NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 1 July 2025 (June meeting) at 9.30
Small Conference Room – Wellbeing and Development Centre
Fieldhead Hospital Wakefield

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**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	
4.	**9.38**	**Minutes from previous Trust Board meeting held 29 April 2025**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 29 April 2025 and board action log**	Chair	**Paper**	5	To approve
6.	**09.45**	**Chair's remarks**	Chair	**Verbal item**	3	To receive
7.	**09:48**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
8.	**09:55**	**Assurance from Trust Board Committees and the Members' Council** - Members' Council 7 May 2025 - People and Remuneration Committee 13 May 2025 - Quality and Safety Committee 13 May 2025/11 June 2025 - Mental Health Act Committee 4 June 2025 - Commissioning Committee 17 June 2025 - Finance, Investment and Performance Committee 12 May 2025/23 June 2025 - Audit Committee 25 June 2025	Committee Chairs	**Paper**	10	To receive
9.	**10.05**	**Performance**				
	10.05	9.1 Integrated performance report Month 2 2025/26	Executive Directors	**Paper**	30	To receive
	10.35	9.2 Care Group performance report	Chief Operating Officer	**Paper**	15	To receive
	10.50	*Break*			*10*	
10.	11.00	**Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	15	To receive
11.	11.15	**Risk and Assurance**				
	11.15	11.1 Patient Safety Oversight Annual report	Chief Nurse/Director of Quality and Professions	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.25	11.2 CQC action plan update	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11.30	11.3 Patient experience annual report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11.35	11.4 Safer staffing report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11:40	11.5 Quality Account	Chief Nurse/Director of Quality and Professions	**Paper**	10	To receive
	11.50	11.6 Cheswold Park update	Chief Operating Officer	**Paper**	5	To receive
	11.55	11.7 Update of actions SWYPFT is undertaking as a result of the review of Notts Healthcare	Executive Trio	**Paper**	5	To receive
12.	**12.00**	**Integrated Care Systems and Partnerships**				
	12.00	12.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.05	12.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Chief Executive	**Paper**	5	To receive
	12.10	12.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources/Director of Provider Development	**Paper**	5	To receive
13.	**12.15**	**Governance matters**				
	12.15	13.1 Compliance with NHS provider licence conditions and code of governance - self-certification	Director of Strategy, Inclusion and Change	**Paper**	10	To receive
	12.25	13.2 Trust Seal	Company Secretary	**Paper**	5	To receive
14.	**12.30**	**Strategies and Policies**				
		14.1 Digital strategy bi-annual update	Director of Finance, Estates and Resources	**Paper**	5	To receive
15.	**12.35**	**Trust Board work programme for 2025/26**	Chair	**Paper**	3	To approve
16.	**12.38**	**Any other business**	Chair	**Verbal**	5	To receive
17.	**12.43**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 29 July 2025	Chair	**Paper**	2	To receive

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

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the public Trust Board meeting held on 29 April 2025
Large Conference Room, Learning and Wellbeing Centre, Fieldhead Hospital

Present:	Marie Burnham (MBu)	Trust Chair
	Natalie McMillan (NMc)	Deputy Chair, Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Margaret Kitching (MK)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	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:	Dawn Lawson (DL)	Director of Strategy, Inclusion and Change
	Gary Ellis (GE)	Non-Executive Director
	Sean Rayner (SR)	Director of Provider Development
In attendance:	Christine Brereton (CB)	Interim Chief People Officer
	Adele Fox (AF)	Chief Operating Officer
	Sue Barton (SB)	Deputy Director of Strategy, Inclusion and Change
	Izzy Worswick (IW)	Assistant Director of Corporate Governance
	Emma Robinson (ER) (item 6 only)	Associate Director of Operations (Transition and Integration) Cheswold Park Hospital
	Joanne Parry (JP) (item 6 only)	Medical Clinical Lead, Cheswold Park Hospital
	Estelle Myers (EMy) (item 10.6 only)	Freedom to speak up guardian
	Andy Lister (AL)	Company Secretary
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)
Observers	Dr Nikhil Bhuskute (NB)	Gatenby Sanderson insight programme candidate
	John Laville (JLa)	Public Governor – Kirklees (Lead Governor)
	John Lycett (JLy)	Public Governor – Barnsley

TB/25/18 Welcome, introductions and apologies (agenda item 1)

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

MBu introduced Dr Nikhil Bhuskute from the insight programme run by Gatenby Sanderson, who would be observing the meeting. The insight programme is for aspirant executive and non-executive directors and as part of the programme they are given attachments to local NHS Trusts to gain insight into the workings of a Trust Board.

MBu outlined the Board meeting protocols and etiquette, and reported the meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting.

MBu noted that it would be last meeting for David Webster (DW), non-executive director, and Sean Rayner (SR), director of provider development, however SR had given apologies for the meeting.

MBu also welcomed Christine Brereton (CB) to the meeting as interim chief people officer.

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 that they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

TB/25/19 Declarations of interest (agenda item 2)

Andy Lister (AL) reported that Dawn Lawson (DL) has been appointed as vice chair of the Barnsley 2030 Board.

It was RESOLVED to NOTE the updated declarations of interest.

TB/25/20 Questions from the public (agenda item 3)

No questions were received from the public.

TB/25/21 Minutes from previous Trust Board meeting held 25 March 2025 (agenda item 4)

Darryl Thompson (DT) noted on page twelve of the minutes "The report included an appendix from the Learning from Healthcare Deaths report". DT advised that the report was the appendix and the minutes should be reworded.

DT also noted that the service user story (item TB/25/23) contained potentially identifiable information and DT submitted a suggested adjustment to the wording to reduce the amount of identifiable information contained within the minutes.

The minutes were accepted as an accurate record of the meeting, subject to the changes noted above.

Action – Corporate governance team

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 25 March 2025 as a true and accurate record.

TB/25/22 Matters arising from previous Trust Board meeting held 25 March 2025 and Board action log (agenda item 5)

TB/25/09d(1) MBr queried whether the response to the action regarding prescribed medication was detailed enough and provided adequate assurance to Trust Board. Trust Board members agreed that there is sufficient assurance and the action would continue to be monitored through the Quality and Safety Committee.

In relation to action TB/25/09f(2) Mike Ford (MF) queried whether there would be an opportunity for acuity to be discussed further. It was agreed that acuity would be discussed at the Quality and Safety Committee following which a paper would be presented to a future Trust Board development session.

Action – Andy Lister

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

TB/25/23 Service User/Staff Member/Carer story (agenda item 6)

Adele Fox (AF) introduced Emma Robinson (ER), Associate Director of Operations (Transition and Integration) Cheswold Park Hospital and Joanne Parry (JP), newly appointed Medical Clinical Lead, Cheswold Park Hospital who presented an overview of the services provided by Cheswold Park Hospital and the experience and outcomes of service users.

ER presented the positive progress that has been made since the acquisition of Cheswold Park Hospital in October 2024, particularly in relation to the work regarding admissions, developing the relationship with the South Yorkshire Adult Secure Provider Collaborative and building confidence in service provision at Cheswold Park Hospital.

With regards to admissions into Cheswold Park Hospital, ER reported that a weekly bed management meeting takes place across the provider collaborative in South Yorkshire. The Trust has committed to engaging in a further development session with the Provider Collaborative to review demand in South Yorkshire, and to focus on repatriations into area, working in a person centred way. ER stated that a flexible approach to admissions was being taken, in line with demand from the Provider Collaborative. Initially admissions received were for more settled patients, and this had now progressed to admitting more acutely unwell patients. There have been ten successful admissions to Cheswold Park so far since transfer of services to the Trust, with a further two admissions scheduled to take place in week. There are ten potential admissions being considered between April and June 2025. All acute admissions into Cheswold Park Hospital have been managed effectively and the leadership team have worked hard to support the staff with admissions and help build confidence.

There has been a focus on the configuration of the wards at Cheswold Park and the team have undertaken a review of every service user at Cheswold Park Hospital to understand where they are in their journey and their needs in order to move forward with their recovery.

Aire Ward has been developed as an admissions ward and this has included undertaking a significant amount of work with staff unfamiliar with the admission process to support them to understand the process and increase their confidence. ER reported that a service manager had been appointed who has supported the assessments and supervises the nursing team, increasing their confidence when undertaking admissions. A lot of work has taken place with the Provider Collaborative to consider and clarify the purpose of each ward in order to provide a pathway through the hospital while maintaining the focus on recovery. The Trust's response to the demand in the system has been well received by the Provider Collaborative.

Positive feedback has been received from both service users and staff following the acquisition of Cheswold Park Hospital. All admissions have been successfully managed by the staff at Cheswold Park and the leadership team continue to provide support to staff and work closely with the Provider Collaborative to offer further assurance to the team. The leadership team have also supported the successful implementation of various systems including SystmOne.

David Webster (DW) joined the meeting.

The initial target for occupancy of seventy patients by end of March was achieved, with seventy one patients at the end of March and the team are confident that this will increase further, up to eighty, by the end of June.

As part of the work with the Provider Collaboratives, a thorough synopsis of each patient is undertaken in order anticipate any discharges within the next quarter. ER summarised the referrals expected within the next quarter and advised that a Women's Enhanced Medium Secure Services (WEMSS) admission is expected which will provide additional challenges for

the service. The team at Cheswold Park are working with colleagues from the wider forensic care group to gain support.

There has also been an increase in medium secure female referrals, and Cheswold Park continue to monitor quality and safety when considering new referrals.

ER reported that there continue to be challenges regarding medical establishment, however a clear plan is in place around medical establishment requirements in order to transition to a substantive workforce, with recruitment of medics who align with the Trust vision and values. ER added that there is also a focus on ward culture and the service are working with the People Directorate on ward manager development to promote a positive working culture and support multidisciplinary working. An establishment review is also in progress.

A video was shown to Trust Board which provided positive feedback from both staff and service users on their experience of admissions and the service at Cheswold Park Hospital. ER also advised the Provider Collaborative had undertaken an annual quality review and feedback received was overwhelmingly positive.

Subha Thiyagesh (ST) thanked ER and JP for the positive update and acknowledged the hard work that has taken place to get to the current position. ST queried whether there are any service users who are clinically ready for discharge who require additional support to move on. ER confirmed that there are two service users who are currently clinically ready for discharge and work was underway to move these people on and ER stated that this is not a significant issue for the service.

Nat McMillan (NMc) also thanked the team for their hard work, noting the difference made to people whilst continuing to adhere to the Trust values by being patient centred and caring. NMc also acknowledged the work undertaken by the leadership team.

EM raised a question regarding how the population within Cheswold Park Hospital is managed, noting that in January 2025 there were sixty five detained patients. ER confirmed that Cheswold Park Hospital is a secure hospital therefore all the patients are detained under the Mental Health Act and new admissions were predominately section 3 patients who are expected to remain in hospital for extended periods. EM also noted a previous discussion at the Mental Health Act Committee meeting regarding good record keeping and raised a question about record keeping quality. JP confirmed that there is some improvement in record keeping and the next piece of work would be to focus on improving the quality of tribunal and manager reports produced to ensure they are of a higher standard which will be of benefit to service users. AF suggested having a more detailed conversation with EM outside the meeting.

DT shared the positive feedback received from Provider Collaborative Commissioning Hub colleagues who found the leadership team to be responsive and engaging. DT also thanked ER for her excellent leadership and the commitment of the team to safely increase admissions which had provided Trust Board with a level of assurance.

MBr noted the positive presentation and update and the progress made over the last seven months. MBr acknowledged the leadership and enthusiasm of teams with 97% of Cheswold Park Hospital staff having participated in the SystmOne training. Work on the harmonisation of policies, communication and engagement has also been positive and the Trust is working with NHS England (NHSE) as well as other organisations to share the positive learning following the acquisition of Cheswold Park Hospital.

MK acknowledged the team's efforts and commitment, noting the positive “can do” attitude that has contributed to the progress already made.

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

TB/25/24 Chair's remarks (agenda item 7)

MBu noted that the private board meeting would include:

- Private risk register
- Commissioning Committee minutes due to being commercial in confidence
- Investment Appraisal six monthly report
- Finance forecast paper

It was RESOLVED to RECEIVE the Chair's remarks.

TB/25/25 Chief Executive's report (agenda item 8)

MBr presented the Chief Executive's report which was taken as read.

- MBr noted Dawn Lawson's (DL) apologies for the meeting due to attending a national meeting in London regarding the changes previously announced in relation to NHS England, the 50% reduction in Integrated Care Board (ICB) costs with further information expected to be announced that day. MBr noted a key focus for the future is provision of neighbourhood care, and the development of provider alliances and confirmed that the Trust is fully engaged in conversations around this work.
- The Spring statement has been published which demonstrates a deteriorating economic position nationally since October 2024. A reduction in welfare benefits spending was expected. However, the impact of this on the Trust and service users is not yet clear. MBr also noted the announced reduction in NHS spend on mental health services as a proportion of total NHS expenditure.
- The Trust achieved the overall financial position of breakeven in 2024/25 with £20m saved, predominately through non-recurrent savings and vacancies. The 2024/25 year end process is underway with update reports on this process included in the Trust Board agenda. Further updates will follow.
- The NHS social attitude survey is conducted annually and is related to public satisfaction with the NHS. This was noted to be at an all-time low, with only one in five people satisfied with the NHS and over half expressing their dissatisfaction. This provides additional context around the challenges faced by NHS organisations and the work required to increase confidence in service provision as an organisation.
- NHS England issued guidance for Board member appraisals with clear expectations set to enhance consistency in Board member appraisals. The guidance sets out the principles, process and assessment ratings for appraisals with the expectation that these principles will be adopted. This will be subject to further review at the People and Remuneration Committee with an update to Trust Board
- The Care Quality Commission (CQC) recently published the annual community mental health survey 2024.
- The Trust's annual long service awards, training and excellence awards are scheduled to take place on Thursday 1 May 2025 in Barnsley. MBr thanked everyone for their contribution to this year's event.
- MBr noted the service user story positively acknowledged the Trust's approach to risk when a risk related to Cheswold Park Hospital was identified last year. The presentation by ER and JP demonstrated how effective positive risk management can be, with a focus on mitigations and how these can be resourced effectively.
- Sean Rayner, Director of Provider Development, will be leaving his substantive role at the end of April 2025 and MBr recognised the significant contribution he has made to the Trust over a number of years. Sean has agreed to continue working on a part-time and temporary basis for the Trust as Director of Integrated Care, Wakefield

- MBr advised that it was David Webster's last Trust Board meeting and thanked David for his valuable contribution as a non-executive director over the past three years.
- Erfana Mahmood (EM) noted that the Trust has reported no admissions of children and young people onto adult wards and noted an improved position over previous months. EM asked whether the improvement was a result of the system working effectively. Adele Fox (AF) advised that staff continue to work hard to minimise the use of adult beds for children and young people as much as possible. However, there continue to be challenges related to acuity. Strong working relationships between the Chief Operating Officers across West Yorkshire are in place and contribute to the current position.

MF recognised the leadership of the Board in the success at Cheswold Park Hospital and the progress made to date which has been outstanding.

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

TB/25/26 Assurance and approved minutes from Trust Board Committees (agenda item 9)

Commissioning Committee (CC)

Margaret Kitching (MK) provided an update on behalf of Gary Ellis (GE) and advised that South Yorkshire and West Yorkshire Provider Collaborative Boards are forecasting losses this year with West Yorkshire forecasting a loss of £995k, of which the Trust's share is 42.3%.

Referrals from Psychiatric Intensive Care Unit (PICU) in West Yorkshire accounted for one third of all referrals to the West Yorkshire Adult Secure Provider Collaborative in January and February 2025. This has been identified as a significant increase and a deep dive has been requested.

An additional risk has been identified within the Trust's forensic community transition team as the Trust is only part funded by the West Yorkshire provider collaborative for the team.

In relation to the reported deficit in 2024/25, MBr advised that there was one exceptional package of care which cost more than the deficit. Adrian Snarr (AS) and AF will continue to manage our approach to exceptional packages of care with our ICBs to ensure the financial cost is dealt with appropriately.

EM advised that a discussion took place at the Mental Health Act Committee meeting regarding an individual package of care that cost over £1m. AS stated that it was an exceptional package of care and was in place whilst waiting for a suitable placement. He advised, there have been some lessons learned from the case which was the main driver for the West Yorkshire Adult Secure Provider Collaborative deficit last year. At the end of April 2025, the enhanced package of care was stepped down however the service user has not yet been discharged. AS confirmed that no additional costs will be incurred for 2025/26.

MBu confirmed that the minutes of the Commissioning Committee meeting held on 4 February 2025 would be reviewed in the private section of the Trust Board meeting.

Quality and Safety Committee (QSC)

Margaret Kitching (MK) provided an update from the Quality and Safety Committee meeting of 8 April 2025. The report was taken as read.

Following a previous discussion at Trust Board, MK confirmed that the Quality and Safety Committee received a report on the management of plastic bags within mental health inpatient settings. The report included the Trust's learning and actions with regards to the oversight

and management of plastic bags. Clinical aspects were discussed in more detail in the private section of the Committee.

MK advised that clinical record keeping was also discussed, noting the feedback in relation to the Care Quality Commission (CQC) mental health act inspections and identified areas for improvement. Alignment of clinical record keeping standards with the Audit Committee was also discussed to ensure that the standards are assessed and audited moving forward.

Prone restraint continues to be monitored by the Quality and Safety Committee, and the Committee agreed the need to be more explicit with regards to the Trust's ambition for zero prone restraint. It was reported an extensive presentation was provided on reducing restrictive physical interventions and prone restraint.

Audit Committee (AC)
Mike Ford (MF) provided an update following the Audit Committee meeting held on 15 April 2025.

MF confirmed that Audit Committee received an internal audit report with limited assurance around temporary staffing: bank and overtime. Audit Committee acknowledged that there are significant opportunities to secure better value for money when filling gaps in rosters and this has been identified as an area of risk. MF confirmed that actions from the audit are already underway.

The internal audit update to Committee included a discussion of this year's head of internal opinion. In previous years the Trust has received an internal audit opinion of significant assurance. An opinion is not available at this stage as a number of internal audit reports for 2024/25 are in the process of being finalised. However, MF raised that, as the Trust received more audits with a rating less than significant assurance this year compared to previous years, and there is a risk the Head of Internal Audit Opinion could reduce to "moderate". At this point, Audit Committee would need to consider whether this reflected an overall deterioration of the Trust's control environment. A further discussion will take place in Audit Committee once the Head of Internal Audit Opinion is received.

Audit Committee undertook a review of risks and no further changes were recommended in relation to capacity. The Audit Committee will review risks in more detail at a future meeting.

MBr explained the Trust takes a mature approach to internal audit and identifies areas of risk to audit. He added that when the audit plan was set in 2024/25 he raised the issue regarding the potential impact on the Head of Internal Audit Opinion. MBr requested that Audit Committee review the limited assurance audits to identify patterns or trends. MF agreed to take this back as an action for Audit Committee.

Action – Audit Committee

Finance, Investment and Performance Committee (FIP)
David Webster (DW) confirmed that the Trust has achieved its 2024/25 financial plan, noting there are some significant "below the line" adjustments following the acquisition of Cheswold Park Hospital.

DW advised that the Trust's risk share from the specialised provider collaboratives is £1.1m and includes the South Yorkshire Adult Secure Provider Collaborative where the Trust holds all financial risk.

There are two financial sustainability risks which have increased in consequence score from "moderate" to "major" and the Committee agreed to undertake a review to consider whether a more objective measure can be put against these to help understand the consequence.

The importance of ensuring value for money will increase for the year ahead and will be reviewed in detail to ensure accountability. Trust Board will continue to regularly monitor the position going forward.

DW advised that the Committee had raised a question regarding planning and further consideration is required about which Committee should oversee this.

AS provided an explanation regarding the reference "below the line" and advised that this related to impairment for the Cheswold Park Hospital acquisition and did not count towards the Trust's overall financial performance. The breakeven duty for the Trust and the ICB will not be impacted by the impairment accounted relating to the acquisition of Cheswold Park Hospital.

Nat McMillan (NMc) asked that since that the Value for Money Board provide assurance to FIP how progress is demonstrated to the Committee in order to be assured. DW advised that a more detailed discussion is planned for the private Board meeting. The frequency of the Committee has increased to ten meetings per year with two meetings dedicated to finance. Value for money has been added to the agenda as a standing agenda item in order to review the position in more detail. AS confirmed that a new template was presented to FIP along with a proposal for a monthly, high-level update on each value for money scheme to be presented to Trust Board to provide a description and report on milestones, decisions and actions. MBr confirmed that a review of the flow of information from the Value for Money Board, executive team meeting (EMT) and FIP has been requested and an update will be presented at the next Trust Board meeting and will include a review of cost improvement programmes to ensure there is adequate rigour in the system.

It was RESOLVED to RECEIVE assurance and minutes from Trust Board Committees.

TB/25/27 Risk and assurance (agenda item 10)

TB/25/27a Board Assurance Framework (agenda item 10.1)

Izzy Worswick (IW) provided an update on the Board Assurance Framework (BAF) for quarter four and noted that it was the final report on the BAF aligned to the Trust's 2024/25 strategic objectives. Going forward, the BAF will be aligned to the new Trust Strategy. BAF risks for 2025/25 were approved by Trust Board on 25 March 2025 and future reports will be aligned to these.

On 3 April 2025, the Executive Management Team reviewed the board assurance framework for quarter four 2024/25 to consider changes since the last report. This included a review of the following matters and how they impact on the Trust's strategic risks:

- The announcement regarding NHSE and the future role and capacity of the Integrated Care Boards given their required savings of 50%.
- Financial pressures.
- Internal progress in relation to integration of Cheswold Park Hospital.
- Staff survey results.

Trust Board were asked to review the amendments to the BAF risks and approve the proposed changes to the board assurance framework.

MF noted the although the capacity risk had decreased and agreed it was appropriate to reduce the risk for the time being, he commented that it may increase again in the future.

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

TB/25/27b Corporate / Organisational Risk Register (agenda item 10.2)

IW presented the organisational risk register and advised EMT reviewed the report on 3 April 2025. The report is presented to Trust Board on a quarterly basis.

The 2024/25 quarter four report will be the final version presented to Trust Board aligned to the Trust's 2024/25 strategic objectives. Future reports will be aligned to the new strategic aims. IW confirmed that the report outlined the proposed changes to the organisational risk register risks and Trust Board was asked to review and approve these changes.

MF queried the merger of risk 773 with risk 812 and the wording of both risks. IW confirmed that it was proposed to change the wording of risk 812 following the merger of both risks. MF agreed to review the new wording of the merged risk outside the meeting. Trust Board agreed to the proposed merger of both risks once the revised wording had been agreed.

Action – Corporate Governance Team

- Risk 1957 – *Risk that the Trust's financial viability will be further impacted by ongoing unfunded pressures on pay awards.* Increase in risk score and change of wording approved.
- Risk 1114 – *Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.* Increase in risk score approved.
- Risk 1820 - *The risk that a negative culture emerging in a team may have a detrimental impact on patient safety and quality of care* - Change of wording approved.
- Risk 695 - *Risk of adverse impact on clinical services if the Trust is unable to achieve the ambitions transitions identified in its strategy* - Change of wording approved.
- Risk 812 - *Risk that place based or collaborative commissioning arrangements change clinical pathways and financial flows which could adversely impact on the quality and sustainability of Trust services outlined in the Trusts strategic ambitions* - Change of wording approved subject to the revised wording being agreed with MF.
- Risk 1614 - *National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations - Reduction in risk score from 3 (possible) to 2 (unlikely) approved.*

MBr noted the changes and requested that Committee chairs increase the focus on risk throughout the next quarter. MBr confirmed that the Executive Management Team undertake a regular review of the organisational risk register. AL added that the provider collaboratives also regularly review risk as well as any emerging risks.

NMc stated that the current internal Trust position is stable and risks are being well managed. NMc queried whether the Trust is exposed to increased external risks that could potentially destabilise the work undertaken internally. DT advised that the Quality and Safety Committee review risks at the start and end of each Committee meeting to consider whether any discussions have brought a different view of risks and suggested that risk be reviewed under this lens. Action agreed for Committee chairs to pick up a discussion regarding risk with executive colleagues in Committee meetings.

Action – Committee chairs

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

In addition, Trust Board RESOLVED to APPROVE the increase in risk score and the change in wording for risk 1957, APPROVE the increase in risk score for risk 1114, APPROVE the change in wording for risks 1820, 695 and 812 subject to the revised wording of risk 812 being agreed, APPROVE the decrease in risk score for 1729 and 1614 and APPROVE the merger of risk 773 into risk 812.

TB/25/27c Draft annual governance statement (agenda item 10.3)

IW informed the meeting that the draft annual governance statement had been prepared in line with annual reporting requirements and that the draft statement was shared to provide Trust Board with early oversight. IW advised the draft had been reviewed by the executive management team and also Audit Committee on 15 April 2025. IW advised that MF, GE and EM had reviewed the draft statement and provided comments, which had been addressed prior to the current draft shared with Board. She thanked MF, GE and EM for their support. MBr confirmed that the final version will be agreed in June 2025 and thanked Non-Executive Directors who had reviewed the statement, IW and AL for their support.

It was RESOLVED to NOTE the draft annual governance statement.

TB/25/27d Quality account process for 2025 (agenda item 10.4)

DT stated the update report outlined progress against the Quality Account submission. He advised his team were confident the Quality Account will be delivered by the end of June with an early draft with quarter three data having been presented to the Executive Management Team and Quality and Safety Committee.

DT requested that Trust Board delegate authority to the chair and chief executive to approve the quality account as the next Trust Board meeting (1 July 2025) is after the submission date of 30 June 2025. The Quality Account will be presented to Trust Board post submission on 1 July 2025. Trust Board agreed to delegate authority to the chair and chief executive.

It was RESOLVED to RECEIVE the update on the quality account for 2024/25 and the timeline for completion.

TB/25/27e Cheswold Park update (agenda item 10.5)

Following the update presented to Trust Board under item six of the agenda, AF advised that next steps in the integration of Cheswold Park Hospital into the Trust are to consider planning for the next six months, including working with the wider system and embedding Cheswold Park into the forensic care group.

AF confirmed that further work is required in the next phase particularly in relation to the staffing establishment. Work has already begun in relation to patient flow and the Trust is progressing this with the South Yorkshire and Bassetlaw Adult Secure Provider Collaborative.

EM stated that she understood a key priority needed to be clarifying the workforce establishment and that, as Trust Board have already spent a significant amount of time reviewing Cheswold Park, other Trust priorities also need to be considered. MBr noted that the progress so far to integrate Cheswold Park Hospital had exceeded his expectations. However, there continue to be risks related to Cheswold Park and the focus should remain on significant issues. MBr agreed to review this outside the meeting with AF and suggested a Cheswold Park report be presented to Trust Board monthly for the first year following acquisition. MK added that Cheswold Park is the only service within the organisation that has received an inadequate rating from CQC (under the previous ownership) and is subject to an intensive support quality improvement approach which is the highest level of risk assurance for Trust Board. As such, anything at that level of assurance oversight should be included in monthly Trust Board monitoring. MF suggested picking up a separate conversation with AS

regarding the accounting implications once Cheswold Park is operating under “business as usual”.

It was RESOLVED to NOTE the Cheswold Park Update report.

TB/25/27f Freedom to Speak Up bi-annual update (agenda item 10.6)
Estelle Myers (EM) joined the meeting

Estelle Myers (EMy), freedom to speak up guardian, presented the bi-annual update on freedom to speak up.

- The number of concerns raised within the Trust in 2024/25 increased compared to the previous year. Eighty three cases were reported to the National Guardian’s Office in 2024/25 compared to fifty four in 2023/24. The rise in reported cases is believed to be partly due to the acquisition of Cheswold Park Hospital and greater awareness of reporting processes. Out of the eighty three cases, twenty seven required dedicated case support from the freedom to speak up guardian.
- Twenty anonymous concerns were raised in 2024/25 compared to twelve in 2023/24. It was felt that this may reflect a change in staff confidence to raise concerns as well as a perceived negative impact of reporting. Six out of twenty anonymous cases were in relation to Cheswold Park, and work will continue to promote freedom to speak up as a safe way to raise concerns. Ongoing work around Trust culture and the trauma informed approach will also help to improve psychological safety within the Trust
- The Trust benchmarks well against peers and typically reports a lower number of concerns raised than peer organisations. There has been an increase in the number of freedom to speak up concerns raised each year, however other peer organisations have shown greater increases.
- No complex case reviews took place in 2024/25.
- There was one case of potential detriment in 2024/25 which is being investigated.
- The Trust has completed the freedom to speak up action plan and a review against the freedom to speak up reflection and planning tool will take place in due course. The Operational Management Group and Freedom to Speak Up Steering Group will also provide input and agree a new action plan. Quality monitoring oversight, quality monitoring visits, staff surveys and complaints are also reviewed to identify areas that may require more dedicated input.

MF noted the freedom to speak up oversight responsibility has moved to the Audit Committee and the Committee will develop a reporting and oversight plan going forward. MF added the majority of concerns raised relate to management and staffing issues with very little related to patient safety which reflects a strong risk and incident reporting culture across the Trust.

MBr raised a concern regarding the language used in section six related to two cases where it was found the staff did not suffer detriment in legal terms, however learning was identified. EMy confirmed that the cases were related to a specific team and both cases were reviewed by the legal team with learning identified.

In relation to the transfer of oversight from the People and Remuneration Committee to the Audit Committee, Christine Brereton (CB) advised that themes raised through the freedom to speak up process will continue to be monitored and incorporated into the People Plan. AL added that freedom to speak up is included in the People and Remuneration Committee terms of reference and this is due to be reviewed.

Izzy Worswick (IW) noted that many of the anonymous concerns raised were from staff at Cheswold Park Hospital where historically there was no reporting culture. EMy will continue

to focus on Cheswold Park and monitor Trustwide anonymous concerns raised in order to consider whether they reflect a lack in confidence in reporting issues.

It was RESOLVED to NOTE the freedom to speak up update.

Estelle Myers (EM) left the meeting.

TB/25/09k PLACE report (agenda item 10.7)

Adrain Snarr (AS) provided a summary of the PLACE report which was taken as read. He advised that:

- The PLACE report covers six domains which are detailed within the report and also includes three key charts which compare the organisation's scores against the national average and the previous year's scores. AS confirmed that the Trust outperforms the national average in every domain
- Trust performance is above the national average with one exception related to the food provision at The Poplars and this continues to be an area of focus.
- Chart three compares the Trust to geographical peers and it was noted the Trust performance was strong and above the national average.
- The variety of food on offer is an area of focus and a trial has taken place at Kendray Hospital in Barnsley with a plan to extend this Trustwide.
- Although the Trust outperforms the national average in terms of disability and access, and the overall results are positive it was noted further work is required as there continues to be room for improvement.

MBu stated that it is necessary to triangulate all aspects of these types of reports to provide assurance and consider the implications for the organisation. AS noted that the results are strong and some indicators are in the top five mental health Trusts nationally. MBu suggested that Trust Board take some time to reflect on all the positive work that has taken place. Sue Barton (SB) added that strategic aim 3 of the new Trust Strategy is "to be ambitious," and proposed discussing potential methods to progress and monitor strategic aim 3 at the next Trust Board strategy meeting. MBr noted it may be challenging to maintain these standards in the future due to tough financial decisions that will need to be made going forward. MBu agreed to discuss this further with MBr outside the meeting.

It was RESOLVED to NOTE the update report.

TB/25/28 Performance (agenda item 11)

TB/25/28a Integrated Performance Report (IPR) Month 12 2024/25 (agenda item 11.1)

AS provided a brief summary of the integrated performance report and the key points to note:

- The new mental health care plans for both inpatient and community services have been implemented which demonstrate improvement from February 2025 to March 2025.
- Twenty four incidents of violence and aggression against staff involving race were reported during the reporting period.
- There was an increase in staff turnover to 8.6% and this is largely a result of the TUPE transfer of staff from the Trust liaison and diversion service to a new provider.
- Information governance training performance reduced to slightly below the 95% target. It was noted that it is not unusual for the time of year due to annual compliance expiring for a number of staff at the same time. However, it was agreed at the executive management team meeting that weekly monitoring would take place until performance levels have increased back to the 95% target.

- The Trust has achieved the planned breakeven position for 2024/25 and also achieved the revenue and capital plans.
- There was some slippage related to the older people's transformation programme which resulted in a number of schemes being brought forward.
- The Trust also signed the lease for Beckside Court in Batley which is a key element of the estates strategy and will become the North Kirklees Hub.
- The Trust delivered a small revenue surplus of £100k and hit the capital balance. AS noted that the results are provisional and subject to audit.
- MBr highlighted the number of violence and aggression incidents against staff in order to make Trust Board aware of the type of challenges faced by staff every day.
- An increase in the number of service users clinically ready for discharge was noted and AF stated that a robust monitoring process has been established with escalation to the Chief Operating Officer for cases that require a higher level of involvement. The Trust has also been accepted onto the mental health and acute emergency department interface improvement programme collaborative which is a national programme run by the NHS confederation. AF will work together with several other chief operating officers as part of the programme.
- A discussion took place last year regarding reducing the information governance training target from 95% to 90% in line with national flexibility allowed. Following discussion, the executive management team agreed that the 95% target should remain with enhanced communications given the importance of strong information governance awareness.
- Paediatric audiology performance has improved following the recruitment of two agency staff with one transitioning into a permanent post. The work undertaken has been significant and it is expected that this will continue.

MF noted that the twelve-month turnover rate increased to 8.6% in month and is related to the end of the liaison and diversion service contract. MF stated that turnover is related to staff leaving or joining the organisation and the cessation of a service should not be included in these numbers. AS confirmed that the service has not ended, the Trust were not awarded the contract therefore staff were transferred to a different organisation therefore technically have left the Trust. AS added that a decision was made to include those staff in the turnover numbers, and it was important to note that the turnover rate in February 2025 was 7.7% and that the long-term trend continues to reduce month on month.

NMc raised a question regarding mandatory training patterns at certain times of the year and asked whether these patterns were analysed. AF responded that operational services are working with the learning and development team to undertake block training to support the management of rotas and enable staff to complete their training at the time of induction. This will help support quality and safety, reduce the need to release staff while on duty and also limit the number of staff renewing their training at the same time. AS added that a piece of work is also taking place regarding corporate efficiencies including ensuring that the learning and development offer is aligned. AF stated that it is important to note that care groups and clinical areas are currently achieving their training compliance targets.

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

TB/25/28b Care Group performance dashboards (agenda item 11.2)

AF provided a summary of the care group performance report for the children and young people's service and advised that following a review, the service has been divided between the mental health care group and the physical health care group. This will help to support a smooth transition from the children and young people service to the adult service and aims to close the gap between children and adult services.

- The service have managed the transition onto the new appraisal system well and there is a continued focus on appraisal performance, ensuring staff receive a quality appraisal.
- Sickness absence remains low despite a number of significant vacancies within the service.
- Reducing restrictive practice interventions (RRPI) training performance is low and includes both inpatient and community services. A national review is underway to consider the level of training required for community services.
- Information governance training performance has reduced and the operational management group continues to have oversight.
- Staff turnover rate for registered nurses was 3.5% at the end of February 2025, the lowest rate since March 2024. Following the transition to mental health services, it is hoped that this will help to improve the turnover rate further and provide additional learning.
- Agency usage remains high due to a high number of medical agency staff. However, the service have successfully recruited two children and young people consultants, therefore agency usage is expected to reduce.
- The response rate threshold for children experiencing a mental health crisis is four hours, and the service continue to perform well against this target. There are waiting well plans in place which are well documented, and work is taking place with commissioners to reduce the gaps.
- Paediatric audiology referrals continue to be higher than previous years and a plan is in place to improve the position going forward.
- There are ongoing challenges with the Calderdale and Kirklees children adolescent mental Health service (CAMHS) pathway with long waits for children accessing treatment on the core pathway. The service continues to work with commissioners to address the issues.
- Neurodevelopment waits are an area of concern with a 36% rise in the number of people waiting for an assessment in February 2025 compared to February 2024. Active engagement with commissioners is ongoing across the Place to address the growing demand.
- Barnsley CAMHS provide assessment and treatment for attention deficit hyperactivity disorder (ADHD) through a single pathway, while autism services are commissioned from the acute Trust. Waiting times are shorter, with practitioners supporting medical staff in managing caseload pressures related to medication prescriptions.

MBr acknowledged the rise in CAMHS waiting times over the past three months and requested a review to understand and address the issues. AF noted the number of inappropriate referrals and the team's efforts to work with referrers to improve the process. There have also been a number of DNAs (Did Not Attend) which are followed up with future appointments. It was agreed that a discussion with commissioners is required due to the significant increase in demand.

It was RESOLVED to RECEIVE and NOTE the report.

TB/25/28c Priority Programmes (agenda item 11.3)

The strategic improvement programmes report was taken as read. SB shared the strategic improvement annual priorities for 2025/26.

The revised Trust Strategy was approved by Trust Board in October 2024, and the annual planning process was used to develop a "long list" of priorities. The report summarises the focus, grip and pace required and identifies the key priorities for 2025/26. There are six priorities identified, four under “best we can be” and two under “ensuring our values”. It was agreed that safety is an essential part of this, and improvement priorities should be around

managing resources in line with the Trust values and health inequalities as well as supporting the workforce. Trust Board were asked to approve the priorities for 2025/26.

MBu advised that she had agreed with MBr outside the meeting that a review of the six priorities should take place during the Strategy Trust Board in May, with a drill down to the next level to consider what it means for clinical and corporate services and agree specific outcomes by the end of June.

EM queried whether the priorities have been reviewed in light of the current financial constraints and asked whether they are feasible. SB confirmed that the executive team have been involved in a number of discussions regarding these priorities. The "best value" priority is related to resources and support for colleagues living the Trust values ensuring that work on resources does not disrupt other work. A review of resource plans will then take place with the quality improvement processes contributing and determining where to concentrate efforts. Consideration is also required around areas that will provide the greatest impact.

In relation to enhancing clinical pathways, MK stated that it is also a measure of clinical effectiveness and highlighting them as a quality indicator demonstrates that pathways also relate to quality of care. SB stated that it would be useful to add triangulation of these measures in order to demonstrate quality of care.

MBu confirmed that each of the priorities will be aligned to committees.

MF asked whether the strategic priorities will be included in the integrated performance report and whether the "best care" and "best value" headings would be used going forward to ensure there is a link between strategy and current care group performance. SB confirmed that work is already underway to map the work against the integrated performance report and the care quality commission (CQC) domains. In terms of best place to work and learn, Subha Thiyagesh (ST) advised that evidencing the learning from trainees, student nurses, complaints and incidents is also an important part of the priorities and impacts on staff and patient experience.

It was RESOLVED to APPROVE the priority areas of focus for 2025/26.

TB/25/28d Financial and Operational planning (agenda item 11.4)

AS informed the meeting that the planned submission was discussed as part of the private session on 25 March 2025 in order to meet the deadline and is shared for information today.

The draft operational and financial plan for 2025/26 was reviewed and discussed at the Finance, Investment and Performance Committee. AS advised that whilst there is a focus on the financial aspects of the submission the workforce plan and activity have also been submitted. A review of the actions from the Finance, Investment and Performance Committee is required to determine what activity should be reported to the committee. It is also necessary to understand activity profiles and identify what needs to be delivered as part of Trust contracts. A meeting has been arranged with the Committee Chair, MBu, MBr and AS to determine how the value for money work will be presented to Committee, what will be presented to Board and the escalation process between Trust Board and Committee. AS added that a balanced financial plan has been submitted with a level of unaddressed risk across the Trust and the system which will be a key area of focus going forward. The Trust needs to ensure that focus is maintained throughout the year as well as demonstrate delivery. MBu stated that it is necessary to review current activities and there remains substantial work to be done regarding productivity and performance, particularly in terms of how these metrics are assessed against quality and outcomes.

It was RESOLVED to CONFIRM that "the Board has systematically reviewed and is assured that it has plans in place to address the key opportunities to meet the national

priorities for the NHS in 2025/26." NOTE that the Trust has a process to identify further opportunities to consider realistic in-year productivity and efficiency opportunities, and continue to reflect these in the organisation's operational, workforce and financial plans on an iterative basis. CONFIRM that the Board is assured that the Trust has a robust process to ensure that key risks to quality linked to the organisation's plan are identified and appropriate mitigations will be put in place. NOTE that the Trust has a process to review the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, clarification of planning assumptions with the ICB, and mitigations against key delivery challenges and risks. APPROVE a balanced operational and financial plan 2025/26 position as the Trust's submission to West Yorkshire ICB, along with the planning assumptions and caveats that have been confirmed in writing to the West Yorkshire ICB.

TB/25/29 Integrated Care Systems and Partnerships (agenda item 12)

TB/25/29a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 12.1)

MBr provided an update on the South Yorkshire integrated care system and partnerships and advised that there have been limited meetings since the last update at Trust Board, and those meetings have focused on the national changes announced by NHS England and the financial plan. A recent meeting in Barnsley focused on the development of neighbourhood care and the planning priorities for 2025/26. Katy Calvin-Thomas was announced as the new executive director for place health and adult social care, a joint role shared between Barnsley Council and the South Yorkshire Integrated Care Board.

MBu advised that she and DL attended a meeting in Barnsley regarding health on the High Street. Colleagues from the acute sector and council leaders were also present to observe the work taking place at the Alhambra in Barnsley town centre. MBu stated that building work has begun, and acute colleagues have been working hard to support the transfer of patients to the Alhambra. The work is expected to be completed by the end of 2028 and SWYPFT services will move into the Alhambra in due course, based on improving patient pathways and delivery.

It was RESOLVED to RECEIVE the SYB ICS update.

TB/25/29b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update (agenda item 12.2)

MBr provided an update and advised that the main focus of the West Yorkshire Health and Care Partnership meetings was the announced national changes and financial planning.

- There has been increased focus on how neighbourhood care and provider alliances will develop and what could potentially be delegated from the integrated care board to a provider alliance.
- Developments on neighbourhood care are aligned to the national and Trust priorities.
- The Kirklees delivery collaborative meeting has been paused to focus on core essential work.
- Dr Sara Munro will be acting as interim chief executive for Leeds community health while a leadership review across Leeds takes place.
- A review of senior leadership is also taking place in Kirklees, Calderdale and Wakefield and it is anticipated that this will take place as soon as possible.
- West Yorkshire Integrated Care Board Chair has been suspended for the time being.

