support from the corporate teams which will give full insight into delivering those changes.
MB was happy with the detail of the report however highlighted the need for a reporting system where assurance can be felt.

DT thanked the group for the helpful points raised.

NM added that there was now a need to see the impact of the actions happening with the organisation and was assured that the processes are in place and learning identified. However, there needs to be the assurance that they have been followed through.

It was RESOLVED to RECEIVE the Quality & Regulatory Oversight Paper.

QS/23/257 Care Group Quality and Safety Report (agenda item 9)

CH advised the Committee of the pressing issues within the report.

Key Issues for January Committee

Care group changes

The care group structure has been reviewed and a new care group 'Children and Families' has been established. The care group will bring together all services for children and young people and the services provided for families at Urban House. This builds on the positive work of the children's governance structure and provides an exciting opportunity for the needs of the child to be first and foremost to the business of the care group. Recruitment to the director of services was undertaken, and we are very pleased to announce that Carmain Gibson-Holmes, the current Deputy Director of Nursing, Quality and Professions has been offered and has accepted the role of Director of Services (Children and Families).

Barnsley community mental health services have moved from the Barnsley care group into the inpatient, adult and older people services care group. This brings together all adult mental health and provides an enhanced opportunity to share learning and improve care pathways. The care group will be known as the mental health care group with Chris Lennox as director of services.

Barnsley, physical health and wellbeing services care group will be led by Gill Stansfield as director of services. Most general physical health services are provided in Barnsley although the care group will share physical health knowledge and expertise across all areas.

The forensic care group and learning disability and adult ADHD/ASD care groups along with the operational leadership of the charities will remain with Sue Threadgold as director of services.

Patient flow and inpatient improvement

Reduction in the reliance on out of area beds has been maintained. The improving mental health oversight group received an update from the care closer to home workstream about their initial review of performance metrics across the wider system. The review so far has demonstrated no adverse impact elsewhere in the system, patient safety incidents and intensive home-based treatment caseloads being key examples of where we are being particularly vigilant around impact. It is important to note that whilst bed occupancy in the acute pathway is high, this has been the position for a long time and has not increased in line with the reduction in out of area bed use.

The mental health improvement programmes are interlinked and the success of the care closer to home workstream can also be attributed to the inpatient improvement programme as work has been undertaken to improve the therapeutic offer, provide trauma informed care and to ensure discharges are proactive, safe and effective.

Christmas
Visits to clinical areas ahead of Christmas demonstrated a real commitment to helping people celebrate in the way that mattered most to them.

We know that families and carers matter. Actions were taken to support people to be at home with family and friends wherever possible. This meant that nursing, medical and pharmacy staff worked hard together, and around the industrial action dates, to proactively plan leave and medication availability so that people could be at home safely. The general community teams in Barnsley worked with partners from Barnsley Hospital to support 372 people to be discharged from hospital in time for Christmas between 20 and 22 December. The usual average number of discharges supported by the team is 75 to 90 per day.
Where people needed to remain in hospital, festive activities, food and visits were arranged, with staff and service users working together to enjoy the festive period.

Industrial action
Further industrial action from trainee doctors took place prior to Christmas for three days with a further six days planned in January 2024. All areas were and will be covered safely. Whilst no patient safety incidents as a direct result of the action have been escalated from the action taken prior to Christmas, the patient safety oversight group will maintain oversight of all incidents potentially linked to industrial action going forward.

CQC reports and next steps
The reports for the adult acute inpatient and PICU service and the forensic service are now published on the CQC website.

- The acute inpatient and PICU service has been rated as requires improvement across all domains with 16 MUST DO actions and 12 SHOULD DO actions.
- Forensics services are rated good for caring and required improvement across all other domains with 7 MUST DO actions and 7 SHOULD DO actions.

The ‘must do’ actions all have improvement plans in place, and the ‘should do’ actions are being mapped against improvement workstreams already underway so that gaps can be identified and addressed. Care groups will be supported by the quality improvement and assurance team to demonstrate and evidence delivery against the actions.

The executive trio have visited clinical areas and held drop-in meetings for staff teams following publication of the reports. Without exception staff members demonstrated a positive approach to the improvements required and are keen to deliver against the actions in order to improve the service offer for service users.

Inequality for people with a learning disability
Negotiations are underway with commissioners in relation to people with a learning disability not having access to assessments for ADHD. Progress on this will be picked up in January

Barnsley CAMHS have escalated an inequality in provision as there is no specialist service for children with a learning disability in Barnsley. This means that there is no pathway for children with a learning disability who require specialist CAMHS learning disability support. Commissioning decisions were made historically to remove the provision from the council, with plans to review need. However, CAMHS have noted an escalating position post-pandemic and children appear to have more complex needs that cannot be met by the local CAMHS service or the mutual aid support from across the integrated care system. The issue

has been escalated in Barnsley Place and discussions on how to address the need have commenced.

Neurorehabilitation service
The eight commissioned beds for Barnsley are all occupied, and the appropriate staffing resource is in place. However, a further seven Barnsley people are currently waiting for a bed to become available. This is an unprecedented rise in demand, which is further complicated by the local authority struggling to find two placements for people with highly complex needs, resulting in two delayed transfers of care. The unit has an additional four unfunded beds for spot purchase out of area placements, but we will only offer the beds where safe staffing is available. This will be kept under review and if staffing can be secured, Barnsley Place can be offered spot purchased beds.

Internationally recruited nurses
The executive trio has oversight of the actions in place to support the internationally recruited nurses. This month specific actions have been completed to ensure that support is available to the nurses to avoid loneliness and homesickness over the festive period, with get-togethers planned for Boxing Day and 8 January 2024.

The Quality Care Group and Safety Report was RECEIVED and NOTED.

QS/23/258 RCPsych Review Report (agenda item 10)

It was agreed to take this item in the private section of the agenda. It was confirmed that the report was not being presented in terms of assurance, at this stage and was just for information.

QS/23/258 Safer Staffing Report (agenda item 11)

CGH noted that this paper had been to the Committee previously which was back for further discussion today and the paper was taken as read.

Safer staffing remains a priority and challenge both nationally and within the Trust and a significant review is underway with regards to the focus and structure of future versions of this report, to ensure that the analysis of safer staffing levels is more easily identifiable by Care Group, rather than the current Trust-wide view.

- Key areas to note:
- 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 international nurse recruitment, flexible working, and recruitment of bank and agency staff. This has allowed us to reduce our vacancy rate and maintain higher fill rates whilst reducing agency usage.
- In the current year to date 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 nurse recruitment programme we have successfully recruited 110 nurses. An improvement plan has been developed to support their integration into the clinical areas based on feedback from the nurses and the clinical areas.
- 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.

- 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 shows wards are busy with high acuity.
- 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, the Trust has the lowest turnover rate in our region and the highest score for the staff stability index.

NM thanked CGH for the report and the discussions that had taken place with colleagues in the last week regarding the safer staffing report.

MB thanked CGH for presenting the paper and noted that there wasn't a representative from the people directorate to assist with the discussions, however stated that the report still didn't tell her how or what was being done and was still reporting the problems and doesn't report on what initiatives are being put in place to resolve the issues such as student nurse placements being taken by other trusts. The report also doesn't mention change to policies or procedures around such as golden handcuffs, how long the Trust can keep trainee staff for and also the ability to over establish. MB would like more specifics around what is actually taking place and did note that the Trust benchmarked against others at this time.

SThi informed the group that in relation to student placements, discussion have taken place with DT and Izzy Worswick about how we can improve the offer, be creative and be flexible and also consider the different skill mix. SThi advised that work is continuing on this and is on their agendas going forward and were working closely with operational colleagues.

DT advised the group of a discussion which took place with a university trust in the Midlands (Hertfordshire) who had significantly increased their student placements since the COVID-19 pandemic and our teams are liaising with them regarding learning.

MB requested that at the next meeting she would like a breakdown of how many student places the Trust have both pre and post COVID-19 and then future predictions. CH noted that there will be a need to get the narrative and balance right in the breakdown.
Action: TRIO

NM had discussed the above concerns with DT outside of the meeting and concurs with MB that the report is not where it is needed to be however advised there was enough improvement to approve the report for Trust Board.

NM stated that she would also like assurance around what establishment reviews have taken place and the plans in place.

MB queried the establishment officer post that was removed during a restructure of the people directorate and would like NM to check with Mandy Rayner (as Chair of People and Remuneration Committee) what the position is with this post.

Action: NM

The Committee RECEIVED and COMMENTED on the Safer Staffing Report.

QS/23/259 RRPI Update including update of Prone Restraint (agenda item 12)

This paper was taken as read and DT highlighted the key headlines

Key headlines:

- The purpose of this paper is to provide an update and assurance regarding the use of restraint within the Trust, with a particular focus on the use of prone position restraint. The paper will demonstrate the use of restrictive physical interventions, including a focus on the use of prone restraint and quality improvement initiatives to reduce the use of restrictive physical interventions.

- **Reducing Restrictive Physical Intervention November 2023**
  There were 153 reported incidents of restrictive physical interventions in November 2023. This is a reduction of 45 incidents from October 2023. The spike in incidents between September 2023 and October 2023 was due to acuity across three wards (Beamshaw, Newhaven & Poplars) which resulted in 63 incidents of restraint for four service users.

- **Seclusion**
  In November 2023 there were 47 incidents of seclusion use Trust wide. This is an increase of six from October 2023. Although the use of seclusion remains lower than the same period last year, there has been a consecutive increase in use for the past two months.
- In response to the current increase in seclusion use, the RRPI team are working with Care Groups and the Datix team around improvements in data collection to enable improved analysis on time spent in seclusion.

- **Prone Restraint**
  Following a CQC inspection of acute wards for adults of working age and psychiatric intensive care units and forensic inpatient and secure wards in May 2023, the Trust received must do actions for improvement regarding reducing the number of prone restraints. The Trust has a positive reporting culture and so we are confident that when a prone restraint takes place it is reported. We also recognise the need to reduce and aim to remove the use of prone restraint.

- In low and medium secure wards the benchmarking data shows that the use of prone restraint is lower than the national. Prone restraint for administration of intramuscular (IM) medication remains the most common reason for use of prone for all Care Groups. The alternative injection site task and finish group will continue to work through their actions to support reducing prone restraint. Exiting seclusion is the second most common reason for the use of prone restraint within all care groups. The RRPI team are piloting a specific safety pod for use in seclusion rooms to remove the need for prone. They have established safe techniques for exit which need to be risk assessed by moving and handling colleagues. Once these are approved, this will be piloted on Newhaven Ward before being rolled out.

- **Training Compliance**
  De-escalation and breakaway training compliance is currently at 66% against a target of 80%. We are working with two external providers to deliver this training and increase compliance as a soon as possible.

MB stated that before the CQC visited the Trust, assurances were received that the use of prone was appropriate in areas of the Trust however we are now being advised that prone is being reduced and queried as to why., DT advised that prone restraint is never ok and is always something that will be avoided wherever possible and the RRPI team will also provide visits to wards to seek alternative options where we reported. DT noted a step change in our ambition since the CQC visit with a desire of zero prone restraint.

MB queried if there had been a change in clinical practice or a change in how prone restraint was being recorded. DT offered clarity that the Trust was not suddenly reducing the use of prone restraint and that there had been a trend reduction since November 2022 and confirmed that there has been a change in clinical practice.

CGH confirmed that the reporting continues to be accurate, including the recording of where it is taking place. From conversations with the team who are engaging with other organisations who report zero prone restraint, they have made adaptations to their reporting and practice which have made a difference to them being able to report zero prone restraint and a meeting with them is being rearranged for later in January to discuss.

NM summarised the discussions and noted that updates will still continue to come though this Committee, taking on board that a certain level of assurance is being sought in relation to improvements.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/260 Clinical and Strategic Approach to Improvement in Learning Disabilities (agenda item 13)

NM noted that this report was to receive and note the highlight report and the Committee were happy to receive the report.

NM would like an update come to back to the next Committee with regards to the Oliver McGowan training about people with a learning disability and autistic people, and whether or not there is deadline for this to be completed within this year.
Action: DT

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/261 Reports from Formal Sub-Committees (agenda item 14)

QS/23/261a Drug & Therapeutic TAG (agenda item 14.1)
The report was taken as read and received.

QS/23/261b Infection, Prevention and Control (agenda item 14.2)
The report was taken as read and received.

CQS/23/261c Joint Safeguarding (agenda item 14.3)
The report was taken as read and received.

QS/23/261d Reducing Restrictive Physical Interventions (agenda item 14.4)
Included at item 12.

QS/23/261e Improving Clinical Information Governance Group (agenda item 14.5)
The report was taken as read and received.

QS/23/261f Clinical Governance Group (agenda item 14.6)
The report was taken as read and received.

QS/23/261g Clinical Ethics Advisory Group (agenda item 14.7)
There was no update for this item.

QS/23/261h QUIT (agenda item 14.8)
The report was taken as read and received.

QS/23/261i Safer Staffing (agenda item 14.9)
Included at item 11.

QS/23/261j Physical Health (agenda item 14.10)
The report was taken as read and received.

QS/23/261k Nutrition Steering Group (agenda item 14.11)
There was no update for this item.

QS/23/261l Falls Q2 Update (agenda item 14.12)
There was no update for this item.

QS/23/262 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 15)

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 Families.
- 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 has 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 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.

QS/23/263 Risk Register review (agenda item 16)

No further risks to discuss.

QS/23/264 Work Programme (agenda item 17)

There were no further updates for this item.

QS/23/265 Date of next meeting (agenda item 18)

The next meeting will be held on 13 February 2024 (MS)

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Quality & Safety Committee meeting
Tuesday 13 February 2024
9.00am – 11.15am
Microsoft Teams

Present:	Nat McMillan (NM) Darryl Thompson (DT) Marie Burnham (MB) Dr Subha Thiyagesh (SThi) Carol Harris (CH) Kate Quail (KQ) (Chair)	Non-Executive Director (Chair of the Committee) Chief Nurse / Director of Quality and Professions (Lead Director) Chair of the Trust Chief Medical Officer Chief Operating Officer Non-Executive Director
Apologies:	Carmain Gibson-Holmes (CGH) Julie Williams (JW) Yvonne French (YF)	Deputy Director of Nursing, Quality and Professions Assistant Director of Corporate Governance & Risk Assistant Director of Legal Services
In attendance:	Sarah Harrison (SLH) Jane Barratt (JB) John Laville (JL)	PA to Chief Nurse / Director of Quality & Professions (author) PA to Chief Executive (observing) Governor (observing)

QS/23/268 Welcome, introduction and apologies (agenda item 1)

As Nat McMillan (NM) was dialling in from out of the country, Kate Quail (KQ) undertook the role of chair and 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. John Laville (Governor) and Jane Barratt (Personal Assistant) were observing the meeting today.

KQ outlined the Microsoft Teams meeting protocols and etiquette.

QS/23/269 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/23/270 Minutes from previous Quality and Safety Committee meeting held 9 January 2024 (agenda item 3)

The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 9 January 2024 as a true and accurate record.

QS/23/271 Matters arising from previous Quality & Safety Committee meeting held 9 January 2024 and action log (agenda item 4)

KQ raised a queried on the action log from the 9 January, an item relating to the full cost improvement programme (CIP) and will pick up a discussion later in the agenda on this.

Nat McMillian (NM) advised of a meeting which took place on the 5 February regarding safer staffing reports and advised that a really good discussion took place on the progress of this report which will return to the Committee in April.

The action log was reviewed and updated as follows:

- QS/23/258 Safer Staffing Report
  NM is still to speak to Mandy Rayner in relation to the Establishment Officer Post. Ongoing.
- QS/23/258 Safer Staffing Report.
  Student Placement report on the agenda today.
  Closed.
- QS23260 Clinical and Strategic Approach to Improvement in LD Services.
  Oliver McGowan training is on the agenda today.
  Closed.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates.

QS/23/272 Committee related risks were reviewed in accordance with the terms of reference. Including:

DT advised the Committee of a broad update being received today and the new risks that have been added from previous discussions at Committee.

DT asked for a discussion around the children's services risk. Carol Harris (CH) advised she would like to discuss the paragraph that relates to RISK ID 275 which is a risk level of 15+.

CH advised that when this report was written, the information was correct and relates to the Kirklees Keep in Mind Contract (which is also included within the Care Group Report later on the agenda).

The council have decommissioned Northorpe Hall (Tier 2 CAMHS). As a result of this closure the referral service will transfer to SWYPFT and, with this change of pathway we are being asked to cover 100% of schools, when previously the Trust covered around 50%, therefore it is a growing concern. Conversations are taking place with commissioners. This has happened since this risk report was written.

Marie Burnham (MB) advised that she met yesterday with Mark Brooks to discuss this concern and the financial pressures that this will incur and the Trust being the main overall provider for CAMHS. MB and Mark noted that this will need to be discussed at Trust Board as a major risk in terms of escalating waiting lists and the financial pressures.

MB confirmed that this will be discussed in the Board strategy refresh.

DT informed that discussions had previously taken place at each Place Quality Committee and as providers and partners in the system, the sharing of quality impact assessments would take place if it was deemed that a decision would impact other organisations. DT advised that this has not happened in this situation.

The Committee were assured around the current risk levels in the report.

KQ referred to a discussion at the January Committee meeting relating to ownership and accountability of risks. In some cases there were multiple owners of the risks and KQ wanted to drill down into who was ultimately responsible for overseeing the management of a risk.

DT informed the committee that when initials are aligned to the risk, this in turn invites each Director to have a role in the accountability of said risk.

CH informed that as part of the Trust's leadership style, collective leadership is practiced and therefore all directors are responsible, which is echoed throughout the Trust.

MB confirmed that she was in support of KQ and was supportive of collective leadership however could not support collective accountability and that an accountable officer should be identified who can hold executive colleagues to account. The group agreed to discuss this outside of the meeting.

NM raised a query regarding RISK ID1624 relating to the availability of Section 136 suites. The risk narrative suggested potentially reviewing and closing the risk in quarter 4. NM asked if there was confidence to continue with this plan and close this risk. CH advised that although progress had been maintained in relation to out of area use, this still required close management and therefore she would not recommend that the risk is closed. Committee agreed.

It was RESOLVED to RECEIVE the update.

QS/23/273 Staff / Team Story (agenda item 6)

There was no staff story or update this month.

QS/23/274 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:

- Quality impact assessment for the care closer to home initiative. Efficiency programs such as this are in place which are about improving quality and not to implement cost improvements within services. DT and SThi have reviewed the quality impact assessment and further work has been requested with regards to the detail of the metrics and their reporting structures.
- Feedback from the Calderdale Quality Committee where the Trust's CQC inspection was discussed, and also the Chair of Calderdale Quality Committee visited the Laura Mitchell building last week (more detail next month).
- Cathy Winfield, Chief Nurse for South Yorkshire ICB visited the Trust and gave very positive feedback about the teams that she met at Kendray Hospital.
- Oliver McGowan Training in learning disability and autism.
  The e-learning aspect of Tier 1 training (mandatory) has now been completed by over 2500 members of staff, with plans in place for the attendance at webinars, to complete the Tier 1 compliance. We have received positive feedback on this training.

  NM asked if there was a target for level one training or do we have to wait for the webinar to be provided. DT advised that we have submitted to the CQC our e-learning

attendance which shows the commitment and delivery to the training as we were given a target of 10% which would satisfy the CQC requirements at this time. DT confirmed that for the Trust the target would be 80% as this is mandatory training. Level two training will be essential to job role training where uptake would be reported.

NM would like this to be captured within the integrated performance report (IPR) to enable monitoring around the training.
Action: DT

KQ would like to see trajectory and clarity of which staff members have undertaken the training for levels one and two.
Action: DT

QS/23/275 Quality and Regulatory Oversight Paper Inc Quality Monitoring Arrangements (agenda item 8)

The paper had been circulated to all members prior to the meeting.

DT gave a brief update.

The report for February 2024 contained the following information:

- An update on the approach to the action plans and progress against the MUST DO and SHOULD DO actions within the CQC inspection reports.
- Detail of the quality monitoring visit to Walton Ward which took place in January 2024.
- The quality monitoring visit schedule up to March 2024.
- Information about the proposed quality oversight, monitoring and support (QOMS) approach which is being developed to enhance and support oversight of monitoring the quality of Trust services.
- Updated data on the new enquiries received into the Trust from the CQC, broken down by Care Group.
- Information about the CQC's single assessment framework.
- An overview of the process for CQC mental health act inspections within the Trust, including the receipt of reports and action plans.
- Update on the plan for developing the Quality Account for 2023/24.
- An update on the implementation of the Triangle of Care across the Trust to support a consistent offer to unpaid carers.

KQ acknowledged the helpful and clear paper and liked the new development of the QOMS.

NM would like a wider discussion at Board for "drop ins" to wards to see what is happening on a day-by-day basis, obviously to not give any disruption to staff and service users, but to gain a helpful insight without causing alarm.

DT confirmed that both QOMS and QMV's will remain but with a blend of intelligence of data.