IW confirmed that the Wakefield mental health alliance agreed in April to move into shadow year for the delegation of integrated care board functions to the Alliance. It was noted that Sean Rayner chairs the Wakefield Mental Health Alliance.

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/25/29c Provider Collaboratives and Alliances (agenda item 12.3)

AS provided a summary of the provider collaboratives and alliances update.

- The West Yorkshire Provider Collaboratives have reported a year end deficit in relation to Children and Adolescent Mental Health (CAMHS) inpatient services (tier 4), adult eating disorder services and adult low and medium secure services. AS advised that the pressures on the adult eating disorder service and CAMHS should be noted as the Trust is a partner in both services.
- Forensic CAMHS are led by SWYPFT and will breakeven for the year.
- Leeds and York Partnership NHS Foundation Trust (LYPFT) are the lead provider for perinatal services across the whole of Yorkshire. A governance framework is being developed with all mental health providers in Yorkshire and Humber involved in the oversight group for the collaborative.
- AS noted that the Trust is not in a risk share for specialised commissioning in South Yorkshire and therefore are not required to report to the board for CAMHS or adult eating disorder services.
- South Yorkshire Adult Secure Provider Collaborative reported a small deficit. The deficit has been reduced by the increase in Cheswold Park Hospital admissions which resulted in reduced pressure for the adult secure provider collaborative. The provider collaborative made the decision not to invest in a forensic community service until a stable financial position has been reached. This decision will be reviewed in 2025/26.

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

TB/25/30 Governance (agenda item 13)

TB/25/30a Audit Committee annual report including committee annual reports and terms of reference (agenda item 13.1)

MF reported that the audit committee had received reports from each of the Trust committees which included a review of the terms of reference, areas for improvement, and effectiveness survey results. MF confirmed that it had been agreed that the Chair of each Committee would meet with the corporate governance team to go through the results of the surveys in more detail to consider any changes to how Committees operate.

MF noted that a fifteen-minute private meeting with non-executive directors, internal and external auditors had been established to provide an opportunity for raising any concerns and to obtain external assurance that actions are in line with best practice. Positive assurance has been received from external assurance providers.

MF thanked non-executive director colleagues for their time and attention during this process and asked Trust Board to receive the Audit Committee annual report and approve the updated terms of reference for Trust Committees.

It was RESOLVED to RECEIVE the audit committee annual report and APPROVE the update to the Terms of reference for Trust committees

TB/25/30b Going concern statement (agenda item 13.2)

AS presented the going concern statement and advised that it is a key element of the annual reporting requirements to demonstrate the Trust has made an assessment of the going concern principles. AS added that it was important to note the statement which is related to the sustainability of services provided by the Trust and that they will continue to be delivered:

"Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept."

Trust Board approved the going concern statement.

It was RESOLVED to APPROVE the going concern statement.

TB/25/31 Strategies and Policies (agenda item 14)

TB/25/31a Risk Management Governance Framework (agenda item 14.1)

IW presented the updated Risk Management Governance Framework and advised that the corporate governance team, Audit Committee and the Executive Management Team had reviewed the framework and that the final version presented to Trust Board was for approval.

IW noted a discussion took place in Audit Committee about how the framework fits with operational procedures and confirmed that the framework is supported by an operational procedure which advises staff on the day to day management of risks.

Trust Board noted that it would be helpful to include a flow chart within the framework to make it easier for people to understand the process. IW agreed to add a graphical representation of the process to the document.

Action – Izzy Worswick

It was RESOLVED to APPROVE the updated risk management governance framework.

TB/25/32 Trust Board work programme 2024/25 (agenda item 15)

Trust Board agreed to note the Trust Board work programme for 2024/25.

It was RESOLVED to NOTE the work programme.

TB/25/33 Date of next meeting (agenda item 16)

The next meeting will be held on 1 July 2025 (June meeting)

TB/25/34 Any other business (agenda item 17)

MBu thanked David Webster (DW) on behalf of Trust Board for his contribution as a non-executive director and wished him well for the future.

MBu also thanked Sean Rayner for his significant contribution to the organisation. It was noted that Sean has worked for the NHS for 38 years and 193 days and never had a day off sick.

Signature:

Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 29 April 2025 – ACTION POINTS

= completed actions

Actions from 29 April 2025

Min reference	Action	Lead	Timescale	Progress
TB/25/21	Darryl Thompson (DT) noted on page twelve of the minutes "The report included an appendix from the Learning from Healthcare Deaths report". DT advised that the report was the appendix and the minutes should be reworded. DT also noted that the service user story (item TB/25/23) contained potentially identifiable information and DT submitted a suggested adjustment to the wording to reduce the amount of identifiable information contained within the minutes.	Andy Lister	May 2025	Minutes updated and added to the Trust website.
TB/25/22	In relation to action TB/25/09f(2) Mike Ford (MF) queried whether there would be an opportunity for acuity to be discussed further. It was agreed that acuity would be discussed at the Quality and Safety Committee following which a paper would be presented to a future Trust Board development session.	Andy Lister/Adele Fox	July 2025	
TB/25/26	MBr requested that Audit Committee review the limited assurance audits to identify patterns or trends. MF agreed to take this back as an action for Audit Committee.	Audit Committee	July 2025	

With all of us in mind.

TB/25/27b(i)	MF queried the merger of risk 773 with risk 812 and the wording of both risks. IW confirmed that it was proposed to change the wording of risk 812 following the merger of both risks. MF agreed to review the new wording of the merged risk outside the meeting. Trust Board agreed to the proposed merger of both risks once the revised wording had been agreed.	Corporate Governance Team	July 2025	EMT have agreed the updated risk description, and this will be presented to Board for approval on 29 July.
TB/25/27b(ii)	DT advised that the Quality and Safety Committee review risks at the start and end of each Committee meeting to consider whether any discussions have brought a different view of risks and suggested that risk be reviewed under this lens. Action agreed for Committee chairs to pick up a discussion around risk with executive colleagues in Committee meetings.	Committee Chairs	July 2025	
TB/25/31	Trust Board noted that it would be helpful to include a flow chart within the risk management governance framework to make it easier for people to understand the process. IW agreed to add a graphical representation of the process to the document.	Izzy Worswick	June 2025	Diagram added. Action complete

Actions from 25 March 2025

Min reference	Action	Lead	Timescale	Progress
TB/25/27a	Further discussion required regarding prone restraint with monitoring via the Quality and Safety Committee	Darryl Thompson, Prof. Subha Thiyagesh and Margaret Kitching	June 2025	Update 1 July 2025: Discussed in Quality and Safety Committee on 10 June 2025. Going forward, all prone restraints that have been purposefully applied by staff (therefore not those where the service user has led the decision), will be reported to Committee, with an individual description of the rationale for and learning from each.

TB/25/27b	Review friends and family tests in Calderdale and Kirklees in order to increase the levels in line with Barnsley and Wakefield	Adele Fox	June 2025	The team who service friends and family tests have been asked them to look at how they can improve response levels in these areas and are focussing on improving and encouraging people to feedback .
TB/25/28f	Board Assurance Framework to feature in the Trust Board strategy session later in the year	Andy Lister	May 2025	Added to work programme for future strategy meeting.
TB/25/28j	Trajectory for closure of CQC actions to be agreed by EMT and to go through Quality and Safety Committee to Board	Darryl Thompson	June 2025	Update 1 July 2025: Updated report on today's agenda including this detail, with an agreed plan going forward of reporting to Quality and Safety Committee.
TB/25/28k	JH to have a discussion with NMc and the People and Remuneration Committee to consider a staff survey action plan and target areas for improvement	Christine Brereton	July 2025	

Actions from 26 November 2024

Min reference	Action	Lead	Timescale	Progress
TB/24/119c (1)	MBr suggested that there is a role for JHe in addressing the barriers to learning and training as the culture on training needs to be driven by the People Directorate. JHe reported the barriers to embracing learning need identifying, including operational pressure due to high turnover and high vacancies. Ease of access to learning also needs to be reviewed looking into and could be improved.	Christine Brereton	July 2025	An early version of the proposed Workforce Strategy was shared at PRC which will start to address these issues alongside this will be a refreshed people plan. The strategy will be shared at a future Board meeting in July or September. In the interim our LNA is nearly concluded with a positive response from care services, and we are currently analysing the responses to support the development of our training offer for 25/26.
TB/24/120b	MBr confirmed that data from Cheswold Park will be included in the ligature report in the future.	Darryl Thompson	November 2025 (date of next report)	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 7

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Lead Director:	**Mark Brooks - Chief Executive**		
Mission/values:	As an all-encompassing report this reports aligns fully with the Trust mission and all of its values		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The report includes highlights of what is happening in both our systems and places. The Trust regularly reviews that its own objectives are aligned to those of our systems and places as well as taking account of national guidance and requirements		
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the Trust Board meeting and also external papers and links.		
Executive summary:	Since the announcement made in March regarding the future of integrated care boards (ICB) our two local systems have been working hard and at pace to develop new structure proposals. Strongly influencing their thinking has been the publication of the model ICB blueprint. As strategic commissioners ICBs are expected to fulfil four core functions of 1) Understanding the local context 2) Developing a long-term population health strategy 3) Delivering the		

strategy through payer functions and resource allocation and 4) Evaluating impact.

We are very mindful in the Trust that a significant number of colleagues in ICBs face a very uncertain future. With a requirement to save 50% of costs, this equates to approximately 1,000 roles across South and West Yorkshire.

Reference is also made to the potential transfer of some functions into providers or provider collaboratives including

1) local workforce development and training
2) green plans and sustainability
3) digital leadership (enabled by national data and digital infrastructure)
4) development of neighbourhood and place-based partnerships
5) medicines optimisation
6) pathway and service development programmes and
7) estates and infrastructure strategy

The Trust is engaging with both of its integrated care systems and at place with other provider trusts to support the development of future structures and ways of working.

In terms of an update for Board members it is understood the development of the 10-year plan for health is nearing completion, with an expected publication date of sometime in July. A summary of key points will be made available to Trust Board members once published.

The government recently announced and published the outcome of its three-year spending review. Headlines from this include:

- NHS revenue budgets will grow in real terms by 3% each year on average over the course of the spending review period, totalling £232bn in 2028/29.
- Capital budgets will be held flat in real terms, peaking at £14.8bn in 2028/29.
- The government has reaffirmed its commitment to delivering the New Hospital Programme and replacing the seven hospitals most at risk to RAAC (reinforced autoclave aerated concrete).
- £10bn of investment in NHS technology and digital transformation projects by 2028-29, primarily on improving the NHS App and implementing a single patient record

The NHS has fared better than many public sector bodies in the spending review and we all recognise the need to spend monies wisely. It is not clear at this point what the impact on mental health and community health services will be. The additional funding comes with some conditions. The NHS is being asked to go further and faster to improve productivity levels and deliver the best possible value for the taxpayer's money. The Department of Health and Social Care (DHSC) has committed to delivering 5% efficiency savings over the course of the spending review period and the NHS has already been tasked by government to deliver 2% productivity growth each year, although the true efficiency ask will likely be much greater than that given demand and cost pressures that regularly arise.

We were delighted to announce that the University of Leeds has approved our application to become a Teaching Trust. There are some final points to cover including agreement of name change and appointment of an associate non-

	executive director. We expect to have a launch event by the end of summer/early autumn. Spearheaded by our chair Marie Burnham, with executive leadership from Subha and Izzy, this is the fruition of much hard work and a very robust process that we envisage will provide very tangible benefits to both the Trust and University in the years to come. There have been several national communications relating to workforce that our interim chief people officer, Christine Brereton will lead on. A new framework has been published regarding pay for very senior managers. Our People & Remuneration Committee will provide oversight on behalf of the Trust Board and will be responsible for agreeing the process the Trust will adopt in order to implement the new framework. For provider trusts remuneration is based on turnover and there will potentially be implications for directors of trusts in recovery support or not achieving their objectives. On the subject of pay for NHS staff, the Secretary of State for Health and Social Care has accepted the independent Pay Review Bodies' headline pay recommendations for NHS staff. Colleagues on Agenda for Change terms and conditions will receive an uplift of 3.6%. Resident doctors will see an average uplift of 5.4% (a 4% rise plus a consolidated payment of £750), with a pay rise of 4% for consultants, specialty doctors, and specialists. This is higher than the 2.8% guidance provided for planning purposes, and it is not clear at this stage what funding will flow to fund this additional level of pay award. A risk of industrial action has returned with the British Medical Association (BMA) and Royal College of Nursing (RCN) holding ballots following the announcement of the pay award. A joint letter from the Secretary of State for Health and Social Care and Chief Executive of NHS England has been sent to all providers and integrated care boards. This letter re-emphasises that trusts must reduce their spend on agency staffing by at least 30% in the next financial year. There is an ambition to collectively be more ambitious than this and eliminate agency use altogether by the end of this Government's term of office. To ensure there is a determined focus on this objective, a delivery group, across DHSC and NHS England is being established to monitor progress and ensure that trusts are taking robust action to comply. If there is insufficient progress by the autumn, there will be further consideration of actions to take legislation. The financial position of the Trust is adverse to plan after the first two months with a deficit of £1.4m recorded to date. Given the £18m cash releasing saving required for the full year this broadly suggests that circa half of this saving is being realised in some manner. Progress is typically being made across most areas of saving. Communication updates have been provided to all colleagues. The operational pressures on inpatient beds in particular with occupancy regularly exceeding 100% are hindering the realisation of the scale of temporary staffing cost savings required. This position is not being helped by an increased number of people clinically fit for discharge who have not been able to move on due to lack of suitable placements for them. Via our chief operating office, Adele Fox working with partners, we are increasing the profile of this issue, such that people can receive the right care and support at the right time and in the right place. This is an issue affecting many providers of mental health and learning disability services across the country.

	The 2025/26 financial and operating plans for West and South Yorkshire ICBs have been agreed with a number of observations made. Copies of the letters from NHS England can be attached via the following link. NHS Providers has published the results of its recent survey of provider organisations relating to the 2025/26 financial landscape. 47% of trust leaders surveyed stated they are scaling back services to deliver tough financial plans, with a further 43% considering this option. 37% said their organisation is cutting clinical posts as they try to balance their books, with a further 40% considering this. 94% were concerned the steps needed to deliver financial plans would have a negative impact on staff wellbeing and culture. Since the last board meeting in public at the end of April the Trust has continued to engage with and participate in various awareness weeks. These awareness weeks are of great importance as they increase the profile of critical issues and also enable us to celebrate the contribution colleagues and groups make to both services and society. Examples of these include mental health awareness week, carers' week, volunteers' week, dementia action week, pride month, international nurses' day, national moving & handling day, business continuity & awareness week, and learning disability week On the subject of carers our Trust has become the first NHS Trust in the north of England and third nationally to achieve Carer Confident Ambassador status. It is presented to employers who have demonstrated that they have built an inclusive workplace where carers are recognised, respected and supported. Whilst we are in the early days of summer the NHS has already held its first winter planning meetings and issued initial guidance. Key points to note are an increased focus on vaccinations, faster flows through hospitals into community, and seven day a week discharges. This will include an aim to reduce the time spent in emergency departments by people presenting with mental illness with particular emphasis on reducing people waiting more than twenty four hours. A recent report has highlighted that take up of the flu vaccination by NHS staff across the country in 2024/25 was the lowest it has been for several years. We are conducting our own review to identify why people took up or did not take up the offer of a vaccine so that can inform our approach for 2025/26. In line with the improvement approach promoted via NHS Impact and the creation of 16 Learning and Improvement Networks (LINs), the North East and Yorkshire Mental Health Learning and Improvement Network is being launched. And its initial focus will be on mental health inpatient flow and discharge of adult patients from mental health settings. We are planning to be an active participant in this network. The Trust continues to review and adopt any relevant guidance provided by regulators and professional bodies. Recent guidance provided has included: • ADHD data improvement plan • ADHD diagnosis and management • Freedom to speak up guidance • Mental Capacity Act guidance

- Staying safe from suicide guidance

This month's Board papers include a ranger of year-end reports which provide an excellent reflection of a range of activities carried out by the Trust and its colleagues. Thanks are recorded to all colleagues who have been involved in the year-end process and preparation of year-end reports.

A key focus of this month's Trust Board meeting is on performance. I have already highlighted the challenges being experienced on our inpatient wards through demand and complexity. We are also seeing some increases in wait times in some services such as CAMHS. Our colleagues continue to work with great commitment to provide the best possible care in what continues to be a challenging environment.

Our annual learner recognition, long service awards and excellence awards took place on 1 May in Barnsley. These once again demonstrated the loyalty, commitment and excellence of our colleagues and it was humbling to be in the presence of so many people who give so much to support others. The awards were a great success and whilst we have a very challenging financial environment we need to continue to recognise and celebrate the achievements of our colleagues. Huge thanks as ever to the organisers of the events.

I am delighted to formally welcome Christine Brereton to our Trust Board as interim chief people officer. Christine is currently on secondment with us until May 2026 and has already had a hugely positive impact on the people directorate and executive management team. Christine has also successfully recruited into senior leadership roles in the directorate which have previously been either vacant or filled on an interim basis. This will add some much needed certainty and capacity to the team.

Today is also the first Trust board meeting being attended by Martin Neeson, who is joining us after an extensive career in senior roles in a range of leading companies. Rokaiya Khan will also be joining us as a non-executive director in September to replace Erfana Mahmood, when Erfana's term ends.

In keeping with my previous Board reports I will end this month's report by highlighting further examples of positive work being carried out across the Trust.

- Five of our allied health professional apprentices won awards or were highly commended at the University of Huddersfield Apprenticeship Awards
- The Trust's caring garden at Fieldhead received a gold award from the Yorkshire Wildlife Trust in recognition of its exceptional contribution to local wildlife and positive impact on the community
- The 'Art on the corridor' exhibition, located along a corridor at Fieldhead, welcomed a collection of 80 new artworks created by staff, service users, volunteers, ward-based groups, community groups and Creative Minds partners from across all our areas
- Results from our first stationery amnesty held in March showed that we had repurposed an estimated £2,500 worth of stock

	• Dr Estelle Verdi, principal counselling psychologist and service lead of the West Yorkshire maternal mental health service – Paths, was awarded a Medical Humanities in Practice Research Fellowship with the Institute for Medical Humanities (IMH) at Durham University • We revamped our wellbeing and learning centre at Fieldhead to better suit working needs, with eight additional hot desks and two private pods • Led by deputy chief executive and director of strategy, inclusion & change, Dawn Lawson a small team from the Trust presented at the NHS ConfedExpo event highlighting the approach to engagement the Trust took with its strategy refresh
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Chief Executive's report.

NHS
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NHS Foundation Trust

The Brief

5 June 2025

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

With **all of us** in mind.

Our purpose and values

South West Yorkshire Partnership NHS Foundation Trust

It is important we focus on our values.

Our purpose is to help people reach their potential and live well in their community.

To achieve our purpose 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



Over 130 people participated in our first trauma informed celebration and learning event for colleagues and partners, which took place on Tuesday 13 May, at the BHF Priory Centre in Barnsley.

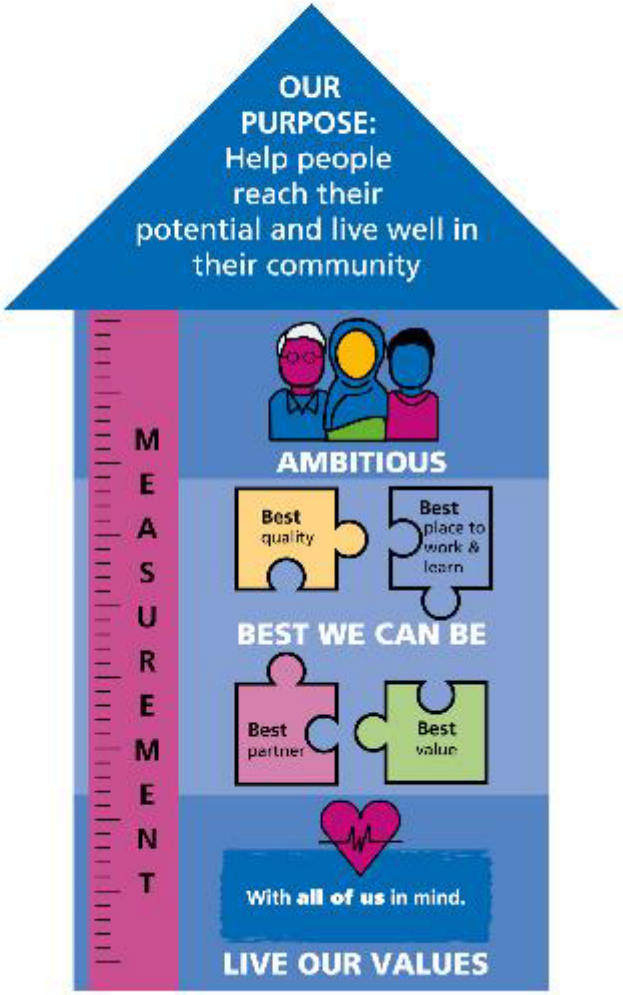
With **all of us** in mind.

Our priorities for 2025-2026

We will be the best we can be and will focus on keeping our services safe.

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Our improvement priorities	
BEST WE CAN BE	
Best Quality	**Improve our clinical pathways** so they are more effective and efficient and provide the best possible patient experience
Best value	**Make the most of our resources,** increasing efficiency and living within our means
Best place to work & learn	Ensure we continue to **support all our colleagues** so that they feel they belong, are proud to work here and want to stay
Best partner	Work with our partners, patients and service users to play a **leading role in integrated neighbourhood working**
LIVE OUR VALUES	
With **all of us** in mind.	Ensure we **live our values** in the decisions we make and the way we behave
	Reduce inequalities and better describe our impact on those we serve



Best partner Teaching Trust



NHS
South West Yorkshire Partnership
NHS Foundation Trust

We are delighted to share that the University of Leeds has approved our application to become a Teaching Trust. This will help us to continue our journey to further create innovative opportunities in teaching, learning, and research, and to embed evidence-based practice.

The Trust and the University of Leeds have a strong history of partnership working with regards to student education and research and development and already have an Associated Teaching Trust agreement. Over the past two years we have been working more closely to formalise our partnership.

This new partnership is one of very few nationally where Teaching Trust status has been achieved by a Trust which provides not only community services but also mental health, learning disability, autism and wellbeing services, and demonstrates our collective commitment to parity of esteem for physical and mental health.

As a part of this work we are proposing that we change our name to **South West Yorkshire Partnership Teaching NHS Foundation Trust**. This will help partners, service users and the public to understand our Teaching Trust status and what it means. We will further engage with colleagues, service users, carers and families and partners as part of this process. More information on how you can have your say can be found on the intranet and our website.

Present

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Proposed

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South West Yorkshire Partnership Teaching
NHS Foundation Trust

With **all of us** in mind.

Best partner

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South West Yorkshire Partnership
NHS Foundation Trust

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

Attend the **'introduction to behavioural science workshop'** for staff and partners on 20 June**,** from 10am-12pm, at the Barnsley Recovery and Wellbeing College. This workshop will explore how people behave and brings together methods from a range of disciplines including psychology, economics, data analytics and service improvement. To book please email Georgina.williams@swyt.nhs.uk

BBC Radio Sheffield joined us on 22 May to talk about the **'capturing the seasons' project**. This was developed by the Creative Minds in collaboration with the Barnsley integrated community stroke team and the Stroke Association. Meeting over the course of a year, a group of eight stroke survivors photographed the changing seasons in Locke Park in Barnsley. The artwork is on display at the Cooper Gallery in Barnsley and will then be permanently moved to the Stroke Recovery Unit at Kendray.



Mental health crisis support is now available by calling NHS 111 and selecting the mental health crisis option. The **West Yorkshire Health and Care Partnership** is keen to hear about experiences of accessing mental health crisis support using NHS 111 and other crisis support services. Answers will help identify future improvements that could be made to the service.

Carers Week is an annual campaign to raise awareness of caring, highlight the challenges unpaid carers face, and recognise the contribution they make to families and communities throughout the UK. The Trust is offering funding of up to £250 to staff, partner organisations and groups who are supporting those who care for someone under our services for Carers Week events. Email Gill Cowell for an application form. Make your pledge to support carers on the intranet.



South Yorkshire Integrated Care Board has launched a partnership with **mental health** service Shout to offer 24/7 text support across the region. Anyone in the area experiencing mental health challenges can use the service by texting the word 'EYUP' to 85258 at any time of day or night.

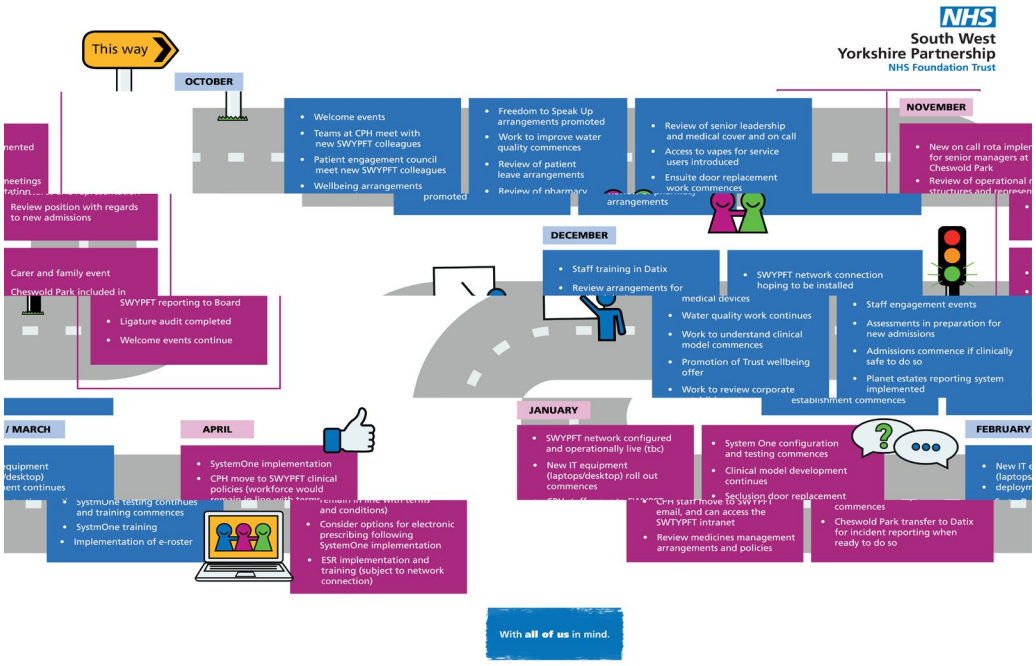
Best partner
Cheswold Park Hospital

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It has now been over 8 months since the Trust was asked by NHS England to take over the management of Cheswold Park Hospital. Thank you to everyone who has helped with the transition and contributed to getting us to the strong position we now find ourselves in.



In the months up to the 1 October 2024 a team in the Trust developed a plan of how we would start to align the hospital to NHS ways of working along with its systems and policies. The diagram below shows the key areas of work that were achieved by 31 May 2025.



We are pleased to share the great news that NHS England has taken the hospital off enhanced monitoring. This means that they are satisfied we have the people, systems and policies in place to deliver high quality safe care to our patients.

We are keen to know from staff at CPH how you would like us to communicate and engage with you going forward. We have had some great ideas so far. Please fill out the forms found around the hospital with your ideas and suggestions and put them in the boxes outside HR, in the L&D office, and in the staff kitchen.

We have all collectively achieved so much already but the journey is not over. The next phase of integration between now and the end of the year will continue to build on the great success we have seen so far.

Best quality
Our performance in April

South West Yorkshire Partnership NHS Foundation Trust

- **51%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **100%** within 6 weeks.
- **89%** of MH service users followed up within 72 hours of discharge from inpatient care
- **75%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **82.6%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **89.7%** of people died in a place of their choosing
- **73%** in CAMHS services waiting less than 18 weeks for treatment

The Trust has been revealed as one of the top five mental health providers in the country for supporting privacy, dignity and wellbeing in care. The results were published as part of NHS England's 2024 Patient-Led Assessments of the Care Environment (PLACE) programme.

As an integral part of the Culture of Care programme our Sandal ward led several table-top exercises about good practice and showcased their current change ideas at the Regional Culture of Care Event in Leeds.

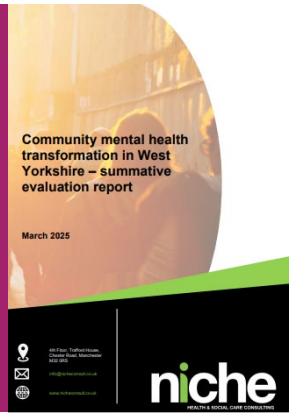


Dr Estelle Verdi awarded Medical Humanities in Practice Research Fellowship

Awarded by the Institute for Medical Humanities at Durham University, the Fellowship will support Estelle to develop her research, titled, 'Illuminating Grief: Mental Health Support for Muslim Women Experiencing Baby Loss'. Read more.



The third and final formative report conducted by NICHE health and social care consulting, assessing the impact of the community mental health transformation programme of work in West Yorkshire has been published. Read the findings and learnings from the report here.



Best quality
Our performance in April



NHS
South West Yorkshire Partnership
NHS Foundation Trust

- 144 inappropriate out of area bed days
- **0** children / young people under 18 in adult inpatient wards
- **68.1%** waiting for referral to assessment within 2 weeks
- **5.9%** of service users clinically ready to discharge (46 people)
- **48%** with care plan that includes service user input/views
- **95.2%** of our service users have their ethnicity equality data recorded, **51%** their disability status, **56%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had 13 information governance breaches

Join the Lexacom live demonstrations and Q&A session in June. Learn more about its features or refresh your knowledge. For session dates and times visit the digital dictation intranet page.

Our **customer services** team dealt with **32** new formal complaints in April and closed **16** formal complaints. **51** informal concerns were received and closed. They also received **25** compliments about our Trust. The team also received and closed **127** enquiries. Please continue to send all compliments and complaints you receive to the team.

We have seen considerable interest in applications for the **physiotherapy and OT level 7 undergraduate apprenticeship scheme.** For two OT places we received 16 applications and for the one physio place 10 applicants. It demonstrated the overwhelming interest in these opportunities from our support staff.

96% of respondents in the friends and family test rated our physical health services either good or very good; **95%** in our mental health services, **100%** for learning disability services, **100%** for adult ADHD and autism service, and **96%** for community (CAMHS and forensic services figures were not available for April).

What made you choose to have your **flu vaccination** this year? If you didn't then help us to understand why you made that decision. Provide your feedback which will help us to plan for our 2025/26 flu vaccination programme. Please fill in our anonymous survey.



Best quality Disposable vapes



NHS South West Yorkshire Partnership NHS Foundation Trust

From 1 June 2025 **disposable single-use vapes** are banned from sale and supply in England. Vapes are recognised as a successful tool for managing patients' tobacco dependence and nicotine withdrawal, and for facilitating and enabling compliance with the Trust's smokefree environment policy within inpatient and forensic services.

The Trust has transitioned to a rechargeable vape provider (Dinner Lady) and continues to offer a vape device and up to 3 days of pods free of charge to new admissions that smoke or vape. Nicotine Replacement Treatment is also still available.



The vending machines that sold the disposable E-Burn vapes have been emptied and will shortly be removed with no replacement. Patients on our mental health wards wanting to purchase ongoing supplies of the Dinner Lady vape pods can order online using a QR code. In our forensic services they will be on sale in our shops. A long-term solution for ongoing supplies is being discussed and details will be shared once finalised.

Surplus stock of the disposables can be returned to E-Burn for recycling.



Details of how to order the new vapes and the processes involved are available on the shared drive K:\WAA&OPS Inpatients\TrustwideDinnerLadyvapeSOP

With **all of us** in mind.

Best value
Our finances in April



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Performance Indicator	Year to Date	Forecast 2025/26
Surplus / (Deficit)	£(0.9m)	£0m
Agency Spend	£0.4m	£3.3m
Bank Spend	£2.2m	£23.7m
Corporate Spend	£5.5m	£67.2m
Financial sustainability and efficiencies	£1.2m	£28.2m
Cash	£56.2m	£55.7m
Capital Spend	£0.2m	£14.2m
Better Payment Practice Code	96%	

The financial performance for April 2025, as the first month of the financial year, is a deficit of £0.9m. This is £0.1m worse than plan and to ensure delivery of the breakeven financial target actions to improve the run rate are required.

In April agency spend was £0.4m, which is less than plan. This is forecast to continue in line with planning guidance.

Trust bank expenditure has been exceeded in April with spend of £2.2m. This is £0.6m more than plan and due to the scale of the variance, will require significant reductions to bring run rate back in line with plan.

Recorded efficiencies in April 2025 are £465k behind plan. This is mainly due to workforce drivers with more staff utilised, and additionally more bank staff utilised, than planned.

Cash is higher than plan in April and work continues to ensure this is maximised.

The Trust capital programme is focussed on the older people transformation scheme. We have, however, been successful in securing a number of additional grants.

96% of invoice have been paid within 30 days of receipt.

Best value
Our value for money drive



NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Government has set out its intention to make changes to the NHS. It is very clear that NHS providers like us are expected to deliver our services within allocated budgets while become more cost effective and more productive. This includes a requirement to reduce our corporate services growth since 2020 by 50%.

A key focus of our value for money work is to **reduce the use of agency and temporary staffing**. We have now reduced the use of non-clinical agency use in corporate support services by over 95% this year. We have also focused on reducing the use of agency staff on our wards with some notable achievements. Our forensic services have reduced their use of agency staff to zero for the first time ever. Across the organisation we have reduced agency use in line with our target by over 30%. This is a great achievement that has been done with care to ensure our services are safe and we are delivering good quality of care. However, there is more to do as our use of **bank staff** has increased. We are planning to sustainably and safely reduce the use of use non-registered bank staff in particular by recruiting to substantive healthcare assistant roles across our mental health and forensic inpatient services.

This recruitment is a 'spend to save activity' and will enable us to operate safety. This, along with work to improve our approach to **e-rostering**, will ensure that we have enough staff to cover shifts, and to continue to provide high quality care to our patients. As a result of this recruitment, we also expect to see a reduction in the need for bank staff to cover shifts on the wards. Applications will open in the next few weeks. We have also reduced the number of colleagues who have been working with us on a temporary or fixed term basis.

We continue to focus on our **non-pay budgets**. This includes reducing the ordering of IT peripherals such as mouses, keyboards and cables, replacing only broken furniture and fittings where we can, looking at cheaper options around medicine and more consistent prescribing, reducing postage and printing costs, and ensuring that where we can we only order books, subscriptions and journals through the Trust library. All of these, when taken together, will make a considerable saving in our Trust non-pay expenditure.

Visit our new Value for Money section on the intranet for more information.

Best value: Treat well for less

The pharmacy team are restarting their drive to help our Trust ‘Treat Well For Less’. Your actions can help to save money, our planet, and improve patient care.

NHS South West Yorkshire Partnership NHS Foundation Trust

Treat Well For Less?



Each year the Trust spends £4.6m on medication for those people who use our services.

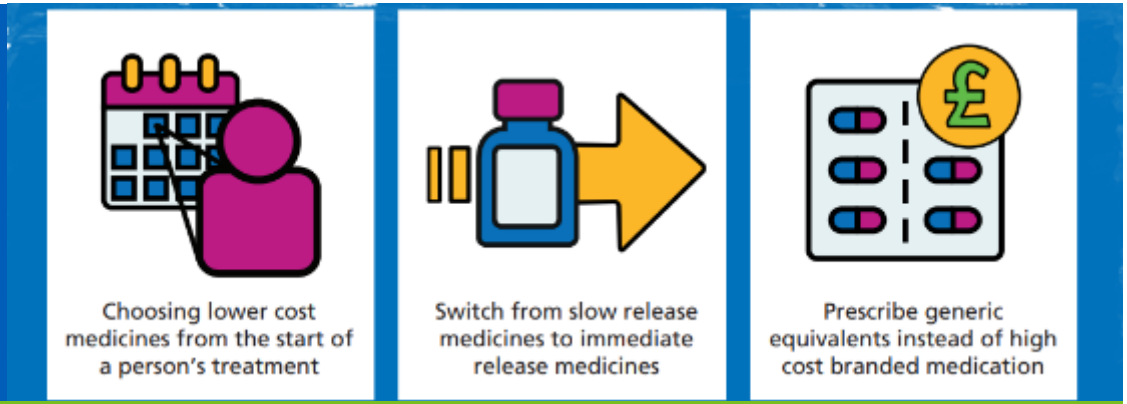
Effective prescribing (balancing cost and clinical effectiveness) can save the Trust £170,000 every year.

Our i-hub challenge invites you to give us your ideas, share learning and experiences, and make suggestions for how we can provide better value for money while protecting services and supporting each other.



Swap to save to help you treat well for less

Swap… medicine compliance aids for medicines in their original packaging or other alternatives.



Search ‘treat well for less’ on the intranet.

Managing risk



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NHS Foundation Trust

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

Key areas of risk identified in the risk register are:

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

It's important that you use only Trust approved applications and systems. These have been reviewed and approved by IT and information governance to ensure they are appropriate and secure for use. Read more on the intranet.

A big part of cyber security is keeping our IT up to date. Machines that don't get frequent updates are removed from the network as they eventually become a security risk. If you have any communal computers within your team that aren't used daily, please make sure these are turned on for at least half a day once a month to enable them to update. Please also keep your own laptop up to date.



With **all of us** in mind.

Best place to work and learn

Our performance in April

- **4.7%** sickness rate for the month.
- The rolling 12 months sickness rate is **4.7%**
- **87.1%** of staff have a completed annual appraisal
- We have **4,988** contracted staff in post, including Cheswold Park. We had **25** starters and **74** leavers.

The **caring garden at Fieldhead,** a cherished community space developed through the Creative Minds initiative, has proudly received the prestigious gold award from the Yorkshire Wildlife Trust. This recognition highlights the garden's exceptional contribution to local wildlife and its positive impact on the community. Read more about this on the intranet.

Congratulations to our four **AHP apprentices**; Tamara Kerins, Lisa Kelly, Rebecca Webb and Laura Clayton, who have won awards or been highly recommended at the University of Huddersfield Apprenticeship Awards.

A new dashboard has been created to support managers when reviewing absence. This is a dashboard which enables managers to view everything they need to know from current sickness levels, comparisons of historic data and the reasons for sickness. Find the absence, appraisal, training and recruitment dashboards all in one handy place. Read more on the intranet.

Thank you to all staff who helped us achieve 95% compliance for **information governance mandatory training**. It is important that we stay up to date with our professional learning in the interests of patient safety, privacy and confidentiality.

During **Dementia Action Week**, which was held from 19-25 May, Dr Mohinder Kapoor authored a blog about the event - read the blog on the intranet

Become a **bereavement support** link worker to help us offer the best care and support to families, carers and colleagues following a bereavement. The role is open to staff at all levels, and you don't need to have any clinical training. Find out more on the intranet.

We have launched 80 new pieces of **artwork** from staff, service users and partners to our 'art on the corridor' exhibition at Fieldhead.



The Good Mood League Super Cup will be held on 12 June at West Riding County FA HQ. If you'd like to enter a team, email Creative Minds.

Share the poster for our upcoming **healthcare career pathways event** on Monday 30 June, 4-7pm in the Wellbeing and learning centre at Fieldhead.

A great place to work
Our day of celebration

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

On 1 May we held our day of celebration, with our learner recognition and long service event followed by our Excellence awards.







Congratulations to everyone whose achievement was celebrated on the day. More info and photos can be found on the intranet.



Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Safety comes first. Do all you can to make our services and places as safe as possible.

Have your say in a potential change to our name due to our new Teaching Trust status.

Support carers week by making a pledge and access the funding on offer.

Help us to improve our flu vaccination programme for 2025 by taking par tin our survey.

Keep your IT equipment safe by ensuring it is secure and up to date.

Help us to reduce our medicine and pharmacy costs through ‘treat well for less’.

Visit our new value for money intranet section to find out more about what we are doing Trustwide.

Your wellbeing is important. Do all you can to support yourself and others.

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 1 July 2025
Agenda item 8 – Assurance from Trust Board Committees

Members' Council	
Date	7 May 2025
Presented by	Marie Burnham, Chair (Chair of Meeting)
Key items to raise at Trust Board	**Key points** • Governor's received feedback from Trust Board and the Chair's report. • Members' Council approved the appointment of two non-executive directors and the appointment of the Deputy Lead Governor. • Members' Council received the Audit Committee Terms of Reference. • Members' Council received a presentation on the Quality Assurance System. • The Members' Council received the Quality monitoring visits annual report. • Members' Council received the Care Quality Commission action plan update. • Governor feedback and approved appointments to Members' Council groups were received. • Members' Council approved the annual report and Terms of Reference for the Members' Council groups and the Nominations Committee. • The Members' Council elections results were received. • The Integrated Performance Report (IPR) was received. • Members' Council received a presentation around the governor's capacity. • Members' Council received a presentation update around Teaching Trust status.
Approved Minutes of previous meeting for receiving	14 February 2025

People and Remuneration Committee	
Date	13 May 2025
Presented by	Nat McMillan, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • The committee agreed that the risk around Band 4-6 which was discussed, and a previous action would be added to the risk register. • The committee noted the need to consider emerging risks around the workforce with the financial austerity, and this was agreed to be an action for July's meeting. **Advise** • The committee was advised that the Trust has communicated with staff around the recent high-profile changes around immigration and the Court of Appeals judgement on gender identification. This has recognised that there will be some anxiety and to reassure that it is being looked at and staff will continue to be kept informed.

With all of us in mind.

	• The committee agreed to step down the OD Tactical Plan with the move to one overarching people strategy. • There continue to be limitations with ESR and its functionality around appraisal documentation meaning a risk to lower levels of compliance. • Both CPR and RRPI training had seen a drop in completion numbers. However, this is the first drop in 8 months so not necessarily a trend and it will continue to be monitored. There is a risk of an impact on mandatory training with the current high bed occupancy rate and staffing resulting in high DNA rates. The committee will continue to monitor the mandatory training compliance rates. **Assure** • The establishment review is complete in In Patients and has illustrated that there is a need to recruit Healthcare Support Workers (HCSW). There is consideration of this messaging when there is a vacancy control process and perception that the NHS is not recruiting and the current financial challenges. • Sickness absence rates have reduced but there remain persistent hotspots such as forensics and estates. The committee was advised that a new sickness absence dashboard is being piloted to try and address this. • The committee made a decision to scrutinise the medical workforce spend and productivity by undertaking a deep dive to understand the temporary spend and job planning process. This will happen at the September meeting. • The committee received the update on the internal audit - Temporary Staffing: Bank and Overtime and noted that 7/9 actions were complete and the remaining 2 were on track. • The committee received the Staff Survey and Action Plan report and noted the good results overall but with a need to recognise that there are some areas which need improving. The workplan will come back to PRC at September meeting for ongoing oversight of progress. • The committee received the Annual Workforce Equality Report and were keen that we consider how we use this for improvement. • The committee received the Annual Pay Gap reports and agreed to publish data that is statutorily required.
Approved Minutes of previous meeting for receiving	18 March 2025

Quality and Safety Committee	
Date	13 May and 11 June 2025
Presented by	Margaret Kitching Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • Update was received on progress around care planning and clinical risk assessment. • Update was received from the safeguarding team. Discussion focused on the number sexual safety incidents that had been reported on the Trust's only mixed sex working age adult ward, and the scrutiny of these incidents. Further update to be received by Committee in July. • Clinical record keeping discussed as a theme, and the need to ensure electronic care record system enables this to be completed in as efficient a way as possible. • Progress was challenged with regards to completion of timely care plans and clinical risk assessments, and the need for greater assurance as to progress.

	Advise • Committee received an update on the legalities of being able to search service users who are in our care, when there are concerns about clinical risk. • The Wakefield Community Learning Disabilities Team presented their work, including how they do not have a waiting list for their services. • Update received on the Quality Assurance System, noting the progress of two wards who have returned to routine monitoring, and the ongoing progress at Cheswold Park Hospital. • The Mental Health Care Group discharge audit was received and noted, as per the action from the Members' Council meeting. **Assure** • The Quality Account for 2024/25 was reviewed and recommended to go out to external consultation, prior to final sign off by the Chair and Chief Executive, with delegated authority from the Trust Board. • The Infection Prevention Annual Report was received and noted. • The Apparent Suicide Annual Report 2023/24 was received and noted.
Approved Minutes of previous meeting for receiving	8 April 2025

Mental Health Act Committee	
Date	4 June 2025
Presented by	Erfana Mahmood, Non-Executive director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** MHA Office activity • The activity levels Trustwide remains high and pressured in the MHA offices. • To support clinical staff with compliance requirements a total of 41,735 reminders were sent out over the past year, this does not include work generated by the processes to administer the component acts of each detention (approximately 3,478 per month) • To support compliance with s.17 leave requirements 29,017 leave forms were scrutinised (approximately 2,418 per month) Independent Associate Hospital Managers • Existing Trust and Cheswold Park Independent Hospital Managers have integrated to form a single Trustwide body • Recruitment plans are in progress to increase diversity of the Hospital Managers, and replace those who have stood down over recent year to enable the Trust to meet the legal requirements for Hearings **Advise:** Mental Health Act Bill • The Bill is progressing having had the first and second reading and has now entered Committee Stage which is due to hold the final session hearing evidence on 26 June 2025. Community Treatment Orders deep dive (CTOs) • A newly commissioned report to better understand Trust activity and use of CTOs was received, providing assurance of the appropriate use of CTOs although at a lower rate than the national reported use. This puts the Trust in a strong position for implementation of the CTO proposals within the MHA Bill. Restricted Patients Quality Improvement projects with partners. • The QI projects in collaboration with the Virgina Mason Institute have come to a close. A presentation was received by the Horizon Centre Team on the Advance Choice Document (ACD) work, this has received interest external to the Trust. The work will be continued by

	the Team for learning which will support the introduction of ACDs as part of the implementation of the MHA Bill. **Assure:** CQC action plans update • The Care Groups are meeting most agreed action plan timeframes, with only 7 of the due 45 active actions remaining open at the close of Q4. • A presentation was received for the Forensic Care Group regarding activity and work to close the 1 outstanding action over Q1. Annual audit reports • The MHAC received annual reports showing strong compliance achieved with the support of the MHA office team. • The giving and recording of CTO patient's rights (100%) • Access to statutory Independent Mental Health Advocacy (IMHA) (95%) • Engagement meetings with IMHA service leads to ensure early highlight of emerging issues • Access to IMHA services for under 18-year-olds detained to the Trust and ensuring access for this service for under 18-year-olds detained to partner acute trusts Restricted Patients Ministry of Justice (MoJ) report • The second published annual MoJ report examining restricted patient activity was received with trust activity benchmarked. • Trust activity is comparable for conditional discharge • Trust activity is greater for the s.37/41 activity, rate of transfer back to prison and rate of expiry of restrictions. • Activity is lower than the national rate for transfers from prison to the trust. • The report will be developed to support a more detailed review of trust activity against the national report.
Approved Minutes of previous meeting for receiving	4 March 2025

Commissioning Committee	
Date	17 June 2025
Presented by	Gary Ellis (Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • Referrals from PICU service in West Yorkshire and from HMP continue to be above previous levels. Analysis of the data from January 2024 to March 2025 has revealed that from the 11 cases admitted 55% were from Leeds, 36% Bradford and only 9% (1) from SWYPFT. The next steps are to meet with ICB colleagues and the adult secure clinical leads to understand interface challenges and differences. • In WY the high number of referrals to medium secure and for specialist services is leading to delays in local services ability to repatriate identified cases. Due to high occupancy levels in our medium secure male MI service (Newton Lodge) and following a high number of referrals from HMP, there are several cases waiting for admission with no immediate beds available. There is a need to create flow from medium to low secure to free up capacity for new admissions to avoid potential new OOA requests where delays to admission become a concern.

	• Long standing challenges with delayed cases awaiting transfer to high secure have eased with cases admitted to Rampton. • CRFD delays continue to be monitored and a review meeting has been established with improved oversight of the reasons. More work is ongoing on correctly identifying CRFD patients which is a priority for the provider collaborative. The position in SY to ensure consistency of CRFD reporting is expected to be completed by the end of August 2025. • Both WY and SY Adult Secure Provider Collaboratives are committed to a breakeven position in 2025/26 both will need to take actions based on the latest forecasts. WY current plan shows a deficit of £377k and SY a deficit of £1.6m. • The main issue for SY are service users awaiting NHS Retained Services (High Secure). This has been flagged with NHSE Regional team and a request for a separate financial discussion to mitigate. • One provider in SY remains closed for new admissions and remains in enhanced monitoring. **Advise:** • Since the reopening of admissions at CPH in January 2025, 13 patients have been repatriated back to SYB, from out of area. • CPH Leadership team and the Specialised Commissioning Hub continue to demonstrate positive collaborative working as we move into Phase 2 of the reopening plan. • West Yorkshire and Humber and North Yorkshire Provider Collaboratives are now joined into the Phase 2 plan, with the aim to reach 80 patients by Quarter 2. **Assure:** • More generally both West Yorkshire and South Yorkshire provided the committee with their regular performance reports which included referrals, admissions, length of stay and discharges. • The Lead Provider Contract for 2024-26 has been signed by the Trust and NHSE. The Trust is preparing new contracts for in area providers and out of area providers and good progress is being made on sub contracts for adult secure and FCHAMS providers. • The risk registers were reviewed and updated. • FCHAMS KPI reports highlighted good performance across the service with the majority of measures above required compliance. One hotspot regarding safeguarding children mandatory training was below target but will be addressed by Quarter 1.
Approved Minutes of previous meeting for receiving	1 April (presented in private)

Finance, Investment and Performance Committee	
Date	24 June 2024
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**12 May 2025** **Alert** • Month 1 of the new FY produced a deficit of £0.9m which was £0.1m worse than plan. • The main reason for the adverse variance was spend on Bank Staff (£0.6m worse than plan). Significant actions will be required to reduce the run rate back to plan and the impact of these actions will continue to be assessed. • Agency spend was £0.4m less than plan.

	• Corporate services performance was positive, but this was due to holding vacancies rather than having a fully worked up plan in place. The potential impact of redundancy costs needs to be calculated. **Advise** • Board to note that the rate of savings required increases in H2 due to the profiling of the VFM Tracker. • A key milestone for us to achieve financial sustainability and stability is to ensure the non-recurrent vacancy provision (£10.5m) is transacted by removing posts on a permanent basis to deliver recurrent savings. • WYICB plan is not in balance and requires circa £30m of additional savings. The view of FIP is the Trust's plan is in balance and therefore we will continue with our current targets. **Assure** • Assurance was received regarding the VFM tracker that is now in place and very much a live document to ensure grip and control on the key areas if we are to hit our break-even plan for this FY. • While the unallocated target saving is £3.4m this is reducing as we allocate to specific initiatives. • Capital spend was also green In Month 1 and the key area of focus for this year's programme will be the older people transformation scheme. • Cash was slightly ahead of forecast but lower than historical balances. **23 June 2025** **Alert:** • The cumulative position at Month 2 of the new FY is a deficit of £1.423m which was £0.2m worse than plan. • Although worse than plan there has month on month been a significant reduction in the run rate which in turn supports the impact the value for money interventions are having. • There has been a significant reduction in worked WTE in month 2 and reductions in Bank have been achieved. Agency also remains ahead of plan. • Despite these reductions older people inpatient (Wakefield and Barnsley) CAMHS and Forensics reported pay related financial pressures in the month. Recovery action plans have been requested by the end of Quarter 1. • Mental Health Investment via MHIS and SDF was lower in 2024/25 than previous years and the position for 2025/26 is still subject to further discussions but to date new schemes have been minimal. On a positive note, Barnsley Place has secured £700k and we are confident this will flow through to enable improvements to Trust delivery and services in Barnsley. • To support delivery of the Trusts break even target the VFM Programme target is £28.2m. This can be summarised as £10m from ongoing vacancy management and £18m cash out. • To date we are £0.5m below target mainly due to temporary staff and workforce numbers being higher than planned with some other items such as corporate reductions offsetting this. • Overall, there still remains a risk to delivering the breakeven position in the region of £6m. **Advise:** • Board to note that the rate of savings required increases in H2 due to the profiling of the VFM Tracker.

	• The WYICS has a stretch target of £33.2m that has been allocated to Place but not Providers. As reported previously SWYPFT has currently rejected a direct stretch allocation to the Trust. • The value of any unfunded pressures on the pay award (Risk 1957) will be known in Quarter 2 which may lead to further mitigations being required. • Any risk share from other collaboratives of which SWYPFT is not the lead has not been provided to date but will be included in future financial positions. **Assure:** • Assurance from two deep dives (CYP&F Care Group and People Performance Metrics) was received by the committee. In particular the People Performance Metrics demonstrated the key metrics around turnover, sickness appraisals and statutory and mandatory training were on track or moving in the right direction. • There were also positive steps been taken to improve governance and control through the alignment of a core skills framework for NHS Trusts. • The VFM Group have met 4 times in May and concluded the future actions to address some loss-making services and specific temporary staffing roles. All milestone plans have been reviewed with clear timelines and actions agreed such as Bank reductions. • Further work will be completed by the end of Quarter 1 to further derisk the VFM target as part of the WYICB VFM submission process which is operating on a fortnightly return basis. • Capital Spend was slightly behind in Month 2 due to lease revaluations however the spend is profiled mainly for the second part of the FY (Older people transformation the main investment area) and progress is being made on ensuring the target is delivered. • Cash remains slightly ahead of forecast, and we continue to perform well against the Better Payment Practice Code.
Approved Minutes of previous meeting for receiving	22 April 2024

Audit Committee	
Date	25 June 2024
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	A verbal update will be presented to Board.
Approved Minutes of previous meeting for receiving	Minutes of 15 April will be approved at Audit Committee on 14 July.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Minutes of the Members' Council meeting
14 February 2025, 10.10 – 12.45

Hybrid meeting
Microsoft Teams and Fieldhead Hospital, Ouchthorpe Lane, Wakefield

Present:	Marie Burnham (MBu)	Chair
	Bob Clayden (BC)	Public - Wakefield
	Cllr Geraldine Carter (GC)	Appointed – Calderdale Council
	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Adam Jhugroo (AJh)	Public – Calderdale
	Elaine Lane (EL)	Staff – Allied Health Professionals
	John Laville (JLa)	Public – Kirklees (Lead Governor)
	John Lycett (JLy)	Public – Barnsley
	Valentina McParland	Public – Kirklees
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Natalie McMillan (NMc)	Non-Executive Director/ Deputy Chair
	Reini Schühle (RS)	Public – Wakefield
	Phil Shire (PS)	Public – Calderdale
	Stephen Baines (SB)	Public – Calderdale
	Nesar Rafiq (NR)	Public – Wakefield
	Jacob Agoro (JA)	Staff – Nursing
	Daz Dooler (DD)	Public – Wakefield
	Susan Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
	Emma Hall (EH)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Keith Stuart-Clarke	Public – Barnsley
In attendance:		
	Mark Brooks (MBr)	Chief Executive
	Gary Ellis (GE)	Non-executive director
	Mike Ford (MF)	Non-executive director
	Izzy Worswick (IW)	Assistant director of corporate governance
	Jon Head (JHe)	Chief People Officer
	Margaret Kitching (MK)	Non-executive director
	Dawn Lawson (DL)	Executive director of strategy and change
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
	David Webster (DW)	Non-Executive Director
	Adele Fox (AF)	Chief Operating Officer
	Andy Lister (AL)	Head of Corporate Governance / Company Secretary
	Andrew Betteridge (AB)	Corporate governance administrator
	Gemma Lockwood (GL)	Corporate governance manager
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)
Apologies: Members' Council		
	Bob Morse (BM)	Public - Kirklees

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	Claire Den Burger-Green (CDBG)	Public – Kirklees / Deputy governor lead
	Rosie King (RK)	Public – Wakefield
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Helen Dale (HD)	Staff – Nursing support
	Daniel Goff (DG)	Public – Barnsley
	Leonie Gleadall (LG)	Staff – Non-clinical support
	Sarah Leason – Hurley (SLH)	Staff – Social workers
	Melanie Mott (MM)	Staff – Psychological Therapies
	Anne Magee (AM)	Staff – Staff side
	David Webster (DW)	Non-executive director
	Erfana Mahmood (EM)	Non-executive director
	Fatima Shahzad	Public – Rest of Yorkshire and Humber
Apologies:	Adrian Snarr (AS)	Executive Director of Finance, Estates and Resources
	Sean Rayner (SR)	Director of provider development
	Professor Subha Thiyagesh (ST)	Chief Medical Officer

MC/25/01 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) formally welcomed everyone to the meeting. Apologies were noted as above. The meeting was quorate and could proceed.

MBu reported that the meeting was being recorded to support minute taking, and that the recording would be deleted once the minutes had 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 requested to remain on mute, unless speaking.

MBu informed the meeting that David Webster (DW) had made the decision to stand down as non-executive director at the end of April 2025. MBu thanked DW for his hard work over the last 3 years.

MBu also noted that after 7 years as a non-executive director, Erfana Mahmood's (EM) term was coming to an end. Erfana's term was previously extended by 1 year however, in line with the terms set by NHS England, it is not possible to extend the term any further. MBu thanked EM for her outstanding support over the last 7 years. She advised that a process was already in place to support the recruitment to both non-executive director posts.

MBu advised that Claire Den Burger-Green (CDBG) had also announced her plans to stand down as deputy lead governor. MBu thanked Claire for her support and added that Claire will remain as a governor for the Trust. Nominations for the new deputy lead governor will be sought and a communication will be sent out from the Corporate Governance Team. It was noted that the appointment of deputy lead governors is dealt with through the Nominations Committee and Members' Council.

MBu introduced Adele Fox (AF) as the new chief operating officer for the Trust. Adele joined the Trust at the beginning of January and Mbu stated she had already had a positive impact.

MBu also advised that Julie Hall has been seconded to support the integration of Cheswold Park Hospital into the Trust and Izzy Worswick (IW) seconded into the role of assistant director

for corporate governance for the next 15 months and will oversee the Trust Board secretariat and issues related to corporate governance. IW was welcomed to the meeting.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC/25/02 Declarations of interest (agenda item 2)

MBu asked governors if they had any declarations of interests. Governors did not share any additional declarations of interest.

It was RESOLVED to RECEIVE the individual declarations from governors.

MC/25/03 Minutes of the previous Members' Council meeting held on 15 November 2024 and Joint Members' Council and Trust Board meeting held on 15 November 2024 (agenda item 3)

It was noted that the spelling of Valentia McParland's name was incorrect on page 4 and page 19. It was agreed the minutes would be updated with the correct spelling.

Action – Corporate governance team

It was RESOLVED to APPROVE the minutes of the Members' Council meeting on 15 November 2024 and Joint Members' Council and Trust Board meeting held on 15 November 2024 as a true and accurate record.

MC/25/04 Matters arising from the previous meeting held on 15 November 2024 (agenda item 4)

John Laville (JLa) raised a query regarding the wording of action MC/24/87 and the frequency of updates being brought back to Members' Council. Dawn Lawson (DL) explained that the plan was to bring the Equality, Involvement, Communication and Membership (EICM) strategy back to Members' Council before it is finalised and once finalised it will be brought back to the meeting annually. It was agreed to reword the action to make it clearer.

Action – Corporate governance team

Bob Clayden (BC) requested feedback following the changes to the executive summary format. The meeting agreed that the revised format was helpful, and Andy Lister (AL) confirmed that the executive summary will continue to be produced in this format going forward.

It was RESOLVED to RECEIVE the action log of the Members' Council.

MC/25/04 Chair's report and feedback from Trust Board (agenda item 5)

MBu provided a summary of the chair's report and feedback from Trust Board and advised that the report provided a summary of the work undertaken by the chair and non-executive directors every week. MBu thanked the non-executive directors for their hard work and support to the Trust.

Mbu advised that the report also provided a summary of key events that have taken place since the last Members' Council meeting in November 2024 including the Crofton ward carol service attended by non-executive directors and the Fieldhead carol service attended by the chair.

MBu updated that the shadow board programme continues, which is run in conjunction with Leeds and York Partnership NHS Foundation Trust. The shadow board creates a safe learning space for aspirant directors, allowing participants to support their development in the right environment allowing them to flourish and experience what it is like to be a board director. MBu reported that the shadow board experience has proved successful so far.

MBu updated that the Trust is working towards Teaching Trust status, and that further updates would be provided in due course.

It was RESOLVED to RECEIVE the Chairs' report.

MC/25/05 Chief Executive's Report (agenda item 6)

The chief executive's report was taken as read. Mark Brooks (MBr) noted that since the report was written, the NHS planning guidance had been received which details the financial challenge that all NHS organisations will be facing going forward.

BC raised a question around whether the Trust receives any money for reaching a particular level of flu vaccination compliance. MBr confirmed that the Trust no longer receives any performance related payment. Since the pandemic vaccination uptake in general has declined and the Trust position is similar to most other organisations in terms of the numbers of staff receiving the vaccine.

Councillor Geraldine Carter (GC) provided clarification around her previous request at the last meeting for further updates to the chief executive's report as the report is written and shared a week prior to the Members' Council meeting. MBu confirmed that since the report was written the only additional update was in relation to the NHS planning guidance which MBr had provided at the start of the agenda item.

Daz Dooler (DD) queried whether the government's decision to put £22billion into the NHS had eased any of the financial pressure faced by the Trust. MBr advised that the cost of recent pay increases, national insurance changes, cost of new drugs and pension costs is greater than £22billion. Therefore, the Trust will receive 4% less income next year which equates to circa £15-16 million less than this year and the financial pressure faced by the organisation is expected to continue.

Phil Shire (PS) noted that only 53% of frontline staff had received the flu vaccination. MBr stated that the number of staff receiving the vaccination is not as high as previous years and the overall uptake from the general public is lower, however the Trust is not an outlier, and the figures are comparable with other organisations. Mask wearing was reintroduced across inpatient areas over the winter period due to the flu vaccination numbers being lower. The Trust undertake a significant amount of promotion for the vaccine and a review of this is required in order to understand the reasons why staff are not accepting the vaccine.

PS also raised a question in relation to finance, productivity and partnership working and asked whether there is any scope in improving this as it has been noted publicly that the NHS is not as productive as it should be. MBr stated that a productivity review of the Trust's community mental health services has taken place, led by an external organisation as part of the South Yorkshire Integrated Care Plan. MBr noted that the Trust has the lowest number of out of area bed placements across Yorkshire and Humber, which is positive for service users however comes at a cost due to 7 day working, bed flow and management due to additional staffing. Inpatient occupancy levels are currently between 95% and 105% which is a cost premium due to the additional staffing required. MBr gave an example of productivity following a recent visit with a community team and acknowledged that there are opportunities for better productivity. MBu added that the Trust must also ensure that the public purse is being spent

as efficiently as possible and noted that mental health organisations work on contracts where payment is by block and not on activity levels. Therefore, the Trust continue to accept patients. She raised the importance of making sure staff are looked after and supported whilst continuing to provide safe care to service users. The Trust is also reviewing non-essential vacancies across the Trust and this will continue with some difficult conversations and decisions to be made going forward.

DD raised a concern around the amount of pressure faced by the Trust which is being seen in community services and the voluntary sector following a significant increase in the number of referrals received over the last few months. DD suggested that governors need to push back to the government stating that people need time to recover as mental health issues are not solved quickly. MBu agreed and added that there are also ways the Trust can look to be more efficient to support the challenges.

Margaret Kitching (MK) added that the Trust is working hard on improving digital solutions in order to improve productivity and efficiencies for frontline staff and this is key to enabling staff to spend more time on patient care rather than record keeping. Adam Jhugroo (AJh) stated that artificial intelligence (AI) is being used more and more in general practice to support patient consultation and note writing, and this could be used to increase efficiencies and support digital note taking and record keeping. MBu added that consideration should also be given to moving mental health to a preventative model which would result in less people presenting with higher acuity. MBr provided a summary of work that has already taken place in terms of digital solutions. Electronic prescribing medicines administration (EPMA) has been introduced which has had a significant impact in terms of efficiencies and accuracy of prescribing. The Trust also has an electronic patient system (SystmOne) and work has taken place with the SystmOne team to help identify areas to support staff to be more efficient and effective.

In terms of prevention, MBr stated that although demand has been exceptionally high over the last few years, the mental health investment standard has focused on younger people's services with a mental health support team in most schools. The impact of this will take time to be seen but it is hoped that through engagement with young people this may prevent serious challenges later on. DD added that more work is required around prevention and ensuring that people who are referred to services have the right information. Consideration also needs to be given around information that states that mental health issues do not necessarily mean a referral into the services and this will help reduce some of the pressure. It would also be helpful for schools to start explaining mental health and getting the right information out to children and families. MBu agreed and stated that work is ongoing with the voluntary and private sectors working with the NHS to promote avenues of support.

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

Mark Brooks left the meeting

MC/25/05 Members' Council business items (agenda item 7)

MC/25/06 Review of Trust Constitution (SFIs and scheme of delegation) (agenda item 7.1)

Phil Shire (PS) left the meeting

Izzy Worswick (IW) advised that a yearly review of the Trust's Constitution takes place and a recent discussion and review took place at Trust Board in January where it was agreed to recommend that Members' Council approve the changes to the Trust Constitution. IW noted that there have been some statutory and organisational changes which include:

Statutory changes

- Best practice in relation to non-executive director terms and the need for any extension beyond 6 years (2 x 3 year terms) being subject to rigorous review and NHS England approval.
- Monitor references removed and replaced with NHS England where appropriate.

Organisational changes

- An amendment to governor tenure, to allow, by exception, the extension of a governor's final 3 year term by 12 months, subject to approval by the Members' Council.
- The description of the services the Trust offers has been updated to include the provision of adult secure services at Cheswold Park Hospital in South Yorkshire.
- Trust Board committee updates
  - Quality and safety committee - title updated
  - Commissioning committee – title updated

IW advised that the Standing Financial Instructions and Scheme of Delegation had been included in papers for information only. A full review, involving internal and external stakeholders, has been completed to review and update the Trust's Standing Financial Instructions. Any stakeholder feedback has been incorporated.

Members' Council were asked to receive the recommendation from Trust Board to approve the changes to the Trust Constitution and note the changes to the standing financial instructions.

Andy Lister (AL) added that a meeting took place with Bob Clayden (BC) to go through any points of accuracy and AL will make the necessary changes before the documents are published.

GC raised a query regarding the role and function of Members' Council in relation to "*Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied*". GC stated that there is no information related to the forward plan on the Trust website and requested clarification around the forward plan and what is expected of her in her role as governor. Dawn Lawson (DL) advised that the forward plan is a plan of the work of the Members' Council throughout the year and the role of governors is to bring in the voice of communities to help with decision making and discussion around each item. GC requested a copy of the forward plan to review outside the meeting and present to the health and wellbeing board in order to obtain local feedback from partners. AL stated the Trust strategy is currently going through a transitional phase and the new strategy will be in place from 1 April 2025 along with an updated annual plan that will be added onto the Trust website. DL confirmed that the strategy and annual plan have been written in consultation with partners. More information around the Trust's annual plan is to be added to the Trust website with hyperlinks. An updated annual plan to be shared with governors.

Action – Dawn Lawson

Darryl Thompson (DT) also noted that the annual quality account includes planning and quality priorities for the year ahead and is shared with all partners. This will be presented to the Members' Council Quality Group as well as Members' Council.

GC also noted that the dates of the Members' Council meetings were not listed on the Trust website. Corporate governance team to review and update the Members' Council meeting information, including meeting dates, on the Trust website.

Action – Corporate governance team

It was RESOLVED to APPROVE the Review of Trust Constitution (scheme of delegation).

MC/25/07 Extension of governor final term (agenda item 7.2)

Following the approval to extend governor's final term by 12 months, AL advised that any extension has to be voted through a quorate Members' Council meeting. The meeting today was noted to be quorate. AL stated that as there are a number of governors who are currently in their first 3 year term, a proposal is put forward to extend Phil Shire's (PS) term by 12 months in order to provide additional support to the newer Members' Council governors. AL noted that this has had an impact on the Members' Council elections, in that should the proposal for PS's term to be extended be accepted, this will result in there being one less governor vacancy.

GC declared an interest in that she has known PS for a number of years on a personal level.

Members' Council accepted the proposal to extend PS's term by 12 months.

It was RESOLVED to APPROVE the Extension of governor final term.

MC/25/08 Appointment to Members' Council groups (agenda item 7.3)

PS rejoined the meeting

AL advised that there was a vacancy on the Members' Council Coordination Group and GC has put herself forward to become a member, effective immediately.

AL also noted that following CDBG's decision to stand down as deputy lead chair, there are now vacancies on both the Members' Council Quality Group and Members' Council Coordination Group. Expressions of interest will be sought to fill both these positions in due course.

It was RESOLVED to RECEIVE the appointment to Members' Council groups and Nominations Committee.

MC/25/09 Assurance from Members' Council groups and Nominations Committee (agenda item 7.4)

The assurance from Members' Council groups and Nominations Committee was taken as read.

It was RESOLVED to RECEIVE assurance from Members' Council groups and Nominations Committee.

MC/25/10 Review of Chair and Non-Executive director remuneration (agenda item 7.5)

Jon Head (JH) provided a summary of the review of chair and non-executive director remuneration and advised that the report was for Members' Council to receive and was an

update on remuneration for the chair and non-executive directors in line and in accordance with the national framework arrangements for remuneration. Due to the significant change in the size of the Trust following the acquisition of Cheswold Park Hospital, the Trust is now recognised as being a "large" Trust. The recommended Chair's pay range for the Trust has increased slightly. Renumeration for the audit committee chair and deputy chair, as well as non-executive directors has been set out by the national framework and MBu advised that the Trust is in line with all other NHS organisations. JH also noted that feedback from NHS England has been received stating that they have no intention to revise the levels of remuneration.

GC raised a question around whether there is any flexibility to increase remuneration for non-executive directors as well as the chair as non-executive workloads are also expected to increase along with the increase in the size of the Trust. MBu advised that as a Foundation Trust is it possible to determine the chair and non-executive directors' remuneration however the Trust previously made the decision to follow the guidance from NHS England. MBu acknowledged the significant amount of work that non-executive directors undertake. Mike Ford (MF) added that remuneration reflects wider financial issues and will become more of an issue when recruiting new non-executive directors into the NHS as a whole as well as the Trust due to the amount of work required and the fact that pay has not increased over the last 6 years. Therefore, the Trust may struggle to recruit people with the right level of current experience and skills in areas such as AI, digital and sustainability. MK suggested that recruitment need to be completely honest in terms of expectations when advertising non-executive director roles. MBu agreed and stated that during the last non-executive recruitment process, the requirement was for experienced non-executive directors with specific skills. Nesar Rafiq (NR) stated that the Trust should consider how they recruit non executives from different backgrounds in order to provide a different perspective, in addition to recruiting based on skill set. JLa confirmed that the current non-executive directors are from different areas of industry and not just the NHS. When undertaking recruitment, the Trust will always look for people from different backgrounds and different sectors including non-NHS, and review the skill set of the current Board to consider where there are gaps. MBu thanked Member's Council for their input and comments.

It was RESOLVED to RECEIVE the Review of Chair and Non-Executive director remuneration.

MC/25/11 Care Quality Commission (CQC) action plan updates (agenda item 7.6)

Keith Stuart-Clarke (KSC) joined the meeting.

The CQC action plan update was taken as read. Darryl Thompson (DT) advised that the update has been presented to Trust Board in November 2024 and a further update would be presented to the Quality and Safety Committee in March 2025. DT noted that the CQC actions are under constant review and work are in place to progress them further. DT noted that following a request from Trust Board, an example had been included in the update demonstrating the governance and sign off process for actions and how the Trust maintains confidence that progress is maintained going forward.

Based on the audit, which was carried out in December 2024, JLa queried whether the board of governors was satisfied with the progress made so far and whether the actions should have been completed by now. DT stated that the aim was to close the actions as soon as possible but in a way that ensures that that they have been fully implemented with a plan to embed the actions further going forward. In terms of prone restraint, DT confirmed that the Reducing Restrictive Practice Intervention (RRPI) team are working with care group colleagues to progress this work as soon as possible. DT reported that he is satisfied with the progress

made so far which will help to support a sustained improvement. MK added that the quality and safety committee challenge progress on a regular basis, particularly around prone restraint and RRPI and the committee have scrutinised the evidence across the region and acknowledged that the Trust is doing well in terms of reducing incidents. Where there are issues related to ligatures, non-executive directors also continue to push this issue to ensure that there is a tight grip and the estates plan is prioritised. As a relatively new non-executive director for the Trust, MK stated that her opinion of SWYPFT is that the Trust operates to gold and platinum standards of assurance and the audits demonstrate an acceptable level of assurance. NR also congratulated the executive directors, non-executive directors and staff for their hard work while working under pressure.

BC reported that during a previous quality monitoring visit it was noted that bank staff did not receive the same level of RRPI training as substantive staff and this could lead to a risk that the ward would not have enough adequately trained staff which could potentially be picked up by the CQC. DT confirmed that there are mandatory training expectations for all bank staff, particularly around RRPI training, and only bank staff who are trained and have the right level of clinical skills would be deployed into an inpatient area. There is a clear focus around mandatory training and compliance is monitored to ensure that staff have the required level of expertise.

It was RESOLVED to RECEIVE the CQC action plan updates.

MC/25/12 Chairs' appraisal – process (agenda item 7.7)

The chairs' appraisal paper was taken as read.

AL provided a summary and advised that the process will be led by Nat McMillan (NMc) (deputy chair) and will include executive directors, non-executive directors, governors and internal and external stakeholders who will all be invited to contribute to the appraisal process. A questionnaire was developed last year which was found to be effective and this process will be repeated this year. The lead governor, deputy lead governor and a member of each of the Members' Council groups will be invited to complete the appraisal questionnaire independently before coming together to discuss and agree a resolution. The deadline for the questionnaire is end of June 2025 and updates will be provided throughout the process. There will be an opportunity for governors to have sight of the initial appraisal. The Members' Council approved the process as stipulated within the paper.

It was RESOLVED to RECEIVE the Chairs' appraisal – process.

MC/25/13 Members' Council elections - update (agenda item 7.8)

AL provided an update on the Members' Council elections and advised that the election process was scheduled to begin 2 weeks prior to the meeting but was pending decision today to appoint PS for a further 12 months. He outlined that current vacancies were: 1 vacancy in Wakefield, 2 in Kirklees, 1 in Calderdale and 1 in Barnsley. He advised the "notice of poll" would be issued from Monday 17 February 2025 and added to the Trust website with a link to the website. All the necessary information will be included in all communications through Civica. AL advised that the nomination stage will begin on Monday 17 February 2025 and will be open for a period of 1 month with electoral voting from 7 to 30 April 2025 in order to appoint for 1 May 2025. Therefore, despite the delay, it is expected that the original timeline will be met.

GC queried how vacancies are publicised. AL stated that as the Trust is a membership organisation, applicants need to be a member in order to vote. MBu confirmed that new

members are being sought all the time and members will receive a letter notifying them of the vacancies within their designated constituency. AL confirmed that there are no staff vacancies only public vacancies at this time.

It was RESOLVED to RECEIVE the Members' Council elections – update.

MC/25/14 Governor feedback from virtual meetings (agenda item 7.9)

JLa provided a summary of feedback from virtual meetings and community feedback sessions and advised that in relation to complaints, the feedback received was that the Trust complaints process takes too long and when a response to a compliant is received, it appears to be a standard response stating that the Trust will try to do better with little acknowledgement of lessons learnt while investigating the complaint. JLa queried why, when there has been some learning from a complaint, this cannot be fed back to the individual? MBu stated that the once a compliant process has been completed it is signed off by the chief executive. Over recent years, the complaints process has changed significantly. DT stated that he will pass this feedback to the team but provided assurance that there are no standard responses to complaints and each compliant is reviewed by the executive trio (chief nurse, chief medical officer and chief operating officer) with a focus on the tone of the response as well as to ensure all the elements of the complaint have been addressed and highlight any learning before final sign off by the chief executive. DT stated that he would be keen to understand where this has not been done well enough. DT advised that 18 months previously there had been a large backlog of complaints and the team had worked extremely hard to reduce this. In November it was noted that 100% of complaints received a response within 6 months, which is the national standard. JLa stated that, in his opinion, this needed to improve and that the Trust should be aiming to be outstanding and to respond more quickly. DL added that she was recently involved in the sign off process while the chief executive was on annual leave and 1 particular response was 21 pages long. Therefore, there are complexities when reviewing complaints and the Trust would rather provide a detailed response rather than a quick response which does not get down to the "nitty gritty" detail. DL requested that specific examples be shared with the executive team where the responses were not acceptable in order for the Trust to learn from them.

NR challenged the use of the term "nitty gritty" and provided context to the phrase. Others had not been aware of connotations. DL thanked NR for bringing this to the attention of Members' Council, apologised and stated that this phrase would not be used again.

JLa raised a concern related to patient discharge back to the community and their GP where service users could be discharged back to the community and the care of a GP who has no knowledge of the service user, their condition or mental health medication. Paula Scott-Loftus (quality governance lead) recently joined a group to go through the process of discharge and JLa advised he did not feel the Trust is following the process in all cases. JLa requested an audit of 10 individuals in each of the 4 places to look at the discharge process followed. Adele Fox (AF) advised that she recently joined a carers forum meeting and listened to the experience of individuals who have been referred back to a different GP and found this difficult. AF confirmed that a process is in place where service users must be referred back to primary care and AF agreed to look at this process in more detail in order to ensure that the GP is aware that the service user is back under their care and that they understand the level of support required. AF agreed to review the discharge process for service users back into the community and the care of their GP to ensure that GPs are aware that service users are back under their care and the level of support required. AF to present a paper to the quality and safety committee before bringing it back to Members' Council.

Action – Adele Fox

MBu agreed that a selective audit in 4 localities with 10 service users who have been discharged should take place to check whether the process has been followed. MK suggested undertaking an experience audit of individuals who have been discharged to obtain their experience rather than checking whether the process has been followed. JLa stated that some individuals are reluctant to raise an issue once they have been discharged. JLa agreed to see if there are any service users he was aware of from his discussions who would be willing to talk about their experience.

JLa also raised an issue following the news that a private provider in Bradford has had a negative CQC inspection and asked whether there are any of the Trust's service users placed with that particular provider and if so, what are the Trust's responsibilities to these service users. MBu confirmed that there are no service users from the Trust under the care of the private provider and the only area of responsibility for the Trust would be if the Trust has commissioned that service. MK noted that a poor CQC inspection might mean that the organisation would not be in a position to take any new admissions and this may have an impact on the Trust in terms of additional pressure.

In relation to the Nottinghamshire Healthcare Independent Review, BC requested reassurance that the Trust is intending to review the report in full. MK confirmed that the report has been published in full and is on the government website. It was noted that a paper will be presented to EMT this week and public Trust Board in March.

It was RESOLVED to RECEIVE the Governor feedback from virtual meetings.

MC/25/15 Integrated Performance Report (agenda item 7.10)

Mark Brooks rejoined the meeting.

Gary Ellis (GE) presented a summary of the Integrated Performance Report for quarter 3 and advised that performance metrics (improving health) are all green and above the threshold. The Trust continues to take action around the collection of information related to protected characteristics by codesigning services and ensuring these are representative of the population that the Trust serves.

The number of people with a risk assessment/staying safe plan in place within 24 hours of admission demonstrates an increase for inpatient services with a slight deterioration for community services. GE noted that all service users without a risk assessment are followed up individually within the care group in order to maintain patient safety. The Trust continues to stress the importance of timely risk assessments and continue to look for opportunities to improve the position. The number of service users clinically ready for discharge improved in December however there continue to be a number of service users whose discharge is delayed which may impact future performance. Work is continuing with partners to ensure that people are discharged as soon as possible.

The national target for out of area beds. The Trust has 5 service users currently out of area. This is a largely positive position for service users as well as the Trust's financial position and GE confirmed that the data includes all out of area placements regardless of commissioner. Work continues to ensure service users are cared for close to home. Workforce challenges have led to an increase in temporary staffing, primarily though bank usage and this is expected to continue to be a financial challenge for the Trust.

GE summarised the Trust's financial position and advised that the challenges will continue with the position in December 2024 reporting a £911k deficit against plan which will be a challenge going forward in achieving a breakeven position. There has been additional capital allocation due to the acquisition of Cheswold Park Hospital with a total capital allocation of

£8.1m. One area of spend is the older peoples' transformation and this work has been delayed therefore the teams are working hard to maximise the full allocation.

GE advised that management of the overall workforce continues with a focus on agency spend. There were some significant reductions in the previous financial year (2023/24) and this has continued to fluctuate this year with an increase in spend by £30k compared to last month. However, it was noted that this included the increase in costs associated with Cheswold Park Hospital.

There were 11 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in quarter 3 which is greater than quarter 2 but lower than quarter 1. All staff involved in violence and aggression incidents have been supported through recuperation and follow up appointments with occupational health as well as "welcome back" meetings with departmental managers. There were no enquiries from either the Health and Safety Executive or the CQC following the reporting of these incidents in quarter 3. MBu provided clarification that the 11 incidents occurred in 3 areas of the organisation where there are specific challenges related to individual service users.

The percentage of ligature jobs completed within timeframe is currently 100% and all urgent jobs are being actioned within 2 days. GE thanked the estates team for their hard work in keeping up to the work and reaching this position.

In terms of workforce, turnover continues to be positive at 7.6% which highlights that the Trust is successfully retaining staff within the organisation.

Sickness absence has increased in December 2024 to 5.7% due to the increase in the number of cold viruses, flu and gastric illnesses over the colder months. The majority of sickness is related to short term absence and most care groups have seen an increase in December 2024. Hot spots areas continue to be managed within care groups however the increase has led to an increase in bank and agency staff.

It was acknowledged that it is important that staff receive an appraisal. GE noted that there has been an issue with the appraisal system since 16 December 2024 which has led to a delay in the reporting of appraisals for staff, however an alternative reporting system is currently in place. MBu added that the plan is to move away from WorkPal as a reporting system onto the electronic staff record system (ESR) and staff continue to be appraised in the interim.

Mandatory training compliance remains above threshold including RRPI training which is a positive position. E-rostering continue to ensure that wards have access to adequately trained staff at all times. Information governance training is just below the 95% threshold at 93.6% and work will continue over the coming months to ensure that the Trust meets the 95% target.

Incident reporting remains within the expected range.

The Trust continues to perform well against the national metrics. However maximum 6 week wait for diagnostic procedures remains an area of concern with a current position of 49.5% against a target of 99% and is related to staffing issues within the paediatric audiology service. The service has set a trajectory for improvement and is preparing a business case for commissioners following a demand and capacity exercise.

NR raised a question regarding the 80% threshold for the cardiopulmonary and RRPI training and 85% threshold for fire training. NR asked why the thresholds are not set at 100% with an aim to have all staff trained in these areas. DT advised that the Trust will always aim to reach 100% however the metrics take into account where staff are on leave from work and are not

available to undertake the training. The system provides assurance that there are enough adequately trained staff available on each ward at all times. NR queried when the targets were set and requested that the targets be set at 100%. MBu explained that some of the thresholds are set nationally and are predetermined. However executive colleagues undertake a yearly review of targets which are agreed through Trust Board as reasonable thresholds that are practical, appropriate and ambitious.

In terms of financial sustainability and efficiencies, JLa requested more information around how the £22m savings will be achieved and in which areas. MBr advised that Adrian Snarr, (director of finance, estates and resources) would be able to provide the detail however the focus for the Trust this year is around 2 key areas; reduction of out of area bed usage which has been achieved and reduction in the level of vacancies. Further information is included in the financial performance report which is presented to Trust Board. To obtain more detailed financial information around the required £22m savings for the next Members' Council meeting.

Action – Adrian Snarr

CG asked whether agency spend within the overall workforce includes bank usage. CG noted that it had been highlighted in the national press that there has been an increase in the number of adults diagnosed at GP level with ASD/ADHD (Autism Spectrum Disorder/Attention Deficit Hyperactivity Disorder) and asked whether this is having an impact on waiting times in the Trust. MBr confirmed that the agency figures do not include bank usage. He advised that GPs do not diagnose ASD/ADHD but do refer people into service providers, dependant on where they live. There is a different pathway in Calderdale (Right to Choose) compared to Kirklees and Wakefield. Over the last 5 years there has been a 500% increase in the number of referrals into the Trust which has had an impact on access to services as well as increased waiting times. MF advised that the Members' Council Quality Group are also undertaking a deep dive into ADHD.