NM thought that it also might be helpful to have an appendix at the end of the report with a visual to show the "must do" "should do" actions and the progress of these with evidence of assurance. MB agreed with NM on this. DT advised that this had recently been presented to the executive management team and will be provided to next committee.
Action: DT

MB advised that last week she wanted to visit some wards spontaneously however as the managers were not available she was advised that she couldn't visit. MB did manage to visit Stanley and Nostell wards yesterday which was all very positive and well received. On the back of this visit MB discussed QOMS with DT, as it gave MB a reflective log rather than an inspection log and is encouraged by the QOMS approach as it would help her thinking as a Chair to be more informed.

It was RESOLVED to RECEIVE the Quality & Regulatory Oversight Paper.

QS/23/276 Care Group Quality and Safety Report (agenda item 9)

CH advised the Committee of the pressing issues within the report.

Key Issues for February Committee

Paediatric Audiology

Paediatric audiology is a concern. Performance of 6 weeks for a diagnosis has not returned to target and the team have reported that rising demand, post COVID-19 and a result in changed pathways, is outstripping capacity, with no ready access to additional skilled staff to increase appointments.

Results of a national audit into paediatric audiology have been provided to the chief medical officer via the integrated care board (ICB), indicating a significant concern with the service and setting out the following concerns and expectations:

- There is no evidence of any documentation relating to assessment, management or testing protocols. It is expected this is reviewed and considered urgently. We recommend further to this action once these have been implemented, that a site visit by a subject matter expert is carried out to ensure the service has them embedded.
- There was no evidence of risk or incident ownership or action plan development. It is recommended this information is reviewed and an action plan put in place to ensure risks and incidents are monitored and managed appropriately.

Actions are underway locally and across the ICB to address the concerns. In the audit, staffing scored in the highest category, but this related only to the qualifications of the staff, not the availability and capacity to meet demand.

The executive trio are concerned and have requested an urgent deep dive into both the actions in the audit and the demand and capacity. A further update will be provided to committee in March 2024.

MB is aware of the significant concerns with this and has discussed with Mark Brooks and agreed that the service needs financial support and more staff in place or be moved back into the acute sector due to infrastructure and equipment. CH was in agreement with MB and exec Trio will have oversight of the development plan.

Prone Restraint

Work continues in relation to reducing prone restraint. Attitudes towards prone are tested on service visits and staff are without exception keen to explain that care is taken to avoid prone wherever possible. This continues to be supported through the reducing restrictive physical interventions team reviews of incidents. Safe exit from seclusion and rapid tranquilisation injection sites remain areas of focus. Training is underway on alternative injection sites and

smaller safety pods, (similar to bean bags) to be used to facilitate seclusion exit have been ordered for delivery by 31 March 2024.

Invited review service report into adult autism service
The Trio met the team following the discussion in the last committee to confirm the action plan and the reporting mechanisms. The executive trio have been asked by external and internal stakeholders for a copy of the report and have carefully considered how the information should be shared. In the spirit of the Trust value of being open, honest and transparent, the executive trio have agreed with the team that a covering letter, the report and the associated action plan will be shared with key stakeholders. Work is underway to prepare this for sharing, including advice from the communications team and the associate director of nursing, quality and professions.

Industrial action
A meeting to identify learning from the recent periods of industrial action took place. Trainee doctors reported that the financial impact of strike was hitting them personally. Some doctors didn't strike on all days, to minimise the pay loss. Whilst still no major impact has been reported, the longer-term impact remains not known. Additionally, it was identified that indirect consequences, such as changes in work patterns and activity being shifted to another time are not always quantifiable. Staff are also impacted across all disciplines who change their usual practice or pick up additional responsibilities to mitigate the impact for service users.

Inequality for people with a learning disability
Access to learning disability support for children and young people in Barnsley has been escalated and has been identified as a risk for the Trust and for the integrated care system. Senior discussions are ongoing at Place, but a resolution has not yet been achieved. Access to assessments for attention deficit hyperactivity disorder (ADHD) for adults with a learning disability has not yet been resolved, but following further escalation, the business case is being considered.

Quality surveillance in forensic services
The provider collaborative has a structure of four levels of monitoring for all providers. Routine, focussed, enhanced and intensive. Medium secure mental health services have been under focussed monitoring from the outset in response to concerns regarding the women's pathway and to support monitoring of the Johnson Ward actions that have been reported to committee previously.

Focussed monitoring is the next step from routine monitoring and is applied where quality and performance risks are increasing or persistent. It is used where providers are demonstrating good standards of quality and performance monitoring and actively engaged in assuring care managers and the commissioning hub of specific risks which may require improvement plans and regular updates. An action plan is in place and is monitored as described.

Following the CQC report, low secure mental health wards and Newhaven low secure learning disability inpatients were also stepped up to focussed monitoring. However, this was stepped down to routine monitoring on 1 February 2024 following submission of the CQC action plan and monitoring arrangements.

Kirklees Keep in Mind (CAMHS)
Changes to the way the service is funded and commissioned means that Northorpe Hall, who provided the single point of access and support for children in Kirklees has been decommissioned, with a move towards a whole school approach provided by the Trust. The Trust has been asked to provide mental health support to 100% of schools (previously 53%) within a reduced financial envelope. Whilst this is for the financial, investment and performance committee to oversee, the key concern for quality and safety committee is the likelihood of increased wait times for children to access the service, in an area that has over

recent years made significant improvements in access to core CAMHS services. This will compound the existing waits for neurodevelopment assessments. Work is taking place with commissioners on how this can be addressed, and committee will be kept informed.

Trio to Trio

The first of the trio-to-trio meetings, where the executive trio meet with a trio in a care group, was held with the Barnsley community trio. Topics discussed were related to maintaining connectivity between Place, the alliance and the wider Trust, how physical healthcare expertise can be drawn upon by the wider organisation and how to manage the message that we are not a 'mental health' Trust, specifically when we are recruiting staff. There was an additional focus on paediatric audiology and the action plan following the audit. Barnsley trio identified that lots of time is taken up in day-to-day crisis avoidance or management, leaving very little time for reflection and planning. However, they are engaged in the Trust strategy refresh and keen to be involved in delivery and realisation.

Patient flow

The strong focus on patient flow has maintained low out of area mental health bed use. Two incidents, following a very busy weekend led to further discussion in the patient safety oversight group regarding the use of temporary beds as an alternative to sending someone out of area. The process that was agreed in May 2023, along with a patient information leaflet, is in line with the patient flow procedure which advises that if no bed is available the following options should be considered within the locality and recorded on Datix when implemented:

- Keeping someone in a safe place on the ward environment
- Temporary placement on another ward
- Temporary relocation of an existing service user to another ward

Risk and clinical need are considered when determining the most appropriate course of action. It must be noted that if a safe temporary solution is not available then an out of area placement would be progressed.

As the temporary solutions have not been required for some time, the trio have asked the service to review the arrangements in place, including the quality impact assessment and provide assurance that the processes remain appropriate.

Changes to the crash team response on the sites of Mid-Yorkshire Hospital in Dewsbury and Calderdale Royal Hospital in Halifax

Historically, should a service user on any of our in-patient wards on the Priestley Unit or The Dales required cardiac resuscitation, the acute hospital's crash team has been called in addition to an ambulance. This was recently reviewed due to concerns around differences in equipment used and the practicalities of access to wards by the crash team members, all of which brought variance across our mental health inpatient wards with regards to expected resuscitation response (wards in Barnsley or Wakefield simply call an ambulance). It was, therefore, agreed that there was increased risk by using the crash teams than to not, given the focus during an incident needing to be on immediate cardiopulmonary resuscitation rather than managing potential complexity of the crash team response.

This decision was communicated with colleagues in the local acute trusts and in the local ambulance service. It was also communicated with staff via a Bluelight alert, to make sure teams were aware, and the resuscitation team visited all Trust wards on the day of the change. Their findings were that everyone they came across had seen the Bluelight alert and knew that using the 2222 number to call the crash team was now obsolete and to ring (9)999 for an ambulance. All linked phones, posters and equipment has been removed and staff updated. Teams on the Dales and Priestley already call for an ambulance when needed so this is not a change in this practice. Yorkshire Ambulance Service have confirmed that this will not be a change in process for them as they already attend as a priority when called.

Older people's inpatient services transformation – update on public consultation

The public consultation was launched successfully in the beginning of January 2024. There have been a number of opportunities available for feedback on the options proposed. There have been over 300 people engaging in the six events across the three places of Calderdale, Kirklees and Wakefield. Around 400 surveys have been completed with a good mix of feedback from the public, staff, service users and carers. There is a planned mid-point review with the joint overview and scrutiny committee as part of planned assurance point of the consultation process and key metrices. An update has been provided to Trust board and further update will be shared with the committee. Subha Thiyagesh (SThi) confirmed that the mid-point review took place yesterday with around 40 colleagues to share the feedback and it was agreed to plan more events for the public.

RECONNECT
The executive trio are really excited about the development of a new service, in line with a national model, within the health and justice pathways in South Yorkshire and the impact it will have on reducing health inequalities, increasing inclusion and improving the health of a vulnerable group of people.

The health and justice system section of the NHS long term plan identified that 250,000 people go through prison annually and 57% serve sentences of 12 months or less. On leaving prison people are at increased risk of instability, experience an exacerbation of their vulnerabilities and have their care pathways interrupted at a time when they most need continuity of care. The new RECONNECT service will provide a pathway into the four South Yorkshire prisons, working with people before they leave prison to help them to make the connection with community-based services that will provide the health and care support they need. The executive trio will visit the team once they are fully operational.

KQ thanks the Trio for the report and found it self-explanatory and helpful.

KQ queried the ambulance crash team situation and whether there needs to be a focus around CPR training for staff. DT confirmed that there was already a focus on CPR training where required, the crash team response changes do not bring additional risk to this, the situation is being monitored and any areas with a lower uptake of the training are being supported and monitored.

KQ noted the time and effort that has been put into the older people's consultation and queried whether carers have been considered as part of the conversations going forward, as well as the communities that haven't contributed as yet. SThi confirmed that the carers network had been involved and attended the meetings that have taken place.

SThi also advised in terms of the crash team issue above that there will be a focus on the low uptake wards and is part of the IPR.

The Quality Care Group and Safety Report was RECEIVED and NOTED.

QS/23/277 Breakdown of Student Placements Pre and Post COVID-19 and future predictions (agenda item 10)

The paper was taken as read.
DT gave a brief update to the group and advised that this was the overarching placement provision and the reduction comparison to pre COVID-19 placements in some areas.

DT advised that there were 49 fewer places than pre COVID-19. Care Groups are undertaking a piece of work to look at the variants between teams and the ambition is to enhance the Trust's student placement offer. Some teams have challenges of being able to support students as they have a limited number of substantive senior registrants, and they are already supporting trainee nurse associates, preceptee nurses & internationally educated nurses. DT

also advised that student placements are being considered within different parts of the organisation and that the nursing directorate have also taken on students within the infection prevention and control and safeguarding teams.

KQ queried as to whether this will this be taken to the people and remuneration committee (PRC) for them to consider. DT advised this this report was created for this meeting. NM confirmed that this was here for assurance, however suggested it could be an action for the PRC around workforce planning but with a link to this committee for the quality of placements.

SThi informed the Committee that the Trio have discussed this at length, especially with the aspirations of being a teaching trust.

NM agreed to speak to Mandy Rayner about this paper for it to be considered in PRC.
Action: NM

All agreed that this was a helpful paper.
The Committee RECEIVED and NOTED the update.

QS/23/278 Trust Wide Serious Incidents Q3 Report (agenda item 11)

The report was taken as read.

DT gave the key headlines:

Incident Management Trust-wide report

- The number of incidents reported in Q3 2023/24 was 3,766. 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.
- Physical violence from patient to staff (contact made) has reduced for the fourth consecutive quarter.
- All serious incident investigations currently underway are within agreed timescales.

Learning from experience

We incorporate learning from experience into the report. This shares the learning from incidents in Q3 2023/24 and examples of learning in practice. New learning responses linking to PSIRF will be updated in Quarter 4 learning journey.

Serious Incidents

- Patient Safety Incident Response Framework (PSIRF) - replaces the Serious Incident Framework. We transitioned to PSIRF from 1 December 2023.
- There was one serious incident reported in Q3 2023/24.
- Serious incidents account for 0.02% of all incidents.
- We have continued to strengthen our initial review process to ensure we are using our resources to investigate the right incidents, as this will be the approach in the future under Patient Safety Incident Response Framework (PSIRF).
- During Q3 2023/24 there were no 'Never Events'.

Learn from Healthcare Deaths

- 89 deaths were reported in Q3 2023.
- 70 of the 89 deaths were in scope for mortality review.
- There are no areas of special cause variation that require further exploration.
- Quarterly data on deaths is published on the internet page.

KQ stated it was a really good report and had no comments to make.

NM queried page 13 of the report and whether we are reducing the serious incidents as a direct result of the learning. DT advised that at the moment he cannot confidently confirm this given the small numbers. DT will ask the team to reflect in more detail before Trust Board, however there is currently no assumption of a causal effect.

The Committee RECEIVED and NOTED on the Trust Wide Serious Incident Q3 Report.

QS/23/279 Internal Audit Report (agenda item 12)

Nil.

QS/23/280 Learn from Patient Safety Events (agenda item 13)

DT advised the Committee that this was a key part of the new recording system, with a stronger focus on learning and improvement and is here to give the Committee assurance that the Trust is engaged with all expected processes.

The Committee found the paper a helpful summary.

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/281 Engaging with Service Users, Carers and Staff (agenda item 14)

DT advised that this was a core expectation of PSIRF and informed that this was the progress to date on the engaging with service users, families and staff guidance as a key component of the transition to the Patient Safety Incident Response Framework (PSIRF).

DT also advised that three Patient Safety Partners had been appointed who all bring a vast and complimentary range of experiences and skill sets. A family liaison officer has also been appointed who is a very experienced team manager.

The paper is to give assurance of progress to the Committee and DT confirmed that this work is also aligned with triangle of care.

KQ noted the great progress and stated it was a very helpful paper.

NM would like to know whether the above roles have made a difference and would like to have an update in six months' time.
Action: DT

The Committee RECEVIED the report.

QS/23/282 Reports from Formal Sub-Committees (agenda item 15)

QS/23/282a Drug & Therapeutic TAG (agenda item 15.1)
The report was taken as read and received. ADHD medication shortage continues and work is underway on this with partners.

QS/23/282b Infection, Prevention and Control (agenda item 15.2)
There was no update for this item.

CQS/23/821c Joint Safeguarding (agenda item 15.3)
There was no update for this item.

QS/23/282d Reducing Restrictive Physical Interventions (agenda item 15.4)
The report was taken as read and received. NM noted the discussions that have taken place previously on this and would like to thank the teams for their hard work. The report gives the focus and assurance that has been needed. KQ raised the issue of capacity due to some people leaving the team. DT advised that the team have been under a lot of pressure and advised that some members of the team have moved back to shift based ward work or to move over to different areas. DT highlighted to the Committee how demanding the job is and the physical toll that it can take on a person. A lot of work has been done on recruitment and EMT have been very supportive of this. The result is the team has appointed a number of new starters.

NM expressed a wish to visit the RRPI team.
Action: DT

QS/23/282e Improving Clinical Information Governance Group (agenda item 15.5)
There was no update for this item.

QS/23/282f Clinical Governance Group (agenda item 15.6)
There was no update for this item.

QS/23/282g Clinical Ethics Advisory Group (agenda item 15.7)
There was no update for this item.

QS/23/282h QUIT (agenda item 15.8)
The report was taken as read and received. SThi advised that the Trust my not be meeting all the key performance indicators of the QUIT programme as a result of the delay in the "go live" and conversations are taking place in the Trust and across partner organisations.

QS/23/282i Safer Staffing (agenda item 15.9)
There was no update for this item.

QS/23/282j Physical Health (agenda item 15.10)
There was no update for this item.

QS/23/282k Nutrition Steering Group (agenda item 15.11)
There was no update for this item.

QS/23/282l Falls Q2 Update (agenda item 15.12)
There was no update for this item.

QS/23/283 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 16)

Alert:

- Paediatric audiology is a concern. Performance of 6 weeks for a diagnosis has not returned to target and demand. Additionally, the results of a national audit have identified 'significant concern' relating to documentation relating to assessment, management and testing protocols and risk or incident ownership and an action plan is in place locally and across the South Yorkshire ICB (Integrated Care Board). The Trio have requested an urgent deep dive into both the actions in the audit and the demand and capacity.

- **Kirklees Keep in Mind (CAMHS)** Changes to the way the service is funded and commissioned means that Northorpe Hall, who provided the single point of access and support for children in Kirklees has been decommissioned, with a move towards a

whole school approach. The Trust has been asked to provide mental health support to 100% of schools (previously 53%) within a reduced financial envelope. The key concern for the Quality and Safety Committee is the likelihood of increased wait times for children to access the service, in an area that has over recent years made significant improvements in access to core CAMHS services. This will compound existing waits for neurodevelopment assessments. Work is taking place with commissioners on how this can be addressed, and Quality and Safety Committee will be kept informed.

- There is no progress to report in relation to the inequalities for people with a learning disability in Barnsley, conversations as a result of escalation continue.

Advise

- Low secure mental health wards were stepped up to focussed surveillance following the CQC (Care Quality Commission) report. Medium secure mental health wards were already on focussed surveillance. Following assurance of the CQC action plans and the response, the concern was closed and low secure stepped back to routine monitoring, with medium secure remaining on focussed monitoring until the previous issues are resolved.
- The Dales and The Priestley Unit will no longer be accessing the acute trusts' crash teams but calling an ambulance as usual practice. Assurance was given that this will not incur risks, but will instead reduce the risk of variance of practice and response across all mental health wards.
- The Committee received an update on the public consultation of the older people's inpatient transformation, acknowledging the mid-point review and welcoming the drive to widen the diversity of people consulted.
- The Committee was pleased to hear about a new RECONNECT service which will provide a pathway into the four South Yorkshire prisons, working with people before they leave prison to help them make the connection with community-based services that will provide health and care support.
- Committee was pleased to hear about the very positive visit and feedback from the Chief Nurse at South Yorkshire Integrated Care Board, Cathy Winfield, who visited Kendray Hospital on 16 January.
- The Committee was interested to hear about a proposed new Trust Quality Oversight Monitoring and Support (QOMS) approach being developed, to enhance and support oversight of the quality of Trust services.

Assure

- The Committee received a Reducing Restrictive Physical Interventions Highlight Report. Assurance was sought and given of progress with improvement.
- The Committee received the Trust-wide Incident Management Report - Quarter 3 2023/24. Assurance given that:
    - 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.
    - Physical violence from patient to staff (contact made) has reduced for the fourth consecutive quarter.
    - All serious incident investigations currently underway are within agreed timescales.
- Committee received an update on transitioning to the new Learn from patient safety events (LFPSE) and welcomed the progress.
- Update received on Engaging with service users, families and staff following a patient safety incident - as a key component of the transition to the Patient Safety Incident Response Framework (PSIRF)

- Committee were assured that out of area bed use continues to be low, but noted recent pressures have required the use of a temporary bed in line with agreed processes. Assurance received that the executive trio have asked the service to review processes including the quality impact assessment to ensure that they are still fit for purpose.
- The Committee received an update on compliance with mandatory Oliver McGowan staff training on learning disability and autism. As of 29 January 2024, 54.6% of the Trust's workforce had completed the e-learning aspect of Tier 1 training. The Committee asked for further clarification and assurance to come to the next meeting.
- Committee received a Non-Medical Education and Training, Placement Capacity Restoration Review and was assured that activity is underway to restore to pre-pandemic levels and increase placement capacity.

QS/23/284 Risk Register review (agenda item 17)

- Committee reviewed the Organisational Risk Register and highlighted the ongoing discussions around Risk 275 'Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners'. 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. It was also noted that specific work regarding children's services should reduce the risk.
- Risk 1568 'Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm'. Committee discussed and noted that 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 is in use. The scores are expected to remain until building work is complete. This will be reviewed in Quarter 4.

QS/23/285 Work Programme (agenda item 18)

There were no further updates for this item.