BC queried whether the carbon impact in terms of business milage is due to undertaking reduced milage or using better vehicles. MBr confirmed that it is down to both factors. The estates vehicle fleet is almost all electric vehicles and mileage claims reduced during the pandemic however there has been an increase over recent months as teams and services undertake more patient visits in the community. MBr noted that the biggest impact is around estates and when any upgrades to the estate take place, the Trust always look at the most up to date technology in order to reduce the Trust's carbon emissions.

NR asked whether the Trust has made a decision to step away from the social media platform "X" (formally known as Twitter) and whether its use aligned to the Trust values. DL confirmed that a discussion has taken place around the use of "X" and other social media platforms. DL advised that to not use "X" would result in the loss of contact with over 9,000 staff and service users. DL added that there are clinical teams that use "X" as a way to engage with service users, therefore no final decision has been made at this time.

NR requested clarification around the 128% fill rate figure. DT provided an explanation stating that this is related to a requirement for extra staffing over establishment in order to keep service users safe. This also comes at an increased cost to the Trust which is an added pressure. MBu confirmed that AF and DT continue to monitor this going forward. PS asked whether when increasing the fill rate figure, there is a detrimental impact on the quality of service when there is not enough registered staff available or whether this is a better use of resources. DT stated that the use of substantive nurses on shift would be the ideal in order to ensure the best outcomes for service users. However, when that is not possible, the service will seek to appoint a registered nurse onto that shift when there is a gap due to sickness or absence. When a registered nurse is not available, a healthcare support worker will be

brought in to maintain a level of safety. PS asked whether there is a percentage of registered staff required as a standard? DT confirmed that there is a core expectation which varies across all inpatient areas dependent on the demands of the ward and how many registered nurses are on each shift. This is the standard that has been set and will be reviewed as part of the establishment review.

It was RESOLVED to RECEIVE the Integrated Performance Report.

MC/25/16 Focus on item: Update to Equality, Inclusion, Communications and Membership Strategy (agenda item 8)

DL presented an update on the equality, diversity and inclusion (EDI) strategy and following feedback received from the Members' Council, this has been taken forward into objective 6. DL provided a summary of the Trust's strategic aims as part of the revised Trust Strategy and requested support from governors to look at ways to engage with communities, particularly communities where there is very little contact. DL requested thoughts and advice on how to interact with communities and governors were asked to contact DL direct with any ideas. MBu added that the Trust has spent a lot of time this year re-establishing what the strategy should look like in order to be in a position to launch the new strategy for the next 5-10 years. Following the launch, a deployment plan will be put in place where executive and non-executive colleagues will be given objectives to deliver the plan for every year of the strategy. MBu asked that governors review the strategy and the slides before they are finalised, after which a deployment plan will be developed. MBu added that EDI is critical to the Trust strategy in order to understand staff and people being able to access the Trust services. AL agreed to send the slides out to governors in order for them to reply with any feedback.

Action – Corporate governance team

NR stated that the actions of the Trust and its staff is the best way to deliver the strategy, treating everyone with dignity and respect. NR suggested adding a statement saying that the EDI is for everyone and suggested that a briefing with governors to explain the benefits of the strategy would be helpful.

JLa advised that a subgroup meeting took place between governors and Sue Barton (Deputy director of strategy, inclusion and change) and Sharon Kennedy (Assistant director of strategy, equality and inclusion) which was a useful meeting for governors to provide input and challenge. An outcome from the meeting was to obtain a list of organisations that the Trust work with so that governors can support engagement with our communities. JLa added that it is also important that more young people are invited to join as governors. It is important that governors share the message around mental health and the work that goes on within the organisation.

It was RESOLVED to RECEIVE the update to Equality, Inclusion, Communications and Membership Strategy.

MC/25/17 Closing remarks and annual work programme 2024/25 (agenda item 9)

Members' Council agreed to approve the work programme for 2024/25.

It was RESOLVED to APPROVE the work programme for 2024/25.

MC/25/18 Any Other Business (agenda item 10)

MBu noted that the meeting was the last meeting for BC and thanked him on behalf of Members' Council and the Trust for his contribution as a governor to the Trust and wished him well for the future. JLa also thanked BC for his support as well as the rest of the Members's Council governors.

It was RESOLVED to NOTE any other business.

MC/25/18 Future meetings of the Members' Council (agenda item 11)

- Wednesday 7 May 2025 (hybrid – venue to be confirmed)

It was RESOLVED to APPROVE the date of the next Members' Council meetings.

Close of public meeting

South West Yorkshire Partnership NHS Foundation Trust

Minutes of People and Remuneration Committee meeting held on 18 March 2025 Microsoft Teams Meeting

Present:	Marie Burnham (MBu) (Chair David Webster (DW)	Chair of the Trust Non Executive Director
Apologies:	Adele Fox (AF)	Chief Operating Officer
In attendance:	Jon Head (JH) Lindsay Jensen (LJ) Christine Brereton (CB) Izzy Worswick Natalie Wong (NW) (Part) Richard Marriot (RM) (Part)	Chief People Officer Deputy Chief People Officer Director of People Assistant Director, Corporate Governance Exemplar People Promise Guardian of Safe Working

PRC/25/164 Welcome, introduction and apologies (agenda item 1)

Marie welcomed everyone to the group and noted that this was LJ's last meeting and thanked her for all her hard work on behalf of the committee.

PRC/25/165 Declarations of interest (agenda item 2)

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

PRC/25/166 Minutes from previous meetings of People and Remuneration Committee meeting held on 21 January 2025 (agenda item 3)

Page 5 Staff Survey LJ will amend outside of this meeting. Minutes approved other than this. JH explained that the level of detail will be reduced in future minutes as discussed with Natalie McMillan.

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on the 21 January 2025 as a true and accurate record.

PRC/25/167 Matters arising from previous People and Remuneration Committee meeting held on 21 January 2025 and action log (agenda item 4)

It was RESOLVED to NOTE the above changes to the action log.

PRC/25/167 Actions from the Trust Board (agenda item 5)
Included in the action log.

It was RESOLVED to NOTE the actions from the Trust Board.
PRC/25/168 Chief People Officer Remarks/Update (agenda item 6)

With all of us in mind.

The committee were asked to take the paper as read.

JH updated the committee on guidance for national working on nursing banding and evaluation and that he would be attending a West Yorkshire event to understand the approach across West Yorkshire. JH advised that he is not expecting to see results or proposals of changes to band 4 to band 6 nursing before May 2025. The main questions will be what the costs of this exercise are and what will be funded as we cannot assume there will be any funding for any to the nurse profiles and this is a risk for us.

We will also still need to recruit to AHP levels.

MBu asked JH to pick up the banding as a risk with EMT.

It was RESOLVED to NOTE the update on the Chief People Officers Remarks / Update and comments made.

NW joined the meeting

PRC/25/169 Staff Story – People Promise Exemplar Programme (agenda item 7)

Nat Wong, People Promise Manger for the Collaborative of Mental Health Learning Disability and Autism presented The Exemplar programme which is a national programme lead and funded by NHS. Nat shared the work she has done over the past year and what her legacy will be. Presentation attached.

IW questioned if the Freedom to Speak Up has work got underway and what were the timescales as there has been an increase in queries and is this around the awareness of this work. NW confirmed that she is was working with Estelle Myers (EM) in October and posters were put up around the Trust, this could have had an impact. NW is also meeting bimonthly with EM. It is unclear as to whether the increase in cases is a direct impact from the posters or whether it relates to the stay/itchy feet conversations. As part of the itchy feet conversations, it also sign posted people to the freedom to speak up guardians. There could be many causes of the increase.

JH commented that staff transfer work is important for us.150 people have been able to move because of this work across the three trusts. Even though we have lower vacancy rates and turnover, retaining staff within the NHS is important for us.
CB asked to what extent can we measure this work against the staff survey outcomes? May need to be mindful around at risk staff given changes in the NHS and where this lands, focus is around redeployment. CB also expressed the importance of the role of the line manager that we keep them included.

NW responded that this year's staff survey results won't be a true reflection, using flexible working as an example as this has not been fully implemented. Next year's show that an increase in positivity will be seen for those results. At present there is no direct way that a specific intervention will have impacted the result. The current interventions were pilot learning, as time goes on we can learn from data sets and implementing ways we can collect rich data to learn further.
LJ thanked NW for all her hard work and advised that NW will produce a report to summarise her work and learning for the past year.

NW left the meeting

MBu expressed concerns about the programme not being linked together and questioned what had been spent on something we should be doing ourselves as we already have the teams in place to do it whilst aligning to the people promise programme.

JH advised it has no cost attached as it is a centrally funded initiative. There are good examples of NW working with the retention team and there have been positive outcomes but this needs evaluating. The programme is being completed with neighbouring trusts.

LJ advised it was a pilot and NW has tried to work with teams to get alignment. The downside is that she has now gone which leaves unfinished work with some expectations and would have needed longer to get more benefit.

CB advised that she supports the people promise as you can measure against the staff survey. Although she wasn't satisfied with how we measure the people promise, and this should be done through our own staff survey. CB felt that the national initiative funding could be withdrawn due to the current climate and it should be integrated into our own people plan.

MBu suggested that there are some positives but that it should be integrated into our people promise.

It was RESOLVED to Note the Staff Story – People Promise and agreed that this work would be integrated into wider work around People Strategy development

PRC/25/170 Consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks) (agenda item 8.1)

The committee were asked to take the paper as read.

LJ advised that the risks went to trust board on 18th January.
1887 Speak up Risk, speak up has moved to audit LJ asked should this committee still hold this risk?

1888 Sexual Health, approved by board to come to this committee and it has been regularly updated.
11381 inability to recruit, reduce this risk to 6 in light of all the work done and focus is now on workforce numbers. JH clarified that we want to reduce but also to look at narrative, EMT will look at this, agreed on impact of the workforce changes but want to revise the narrative.

DW questioned if Freedom to Speak Up is appropriate to move to Audit as we may lose the focus.

JH advised that the workforce strategy will set out the business critical culture and a big part will be psychological safety, culture of feedback and making sure teams and

leaders are supported in having an open supporting environment where people can put forward their concerns.
CB stated that it was important that key themes identified through FTSU were made aware to this committee.
MBu agreed that aspects need to come to this committee to ensure it was not lost.

It was RESOLVED to RECEIVE the Consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks)

PRC/25/171 Integrated Workforce Performance Report (agenda item 9.1)
The committee were asked to take the paper as read.

MBu asked if evidence is ever triangulated on areas of concern with other directorates? JH responded that the triangulation takes place at granular local level looking at key data in the IPR and also looking at other data to give a bigger picture then the business partners are included. MBu asked whether there was high level exec oversight of performance in the trust. JH confirmed that we don't routinely or consistently, but we do do it, at executives. Temp staffing is an example of looking at specific issues in a more holistic way.

It was RESOLVED to RECEIVE the Integrated Workforce Performance Report.

PRC/25/172 Temporary Staffing Scrutiny & Management Group (Agenda item 9.2)
The committee were asked to take the paper as read.

A discussion took place lead by MBu around whether business partners should attend the temporary staffing grip and control meetings as she felt they should be in attendance to provide key information.

JH felt that at the moment the meetings should stay at a more senior level and will then move on to include the Business Partners at a later date.

CB expressed concern around capacity being an issue at the moment with Business partners, it may also be an idea to reset priorities for the Business Partners before they are included in further work.

It was RESOLVED to RECEIVE the update on Temporary Staffing Scrutiny & Management Group and the comments made.

PRC/25/173 Update on Disciplinary and Employment Tribunal cases and any high-profile disciplinary investigations (agenda item 9.3)
The committee were asked to take the paper as read.

LJ updated that feedback had been received from the committee on changing the format of the report. It will now include themes including protected characteristics rather than personally identifiable information. It will also include current tribunals.
MBu commented that it would be good to know how long the cases are taking and could start and finish dates be included from now on. IW requested a narrative on the

key cases that the committee need to be aware of. CB asked if we do anything around lessons learnt, feedback masterclasses for managers. Do we triangulate back to care groups and corporate services to learn lessons? LJ confirmed we do have lessons learnt, although we don't routinely report back to this committee.

It was RESOLVED to Receive the update on Disciplinary and Employment Tribunal cases and any high-profile disciplinary investigations, and the comments made.

PRC/24/174 Guardian of Safe Working (agenda item 9.4)
The committee were asked to take the paper as read.

MBu suggested JH meet with RM to progress the rostering issues. JH confirmed that we would be rolling out e-rostering across the Trust but the priority had been CPH
MBu offered her support to RM.
MBu commented that there was no front sheet for RM's report and this should be corrected for next time. It was suggested that JH speak to MB regarding which directorate the Guardian of Safe Working should sit in.

It was RESOLVED to RECEIVE the Guardian of Safe Working report and the comments made.

PRC/25/175 Staff Survey Update (agenda item 9.5)
JH updated that the survey had a 57% response rate which was a 5% increase on last year. Outcomes were in the same position as last year. We benchmarked above the peer group average on 8 of the People Promise values. One area we were slightly below was learning. High level analysis about care groups is favorable. JH has identified and provided data on hot spots, this is also against the 9 people promise areas. The embargo was lifted on the 7th March and data was published on 13th. JH advised that he is looking to develop two sets of analysis on care groups. One being the further granularity around people promise areas to allow care groups to work with HR BP's to identify areas to progress. Producing analysis on all questions by teams that are RAG rated to identify the areas to focus on and compare teams. Paper going to EMT that includes timelines for delivery. Staff Survey data will be incorporated to validate emerging workforce strategy.

MBu advised JH that she had not received the analysis or interpretation of the staff survey results since the embargo was lifted on the 7th March and that it was the first time she had been updated of the plans of what will be happening with the data.
JH commented that this is the first time the plan of how he will use the information had been shared.

MBu followed up with a request to JH that she required a report from him for the Execs and Board to confirm what was said today and that he should pick up with MB. MBu suggested that when the reports are received next year in January, as soon as possible the information should be release and the reports should be sent to Board. MBu requested a tabled report.

It was RESOLVED to RECEIVE the Staff Survey update and the comments made and agreed that a report would be submitted to Board.

PRC/25/176 Early Development of Workforce Strategy (agenda item 10.1)
JH presented PowerPoint Presentation.

MBu praised the strategy and encouraged JH to reference the research and evidence in the strategy. CB commented that the key is having the deliverable objectives to make it happen and that we measure it.

JH shared that this will be a five to ten year plan for the trust. Delivery will be supported by the faculty of psychological wellbeing. A full set of metrics will need to be developed to evaluate this. JH advised this will be taken to OMG and then to Board in July.

It was RESOLVED to Receive the update on Early Development of Workforce Strategy and the comments made.

PRC/24/177 Operational Workforce Plan (agenda item 10.2)
The committee were asked to take the paper as read.

Based on draft submission to ICB the committee were advised that work continues on this.

DW suggested that the plan aligned with what had been seen at FIP.

It was RESOLVED to Receive the update on the Operational Workforce Plan and the comments made.

PRC/25/178 Interim People Plan (agenda item 10.3)
The committee were asked to take the paper as read.

MBu commented that it doesn't feel complete, but this is due to the national agenda changing quickly.

It was RESOLVED to Receive the update on Interim People Plan – Update on Progress and the comments made.

PRC/25/179 Committee Annual Report Including Effectiveness Review (agenda item 11.1)

The committee were asked to take the paper as read.
LJ advised that finalisation from areas discussed today to be updated in the report after the meeting.
IW informed the committee that the effectiveness results have been received and meetings will be held with the Chairs of the committees

It was RESOLVED to Receive the update on Committee Annual Report Including Effectiveness Review and the comments made.

PRC/25/180 Review of Terms of Reference (agenda item 11.2)
The committee were asked to take the paper as read.

The committee agreed to the Terms of Reference.

It was RESOLVED to Receive the update on Review of Terms of Reference and the comments made.

PRC/25/181 Work Programme (agenda item 11.2)
The committee were asked to take the paper as read.

The committee agreed to the Work Programme

It was RESOLVED to NOTE the update on the Work Programme and the comments made.

PRC/25/182 Items to bring to the attention of the Trust Board (agenda item 11.1)

Date	18 March 2025
Presented by	Marie Burnham – Chair
Key items to raise at Trust Board	**Alert:** • Work is starting on the new national nursing job profiles bands 4-6 which may pose a financial risk to the Trust. A risk is being developed to review this. • Guardian of Safe working continues to highlight challenges with Resident doctors rostering which needs to be urgently resolved before the next intake of doctors in August. The e-rostering team to work with the medical and operational services • Workpal e-appraisal system contract has ended, and we are now using ESR system to record appraisals going forward. **Advise:** • The CPO presented a report on current activities taking place across the people directorate, this included reference to the recent financial position and changes to the system. • Verbal update on the latest position on the Staff Survey and following the ending of the embargo on 13 March a report is going to Trust board on 25 March. • The committee received a presentation from the People Promise Manager who is supporting retention initiatives across the 3 Trusts in the MHLDA collaborative aimed at supporting flexibility, stay conversations and transfer schemes. This work would now end and be incorporated into the wider development of the People/Workforce Strategy • Committee received a report on absence over the last two years as absence rates are above target to allow track and monitoring of sickness trends by the people teams. • The CPO presented an early version of the Workforce Strategy which will be discussed more widely and will come to Board in due course.

	Assure: • The temporary working group reported on the establishment of a grip and control process to support the reduction in bank and temporary staffing • Workforce IPR highlighted key areas of concerns and included some good benchmarking data. Discussion concentrated on key areas such as on Appraisal, Forensics, and Estates and facilities. • FTSUG reporting has moved to the Audit Committee, however, there still will be a link to PRC based on the new culture work to be undertaken as part of the new workforce strategy. • The interim plan for the people directorate was presented at year end with activities concluded and evidence of good work on inclusive recruitment with clear actions for next year. **Risk Register** • Discussion took place on risk 1887 relating to FTSU and whether this should go to the Audit Committee it was recommended that the wording of risk be reviewed.
Approved Minutes of previous meeting for receiving	21 January 2025

It was RESOLVED to NOTE the update on Items to bring to the attention of the Trust Board and the comments made.

PRC/25/183 Agree redactions for minutes going to public board (Agenda item 11.3)

It was RESOLVED to NOTE the redactions for minutes going to public board and the comments made.

PRC/25/184 Date and Time of Next Meeting (agenda item 13)

16th May 2025 2pm

It was RESOLVED to Note the date and time of the next meeting.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Quality & Safety Committee
Tuesday 8 April 2025
9.00 – 12.00
MS Teams meeting

Present:	Margaret Kitching (MK) Nat McMillan (NM) Mike Ford (MF) Darryl Thompson (DT) Dr Subha Thiyagesh (SThi) Amy Hartley (AH) Adele Fox (AF) Yvonne French (YF)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Medical Officer Deputy Director of Nursing, Quality & Professions Chief Operating Officer Associate Director of Legal Services
Apologies:	Julie Hall (JH)	Deputy Director of Corporate Governance
In attendance:	Sarah Harrison (SLH) Sam Johnson (SJ) Donna Lyon (DL)	PA to Chief Nurse / Director of Quality & Professions Assistant Director of Nursing, Quality & Professions (item 6) Reducing Restrictive Practice Clinical Advisor (item 6)
Observing	Nil	

QSC/25/1 Welcome, introduction and apologies (agenda item 1)
Margaret Kitching (MK) welcomed all to the meeting and apologies were noted as above, and with quoracy, the meeting could proceed.

QSC/25/1 Declarations of interest (agenda item 2)
The Committee noted that there were no further declarations over and above those previously made.

The Quality & Safety Committee NOTED the declaration.

QSC/25/3 Minutes from previous Quality and Safety Committee meeting held 11 March 2025 (agenda item 3)
The minutes of the 11 March 2025 were approved as an accurate record.
MK added for context that the discussion in the last meeting where it was agreed to extend the meetings to three hours will be to try to work through the agenda in two and half hours, leaving 30 minutes grace time should this be needed for further detailed discussions.
Mike Ford (MF) suggested that adding timings to the agenda could be a helpful addition given the large agenda of this Committee and this was agreed by the group.

With all of us in mind.

Action: Sarah Harrison

Also, on page five of the minutes MF queried as to whether there was a missing action in relation to the Quality Account being aligned with the Trust Strategy. However DT advised that the Quality Account is on the workplan and will be brought back to the Committee in due course for further discussions and would not be stepped down or merged without input from this Committee.

On page seven of the minutes in relation to the Clinical Audit aspect of the Quality Account being taken through Audit Committee via the Quality Account, this is no longer on the Audit Committee agenda as the Quality Account no longer is sent to the external auditors. MF has asked for this to be placed back on the Audit Committee workplan going forward and DT will also flag this nationally to colleagues and liaise with Izzy Worswick, Assistant Director Corporate Governance regarding the Audit Committee Workplan.
Action: DT

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 11 March 2025 as a true and accurate record.

QSC/25/4 Matters arising from previous Quality & Safety Committee meetings and action log (agenda item 4)

The action log was reviewed, and the following was noted:

- **Matters arising**.
- No matters arising today.

- **Action Log**

- **QSC/24/239 Complex Clinical Incident Report. Plastic Bags / Searches**
  There is an update on the agenda today which is a month early due to a discussion at Private Trust Board. A detailed conversation will be had in the private section of this Committee due to person identifiable information.
- **QSC/24/239 Complex Clinical Incident Report. Thematic presentation.**
  DT noted that some stand-alone incidents come through for the private section of the Committee and as this becomes more embedded any emerging patterns will be noted. An updated timescale of May will be added.
- **QSC/24/230 Committee Annual Plan, ToR and Survey**.
  MF advised that he has raised this with Izzy Worswick and training will be considered for new members of Committees. Complete.
- **QSC/24/225 Quality Regulatory Oversight Update.**
  DT advised that some information is still being collated and that pressure ulcers will be added for the next update.
- **QSC/24/210 IPC BAF. FFP3 mask Fit Testing.**
  A paper has been prepared for the Executive Management Team (EMT) meeting with an updated denominator of colleagues requiring FIT testing. Colleagues have been asked for a position of compliance and time frame. To remain action log until a further is available.
- **QSC/24/211 Consideration of ICB Colleagues attendance at Committee.**
  This has been discussed at Trust Board. DT to contact senior colleagues at the ICBs to agree a formal request to the Chair of the Trust.
- **QSC/24/193 Complex Clinical Incident Report.**
  MF advised that work has started however consideration is needed about the timetable for this. Yvonne French (YF) has undertaken some work and in turn discussed with DT and Subha Thiyagesh (SThi) and Adele Fox (AF). The paper is in the private section of the Committee today, however further refining will be undertaken. Complete.

- **QSC/24/194 Serious Incident Update.** Search legalities.
  DT made a request to move this date to May. Amy Hartley (AH) has a focus on this issue. Subha queried whether this should be discussed in the private section of the committee.

Matters arising / actions from Trust Board:

- NIL

It was RESOLVED to NOTE the changes to the action log and AGREE to close all appropriate actions.

QSC/25/5 Review of Committee related risks – update following Board discussion (agenda item 5)

DT advised that this was a routine update of the risks which are held by this Committee which have been reviewed by all the Executive Director Leads. It was noted that more detail has been added at the request of the Committee to show the process that leads to the decisions made if a risk rating or descriptor is changed, or not.

DT noted the following:

A proposal to merge RISK ID 773 and RISK ID 812 which both focused on external partners.

A change to RISK ID 695 where the word transition has been replaced with ambition.

RISK ID 1820 – proposed changes to the wording.
DT informed that this was discussed in EMT and that the Executive Trio and Jon Head, Chief People Officer met to discuss the risk as there were multiple factors to consider regarding culture. The revised version states that "The risk that a negative culture emerging in a team may have a detrimental impact on patient safety and quality of care." This will be measured by the use of temporary staffing, supervision rates etc. NM noted the People and Remuneration Committee (PRC) will be undertaking the leg work around the controls which that needs to be strengthened together with triangulation. In relation to this risk and from a quality perspective the Committee felt it was aligned appropriately.

It was agreed that this risk now makes more sense and the Committee were happy with the revision of this and the other risks changes noted above.

MF noted RISK ID 1614 and the proposal to downgrade this and queried as to whether this had been to EMT. DT and AF confirmed that it had. MF pointed out that on the report the risk score had not been altered to reflect this and therefore DT will inform the Corporate Governance Team.
Action: DT

It was RESOLVED to RECEIVE the update.

QSC/25/6 Staff / Team Story (agenda item 6). The Reducing Restrictive Physical Interventions (RRPI) Team

DT introduced the Team attending Committee today. Donna Lyon, Reducing Restrictive Practice Clinical Advisor, and Sam Johnson, Interim Assistant Director of Nursing, Quality & Professions. They were in attendance at the request of the Committee Chair in relation to

reducing restrictive practice to give an update on their work and achievements to date. A presentation had already been circulated to the group and was also shared on screen.

The group were very impressed with the team and their achievements.

AF thanked DL and SJ for joining the group today and noted how good it was to see the journey that the team had been on. AF noted the higher-level incidents that are being monitored however asked whether the lower level incidents of restraint showing in one ward or area that have emerging risks are also being monitored for themes, to try to prevent them from escalating. DL confirmed that the specialist advisors within the team monitor Datix and where there are any clusters of low level incidents, in-reach work is offered. The team are wanting in reach work to become common practice for teams given the frequency and intensity of some incidents.

AF asked how triangulation with the integrated performance report's (IPR's) information could help to identify an emerging risk. DL advised that a review was undertaken last year in relation to understanding any potential links between incidents and staffing levels etc, but no correlation was identified. The team are considering undertaking this report on a quarterly or six-monthly basis going forward. SJ also added that a positive reporting culture will help to identify lower level holds and the in-reach work is a key support.

AF stated that the updated seclusion policy will be complete next year but given the work that has already taken place and has been implemented whether this would be included in the current policy. DL confirmed that they are including the 72-hour reviews in the policy and once the Safety Pods (bean bags that can support safe patient care during times where de-escalation and restraint is being considered) have gone live across the Trust and this can also be added.

SThi also echoed how helpful the presentation was and noted the various conversations that have already taken place on this issue. In terms of the Safety Pods, SThi recalled that at Newhaven last year the reduction could already be seen and wondered why this hasn't gone live across all wards as yet and asked whether there was anything that QSC can do to help with this roll out. DL explained that Newhaven had a different type of Safety Pod where a different exit technique is used. Version 3 is the type used on Newhaven which is a larger pod. SThi also asked in relation to protected characteristics and data cleansing and whether we have started to see the impact of this triangulation of who would be more likely to be restrained. DL confirmed that the data is being received through the RRPI Trust Action Group (TAG) which is being given by ward area / individuals to enable to full drill down. Nothing within the data suggests that the Trust is an outlier. SJ added that the data is considered by the Specialist Advisors and anything that relates to protected characteristics, the in-reach work will help with.

AH highlighted the need to strengthen the links to different inpatient areas and the specialist advisors, this is so important given the differences between clinical practice to the real environment and continued training and learning will influence culture and practice. AH reiterated our reporting, how an open culture enables the deep dives and that the Trust adheres to the Code of Practice and the Use of Force Act, which is very clear about the definitions on what needs to be recorded as prone restraint, physical restraint and clinical care. AH added that the team are a testament to this organisation that this line has been upheld and that the Trust adheres to the Code of Practice and the Use of Force Act.

NM said how useful this presentation was having visited the team previously and it was great to see the improvement and focused work that has been undertaken. NM asked what the ultimate outcome of the training would be. DL advised that in terms of prone restraint, this needs to remain a person-centred approach and listening to the service user's needs,

however, the use of safety pods and to eliminate / reduce any type of restraint would ultimately be the goal.

MF highlighted that there is an indication from other organisations that they do not use prone restraint and that SWYPFT was an outlier. DL informed that the team have had meetings and collaboration days with other organisations where each other's techniques have been considered and in particular the seclusion exit.

DT advised that we benchmarked higher in our use of prone when the CQC were here in around half of services, and benchmarked lower in the other half.

MK added any restraint is trauma induced, in particular prone restraint and the Trust is trying to be a trauma responsive organisation with a main aim of reducing this. MK would like the Exec Trio to support the incredible job that the team are doing and give any support required.

QSC/25/7 Management of Plastic Bags (agenda item 7)

DT advised that this item was at the request of the Committee and more detail will be given on a specific incident within the private section of the agenda.

The report contains an update in relation to the activity since an incident occurred, including learning and changes in practice that have been put in place. It was noted that the assurance process will be taken in the private section of the agenda due to confidentiality.

NM asked in terms of what has been put in place now how would we know if something happened again and are the checks that are in place robust enough. DT advised that he is confident in the systems and processes that have been put in place and is aware of any reporting of plastic bag incidents on Datix, which in turn informs that this is very much on our staff radar as a banned item.

AF acknowledges that the risk can never be truly eliminated, however mitigations are put in place as much as possible. AF advised that on meeting staff and asking what the prohibited items are, the first response she is getting is plastic bags and lighters which is reassuring that it is at the forefront of minds. The challenge the staff have is the search policy especially on mental health wards. This is being reviewed.

DT advised that it is important to note when there has been a breakdown in processes which has enabled a plastic bag to be taken to a ward or when a plastic bag has been secreted by a person on to a ward, it is the latter which is difficult to be able to offer assurance that that it could never happen.

It was RESOLVED to RECEIVE the update

QSC/25/8 Executive Perspective on Quality (CMO/CNO) - Update Paper Inc update of topical & legal risks, escalations, quality impact assessment (QIA)/equality impact assessment (EIA) reviews / escalations, QIA / Quality Account (agenda item 8)

The paper had been circulated to all members and was taken as read.

Headlines of topics discussed:

- There is a focus on Quality Impact Assessment (QIA) for all Value for Money Schemes as the Trust enters a new financial year.
- Quality Account Working Draft which is on the agenda for the Committee today.

- Feedback from West Yorkshire Clinical and Care Professional Forum.
- Feedback on relevant policies that have been to EMT.

It was RESOLVED to RECEIVE the update.

QSC/25/9 Quality Regulatory Oversight Update (agenda item 9)

This paper was taken as read.
DT advised that this a routine Quality Regulatory Oversight update which will now alternate with the Quality Assurance System update going forward.

- There have been seven enquires from the Care Quality Commission (CQC). Five of these were for acute mental health wards, one for Cheswold Park Hospital (CPH) and one for older people's inpatient wards.
- There was a CQC Mental Health Act Visit to Crofton Ward which included several positives, as well as some actions.
- A section on pressure ulcers has also been included.

MK noted that record keeping seems to be mentioned in most visits and raised this as a concern and key area for our Trust, but acknowledged it is for other trusts also. DT informed the Committee of a new improvement group and audit programme which is being put in place and the detail will be added to the Quality Account. This will also be reported more frequently into this Committee and DT acknowledges that record keeping is a key part for any provider. It will always be a focus of any CQC visits.

MF noted that care plans and risk assessments have both been areas of focus on the IPR for a number of years and overall has seen an improvement, however notes the above where the CQC will always have a focus on this even with the small sample taken.

AF advised that on looking at the last IPR report and the deep dive into this, it is clear that the team leaders are aware of what has been missed and why it has been missed. On completion of audits and reviews within the Care Groups, the clinical teams advised on what has been omitted and the reasoning behind this.

YF informed the Committee that the CQC only review a small sample of records when they undertake MHA visits also.

DT will speak to the Quality Governance Team to see if they can ascertain any organisations where records keeping is not an issue to see their systems and processes and DT will also ask within his networks.
Action: DT

AH will also check this within her networks also for both CQC and MHA.
Action: AH

It was RESOLVED to RECEIVE the Quality Regulatory & Oversight Update

QSC/25/10 Quality Account Working Draft Update (agenda item 10)

DT presented the developing Quality Account as a working draft.

MK suggested the group might want to send any comments through to DT given the size of the document.

NM noted the working draft however given the earlier conversation around RRPI would like consideration to be given to being more forthright around the Trust's ambitions of zero prone.

NM also made a broader comment around quality improvement and that sometimes the improvements that are being made don't always make it through to this Committee and in turn Trust Board aside from in the Quality Account and felt an opportunity could be missed here.

MK commented that the recording keeping and audit cycle could be made clearer and agreed with NM in terms of RRPI.

Further comments to be sent back to DT and Sarah Whiterod, Associate Director of Nursing, Quality & Professions by 22nd April 2025.
Action: All

It was RESOLVED to RECEIVE the Quality Account Working Draft update.

QSC/25/11 Patient Experience Update (agenda item 11)

This report was taken as read and DT gave highlights to the Committee:

- Development of age appropriate friends and family test card.
- Work to capture the experience of young people admitted to adult wards.
- Development of patient experience surveys across remaining service lines.
- Development of a volunteer role to help collect patient feedback and to support complainants.
- Work to better identify and understand equality and diversity of people making complaints.
- Changes to monitoring of complaint timeframes to look at working days from open to close.
- Improving the number of complaint responses provided within six months.
- Improving the quality of complaint investigations and responses. The Trust has recently been involved in a 360 audit around complaint management.

MF queried the meaning of a "was not brought" project. DT confirmed that this is in relation to a child or young person "not being brought" to an appointment by a parent or carer.

NM would like to see comments included directly from patients / hearing their voices within the highlight reports as this is very powerful.
Action: DT

It was RESOLVED to RECEIVE the Patient Experience update.

QSC/25/12 Care Group Quality and Safety Report (agenda item 12)

The paper had been circulated to all members prior to the meeting and was taken as read.

DT gave a verbal overview of:

- The continuing focus on Care Closer to Home, and the potential quality and experience impact of the work to maintain low out of area bed usage.
- The Trust's successful application to be part of a national improvement programme focused on patients who are clinically ready for discharge.

- The accreditation against national standards of reducing restrictive physical interventions training at Cheswold Park Hospital and across the wider Trust.
- An update on the Cheswold Park Hospital implementation plan, including the move to the Trust's electronic clinical record system, SystmOne.

AF added in terms of care closer to home and the discussions last time around the unintended consequences. In January and February, the inappropriate beds have not been used due to estates work taking place.

In terms of CPH we are on target to potentially have 80 people admitted by the end of April.

SThi advised that YF and her team have undertaken a significant piece of work to move all the legal paperwork onto SystmOne and are supporting the teams to navigate the system in CPH.

The Care Group Quality and Safety Report was RECEIVED.

QSC/25/13 Internal Audit Reports (as appropriate) (agenda item 13)

Nil.

QCS/25/14 Clinical and Strategic Approach to LD Improvement (agenda item 14)

This report was taken as read and was noted to be self-explanatory.

SThi highlighted that the report contained a detailed response to STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines) which has been mentioned in Trust Board. Also highlighted was the work that the Horizon Centre have done in terms of quality improvement work and working with the service users. The engagement and joint working with colleagues has had a significant impact on the reduction of violence and aggression.

NM noted all the work taking place but could not see the data included to provide a level of assurance, and having the supporting data for this report would be beneficial as an extra level of assurance.

AF and SThi will check with the team and also in the IPR.
Action: AF and ST

The Clinical and Strategic Approach to LD Improvement Report was RECEIVED and NOTED.

QSC/25/15 Reports from Formal Sub-Committees (agenda item 15)

Updates were received and taken as read and it was noted that there is a new quarterly sequence of the AAA reports for the Committee.

MF queried what the role of the clinical governance group is and will speak too Darryl.
Action: DT and MF

The Committee RECEIVED the updates.

QSC/25/16 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 16)

Alert:

- Committee received a report on the management of plastic bags within mental health inpatient settings, including the Trust's learning and action with regards to the oversight and management of plastic bags. Clinical aspects were discussed in more detail in the private section of the Committee.
- Clinical record keeping was discussed, noting the feedback contained within such as CQC mental health act inspections that there needs to be improvement. Also discussed the need to align clinical record keeping standards with the Audit Committee.
- Prone restraint and our reporting of this in the annual Quality Account. Agreed the need to be more explicit with regards to the Trust's ambition for zero prone restraint. Agreed to take a quality improvement approach to this and to identify metrics to track progress month on month.

Advise:

- Committee received a presentation from the reducing restrictive physical interventions team, detailing the overall ambition to reduce use of seclusion, promote de-escalation of incidents and reduce restraint, including prone. This was presented in line with the expectations of the Use of Force Act.
- Committee members reviewed an early draft of this year's Quality Account. Agreed to explore how to inform Committee and Board members of the examples of quality improvement that are contained within

Assure:

- The Committee received an update on the Learning Disability Service's improvement programme. Progress was noted, with a recommendation that more data to evidence that improvement would be welcome in any future reporting.
- Progress at Cheswold Park Hospital was noted, including the achievement of the required number of admissions by the end of March 2025.
- Pressure ulcers – Committee members agreed to add a quarterly update and an annual report to the workplan.
- The risks aligned to the Committee were reviewed. Committee members noted the current risks scores and discussed the relevant Trust-wide corporate / organisational level risks. Committee members were assured that the current risk level, considering Trust risk appetite, given the current environment is appropriate. Members also noted the proposed change to the risk wording of risk 1820, noted the proposed change to the risk wording of risk 695 and noted the proposed change to the risk wording of risk 812 and merger with and closure of risk 773.
- Minutes of 11 March 2025 were reviewed and approved as a true record.

The Committee RECEIVED and NOTED the above points and will CONSIDER which to bring to the attention of Trust Board / Committees.

QSC/25/17 Risk Register review (agenda item 17)

Assurance was given that all risks have been reviewed and addressed, and none of the conversations today would trigger a review of the rating of any of the Committee's risks.

QS/25/18 Work Programme (agenda item 18)

The Committee agreed to add an annual report and quarterly AAA to the workplan for pressure ulcers.
Action: SH

QSC/25/19 Date of next meeting (agenda item 20)

13 May 2025 – face to face.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Mental Health Act Committee Meeting
Tuesday 4th March 2025
Virtual Meeting via Microsoft Teams

Present:	Erfana Mahmood (EM) Gary Ellis (GE) Margaret Kitching (MK) Subha Thiyagesh (ST) Darryl Thompson (DT)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Medical Officer (Lead Director) Chief Nurse / Director of Quality and Professions
Apologies:	Chris Lennox (CL) Carly Thimm (CT)	Director of Services, Adults and Older People Mental Health Mental Health Act/MCA Senior Manager (Trust Wide)
In Attendance:	Julie Carr (JC) Nancy Cartwright Yvonne French (YF) Claire Wilkinson Gemma Williamson (GW) Sarah Burns (SB)	Clinical Legislation Manager Chair of Independent Associate Hospital Managers Associate Director of Legal Services Mental Health Lead for Quality, Governance and Performance Mental Health Act/MCA Manager (CPH, C&K) PA to Chief Medical Officer/Minute Taker
Observing	Mark Brooks	Chief Executive

DRAFT

MHAC/25/01 Welcome, Introduction and Apologies (Agenda item 1)
The Chair, Erfana Mahmood (EM) welcomed everyone to the meeting and the apologies were noted

The meeting was deemed to be quorate.

EM outlined the meeting protocols and etiquette. The meeting would be recorded for transcription purpose and will be deleted once minutes have been agreed.

MHAC/25/02 Declarations of Interest (Agenda item 2)
The Committee noted that there were no new declarations of interest.

MHAC/25/03 Act in Practice – Update on MHA Bill (Agenda item 3)
The presentation by JC provided an update on the Mental Health Act Bill.

JC explained that there were a number of drivers that the Government have requested for a review of the Bill, these areas relate to:

With all of us in mind.

- Increase in detention rates across the whole system
- Blockages in the judicial system which relates to the transfer of patients between secure services and prison
- Disproportionate use of the action for ethnic minority groups
- Changes to provision for people with learning disabilities
- Amendment of the MHC introducing LPS

The aims of the new MHA Bill will be to:

- Lower rates of detention for people with psychiatric disorders
- Improve patient and prisoner flow
- Greater say in a person's care and treatment
- Address racial disparity
- Limit the use of the act for those who have learning disabilities and autism
- Achieve a closer aliment with the MHA
- Address health inequalities

The Bill will be presented for a third and final time to the House of Lords which will be the last opportunity for any further changes to be made, it will then be passed though to the House of Commons for a final reading, then follow through for royal assent with a timeline for this being towards the end of 2025.

The four principles have been agreed which are:

- Choice and Autonomy
- Least Restriction
- Therapeutic Benefit
- The person as an individual

JC explained that the only point being argued at this stage is to whether these will sit on the face of the Act or whether they will remain within the code of practice.

JC explained that in order to prepare for the implementation of the Bill, a number of workplans have been established and recognise that there will be an impact on training and on the workforce and review of current policies and procedures.

It will be a phased implementation over 6 to 8 years.

ST explained that the new Bill is focusing on reducing the number of detentions in the community and on the wards; however there remains current concerns shared by other organisations and public inquiries, which the trust still needs to be cognisant of and ensure that patients are appropriately detained for those who require it, taking into consideration of the risk to themselves and the general public.

ST stated that the implementation of the Bill would have a significant impact on the trust's resources and workforce and how the trust would need to prepare for the upcoming changes. Work is being carried out in relation to detention numbers, quality and via quality improvement work on the learning disability wards

DRAFT

JC confirmed that there are issues around the implementation as there are not enough people to support the tribunal panels, insufficient Second Opinion Doctors to meet the current demand though there is a proposal to introduce an option for the Second Opinion Doctors to carry out remote assessments rather than attend in person.

EM stated that this will be discussed further at Board and will continue to keep the MHA committee updated on progress.

It was RESOLVED to RECEIVE the presentation from the Update on the MHA Bill.

MHAC/25/04 Minutes from previous Mental Health Act Committee Meeting held on 3rd December 2024 (Agenda item 4)

There were no further amendments or corrections to the minutes from 3rd December 2024.

It was RESOLVED to APPROVE the minutes from previous Mental Health Act Committee meeting held on 3rd December 2024.

MHAC/25/05 Matters arising from previous Mental Health Act Committee meeting held on 3rd December 2024 (Agenda item 5)

Committee agreed that there were no matters arising from the previous meeting, other than those on the Matters Arising action log.

- MHAC/24/53a - EF confirmed that this had been actioned and will be outlined in today's meeting. Nothing further to add. It was agreed to mark as completed and the action closed.

- MHAC/24/52a – This will be presented at the next committee meeting in June 2025. Action to remain until report presented.

- MHAC/24/35a - This will be presented at the next committee meeting in June 2025. Action to remain until report presented.

MHAC/25/06 Care Quality Commission Visits (Agenda item 6)

MHAC/25/06a Visits and Summary Actions Quarter 3 including Care Group Assurance Report (Agenda item 6.1)

Over Quarter 3, there had been 3 multi-site visits, these have been to the seclusion rooms at Cheswold Park, a cluster of female working age adult wards, and a patient focus group, additionally there has been an individual ward inspection at Cheswold Park.

There was one report due for submission in Quarter 3. Further reports have been received for completion in Quarter 4 these will be presented at the next committee in June 2025.

DRAFT

Across the trust 29 of 51 actions that were open over Quarter 3 have now been closed, with a 22 actions remaining open at the end of Quarter 3, with 11 of these not due for completion within Quarter 3.

All environmental factors raised are currently being dealt with through relevant workstreams. The ligatures concern raised in Quarter 2 has now been resolved and closed.

MHAC/25/06c Mental Health Care Group Action Progress (Agenda item 6.3)

CW confirmed that the Mental Health in-patient service has received 3 MHA visits over Quarter 3. These visits were to Clark, Elmdale, and Nostell and formed a themed inspection of working age adult female acute wards.

The visits generated the following actions:

- 18 actions in total, including the standard action for each ward of sharing findings with service users.
- 9 actions raised on 2 or more wards encompassing 5 themes: - Care planning, Interpreter access, access to gardens/courtyards and staff interactions
- 5 action themes were also identified on previous visits: - Seclusion reviews, care planning, staff interactions, interpreter access and treatment certificates.

CW explained that from the actions identified in relation to care planning, the trust has launched the My Care and Safety Plan with an emphasis on the service user and carers voice and views and what they need support with. Producing a document that is service user friendly. The introduction of “My Ward Round” form which encourages patients to share how they feel their progression has been over the week and supporting them as to what they may need from upcoming ward rounds in relation to care and treatment. This has also been incorporated onto SystmOne and will cover all in-patient wards. Work is currently in progress developing the in-patient care planning standards with each ward having in place a carer lead, supporting carer, and family engagement.

CW explained that actions identified in relation to interpreter access are being addressed through the change of interpreting and translation provider changing to the Work360 service. Senior leadership will have oversight of the transition between service providers, and training is being provided to staff on how to access. Staff are being encouraged to submit a Datix if any issues arise which will help to identity any challenges and to escalate appropriately.

CW explained that from the actions identified in relation to access to courtyards and gardens some of the areas are locked with supervised access that is based on an individual risk assessment. A bid has been submitted for improvement works to the courtyard at the Oakwell centre and the Priestly unit to review whether these areas could be made unsupervised and open access made available. Service user feedback on this area is being sought though community meetings.

Further discussion will take place though the care group regarding how to capture when service users are accessing outside areas and whether this is available to them.

DRAFT

CW explained that the actions identified in relation to staff interaction and attitude, is an important area, work aims to ensure that the service users are first and, in the centre, and receive positive engagement. Currently in the service is in the process of developing a standardised ward induction competency checklist with an emphasis on the trust values. Any issues raised are monitored by the ward leadership teams and addressed in a timely manner. Links with the trust bank operational manager have been made to support highlighted any issues relating to the temporary workforce. This action is monitored by matrons during wards visits, during monthly quality audit discussions with service users and via In-patient Quality & Performance meetings.

MK expressed concerns about repeat actions being identified, particularly record keeping which is identified across a number of areas, collaborative care planning, medical seclusion reviews and treatment authorisation certificates which are out of date and the area of respect and dignity.

JC confirmed that the respect and dignity issues relates to an overarching matter of a variety of points that have been raised around staff attitudes observed by the CQC, and with each case identified individuals have been approached and work continues to make improvements for the services users in the trust's care.

ST stated that these are themes which are fedback and addressed via the quality improvement initiatives and though the work programmes. In regard to seclusion, the patient safety team are currently investigating on how this can be improved.

EF clarified that the committee focuses on the statutory compliance and record keeping that relates to MHA though areas are connected to a trust wide issue that need to be addressed within other committees.

MK suggested that record keeping training should be mandatory to demonstrate that the trust is engaging and adhering to the patient experience standards, though consideration is required to determine what would help staff to remain consistently complainant with record keeping requirements.

DT confirmed that there are several streams of work taking place, within the Clinical Safety Design Group, as with the record keeping now being via an electronic system, understanding that systems are not always user friendly, and the group will be focusing on how to make it as easy as possible for staff to record details accurately. Each care group have their own clinical record keeping checks though a focus group, led by the Quality and Governance team, will be established to look at trust wide clinical record keeping, the consistency of audit, a confidence knowledge of standards across the organisation.

ST stated that the with updated MHA Bill, the scope of work will increase and will be challenging for the administration element, with consideration for potential digital solutions to assist with responding to the changes.

MHAC/25/06b Cheswold Park (Agenda item 6.2)

DT confirmed that there are clearly areas of learning, though the general perception from the CQC recognised the progress since the trust took over and the CQC feedback to the NHSE was that the trust was open and responsive to activity.

DRAFT

It was RESOLVED to RECEIVE the Visits and Summary Actions Quarter 3 including Care Group Actions Assurance Report.

MHAC/25/07 Feedback from Local Partners (Agenda item 7)
MHAC/25/07a Partner Engagement Report (Agenda item 7.1)

There is continued benefit from the range of engagement meetings and the support being offered to the acute trust including improved understanding of the application and limitations of MHA, a reduction in errors on documentation and greater engagement in terms of contact with the Mental Health office when seeking advice

The service level agreements are due for renewal in March 2025. For each of the acute trust partners, the trust offers support for the administration of the MHA.

Positive engagement and improvement between CHFT and statutory advocacy where children are admitted to the acute trusts.

Continue to have meetings and provide support with psychiatric liaison who are experiencing issues with people in the acute hospitals under the MHA

The CQC have started a focus engagement group with advocacy leads to enable them to have an input in the direction of the CQC visit plans.

Raised awareness for how patients who lack capacity can apply for discharge which has been an issue previously with tribunal service and how to make applications to support these patients with assistant from advocacy.

Further information has been added to the intranet for clinical staff addressing how to access advocacy and ad hoc sessions being provided for staff to increase understanding of the service and support training of new staff.

EF proposed outlining in the report any challenges that may transpire.

It was RESOLVED to RECEIVE the Feedback from Local Partners and the Partner Engagement Report

MHAC/25/07b Independent Hospital Managers Feedback (Agenda item 7.2)

NC reported very good on-going working relationships with the administrators.

NC confirmed that a meeting has taken place with the Forum chairs at Cheswold Park. Different practices between SWYT and Cheswold Park have been noted and work is on-going to integrate the practices.

Observation will take place for different hearings to help identify common practices.

NC acknowledged that due to the integration there may be some hospital managers who may wish to step down and CT and GW will be assisting with a recruitment programme.

DRAFT

With the requests for hearings and tribunals rising, EF recognised that the hospital managers are working hard to meet demand and appreciated their ongoing support.

It was RESOLVED to RECEIVE the Independent Hospital Managers Feedback.

MHAC/25/08 MHAC Annual Review (Agenda item 8)
MHAC/25/08a Annual Report (Agenda item 8.1)
The report presented at committee was still in draft format though content had been agreed.

The membership attendance is to be checked and finalised.

The updated draft report will be circulated to the Chair, Non-Executive and Executive Directors for final comments.

No further comments were received in relation to the MHAC annual report.

The annual report will be submitted to Trust Board on 25th March 2025.

MHAC/25/08b Terms of Reference (Agenda item 8.2)
No further comments in relation to the Terms of Reference were received.

The Terms of Reference were approved.

MHAC/25/08c Work Programme (Agenda item 8.3)
No further comments in relation to the Work Programme were received**.**

The Work Programme was approved**.**

MHAC/25/08d Self-Assessment (Agenda item 8.4)
EF recognised that some committee members had only recently joined the committee so had limited experiences in order to respond to some of the questioned raised through the self-assessment survey.

It was RESOLVED to RECEIVE the MHAC Annual Review, the Terms of Reference, the Work Programme and the Self-Assessment.

MHAC/25/09 Risk Registers (Agenda item 9)

MHAC/25/09a Consideration of the items from the Organisational Risk Register (Agenda item 9.1)
MHAC/25/09b MHA Committee Risk Register (Agenda item 9.2)

EF explained that whilst the ORR does not identify the MHA Committee as the lead for any identified organisational risk, the MHA committee considers the organisational risk register as a whole to identity whether there are any risks that may have an impact for the MHA or MCA.

Following the last committee meeting, JC highlighted that risk 1956 has been graded at amber, above risk range.

DRAFT

JC reported that there were no recommendations to stand down any of the previously reported or include any new risks.

EF questioned the risk in relation to Approved Mental Health Professional (AMHP) availability, marked as red. The AMHP services are the responsibility of the relevant Local Authority. JC confirmed that on occasion the local authority were not able to provide a 24-hour AMHP. At these times the relevant AMHP service have given the trust notice of the temporary closure. All MHA assessments have been completed in a timely manner.

DT confirmed that ongoing conversations take place with local authorities in regard to AMHP availability.

No further comments were raised by the committee.

It was RESOLVED to RECEIVE the Consideration of the items from the Organisational Risk Register and the Mental Health Act Committee Risk Register.

MHAC/25/10 Statistical information use of the MHA 1983 and MCA 2005 (Agenda item 10)

MHAC/25/10a Performance Report – Monitoring Information, Quarter 3, October to December 2024 (Agenda item 10.1)

An increased in use of Section 2 and Section 3 of the MHA which is inline nationally was noted, as was the percentage of people who are admitted subject to the MHA.

A reduction in the use of Section.5(2) was highlighted.

A high rate of internal transfers over Quarter 3 was considered, however assurance was provided that no appeals, hearing or tribunals have been adversely affected or impacted, as a consequence of transfer activity. Patient rights have been upheld.

Compliance rates with quality improvement projects remain at a good standard specifically of the recording and giving of patient rights and the recording of capacity assessments.

There were 4 CQC reportable deaths over Quarter 3 which is usually high, although all were as a consequence of natural causes. All statutory notifications required by HM Coroner and the CQC have been completed. No concerns have been raised.

EF inquired as to how often physical health check are carried out on patients and if a patient is extremely unwell would they be transferred to a more appropriate hospital for treatment. CW confirmed that the physical health check is around the patient's individual needs which would be discussed at the multidisciplinary team meeting and minimum check would be once a week. The use of National Early Warning Score (NEWS2) to assist with the assessment and escalation of a patient's physical health.

DRAFT

Work had been carried out recently for a visual A to E assessment tool which allows staff to carry out an assessment from a distance if a patient is refusing to have physical observations. Where attendance at the Acute Trust or other health appointment is required, this is supported by ward staff and informed by risk assessment.

GE outlined from the report that the fastest rate of increase in the use of the MHA (Part 2) was seen in Barnsley with the trend line showing an increase rate of 10% over 2 years. JC suggested that this may be associated to the use of single bed state, rather than a local issue.
EF requested for clarification on this point.

ACTION: Julie Carr/ Claire Wilkinson

DT confirmed that when a bed is required it will be identified as to where within the trust wide bed base it can be located and where the patient can be admitted.

MK described that there are some significant differences in deprivation indices in Barnsley which may be an element to explain the increases.

It was RESOLVED to RECEIVE the Performance report – monitoring information October to December 2024.

MHAC/25/10b Cheswold Park Care Group Performance Report (Agenda item 10.2)
EF confirmed that at the Quarter 1 2025/26 committee, the report will be incorporated into the main performance report This was agreed by the committee.

One patient was transferred to another trust in West Yorkshire as a return to their home area.

No new admissions were received throughout Quarter 3.

MHA detentions will be recorded on SystmOne from 1st April 2025. GW confirmed that the teams had gone through all of the patient records and scanned documentation in preparation for the system to go live.

It was RESOLVED to RECEIVE the Cheswold Park Care Group Performance Report

MHAC/25/11 Audit and Compliance (Agenda item 11)
MHAC/25/11a Annual S.17 Leave Compliance Report (Agenda item 11.1)
The scope of this report is for Section 17 leave that had been cancelled for those patients whose only leave option is for escorted leave. This quality improvement programme does not currently include Cheswold Park activity.

The annual review identified improved rates of access to escorted leave within both forensic settings and mental health care groups with high levels of compliance.

It was proposed that next year the report should be extended to include staff responses and the work with the care groups following the views raised to CQC during MHA ward inspections.

DRAFT

MK remarked as to whether some of the reasons for leave cancellation should be included within the figures, for example unit lockdown or a patient being unwell, was this a mandatory requirement for these categories to be recorded. YF confirmed that following a quality inspection from the CQC, comments were made within the report referring to the recording of the reasons as to why leave was cancelled, and the trust is required to evidence the cancellations in a written format. This data is also discussed within the clinical groups.

It was recommended to continue to include the report on the annual work plan and continue the monitoring and regular reporting through the performance report.

It was RESOLVED to RECEIVE the report and ACCEPT the recommendations.

MHAC/25/11b Consent to Treatment Review Report (Agenda item 11.2)

It is a requirement of the MHA 1983 code of practice for the approved clinician in charge of treatment to make a full record of the patient's capacity to consent to the proposed medication treatment plan. Additionally, they are required to make a record of information the patient of the outcome of the Second Opinion Appointed Doctors (SOAD) decision, unless it has been determined that this information should not be shared. Where not to be shared a record of the reason should be made in the clinical notes.

The consent to treatment quality improvement does not currently include Cheswold Park activity.

Compliance for the recording of capacity assessment has risen from 23% as the baseline in 2022 to 99% in 2024.

The recording of SOAD outcomes was introduced to the quality improvement programme for consent to treatment in this report. A prompting system was established by the MHA administration team with a compliance rate being established at 92%.

The MHA Office prompt systems have been well received by medical staff

The recommendation for next steps of the quality improvement project for the recording of capacity assessments is to review the quality of the assessment records over the next 12 months though this will require a consultant psychiatrist to agree to work on this project. The recommendation was supported.

It was recommended to retain the annual consent to treatment report on the MHAC workplan to provide continued assurance of embedded routine practice was accepted.

It was RESOLVED to RECEIVE the report and ACCEPT the recommendations.

DRAFT

MHAC/25/12 Legal Briefings (Agenda item 12)

MHAC/25/12a Health Inequalities Project Work Update (Agenda item 12.1)
Project 1 is supported by the NHS Confederation, mapping the journeys and experiences of males from Black and Asian heritage against White comparators. The project aims to better understand the journeys, themes and contacts with services that result in it being more likely for Black and Asian men to be detained under the MHA than their White contemporaries.

Meetings continue with the Clinical Reference Group who will generate questions arising from the data that will inform the community engagement work being led by the Equality, Diversity and Inclusion Team via community connectors to assist with the project. The currently phase of this project is planned to be completed in late spring 2025.

Two further groups have been working with the Virginia Mason Institute and the Public Service Consultants who have been providing the clinical groups with weekly coaching sessions.

The Newhaven project has worked with their service users to develop a suite of hand held accessible documents that track progress against C(E)TR recommendations and personally identified goals that can be taken into multidisciplinary team meetings and how to track progress. The suite of documents also includes a booklet that will track the process, milestones and actions to support progress to multiple discharge routes from Newhaven.

The Horizon project has focused on how to implement advance choice documents (ACD) within a learning disability setting. The ACD is based on the factors identified in the White Paper: Reforming the MHA 1983 The document has been adapted to develop an assessable format. It has been put into an initial trial with new admissions with a positive response from carers and service users. Best Interest informed process has been developed to support those with higher levels of need with next steps being to trial ACD with an intensive support team as a pre admission option with the potential to move out wider collaboratively. This has produced interest outside of the trust and the team have presented their work at a national webinar hosted by the NHS Confederation.

ST informed the committee that the trust had been approached by other organisations to work collaboratively on the impact of detention rates and the prevention elements, as this is a focus nationally and evidence has shown that black men receive a different response compared to white men when they come in contact with mental health teams.

EM requested the once the projects have been completed to incorporate this part of the act in practice section of upcoming committee meetings.

It was RESOLVED to RECEIVE the legal briefing for the Health Inequalities project Work Update

DRAFT

MHAC/25/13 MHA/MCA Code of Practice Oversight Group (Agenda item 13)

MHAC/25/13a AAA Report (Agenda item 13.1)
JC confirmed that this was for information and was taken as read.

No further comments from the committee.

It was RESOLVED to RECEIVE the report.

MHAC/25/13b Annual Blanket Restrictions Report (Agenda item 13.2)
JC confirmed that this was the first submission of the report, and a bi-monthly report will be produced and will then be presented to the Code of Practice Group.

No further comments from the committee.

It was RESOLVED to RECEIVE the report.

It was RESOLVED to RECEIVE the update for the feedback report in relation to the MHA / MCA Code of Practice Oversight group.

MHAC/25/14 Key Messages to Trust Board and other Committees (Agenda item 14)

Messages for Trust Board agreed as:

Alerts from the AAA report:
- Approved Mental Health Professional (AMHP)
- Mental Health Act Bill (Impact and Implementation)

Advise from the AAA report:
- QI projects in collaboration with NHS Confederation and Virginia Mason Institute
- First CQC MHA themed visit to Cheswold Park
- Performance and Monitoring report provides assurance and will incorporate Cheswold Park Hospital activity from Quarter 1

Approval from the AAA report:
- Annual Report
- Terms of Reference
- Self-Assessment

Assurance from the AAA report:
- Action statements responding to issues identified through CQC MHA inspections are in process
- Compliance with recording to support consent to treatment maintained
- Cheswold Park MHA administration has completed preparatory work for transition to SystmOne
- Section 17 escorted leave facilitated at a rate of 90% or more

DRAFT

MHAC/25/15 Work Programme (Agenda item 15)
No further comments from the committee.

EM confirmed that the programme is up to date and work is on track.

It was RESOLVED to RECEIVE the work programme.

Date and Time of Next Meeting:
The next meeting will be held on 4th June 2025 at 14:00 – 16:30 via Microsoft Teams

EM closed the meeting.

DRAFT

Minutes of the Finance, Investment & Performance Committee
Held on 22 April 2025
(Virtual meeting, via Microsoft Teams)

Present:	David Webster (DW)	Non-Executive Director (Chair of the Committee)
	Marie Burnham (MBu)	Chair of the Trust
	Gary Ellis (GE)	Non-Executive Director
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Mel Wood (MW)	Head of Performance & Business Intelligence
	Rob Adamson (RA)	Deputy Director of Finance
	Adele Fox (AF)	Chief Operating Officer
Apologies:		

FIP/25/01 Welcome, introduction, and apologies (agenda item 1)

David Webster (DW), Chair of the Committee, welcomed everyone. The meeting was quorate and could proceed. DW informed attendees that the meeting was being recorded for administrative purposes and would be deleted once the minutes were completed.

FIP/25/02 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare in relation to the agenda for the Finance, Investment and Performance Committee.

The Finance, Investment and Performance Committee NOTED the above declarations.

FIP/25/03 Minutes from previous Committee meeting held on 17th March 2025 (agenda item 3).

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It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 17th March 2025 subject to the amendments being made

FIP/25/04 Matters arising from previous meeting held on 17th March 2025 and action log (agenda item 4)

The committee reviewed the open actions, AS provided updates where appropriate.

MB referred to the annual plan, noting that there is currently no planning group within our Trust. She acknowledged the presence of a Value For Money (VFM) Board that addresses financial aspects but pointed out that the Board is not briefed on our planning objectives or progress against the plan. AS responded that much of this information is covered within the IPR, which Mel Wood (MW) will update the committee on later. He mentioned that finance reports go through VFM, and all performance requirements outlined in the mandated plan are addressed through the IPR.
MB was unsure if they were picked up correctly and she felt planning was poorly reported. She said she would pick this up separately outside the meeting with Dawn Lawson (DL) outside the meeting.
AS stated he felt it was a fair challenge that we did not have a point of contact for planning this year and it was slightly fragmented with workforce, finance, and performance. He said there had been executive discussions around some gaps that have been identified given Izzy's secondment to Corporate Governance and Sean Rayners impending retirement and he is in currently in discussion with Mark Brooks, Chief Executive around this, as they both have portfolios. He said we are looking at reductions across corporate structures so we are looking at

putting some resources in, at the same time we are taking some resource out elsewhere so we have to manage this both sensitively and practically.
MB thanked AS for the update.

It was RESOLVED to NOTE the updates in relation to the action log.

FIP/25/05 Items delegated from Trust Board (agenda item 5)

DW confirmed that there was nothing delegated from Board.

It was RESOLVED to RECEIVE the updates in relation to items delegated from Trust Board.

FIP/25/06 Performance update (agenda item 6)

6.1 Finance, Investment and Performance (FIP) Risk Register

AS stated that we are now closing down 2024/25 and focusing on 2025/26, reflecting this in our risk register reviews. The key change proposed is rewording risk 1957 to remove the time-bound reference to 2024/25. We anticipate ongoing pay award pressures, so we have made the wording more generic to avoid frequent updates.

AS remarked that in relation to risk 114, due to current pressures, we recommend increasing the risk score from 3 (moderate) to 4 (major), resulting in a combined score of 16. Although it seemed unnecessary when we met the 2024/25 plan, the challenges of the 2025/26 plan now justify this increase.

MB expressed confusion about risk 114, stating she believes we would overspend rather than put services at risk. She feels that this is not the implication of the risk.
AS clarified that risk 114 pertains to financial stability and that continuous overspending over the years could lead to unsustainability despite having cash reserves. Sustained deficits would deplete these reserves and make us financially unstable.

MB asked if AS was suggesting that this matter is now considered a major issue instead of a moderate one. If so, we need to discuss at the Board what actions are currently not being taken.
AS replied that he was saying that and 6.8% efficiency programme we are running to achieve break-even is higher than our previous targets, which increases the risk of success compared to before. He clarified that a deficit in the first year would not make us unsustainable, but a continued run rate resulting in a perpetual deficit would have significant implications.

MB remarked that she is not convinced that this is major at this stage, she appreciates that executives decide on the risks and then it is up to us to say if we agree or not, but she still felt a Board conversation was still required.

DW asked if risks 1957 and 114 are essentially the same since both involve unfunded pay pressures impacting financial sustainability. AS clarified that risk 1957 specifically addresses the shortfall in pay award funding, based on evidence from the last two years. He added that risk 114 is intended to be a much broader risk and encompasses everything that impacts finances. He stated that managing Risk 1957 is significantly more challenging for us as a Trust, while Risk 114 allows us to make decisions to control it effectively. DW remarked whether Risk 1957 exists primarily for political reasons to emphasise its importance. AS commented that this perspective is indeed quite important to consider.

Gary Ellis (GE) noted that there had been a discussion regarding Risk 1957, addressing its potential political implications. He said in reference to Risk 114, he stated that while he doesn't

wish to overcomplicate matters, his experience indicates that unsustainable losses can impact cash balances. Consequently, it is important to consider what our target cash position should be, although he acknowledges that determining this is not straightforward.
He stated the Trust has £50m in cash, which is healthy, but noted that large losses can quickly deplete this balance, although the Trust has not experienced such losses.

RA remarked that even though the Trust have £50m in the bank he is worried about cash because we used to have much larger balances, and some of how we have got to this years position has been non cash based. RA said he is getting the team to focus on how do we make sure we are covering debt timely as he would like our cash position to be higher.

Adele Fox (AF) mentioned that they are currently facing challenging decisions and discussions regarding certain services that are not adequately funded, and the fact that if this situation continues, it could lead to financial instability.

DW noted that the discussion had been productive and would be included in his AAA report for the Board's review.

AS said he would also work with Andy Lister to reflect some of this discussion in what will become the Board paper for review.

6.2 Monthly performance review

IPR Metrics
AS explained that the metrics were discussed at an EMT time out a few months ago, and the strategy section was agreed upon at EMT two weeks ago. MW has since compiled this information for the IPR, but they haven't yet presented the composite position back to EMT.
AS confirmed that what is Mel Wood (MW) has put in the paper had all been agreed and supported by EMT.

MW continued to provide the committee with the key information around the report.

DW discussed prone restraints, noting numerous caveats and exclusions. He suggested using absolute numbers since the goal is to eliminate them completely.
MW said the proposed high-level metric for the quality dashboard will include exclusions and detail, so all prone restraints will be reported in the quality headlines, showing total number and duration. The metric supports the Trust's goal to eliminate restraints.
Adele Fox (AF) mentioned that while the goal is to achieve zero, it may not always be feasible if an individual initially places themselves in a prone position. She emphasised the importance of examining the details behind the metric, as the metric alone does not provide all the necessary information.

MB asked MW what she wanted the committee to approve. MW requested approval of all the metrics in the IPR by section for 2025/26.
MB inquired whether any of the thresholds for the metrics had been revised.
MW responded that generally, the thresholds would remain unchanged as there had been no appetite to alter any specific metrics.
MB felt we set ourselves up for failure on some thresholds and fears the CQC might judge us unfairly, even though we perform better than most in the country.

AS mentioned that while they would adjust the national metrics threshold if instructed, he wasn't aware of any changes so far. MW confirmed there are adjustments to align with annual planning, but the static metric targets remain unchanged.

DW indicated that we are generally in agreement with these approvals. However, considering MB's earlier point, it may be prudent for the executive team to review the thresholds to ensure they are both appropriate and achievable.
MB noted that some of the thresholds need to be cross-referenced with those in the business planners. She was happy for this matter to be addressed outside the meeting.

ACTION: Mel Wood

AS stated that they had reviewed the model hospital, noting improvements in mental health indicators. There is an appraisal indicator in the model hospital, and performance is strong, although it has a significant time lag, reflecting 23/24 information. Despite the discussed challenges over the past year, the benchmark indicates that appraisals are timely and our position remains strong.
AS confirmed the executives are going to carve some time out to review the revised model hospital content and ensure its optimal use as it is showing improvement. He stated that we will soon address corporate cost reduction, which is based on corporate benchmarking within the model hospital. He mentioned that all measures are now being routed through this portal nationally, so it is imperative to remain vigilant and comprehend what is included there and how we compare, as we perform favourably on several indicators.

MW informed the committee that the name of the Quality section has been changed to Quality and Safety, in order to encompass certain safety elements that will be integrated into Quality going forward.

The committee agreed with this proposal

MW stated that they have undertaken some work to map the metrics in the IPR to the new Trust strategy. The proposal is that they will include an additional column to each of the dashboards to show which strategic objective those metrics align to.

DW confirmed the committee were happy with the approach to mapping the metrics.

MW informed the committee that the strategy reporting will occur outside of the IPR. This proposal has been approved by EMT. MW stated that this aligns with MB's earlier comments regarding certain metrics and differences in thresholds. She indicated that this will be covered in a separate report to the Board, while the IPR will focus on organisational performance going forward.

MW informed the committee that the NHS performance assessment framework was presented to the NHS England Board at the end of March. It is currently undergoing an engagement process during Q1, with a finalisation expected by the end of Q1. She stated that this implies the framework will be effective from Q2, which might necessitate adding additional metrics into the IPR accordingly. She indicated that this will be done as required.

DW said the paper looks good and thanked MW for the update.

MH community deep dive

AF provided an update, indicating that the Board had reviewed the paper and engaged in a thorough discussion regarding its comprehensive content. She also mentioned that the committee has received a highlight report.

Key headlines

- Appraisals have improved

- Barnsley is an area which we are focussed on due to vacancy turnover and higher sickness levels within that area. The care group are looking at what we can do to support Barnsley, and particularly Kirklees around their waits and some of their other performance indicators, which show there is a discrepancy which we think relates to an increase in referrals and vacancies.

GE inquired if any insights were gained from the exit interviews conducted with departing staff members. He mentioned that he had recently spoken to two individuals who had left SWYPFT, citing inadequate supervision as their primary reason for leaving. He contrasted this with the notable improvement reflected in the friends and family test, indicating a positive perception from that perspective. GE emphasised the need to delve deeper into the issues, as they seem to be an anomaly compared to other areas.

AF noted that supervision has been a major focus recently, which should address one of the reasons for staff turnover, as reflected in the figures.

AF mentioned that some individuals do not complete exit interviews. It has been reported that people are leaving to work in Sheffield or other locations where similar jobs have a higher banding. AF noted that she does not consider this the primary cause and stated that turnover figures in Barnsley were higher due to three retirements. She also mentioned that two more individuals are expected to retire, which will further increase the turnover.

AF stated that individuals are retiring because there are various roles available in the community, including those in schools and within Primary Care Networks (PCNs). She said that many areas are expanding their PCNs. AF stated that she has requested themes from exit interviews and found no particular patterns; therefore we have to rely on anecdotal information. She expressed her belief that people either leave for promotion or dissatisfaction with their working environment. Additionally, she remarked that many individuals cite line management as a reason for leaving, but she hopes this is not the case here because our values definitely shine through.

GE thanked AF for the update

FIP/25/07 Financial update (agenda item 7)

7.1 Month 12 finance report

RA presented the updated stating this is the final report for 2024/25. He said the key headline is that we have, albeit unaudited, demonstrated that we have hit our financial target of breakeven or better for the year. He said it has not been without its challenges and they know some of this rolls into next year. He said the report shows a small surplus of £245k. He said this has been achieved through a number of non-recurrent mitigations which are outlined in the report.

AS noted that we have delivered a small surplus, which is beneficial as it provides flexibility for minor issues during the audit.

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DW agreed stating this was a really good position. He asked if the final position covered the impairment. RA replied that it did and he provided additional information around this.

DW noted that, as it was discussed in the Audit Committee last week, it is important to highlight this information. He said that it does not alter any outcomes and is primarily an accounting adjustment.

AS clarified that this accounting adjustment is handled below the line, meaning it is not a performance measure and does not affect our statutory break-even duties for the system.

AS mentioned that RA's initial assessment reviewed all the financial performance indicators. We engaged in extensive discussions regarding capital, and we concluded within an acceptable margin for capital. He noted that our actual expenditure amounted to £7.5m, and we flexed the plan slightly in the last six months of the year between capital expenditure and IFRS16 leases.

MB referenced laptops, noting that our treatment of IT equipment differs from others and questioning its impact. RA responded that ultimately, we did not adopt a different approach; laptop purchases have been treated as revenue. He mentioned there was discussion about capitalising it, but he expressed relief that this path was not taken, as it is financially impractical and a lengthy process.

DW inquired if we are still out of sync with others. RA responded that while most capitalise, not everyone does, and we remain compliant with accounting standards.

AS noted that this issue poses a significant dilemma for us as it represents an easy £1m revenue saving. However, we cannot implement the switch at this time due to insufficient capital within the system. He expressed his preference to align with the majority but acknowledged that we are unable to proceed without securing recurrent CDEL cover. He acknowledged that this debate is likely to recur; however, we have decided to continue with the existing accounting treatment for the present time.

GE referred to page 10 of the report to verify his understanding of non-pay spend. He noticed a discrepancy between the total figure for April 24 – March 25 and the year-to-date figure and asked if they should be in sync.
RW confirmed they should match and said he would look at this.

ACTION: Rob Adamson

RA mentioned that he wanted to highlight the Better Payment Practice Code and express appreciation for his team's work in this area. He stated that the Trust's performance on the Better Payment Practice Code has been excellent this year and consistently good over many years. He noted that suppliers are paid promptly, and there are no issues with aged debt under this position, as the team resolves issues efficiently within 30 days.

DW praised the finance team for their excellent work in paying small businesses promptly and asked RA to convey the committee's thanks to the team.

RA informed the committee that a briefing paper on the Trust's financial performance for 2024/25 was shared. Despite significant challenges noted six months ago, actions were taken to mitigate these issues and deliver the year-end position successfully. He explained they achieved the year-end position partly due to extra income received in March from ICB depreciation funding, which reduced the need for identified mitigations.

MB observed that the year concluded with a strong financial position. While attributing this partly to the new Chief Operating Officer's enhanced control over banking and agency matters, she also recognised the positive impact of increased income. Nevertheless, MB questioned the organisation's overall effectiveness in financial management.
RA replied that normally we are pretty good, and some of it relates to new people coming in and seeing improvements. He said last year it was similar, but when we received the depreciation total at year end it was less than £100k, so this years was much more significant figure. He said the previous week they were told not to expect anything, but we did receive a payment.

AS elaborated on the various measures established to achieve our break-even plan. He noted that these measures became increasingly challenging as we deviated further from our plan and he provided further details to the committee regarding this.

MB thanked AS for the detailed explanation.

GE found the paper useful as it provided practical insights beyond financials, effectively illustrating the events of the year. He mentioned a section on mitigations and noted that positive developments reduced the requirements compared to previous models, which he is trying to understand. He observed areas where risks were unnecessary and others where more effort is needed this year, suggesting there should be additional benefits..

MB remarked as we saying we feel more comfortable now compared to before. AS responded by noting that this is a relative term, as the previous situation felt very uncomfortable.

Efficiency Plan

AS mentioned that this report will be used here, with some version of it also included in the full Board report, although possibly without as much detailed information. He indicated that they have been addressing all the high-level initiatives and provided further details to the committee regarding these.
AS expressed increased confidence in temporary staffing and in the prospects of having a corporate plan, although acknowledging the challenges it will entail. He also noted that decisions have been initiated regarding loss-making services. He emphasised the need to improve workforce information systems to obtain timely insights ahead of finance reports.

AS stated that he feels this is progressing well, and he has increasing confidence that we are gaining control of the situation. He said it is not uniform across all areas; some are more challenging and will take longer to address. However, it is evident that those on the VFM Board, which includes every director except Mark Brooks and every care group director, now have a clear understanding of expectations regarding how the group will operate and how collective decisions will be made and implemented. He stated that there will likely be challenges ahead because some aspects are complex. However, he believes we have a clear process to monitor financial implications, which is the main purpose, as well as the outcome implications of the changes we will implement.

DW noted that this provides clear visibility of ongoing activities and receiving updates throughout the year will be beneficial.

AF noted that there are activities occurring behind the scenes that contribute to the VFM programmes, specifically regarding temporary staffing data, and Vic Humble is assisting with that data, which aids in decision-making without affecting quality. This is the primary goal within the temporary staffing meeting.

MB remarked that there were two concerns for her, firstly the non-recurrent and the recurrent aspect of the plan. She said the non-recurrent worries her at the high level of over £17m, as about 60% of it isn’t recurrent savings and that is going to be carried forward.
She expressed concern that if we face another financial issue next year, having a higher non-recurrent level than recurrent level significantly increases the Trust's risk.

MB expressed her concern regarding the £5m still unallocated, stating that if we are serious about taking control and ensuring that responsibilities are met, having £5m unallocated at this stage is interesting. She also mentioned the establishment review and questioned the rationale behind having two separate lines for it.

MB stated that while she thought the PID was okay but it lacked accountability. She believes it should be evaluated by both area and director, providing her reasons accordingly.

AS concurred with MB regarding the non-recurrent expenses and the high vacancy provision. He explained that the reason they classify it as non-recurrent is because that is how it is currently managed. However, once the establishment reviews are completed, these should transition from non-recurrent to recurrent. This requires the disestablishment of certain roles. When the plan was set, no roles had been disestablished, which is why they were appropriately categorized as non-recurrent. He stated that it will attract external focus, which has already begun. When we conduct the establishment review expected to be completed in Q2, things will transition from non-recurrent to recurrent, thereby reducing the number, he said MB is correct in saying that we need to maintain the right balance.

AS acknowledged the accountability challenge and he agreed to take this away to reflect on it. He said he views the VFM board as a platform for joint accountability, and accountability will be managed through the SROs, primarily involving AF and himself. They discussed a more balanced distribution of SROs across the exec team but decided against it due to the technical nature of some of his responsibilities and the operational impact of many of AF's responsibilities so he felt their current approach was appropriate.
AS stated that the VFM Board is critical in decision-making because all members will be accountable for its decisions and responsible for implementation. Membership is limited to executives and care group directors, with input from subject matter experts. He explained that Mark was excluded to provide a point of escalation if the execs cannot reach consensus, allowing the EMT to involve Mark as the Chief Executive and accounting officer.

AS remarked that if MB felt this did not demonstrate accountability, he would relay this feedback to the VFM group for a collective discussion on potential improvements. He acknowledged that while there have been enhancements, there may be opportunities to further clarify accountability lines.

MB responded that she was willing to discuss this outside of the meeting. She noted that it was already April and there was still no plan in place for holding individuals accountable according to the budget. She provided the example of doctors on call being zero and commented that difficult conversations were consistently being avoided.

AS replied that they are not avoiding challenging conversations around this issue, which is why it remains on the list. However, he does not want to quantify it until an agreed scheme is established. He noted that he continues to face resistance to removing it from the list. AS said he would discuss the matter further with MB offline and explore ways to strengthen the emphasis on this issue.

ACTION: Adrian Snarr

AS stated that he wished to briefly highlight one specific aspect: the corporate benchmarking activity. He said FIP members are aware that Meridan was commissioned to perform a short-term analysis, and the feedback was provided to the EMT on Thursday of last week. The slide deck has been received, and we are currently awaiting the report from them. While AS does not intend to oversimplify the findings, he noted that there are two key takeaways being discussed by the executives.

AS stated that the Meridian business model is tried and tested for them as a company. They are pitching similar work in Bradford; they are also pitching work and Sheffield Health and Social Care. He said the value for us as a system is if Bradford do commission them we know the model so we know we can compare across the organisations.

AS provided the committee with further detail around the Meridian activity.

DW thanked AS for the update.

MB inquired if Meridian reviewed only corporate services or everything. AS clarified that the review covered only corporate services. He added that last year they reviewed community mental health, and AF is considering it as part of the productivity review.

GE noted that we have set a target of £2 million and inquired whether this figure was calculated based on specific criteria. AS responded that this calculation was made when the planning guidance was initially released, using the available information at that time. Subsequently, we have been given a revised target of £2.2 million. Although our initial assessment was close, the slight increase is due to the inclusion of non-pay elements in their calculation, which contribute to corporate benchmarking, rather than solely focusing on headcount.

AS inquired whether the committee is generally satisfied with the content, notwithstanding MB's comments regarding accountability. If so RA will begin incorporating this into the Board report.

MB said her only concern was the nonrecurrent element of it because it is too high.

DW said in terms of the report it has good visibility and if there are any variations we will be able to address these early and adjust accordingly.

MB inquired if AS would present this to the Board. AS responded that he would not prepare a detailed PID for every scheme but would provide the top two sheets, which include the schemes and their respective phasing.
MB noted that Mark Brooks is not part of the management team responsible for escalation if needed. AS confirmed that Mark is not a member of the VFM Board. MB inquired if there was a Terms of Reference for this process that details how to escalate an issue to the Chief Executive. AS responded there is and that Mark may also opt for accountability through objectives, as we are currently in the objective setting phase.

<u>West and South Yorkshire Collaboratives Financial updates</u>
RA provided the update for M11. He stated that the key headline is a significant improvement between M10 and M11 in the Integrated Care Board (ICB) due to national negotiations regarding elective recovery funds and their treatment. He believes that West Yorkshire has achieved its financial targets for 2024/25 and will be finalising their accounts.
AS confirmed that South Yorkshire had also met their target, pending audit.

MB remarked that upon reviewing the appendices and efficiencies, the underspend of £0.4m at year-end does not appear to align with the reported figures. She believes there is a discrepancy between the two.
RA responded that the £20.7m does align; however, there is a discrepancy in our plan that was identified at the beginning of the year. He noted that the Trust's efficiency plan was for £22m, while the ICB had recorded £20.1m. AS further mentioned that this variance has been reported throughout the year.

<u>West and South Yorkshire Collaboratives updates</u>
RA presented the update, observing that all collaboratives faced a financial deficit this year except for forensic CAMHS. He mentioned a decline from last year when West Yorkshire had a surplus and others broke even. He explained that the main factor remains OOA placements and managing activity and demand; there have also been increases in exceptional packages of care. He explained that the CAMHS position worsened at year-end because the anticipated investment fund was not applied, increasing their deficit more than expected. He also noted ATU OOA placement pressures in Q4.

AS stated that the ATU Collaborative is quite high on our list of issues to resolve, as it doesn't work from a financial or operational point of view. He said they are pushing quite hard to get the whole ATU Collaborative reviewed and put on a more sustainable footing. AS confirmed we are a provider in the ATU Collaborative at the Horizon Centre, so there are some risks we are managing but we are also getting hit with commissioning risks through the collaborative.

MB raised concerns regarding the CAMHS partnership with Leeds & York Partnership,

AS explained that the challenges Leeds face in CAMHS are not dissimilar to what we report in adult secure so their financial pressures are largely driven by OOA placements and enhanced packages of care.
AS noted that the issue of Red Kite being closed to admissions is related but separate. He suggested that Leeds & York might similarly criticise our adult secure services if they believe we are mismanaging OOA placements and causing them financial strain. He said on a positive note that demonstrates the strength of relationship in West Yorkshire that we enter into a risk share, and that risks and benefits go either way and at least we have that Collaborative position in West Yorkshire He said we do not have a similar one for South Yorkshire although he does know that South Yorkshire CAMHS has similar financial pressures to West Yorkshire CAMHS for the same reasons.

MB mentioned being comfortable with collaboration and risk-sharing but expressed concern about not having control over their outcomes. AS responded that this is the definition of a Collaborative.
AF mentioned that the ATU Collaborative is being reviewed due to a perceived lack of financial and operational benefits. She noted that commissioners support this review, and there are plans to draft a paper with one of the commissioners to communicate the need for a prompt review to the relevant group, as the current arrangements are ineffective.

GE noted that efforts are being made on the West Yorkshire Forensic Secure side. He inquired about the mitigating actions that Leeds & York CAMHS intends to take from their perspective.
AS replied that although he lacks specific details, a similar approach is being implemented for adult secure services. He said the main difference is West Yorkshire has five providers for adult secure care, while Tier 4 CAMHS has only one, Leeds & York Partnership, and ineffective patient flow management at Red Kite View could result in patients being sent OOA, thereby increasing that risk share. He said unlike adult secure services, CAMHS does not have multiple providers in the system. South Yorkshire faces a similar situation but we are not in the same collaborative arrangement in South Yorkshire so all Tier 4 patients are dealt with by Sheffield Children's Hospital. He said Tier 4 CAMHS nationally used to be problematic because there was evidently not enough beds in the country and he still didn't think this position has been resolved but it doesn't get the headlines it used to.