QS/23/286 Date of next meeting (agenda item 19)

The next meeting will be held on 12 March 2024 (MS)

AOB

DT advised the Committee that as of the 1 March 2024 Carmain Gibson-Holmes will be moving to Carol Harris' directorate to become the Director of Services for the Children and Families Care Group. DT wanted to note Carmain's significant contribution to the nursing, quality and professions directorate and to this Committee over the last two years.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Equality, Inclusion & Involvement Committee meeting held on 13 December 2023 Via Microsoft Teams

Present:	Marie Burnham (MBu) Dawn Lawson (DL) Erfana Mahmood (EM) Mike Ford (MF) 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) Greg Moores (GM) Chris Lennox (CL) Sue Threadgold (ST) Zahida Mallard (ZM) Heather McKnight (HMc) Melissa Harvey (MH) Sarah Whiterod (SW)	Non-Executive Director HR Business Manager Chief People Officer Director of Services, Adults and Older People Mental Health Deputy Director Equality & Involvement Manager Equality & Involvement Manager General Manager, Adult Community Services Associate Director of Nursing, Quality & Professions
In attendance:	Gemma Lockwood (GL) Dawn Pearson (DP) Gillian Cowell (GC) Paul Cartwright (PC) Catherine Musegedi (CM) Lindsay Jensen (LJ) Sophie Hempsall (SH) Mike Garnham (MG) Sara Javid (SJ) Michaela Kenworthy (MK) Aboobaker Bhana (AB) Iffath Hussain (IH) Carmain Gibson-Holmes (CGH) Naomi Fernandez (NF) Amanda Miller (AM) Jane Barratt (JB) Laura Hickling (LH) Tony Wright (TW) Claire Strachan (CS)	Corporate Governance Admin Manager (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 Deputy Chief People Officer Associate Director for Nursing & Professions Health Intelligence Analyst/Information Manager Public Governor for Kirklees LGBT+ staff network Chair Equality & Involvement Manager Diversity, Inclusion & Belonging Lead Deputy Director of Nursing, Quality & Professions Head of People Experience Associate Director of Operations PA to Chief Executive Vice Chair of Disabled Staff Network Sustainability Change Manager Head of Quality for Children's Services

Section 1 – Standing Opening Items

EIC/23/72 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.

EIC/23/73 Declarations of interest (agenda item 2)
None.

EIC/23/74 Minutes of previous meeting held on 13 September 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 13 September 2023.

EIC/23/75 Matters arising from previous meeting and action log (agenda item 4)
Dawn Pearson (DP) reviewed the action log and updates were added.

EIC/23/76 Actions from Trust Board (agenda item 5)
MBu advised that the strategy refresh will be discussed at the Strategy Board meeting next week and this committee will be looked at in terms of functionality and to ensure the focus of the committee is where it should be.

EIC/23/77 Review of Committee related risks and any exception reports as required (agenda item 6)
Dawn Lawson (DL) reviewed the risks with updates below.

Mike Ford (MF) raised that Risk 1729 around staff wellbeing is shared between Equality, Inclusion and Involvement Committee and People and Remuneration Committee and queried if Risk 1157 around diverse and representative workforce should be shared between the committees as well to ensure it receives the correct attention from both PRC and EIIC. LJ advised that the risk is already shared across the committees. MBu requested that EMT look at the shared risks to determine an owner and reiterated that our risk register needs to be reflective of what is happening in the real world.

MF mentioned the discussion around an emerging risk around capacity and advised that there is already a risk assigned to Audit Committee relating to this and queried if this can be covered in Audit Committee or if a new risk is needed in EIIC. MB agreed that the emerging risk can be encapsulated within the existing risk through Audit Committee.
MF queried if the expected data completion date of March 2024 is realistic in light of the risks around capacity and MB responded that due to an internal audit around our overall risk approach and a recommendation that if an action is ongoing, there needs to be a due date, or a due date for review of progress.

Action – Dawn Lawson

Risk 1729 – DL confirmed this risk will be reduced from likely to possible as agreed in the last committee meeting.

Risk 1689 – DL confirmed the wording for this risk, mitigation and controls have been updated for approval. MB queried the rationale for the removal of some of the controls in Risk 1689 and DL responded that data was not reliable and that controls will be put back in when the data is more accurate. It was agreed to put the controls back in and to review again at a later date and also at EMT.

The Committee members NOTED the current Trust-wide corporate/organisational level risks.

EIC/23/78 Context report – National, ICS and Trust level (agenda item 7)
DP took the report as read and highlighted the summary on the front sheet of what the committee needs to be aware of and consider including:

- The patient and carer race equality framework which will need to be implemented with some work ongoing in the background.
- There is a workforce race equality standard which is emergency for Pharmacy which will be released soon.
- There is some new chaplaincy guidance which outlines support that can be provided to people.
- There is some emerging guidance around perinatal mental health and supporting people which as a Trust we are doing.
- The 10 year government plan around a mentally healthy nation which will align with our action plan.
- The role of the NHS in the delivery of sustainability and responsibility.
- NHS England including health framework as part of addressing health inequalities.
- New suicide prevention strategy.
- Digital and mental health and how it is used which will be fed into the strategy refresh.

MB advised that when the patient care and risk quality framework was in development, a paper was presented to EMT to align our action plan to what was being recommended which would be useful to bring to this committee.

MB mentioned the massed of guidance that is issues and how do we know these have been aligned to our own guidance and encapsulate the guidance that is important to the Trust. DP confirmed the relevant documents are shared with the relevant teams and go through OMG and care groups, with the acknowledgement that there is a lot and it is difficult to establish what the priorities are, however there is a process. MBu suggested a schematic about how we take guidance, what we are going to do and what we'd like to do.

Action – Dawn Lawson

The Committee members NOTED the contents of the context report.

Section 2 – Insight, feedback, and programme updates

EIC/23/79 Staff network update (agenda item 8)

LJ introduced Iffath Hussain (IH) to give an update on the staff networks. IH confirmed that elections have been carried out for the Disability Staff Network with Laura Hickling elected as the Vice Chair and Sarah-Jane Wilson as Chair. IH advised that an infrastructure is under construction for all networks with an annual comms and action plan for 12 months. An annual members calendar is also in development to ensure members can attend meetings in an equitable way.

MB advised that a proposal is due to go to EMT around protected time and budgets and Iffath responded that the EIA is underway for the new policy and expressed that an Exec sponsor for each network would be nice. EMT paper is expected in early January.

MB passed on thanks to GC for all her hard work over the last few months and acknowledged Aboo's contribution. MB queried comms and awareness across the trust and queried if any more needs to be done. GC reiterated that the training needs to be rolled out more and more time allocated, which will help raise awareness.
CGH reflected that the restorative nature of nature and the sustainability agenda link together and is important to us as human beings and important for wellbeing. How can these networks be merged with sustainability factors.
AB added that the work around supporting staff networks is crucial and the Trust should think about how funding for retreats etc can be funded, recognising that it does work and if it does work why not invest more in it.

Disability Network
Laura Hickling (LH) gave an update on the ongoing work within the Disability Network including a revamped intranet page, six new members and a dedicated stall at welcome events.

REaCH
Aboo Bhana advised that the REaCH network event was hugely successful and helped revitalize the network with 40+ new members in three months. Aboo and Catherine will step away with elections to recruit new people starting in January with the hope of taking the network to the next level.

Carers Network
IH confirmed that elections are underway for the carers network and IH reiterated thanks to Gillian Cowell for all her hard work.

Gillian Cowell (GC) took the committee through some slides around the carers network and played a video. 600 people per day leave work to care and one in three NHS staff provide unpaid care at home with more than 1.9 million people in paid employment becoming unpaid carers every day. The network was formed in November 2020 with a distribution list of over 80 staff carers which is 50% larger than last year and still growing and staff carers can now be identified on ESR. The Trust is maintaining the level 2 benchmark, aiming for level 3 in 2025.

LGBTQ+
IH confirmed that elections have been held and there is a brand new steering group in place. Michaela Kenworthy (MK) is the new Chair of the network. MK advised that the intranet pages are being refreshed with lots of proactive ideas in the pipeline including collaboration with other networks.

The Committee members NOTED the staff network update and presentation.

EIC/23/80 Care Group Highlight Report (agenda item 9)
Claire Strachan (CS) joined the meeting and briefly took committee through the report highlighting the following:

- The Quality Improvement and Action Group has been merged with the Children's Services Experience Group.
- In reviewing the EIAs for financial poverty and access to poverty, this was frequently not applicable which was challenged to encourage review to understand the impact on attending appointments, particularly in the local community.
- Work has gone into creating a more equal mixed gender team to enable service users to be able to choose who they would like to have an appointment with.

MB queried if services are aware of where support is available and CS responded that there is collaborative working. Mike Garnham (MG) confirmed there are groups looking into data around protected characteristics which now includes financial poverty and highlighted that post codes don't always provide an accurate reflection.

The Committee members NOTED the contents of the Care Group highlight report.

EIC/23/81 Patient/Public Story/Campaign (agenda item 10)
DP presented a film about young carers and AB added that the film was not scripted and is young people talking about what they need. DP highlighted that the messages in the film apply to all of us, in trying to make sure that service users feel supported, especially young carers. AB confirmed that young carers are now included in the carers training.

The Committee members NOTED the film.

EIC/23/82 Sustainability report (agenda item 11)

Tony Wright (TW) took the paper as read and highlighted the following:

- The Green Team has been developed, which anyone can get involved with, and over 300 members of staff have already expressed interest.
- The ebike scheme is soon to go live with the first four members of staff due to receive their bikes in January.
- TW attended COP28 in Dubai and advised that it is all about changing hearts and minds and convincing people to get on board. Work smarter and greener, not harder.

IH suggested the networks would be an opportunity to socialise the ebike scheme, and other schemes, and TW advised it will be mentioned again in comms and the scheme is open to everyone. MB reiterated the need to get everyone thinking about what they can do to make a difference.

The Committee members NOTED the update.

Section 3 – Strategy and Policy

EIC/23/83 Strategy and Policy (agenda item 12)

DL advised that a strategy refresh is underway and reflected that this is something we do, rather than a way of being and how does this become business as usual as an agenda. DL is part of a national NHS Providers EDI programme to ensure we are learning from others and looking outwards as well as inwards.

We are embarking on a refresh of the Trust strategy which should be ready by late Spring with a number of other strategies due for refresh including, EDI, digital, workforce and clinical strategy and development with engagement across the Trust.

Erfana Mahmood (EM) highlighted that a lot of works goes into collating data for E&I, with a lot of issues to be tackled, and is it worth picking out big ticket issues to concentrate on, measure and make strong improvements on. EM confirmed that the previous E&I strategy cut across all other policies and was the golden thread that ran through, viewing every policy with an E&I lens and would like to continue this.

MB highlighted that there are too many actions in the plan and we need to make sure the scale of ambition, and how the ambition is achieved in a meaningful manner is realistic and achievable.

The Committee members NOTED the update.

Section 4 – Performance Reports

EIC/23/84 Performance dashboard/Case Study (agenda item 13)

DP highlighted the case studies within the paper which highlight the work that has been undertaken and shows that data does drive improvement.

IH outlined the workforce data bank banding. Previously that a relatively likelihood figure and the team are working towards a real time EDI dashboard. For this quarter there has been a focus on where staff are sat based on BAME by banding with the aim to see more BAME representation at band 7 and above. The data will be interrogated further for deeper understanding of the workforce and where efforts need to be focused.

MB advised that we are the first Trust across West Yorkshire to develop a dashboard of this type and the numbers speak for themselves, showing where efforts need to be focused. Numbers are one thing and experience is something very different. Staff from ethnic background shot not have to work harder for positions with equitable processes. Catherine Musegedi (CM) queried if it was possible to break numbers down into clinical and non clinical and also operational management to be able to further understand the data and MBu agreed this would be helpful.

Sara Javid queried if exit interviews are held and what is done with the information raised in them? SJ added there is evidence that line managers are usually the people who block development and training and is there another way to collect qualitative feedback and experience from people and how this can be done creatively. EM queried if we can collate and compare data for people from a BAME and a deprived background which would really show if we are making a difference in communities.

The Committee members NOTED the development of the dashboard.

EIC/23/85 Equality, Involvement, Communication and Membership strategy implementation action plan highlight report (agenda item 14)

DP took the paper as read and highlighted the update on all of you race forward as this was requested at the meeting in September.

The Committee members NOTED the update from the highlight report.

EIC/23/85a Staff Survey Update

Naomi Fernandez (NF) confirmed that our score has improved by 1% this year with a 50% response rate with a good representation of staff and 23% response from bank staff which is down 5%. Improvements have been noted in all nine areas compared to last year's score. A paper will be presented to EMT with further details of the outcomes and action plans following these results to demonstrate the you said we did. NF advised that we are slightly higher than mid range in comparison with other local trusts. IH added that the results of the staff survey will be quantified with the staff networks to break down responses from the different networks which will help form action plans.

EIC/23/85b Inclusive leadership and development programme update

NF confirmed that we are at the end of phase one of the inclusive leadership programme, working with Monique Carayol and is finishing with the last of the Your Voice Counts appreciative enquiry sessions with staff to hear their voice and listen to their voices. Monique is working on the results and the review diagnostic with a report due back in January 2024. This will then be presented to Trust Board and EMT with a plan to move forward to phase two.

EIC/23/86 Equality Standard update (WRES & WDES) (agenda item 15)

LJ updated committee members on the WRES and WDES action plans. LJ raised if we think these reports are coming to committee too frequently and not leaving enough time to work on improving the reports? IH added that there has been some peer comparator, aligning our action plans with other trusts and how they have worked towards changing the dial.

MB suggested an action around looking at all action plans, how they can be aligned and consolidated and how regularly and where they need to be reported.

Action – Dawn Lawson and Lindsay Jensen

The Committee members NOTED the update.

EIC/23/87 Equality Delivery System (EDS 2022) Update (agenda item 16)

DP advised that we are now delivering the new equality delivery system 2022 which is being consolidated to look at three areas of focus which are set out in the paper. The evidence that has been submitted needs reviewing and to note, we are taking the areas for work through the public with stakeholder events in January. The work this time will be different as the areas around commissioned or provided services will include three services that need to be reviewed with an honest appraisal of what we have and how this can be evidenced. A small panel from Committee will need to be assembled at the end of January to give a final grading.

IH confirmed that a stakeholder panel and peer review panel has taken place for scoring which has been evidenced in the paper. The panels largely agreed with our grading with some additional comments which are currently being addressed.

The Committee members NOTED the update and agreed to meet to finalise grading in January 2024.

EIC/23/88 Accessible information Standard Audit Report (agenda item 17)

DP advised that there has been an audit on the Trust's accessible information standard which has included translation and interpretation which is not part of the standard but been included for completeness. All actions and recommendations are being addressed and an update will be presented to committee in March 2024.

The Committee members NOTED the outcome of the internal audit.

Section 5 – Annual Items

EIC/23/89 Draft Equality, Diversity & Inclusion Annual Report for Trust Board (agenda item 18)

DP noted the final draft of the report and asked committee member's to approve the report to be presented to Trust Board in January.

The Committee members APPROVED the final draft of the report to be presented to Trust Board in January 2024.

EIC/23/90 Commitment to Carers Report (agenda item 19)

AB advised this is the annual update to be taken as read. AB highlighted that it has been a ground breaking year. The next key project is the triangle of care, as set out in the paper. AB noted that the carer's therapeutic fund is a small amount which has been supported by EyUp! And recommended that if the Trust want to make a difference to carer's lives, it would be good to invest in the fund.

Section 7 – Standard Closing Items

EIC/23/91 Work Programme (agenda item 20)

MB suggested that with Dawn Lawson bring new in post, it could be an opportunity to review the workplan and ensure it is still appropriate.

EIC/23/92 Items to bring to the attention of Trust Board or other Committees (agenda item 21)

- Risks and review of risk register.
- The Patient and Carer Race Equality Framework (PCREF)
- NHS England's inclusion health framework,
- Equality dashboard and our work around what we are going to do next.
- WRES and WDES.
- Annual report for Equality, Diversity and Inclusion has been agreed by the committee.

- Annual report for Equality, Diversity and Inclusion
- Care Group update: Children and Adolescent Mental Health Service CAMHS
- EDS2022: The committee received the first set of evidence for domains:
- A focus on the Carer staff network achievements and progress
- The Trust commitment to carers annual update
- The EII exception and highlight report
- National, local, and regional updates which include legislation and publications
- Progress on the Equality dashboard and metrics
- Kirklees Child and Adolescent Mental Health Services (CAMHS) case study

EIC/23/93 Any Other Business (agenda item 22)
None.

EIC/23/94 Date of next meeting (agenda item 23)
The next meeting will be held on 13 March 2024.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 22nd January 2024 (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 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 other than the ask to focus on the IPR which was currently happening.

FIP/23/85 Matters arising and action log from the meeting held on the 23rd October 2023 (item 5)

FIP23/73
AS apologised for missing the paper deadline for the non-pay update which is on the agenda today. He advised that RA had completed the work and it could be shared on screen.
DW responded that it would be good if RA could share this with the committee on screen, as whilst he appreciated this is a small area, it has a large variance.
It was agreed to close action FIP23/76, FIP23/77, FIP23/78.

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 presented the update stating there are no changes to the risk register in terms of scoring. He remarked as has been discussed previously if there is an increased risk of financial unsustainability once they get into planning, we would need to review the risks. He said we have not received the planning guidance yet, so although they are progressing an internal plan we do not know what the external ask might be as part of that planning framework, so cannot change that at this point in time.
AS remarked that the Committee will also see when we get to the finance paper we have no immediate short term risk to sustainability, and we will hit plan for this year, this is more about looking ahead.

AS stated in relation to capital, it is still a challenge, as the risk is saying there is not enough capital to go around, but we are saying we are struggling to spend what we have, so there is a slight mismatch in there. He said in terms of the national position, capital is really tight and again we have no planning guidance so we do not know for certainty what our capital allocation will be. We do not think the West Yorkshire capital allocation will move, so the risk to us as a Trust is whether the distribution of that allocation within West Yorkshire changes.

DW remarked that he appreciates this is a waiting game, and as soon as we receive some more guidance on future years this is going to have a significant impact.

NM asked how do we make sure the wider board understand the risk that AS has articulated, which is somewhat different to the way it is written in terms of risk 1585, and although we as a committee know why this is, she asked AS if he thought the other NEDs would know this based on what they see in the risk register.
AS responded possibly not, as the risk is different internally, and it is a risk we have created ourselves. He said the cyclical nature of Capital in the NHS makes it is really difficult because you tend not to start delivering your capital plan until your plans are signed off and the NHS have a history of signing plans off late. We then have to condense the capital plan into the last half of the year which always brings a challenge, so we are taking steps to remedy this by taking a slightly different approach which should mitigate some of that internal risk.
AS stated that maybe we need to clearly articulate the risks that we are in control of which we cause ourselves, as opposed to the system risk which is what this entry is trying to articulate, in that there is not enough capital coming into our organisation. He said although Nick Phillips provides this update, we need to be mindful that some of it is spent on digital, although digital works do tend to have a shorter lead in times than building works.

AS remarked that the NM was right to be concerned as both he and RA are, and they meet frequently with NP and PF and this would be covered in further detail when they get to the capital update.

NM commented that the mechanism today is that DW can escalate it through the chairs report, but she also thought it was worth thinking about from a risk register point of view. She said if we are going to mitigate and do something, it would be a wasted opportunity if we do not show a risk that we have actually proactively managed, so it would be good to have it recognised.
It was agreed that AS would better articulate this.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the risks, relevant to this Committee,

FIP/23/87 Month 9 Finance Report update (agenda item 7)

RA presented the financial position for month.

Key headlines:-

- Total consolidated performance is a deficit of £66k in month which is £132k better than planned
- The core Trust position for December was a surplus of £79k (£277k better than plan).
- Overall, the total year to date position is a surplus of £1,136k (£601k Trust). This is £266k better than plan in total. For the core Trust this is currently £269k behind plan.
- The Trust in-month position has been driven by:
  - Additional investment agreed with commissioners which are not yet recruited to therefore giving a larger financial benefit than the contribution alone.
  - Continued increase in pay expenditure through workforce growth offset by reductions in agency (some at premium rates).
  - Continued low levels of out of area placements in month.
- Pay - Workforce growth (substantive) has continued in month with an increase of 37 worked WTE and a further 20 WTE in bank staff. This has helped to contribution to, and maintain, a reduction in agency staff worked.
- Non pay expenditure, work ongoing trying to reset budgets for next year.
  RA said the area of focus is other non-pay, and he shared the analysis on screen on work being done to break this down, it showed that the majority of spend was within support services.
- Value for money - positive movement in last couple of months due to maintained low levels of OOA placements and secured contribution from new investment from commissioners.
- Capital – £456k expenditure reported in month which is an increase from previous run rates.
- Cash does remains positive

AS remarked that the committee will have spotted that agency is now green, and there is only one red, which is around capital. He said in year this is a really positive set of figures, and what is going to be the challenge for RA and himself is trying to explain why next year is going to be so hard.
AS explained when you look at the workforce, we have been saying for quite some time that we need more staff, and we have been successful in getting more staff, but those staff cost money. The financial position is tightening because we have been seeing positive recruitment, which is great, and we are now starting to see some benefit on reductions in agency utilisation which is really positive. He said planning discussions that have taken place at EMT have focussed on the fact that we need a more sophisticated approach to workforce planning, along with a more robust workforce plan that we stick to. He said the committee will hear more about this as they start to take planning through the Board
AS remarked that he did not want to underplay what a fantastic job everyone has done this year. We have been talking about OOA for a couple of months now, but the agency work is starting to demonstrate that workforce is in a much better place than it was. He said we need to do slightly better at articulating the benefits that this is starting to show aw we start to see some of the key metrics move.
AS said he was really pleased to see that we have got the agency figure down, as it was only 3 or 4 months ago when he had said we have not got a hope of hitting the agency target, and now we are 0.1% forecast away from hitting it, which is great.

DW remarked that this is great and a real testament to everyone's hard work at getting both agency and OAA under control.

KQ referred back to the non-pay and consultancy fees, she asked what the governance was around this as they had not seen this before, she also asked for some clarification around Altogether Better.
RA responded that from a financial perspective consultancy fees are where they have used someone for advice and guidance, he said Altogether Better is funded, so it uses its own income and pays for third parties to advise on how products should be run in their locality. He said it is basically utilisation of their own funding.
KQ wondered if this needed to be clarified more so that Board members understand the process around this.

KQ referred to the Trust's strong position around cash, and she asked if there are any restrictions on how we spend this, also does it present us with investment opportunities.
AS responded this is a tricky one as the reality is that cash is locked in for perpetuity.
RA remarked we can invest it but only with National Loan fund, so there are very limited investment opportunities. He said the Audit Committee have been looking at this in terms of the risks versus the reward and it was decided we will not be investing anything this year.

DW remarked that we have been getting really good interest rates which is a positive. He said in relation to capital the committee had asked for a month on month breakdown, and he had expected this to be an itemised list. He asked if it was possible for this information to be shared on screen if available.
RA responded that there is a lot of information and it is very detailed, but he was happy to share on screen so the committee could see exactly the process that is undertaken.

NM remarked that she wanted to support DW in that at moment the paper is only really giving us reassurance, yet at this stage she does not feel reassured, for all the reasons that have been openly talked about here. She said we have historically year on year struggled to spend the capital, and therefore in January to read in the paper that it is all in hand and everything is going to be okay. She said there is a lack of assurance and evidence for her to feel as confident as the team do in the paper that it can be done and at this stage it looks highly unlikely that we are going to spend that money.
AS responded that is the reason there is a red indicator in the dashboard, and he totally agreed with NM. He said both himself and RA were working really closely with the team.

It was RESOLVED to NOTE the Financial update

FIP/23/88 Financial forecast (agenda item 8)

RA presented the update, stating that he wanted to flag that he had included the standard agency report for information, so the committee can see the level of detail and conversations taking place in the agency scrutiny committee meeting, along with OMG.

Key headlines:-

- Within main forecast report it is flagged what the West Yorkshire ICB financial position looks like. Have seen an improvement over last couple of months in that forecast position. Improvement of £19m from month 7 and £42m since month 6, however it does not get us to the ICB target and there is still a lot of work required across to ensure they can deliver their positions.
- Forecast baseline deficit surplus of £2.7m, this is an improvement from the report that came to FIP in October which was around break even. The main driver has been the additional income we are receiving from commissioners and the slippage that we are experiencing against those. Previous scenarios included £2m – additional £500k identified. Now included within baseline.
- 700k surplus for year end, very much now focusing on realising risks and opportunities to get towards that position and some more of those will be transacted through M10.

- Risks and opportunities, AS confirmed the Bands 2 and 3 are still in there as a risk if we have to do any back pay. If this issue materialises it will impact on our plan as it means we will have to uplift recurrently some bandings across the organisation, so whilst this risk forecast is about this year, some of the things in here will feed into next year and this is probably the most material one at this stage.
- It has been agreed that people can carry a maximise 5 days annual leave, this cannot be done until the 31st March until we know what annual leave people have taken, as this is system generated.

AS remarked that as RA has stated there are a few things that we have to wait until 31st March for, such as leave accrual, so we will have to have a level of prudence that gets get us close to break even, which is quite tricky as it has to be an auditable figure, and we are seeing a lot of external scrutiny across the system.
AS advised that RA was part of a group that looked at everyone's balance sheets to make sure that wherever possible we deal with things consistently, and there was definitely an inconsistency in there. He said we are maintaining our position at this point and saying the most likely is less than £1m, and as far as he is aware there is only one organisation that has implemented the formal process to revise their forecast and that is in a negative direction because they do not think they are going to hit their plan. .

DW remarked that there is an opportunity of a more optimistic outcome if a lot of the opportunities come through, and not so many risks, and he appreciates we are not going to know this until the last minute.
RA responded we are working on mitigations in terms of, is their spend that we can spend this year rather than next year, and what are the lead in times etc, so it is a fine act of juggling to manage this across the years.
AS remarked that rightly or wrongly the key message for us is that we have said we are going to break even so we need to break even or slightly better, not break even and slightly worse. He said if we are £0.5m under we could post this as a surplus into our accounts and it would not cause ructions across the system, but if we posted a £0.5 deficit it would do.
DW remarked that he was fairly comfortable with that.

KQ referred to the financial pressure due to industrial action, she asked AS if he knew what the figure was across the ICSs in terms of additional workforce payments, and how much it is for us as a Trust.
AS responded that he did not have a figure to hand, but the industrial action prior to Christmas was calculated by everybody and that was covered as part of the £800m distribution of funds nationally. He said all organisations were asked to estimate what the cost of industrial action was for the Christmas strikes and any potential between now and the end of the year. He said we always forecast nil because there is not a financial cost for us, whereas in the acute sector they tend to cancel elective work so they suffer an income loss, whereas we do not, and this is in line with all community and mental health trusts, none of them have indicated a financial loss. Ours continues to be nil notwithstanding the fact that it causes operational issues, waits go up etc, but no financial loss. AS said he could get the system figure.

KQ remarked that it is really interesting that we have not had to pay out over time for any extra shifts from consultants or additional staffing costs.
RA responded that we have incurred some but from his perspective it has been lost in the rounding down in the spreadsheets. He said it is so minimal compared to the huge number that AS has described.
AS stated that in certain instances you cannot bring agency members of staff in to cover working staff.

KQ thanked both AS & RA for the very helpful update.

It was RESOLVED to NOTE the Financial Forecast

FIP/23/89 Non recurrent expenditure update and tracker (agenda item 9)

RA said he was a little bit confused by this one as we have not had non recurrent funding this year. and that we did last year and OMG approved an amount and that a paper had been brought to FIP showing progress against all of those and where they had got to. He said he has not gone back to check where we are with those, in terms of are they still realising benefits.
RA asked DW if that was this ask on this one.
DW responded that if he remembers rightly, it is in the work plan twice yearly.
AS remarked that he had completely misread the agenda item and he thought this related to the non pay information we had just talked about, and it clearly does not state that so he apologised.
DW responded if we feel this is not long relevant we can remove it when we review the workplan at the end of the year, and it gives an opportunity for us to add some else in that is relevant.

RA advised the committee for information that for 2023/24 they have not run a non-recurrent investment pot and process so no bids have been taken through OMG. He said there are bits of non-recurrent spend within each of the care groups but that is managed by them as part of their overall financial responsibilities, and is nothing like the scale of what had been done previously, it is more practical things for example replacement of curtains etc.

It was RESOLVED to NOTE the non-recurrent expenditure update.

FIP/23/90 West & South Yorkshire collaborative financial update (agenda item 10)

RA provided the update stating that following conversations with his colleagues at Leeds and Bradford, all three trusts will now be presenting the financial position in that same table. He said from our perspective it shows that:-

- Financially adult secure and ATU is rated as green
- Financial pressures highlighted within the adult eating disorders collaborative
- Pressures within CAMHS these are being managed recurrently, but there is a recurrent pressure as we go into next year.

RA said all collaboratives are still working through the issues that OOA placements gives them, both in terms of the income expectations that they all had being able to sell their beds, but also having to place people OOA and the exceptional packages of care and volatility of those continues to give uncertainty into where we are. He said all of these will be resubmitting plans for 2024/25 and we will share what the CAMHSs one in particular looks like as for him this one may give us a risk that is not within the core risk stuff if we have to do the risk reward shares going forward.

RA advised that Izzy Worswick, Business Development Manager, prepares a report that goes into Board around some of the operational issues that go behind all of these.

RA stated that for South Yorkshire this one flows directly into our main finance report. We are reporting a surplus year to date, and a forecast surplus for South Yorkshire Collaborative this year, again, there is still some uncertainty and volatility relating to both activity and price for South Yorkshire and it is a reduction from last time. He advised that he is still working with colleagues to work out how we are going to transact some of this for year end and how this feeds into our forecast scenarios.

DW remarked that it is good to see everyone working together and collaboratively and working on the same thing.
AS remarked that consistency reporting is good, and it is a time saving, but they had a slight concern that the other organisations were not consistent in how they were going to redistribute surpluses, and if the committee recollects, we carried funds forward historically through the adult secure collaborative and we got some criticism from the External audit for doing that. He said we have been quite clear all year end surplus funds are handed back to organisations, and we felt that the receiving organisations might not be crystal clear on that so the work that RA has carried out to make sure it is consistent means we all know what we account for.

It was RESOLVED to NOTE the Provider Collaborative update.

FIP/23/91 Costing update (agenda item 11)

RA presented the update stating they are starting to look at Q3 patient level costing information, which is an important tool, and they are looking to share it around the organisation. He said it is an enhancement from our previous service level reporting information which we used to have which stopped during Covid, has now been further delayed because of the delays in the national cost collection. RA said he was excited to share this information at OMG as it should feed into the trust benchmarking group and we can bring things back here by exception, it will also go into the other groups for action and knowledge.

It was RESOLVED to NOTE the Costing update.

FIP/23/92 Annual Plan update (agenda item 12)

RA provided the update stating there has been no national planning guidance, and he had attended EMT last week and updated them on the financial position. He said from his point of view they are sticking to the original deadline of the end of February for the financial return, so we will be submitting a plan on that date, he said how we get to that point is still to be worked through.
DW remarked so we have literally received no updates at all.
AS responded we have had some email updates and we are supposed to be getting some templates this week, we were also promised the full planning guidance this week, but we were also promised it last week.
He said as RA has stated from a Trust point of view they do not change the deadlines and we have a plan by 31st March so we are ready to go on the 1st April. He said the more time ticks by the harder this is going to be, particularly if there is anything unexpected when the guidance comes out.

KQ remarked that this affects every single provider trust in the whole country so she can see why we are nervous but nobody has received the guidance. She suspected we were a little bit shielded from any criticism by the regional teams and they are the ones who will be doing the fighting with Treasury.
AS responded that KQ is quite right and part of the nervousness is the time commitment on the team as it will also be year end, so we are going to be expected to do both this year in parallel and we have relatively small teams.

RA commented that from his point of view if anything he is getting slightly more asks from the ICBs, the main concern for him is what does our realistic workforce trajectory look like, and what does that leave us as our CIP gap, and although we have some progress it is quite limited.

KQ remarked that the pressure on teams is a serious point, it is not good and people need to be made aware of the pressure on our staff. She said her personal view is that it is outrageous and the pressure on our staff is intolerable.
DW remarked this is definitely one to raise in the AAA report to Board, he said budgets are always a tough time but when you have got to do it in a month even more so.
AS responded that the acknowledgment does help and one of the pleas to the Board will be around flexibility, as they would normally be taking a paper to this month's Board on the content of the planning documentation. He said we are taking a paper on planning and it might appear before the Board meeting but not before the board paper deadline, he said we will be asking the Board for some flexibility around review and sign off between now and the end of March.

KA commented that some papers are verbal to committees so lightening the governance load where possible is good.

NM agreed with KQ in that there is a serious point to this and she felt as a board we do have it within our gift to document at Board our recognition of the impact that this has and that it is not okay. She said it is well within our right as a sovereign organisation and as a board to call it out, otherwise everyone just accepts it, and there is an impact on people, and there is a real risk that despite how great people work now, how can they be expected to do their best possible work under that pressure. She said it is really important at Board that we do call this out and that teams understand that the Board recognises that what they are being asked to do is not okay. She said finance can be unsung heroes in the background and not always recognised for what they do.

DW stated that he would highlight this one in particular.

It was RESOLVED to NOTE the Care closer to home update.

FIP/23/93 MHIS progress update (agenda item 13)

AS provided the update stating they have now separated mental health investment from the broader report that we had on investment and tender opportunities, as it was quite a significant report when it came through.
AS advised that MHIS is remaining for next year, although we have not got the planning guidance yet we have been assured through many senior communications that it is going to continue. He said technically we are at the end of the MHIS cycle, notwithstanding the fact that there has been a senior commitment for it to carry on, it has been quite a challenging year to get confirmation of all the funding flows from our places. Predominantly the reason being is that Places are also in a difficult position, so they want to make sure they can maximise the funds that go in. There are also pressures around SDF funding, which is in addition to MHIS, so it has been quite hard to land on the financials for this year even though we are at the end of a cycle.
AS stated what they have seen in many areas is a lot of schemes are looking at coming up to full year effect, so they are not all new, some of them are pre commitments. He said in Wakefield as we move into next year a significant part of MHIS is pre committed for decisions already taken

where we will see the full effects of the funding coming through next year. He explained because of all that we have seen some slippage in spend.
AS stated we are starting to see some risk coming through on MHIS, and at this point in time there is still a lot of focus on the money and spending the money before we see the real benefits coming through.

AS stated there was nothing in particular he wanted to call out in any Place, other than the general challenge, in that it has been slightly more difficult in Kirklees, which was slightly surprising as we normally work very well and at pace with them to get things done. He said for various reasons they have taken a long time to formally sign off through their sub committee structure. Wakefield was quite specific where we did a lot of things case by case, and Calderdale was easier. He said I don't think that tells us anything it maybe just indicates there is a different type of focus coming through the Places at the minute.

DW remarked there were a couple of things that stood out for him, at least two if not a few more of the ones that were most behind are relating to young people, one in Calderdale, and another in Barnsley, also a couple on the wider ones. He wondered if there was anything specific around recruitment, particularly around those posts that we need to be aware of.
AS responded that recruitment is challenging in CAMHs services in particular. He did not think there was a correlation between the fact that all areas are looking at some investment in children and young people's services and the workforce. He said there does tend to be a distinction between what happens in Barnsley and West Yorkshire.
AS stated that DW was quite right to call it out as reports elsewhere will show a significant increase in demand.

NM remarked that AS might have partly explained it by saying that although we know it will continue in 2024/25 we might not know the detail, because across all the reports even ones that are not sitting in terms of the RAG rating for 2023/24, if you look at 2024/25 they are nearly all green which seems over optimistic. She said what could you assess it against if we don't quite know what the schemes are going to look like
AS responded we did say we need to move on from assessing against spend on staff, and actually go back to a core KPI around increased activity or reduced access times etc. He said there is a level of optimism that says we should recruit everybody this year and everything else should be up and running next year, otherwise we are going to be into another conversation about slippage.
AS remarked that if MHIS has slippage it does not necessary mean that funds will stay with SWYPFT, or will be invested with SYPFT, slippage could go elsewhere non recurrently and does so on occasion. He said that we still think we can maximise the benefit of MHIS but if we do not recruit it may get spent elsewhere.

DW thanked AS for the update.

It was RESOLVED to NOTE the Mental Health Investment Standard update.

FIP/23/91 Capital update (agenda item 14)

Nick Phillips provided the update
DW informed NP that the committee had a brief discussion earlier, the biggest concern for them was the forecast piece for the remainder of the year, and RA had agreed to share further detail around this on screen.

NP responded that if the committee find this helpful we can use this as the basis for information going forward. He said what he had included was what had gone to Board.

Key headlines:

- The main major scheme is the Seclusion Project in secure services which is now on site and is progressing to the agreed plan, this project is the first scheme utilising new standards for seclusion agreed by the Trust and provides a considerably enhanced environment for service users both in terms of robustness in use and quality of environment. The scheme will expend approximately £725k in year with further expenditure in 24/25.
- The minor capital programme has had some delay whilst a term contract was put in place which was tendered at the same time as the seclusion project. The delay was in order to get the correct contractual arrangements in place which is now being resolved and the largest minor work scheme in year has now been let under this umbrella arrangement which is for roofing works at three clinics in Barnsley for approx £500k.
  There is an agreed schedule in place for the other schemes which will bring spending back into line with the overall agreed plan.
  The capital spending plan for month 9 is included at appendix 1. This reflects spending to date across the whole of the capital programme including leases.

AS asked NP if he could provide the Committee with an update around Tilbury Douglas and the fact that those major and minor schemes are single supplier schemes, also the ongoing work with Imran in Procurement. NP proceeded to do this.
AS remarked that as NP has described instead of having to agree a capital plan, we scope it, then we go out to the market, we do not need to go to the market first, because we have a consistent supplier, so we can scope it with the delivery partner, therefore the turnaround getting the plan approved and getting people on site is significantly reduced. He said we are not going to see the benefit of this in this financial year but we should see the benefit in the early part of the next financial year.

NM remarked that sitting here she feels assured around the process that has been put in place and mitigating it, which as NP has said there is something around accepting where you are now and what can be done looking ahead and she said this was great and really good practice, not least in terms of the amount of time it will no doubt save the team around the tendering process. She said in terms of thinking about the assurance process for this Committee, we will be able to hold to account and monitor each quarter much more of that plan, and we will be in a position to pick things up much quicker, so it will give us a lot more confidence.

<u>Digital Capital</u>
AS advised that the Trust went out to tender for digital dictation and due to some technicality on process we decided to rerun the tender with a more robust scoring and evaluation methodology.. He said we have now rerun the process, the bids are in, they have been evaluated, and the contract will be awarded in January. This is an c£800k scheme. AS explained that is why IM&T spend is behind plan because we have had to rerun a process, the rest of digital has a slightly shorter lead in time and RA and his team are monitoring purchase orders on the system rather than the plan itself so as soon as they go through we have confidence they will deliver in year. He said digital dictation has been a risk for us but we think we have got that back on track now.

NP informed the committee that there was also some reprioritisation around some wide area networks etc.

<u>Future capital</u>
The Future capital plan is heavily influenced by the Older Peoples Services (OPS) consultation which is in train at the moment. Any scheme arising from the consultation will be a capital project

and will have to be delivered within the wider ICB capital programme. The estates minor works programme and digital programme has been prioritised over three years in order to aid planning of the wider capital delivery and to improve the planning process both at Trust and ICB level. It is anticipated that expenditure would commence on any capital scheme for OPS in financial year 2024/25 and complete in 2025/26.

AS asked DW if it was worth RA giving the committee a heads up on the ongoing risk that sits behind IFRS16, which has not materialised yet, but lingers in the background. DW responded that would be helpful.
RA provided the committee with an update.

AS explained that technically we have capital to spend, and capital to account for through leases, and they are separate at this point in time. He said nationally there seems to be some challenge as they only have one capital allocation and they have to split it, and it looks like the one that deals with leases does not seem to be sufficient at a national level. He said we are just keeping a very close eye on this to see if it has any real implications for us, there are none to date, but we have not had the reassurance that we need that it is not an issue going forward. He said it might come out in the planning guidance or through another route, but if this doesn't resolve as part of the planning round it might be something we need to consider as either an amendment to the capital risk or a risk on its own as we get into the next financial year.

DW remarked that it is a material amount for us and it does really restrict what we can spend on capital, but it would be a way the government could find a way of almost saving money.
AS said he was still struggling with the concept of how an accounting treatment creates a real world issue but that seems to be where we are at the minute.
DW remarked that hopefully there will be a bit more guidance in the planning.

RA shared on screen a capital spreadsheet which provided the committee with an update on each scheme.

DW referred to the RAG ratings and asked if there was anything being done to ensure these forecasts are as accurate as possible.
RA responded the RAG ratings are jointly owned.
NP stated there is an internal meeting where these are all assessed, then a further high level review takes place at the Estates TAG. NP remarked that they will work with Helen Hiscoe in finance to turn the green RAG rating status column into something that is a bit more interactive.

ACTION: Nick Phillips

NM commented that there is a lot of data here and she asked NP what his biggest concern was, given it is the end of January, and which ones is he really concerned about in terms of being able to spend and deliver on.
NP responded that firstly, this is not the time he would normally be roofing buildings, so this is a risk to weather. He said there are mitigations against this, but in future years we will be looking to do this work in either May-June/September-October. Also, there is a risk in relation to the Bretton doors, where the contractor has come back and said the materials for the doors have not arrived, so we are currently negotiating with them regarding this. He said this is the problem with backend loading the project. He said of the others, there could be instances where we go on a ward and the ward becomes extremely volatile and we may have to move things around. He said whilst the team work with us really well and this does not happen often, it does not give us any room for manoeuvre.

NM remarked that this follows on from our earlier conversations around how do we go back to Board and say, we are either confident that this is going to be spent by the end of the year or

actually this is our position, we are confident we might spend 75%, we are not confident about the remaining 25%, and this is the bit we could not quantify/articulate here today, and unless DW feels as if he is able to do this she did not feel she was able to.

DW agreed with NM in that of the £6m we have got to spend by the end of March, he cannot give much assurance from what he has seen or heard today.

NP remarked that there is an opportunity for Paul Foster to spend more on digital, and following a conversation last week, it is possible for us to transfer some from minor works into digital, so when we talk about capital we talk about the whole programme and there is overlap.

DW remarked that all he can do right now is state that following this update, there is a lot to spend, there are projects in place, we believe we can spend it, but we do not have full assurance that this will happen. He said if the RAG rating can be summarised then we could see that bi monthly phasing and we could see where the risk is, and he felt that would give the assurance required.