DW commented that he would raise this as an alert in the AAA report to Board. MB agreed with this approach.

MB asked where do these collaboratives sit in terms of our cost improvement programme and are they making any contribution.
AS replied that we have a collaborative efficiency workstream which is focused on adult secure, and he has tasked both adult secure collaboratives in West and South Yorkshire to get back to a break even position. He said South Yorkshire should be able to get there because of the Cheswold position and West Yorkshire should have a reasonable chance of doing this because of patient flow through to high secure.

AS remarked that the broader point MB raised about the Collaboratives we do not control is a separate issue. We seek assurance from those leads on how they manage the risk, although

we do not have direct influence on their delivery plan. We informed our collaborative partners that we aim to break even, aligning with their planning assumptions. We also told Leeds & York Partnerships that we plan to break even on Collaboratives, emphasising the need to achieve this to avoid in-year risk.

MB emphasised the need for stronger accountability, noting that current measures seem too relaxed. AS replied that delegating to ICBs should improve accountability as funds are now managed within the West Yorkshire system. Failures by any Collaborative will impact the overall ICB position, potentially driving improvement.

Annual Plan update
AS provided the update stating the paper provided was broadly in line with the financial and operational plan update paper that will be going to Board. He said it serves to inform and remind people about our recent discussions before the plan submission. He noted the focus will be on patients who are clinically ready for discharge and no longer need inpatient care.
AF provided the committee with further detail on the current focus of the operational team and where she thinks improvements can be made within all patient flow areas, in line with national guidance.

AS outlined sections of the report, noting that feedback may require plan revisions. He assured it will not impact the bottom line assumptions, and adjustments might be needed for consistency with other Trusts, which they are currently working through.

DW thanked AS for the update.

MB inquired whether we would ever submit a financial plan from our Trust without including a financial indicator.
AS replied that that we are commissioned on an activity based contract for the vast majority of what we do and he provided further detail around this. A detailed discussion followed.

MB said we need to be very clear about what our offer is to commissioners in the future.
AS replied he felt the offer is clear and that is we are commissioned to provide a specific number of beds. He said it has been a perennial problem for the MH sector that we do not have contracts that flex with activity in the same way that acute does.

MB remarked that she did not see a reference to this in our annual plan and she is concerned as a mental health provider that we are putting a plan in with no activity associated to it at all.
AS responded that isn't correct, we do have some activity based contracts. MB responded that she could not see any in the plan that is being taken to Board. She remarked that there was also no unit cost in the plan. AS replied that there wasn't but we do have a unit cost through patient level costing. MB said that she needed to have a look at this separately offline.

A detailed discussion ensued around efficiencies.
AS agreed to have a further conversation with MB offline around metrics.

DW stated that he remembered discussing efficiency in his AAA report to the Board, but he could not recall the specific time.

AS agreed to coordinate with RA and include it in the action tracker.

ACTION: Adrian Snarr

FIP/25/08 Capital Plan update (agenda item 8)

Nick Phillips (NP) presented the update, indicating he would take the paper as read. He provided the committee with key headlines and detailed several changes that had occurred during the year.

MB noted that the plan did not meet its intended objectives and queried the purpose of having a plan. NP recognized this as a valid feedback for the current year, citing significant issues with Older Peoples Services (OPS). A detailed discussion followed. She remarked that if we are seriously going to sign off a capital plan we need to deliver against it.

AS noted that there is a challenge in the way NHS manages capital due to its annual planning cycle. Capital projects often require longer lead times, making annual planning difficult. Additionally, delays in approvals can result in projects not starting until Q2 or Q3, which hampers timely execution.
AS remarked that as NP has indicated, there are a few aspects that could have been approached differently, including some systems that may need improvement. One of the main issues identified is the continuous addition of capital throughout the year. It was suggested that we should improve our ability to review past and future plans, as although we adhered to our three-year plan, not all objectives were accomplished in the second year.
AS acknowledged that MB's comment was fair, but noted the difficulty in managing capital down to the exact penny. He emphasised the importance of recognising our achievement, as there was initially low confidence in the Trust's ability to meet the plan. We achieved this by bringing initiatives forward rather than creating new schemes solely based on having surplus cash.

GE inquired whether the spending this year would be more front-loaded. NP confirmed that it would be.
NP provided the Committee with additional information regarding the 2025-2030 capital plan.
DW thanked NP for his update.

Any other business (agenda item 9)

There were no further items to discuss.

It was RESOLVED to NOTE any other business.

FIP/25/09 Next meeting date (agenda item 10)

The Committee received the future meeting date:

- Monday 12th May 2025 from 9.30 – 11.00

DW closed the meeting

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 9.1

Private/Public paper:	Public		
Title:	**Integrated Performance Report (IPR)**		
Lead Director:	**Adrian Snarr – Executive Director of Finance, Estates, and Resources**		
Mission/values:	The paper supports achievement of all Trust values: Person first and in the centre; Families and carers matter; respectful, honest, open and transparent; Improve and am to be outstanding, Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for May 2025.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	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 Trust Board meetings held in public eight times a year. On months when meetings in public 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).		

With **all of us** in mind.

	The IPR is reviewed monthly at the Operational Management Group (OMG) meeting.
Executive summary:	Strategic Objectives and priorities The Trust has recently undertaken a refresh of its strategy and as a result has identified three new strategic aims: We will live our values, we will be the best we can be, we will be ambitious. Performance against the Trusts new strategy will be done separate to the IPR for 2025/26, however, all metrics reported in the IPR have been mapped to the new strategic objectives as well as to the CQC domains. Quality & Safety • The Trust had 35 violence and aggression incidents against staff on mental health wards involving race during May, which is a reduction on the previous month. This data now includes Cheswold Park hospital. We are very mindful of the personal impact this has on our colleagues. We provide support to those affected and are working with other trusts to identify other opportunities to reduce the prevalence of these incidents. Within the Trust, we are looking at developing bespoke training for services with a focus on equality and diversity to support this. • The total number of incidents in month decreased to 1,402 in May 2025, this includes incidents relating to Cheswold Park Hospital which were reported separately prior to April 2025. Breakdown of this data can be seen in the Care Group dashboards, and the numbers reported suggest data is in line with the number of incidents reported in previous months. They continue to be subject to review by the patient safety team with relevant governance within the care groups. • 96% of incidents reported in May 2025 resulted in no or low harm or were not under the care of the Trust. An overview of key indicators is below: o 1 incident unfortunately related to a patient death which was sadly of a service user known to mental health community services. Condolences have been passed to the family and investigation and learning will be undertaken. o the number of restraint incidents increased this month from 158 reported in April to 170. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared. o the number of prone restraints during the month was 11. This number, although reducing is disappointing. The medical director, chief operating officer and deputy director of nursing, quality and professions visited the psychiatric intensive care unit to understand barriers to using the new technique to exit seclusion and administer intramuscular medication. A review of the whole training package is taking place which will provide a trajectory of ensuring people are trained in the new technique. A deep dive into each case has been undertaken. • There were 7 information governance personal data breaches during May, this is a reduction on last month (13). A security breach occurred when a laptop and papers were stolen during a break from a staff member's car. An amber incident was reported when a staff member reportedly shared sensitive personal information about a patient in a public place and resulted in a complaint which is being dealt with through the Trust complaints process.

	• A communications campaign is in progress and personal responsibility for correctly identifying services users on the clinical systems is a key focus this month, to prevent further incidents. • The number of inpatient falls reported during May 2025 decreased to 44, which is a reduction from the spike we saw in April (63). We actively risk assess those service users who are at high risk of falling and implement care plans. All falls' incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. • The Trust continues to work to improve the recording and collection of protected characteristics across all services in order to improve our service provision and experience of it. There is one national indicator which is for ethnicity, the Trust is achieving 93.7% against a target of 90%. Disability recording was at 50.4%, sexual orientation 53.8% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report. • Risk assessments and care plans – as we aim to continually improve, we have further developed our metric regarding care plans. The new care plan metrics for community are now capturing the whole community caseload rather than only individuals on the care programme approach. From a safety and quality perspective, the Trust's aim is to work towards achievement of 95% against each of these standards. Clinical staff are adapting to the new requirements of where and how to record items and we have a phased trajectory progressively working towards 95%. • All areas are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live in January. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and May's compliance is impacted further by ward teams adjusting to the new layout and format of care plans. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. Clinical staff are adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme approach recording. • The Trust has seen a reduction in the safer staffing fill rate over the last 4 months; this is linked to the grip and control measures that have been put into place in relation to the use of temporary staffing. At the new temporary staffing meeting, members review all Datix incidents submitted around safe staffing and quality impact to ensure safety is maintained. Each care group have a daily huddle to review staffing and safety. Care Groups • Children's neurodevelopment waits remain a major issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. There is an offer in place to support children and families whilst waiting. The neuro services across both Calderdale and Kirklees continue to see an increase in demand and had 33% more people waiting for initial assessment at the end of March 2025 (2906) compared to March 2024 (2191). Close work with commissioners continues across the Place. • Improvement work on waiting list times in community learning disability services has led to an overall improvement against the 18 weeks standard

	and for the month of May 100% was achieved. This has shown a sustained improvement and has been consistently achieved each month since November 2024. • The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. Demand for beds continues to be a significant challenge and we have experienced increased use of out of are beds days in the last month. The benefits of providing care close to home are very evident. This can have an impact on our inpatient staffing costs given the high occupancy on many wards, and we are evaluating any unintended risks as a result of focus on maintaining local care. We are working with commissioners to address the increase in clinically ready for discharge patients. • Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for a first appointment at the end of May, 74.9% of those waiting had been waiting for a period of 18 weeks or less. This excludes waits for autistic spectrum disorder waits and neurodevelopmental teams which are reported separately. The average wait for neuro development assessment is 907 days in Kirklees and 332 days in Calderdale. Neurodevelopment waits for children remain a concern and discussions continue with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support. • 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. The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees for May is approx. 27 cases per month, the number of referrals for ADHD received for these areas in May was 376. • As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service. An innovative new step has been developed to offer face to face triage for ADHD to ensure only clinically appropriate cases are offered an assessment, this is commissioned in Wakefield and Kirklees. Barnsley and Calderdale have requested updated business cases for their consideration. The ADHD leadership team are working with commissioners to support the findings of the National ADHD taskforce report to align ourselves to the recommendations. • Mental health acute wards have continued to manage high levels of acuity, increased levels of risk to self and others, which requires an increase in observations. Further work is being carried out to understand how efficiency can be improved to release time for nursing staff to care. Continued high occupancy levels contribute to increased acuity. Capacity to meet demand for beds remains challenging and is placing significant pressure on patient flow, Intensive Home-Based Treatment Teams, community teams and wards. This pressure links to the urgent and emergency care planning guidance that escalates 12-hour breaches to the Integrated Care Board therefore, pressure to focus on those patients in the acute Trust Emergency departments. • Temporary staffing has continued throughout May, however, a significant reduction in the use of agency staff on wards and a small reduction on bank staff has been achieved.

	• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation has become more challenging and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored. • A focus on patients clinically ready for discharge is taking place across mental health and learning disabilities. Challenges are those associated to specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (PICU). A review of clinically ready for discharge for Forensic services is also taking place. Further detail can be seen in the care group section of the report. People • Overall sickness absence remains low for May 2025 at 4.7%. Although sickness rates are similar to this period last year, we have seen a reduction in long-term sickness and a slight increase in short-term sickness. The introduction of a new sickness absence dashboard has been rolled out for managers to support them in managing absences and enabling more Trust wide information to be available. • Appraisal compliance continues to improve at 89.8%. An improvement trajectory has been set with 90% and the data suggests this will be achieved by end June 2025. • Our 12-month turnover rate in May has decreased slightly from last month to 9.2%. This is still a lower level than we have seen in previous years. A low turnover rate for the Trust means that more skills and experience have been retained, staff are working in substantive teams, and more service users will receive consistent care from staff that know them. Staffing establishments for mental health have been agreed therefore recruitment has commenced which will improve consistency of care and reduce the requirement for high use of temporary staffing in time. • In May, we had 19 new starters and 24 leavers. We continue to see a downward trend in number of starters which suggests the additional controls put in place are taking effect. May also saw a decrease in substantive staff, this is being monitored against a forecast 2% reduction expected to be achieved by end of March 2026. • Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance. This is the first month of Trust level performance that has achieved compliance in all areas. Dedicated focus on non-compliance continues within all care groups. National Indicators The Trust continues to perform well against the majority of national metrics. The following should be noted: • It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Ongoing development work is taking place to meet increases in demand. Regarding the 6 weeks to a diagnostic appointment target 118 out of 241 children (49%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in May, this is a deterioration in performance. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period

	is completed. A trajectory for reduction of agency staff will coincide with start date. • Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%, this however is an improved position. This relates to 2 service users out of a total of 32, both of which were on the ARFID (Avoidant/Restrictive Food Intake Disorder) pathway. The appropriateness of including these cases in this metric is being explored with NHS England. Performance against the urgent access to treatment measure is 50% in May, there were 2 patients not seen within 1 week of referral in May and this was due to one patient being offered an appointment within the time frame but this was declined by the family and the other was delayed due to the service having difficulties contacting the family to arrange an appointment. • Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold. Increase in demand can also be seen in the attended community care contacts metric which also shows a continued higher level than expected. • The following section provides an update on a number of key national operational priorities that the Trust will contribute to during 2025/26: • Reduction in Acute length of stay (ALOS). The Trust has set itself a local target to reduce adult acute lengths of stay by 10% by the end of March 2025. Performance against this can be seen in the national metrics section above and individual care group and ward level compliance can be seen in the care group section of the report. Overall, the average length of stay for people discharged in May has increased – this can therefore be impacted by a long stay being discharged during the month. In terms of performance against the trajectory, we are meeting the trajectory for May for our West Yorkshire acute mental health and PICU wards (Calderdale, Kirklees, and Wakefield), but slightly above our trajectory for South Yorkshire wards (Barnsley). • Productivity of services for children and young people – work is taking place across the Trust to improve productivity across all services whilst continuing to deliver (and improve) high quality and safe services. To support Trust financial viability. For services to work within the financial envelope defined within the establishment reviews, exploring and exploiting opportunities for working differently and effectively. Updates will be provided as this work progresses. • Expansion of mental health teams in schools – we are working with commissioners regarding the plans for Mental Health Support Teams in 2025/26. • Expansion of talking therapies service - The ongoing expansion of talking therapies services is progressing in alignment with national expansion targets and the corresponding funding provisions further plans for service development can be seen in the national metrics section of the report. Finance • The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) adverse to plan. This means that the year-to-date deficit is £1.4m

	(£0.2m - 17% adverse to plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements. These are being led by the value for money programme. • Agency worked WTE has continued to reduce in May. • The Trust Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However, this does remain higher than plan and further actions will continue to be implemented. • National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. In May spend is £0.3m less than planned. • The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position. • Cash continues to be monitored to ensure effective management of the Trust working capital position. In May 2025 this remains better than planned. • Spend on capital is less than planned in May. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Integrated Performance Report and **COMMENT** accordingly.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



May 2025

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 2025.

The format of the report for 2025/26 has been changed slightly to align with the focus of Trust board. In months where the report is not included on the Trust board agenda (Strategy focus) or has a shorter time allocation (Risk focus) a more data focussed report with key headlines will be produced. For Performance focus months, this will be a full report including supporting narrative and we will continue to develop more in depth analysis over the year.

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:

- Headlines
- Executive summary
- Quality and Safety
- People
- National metrics
- Care groups including ward level detail
- Finance

The Trust has recently undertaken a refresh of its Strategy and as a result has identified three new strategic aims: We will live our values, We will be the best we can be, We will be ambitious. Our Integrated Performance Report (IPR) provides a comprehensive view of Trust performance against our targets. We have mapped this performance information against the new strategic aims, values and best statements so that it is easy to see how the performance data links to the delivery of the strategy. Mapping of metrics included in the integrated performance report against the new strategic objectives has been undertaken and a new column added to dashboards to display this. A separate report will be provided to board with a specific focus on delivery of the Strategy. We have also mapped the metrics included in this report against the Care Quality Commission domains and this can also be seen in the addition of a column to each of the dashboards.

An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2025/26 and the report has been updated to reflect this. In particular, the national metrics section includes metrics contained within the NHS England oversight framework, operational planning guidance for 2025/26 and NHS standard contract items for 2024/25 - this will be updated once contracts for 2025/26 have been agreed. On 1st October 2024 the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides services to patients from South Yorkshire Adult Secure Provider Collaborative and placements for patients who may be from out of the area and need the specific treatment pathways the hospital provides. Over the last eight months the Trust has been undertaking an integration programme to embed Cheswold Park Hospital Services into the Trust and reporting systems. We expect this project to be complete by the end of quarter two and as data becomes available within Trustwide systems, this will be included in the main report during this transition period, any metrics not yet available will be reported separately in the appendix for Cheswold Park Hospital. In this months report we have added a reducing inequalities section, this is linked to the Trust's equality, diversity and inclusion strategy and includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. We will continue to further develop this section of the report over the coming months in line with the depolyment of the Trusts Equality, diversity, and
inclusion strategy.

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.

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	⇔	
% service users clinically ready for discharge	⇩	
Number of Information Governance breaches	⇧	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	⇧	
% with care plan that includes service user input/views	⇧	New metric from April 25
% inpatient care plans commenced within 24hrs before or after admission	⇩	New metric from April 25
% inpatient risk assessment completed within 24hrs before or after admission	⇧	New metric from April 25
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	⇧	New metric from April 25
% on community active caseload at month end with a care plan which has % on community active caseload at month end with a care plan which has been reviewed within the last year reviewed within the last year	⇧	New metric from April 25

People

Metric	Change from last month	Variation/ Assurance
Registered workforce growth	⇧	
Mandatory training - Information governance (IG)	⇧	

Finance

Metric	Change from last month	Variation/ Assurance
Surplus/(deficit) against plan (monthly)	⇧	
Bank spend	⇧	New metric from April 25
Financial sustainability and efficiencies	⇧	New metric from April 25

National metrics

Metric	Change from last month	Variation/ Assurance
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	⇧	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	⇩	
Maximum 6 week wait for diagnostic procedures	⇩	
Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	⇩	New metric from April 25
Diagnostic test activity	⇩	New metric from April 25
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Kirklees	⇧	New metric from April 25
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Wakefield	⇩	New metric from April 25
Oinappropriate out of area bed days	⇩	
Community service waiting list over 52 weeks	⇧	
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Kirklees	⇧	
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Wakefield	⇩	

Care Groups

Children and Young Peoples Mental Health Services (CAMHS)

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
Reducing restrictive physical interventions training compliance	↓	
Information Governance training compliance	↑	
% of feedback with staff values and behaviours as an issue	↑	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
Referral to assessment within 14 days (external referrals)	↑	
Information Governance training compliance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↓	New metric from April 25

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% inpatient risk assessment completed within 24hrs before or after admission	↑	New metric from April 25
% of clients clinically ready for discharge	↓	
Sickness rate (monthly)	↓	
% Bed occupancy	↓	
Information Governance training compliance	↑	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance	↑	
% of clients clinically ready for discharge	↑	
Information Governance training compliance	↓	
Sickness rate (Monthly)	↑	
% of feedback with staff values and behaviours as an issue	↓	

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
Information Governance (IG) training compliance	↑	
Sickness rate (Monthly)	↓	
% inpatient risk assessment completed within 24hrs before or after admission	↑	New metric from April 25
% Bed occupancy (incl leave)	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Bed occupancy	↓	New metric from April 25
% of feedback with staff values and behaviours as an issue	↓	
% Appraisal rate	↑	
Information Governance training compliance	↑	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance	↓	

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 give an overview of key headlines for each section of the report. More detail is included in the relevant sections of the Integrated Performance Report.

Quality & Safety

• The Trust had 35 violence and aggression incidents against staff on mental health wards involving race during May, which is a reduction on the previous month. This data now includes Cheswold Park hospital. We are very mindful of the personal impact this has on our colleagues. We provide support to those affected and are working with other trusts to identify other opportunities to reduce the prevalence of these incidents. Within the Trust, we are looking at developing bespoke training for services with a focus on equality and diversity to support this.

• The total number of incidents in month decreased to 1,402 in May 2025, this includes incidents relating to Cheswold Park Hospital which were reported separately prior to April 2025. Breakdown of this data can be seen in the Care Group dashboards, and the numbers reported suggest data is in line with the number of incidents reported in previous months. They continue to be subject to review by the patient safety team with relevant governance within the care groups.

• 96% of incidents reported in May 2025 resulted in no or low harm or were not under the care of the Trust. An overview of key indicators is below:

o 1 incident unfortunately related to a patient death which was sadly of a service user known to mental health community services. Condolences have been passed to the family and investigation and learning will be undertaken.

o the number of restraint incidents increased this month from 158 reported in April to 170. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.

o the number of prone restraints during the month was 11. This number, although reducing is disappointing. The medical director, chief operating officer and deputy director of nursing, quality and professions visited the psychiatric intensive care unit to understand barriers to using the new technique to exit seclusion and administer intramuscular medication. A review of the whole training package is taking place which will provide a trajectory of ensuring people are trained in the new technique. A deep dive into each case has been undertaken.

• There were 7 information governance personal data breaches during May, this is a reduction on last month (13). A security breach occurred when a laptop and papers were stolen during a break from a staff member's car. An amber incident was reported when a staff member reportedly shared sensitive personal information about a patient in a public place and resulted in a complaint which is being dealt with through the Trust complaints process.

A communications campaign is in progress and personal responsibility for correctly identifying services users on the clinical systems is a key focus this month, to prevent further incidents.

• The number of inpatient falls reported during May 2025 decreased to 44, which is a reduction from the spike we saw in April (63). We actively risk assess those service users who are at high risk of falling and implement care plans. All falls' incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required.

• The Trust continues to work to improve the recording and collection of protected characteristics across all services in order to improve our service provision and experience of it. There is one national indicator which is for ethnicity, the Trust is achieving 93.7% against a target of 90%. Disability recording was at 50.4%, sexual orientation 53.8% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report.

• Risk assessments and care plans – as we aim to continually improve, we have further developed our metric regarding care plans. The new care plan metrics for community are now capturing the whole community caseload rather than only individuals on the care programme approach. From a safety and quality perspective, the Trust's aim is to work towards achievement of 95% against each of these standards. Clinical staff are adapting to the new requirements of where and how to record items and we have a phased trajectory progressively working towards 95%.

• All areas are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live in January. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and May's compliance is impacted further by ward teams adjusting to the new layout and format of care plans. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. Clinical staff are adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme

Care Groups

• Children's neurodevelopment waits remain a major issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. There is an offer in place to support children and families whilst waiting. The neuro services across both Calderdale and Kirklees continue to see an increase in demand and had 33% more people waiting for initial assessment at the end of March 2025 (2906) compared to March 2024 (2191). Close work with commissioners continues across the Place.

• Improvement work on waiting list times in community learning disability services has led to an overall improvement against the 18 weeks standard and for the month of May 100% was achieved. This has shown a sustained improvement and has been consistently achieved each month since November 2024.

• The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. Demand for beds continues to be a significant challenge and we have experienced increased use of out of are beds days in the last month. The benefits of providing care close to home are very evident. This can have an impact on our inpatient staffing costs given the high occupancy on many wards, and we are evaluating any unintended risks as a result of focus on maintaining local care. We are working with commissioners to address the increase in clinically ready for discharge patients.

• Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for a first appointment at the end of May, 74.9% of those waiting had been waiting for a period of 18 weeks or less. This excludes waits for autistic spectrum disorder waits and neurodevelopmental teams which are reported separately. The average wait for neuro development assessment is 907 days in Kirklees and 332 days in Calderdale. Neurodevelopment waits for children remain a concern and discussions continue with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support.

• 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. The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees for May is approx. 27 cases per month, the number of referrals for ADHD received for these areas in May was 376.

As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service. An innovative new step has been developed to offer face to face triage for ADHD to ensure only clinically appropriate cases are offered an assessment, this is commissioned in Wakefield and Kirklees. Barnsley and Calderdale have requested updated business cases for their consideration. The ADHD leadership team are working with commissioners to support the findings of the National ADHD taskforce report to align ourselves to the recommendations.

• Mental health acute wards have continued to manage high levels of acuity, increased levels of risk to self and others, which requires an increase in observations. Further work is being carried out to understand how efficiency can be improved to release time for nursing staff to care. Continued high occupancy levels contribute to increased acuity. Capacity to meet demand for beds remains challenging and is placing significant pressure on patient flow, Intensive Home-Based Treatment Teams, community teams and wards. This pressure links to the urgent and emergency care planning guidance that escalates 12-hour breaches to the Integrated Care Board therefore, pressure to focus on those patients in the acute Trust Emergency departments.

• Temporary staffing has continued throughout May, however, a significant reduction in the use of agency staff on wards and a small reduction on bank staff has been achieved.

• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation has become more challenging and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.

• A focus on patients clinically ready for discharge is taking place across mental health and learning disabilities. Challenges are those associated to specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (PICU). A review of clinically ready for discharge for Forensic services is also taking place. Further detail can be seen in the care group section of the report.

People

• Overall sickness absence remains low for May 2025 at 4.7%. Although sickness rates are similar to this period last year, we have seen a reduction in long-term sickness and a slight increase in short-term sickness. The introduction of a new sickness absence dashboard has been rolled out for managers to support them in managing absences and enabling more Trust wide information to be available.
• Appraisal compliance continues to improve at 89.8%. An improvement trajectory has been set with 90% and the data suggests this will be achieved by end June 2025.
• Our 12-month turnover rate in May has decreased slightly from last month to 9.2%. This is still a lower level than we have seen in previous years. A low turnover rate for the Trust means that more skills and experience have been retained, staff are working in substantive teams, and more service users will receive consistent care from staff that know them. Staffing establishments for mental health have been agreed therefore recruitment has commenced which will improve consistency of care and reduce the requirement for high use of temporary staffing in time.
• In May, we had 19 new starters and 24 leavers. We continue to see a downward trend in number of starters which suggests the additional controls put in place are taking effect. May also saw a decrease in substantive staff, this is being monitored against a forecast 2% reduction expected to be achieved by end of March 2026.
• Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance. This is the first month of Trust level performance that has achieved compliance in all areas. Dedicated focus on non-compliance continues within all care groups.

National Indicators

The Trust continues to perform well against the majority of national metrics. The following should be noted:
• It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Ongoing development work is taking place to meet increases in demand. Regarding the 6 weeks to a diagnostic appointment target 118 out of 241 children (49%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in May, this is a deterioration in performance. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed. A trajectory for reduction of agency staff will coincide with start date.
• Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%, this however is an improved position. This relates to 2 service users out of a total of 32, both of which were on the ARFID (Avoidant/Restrictive Food Intake Disorder) pathway. The appropriateness of including these cases in this metric is being explored with NHS England. Performance against the urgent access to treatment measure is 50% in May, there were 2 patients not seen within 1 week of referral in May and this was due to one patient being offered an appointment within the time frame but this was declined by the family and the other was delayed due to the service having difficulties contacting the family to arrange an appointment.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold. Increase in demand can also be seen in the attended community care contacts metric which also shows a continued higher level than expected.
The following section provides an update on a number of key national operational priorities that the Trust will contribute to during 2025/26:
• Reduction in Acute length of stay (ALOS). The Trust has set itself a local target to reduce adult acute lengths of stay by 10% by the end of March 2025. Performance against this can be seen in the national metrics section above and individual care group and ward level compliance can be seen in the care group section of the report. Overall, the average length of stay for people discharged in May has increased – this can therefore be impacted by a long stay being discharged during the month. In terms of performance against the trajectory, we are meeting the trajectory for May for our West Yorkshire acute mental health and PICU wards (Calderdale, Kirklees, and Wakefield), but slightly above our trajectory for South Yorkshire wards (Barnsley).
• Productivity of services for children and young people – work is taking place across the Trust to improve productivity across all services whilst continuing to deliver (and improve) high quality and safe services. To support Trust financial viability. For services to work within the financial envelope defined within the establishment reviews, exploring and exploiting opportunities for working differently and effectively. Updates will be provided as this work progresses.
• Expansion of mental health teams in schools – we are working with commissioners regarding the plans for Mental Health Support Teams in 2025/26.
• Expansion of talking therapies service - The ongoing expansion of talking therapies services is progressing in alignment with national expansion targets and the corresponding funding provisions further plans for service development can be seen in the national metrics section of the report.

Finance

• The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) adverse to plan. This means that the year-to-date deficit is £1.4m (£0.2m - 17% adverse to plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements. These are being led by the value for money programme.

• Agency worked WTE has continued to reduce in May.

• The Trust Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However, this does remain higher than plan and further actions will continue to be implemented.

• National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. In May spend is £0.3m less than planned.

• The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.

• Cash continues to be monitored to ensure effective management of the Trust working capital position. In May 2025 this remains better than planned.

• Spend on capital is less than planned in May. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Mar-25	Apr-25	May-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	75.9%	73.0%	74.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	20% (4/20)	6% (2/32)	18% (5/28)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	93.8	85.6	116.1	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	88% (14/16)	88% (14/16)	88% (15/17)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	91%	95%	94%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	93%	96%	96%	1
Quality	Number of compliments received	Best Quality	Caring	N/A	46	25	75	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	12	5	3	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	11	13	7	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	6.0%	5.9%	6.1%	3
	Total number of reported incidents [18] *	Best Quality	Safe	Trend monitor	1287	1497	1402	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	28	36	26	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	5	1	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	2	1	1	
	Safer staff fill rates *	Best Quality	Safe	90%	128.7%	123.0%	122.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	101.1%	100.3%	100.2%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	34	39	35	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	Best Quality	Safe	0	1	0	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	44	63	44	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	177	158	170	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	86.4%	84.6%	83.7%	1
	Potential under-reporting of patient safety incidents	Best Quality	Safe					
	% people dying in a place of their choosing [14]	Person first and in the centre	Responsive	80%	96.2%	89.7%	88.9%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	13	16	9	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%	Q4 - 69.2%	Due August 2025		
	Number of violence and aggression incidents against staff on mental health wards involving race *	Best place to work and learn	Safe	Trend Monitor	25	38	35	N/A
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	10	Due July 2025		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	96.7%	95.4%	99.5%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	77.8%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.7%	95.4%	93.7%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	53.3%	51.9%	50.4%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	57.6%	56.0%	53.8%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.5%	99.5%	99.6%	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Mar-25	Apr-25	May-25	Year End Forecast*
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	94.9% Service 100% Policy	100% Service 100% Policy	88.2% Service 100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring	Interim trajectory 75-80%	Reporting commenced April 2025	58.7%	66.4%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring			66.2%	67.5%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring			86.2%	83.8%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe			75.7%	74.9%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe			82.6%	84.3%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	April and May – 12		8	11	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor		125	92	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor		4525	4814	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	All	Well led	2	2	2	2	
	Overall CQC rating	All	Well led		Good			
	CQC well - led rating	All	Well led		Good			

Quality & Safety Headlines

• Complaints - Number of responses provided within six months of the date a complaint received – reporting against this metric aligns to the NHS Complaints (England) Regulations 2009 stating that complaints should be responded to/closed within six months of the date received. The Trust is undertaking work to review the time taken for complaints to be investigated and responded to, to help understand any areas for improvement and how this can be monitored locally. Of the 17 complaints responded to during the month, 15 were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 116.1 days. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process.

• The number of reported incidents - the total figure for May incudes 155 incidents that are attributed to Cheswold Park Hospital; 1247 incidents were attributed to the rest of the Trust and this is in line with figures previously reported.
  • there was no severe harm incidents reported during the month.
  • there was sadly, one patient that died. Condolences have been passed to the family and investigation and learning will be undertaken and disseminated as appropriate.

• The overall number of restraint incidents in May was 170 which is an increase compared to the April figure of 158 and now also includes data for Cheswold Park Hospital. 28 of these incidents were attributed to Walton Psychiatric Intensive Care Unit and 22 to Elmdale ward. 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.

• Clinically ready for discharge (previously delayed transfers of care) - Overall Trust position for May was 6.1%, this includes data for Cheswold Park Hospital. The performance excluding Cheswold Park Hospital is 7.1% which is a further increase on last month. There are still a significant number of people who are delayed which may impact on performance in future months and further detail regarding hotspot areas can be seen in the care group and ward level sections of this report along with work taking place to reduce the number of delays, with partner agencies.

• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. In May there were 44 inpatient fall incidents which is a decrease on the 63 reported in April and is in line with previous months. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.

• % of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened) has increased to 100% in May.

• Following the implementation of the new care plan in January 25, a set of new metrics have been identified to monitor care plans and risk assessments and these have been in place since April 25. These now cover the whole community caseload rather than only individuals on the care programme approach (CPA) and this has impacted on the overall performance across all metrics. From a safety and quality perspective, the Trusts aim is to achieve 95% against each of these standards. Clinical staff are adapting to the new requirements of where and how to record items and this is adversely impacting on the overall compliance, as a result an interim trajectory of 75%-80% has been identified and work is taking place to set a trajectory of improvement to get services up to the 95% standard.

• All areas are focussing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live on 6th January. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and April's compliance is impacted further by ward teams adjusting to the new layout and format of care plans. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. The go live of the new mental health care plan has negatively impacted on this metric reporting, in part due to clinical staff adapting to the new requirements of where and how to record items measured in the metric, and some changes to CPA recording. Oversight of these in each team is taking place.

• There were no patient safety alerts that were not completed by deadline in May 2025.

Quality & Safety Headlines Cont…

Patient Safety Incident Response Framework (PSIRF)
A review of the Trust's PSIRF plan and policy is currently underway.

Safety Incident Response Accreditation Network (SIRAN)
Feedback has been received from the accreditation committee. There are two standards remaining outstanding relating to the implementation of feedback surveys. These are currently being finalised and will be submitted as evidence before September.

Quality & Safety Dashboard Footnotes:

1 - Number of pressure ulcers which developed under SWYPFT 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. 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 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - 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. Please note, the wording of this metric has changed from the November 24 report to align with wording used in the national reporting. This relates to complaints received during the month and until investigation process is complete, this may result in not all of those being upheld.

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.

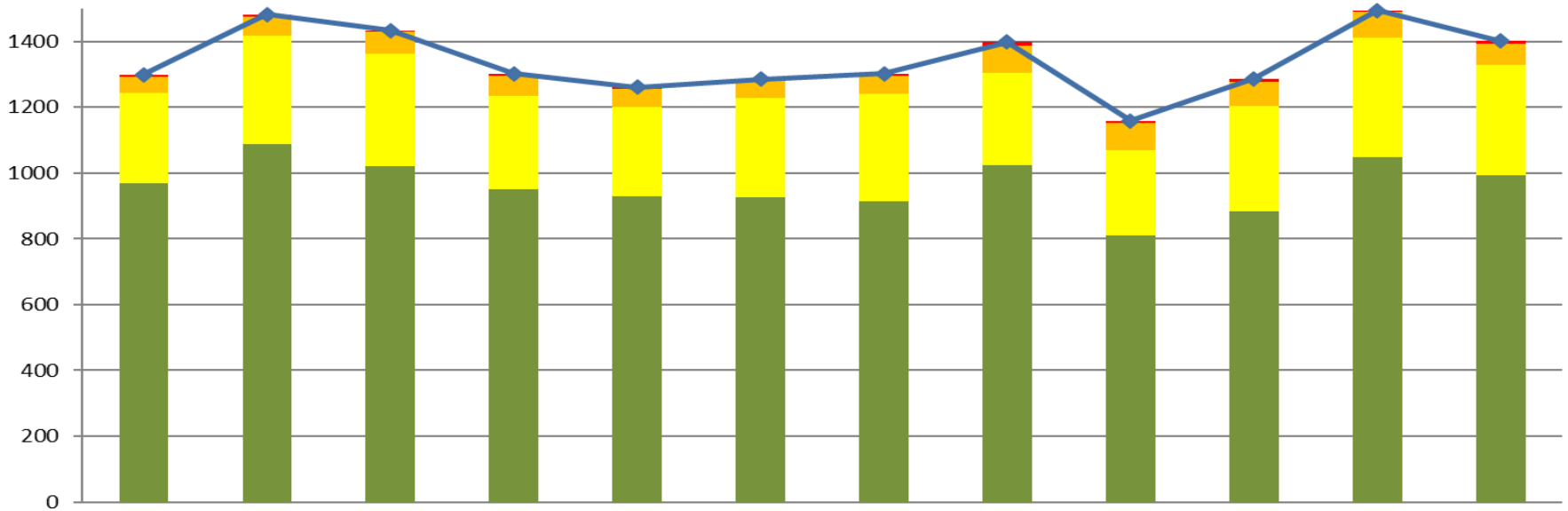
16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

* - includes data for Cheswold Park Hospital from April 2025.

Safety First

Summary of Incidents

Although we have reported 14 red incidents in March, incidents may be subject to regrading as more information becomes available so this figure is subject to change.
96% of incidents reported in May 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in May 2025



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Red (should not be compared with SIs)	6	7	5	6	4	5	6	11	6	11	4	8
Amber	50	57	65	61	56	54	57	83	82	72	79	64
Yellow	275	331	344	285	272	300	326	280	261	319	362	337
Green	968	1088	1020	951	929	927	914	1024	810	885	1049	993
Total	1299	1483	1434	1303	1261	1286	1303	1398	1159	1287	1494	1402

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 Trustwide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Safety First cont…

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

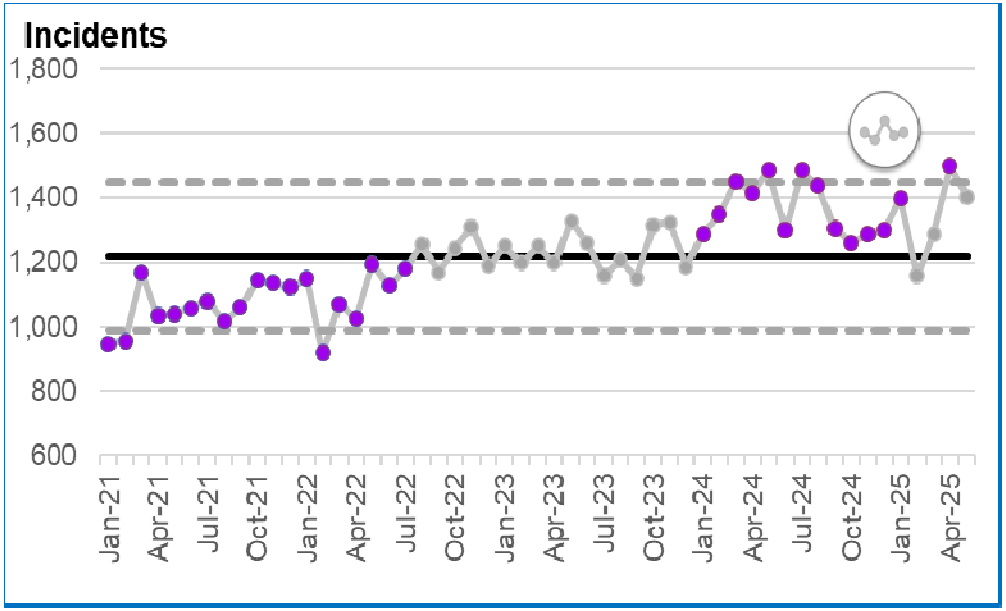
Breakdown of incidents in May 2025

26 moderate harm incidents:
The most common subcategories for incidents were pressure ulcers and self harm. The moderate harm pressure ulcers have been reviewed, the service have seen an upward trend in all category 3 pressure ulcers since July 2024. The service are doing a deep dive into this to better understand contributing factors and to help to determine opportunities for prevention of escalation in category.

There were no severe harm incidents

Sadly, there was one patient safety related death for a service user know to the Trust's mental health services. These incidents are subject to review and any learning will be identified.

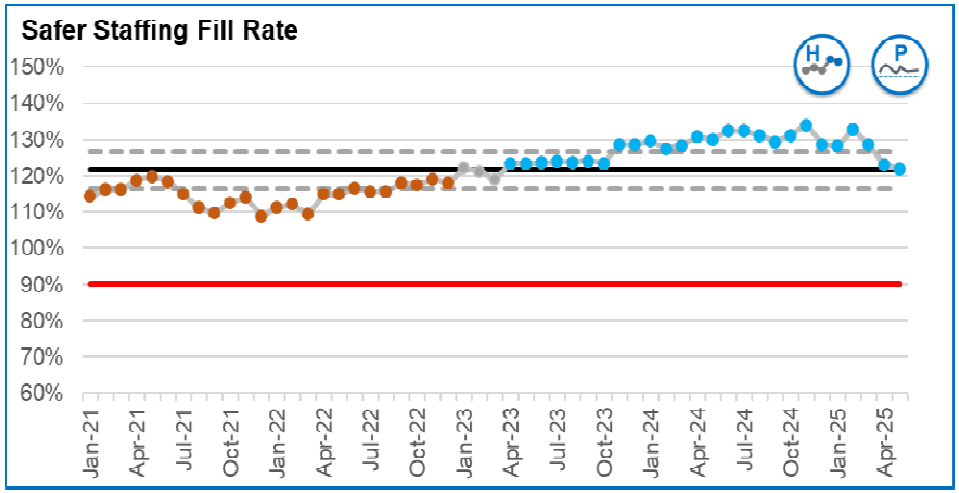
Incidents

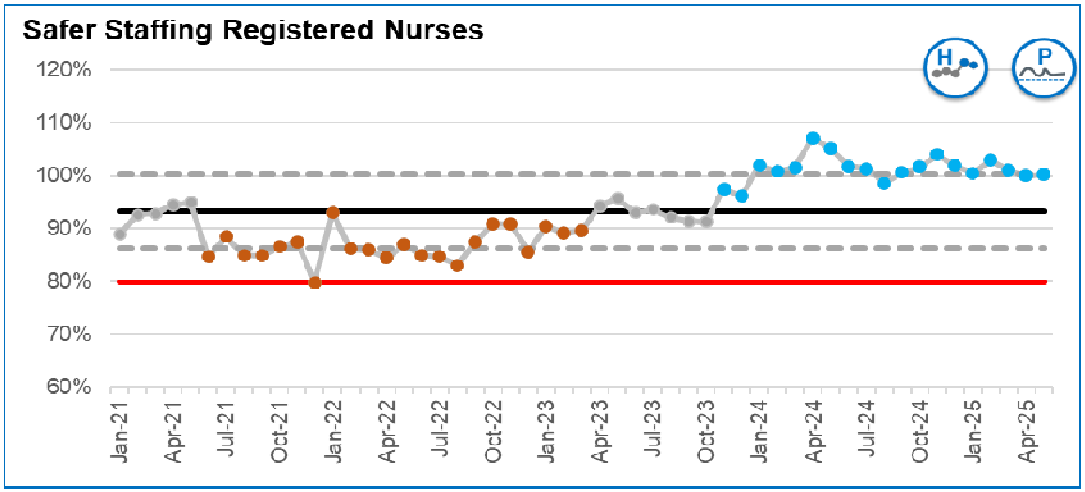


We have re-entered a period of common cause variation in May 2025 due a decrease in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. Any outlier areas are explored with specialists and care groups, who are best placed to understand changes in light of other factors. They also ensure we are doing everything we can to support individuals to minimise patient safety incidents.