Nick Phillips ACTION

It was RESOLVED to RECEIVE the Capital update.

FIP/23/92 Performance update (agenda item 15)

JW provided the performance update in terms of the IPR development. She stated that they have provided a paper this month looking at the introduction of a heatmap. She explained this gives the committee a visual view at the beginning of the IPR of what has changed, or anything they would really like to draw attention to. JW explained this is not only to help Board and stakeholders with but also members of the public in terms of interpreting the IPR, or seeing what the big ticket items are without having to read the whole document.
JW explained that alongside this work there has also been a lot of work to reduce the narrative in the quality and the priority programmes section. She said there is still a lot of work to be done with Darryl Thompson and his team with the quality section, but that the committee will see a significant change, particularly in the priority programmes section this month.

NM remarked that she really liked this and having something that you can look at that shows the change and an indictor is good and will give us a good sense of where we are on some of the big ticket items. She said she had seen a really good example of an IPR in the last couple of weeks around the narrative in terms of interpreting the IPR, she felt this is something everyone struggles with. She agreed to share this with JW outside the meeting.

DW remarked that he also liked the heatmap, for him it was not about losing focus on everything else but more about highlighting the big ticket items.

KQ agreed this was good and what they have been asking for and working towards, as with a massive report it has been hard to drill down. Her only concern of having this as a heatmap is that if she was an external stakeholder and she looked at this she would not see all the positives, and it could look like we are really poor on every measure, and only achieving a minimal number of metrics across the board. She said she did appreciate we are trying to balance the drilling down so we can see the hotspots, versus something useful where we do not get too much data.
KQ remarked that being said it is really helpful as NEDs in Board to focus and drill down, and it also focuses our attention as a committee.

DW remarked that with the number of reds the immediate concern could be what is going on here, but looking at it from another perspective we could say we are ambitious, and we want to set targets that are going to be stretching. It was agreed that this would be included within the wider IPR from January. CH remarked that the colour stands out more than the arrow. JW felt that it would help by bringing the key to the front of the document.

FIP/23/93 Waiting times report including Paediatric audiology update (agenda item 16)

Vicky Humble gave a verbal update, she apologised for there being no report this month, she said it would have only included the October/November data, and due to time pressures the information it had not been able to be cascaded in time for the meeting today.

Key headlines:-

- Continue to work on the possible streamlining of the report and the automisation of some of the processes as it is currently a labour intensive report.
- Continue to tabulate rolling 12 month data, the longer trend data will only be visible on the charts. Work continues to transfer outstanding data onto SPCs.
- Scope of the original report is under review, work is currently ongoing looking at the whole waiting times data set which is increasing each month.
- Long term ambition is to continue working on protected characteristic information across the trust to make sure the quality of that data is good enough to include in the report to ensure we can analyse our waiting lists accordingly and ensure we can make decisions based on who is waiting and with what characteristics, to see if we need to make adjustments to those lists.
- In terms of adult ADHD services there is an increasing trend which is in line with the national picture. Referrals continue to be significantly higher than pre pandemic. Discussions have taken place with Izzy Worswick and colleagues to ensure this information is included in commissioning reviews and discussions to see how we can meet that increased demand within the commissioning restraints.
- Looking at including new additional information in relation to Autism services.
- There is an early indication that there is a plateaux in the data with Barnsley CAMHS Core Services both in the numbers waiting and the length of wait and we will continue to monitor this.
- LD services have now all transferred onto SystmOne functionality, this is in the data review phase to make sure the quality of the data is good.
- Core Psychology, there is a review of baseline data being conducted of waits, referrals in services etc and this is reporting into improving access to care to ensure we fully understand those services, and aspects of those services can be targeted where improvements might need to be made to help with those waits, both in assessment and therapy.
- CAMHS Neuro services work continues to report in to improving access to care. We are still seeing challenges in the commissioning of those services coupled within the increase in demand.

DW thanked VH for the update. He said he was due to undertake a review of the workplan with AS in the near future and this will form part of that review, to ensure the workplan is aligned with reality. CH asked VH if paediatric audiology is included. VH responded that this is.

It was RESOLVED to RECEIVE the Waiting Times update

FIP/23/94 Work plan (agenda item 13)

DW remarked that as agreed this needs to be reviewed. He said this is the first year where there has been a cycle, and it has become apparent there needs to be quite a few changes made, also there is a need to ensure the agendas are spread evenly across the year.
DW agreed the normal time to review this would be March/April.
KQ commented on the performance piece, and she asked what our approach is for selecting which services we want to look at and is there something about articulating our approach to this.

JW commented that her suggestion would be to look at this when we look at the Triple A report, to help inform the areas we need to have a focus on in terms of performance.
CH agreed that this was a good idea and would be really helpful for her, as since we have put these on the workplan, Board are now receiving an update from each of the care groups. She said in an ideal world those detailed updates would come here first before they went to Board but because of timing it does not work out that way. She agreed it would be good if we could agree a process for how these were selected.

AS stated that we did initially have deep dives into the private session of the Board and CH used to provide an update either on a care group or care group area, we said that if the Board requested us to do any deep dives then we would do them. He said there have been relatively few requests coming formally from the Board so maybe we need to be more proactive and try and set a plan but also allow ourselves some flex in case something is discussed in a full Board meeting that says that we would like FIP to do a deep dive.
DW agreed that the Triple A report was a good option, we could also put a few place holders in as part of the plan. He said we need to fully formalise this as part of the workplan as the performance section has improved but it is not quite there yet.
AS remarked it does not necessarily need to be a service area, it could be a particular aspect of performance that is a concern, and we just need to double check that this is not being covered by different committees, this is relatively easy to check against other work plans. JW requested that this be added to the March agenda for discussion.

ACTION: Julie Williams

FIP/23/95 Any other Business (agenda item 13)

DW confirm there were no items to discuss.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 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 – Executive 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 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. This report provides an update of key points discussed at from the most recent Integrated Care Board meeting including the patient story, highlights by place, performance, and planning. The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative continues to develop. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the Health and Care Alliance. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board is asked to NOTE the SY ICS and Barnsley Place updates.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 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 6th March 2024
	
	Key items discussed were:
	
	• Story telling- this item focused on an NHS Dentistry patient story. The story focused on a pilot of a dental care offer for homeless people in Doncaster which is having a positive effect on those people who have been able to access it.
	• Chair's update- updates included:
	  ○ The second meeting of the Equality, Diversity and Inclusion Group has taken place.
	  ○ At a national Chairs' meeting there was strong emphasis on finance and productivity.
	• Chief Executive report- key updates included:
	  ○ Integrated Care Partnership Board- the January 2024 Integrated Care Partnership meeting fincluded a focus on employment and the relationship between work and health.
	  ○ Financial position- despite the challenging financial environment this year, the position in South Yorkshire has stabilised over the last couple of months.
	  ○ Industrial action- the NHS in South Yorkshire has continued to maintain urgent and emergency care, as well as some planned treatment and appointments where possible during industrial action.
	  ○ Director of Performance and Delivery- NHS South Yorkshire has appointed Sarah Perkins as its new Director of Performance and Delivery following a competitive process.

	○ NHS England ICB Running Costs Allowance (RCA)- The Integrated Care Board is concluding a restructuring programme in response to a nationally mandated 30% reduction of its running costs allowance. ○ Pharmacy First- NHS South Yorkshire has welcomed the national launch of the Pharmacy First service. ○ NHS Dental Recovery Plan- the NHS Dental Recovery Plan was announced on 7 February 2024 with a key focus on improving access to NHS dentistry for local people. ○ Measles- parents and carers in South Yorkshire are being urged to book their children in for their missed measles, mumps, and rubella (MMR) vaccine. ○ Start with People Strategy- NHS South Yorkshire is encouraging partners and wider communities to help refresh the 'Start with People: South Yorkshire' strategy, which was launched in July 2022 when NHS South Yorkshire was created. The strategy outlines how NHS South Yorkshire listen to communities and involve them in the way NHS and care services are provided. ○ Race Equality #CallMyNameRight- staff across the NHS and care in South Yorkshire are encouraging colleagues to "call my name right". ○ LGBT+ History month- staff from across the Integrated Care System supported LGBT+ History Month throughout February 2024. • Place reports. Key updates included: ○ Barnsley – the intermediate care redesign has been completed with a new service model established, workforce modelling and medical oversight plans finalised. At the end of February, the Family Hubs in North East and North Barnsley were launched. Partners in Barnsley have come together to agree a shared ambition for a whole-system approach to increase physical activity across the Borough. ○ Doncaster- there is a focus on development of priorities at Place, focusing on areas which will have the greatest impact on people's lives, and on the longer-term financial position. ○ Rotherham- in December, the government published their response to the safeguarding review of children and young adults with disabilities and complex needs in residential settings. The safeguarding team, Named Nurse for Looked After Children and Care Leavers and Head of All Age Continuing Care have continued to work alongside Rotherham Council's social workers, commissioners, and virtual school to ensure assurance of the safety and progress of children and young adults with disabilities and

	complex needs in residential settings. Rotherham has drafted strategies for people with a learning disability and all age autism. Both are built on co-production and engagement, and both align with the South Yorkshire Integrated Care Partnership priorities. o Sheffield – Planning/financial efficiencies work is being carried out with all partners in the place considering estate opportunities, demand management and structural reform. • South Yorkshire Joint Forward Plan Refresh 2024-25- updated NHS Joint Forward Plan (JFP) guidance for 2024/25 was published on 22nd December 2023. A light touch refresh approach was agreed in January 2024 and no major changes are recommended. The refreshed JFP reaffirms the continuation of the priorities identified in the initial plan. • South Yorkshire Financial Plan update. • Dentistry Plans 2024/25. • Non-surgical Oncology Outpatients- options appraisal/ recommendations. • Integrated Performance Report (IPR). • Corporate Assurance Report. • SY ICB Safeguarding Adults and Children's Policy. • Minutes of the South Yorkshire Integrated Care Partnership (ICP) public meetings. • Minutes of the South Yorkshire ICB System Leaders Executive meetings. • Assurance Committee minutes. • Minutes of the ICB Place Committee meetings for the period.
Date of next meeting	Next meeting in public is scheduled for 1st May 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 13th March 2024 Key items discussed included: • Lived experience story. • Managing Director Report- it was updated that NHSE has now published the expected guidance on arrangements for delegation and joint exercise of statutory functions. • Delivering our work programme- an update was given of progress on the four programme objectives for the South

	Yorkshire Mental Health, Learning Disability & Autism (MHLDA) Provider Collaborative- neurodiversity, health-based place of safety, stopping overmedication of people with a learning disability (STOMP), and all age eating disorders. • Eating disorders progress. • Mental Health Investment Standard for 2024/25. • ICB Feedback. • National MHLDA Inpatient Quality Transformation Implementation Brief. • Board Assurance Framework principles- draft principles for the development of the South Yorkshire Mental Health, Learning Disability & Autism (MHLDA) Provider Collaborative's Board Assurance Framework were shared for discussion and to guide the next stage of development. • Specialist Commissioning Update.
Date of next meeting	The next meeting is scheduled for 15th May 2024.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair

Items discussed	<u>Update from meeting on 29th February 2024</u>
	
	Key items discussed included:
	• Story from our communities- a day in the life of a paramedic.
	• Questions from the public.
	• Place Director update and Place achievements. Updates included:
	  o Health & Care Plan- work continues to progress with the areas of focus (respiratory, urgent and emergency care and frailty).
	  o SEND- work continues through the SEND Improvement Board to prepare for inspection.
	  o Learning Together- Barnsley was the first place across South Yorkshire to establish a virtual ward approach. Partners have worked to conduct an evaluation with support from the University of Sheffield, Health Services Research Section (ARC). The draft report has been received and findings of this will be shared with place partners and the ICB Board over the coming months.
	  o Pharmacy First has now launched with 54 of the 57 pharmacies in Barnsley having taken up the scheme in Barnsley.
	  o Dentistry- a national dental recovery plan has been produced.
	• Feedback from South Yorkshire Integrated Care Partnership Board.

	• Partnership approach to research. • Update on Place Plan and priorities. • Preparedness for CQC inspections – Adult Social Care. • Performance dashboard (including SY ICB Performance Report). • Committee Minutes and Assurance Reports. • Oncology consultation, and approach to this as a Barnsley Place.
Date of next meeting	Next meeting scheduled for 28th March 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 12th March 2024 Key items discussed included: • SWYPFT strategy refresh. • Joint Forward Plan 2024/25 Refresh- a summary of the 'light touch' approach taken to refreshing the Five Year NHS Joint Forward Plan (JFP) for South Yorkshire for 2024/25 in response to the recently published NHSE JFP refresh guidance was given. • Barnsley Virtual Ward evaluation- overview of the evaluation was shared, which aims to outline the impact the Virtual Ward service has on patient care and the wider system. Further work will take place as a partnership to interpret findings into conclusions and agree actions. • Overview and Scrutiny report- Barnsley Council's Overview and Scrutiny Committee will be considering the Health and Care Plan 2023-25 in April 2024. • Mental Health, Learning Disabilities, Dementia and Autism Group. • Escalations from other subgroups. • Escalations for Partnership Board.
Date of next meeting	Next meeting scheduled for 9th April 2024.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy and Change
Items discussed	Update from meeting of 28th February 2024 Agenda items included: • Frailty and Dementia closure report. • Learning Disability health checks closure report. • District Nursing review. • Care Homes. • Development session – Barnsley Community and Voluntary Sector. • Alliance and Barnsley Hospital. • Reporting to Partnership Board.
Date of next meeting	Next meeting scheduled for 24th April 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. A development session was held on 22nd February 2024.
Date of next meeting	The next meeting is scheduled for 6th June 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 Yorkshire Mental Health, Learning Disability & Autism (MHLDA) Board

Relationship between SYB Specialised Commissioning and SY MHLDA PC Board – Revised Terms of Reference

March 2024

1. Purpose

In January 2024, the SY MHLDA PC Board clarified the future relationship between the current specialised commissioning governance arrangements and the Board of the SY MHLDA PC. The purpose of this paper is to highlight to member Boards the subsequent amendments to the Terms of Reference that have been made to strengthen this future relationship.

These changes have been considered and agreed by the members of the SY MHLDA PC Board. Given their role in originally agreeing the terms of reference and joint working agreement, Trust Board members are also being asked to agree these amendments.

2. The role of this Collaborative in the oversight of the Specialised Commissioning arrangements for Tier 4 CAMHS, AED and Forensic Services

Each provider Trust holds individual responsibility for the administration of their contracts but works together in using the hub's services and in working alongside NHSE. The SYB's Specialised Provider Collaborative currently hosts a Partnership Board, which is a provider shared board, shared among those leading the indicated 3 services, with additional stakeholders from SHSC as members and the ICB and the SY MHLDA Provider Collaborative as attendees.

At SY MHLDA PC Board in December the role of the SY MHLDA PC in the oversight of the Specialised Commissioning arrangements for Tier 4 Child & Adolecent Mental Health Services (CAMHS), Adult Eating Disorders and Forensic Services was discussed. It was agreed that there was a need to retain the existing Partnership Board as a separate forum to maintain programme oversight of the specialised collaboratives and share learning in a focused way. However, there was acceptance that the term Board may create some confusion, not least given that NHS Trust Board's retain individual ownership, and that the Board of the MHLDA Provider Collaborative is an important and recognised part of the SLE/ICB landscape. The proposal is therefore that the previous Partnership Board becomes a Steering Group. This change in nomenclature is reflected in the revised terms of Reference.

In addition, the SY MHLDA PC Board discussed and agreed suggested amendments to the Terms of Reference of the Specialist Commissioning Partnership Board (now the Steering Group) and the SY MHLDA PC Board Terms of Reference and Joint Working Arrangement to reflect the changing landscape. The amendments are highlighted below for ease of reference rather than appending the full documents, but these are available if required. A relationship diagram is included at Appendix One for reference.

The changes have been made to align with the following points:

- Ensure that annual plans and key strategic documents associated with the three services and the funded hub functions are reviewed and considered by the Collaborative Board prior to their adoption and approval elsewhere.

- Provide for formal engagement with the Board prior to any major commissioning or de-commissioning decisions, including long term material agreements or the development of procurement exercises.

- Receive a regular report for information on matters of finance, risk, clinical safety, and performance given the broader oversight role in sectoral services expected of the collaborative by the ICB.

Further amendments to the Terms of Reference might be necessary as the potential commissioning and delivery models for Eating Disorder services across South Yorkshire are considered and operationalised.

3. Next Steps

Following agreement of the revised Terms of Reference and JWA, communications will be drafted to make the relationships clear.

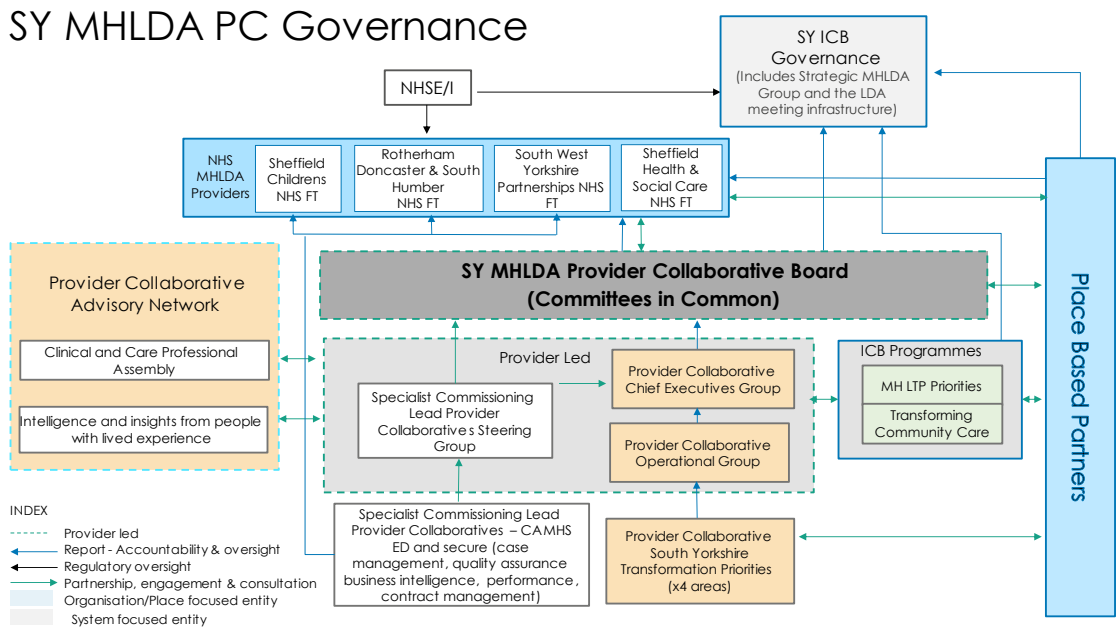
The SY MHLDA PC workplan will be amended and we will consider how to formulate and organise the risk registers of both groups to ensure risks are appropriately highlighted and that route of management and accountability is clear.

4. Recommendation

Board is asked to agree the amendments proposed to the terms of reference and joint working arrangements described within the paper.

Marie Purdue, Managing Director, SY MHLDA PC

Appendix – Diagram to illustrate the Provider Collaborative relationships



South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 March 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:	Mark Brooks- Chief Executive Sean Rayner- Director of Provider Development		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission - to help people reach their potential and live well in their community. The Trust Values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire where the Trust provides services (Calderdale, Wakefield, Kirklees).		
Strategic objectives:	Improve Care	√	
	Improve Health	√	
	Improve Resources	√	
	Make this a great place to work		
BAF Risk(s):	Risk 1.1 - Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other partners to tackle shared challenges through Place-based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board.
Executive summary:	West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts. NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the West Yorkshire (WY) population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. All nomination and appointment processes to the Board include a commitment to improve the diversity of the WY Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. The paper summarises key developments from recent ICB and place-based partnership meetings.
Recommendation:	**Trust Board is asked to RECIEVE and NOTE the update on the development of Integrated Care Systems and collaborations:** ○ **West Yorkshire Health and Care Partnership.** ○ **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** • **Receive the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 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 to develop effective system working and improve population health.

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 19th March 2024</u>
	
	Key agenda items included:
	
	• Focus on Acute Services- An update on the work of the West Yorkshire Association of Acute Trusts, its work to date, benefits of the collaboration for patients and the population of West Yorkshire, and future strategy was provided.
	• Chair's report- key updates included:
	  ○ The ICB has been reviewing its governance cycle for 2024/25, reflecting on learning from the first 18 months of operation as a statutory organisation. Following support from the ICB Executive Management Team and the ICB Non-Executive Members it has been agreed that the ICB Board and its Committees will move to a quarterly governance cycle in 2024/25.
	  ○ The ICB agreed its five-year Joint Forward Plan in the July 2023 Board meeting. There is a requirement to refresh the plan annually, and the ICB agreed to take a light touch approach to the refresh. This will be finalised in line with the 2024/25 operational plan.
	  ○ The last meeting of the West Yorkshire Partnership Board was in-person on 5 March 2024. The meeting in public included a deep dive into the progress to date and further plans for two of the ICB 10 big ambitions to reduce antimicrobial resistant (AMR) infections and to tackle climate change.
	  ○ The West Yorkshire Health and Care Partnership hosted a visit from the Chair of NHSE, Richard Meddings.
	  ○ The ICB Board continues with its visits programme to the five Places, distinct sectors and provider Trusts to ensure that the Board is visible and engaged across the system.
	• Deputy Chief Executive's report. Key updates included:
	  ○ Spring Budget 2024- on 6 March 2024, the Chancellor delivered the Spring Budget for 2024. A summary of the key areas that impact the health and care system and its workforce was provided.
	  ○ Winter Planning.
	  ○ Covid-19 vaccinations.
	  ○ Covid Inquiry.
	  ○ Industrial action- all NHS providers in West Yorkshire have worked to ensure that urgent and emergency care, and other essential services, remained in place throughout this period to keep people safe.

	○ Measles- activity to improve Measles Mumps and Rubella (MMR) vaccination remains an important priority. ○ Race Equality Week took place between 5 and 11 February 2024. A report, “Too Hot to Handle" from the charity BRAP was published on 5 February 2024 which explores the impact of racism within the NHS. ○ Financial and operational planning 2024/25- the ICB have been developing financial plans for 2024/25 within West Yorkshire since the end of 2023, building on the Medium-Term Financial Planning work undertaken previously, and have worked with all NHS partner organisations to develop individual, Place and system plans. Work continues but initial outputs would indicate that the delivery of a breakeven position for 2024/25 will present a significant challenge. All partners have been asked to explore options for the delivery of a break-even plan, reflecting on strategic choices alongside more traditional technical and allocative efficiencies. Headline financial plans were submitted to NHSE on 29 February 2024, with detailed plans due on 21 March 2024. ○ Following support from the Partnership Board on 5 March 2024, the ICB Board were asked to support becoming the first ICB to adopt Locality’s ‘Keep it Local’ approach as an organisation joining local authorities across West Yorkshire who are already ‘Keep it Local’ Councils. ○ The ICB held its second Neurodiversity Summit in February 2024. ○ The ICB hosted a three-day Adversity, Trauma and ○ Resilience Knowledge Exchange 2024 run jointly with the West Yorkshire Violence Reduction Partnership. ○ The National NHS Staff Survey 2023 Results were published on 7 March 2024. • Board Assurance Framework. • Integrated Performance Report including financial performance. • Corporate Risk Register. • Winter planning update. • West Yorkshire and Harrogate Local Maternity and Neonatal System overview. • Freedom To Speak Up- the first formal Freedom to Speak Up report to the West Yorkshire ICB Board from the ICB was received. • Emergency Preparedness, Resilience and Response (EPRR) Annual Report. • Modern Slavery Statement. • ICB Constitution/Standing Financial Instructions/Financial Scheme of Delegation/Terms of Reference. • Standards of Business Conduct Policy. • Committee ‘AAA’ reports.

Date of next meeting	Next meeting scheduled for 25th June 2024.
Further information:	https://www.westyorkshire.icb.nhs.uk/meetings/integrated-care-board/nhs-west-yorkshire-icb-board-meeting-19-march-2024

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 5th March 2024 Agenda items included: • Update from the Partnership Chief Executive Lead. Key updates included: ○ NHS England (NHSE) has launched a major drive to invite those not fully vaccinated against measles to come forward and catch up on missed doses. ○ The NHS is planning for a seasonal dose of COVID-19 vaccine in spring 2024, following the government's acceptance of advice from the Joint Committee on Vaccination and Immunisations (JCVI). Advice on eligible cohorts and contract dates for the spring 2024 COVID-19 vaccination campaign has been issued. ○ Race Equality Week - an annual UK-wide movement uniting organisations and individuals to address the barriers to race equality in the workplace took place between 5 and 11 February 2024. ○ There was further industrial action in February. All providers have worked hard to protect urgent and emergency care and ensure that patients and essential services are safe. ○ The Board of the NHS WY ICB met in public on 16 January 2024. A key focus of the meeting was Winter Planning 2023/24. ○ Work has been taking place to develop financial plans for 2024/25 within West Yorkshire since the end of 2023, building on the Medium-Term Financial Planning work undertaken previously. Initial outputs indicate that the delivery of a break-even position for 2024/25 will present a significant challenge. All partners have been asked to explore options for the delivery of a break-even plan. ○ There is a public consultation by NHS West Yorkshire ICB and South West Yorkshire Partnership NHS Foundation Trust which asks for views on proposals to create specialist inpatient wards for older people with dementia, and other mental health needs (such

	as anxiety, depression or psychosis), in Calderdale, Kirklees and Wakefield. • Fair Work Charter. • West Yorkshire – A Creative Health System- In December 2023, the NHS West Yorkshire Integrated Care Board, Mayor of West Yorkshire and the West Yorkshire Combined Authority announced our region as a Creative Health System. The mission of this work is to bring alignment, amplification and connection across our system to enable people to engage in creative approaches so that they can live well in their community and achieve their potential. • Becoming the first "Keep it Local" Integrated Care System. • Our ambition to reduce antimicrobial resistance. • Patient and Public Voice. • Our ambition to tackle climate change.
Date of next meeting	Next meeting scheduled for 16th July 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-march-2024

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 March 2024 Agenda items included: • Chair's update. • OpCourage- a presentation was given on the Veterans Mental Health and Wellbeing Service (OpCourage). This is a specialist service for ex-armed forces, veterans, families/carers and service personnel who are approaching discharge, to support and recognise the early signs of mental health problems. • Neurodiversity data work. • Maternal mental health- a presentation giving overview of work to implement the WY Maternal Mental Health Service was given. Recurrent funding from all West Yorkshire Places has now been confirmed, and recruitment has progressed. A proposal for timescales of go live of each of the service pathway was outlined.

	• Inpatient quality- it was outlined that within the Commissioning Framework is a self-assessment intended to prompt to and promote local discussion and support planning of change for in scope services. This will support work to ensure inpatient services are local, inclusive and delivering safe, personalised and therapeutic care. This work is overseen by the Secondary Care Pathways workstream. A draft of the adult self-assessment is due to be submitted on 28th March 2024 by the ICB. A Children and Young People's self- assessment will also be completed, but timescales for this differ. • Older people's mental health. • Planning, performance and draft 24/25 priorities • Escalation from AAA reports.
Date of next meeting	Next meeting scheduled for 18th April 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 7th March 2024 Key items discussed included: • Report of the Place Lead. Key updates included: o West Yorkshire Annual NHS Joint Forward Plan- NHS England updated the guidance for Integrated Care Boards (ICBs) on December 22, 2023. The updated guidance for 2024/25 highlights the development or revision of annual Joint Forward Plans (JFPs) as shared delivery plans aligning with Integrated Care Systems' Five-Year Integrated Care Strategies. o Health and Care Act New powers- Changes to health scrutiny arrangements that were signalled in the Health and Care Act 2022 came into effect from 31 January 2024. o West Yorkshire Mutual Accountability Framework. o Wakefield District Health and Care Partnership – Chair Role- Dr Ann Carroll has agreed to continue for a further 12 months in the role of Chair of the Wakefield District Health and Care Partnership until 31st March 2025. o Wakefield Medical Director for Integrated Community Services- Dr Colin Speers took on the role in January.

	○ Measles, mumps and rubella (MMR). ○ NHS West Yorkshire Integrated Care Board (ICB) operating model- The Programme Board met on Tuesday 23 January 2024. There was a focus on the implementation of the ICB operating model from 1 April 2024. ○ UNESCO Global Network of Learning Cities- Wakefield District's application to join the UNESCO Global Network of Learning Cities (GNLC) has now officially been accepted and fully endorsed. ○ What's Next for Nova: New Business Plan is Live. ○ Wakefield District VCSE Collaborative- Partners across the Voluntary Community Social Enterprise (VCSE) and statutory sectors have been working together to design a new Wakefield District VCSE Collaborative. • Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative). • Children & young people ○ Children and Young People Alliance Video ○ SEND inspection readiness update- the partnership is currently preparing for an inspection of services for children and young people who have special educational needs and disabilities (SEND). This inspection will be jointly led by Ofsted and the Care Quality Commission and will be based on a revised inspection framework. To support Wakefield to prepare for inspection the Local Government Association was invited to undertake a Peer Review (November 2023). An action plan is in development to respond to the findings of the Peer Review. • Outcomes framework. • Wakefield Place Risk Register including West Yorkshire Board Assurance Framework • Quality, safety and experience highlight report. • Finance update month 10. • Health inequalities update. • 2024/25 Operating Plan update • Issues escalated/for escalation.
Date of next meeting	Next meeting scheduled for 6th June 2024.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

	https://www.wakefielddistricthcp.co.uk/wp-content/uploads/2024/03/WDHCP-Meeting-Pack-7-March-2024-Publication-1.pdf

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 21st March 2024
	
	Key agenda items included:
	
	• SWYPFT Strategy Refresh
	• Programme highlight reports.
	• Enabler highlight reports.
	  ○ People Alliance.
	  ○ Housing and health.
	  ○ Health inequalities.
	  ○ Digital and business intelligence.
	• Embedding quality in priority programmes
	• Update on the SWYPFT older people's inpatient consultation.
	• Specialist Weight Management Service.
	• Total Place Budget approach.
	• Developing system leadership capabilities.
	• Proposal to embed assurance functions within the Transformation and Delivery Collaborative.
	• Next steps for system efficiency schemes and Transformation Delivery Plan refresh.
	• Items for escalation to Wakefield District Health and Care Partnership Committee.

Date of next meeting	Next meeting scheduled for 30th April 2024.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	Update from meeting on 20 March 2024
	
	Key agenda items included:
	
	• Mental Health Alliance performance dashboard.
	• Perinatal mental health deep dive.
	• SWYPFT Strategy refresh.
	• Standing item updates:
	  ○ Mental Health Emergency Dept Strategy Group.
	  ○ Community Mental Health Transformation.
	  ○ NHS 111 roll out.
	• Mental Health Alliance stakeholder meeting.

	• Development session feedback. • Partner updates. • Wakefield Transformation and Delivery Collaborative feedback. • Wakefield District Health and Care Partnership Committee feedback. • West Yorkshire MHLDA Partnership Board feedback. • 2024/25 planning update. • Alliance Forward Plan.
Date of next meeting	Next meeting scheduled for 24th April 2024.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting of 21st March 2024: Key agenda items included: • Homelessness. • Stopping the start: our new plan to create a smokefree generation - consultation update. • Your Money Matters Benefits Campaign. • West Yorkshire and Wakefield Place Joint Forward Plan approach 2024/25. • Better Care Fund - Quarter 3 Reporting. • Wakefield District VCSE Collaborative. • Overview and Scrutiny Committee Papers. • Older people's mental health inpatient services – public consultation.
Date of next meeting	Next meeting scheduled for 23rd May 2024.
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

Calderdale

SWYPFT is a partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 25th January 2024 Agenda items included: • Public questions. • Place Lead Report. • Deep Dive: Community and Voluntary Sector. • Clear Improvement Plan Emergency Department. • Quality and safety report. • Place finance report.

	• Place Committee Work Plan. • Quality Group Terms of Reference. • Papers received for information: ○ Quality Group Minutes.
Date of next meeting	Next meeting scheduled for 28th March 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 14th March 2024 Items discussed included: • SWYPFT Strategy Refresh. • Ageing Well. • Update and outputs of the Calderdale Cares Community Programme Board Workshops. • Launch the Public Part of Capital Appeal.
Date of next meeting	Next meeting is scheduled for 11th April 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 of Provider Development.

Items discussed	Update from meeting of 29th February 2024
	
	Items discussed included:
	
	• Ageing Well Update- the Senior Public Health Practitioner, Public Health provided an update on progress towards the Health and Wellbeing Strategy goal for Ageing Well "older people have strong social networks and live in vibrant communities". The report outlined the following key points:
	  ○ Calderdale are working towards becoming an Age Friendly Borough and have joined and engaging with the UK Network of Age Friendly Communities.
	  ○ Work has taken place to develop an Age Friendly Plan, with five key themes (Housing, Accessibility, Things to Do, Safety and Belonging and Getting About) informed by appreciative enquiry with communities.

	○ Work is ongoing to seek to improve visibility and access to information about Age Friendly Calderdale using the Age Friendly logo and by developing an online resource. • Neighbourhood Partnerships (Integrated Teams)- an update was provided on the development of Neighbourhood Partnerships in Calderdale. • Developing Calderdale's Health and Wellbeing Board (Policy and Partnership Support Officer)- an update was provided on developing Calderdale's Health and Wellbeing Board and the proposed changes to ways of working, following the recent development sessions that were independently facilitated by the Local Government Association and sought endorsement from the Board for changes to the Terms of Reference ahead of the new municipal year 2024/25. It was agreed that the terms of reference be amended to reflect four formal meetings a year, and each formal meeting of the Board focus on one of the four life stages: Starting Well, Developing Well, Living and Working Well and Ageing Well. • Health and Care priorities update.
Date of next meeting	Next meeting is scheduled for 18th July 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 13th March 2024 Items discussed included: • People story. • Dying Well programme update- an update was given on the establishment of the Kirklees Dying Well Programme Board, and the work taking place within four key priority areas (stigma and comms, identification and care planning, bereavement and care at home). • Governance review. • Accountable Officer's Report.

	Key updates included: ○ NHS West Yorkshire ICB Operating Model Review- the new ICB Operating Model will take effect from 1 April 2024. The two key workstreams for the coming months are the approach to organisational development and partnership working in our new operating model. ○ Visit to West Yorkshire by Richard Meddings, Chair of NHS England. ○ South West Yorkshire Partnership Foundation Trust Strategy Refresh. ○ Covid-19 Vaccination Programme Spring Campaign- the National Director for COVID-19 and flu vaccinations programmes at NHS England has asked ICBs to prepare for a successful spring 2024 Covid-19 vaccination campaign. ○ Locala Wound Care Service Award. • Kirklees Place Quality Report. • Kirklees Financial Update – Month 10. • Contract Report. • Performance Report against Key Performance Indicators for 2023/24. • High Level Risk Report: Cycle 6 2023/24 (November 2023 – January 2024). • Items for the Attention of the ICB Board. • Committee Work Plan. • Receipt of minutes.
Date of next meeting	Next meeting scheduled for 8th May 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 2nd February 2024 Items discussed included: • Kirklees Health and Care Plan- update on refresh of Kirklees Health and Care Plan. • Healthwatch Kirklees update. • The Big Plan- update on the refresh of the SEND Strategy. • Kirklees Health and Care Partnership Forum- future meeting frequency. • Work plan.
Date of next meeting	Next meeting scheduled for 6th June 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 4th March 2024 Key agenda items included: • Operational planning update 2024/25. • Health and Care Plan priority – holistic approach to out of hospital care. • Living Well programme update. • Ageing Well programme update. • Operating Model changes and Delivery Collaborative 2024/25. • SWYPFT Strategic Plan. • Update on SWYPFT Older People's Mental Health Inpatient Consultation.
Date of next meeting	Next meeting scheduled for 8th April 2024.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 4th March 2024. Agenda items included: • Relational Practice Speaker. • SWYPFT Strategy Update. • NHS 111 • Meetings for next financial year
Date of next meeting	Next meeting scheduled for 7th May 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.**

West Yorkshire
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

West Yorkshire Mental Health, Learning Disability & Autism Collaborative

Committees in Common (CinC) - TERMS OF REFERENCE

1. Scope

   a. The West Yorkshire Mental Health, Learning Disability & Autism Collaborative ('the Collaborative') is the collective governance vehicle for joint decision making, with delegated authority for the four NHS mental health, learning disability and autism provider Trusts in West Yorkshire.

   b. The Collaborative is one part of the wider West Yorkshire Health and Care Partnership, which is committed to putting combined efforts into tackling the long-term trends of ill-health. This includes specific ambitions to:

      i. Achieve a reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (including a focus on early support for children and young people)

      ii. Reduce suicide

   c. The overall responsibility for delivery of these two ambitions rests with the whole Partnership. Commissioning of NHS provision within this ambition rests with the West Yorkshire Integrated Care Board (ICB), comprising five places (Bradford, Calderdale, Kirklees, Leeds and Wakefield) each with delegated responsibility from the ICB for local commissioning.

   d. Oversight of progress against the strategic ambitions and coordination of West Yorkshire wide activity to transform services, deliver improvement and meet national and system ambitions for the MHLDA population is discharged and governed by the system-wide Mental Health, Learning Disability and Autism Partnership Board which is comprised of providers and commissioners, covering the NHS, local authority, VCS and other partners.

   e. The Collaborative is the collective entity for significant service change and transformation at scale within MHLDA services in West Yorkshire by:

      i. Leading 'do once' and 'design once' priorities on behalf of partners
      ii. Taking responsibility for commissioning and provision of specialized services and some ICB commissioned services
      iii. Playing a critical leadership role in visibility of the MHLDA agenda across the Health and Care Partnership
      iv. Identifying and leading bespoke projects at the request of the ICB
      v. Supporting the establishment of strong place-based arrangements across the Trusts, VCSE, local authorities and primary care

   f. **The formal governance forum for collaboration between Collaborative partners is the Committees in Common which reports into the Board of**

each individual provider within the Partnership (BDCT, LCH, LYPFT, SWYPFT). It is overall responsible for supporting service transformation, integration and innovation and specifically, responsible for leading development of identified workstreams, improving service delivery to support the overall ambitions of the Collaborative and the wider Health and Care Partnership.

g. This Terms of Reference was initially approved through each individual provider Board and subsequent iterations via the Committees in Common making recommendations to provider Boards.

h. Appendix 1 to the Terms of Reference describes this relationship in a diagram

2. Standing

a. Members shall only exercise functions and powers of a Party to the extent that they are permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the Collaborative Committees in Common

a. Ensuring alignment of all parties to the WY ICB Strategy and particularly the components relating to Mental Health, Learning Disability and Autism, confirming the role of the Collaborative in delivery;

b. Providing overall strategic oversight and direction to the improvement of services within the Collaborative for people with a Mental Health condition, learning disability and/or autism; instigating the creation of collaborate work to support service improvement.

c. To emphasize the primacy of individual organisations' decision making ability and relationship with their local place, but also to set the expectation through individual boards and within operational teams that:

i. Where agreed through the CinC there will be service delivery, development work and clinical/operational relationships that require a 'WY first' viewpoint, rather than an individual organizational viewpoint.

ii. All partners within the collaborative take informed decisions in consultation with other collaborative partners and relevant stakeholders where there might be an impact on others' services.

iii. The CinC will consider and agree adoption of joint policies and procedures across all organizations that will benefit the work of the collaborative.

d. Working in partnership with the wider MHLDA Partnership Board to support identification of capacity and capability within identified workstreams, reviewing the key deliverables and ensuring adherence with required

timescales and receiving appropriate assurance regarding process, progress and impact of workstreams.

e. Reviewing and identifying the risks associated with the performance of any of the Parties in terms of the impact to the Collaborative or to the ambitions of the Partnership, recommending remedial and mitigating actions;

f. Receiving assurance that the risks associated with the Collaborative work programme are being identified, managed and mitigated;

g. Formulating, agreeing and implementing strategies for delivery of the Collaborative workplan;

h. Seeking to determine or resolve any matter referred to it by the Programme Team or any individual Party and any dispute in accordance with the MoU:

i. Considering the shape of the Programme Team, agreeing and reviewing the extent of the Collaborative's financial support for the team, against wider Partnership funding;

j. Reviewing and approving the Terms of Reference for the Committees in Common;

k. Reviewing and agreeing the deployment of any joint Collaborative budget, with reference to the deployment of Service Development Funding and ICB baselines; this includes collective approval of substantial capital funding decisions in accordance with the Risk and Gain Sharing Principles.

4. Members of the Collaborative Committees in Common

a. Each party will appoint their Chair and Chief Executive as Committees in Common Members and the parties will always maintain a Member on the Committees in Common.

b. All parties will agree and recommend a lead Chief Executive to represent the Collaborative as both the MHLDA Sector Lead on the ICB and to chair the WY MHLDA Partnership Board.

c. Deputies will be permitted to attend on the behalf of a Member. The deputy must be a voting board member of the respective Party and will be entitled to attend and be counted in the quorum at which the Member is not personally present.

d. Each Party will be considered as one entity within the Collaborative.

e. The Parties will ensure that, except for urgent or unavoidable reasons, their respective Committees in Common Member (or Deputy) attend and fully participate in the meetings of the Committees in Common.