Discussion about patient safety incidents has been held through the year at the Patient Safety Improvement Group to aid understanding. During 2025/26, we will be adapting our Patient safety improvement group to focus discussion on the patient safety priorities in our PSIRF plan and this will include considering triangulating data, intelligence from incidents/feedback, local and national learning, and our related improvement work. We will also include looking at emerging patient safety areas not currently in our priorities. We hope to facilitate discussion to explore any hotspots and reasons why there may be changes, consider wider intelligence from other sources including input from care groups and specialist advisors, any national guidance/reports, and what our learning responses and improvement work are telling us.

Safer Staffing Inpatients





The chart above shows that as at May 2025 despite the recent decrease in staffing fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are

The chart above shows that in May 2025, due to the sustained increase in the registered nurses fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet

• The Trust has seen a reduction in the safer staffing fill rate over the last 4 months, this is linked to the grip and control measures that have been put into place in relation to the use of temporary staffing.
• May's figures are reported with Cheswold Park Hospital (CPH) being separated out due to integration issues with all the other data sets, this is being investigated and addressed as a matter of urgency.
• In May the overall demand varied by just one shift on the previous month.
• Within the flexible staffing pool there were a total of one more shift request, and the overall fill rate decreased by 0.2% to 89.47%.
• Within overall fill rates there was a decrease in the fill rates of 4% for Forensic and Learning Disability care group to 116%, Adult and Older Peoples Care Group reduced by 4% to 128% and Barnsley Integrated Services decreased 3% to 103%. Cheswold Park Hospital increased by 7% to 118%
• We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny and e-rostering groups.
• We have stopped utilising agency workers except in authorised situations which is in line with our Grip and Control group.
• The overall fill rate reduced by 3.9% to 122.4% (and had a decrease of 1% with CPH to 122%) The day fill rate for registered nurses decreased by 2.4% to 99.0%. Two wards, a decrease on April of two, Ward 19 (Male) and Willow in the Adult and Older Peoples care group, fell below the 90% registered nurse day fill rate. They were supported through local escalation plans.
• The night registered nurse fill rate increased by 2% to 108%. Night fill rate was not achieved by Calder and Skipton Wards at Cheswold Park and Neuro Rehab in Barnsley Integrated Services. This was an increase of two wards on April.
• In May no ward fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days

The day fill rate for registered nurses decreased by 2.4% to 99.0%. There is a particular decrease in Barnsley Integrated services which is linked to vacancies within the neuro and stroke rehabilitation units.

Registered day rate	Mar-25	Apr-25	May-25
Adults and Older People	101%	102%	99%
Barnsley Integrated Services	112%	118%	101%
Forensic and LD	99%	97%	97%
Cheswold Park Hospital		99%	102%
Overall shift fill rate	**101%**	**101%**	**99%**

Registered Nurses Nights

The night registered nurse fill rate increased by 2% to 108%

Registered night rate	Mar-25	Apr-25	May-25
Adults and Older People	110%	109%	107%
Barnsley Integrated Services	99%	104%	105%
Forensic and LD	127%	120%	121%
Cheswold Park Hospital		79%	90%
Overall shift fill rate	**116%**	**106%**	**108%**

Overall Registered Rate: In May the overall registered fill rate decreased by 0.1% to 100.2%.
Overall Fill Rate: reduced by 3.9% to 122.4% (and had a decrease of 1% with CPH to 122%)

Overall Fill Rate	Mar-25	Apr-25	May-25
Adults and Older People	135%	132%	128%
Barnsley Integrated Services	105%	106%	103%
Forensic and LD	123%	120%	116%
Cheswold Park Hospital		111%	118%
Grand total	**129%**	**123%**	**122%**

Bank staff filled 80.78% (a decrease of 3.87% on the previous month) of registered nurse requests for flexible staffing and 87.28% (an increase of 2.07% on the previous month) of Healthcare assistant requests.
Agency staff filled 0.55% (an increase of 0.04% on the previous month) of registered nurse requests for flexible staffing and 3.83% (a decrease of 1.41% on the previous month) of Healthcare assistant requests.

Information Governance (IG)

Seven personal data breaches were reported during May 2025.

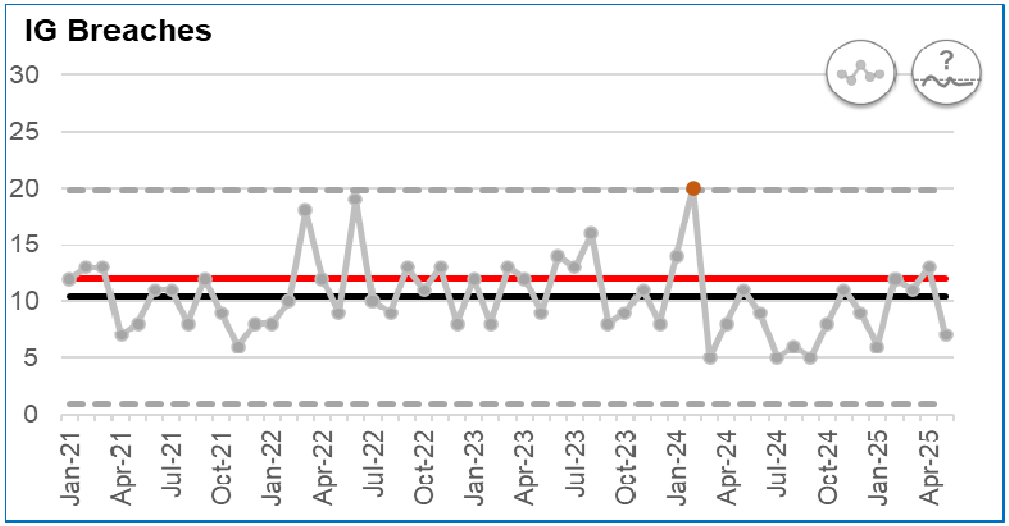
Information disclosed in error continues to be the highest reported category. Breaches during May were due to:
- Multiple patients' letters being put in one envelope
- Wrong patient identified on system and contacted

A security breach occurred when a laptop and papers were stolen during a break in to a staff member's car.

An amber incident was reported when a staff member reportedly shared sensitive personal information about a patient in a public place. The patient made a formal complaint, which is being managed by the ward manager.

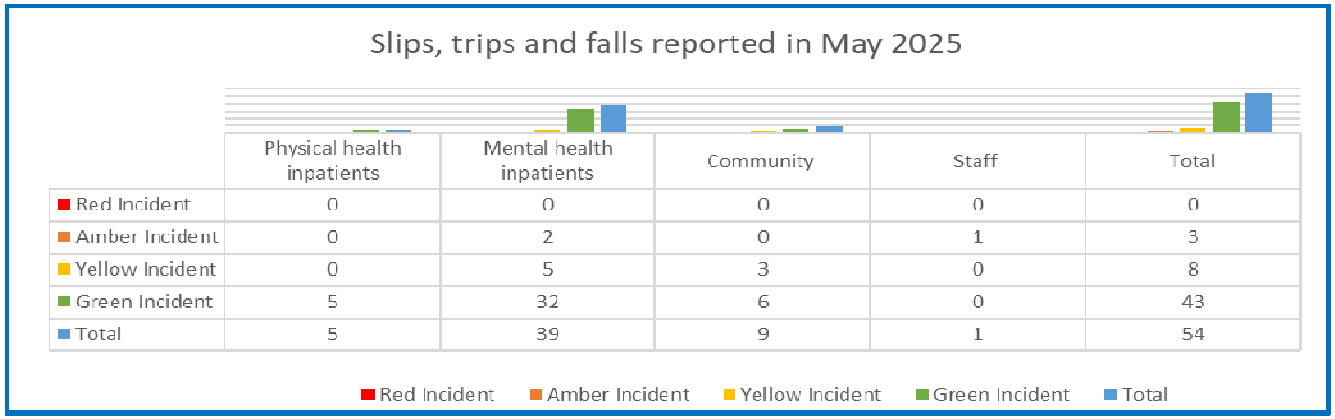
A communications campaign is in progress and personal responsibility for correctly identifying services users on the clinical systems is a key focus this month, to prevent further incidents.

This SPC chart shows that as at May 2025 we remain in a period of common cause variation. Overall there has been a decrease in the number of IG breaches.



Trustwide Falls

In May 2025, a total of 54 slips, trips, and falls were reported. 44 of these were in inpatient wards.



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	2	0	1	3
Yellow Incident	0	5	3	0	8
Green Incident	5	32	6	0	43
Total	5	39	9	1	54

The Trust inpatient falls rate is 2.72 per 1000 bed days. The falls rate has seen a reduction; partly due to a lower number of falls in May, and a further reduction linked to the additional bed days from Cheswold Park Hospital. We continue to be below the National average for inpatient falls of 6.3 per 1000 bed days.

Post Falls Protocol completion has averaged 98% this month, with a continued good response from staff.

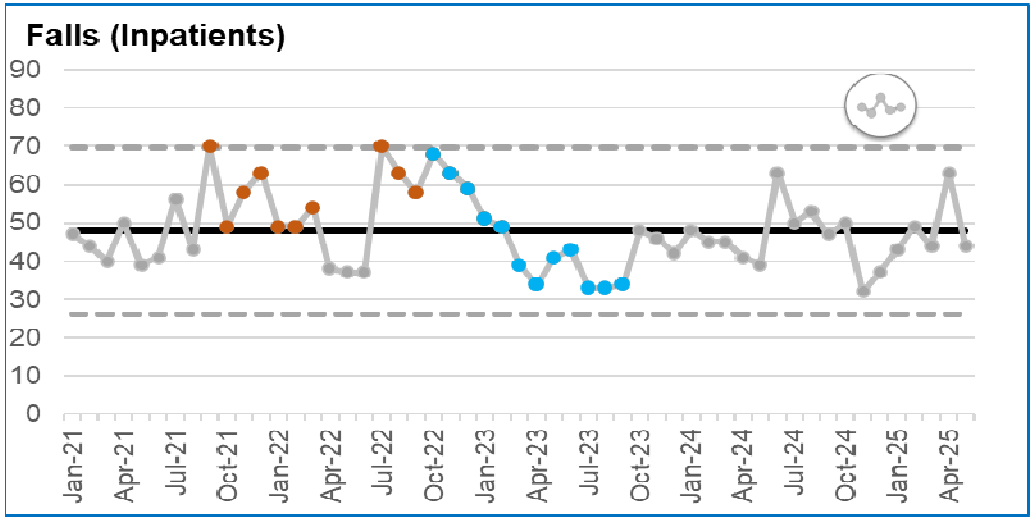
Incident Grading
There were no red incidents.
Amber: A total of three falls (6%), two falls for inpatients who were diagnosed with a hip fracture. One amber fall for a member of staff who did not harm themselves; highlighted as needing further review as appeared to have several previous incidents with the same service user potentially targeting the member of staff.
Yellow: A total of seven (13%) reported events needed higher intervention, such as attending A&E, or minor treatment.
Green: A total of 43 (81%) reported safety events had low, or no harm recorded. Main themes reported linked with over reaching for items; agitation; low blood pressure and dizziness; and early signs of infection.

Inpatient falls had a high correlation with:
• there were 18 falls (41%) were for older adults
• some reported falls (9%) did not occur on the wards. Three falls were patients on leave; one fall for a visitor who fell when they went out with their relative
• there were 27 falls (61%) involving patients with a recognised history of falls, and of these falls:
  - there were 16 falls (59%) for patients with a diagnosis of dementia
  - all 27 patients (100%) had multiple long-term health conditions

NICE quality standard reviews in May 2025 across the older adult, stroke/neuro wards showed approximately 81 patients, 65 years and above; recognised as being at a high risk of falls, of those:
• there were 18 falls (22%) for people aged above 65yrs old
• long-term health conditions were reported in 78 (96%) of all older patients at risk of falls
• there were 56 (69%) patients needing support with daily living skills
• physiotherapy reviews took place for 81 (100%) patients recognised as a higher risk of falls
• individualised mobility plans were in place for 77 patients (95%) and included education, and therapy groups to reduce deconditioning

Falls (Inpatient)

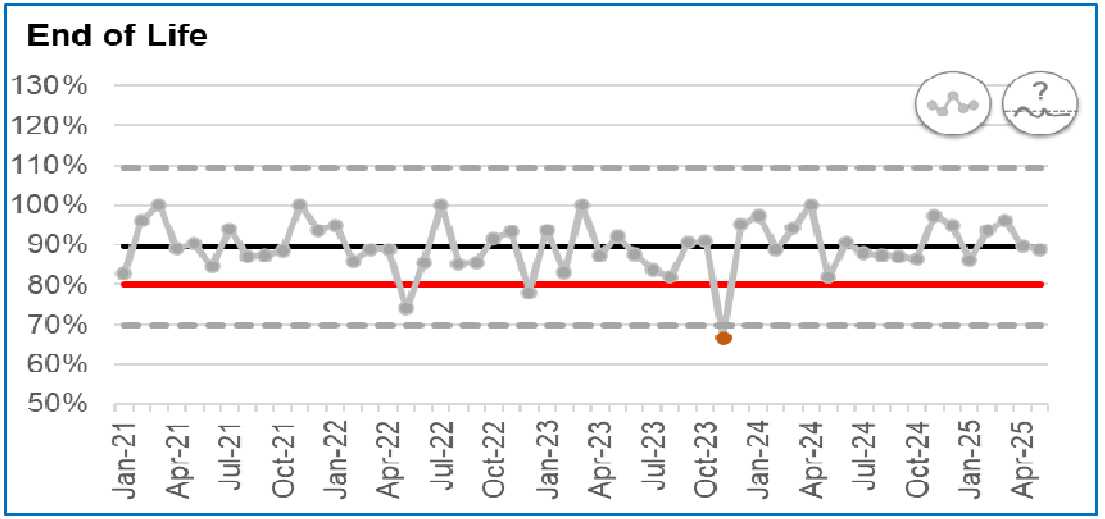
The total number of inpatient falls was 44 in May.



The SPC chart above shows that in May 2025 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 May. As is noted in the quality dashboard, performance against this metric remains above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in May 2025 the performance against this metric remains in common cause 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 results (FFT) show:

- 96% would recommend physical health services
- 94% would recommend mental health services

	Target	March	April	May
Mental health community	85%	95% (249)	95% (208)	95% (314)
Mental health inpatient	85%	90% (51)	91% (23)	91% (32)
Learning Disabilities	85%	100% (22)	100% (21)	94% (49)
ASD/ ADHD	85%	94% (32)	100% (17)	92% (12)
CAMHS	85%	83% (24)	86% (21)	88% (33)
Forensic	60%	63% (32)	N/A	N/A
Mental health overall	84%*	**91% (410)**	95% (308)	94% (450)
Barnsley Physical Health	95%	**93% (318)**	96% (394)	96% (421)
Trustwide	**85%**	**92% (728)**	96% (702)	95% (871)

** weighted for 2023/24*

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

Overall satisfaction across the Trust has slightly decreased in May, however, remains above target.

Trustwide returns have increased for the first time in the past 3 months the overall satisfaction has seen a decreased but remains above target.

Satisfaction across Child and adolescent mental health services (CAMHS) increased in May and is the highest for many months, with an increased number of returns.

All service lines remain above target.

Attention Deficit Hyperactivity Disorder & Autistic Spectrum Disorder services have seen a decrease in returns, but the overall satisfaction remains above target. There is ongoing work with the team to increase the number of returns.

Learning disabilities have seen an increase in returns, the overall satisfaction has decreased but remains above target.

Safeguarding

Safeguarding Adults:
In May 2025, there were 62 safeguarding adult incidents recorded on Datix. Of these, there were Zero incidents graded red, three graded amber, 27 graded yellow and the remaining 32 were graded green. The most common subcategories of these were financial abuse, self-neglect and neglect.

In addition to the Safeguarding Adult Datix's, there were 24 sexual safety incidents recorded on Datix. Of these, 11 were graded yellow and 13 were graded green with the most common subcategory relating to inappropriate sexual behaviour.

Safeguarding Children:
In May 2025 there were 10 Datix categorised as Safeguarding Children. There were no red incidents reported, one was classified as amber, seven were classified as yellow incidents and three were classified as green incidents. The most common subcategories of these were sexual abuse and child protection (non specific).

Complaints

• In May there were 28 new formal complaints received into the Trust. This includes Cheswold Park. This is a slight decrease from April, however is higher than the same time last year.
• Of these, 5 had the initial theme of values and behaviours (staff) as the primary reason for the complaint. It is important to note these are complaints which have not yet been investigated.
• 17 complaints were closed in May and 88% (15) were closed within the six month statutory timeframe. Of the two that were outside of the six month one was delayed due to complex consent issues and the other due to consent and difficulty agreeing the scope of the complaint.
• No complaints were re-opened in May.
• There were 75 compliments received, which is a notable increase from 25 in April.

Reducing Restrictive Physical Intervention (RRPI)

This report includes Cheswold Park data from April 2025. In May 2025 there were

• 170 reported incidents of restrictive physical interventions used in May 2025, this was an increase of 12 (7.5%) from April which stood at 158

• Prone restraint (those remaining in prone position and not rolled immediately) was reported 11 times an increase of 3 (22.22%) from April 2025 which stood at 8. The use of prone has been reducing compared to previous years and focus is being applied to situations where prone is used with the aim of reducing to zero incidents by April 2026. The trajectory of no more than 12 restraints during April and May has been achieved, however, there was an increase in incidents in May. Incidents were mostly attributed to our psychiatric intensive care units. A deep dive into each case is undertaken and learning shared across teams. Reducing restrictive practice intervention training from the 1st April teaches all new starters and refresher training to exit seclusion and administer intramuscular medication without using prone restraint. The trajectory for June and July is no more than 10.

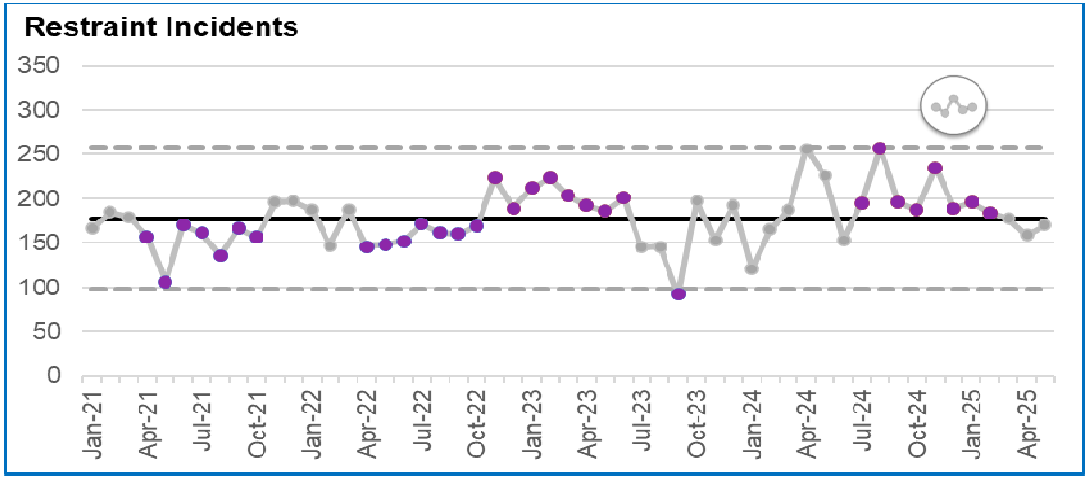
• 100% of Prone Restraints in May 2025 lasted under 3 minutes.

• In May 2025 there were 48 incidents of Seclusion use Trustwide, a decrease of 7 (12.7%) from April 2025 which stood at 55.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	83	35.2%
Safety Pod	46	19.5%
Side	34	14.4%
Seated	31	13.1%
Supine - held on their back regardless of surface	20	8.5%
Prone descent then remained in chest down position	9	3.8%
Restricted escort	6	2.5%
Kneeling	5	2.1%
Prone descent then immediately rolled to other position side/back	2	0.8%

Team Using Prone Restraint	May-25
Walton PICU	3
Melton PICU, Barnsley	2
Stanley Ward, Wakefield	2
Ashdale Ward, The Dales, Calderdale	1
Clark Ward	1
Horizon	1
Nostell	1

Duration of Prone Restraint	May-25
0 - 1 minute	9
1 - 2 minutes	2

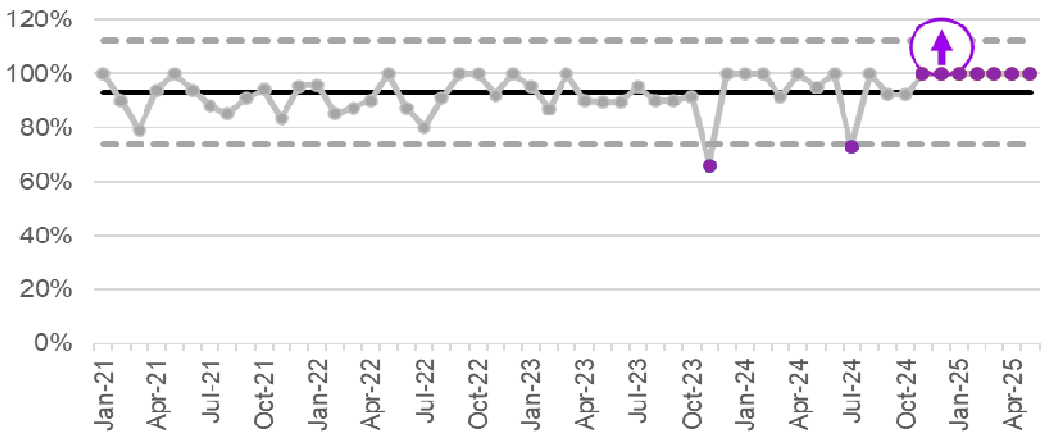


This SPC chart shows that in May 2025 we remain in a period of common cause improving variation.

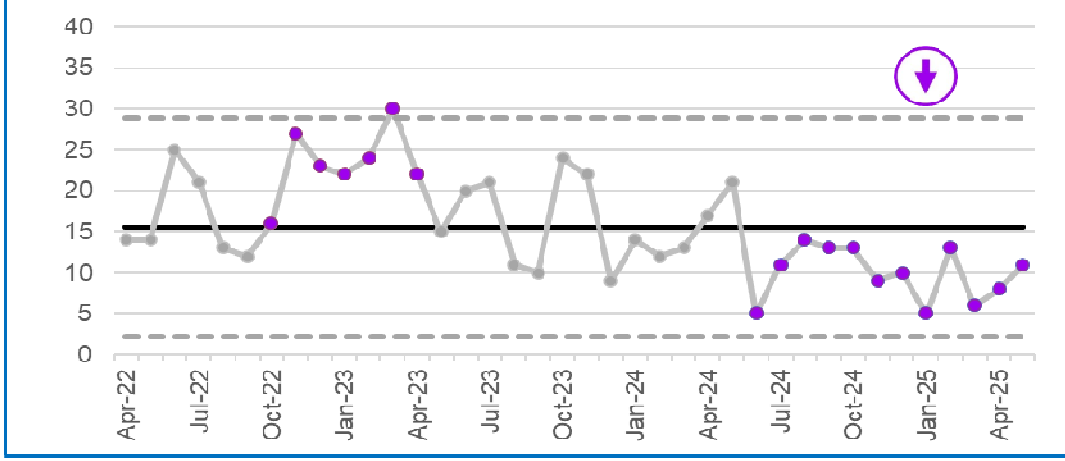
It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.

Reducing Restrictive Physical Intervention (RRPI)

Prone Restraint (% Under 3 Minutes)



Prone Restraint (Incident Numbers)



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.

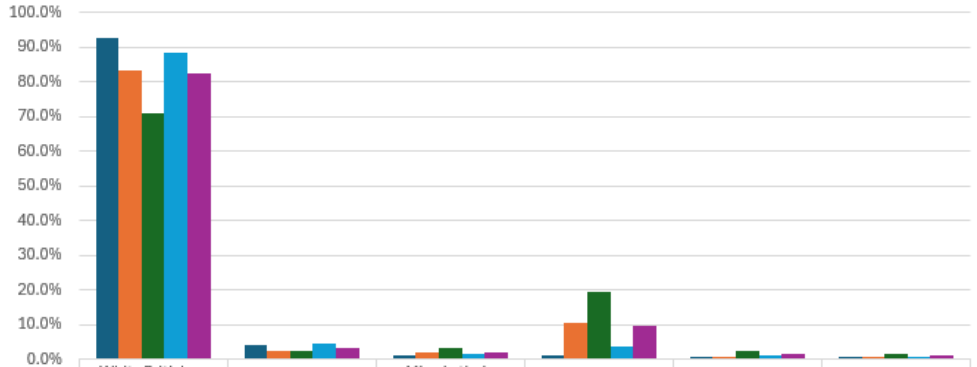
The number of prone restraints has increased in May, however the SPC chart shows an overall reducing trend. All incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group. The improvement work continues.

Reducing Inequalities

This section of the report has been added to give focus to a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. We will continue to further develop this section of the report over the coming months in line with the deployment of our Equality, diversity and inclusion (EDI) strategy.

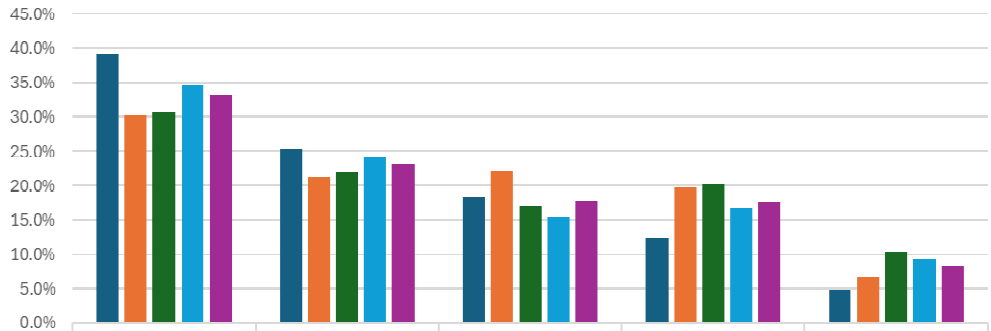
The population our Trust serves is varied in terms of ethnic make-up and also levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 6) Barriers to housing and services, 7) Living environment. These can be examined individually or collectively and as a collective these are known as Indices of Multiple Deprivation (IMD). IMD can be shown grouped as quintiles or deciles (5 levels or 10 levels respectively), with IMD 1 or quintile being the most deprived. From the Trust data it is possible to see that a significant proportion of all our populations experience higher levels of deprivation. The charts below show the populations of the main areas we serve as well as a Trust total split by Ethnicity and deprivation level.

Population Served by the Trust and each of its Main Localities Split by Ethnicity



	White British or Irish	Other White	Mixed ethnic groups	Asian, Asian British	Black, Black British	Other ethnic group
Barnsley	92.8%	4.1%	0.9%	0.9%	0.7%	0.5%
Calderdale	83.5%	2.6%	1.9%	10.5%	0.7%	0.8%
Kirklees	71.1%	2.6%	3.1%	19.4%	2.3%	1.5%
Wakefield	88.5%	4.6%	1.4%	3.6%	1.3%	0.7%
Trust	82.4%	3.4%	2.0%	9.8%	1.4%	1.0%

Population Served by the Trust and each of its Main Localities Split by Deprivation Level



	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Barnsley	39.1%	25.3%	18.3%	12.4%	4.9%
Calderdale	30.2%	21.3%	22.2%	19.7%	6.6%
Kirklees	30.6%	22.0%	16.9%	20.2%	10.3%
Wakefield	34.5%	24.2%	15.4%	16.7%	9.2%
Trust	33.3%	23.1%	17.7%	17.6%	8.3%

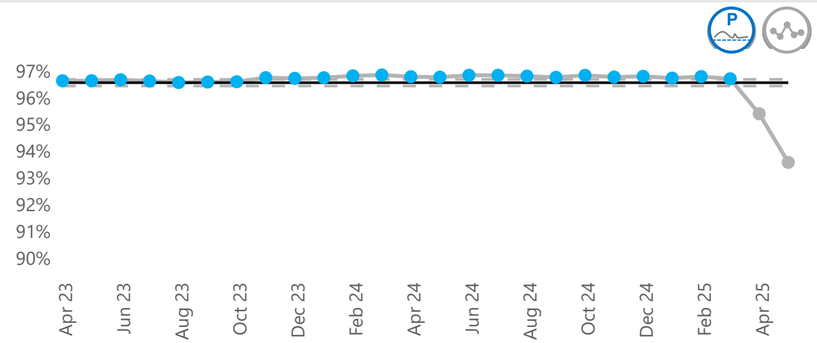
Reducing Inequalities

Data as of : 10/06/2025 12:53:23

NHS South West Yorkshire Partnership NHS Foundation Trust

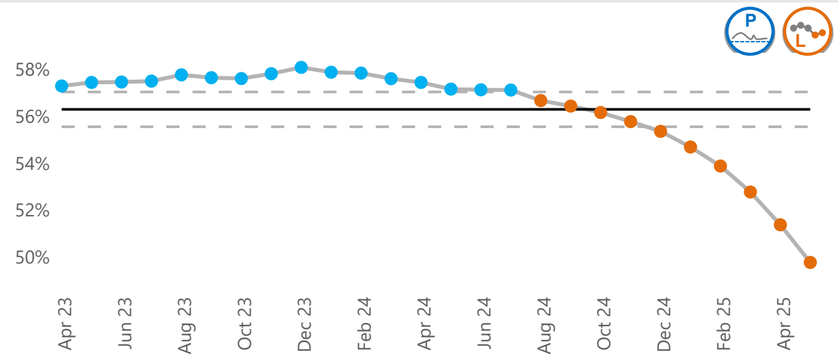
In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. The SPC charts below show the completion rates for these measures.
Please note the scales in the below charts are different due to the small variation between data points, using a larger scale would lose the fluctuation between data points.

M92 - Percentage of service users who have had their equality data recorded - ethnicity



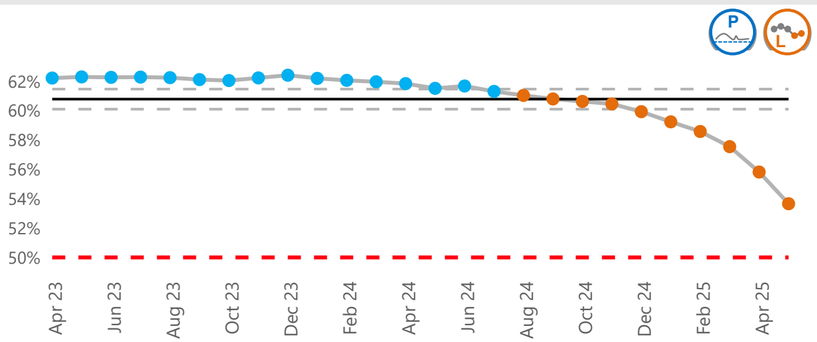
The Statistical Process Control (SPC) chart shows that in April 2025 we remain in a period of common cause variation (no concern). We are expected to meet the target against this metric.

M93 - Percentage of service users who have had their equality data recorded - disability



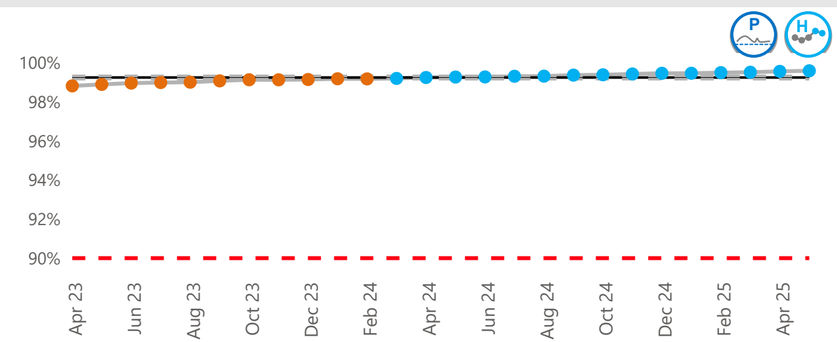
The SPC chart shows that in April 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

M94 - Percentage of service users who have had their equality data recorded - sexual orientation



The SPC chart shows that in April 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

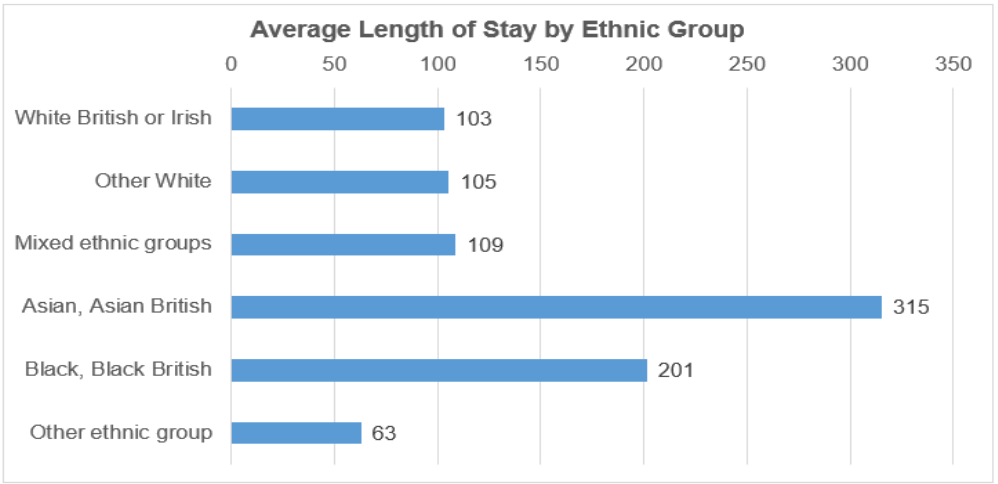
M95 - Percentage of service users who have had their equality data recorded - deprivation (postcode)

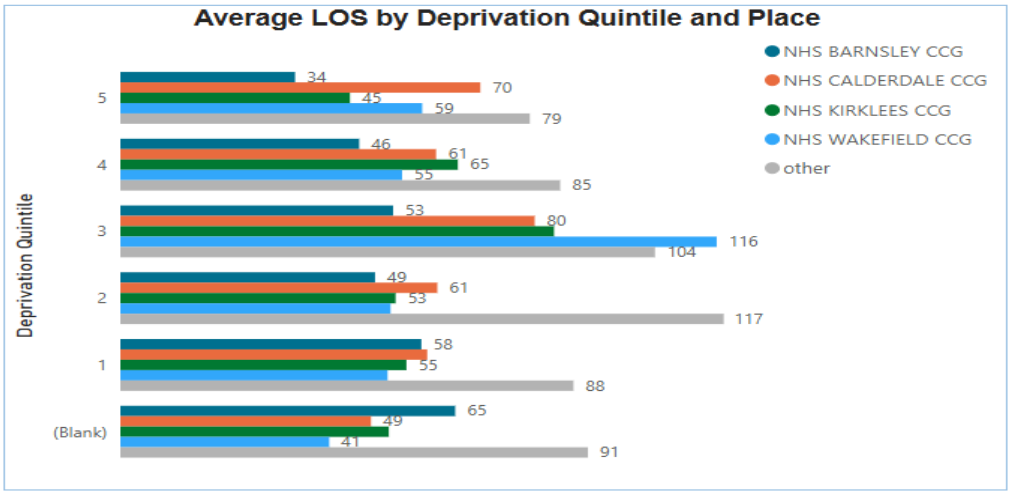


The SPC chart shows that in April 2025 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance.

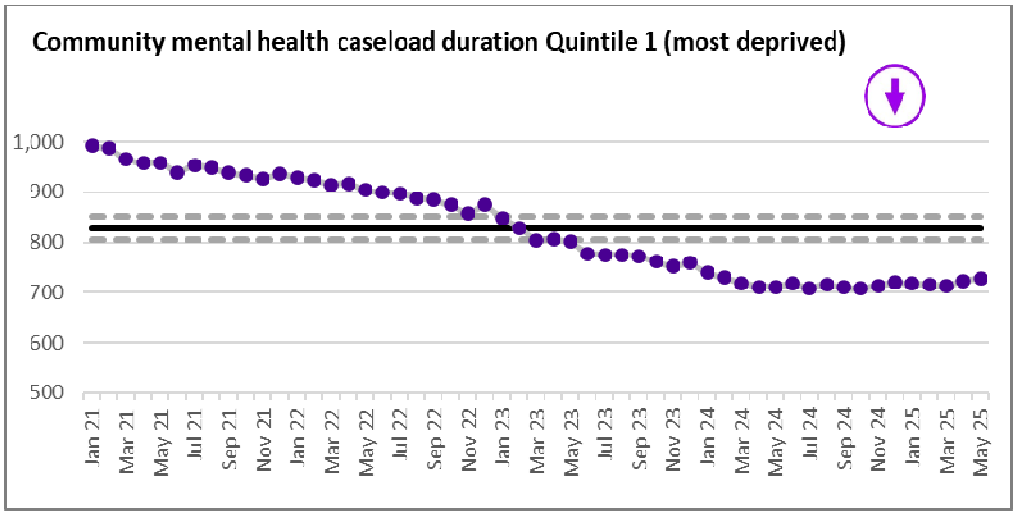
Reducing Inequalities

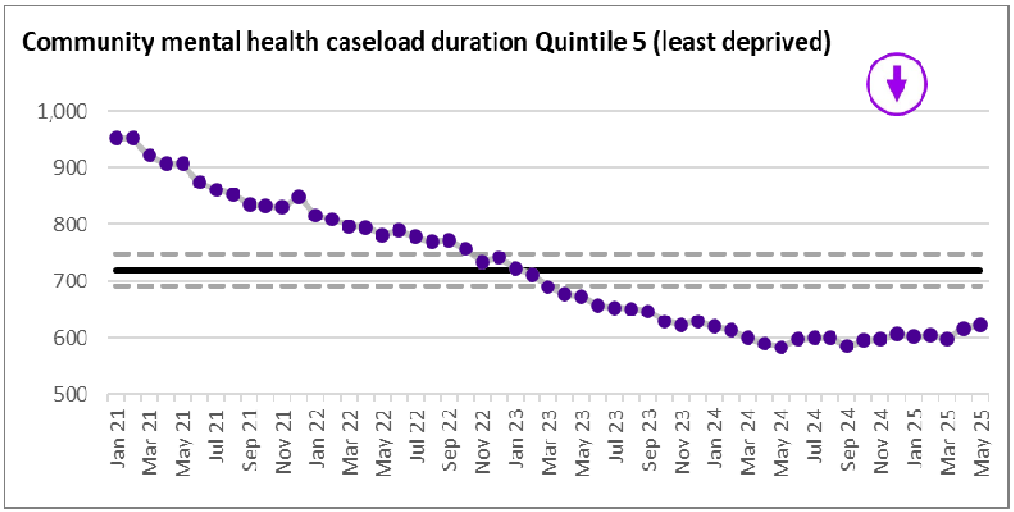
The charts below show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2024/2025 (excluding 136 Suite and out of area stays). The data suggests that deprivation may be an independent factor that affects caseload duration. Services are working hard to understand if and how this may factor in their own data.





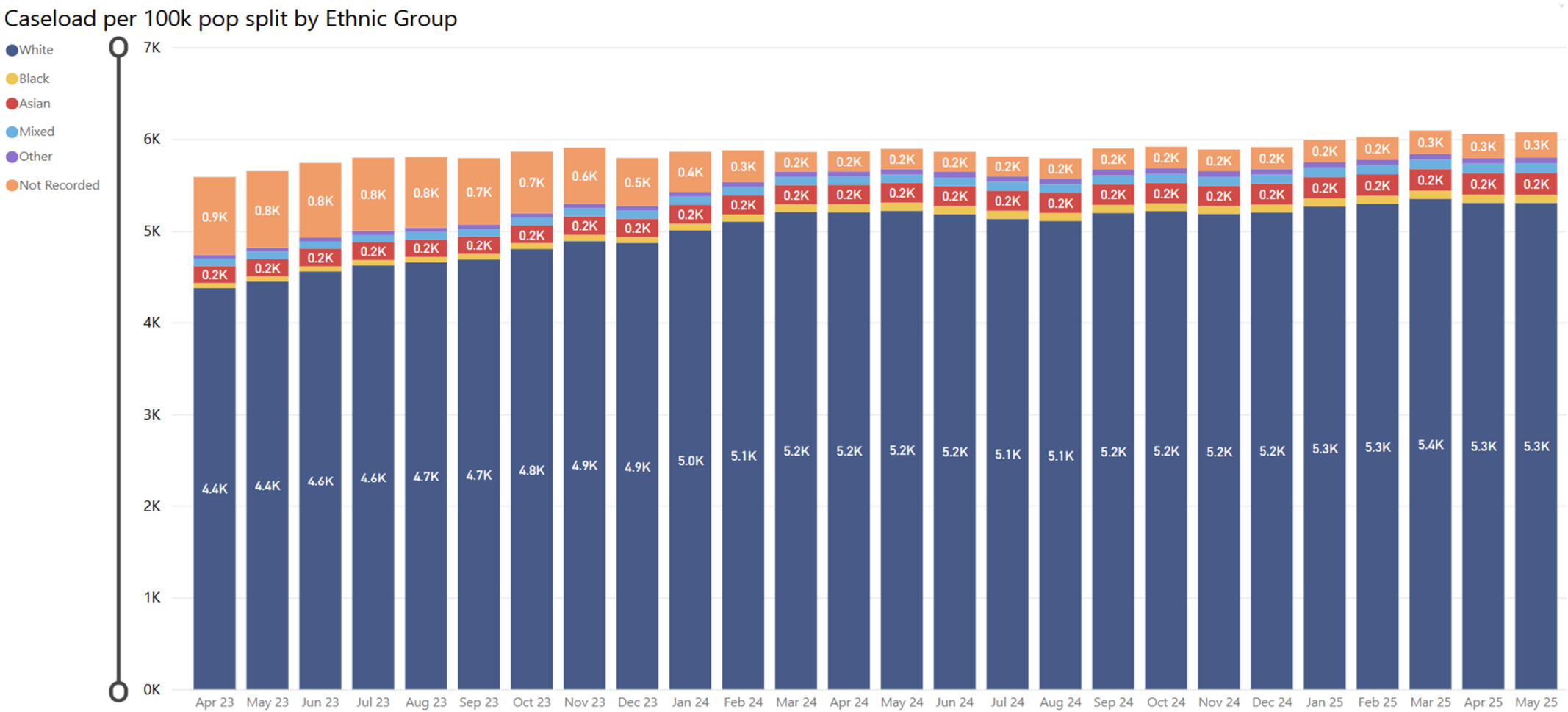
The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Quintile 1) and those with a post code in the least deprived areas (Quintile 5).