5. Proceedings of the Collaborative Committees in Common

a. The Committees in Common will meet quarterly, or more frequently as required.

b. The Chair may call additional meetings as required. Other members may request the chair to call additional meetings by making individual representation, although the chair will make the final decision on whether to proceed.

c. The Committees in Common shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the Members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the Committees in Common into the Parties' Trust public Boards.

d. The Parties will select one of the Parties' Chairs to act as the Chair of the Committees in Common on a rotational basis for a period of one year. The rotation of Chair will follow the established sequence based on which organization has the next turn. The sequence (starting from January 24) is:

   i. LYPFT – Jan 24 to Dec 24
   ii. SWYPFT – Jan 25 to Dec 25
   iii. BDCFT – Jan 26 to Dec 26
   iv. LCH – Jan 27 to Dec 27

e. The Chair will ensure they are able to attend every meeting over that period. If in cases of urgent, unavoidable absence the Chair cannot attend, one of the other Parties' Chairs will be asked to step in.

f. The Committees in Common may regulate its proceedings as they see fit as set out in these Terms of Reference.

g. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one Member present (four members in total).

h. Members of all Parties will be required to declare any interests at the beginning of each meeting.

i. A meeting of the Committees in Common will ordinarily consist of a conference between the Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously. However, the chair may request that Committees in Common takes place face-to-face instead.

j. Each Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the Collaborative.

k. Any issues to be raised within individual Party board committees will be noted and listed for action, with a dedicated agenda item reserved for this purpose.

l. The Committees in Common will review the meeting effectiveness at the end of each meeting with a dedicated agenda item reserved for this purpose.

6. Decision making within the Collaborative

a. Each Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

b. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the service area in accordance with the Key Principles and ambitions of the Partnership when making decisions at Committees in Common meetings.

c. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all Members reaching an agreed consensus decision in common in accordance with the Key Principles.

d. Where this relates to taking decisions about which Party should be a coordinating provider for a collaborative service, all Parties will abide by the principles agreed through the Committees in Common (Appendix 2)

e. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the Collaborative Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at the Committees in Common

a. The Committees in Common shall be entitled to invite any person to attend, such as advisors, experts by experience or Partnership leaders but not take part in making decisions at meeting of the Committees in Common. The Chair will agree final attendance lists for each meeting.

8. Administration for the Committees in Common

a. Meeting administration for the Committees in Common will be provided by the MHLDA Programme Team, maintaining the register of interests and the minutes of the meetings of the Committees in Common. Members are required to openly and proactively declare and manage any conflicts of interests.

b. The Chair will be responsible for finalizing agendas and minutes, based on the agreed workplan and in collaboration with the MHLDA Programme Team.

c. Where required by the agenda, governance leads from the Collaborative will be asked to attend and provide advice to the Committees in Common on

decision making and due diligence.

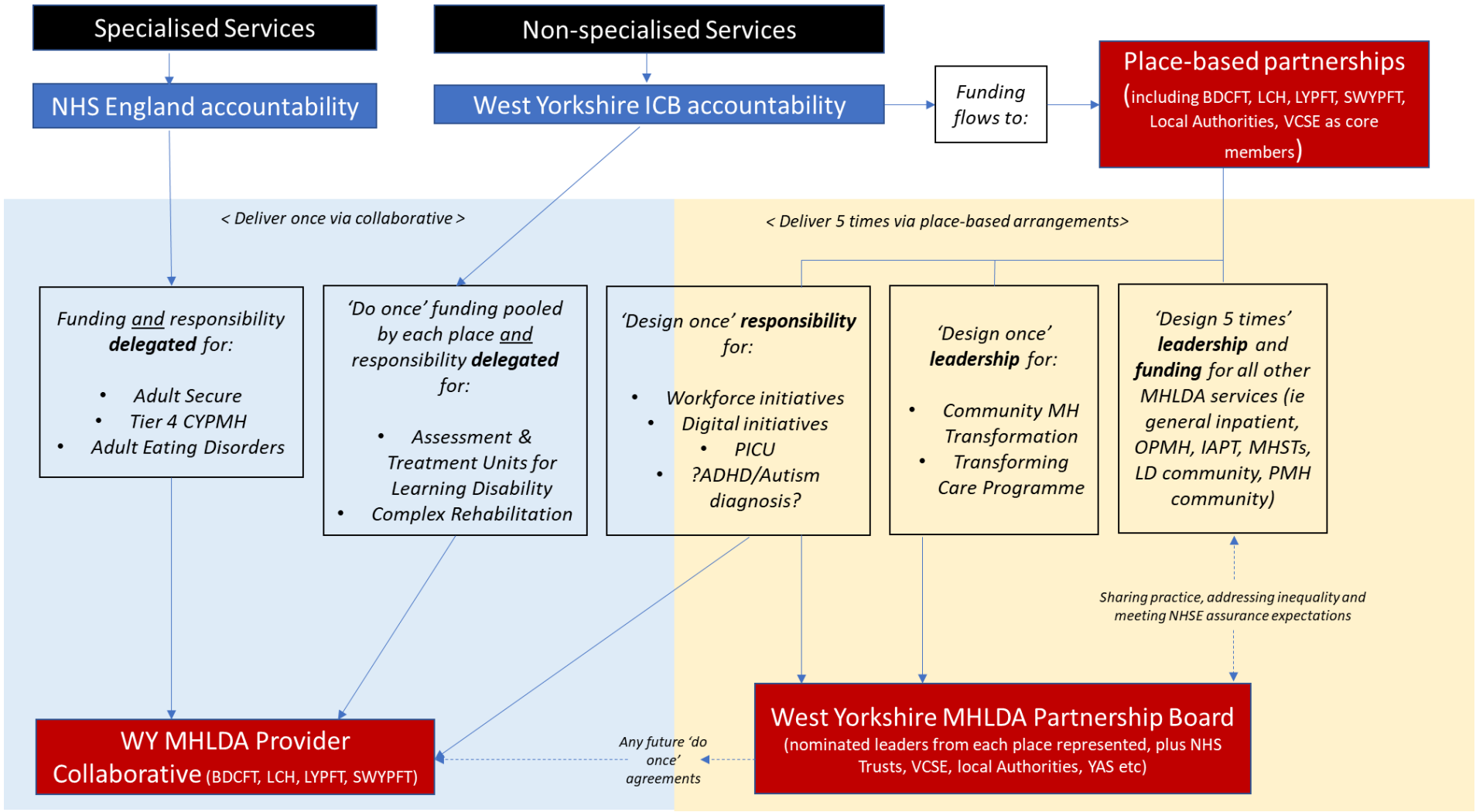
d. Papers for each meeting will be sent by the MHLDA Programme Team to Members no later than five working days prior to each meeting. By exception; and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

e. The minutes, and a summary report from the Programme Director will be circulated promptly to all Members and Trust governance leads as soon as reasonably practical for inclusion on the public agenda of each Parties' Board meeting. Any items not for public consumption will be marked as private in the minutes and be noted at Trust private boards but not circulated with the public papers.

9. Review

a. The Committees in Common will review these Terms of Reference at least every two years.

Appendix 1 – Decision making relationship between the Committees in Common and the wider Partnership



Appendix 2 – Principles for agreeing 'Lead Providers'

Categorizing the principles

- In order to create clarity and aid the decision-making process we propose identifying principles within the following three categories:

1. **Overall principles and use of language** – regardless of the specific service being considered
2. **Targeted principles** relating to three different service profiles
3. **Decision making forums,** the role of **all providers** and the **role of the West Yorkshire** programme team & commissioning hub

1: Overall principles and use of language

- NHS England utilizes the term 'lead provider', however for our collaborative this does not mean that any one provider is either a) more important in terms of decision making or b) can dictate what happens within any other provider

- Instead, we will describe our 'lead providers' as being the ***'coordinating provider'.*** This means they hold the contract with the accountable commissioner (NHSE or ICB) but the mechanics of this remain in the background. At the forefront the ***'coordinating provider'*** must work with all partners to ensure delivery and all providers within the collaborative remain jointly responsible for the collective whole (this will apply regardless of the footprint covered – ie WY, Y&H, North of England, National)

- The most important part of *'coordinating provider'* arrangements are to **promote partnership working and collaboration** between all relevant stakeholders; focusing on strong relationships that **maximize agreed service user outcomes**, enhance the experience of service users and their carers and ensure productive flow within and between services. All of which must be underpinned by appropriate involvement and a commitment to address health inequalities.

- **Recruitment to clinical, operational and project leadership roles for any new *'coordinating provider'* arrangement will be undertaken collaboratively and transparently from our collective talent pool and beyond** to ensure a distributed leadership model; not just defaulting to existing teams within the *'coordinating provider'.*

- The Commissioning Hub is the unifying structure for *all 'coordinating providers'* and it will remain organizational neutral and must be **appropriately resourced** to support any new service transfer, maximizing opportunities to continuously improve the service.

2: Targeted principles

- There are different starting points for making decisions on the *'coordinating provider'* based on historic service delivery, geography and organizational capacity/expertise. We have identified three main principles based on common scenarios:

1. If there is **only one provider** within the collaborative that **currently provides or is highly likely** to provide the full pathway of care required by the relevant specification and across the appropriate geography; then this provider will be our preferred choice to be the 'coordinating provider'. This considers that any concerns regarding this provider's suitability would likely already have been raised within wider collaborative structures as part of normal business relationships. However, to ensure due process the provider must demonstrate clear executive/board support within the organization, meet CQC requirements and be subject to light touch assurance from partners regarding suitability.

2. If there are **one or more providers** within the collaborative that **could provide the full, or major proportion** of the pathway of care required by the relevant specification and across the appropriate geography; and those providers can each make a strong case regarding how they currently promote service collaboration and demonstrate a vision for future service collaboration then a local process should be undertaken by the West Yorkshire Programme Team and the Commissioning Hub to appraise the options and make a recommendation.

   Approaches for the 'light touch' process (1) and the local process (2) are presented in Annex A

3. If there are **no providers** within the collaborative that provide the full pathway of care required by the relevant specification and across the appropriate geography, but there is agreement that it may be beneficial for a West Yorkshire to take on a coordination role:

   a) If one provider can make a strong case regarding how they will promote collaboration then this provider should be the preferred choice
   b) If one or more providers can make a strong case regarding how they will promote collaboration then the process in 2 should be followed
   c) If no providers wish to take on the coordinating provider role, we consider sponsoring an external provider on behalf of the Collaborative

3: Decision making, role of providers, role of the WY teams

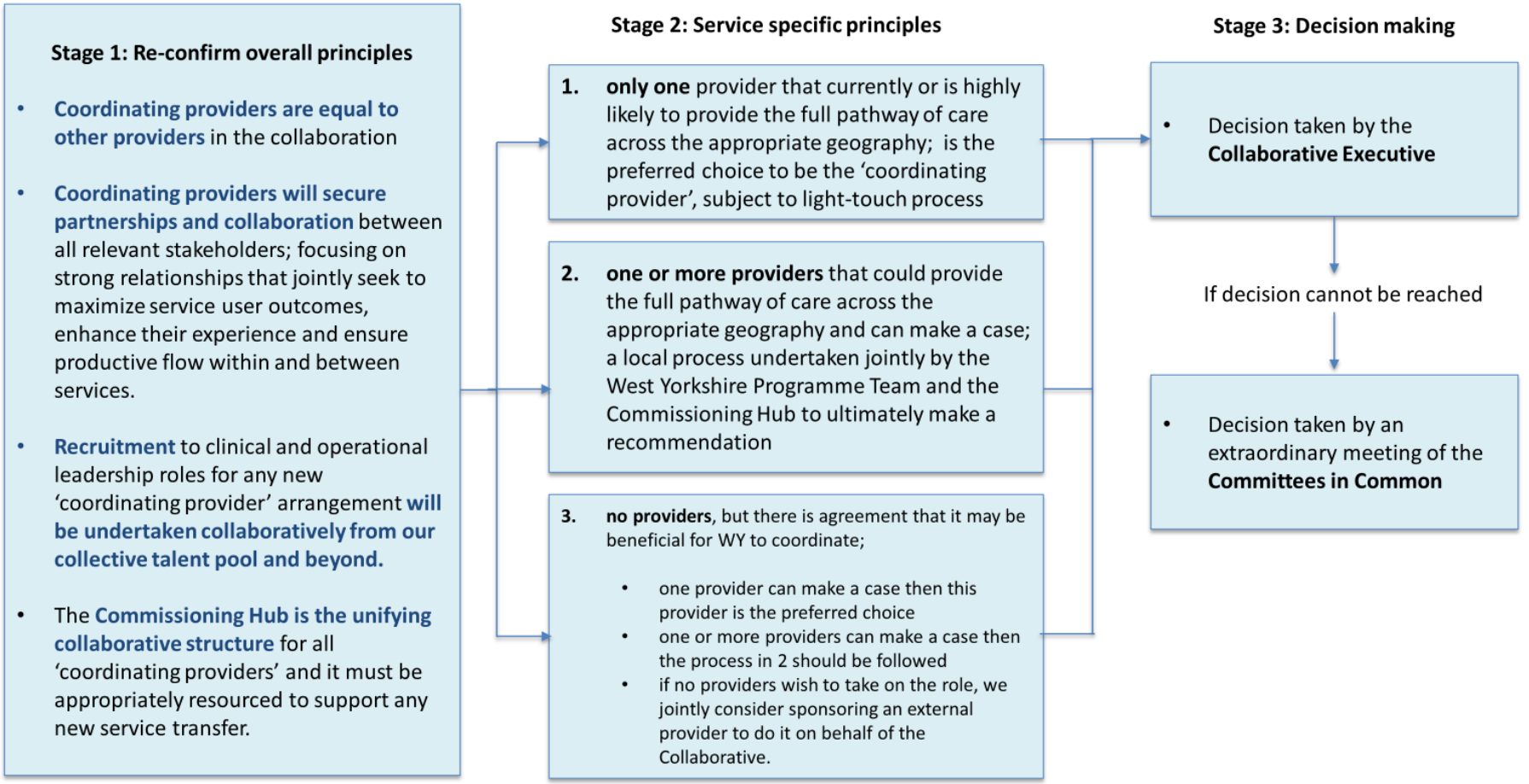
- Formal ratification regarding the *'coordinating provider'* rests with the Committees in Common of the MHLDA Provider Collaborative. Although decision making should take account of all partners within the care pathway, and not just limited to the Trusts. However, it is acknowledged that it is not practicable for this committee to always take these decisions, given the timescales involved. Instead, the following is proposed:

    - **Committees in Common approves these principles** for decision making and sets the expectation that they are followed.
    - Responsibility for taking decisions on the *'coordinating provider'* in line with the principles is **delegated to the Collaborative Executive Group**. For those decisions required where there are more than one potential 'coordinating provider' debate and discussion may also take place through the Specialized Services Programme Board, following a wider engagement process. Decision making and reasons will be reported to the Committees in Common.
    - **Should decisions not be possible** in the Collaborative Executive forum, then a full discussion will take place via extraordinary Committees in Common

- All providers within the collaborative will provide best available evidence, honesty and transparency of views to support decision making, and will support ultimate decisions taken

- Both the WY Programme Team and the WY Commissioning Hub will act as the 'neutral brokers' between partners, relaying information received objectively, factually and candidly, without prejudice

Flow chart of decision making for each new 'LPC' opportunity



Annex A: Questions for each process

1. **Light touch:** 'According to our West Yorkshire MHLDA Collaborative principles we have identified that X is our preferred coordinating provider for Y service because X currently provides/is highly likely to provide the full pathway of care and across the appropriate geography. However, we want to ensure there are no material reasons why X should not be the coordinating provider, therefore please let us know by return email if you have any fundamental concerns regarding X's ability to fulfil this role'

OR

2. **Local process:** 'According to our West Yorkshire MHLDA Collaborative principles we have identified that X, Y or Z can make a strong case to be the preferred coordinating provider for Y service because they all could provide the full, or major proportion of the pathway of care and across the appropriate geography. In order to make a collective decision about who the coordinating provider should be, please could you provide feedback on the strengths and weaknesses regarding service quality, leadership, collaboration and capacity within X, Y and Z'

Annex A: Local Process – Decision making criteria

A. **Level of support from Executive Team(s) and Board** – including confirmation of capacity within the organization to undertake the role, and demonstration of experience and commitment to working collaboratively to improve outcomes in this area (required for light touch and local process)

B. **Level of support from key partners and stakeholders**

- **WY Programme Team/Commissoning Hub asks partners for any fundamental concerns re preferred provider** (light touch only)
- **WY Programme Team/Commissioning Hub asks partners organizations asking if there are any current concerns about:** the quality of services, the leadership/collaborative approach or capacity concerns within the any of the possible 'coordinating providers' (local process only)

C. **Current CQC assessment:**

- **Provider meets CQC requirements within the service specification** (required for light touch and local process)
- **WY Programme Team/Commissioning Hub review of CQC assessments** regarding services being 'well led', and other relevant sector peer review or accreditation from sector bodies (required for local process only)

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
26 March 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 by NHSE as Level 2 'Normalising' on the Quality Maturity Framework. The West Yorkshire Adult Secure Provider Collaborative submitted a response to this request on 8th December 2023. The self-assessment scored the collaborative as compliant against all areas of Level 2 of the Quality Maturity Framework (QMF) and fully meeting all Lead Provider Roles and Responsibilities with the exception of one area self-assessed as requiring further work in relation to contracting. Feedback has now been received from NHSE. The response stated the Trust as Lead Provider for the West Yorkshire Adult Secure Provider Collaborative and lead on the Forensic CAMHS service line, can clearly demonstrate a developing maturity since the point of go live. NHSE have agreed that the West Yorkshire Adult Secure Provider Collaborative has now met all areas of Level 2 of the QMF, and the Collaborative will now move to work towards completion of Level 1. In addition, NHSE agreed with the self-assessment that the Trust are fully meeting all lead provider responsibilities with the exception of two items in relation to contracting where further work is ongoing. This is being progressed as a priority and reflects some of the national challenges experienced with provider collaborative contracting. 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. The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative has progressed among a range of items: • Response to the national review of WEMSS (women's enhanced mediums secure services).

	• The collaborative has led 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. The Adult Secure Provider Collaborative Women's Pathway Lead will co-chair the National Women's Service Pathway Transformation Implementation Support Group and is a member of the National Strategic Transformation group. • 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. • Review of the 2024/25 Commissioning Intentions for the collaborative. • A proposal has been developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements. Events will take place in May and June involving all partners. • 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. A review fo how we embed patient experience into our governance structures is underway with proposed recommendations being developed. • Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned. The Audit has now been completed and will report in April clinical and operational governance groups. • 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 11 months to February 2024 the collaborative operated with a financial surplus of £1,103k. However, this is expected to reduce further in March due to reduced activity from other Provider Collaboratives using West Yorkshire beds, and increased costs and complexity of Exceptional Packages of Care (EPCs) and a rise in OOA placements. A surplus position of £767k is forecast.

The Adult Eating Disorders Provider Collaborative reported a deficit at month 11. A year end deficit position is forecast.

The Children and Young People Mental Health Provider Collaborative reported a deficit position at month 11. 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.

There are ongoing discussions between the Trust, Commissioning Hub and NHSE/I regarding the Lead Provider contract.

The collaborative have submitted a response to the request from NHS England to evidence Lead Provider roles and responsibilities, and progress against the Quality Maturity Framework. Feedback from NHSE is awaited.

The month 11 position for the collaborative is breakeven for both the year to date and forecast.

Phase 2 Provider Collaboratives

Commissioning oversight of Yorkshire and Humber FCAMHS has now transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st January 2024. 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.

Reporting arrangements for FCAMHS continue to be developed under the new provider collaborative arrangements.

A delay to 'go live' for the Perinatal Mental Health Provider Collaborative has been agreed. It is expected the Provider Collaborative will go live on 1st October 2024. A mobilisation group has been established. A Clinical Director for the

	PMH Provider Collaborative is in post, and Provider Collaborative Programme Lead, started 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 the Specialised NHS-Led Provider Collaboratives update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 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 by NHSE as Level 2 'Normalising' on the Quality Maturity Framework.

The West Yorkshire Adult Secure Provider Collaborative submitted a response to this request on 8th December 2023. The self-assessment scored the collaborative as compliant against all areas of Level 2 of the Quality Maturity Framework (QMF) and fully meeting all Lead Provider Roles and Responsibilities with the exception of one area self-assessed as requiring further work in relation to contracting.

Feedback has now been received from NHSE. The response stated the Trust as Lead Provider for the West Yorkshire Adult Secure Provider Collaborative and lead on the Forensic CAMHS service line, can clearly demonstrate a developing maturity since the point of go live. NHSE have agreed that the West Yorkshire Adult Secure Provider Collaborative has now met all areas of Level 2 of the QMF, and the Collaborative will now move to work towards completion of Level 1. In addition, NHSE agreed with the self-assessment that the Trust are fully meeting all lead provider responsibilities with the exception of two items in relation to contracting where further work is ongoing. This is being progressed as a priority and reflects some of the national challenges experienced with provider collaborative contracting. The feedback stated that the Collaborative gave 'excellent demonstration of candour and transparency in all reporting, good examples of relationship management with providers to resolve complex quality issues and clear examples of governance and robust relationships with external stakeholders'.

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. The self-assessment supports the Regional Specialised Commissioning Team with its evidence base prior to issuing the 2024/26 Lead Provider contract.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative has progressed among a range of items:

- Response to the national review of WEMSS (women's enhanced mediums secure services).
- The collaborative has led 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. The Adult Secure Provider Collaborative Women's Pathway Lead will co-chair the National Women's Service Pathway Transformation Implementation Support Group and is a member of the National Strategic Transformation group.
- 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.
- Review of the 2024/25 Commissioning Intentions for the collaborative.
- A proposal has been developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements. Events will take place in May and June involving all partners.
- 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. A review fo how we embed patient experience into our governance structures is underway with proposed recommendations being developed.
- Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned. The Audit has now been completed and will report in April clinical and operational governance groups.
- 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 11 months to February 2024 the collaborative operated with a financial surplus of £1,103k. However, this is expected to reduce further in March due to reduced activity from other Provider Collaboratives using West Yorkshire beds, and increased costs and complexity of Exceptional Packages of Care (EPCs) and a rise in OOA placements. A surplus position of £767k is forecast.

Following review of the 2023/24 Lead Provider Contract Variation, this was 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. This is an area of focus.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 6th February 2024, with a further meeting planned for 2nd April 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 11, a deficit position of £477k is reported. This is a deterioration against a break-even plan and can be attributed to deficits against the OOA budget (£302k) and the cross flows income target (£284k).

The forecast position the 2023/24 financial year is a £534k 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 £198k is reported for the 2023/24 financial year to February 2024 against a balanced plan. High-cost Exceptional Packages of Care (EPCs) are primarily driving the collaboratives deficit position. There is one ongoing high-cost EPC which is forecast to continue throughout the 2023/24 financial year. Funding earmarked for investment on clinical schemes is currently mitigating the year to date deficit position of the collaborative.

The forecast position for 2023/24 is a £197k deficit. This is based on the remaining EPC continuing to the year end and activity levels in other areas remaining stable.

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 collaborative have submitted a response to the request from NHS England to evidence Lead Provider roles and responsibilities, and progress against the Quality Maturity Framework. Feedback from NHSE is awaited.
- There are ongoing discussions between the Trust, Commissioning Hub and NHSE/I regarding the Lead Provider contract.
- 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 11 position for the collaborative is breakeven for both the year to date and forecast.

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 was established with representation from SWYPFT FCAMHS colleagues and the Commissioning Hub to manage the transition to a Provider Collaborative, in line with the MOU.

Commissioning oversight of Yorkshire and Humber FCAMHS has now transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st January 2024. 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.

Reporting arrangements for FCAMHS continue to be developed under the new provider collaborative arrangements.

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 a delay to go live has been agreed. It is expected the Provider Collaborative will go live on 1st October 2024. A mobilisation group has been established. A Clinical Director for the PMH Provider Collaborative is in post, and Provider Collaborative Programme Lead, started in post in February 2024.

Recommendation:

Trust Board is asked to:

Receive and note the Specialised NHS-Led Provider Collaboratives update.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	Andy Lister - Head of Corporate Governance		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Compliance with the Trust's Standing Orders provides assurance to systems and partners of the Trust's adherence to the framework within which the Trust operates and how its officers conduct Trust business.		
Any background papers / previously considered by:	Quarterly reports to Trust Board.		

Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance and Resources of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The Trust Seal has not been used since the last report to Board in November 2023.
Recommendation:	**Trust Board is asked to NOTE the update to the Trust Seal since the last report in November 2023.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2024
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**Internal meetings' governance framework update**		
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:	We are respectful, honest, open and transparent. We improve and aim to be outstanding. We are relevant today and ready for tomorrow.		
Purpose:	To review the Trust's internal meeting governance structure to ensure it supports the delivery of the Trust's mission and values, strategic objectives and legal requirements and provides the Trust Board and committees of the Board with the required levels of assurance.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The internal meetings governance framework provides a structure through which the Trust delivers its strategic objectives and provides evidence of key controls as mitigation for strategic risks in the Board Assurance Framework (BAF).		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	A clear internal governance framework reflects the Trust's lines of assurance, demonstrating that the Trust operates effectively and efficiently to ensure it delivers quality healthcare over the long term, and contributes to the objectives of the integrated care partnerships (ICP), integrated care boards (ICB), and place-based partnerships, through robust governance arrangements.		
Any background papers / previously considered by:	Previous paper to Trust Board September 2022 Draft updates reviewed by EMT on 7 March 2024		
Executive summary:	The Trust internal meetings' governance framework illustrates the relationship between Board governance and corporate/clinical governance, providing the systems, processes, and framework to enable Board decision making. The internal meetings' governance framework identifies key lines of assurance reporting into the formal committees of the Board.		

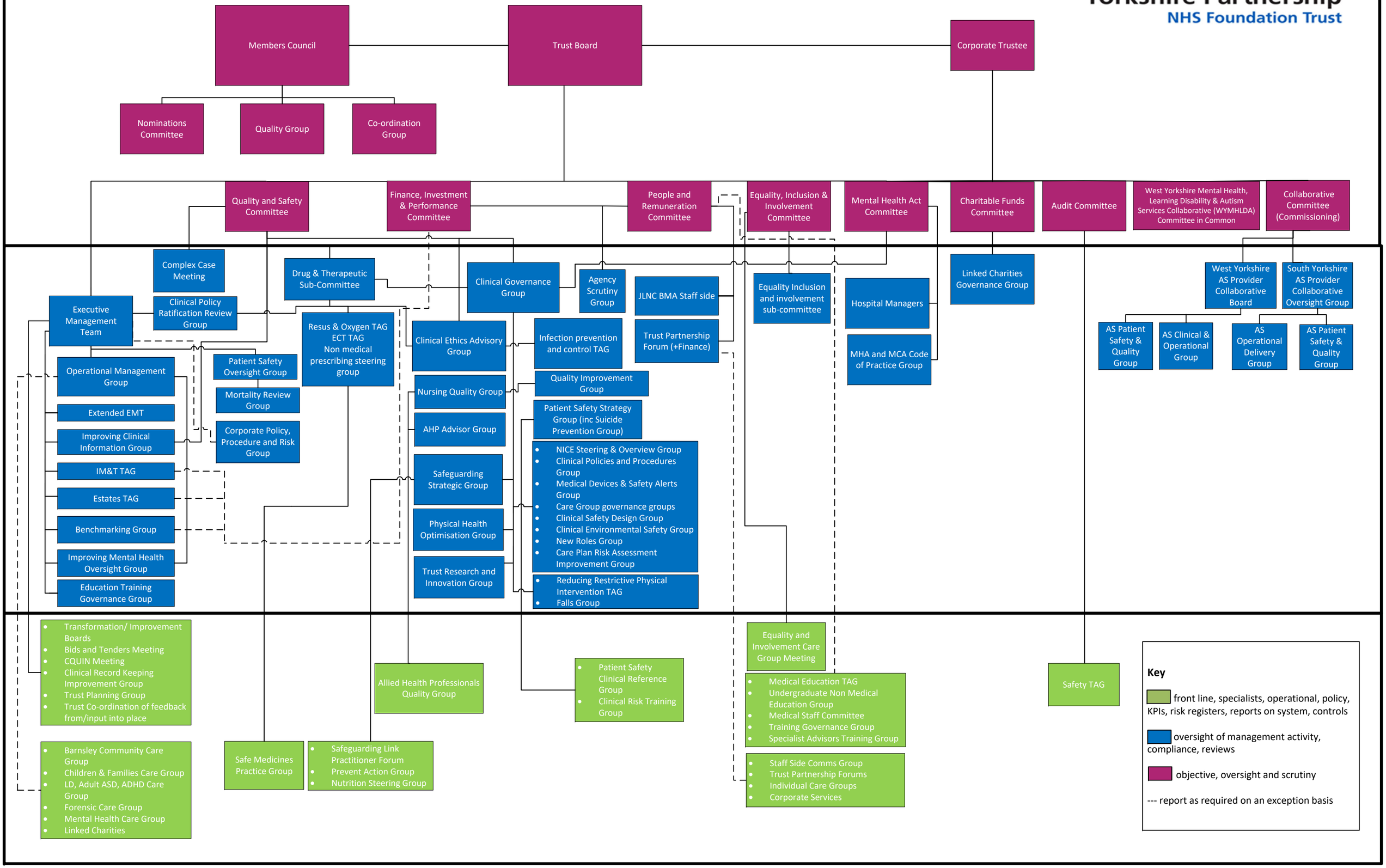
	In November 2023 the head of corporate governance wrote to all key internal stakeholders to review the current internal governance framework and identify any gaps or required changes.
	
	On receipt of all responses, an updated version of the document was presented to the Executive Management Team (EMT) on 7 March 2024 for review, where further amendments and alterations were requested.
	
	The lineation of meetings has been subject to detailed review to ensure governance lines can easily be followed.
	
	The framework has been updated to reflect the following changes:
	
	<u>Operational level (green)</u>
	• Nutritional steering group added.
	• Care group reporting structures have been updated.
	• Equality and involvement care group meeting has been added.
	• Lineation of groups has been made clearer.
	
	<u>Oversight of management activity (blue)</u>
	• The South Yorkshire adult secure provider collaborative oversight group and West Yorkshire adult secure provider collaborative board have been added, with respective sub-groups.
	• Agency scrutiny group has been moved for clearer alignment into people and remuneration committee and finance, investment and performance committee.
	• Lineation into the executive management team and operational management team has been made clearer with the aim of making the document easier to follow.
	• The following groups have been revised/introduced in 2023/24 to ensure reflective of current operating and regulatory environment, and the following have been added:
	  o Clinical safety design group
	  o Clinical environmental safety group
	  o New roles group
	  o Care plan risk assessment improvement group
	  o Improving mental health oversight group
	
	<u>Objective oversight and scrutiny (purple)</u>
	• Collaborative committee title now includes “commissioning” to demonstrate delineation from other committees.
	• Clinical governance clinical safety committee has been updated to show its new name of quality and safety committee.
	
	The internal meetings’ governance framework provides Trust Board with assurance that EMT have in place a clear organisational structure with defined and consistent lines of responsibility, effective risk management processes, and control mechanisms that support the board assurance framework, and meet the requirements of the code of governance for NHS provider trusts (2022).
	
	EMT has asked for an action regarding the structure to determine if there are any opportunities to remove/combine any meeting structures to ease the

	pressure on staff without having a detrimental impact on the Trust's systems of control. This action will be pursued over the course of the next six months.
Recommendation:	**Trust Board is asked to APPROVE the update to the internal meetings' governance framework.**

Internal Governance Structure

Board are required to ensure appropriate risk management processes are in place.
The Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green)

South West Yorkshire Partnership NHS Foundation Trust



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 24
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Estates Strategy Update**		
Paper presented by:	**Nick Phillips Deputy Director: Estates and Facilities**		
Paper prepared by:	Nick Phillips		
Mission/values:	Delivery of the aims and plans of our estate strategy will support the achievement of our vision to provide outstanding physical, mental and social care in a modern health and care system.		
Purpose:	To update the Trust Board members on progress on delivering the Estates Strategy 2023-2033		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The achievement of our estate strategy will have an impact on several strategic risks and in particular: 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. 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. 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. 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. 4.3 Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.		
Contribution to the objectives of the Integrated Care System/Integrated	The Trust estate strategy links to the ICB estate strategy including the allocation of capital across the area.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	The Trust estate strategy was approved by Board in July 2023. Updates on progress against the Trust's estate strategy are provided periodically to Trust Board
Executive summary:	The Trust has an approved estate strategy, which looks at need for the next ten years. The strategy covers operational, strategic development and sustainability issues. This paper is the first update on progress on the current strategy and covers the period to date. Updates are included on the following: • Renewal of leases for key strategic building (Folly Hall) • Update on utilisation and net zero carbon workstreams. • Update on the Bretton Centre/Forensic campus • Calderdale and Kirklees inpatients service • Property utilisation in Barnsley • North Kirklees Hub • Older Peoples Services inpatient development – estate needs (this is still subject to the completion of the consultation for the wider project)
Recommendation:	Trust Board is asked to NOTE and COMMENT on the progress to date on the 2023-2033 estate strategy

Trust Board March 24
Trust Estate Strategy Update

Introduction

The estate strategy for South West Yorkshire Partnership NHS Foundation Trust (the Trust) approved by board in July 2023, set out our proposals for the next 10 years, in line with the vision, mission and strategic objectives of the Trust. It identifies how we will ensure that our estate continues to support high quality care through the provision of high-quality estate which represents value for money and moves us towards a net zero carbon estate. It builds on and supersedes the previous estates strategy.

Following approval of the strategy the workstream priorities have now been assigned to the most appropriate areas of the estate team for action. Whilst some of the priorities are categorised as actual and current projects, some of the areas for action will have a much longer lead in period, and will in some cases required external funding, so early work on these will be beneficial.

This paper provides an update on progress against the agreed priorities for 2023/24 These priorities are being worked on alongside day-to-day operations which include statutory compliance e.g. fire safety, maintaining the estate, reducing backlog maintenance and delivering the smaller non-strategic capital projects.

2023/24 priorities

North Kirklees Hub

This scheme is the final “hub” envisaged in the previous Trust strategy; The accommodation in North Kirklees is primarily centred around Beckside Court, which is leased accommodation where we co-locate with Locala.

This arrangement is in line with the flexible hub concept which was seen as one of the ways forward for this type of provision. The capital projects team have initiated a project group with operational colleagues to understand the need for a hub. At the same time a number of external factors have meant that the scheme has changed slightly. Firstly, we have been given notice on a building in the area which we occupy through the council free of charge. Secondly, the potential for additional space in Beckside Court has arisen given an opportunity to develop the existing property with the least potential operational disruption. The team have so far put together a schedule of accommodation and assessed how that will fit at the location under consideration. Next stages are developing costings for the scheme so as to generate a

business case in quarter 2 of 2024. Capital requirements will be built into the capital plan for 2025/26 or before. Given that the Trust capital allocation is fully committed for 2024/25 any expenditure would be dependent on any changes to the plan or additional external funding becoming available.

Folly Hall Lease

Whilst this is largely a transactional estate issue, it is a key Trust hub for staff and service users alike, so is regarded as strategic in nature. The Trust has worked with partner organisations to evaluate options and after careful consideration we plan to enter into dialogue to renew the lease at Folly Hall, which represents good value for money. We will continue to compare and review other rental properties in the location to confirm value for money.

We will collaborate with the teams at Folly Hall to improve utilisation on the site to ensure it is better used and alleviate some of the pressures on space within the wider geographical area. The current plan is to agree terms for approval in summer 2024 this will be subject to approval in line with Trust standing financial instructions.

Older People Services (OPS) – Estate component

The OPS project is now in the final stages of consultation therefore the full estate implications are not fully confirmed. However, it is clear that developments on Fieldhead are key. Therefore, the Trust has moved forward with a potential scheme to provide up to 10 beds on Crofton ward for this purpose. The capital programme for 2024 to 2026 has allowance for this scheme built into it. No work will commence until after outcome of the consultation is finalised. Subject to the outcome work could commence in quarter 3 2024/25.

Net Zero Carbon

The move to a net zero carbon organisation is wider than the estate strategy, but the estate is a key area for reduction. To date progress has been to turn this into a project within the capital team with a view to overseeing a full plan for achieving the requirement. At present the key aim is to consider the two main sites and put in place a plan to bid for grant funding for some of the schemes. We are also exploring collaboration with partner organisations, particularly Mid Yorkshire Teaching Trust given the close proximity of Fieldhead to Pinderfields hospital. It is worth noting the achievement of a number of schemes which have enabled improvements to be made:

- LED lighting renewal at Fieldhead, Kendray and the Dales (£0.5m)
- Installation of high efficiency gas boilers to replace existing life expired plant. Budget (£0.2m)

- Additions to roofing programme to increase insulation (£0.1m)
- Commencement of work with Wakefield Council and Mid Yorks to consider the use of mine water as a zero carbon energy source (this will be a long term scheme which will require a complete renewal of the heating systems throughout Fieldhead

Whilst these schemes particularly the lighting are important in achieving net zero carbon the decarbonisation of the space heating requirement which is primarily fossil fuel will be the next focus. This aspect will be considerably more expensive and will need to utilise wider funding such as grants hence the commencement of how we can better access these going forward. Additionally, the sustainability agenda and cultural changes will be key in helping to improve on demand for power.

Improved Utilisation

Overall, the work on this area is at the scoping and information gathering stage. This is centred around continuing to roll out the Trust booking systems for space to improve the use of booked space, along with using sensors to better understand utilisation.

The strategy particularly references Barnsley as an area for focus. This is being looked at as a system and an opportunity is currently being explored at an outline development stage to have a “health hub” in Barnsley town centre with the whole health sector involved.

Update to Bretton Centre Project

Board members may recall that the Bretton Centre project was paused following a series of cost plan changes which gave concern to value for money, and the investment available to the Trust given capital limits within each integrated care system. The project team is now regrouping to have a renewed terms of reference and scope. Some early outline design is now happening in order to be able to review costings before a new outline report can be drawn up. This revised scheme will be in line with the forensic hub proposal in the strategy rather than a revisit of the existing ward centred project.

Review of inpatient Provision Kirkleed and Calderdale

This scheme is potentially by far the most ambitious within the Trust, early estimates indicated that required funding is over and above our available organisational resources, so potentially national/regional funds will be needed. Therefore, the scheme will need to be worked up in detail to allow for bids for external funding to be made.

To this end a full review of the initial proposal is being undertaken with a detailed schedule of accommodation being drawn up which will be completed by the end of June. This will be used to review the cost models to date and formulate a project initiation document for agreeing next steps including discussing the proposals at an ICB and national level.

Risks

It is worth emphasising that many estate developments will require capital investment and the current resource limits for the NHS, including our local systems present us with risk. Capital planning is prioritised regularly to make best use of the funds we have at our disposal, and we continue to work with place and system colleagues so that our priorities are better understood and supported. Along with partners we also continue to raise this issue with the NHS Confederation and NHS providers to influence nationally.

Conclusion and recommendations

During the implementation of the strategy, we continue to review and assess priorities based on developing themes and changes at both a local operational and wider system level. The Trust strategy, clinical strategy and digital strategy, which are currently in progress, will potentially have an impact on our estate. Integrated Care Boards have a significant role in the development of capital priorities and we will continue to engage with them as well. Opportunities to bid for additional funding through national and grant routes to support our strategic aims agreed will be pursued.

The Trust strategy identified the Older People's Services, Folly Hall Renewal and North Kirklees Hub as developments that needed to be taken forward in planning in year one, with delivery in years two and three. Board members can take assurance that Progress to date is in line with that intent. The consideration of the Barnsley estate is taking place earlier than identified in the strategy document given availability of premises in the centre of Barnsley.

Whilst this update covers the higher-level strategic issues contained within the strategy, as stated in the introduction there is good progress in the day-to-day estate management, which is worthy of note, particularly.

- The Trust Place scores for 2023 are particularly good and reflect the investment in the estate over a long period of time.
- The current water mist system being installed completes the planned installation programme, putting the Trust ahead of most other organisations in retrofitting these systems extensively.
- Successful management of the property portfolio for electrical, water and gas safety
- Compliance with statutory safety requirements in asbestos safety.

- The ongoing development of the Premises Assurance Model to give high level assurance around a safe and proper estate.

Future regular updates will cover completion and progress on these and other issues contained within the full estate strategy.

Recommendations

Trust Board is asked to NOTE and COMMENT on the update on the Estates strategy.

Nick Phillips
Deputy Director: Estates & Facilities
March 2024

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2024-25

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 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	✘		✘	✘		✘	✘	✘		✘		✘

With **all of us** in mind.

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 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								✘				

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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	✘		✘	✘		✘	✘	✘		✘		✘
<u>Performance reports</u>												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report	✘							✘				
System Oversight Framework (when released)			✘									

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Care Group Performance report	✘		✘	✘		✘	✘	✘		✘		✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
Horizon Scanning – Focus On		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘							✘				
Strategic Objectives												✘
Trust Board Annual Work Programme												✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan												
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												✘
Strategies and Policies												

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		
Policy on Policies *(April 2024)*	✘											
Trust strategy refresh *(July 2024)*				✘								
Equality, Involvement, Communication and Membership Strategy (TBC*)*												✘
Learning from Healthcare Deaths Policy *(June 2024)*												
Workforce strategy/organisational development strategy *(to follow Trust Strategy refresh 2024)*												✘
Digital Strategy (full) *(to follow Trust Strategy refresh 2024)*												✘
Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2025)*												✘

Policy / strategy review dates:

- Trust Strategy *(July 2024)*
- 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 2024) (if required)
- Equality, Involvement, Communication and Membership Strategy (TBC)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(September 2026)*
- Digital Strategy *(to follow Trust strategy refresh)*
- Estates Strategy *(July 2033)*
- Learning from Healthcare Deaths Policy *(next due for review in June 2024)*
- Organisational Development Strategy *(to follow Trust Strategy refresh)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2026)*
- 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 2027)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in September 2026)*
- Workforce Strategy *(to follow Trust Strategy refresh)*
- Research and Development Strategy *(October 2025)*