Reducing Inequalities

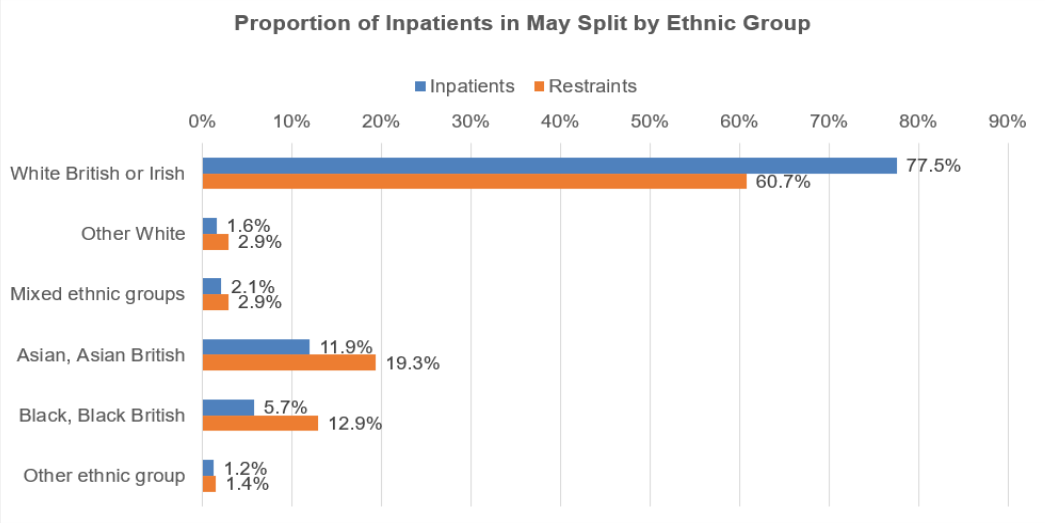
The chart below shows the split by the ethnic group of the clients on the caseload of a community health team, shown per 100,000 population.

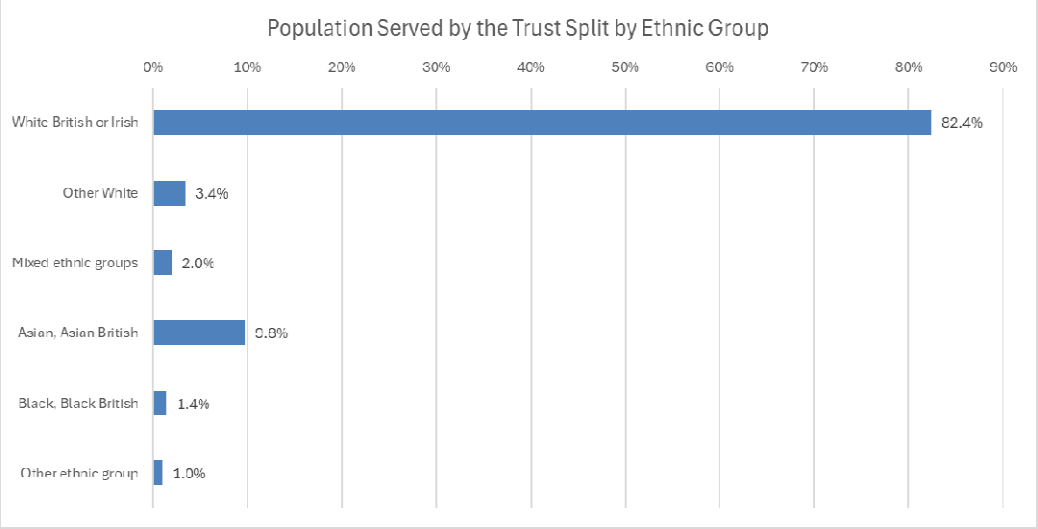


NB: 'White Other' is incorporated in the 'white' category in this chart.

Reducing Inequalities

The chart below shows the proportion of inpatients and proportion of restraints split by ethnic group. The population of the Trust split by ethnic group is shown alongside for ease of comparison.

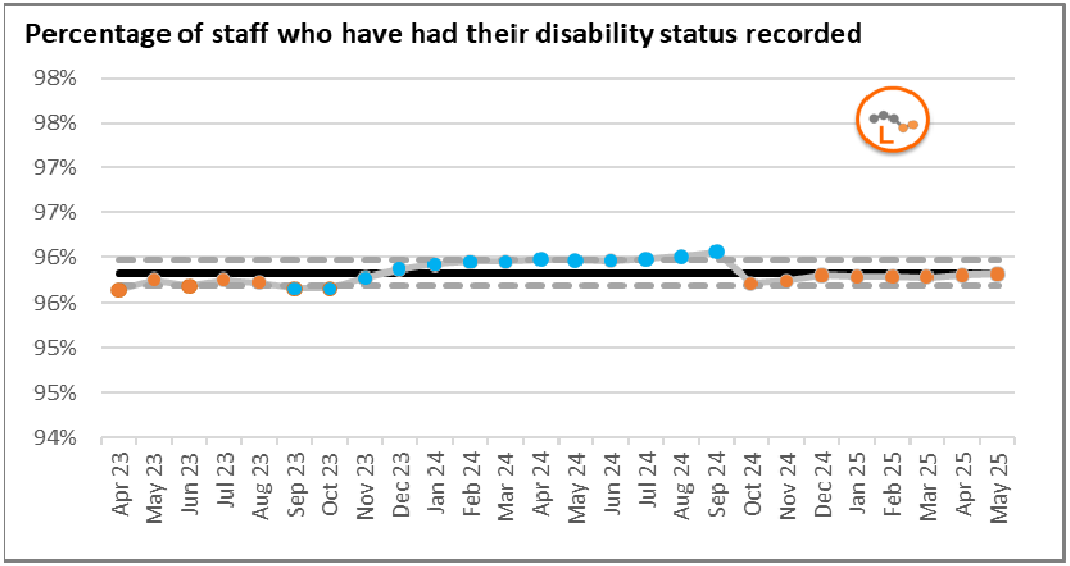


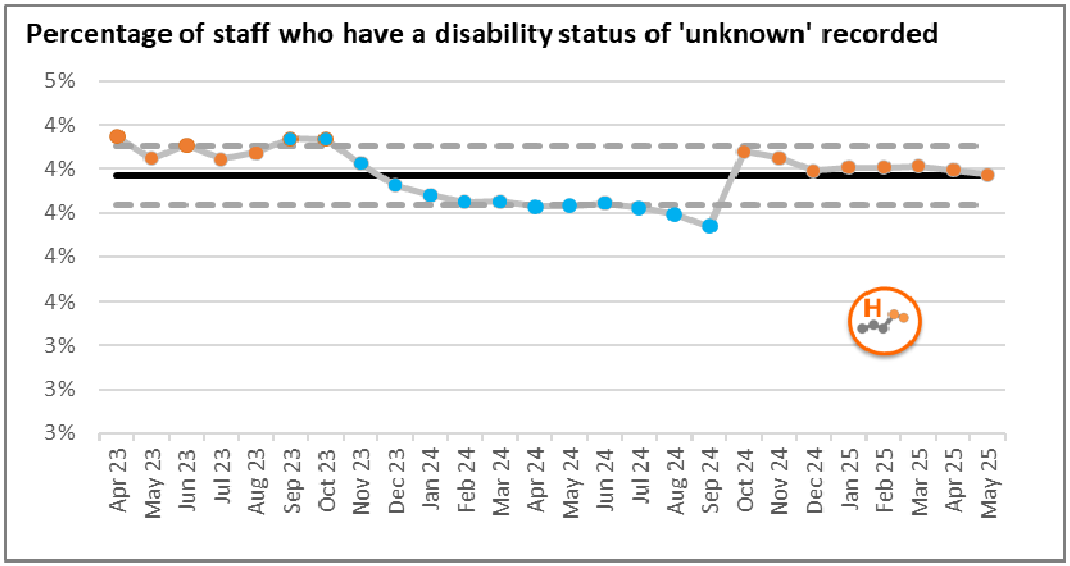


Reducing Inequalities

Disability Confidence and Data Transparency

Objective: Foster a culture where more colleagues feel safe and supported in disclosing their disability status.





Further development of people related metrics will be undertaken over the coming months with focus being on the following areas: Increase Diversity in Senior Leadership, Fair and Trusted Processes, Wellbeing with Inclusion at the Core.

People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Establishment	Best place to work and learn	Well led	-	5524.3	5526.8	5523.1	5514.2	5733.3	5733.3
Contracted Staff In Post (Ledger)	Best place to work and learn	Well led	-	4738.8	4746.5	4747.5	4749.9	4988.0	4971.6
Vacancies	Best place to work and learn	Well led	-	785.5	780.4	775.7	764.3	745.3	761.7
Turnover external (12 months rolling) *	Best place to work and learn	Well led	>12% - <13%	7.6%	7.8%	7.7%	8.6%	9.4%	9.2%
Starters	Best place to work and learn	Well led	-	17.4	48.3	30.6	25.2	21.2	19.4
Leavers	Best place to work and learn	Well led	-	30.0	40.7	26.9	74.1	41.8	24.0
% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	79.2%	83.7%	83.3%	85.7%	84.6%	80.8%
% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	82.6%	82.2%	83.1%	82.6%	85.2%	87.3%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	91.7%	93.6%	92.6%	90.9%	89.7%	89.5%
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in posts band 7 and above, excludes bank staff) *	Best place to work and learn	Well led	-	224 - All staff (17.4%) 89 - excl medics (8.1%)	226 - All staff (17.5%) 89 - excl medics (8.1%)	226 - All staff (17.4%) 91 - excl medics (8.3%)	228 - All staff (17.4%) 92 - excl medics (8.3%)	229 - All staff (17.4%) 93 - excl medics (8.4%)	232 - All staff (17.7%) 94 - excl medics (8.5%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	915 (71.0%)	921 (71.2%)	927 (71.4%)	935 (71.4%)	936 (71.4%)	937 (71.3%)
Sickness absence - YTD	Best place to work and learn	Well led	<=5%	5.3%	5.3%	5.3%	5.2%	4.7%	4.7%
Sickness absence - Month	Best place to work and learn	Well led		5.7%	5.5%	5.1%	4.6%	4.7%	4.7%
Employees with long term sickness over 12 months	Best place to work and learn	Well led	-	2	2	2	2	1	1
Appraisals - rolling 12 months	Best place to work and learn	Well led	Feb 82.3% Mar 84.9% April 87% May 88%	88.6%	84.2%	84.3%	86.3%	88.4%	89.8%
Employee Relations - Suspensions (over 90 days)	Best place to work and learn	Well led	-	0	0	2	2	2	6
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	64	61	71	60	66	72
Workforce growth (substantive staff)	Best place to work and learn	Well led	-2%	2.3%				-0.3%	
Registered substantive staff in post mental health and learning disabilities services	Best place to work and learn	Safe	Establishment - 1315	1,139	1,134	1,138	1,143	1,174	1,174
Registered substantive staff in neighbourhood teams	Best place to work and learn	Safe	Establishment - 169	160	164	165	166	162	160
% staff recommending the Trust as a place to work	Best place to work and learn	Caring	65%	70%				Annual metrics - due Jan 26	
% staff recommending the Trust as a place to receive care and treatment	Best Quality	Caring	65%	72%					
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	93.4%	93.6%	93.7%	93.3%	94.0%	94.7%
Mandatory Training - Reducing Restrictive Practice Interventions	Best place to work and learn	Well led		80.5%	81.5%	80.1%	79.6%	82.1%	84.3%
Mandatory Training - Cardiopulmonary Resuscitation	Best place to work and learn	Well led		82.0%	80.9%	81.3%	79.7%	80.9%	82.7%
Mandatory Training - Clinical Risk	Best place to work and learn	Well led		95.1%	96.5%	96.6%	96.4%	96.7%	97.0%
Mandatory Training - Display Screen Equipment	Best place to work and learn	Well led		97.9%	98.1%	98.0%	98.2%	98.3%	98.5%
Mandatory Training - Equality & Diversity	Best place to work and learn	Well led		96.3%	96.4%	96.3%	95.9%	96.6%	97.3%
Mandatory Training - Fire Safety	Best place to work and learn	Well led	>=85%	90.0%	90.6%	90.9%	88.9%	90.7%	91.9%
Mandatory Training - Food Safety	Best place to work and learn	Well led	>=80%	91.3%	92.2%	92.4%	92.5%	94.0%	94.6%
Mandatory Training - Freedom To Speak Up (FTSU)	Best place to work and learn	Well led		96.9%	97.0%	97.1%	97.2%	97.4%	97.7%
Mandatory Training - Infection Control & Hand Hygiene	Best place to work and learn	Well led		94.9%	94.9%	95.3%	94.4%	95.6%	96.3%
Mandatory Training - Information Governance (Data Security)	Best place to work and learn	Well led	>=95%	93.6%	93.5%	93.1%	91.1%	92.4%	95.8%
Mandatory Training - Moving & Handling	Best place to work and learn	Well led	>=80%	97.7%	97.8%	97.9%	98.0%	98.3%	98.7%
Mandatory Training - Nat Early Warning Score 2 (New S2)	Best place to work and learn	Well led		97.7%	98.1%	97.9%	97.9%	98.0%	98.3%
Mandatory Training - Mental Capacity Act/Dols	Best place to work and learn	Well led		91.0%	91.6%	91.6%	91.3%	91.8%	92.2%
Mandatory Training - Mental Health Act	Best place to work and learn	Well led		88.5%	90.0%	90.5%	90.4%	91.7%	92.4%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1	Best place to work and learn	Well led		92.1%	92.9%	93.8%	94.0%	94.8%	95.3%
Mandatory Training - Prevent	Best place to work and learn	Well led	>=80%	95.3%	95.7%	95.7%	95.4%	96.4%	96.9%
Mandatory Training - Safeguarding Adults	Best place to work and learn	Well led		91.0%	91.1%	91.0%	91.1%	91.6%	91.4%
Mandatory Training - Safeguarding Children	Best place to work and learn	Well led		93.3%	93.6%	92.9%	92.4%	91.7%	91.7%

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.

Staff in post

• The reduction in staff between April and May has been largely down to the ending of Liaison & Diversion services roles (around 33 whole time equivalents) at the end of the contract. There have also been some terminations of fixed term contracts ending in May which have not been renewed (3). Further fixed term contracts will be coming to an end throughout the year.

Vacancies

• Due to the reduction of staff in post we have seen a rise in vacancies (+16.4) against a static establishment figure (no change).
• The Trust has concluded it's first level establishment review and identified 116 Community Support Workers (Health Care Support Workers) vacancies across all ward areas. A full recruitment plan between now and March 2026 is in place. The first cohort (15) was identified on 21st June.

Turnover & Stability

• External turnover has reduced by 0.2% in month. This is still under our target of between 12-13%. We are seeing higher turnover in clinical support roles (12%), but sustained low turnover in nursing (7%) and medics (6%).
• As a result of higher leavers in the first 2 months, our overall stability has dropped, but still remains around 90% which is within expected range.
• As previously mentioned the end of contract for the Liaison and Diversion service resulted in the ending of around 33 whole time equivalent staff. There have also been some terminations of fixed term contracts ending in May which have not been renewed (3). Further fixed term contracts will be coming to an end throughout the year.

Sickness

• Overall sickness absence remains low in May at 4.7%.
• We are seeing higher absence rates in Forensics (7.8%) and Estates (7.0%) with both relating to higher levels of long term sickness cases which are being pro-actively managed between People business partners and Operational leads.
• The higher levels of long term sickness in these two areas are contributing factors to an overall rise in long term sickness as a % of total absence.
• The introduction of a new 'Live' sickness absence dashboard has been rolled out Trustwide, enabling faster, more dynamic intervention and management of hotspot areas for sickness in teams and individuals.

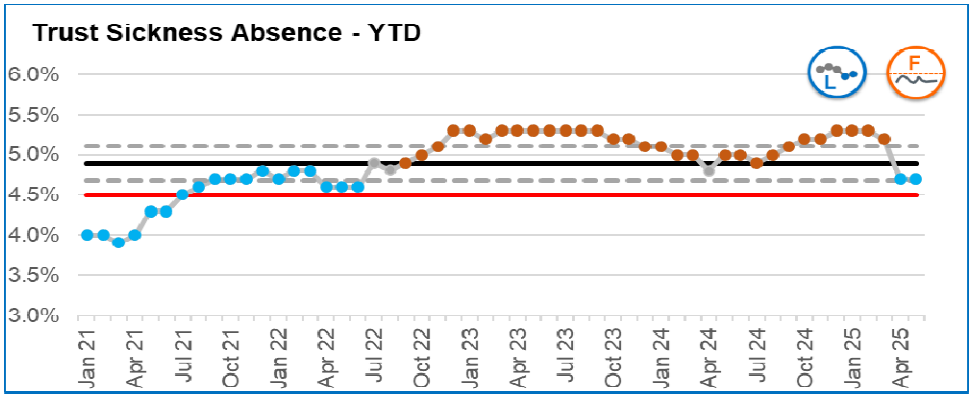
Appraisal Compliance

• The overall year to date figure in May 25 is 89.7%: an increase of 6.7% since March 25.
• We are projecting the rate will improve to 90.1% by the end of June. This will mean we have met the target set by executive management team by the end of June (90% KPI)
• All areas of the Trust have improved their appraisal position month on month since April 25.
• The roll out of online Electronic Staff Record Oracle Learning Management (ESR OLM) continues with development of agreed templates with operational/human resource collaboration for suitability

Training Compliance

• Our overall mandatory training compliance remains above target at 94.7%.
• All mandatory training in May is above our target (Green). This is the first time the Trust has achieved this.
• Information Governance training is now green at 95.8%
• Reducing Restrictive Practice Interventions training self service and manager self-service is open, and training planned until the end of September with availability on both 2 and 4-day programmes and as a result has seen an increase in compliance to 84.3%.
• The Trust Learning & Development team are part of the work led by Skills for Health to reform national mandatory training delivery into the national Core Skills Training Framework. We are also reviewing our 'Essential To Job Training' matrixes.

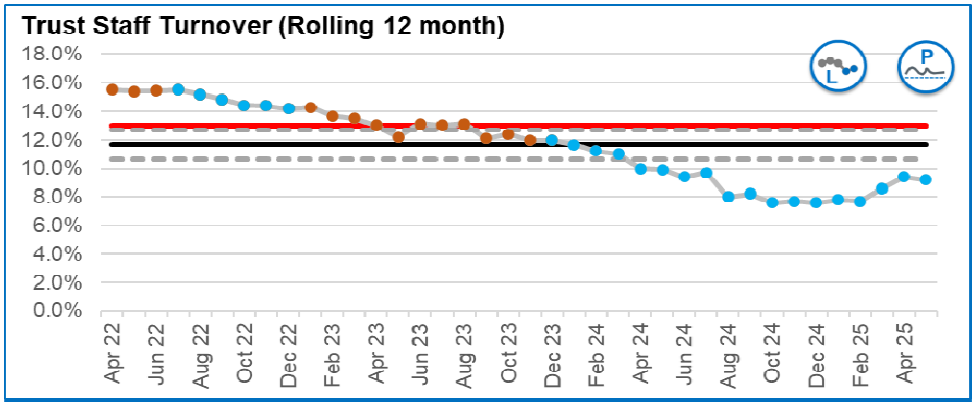
Statistical process control charts



The SPC chart shows that in May 2025 we remain in a period of special cause improving variation (something is happening and this should be investigated).

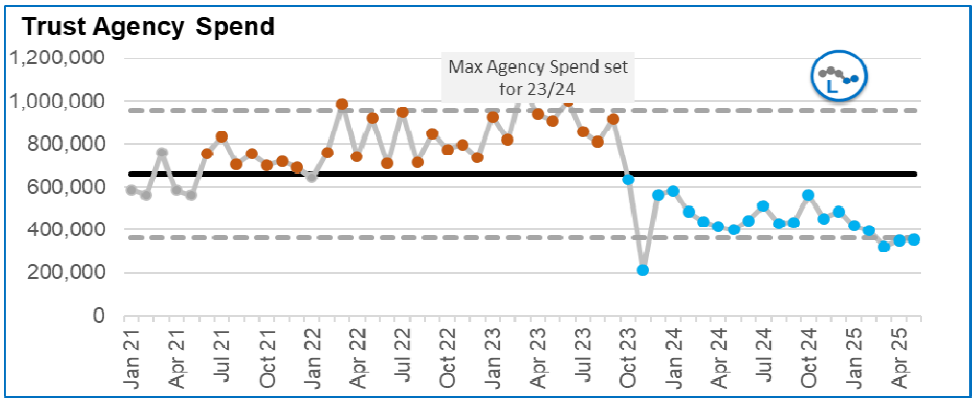
From July 2022 this data also includes absence due to Covid-19.

From April 2025 this data includes Cheswold Park Hospital.



The SPC chart shows that in May 2025, 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.

From April 2025 this data includes Cheswold Park Hospital.



The Trust agency expenditure plan included a reduction in line with planning guidance. In April expenditure (£0.4m) is less than plan and this is forecast to continue.

The SPC chart shows the sustained reduction in spend and in May 2025 we remain in a period of special cause improving variation.

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

National Metrics

Data as of : 19/06/2025 16:39:52

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.

On the 27th March 2025, as part of its Board meeting papers, NHS England (NHSE) published an updated NHS Performance Assessment Framework for 2025/26. NHSE's Board approved the updated framework for consultation (to take place 2nd to 23rd May) and engagement during the first quarter of 2025/26. The intention is to publish the final framework at the end of quarter 1, with the first formal segmentation of all Trusts and Integrated Care Boards (ICBs) being undertaken and published in July. As part of the framework, a number of delivery metrics have been identified that, subject to approval following the consultation, would be applicable to the Trust and would underpin the segmentation scores for each organisation. The Trust awaits publication of the technical guidance and once available, we will undertake an assessment of its performance against these metrics which have been grouped into the following categories: operating priorities, financial and productivity metrics, public health and patient outcome metrics and, quality and inequalities metrics. Once the metrics and definitions have been confirmed, these will also be reported in the IPR. In the meantime, the Trust will continue to report on national metrics from the current version of the NHS Oversight Framework 2022/23, and updates have been undertaken to align with operational planning priorities for 2025/26. In addition, further updates will be made to align to any key contractual reporting requirements that are not already included as the contracts are finalised.

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

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M210	The number of completed non-admitted RTT pathways in the reporting period	Best Quality	Responsive		1700													2174	1906
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%	P		99.9%	99.7%	99.5%	99.5%	99.2%	99.0%	98.2%	97.2%	96.7%	97.0%	97.1%	97.2%
M202	RTT waiting list, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive															31	53
M203	Number of 52+ week RTT waits, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive		0													0	0
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680													3957	4035
M205	RTT waiting list within 18 weeks, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive															1	1
M206	Diagnostic test activity	Best Quality	Responsive		190													128	70
M209	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Best Quality	Responsive		5%													35.7%	51.3%
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			95.6%	97.4%	97.9%	97.5%	100%	97.8%	100%	100%	98.9%	100%	97.8%	97.9%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	114	111	124	138	96	131	127	106	92	128	144	150
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5		L	4	3	4	4	4	5	4	3	4	4	5	5
M208	Average Length of stay for Adult Acute Beds (rolling 3 months)	Best Quality	Responsive					52.2	59.2	56.7	68.9	64.1	58.2	52.9	70.2	61.9	62.3	54.1	57.1
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P	H	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%	96.7%	87.2%	94.3%	100%	87.9%	87.5%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.0%	96.6%	96.8%	96.5%	96.5%	96.9%	98.1%	97.8%	97.4%	96.9%	96.8%	97.2%

National Metrics

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NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%	84.4%	84.3%	83.1%	83.2%	83.2%	83.5%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%	12.8%	12.5%	13.2%	13.2%	13.0%	13.2%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		1	5	5	0	0	1	0	1	0	2	0	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?	L	1	3	1	0	0	1	0	1	0	1	0	0
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?		100%	50%	100%	100%	100%	100%	100%	85.7%	100%	100%	100%	50%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?		96.6%	100%	87.5%	84.8%	88.9%	76%	59.3%	71.8%	71.7%	59.6%	73.7%	93.8%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		81.4%	91.4%	70%	82.9%	86.7%	112%	101%	100%	121%	119%	103%	82.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	6	3	1	1	1	2	2	2	3	2	3	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					99	106	105	97	94	118	96	90	102	92	109	106
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					27.3%	24.5%	25.7%	11.3%	25.5%	20.3%	19.8%	23.3%	15.7%	20.7%	22.0%	23.6%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P	H	98.7%	99.3%	99.4%	99.0%	98.7%	98.6%	97.8%	98.7%	99.8%	99.6%	99.7%	99.8%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%	P		100%	100%	100%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%	P	H	99.8%	99.1%	99.3%	100%	99.0%	99.1%	99.2%	99.7%	99.8%	99.8%	99.5%	99.7%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?	L	48.5%	47.8%	49.8%	50.7%	52.0%	52.6%	50.7%	52.6%	49.4%	50.1%	48.5%	51.9%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?		69.2%	66.2%	69.0%	70.3%	71.0%	68.4%	68.6%	68.9%	67.9%	71.6%	68.1%	68.5%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P		99.5%	99.4%	99.5%	99.5%	99.6%	98.4%	98.4%	98.0%	99.6%	99.6%	99.2%	99.6%
M41	Completion of a valid NHS number	Best Value	Well Led		99%	P	H	99.9%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%
M42	Completion of ethnicity coding for all service users	Best Value	Well Led		90%	P	H	99.4%	100.0%	99.4%	100.0%	99.5%	99.6%	99.5%	99.6%	99.6%	99.4%	99.4%	99.5%
M43	Community health services two hour urgent response standard	Best Quality			70%	?	H	89.9%	92.0%	91.6%	91.6%	90.9%	88.0%	89.2%	90.6%	90.2%	92.6%	90.3%	91.0%

National Metrics

Data as of : 19/06/2025 16:39:52

NHS South West Yorkshire Partnership NHS Foundation Trust

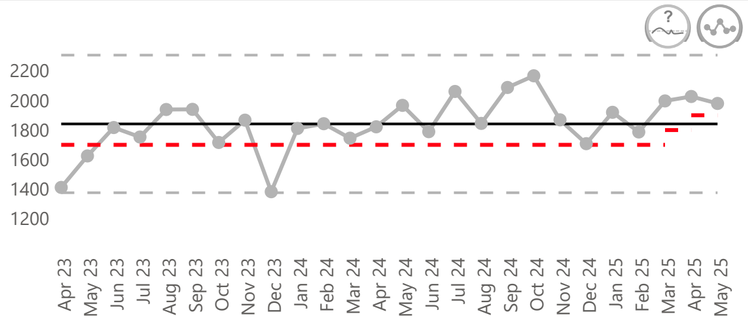
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?	L	51.3%	50.9%	51.0%	54.1%	53.9%	54.6%	52.4%	55.1%	53.0%	53.2%	51.0%	53.5%
				Place	Barnsley	50%	?		52.1%	50.9%	50.4%	51.2%	51.0%	50.8%	50.9%	50.8%	49.4%	52.7%	51.3%	52.8%
					Kirklees	50%	?		50.6%	50.8%	51.5%	56.8%	57.0%	59.1%	53.8%	59.2%	56.3%	53.8%	50.7%	54.2%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				529	554	545	518	679	586	509	633	524	566	615	600
				Place	Barnsley			H	241	237	278	253	355	317	241	311	244	270	318	312
					Kirklees				288	317	267	265	324	269	268	322	280	296	297	288
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months	Best Quality	Responsive	Trust	Trust				10466	10425	10366	10322	10247	10315	10332	10390	10444	10452	10608	10591
				Place	Barnsley	2000	P	H	2148	2146	2174	2164	2182	2218	2206	2209	2202	2183	2202	2205
					Calderdale	1200	F	H	1168	1166	1171	1177	1175	1157	1171	1178	1179	1199	1232	1247
					Kirklees	3600	F	H	3113	3105	3099	3086	3034	3017	3092	3167	3246	3272	3319	3349
					Wakefield	3900	P	L	4037	4008	3922	3895	3856	3923	3863	3836	3817	3798	3855	3790
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	1217	1233	1249	1305	1421	1519	1566	1642	1696	1833	1913	1982
				Place	Barnsley	283	F	H	191	190	197	203	226	244	250	252	255	278	299	314
					Calderdale	247	F	H	225	225	230	242	261	264	269	279	281	302	305	312
					Kirklees	541	F	H	464	468	464	486	521	546	553	570	576	626	660	694
					Wakefield	406	F	H	322	330	335	347	375	418	440	477	508	543	558	567
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	467	470	474	485	482	480	480	483	466	463	448	437
				Place	Calderdale			H	115	115	113	115	113	108	102	109	106	110	104	99
					Kirklees			H	164	168	170	179	167	167	163	161	157	158	153	149
					Wakefield			H	185	184	188	188	186	186	182	173	158	151	150	154

National Metrics

Data as of : 19/06/2025 16:39:52

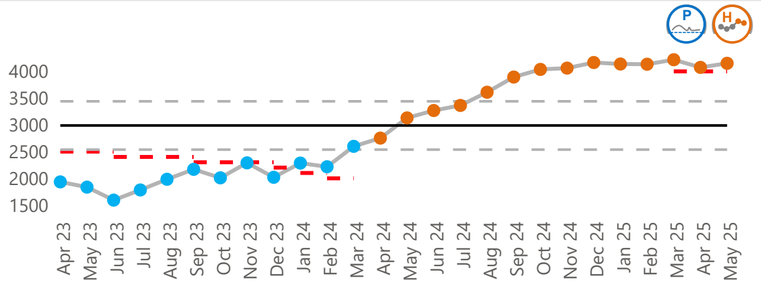
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



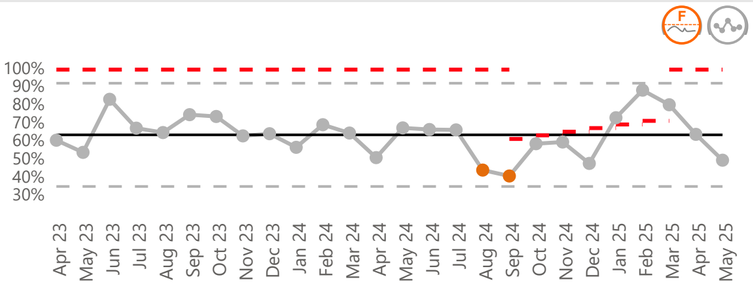
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). We are expected to meet the target against this metric. Though a new target is in place for 2025/26.

M45 - The number of incomplete Referral to Treatment (RTT) pathways



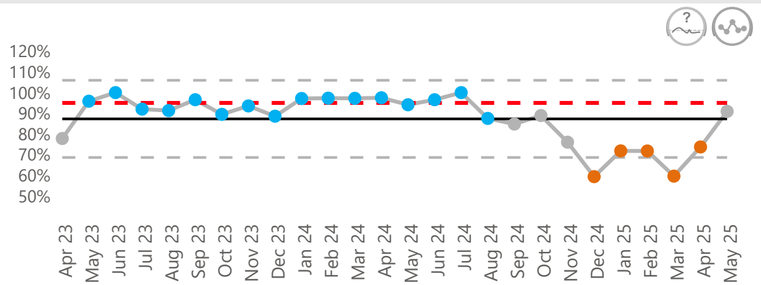
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)



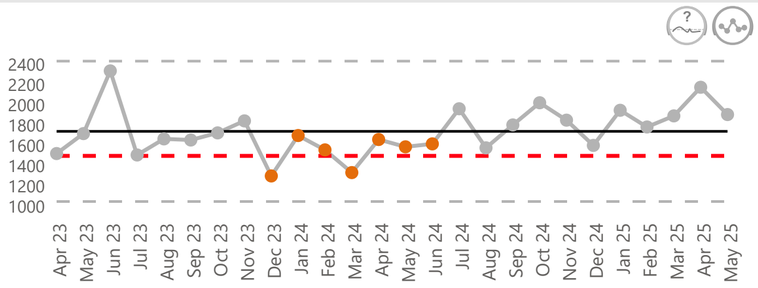
The SPC chart shows that we remain in a period of common cause variation (no concern.

M14 - Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



The SPC chart shows that we have re-entered a period of common cause variation (no concern) following an increase in performance in the last month which is back in line with usual performance.

M44 - The number of completed non-admitted RTT pathways in the reporting period



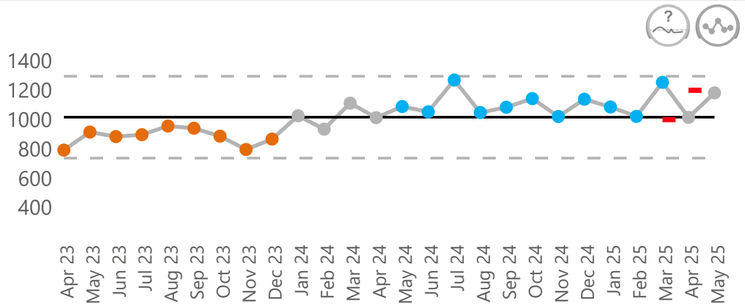
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

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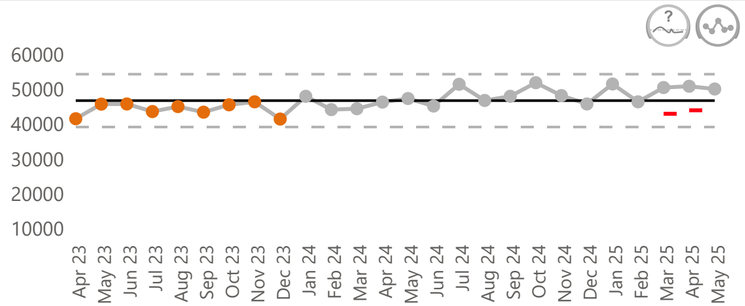
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



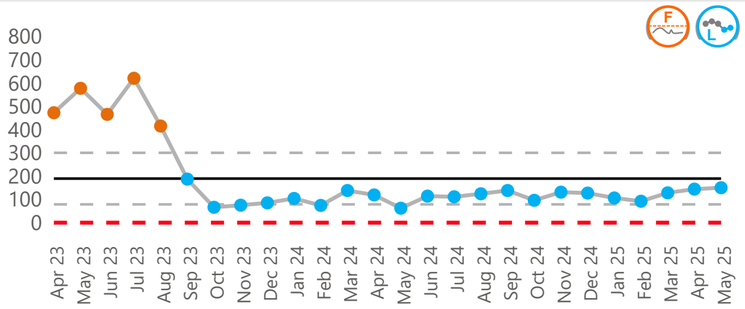
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



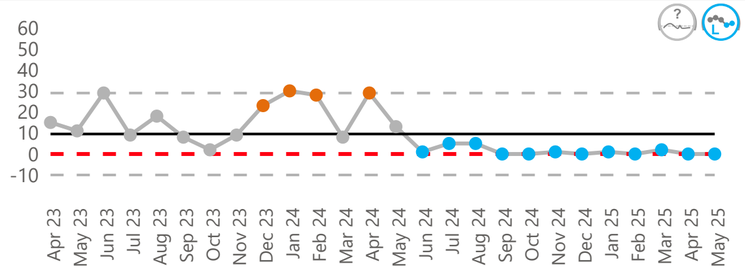
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



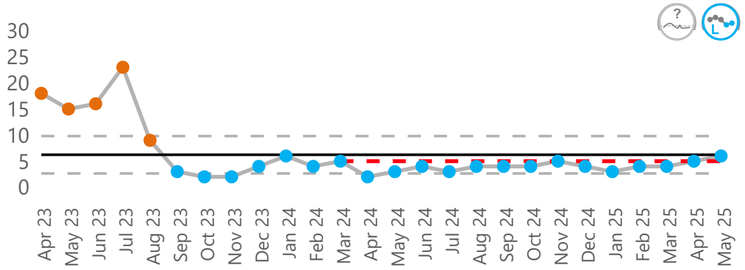
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a continued overall reduction in the performance in May. We are still not anticipated to achieve the target of zero.

M8 - Total bed days of Children and Younger People under 18 in adult inpatient wards



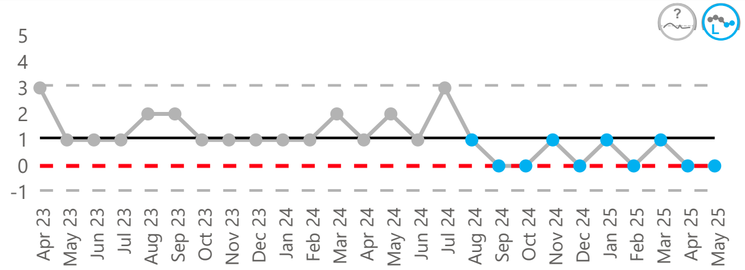
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained reduction in the number of bed days for under 18 year-olds.

M182 - Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)



The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) due a sustained reduction in the number of clients placed out of area.

M9 - Total number of Children and Younger People under 18 in adult inpatient wards



There were no admissions aged under 18 to an adult ward in May 2025.

Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. 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.

National Metrics

Data as of : 19/06/2025 16:39:52

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.

- There were no admissions of under 18 year olds to adult acute mental health beds during May.
- There was a slight increase in out of area bed usage up to 150 days used in May and 6 people remaining placed out of area at the end of the month.
- The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 93.8% in May - this relates to 2 service users who were not seen, both were a result of the impact of the ARFID (Avoidant/Restrictive Food Intake Disorder) pathways and undefined reporting processes. These are being explored with NHS England. The urgent access to treatment measure has dropped to 50% in May. Of the two breaches, one was offered an appointment within the time frame but this was declined by the family and the other was delayed due to the service having difficulties contacting the family to arrange an appointment.
- 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.
- Virtual Ward occupancy rate remains above the target of 80% at 82.7% for May.
- Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold.
- The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks in has decreased in May to 63.9%, remaining below the national threshold of 99%. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed. A trajectory for reduction of agency staff will coincide with start date.

A number of new national metrics were applicable to the Trust from April 2025, these are part of the operational planning framework. Forecasts for 2025/26 were agreed with place commissioners at the start of the financial year aligning to national, local and regional priorities. This is the second month performance against these metrics has been reported in the integrated performance report and a number of these are showing as being outside expected levels:

- The number of non admitted RTT pathways in the reporting period – this relates to the Musculoskeletal service and the higher number than forecast continues to relate to an overall increase in demand for the service.
- Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months – Kirklees - slight under performance against the forecast for May although achieving 93% of forecast target, we will continue to monitor performance against this line.
- Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months – Wakefield – slight under performance against the forecast for May although achieving 97% of forecast target, we will continue to monitor performance against this line.

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

- The reporting for employment and accommodation shows 11.7% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1.2% 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.

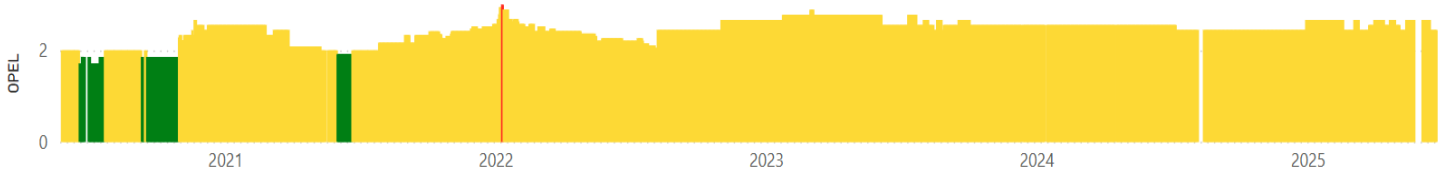
Operational planning priorities

On 30th January 2025, NHS England (NHSE) released its 2025/26 priorities and operational planning guidance.
The guidance outlines the ambition for the NHS to transform and to address the challenges highlighted by Lord Darzi's "Independent investigation of the NHS in England", 12 September 2024, such as long wait times and declining public health. Key priorities include improving productivity, shifting care to community settings, focusing on prevention, and embracing digital transformation. Local systems will have more control over funding, and integrated care is being developed. Leadership and management will be strengthened, and a new framework will assess performance. Financial responsibility is crucial to ensure resources are used wisely within the allocated financial envelope. Additionally, a new 10-Year Health Plan aims to create a modern, sustainable health service. These changes aim to make the NHS more efficient, and patient focused.
The guidance also sets the expectation for integrated care boards (ICBs), Trusts, and primary care providers to collaborate with other integrated care system (ICS) partners to achieve a balanced financial position. Further detail in relation to the Trusts response to this can be seen in the Trusts Operational Plan for 2025/26.

The following section provides an update on a number of key national operational priorities that the Trust will contribute to during 2025/26:

- Reduction in 12-hour breaches of people presenting at acute A&E with mental illness – to be good partners we are working with our acute Trusts in West Yorkshire on a national project to reduce the Emergency Department waits. To understand the impact of this on the whole pathway for those waiting for beds in mental health services, the project will look at how we share data to align the 12-hour breach waits to our internal waits. Once this is established, we will try to report on the 12-hour breaches.
- Reduction in acute length of stay. The Trust has set itself a local target to reduce adult acute lengths of stay by 10% by the end of March 2025. Performance against this can be seen in the national metrics section above and individual care group and ward level compliance can be seen in the care group section of the report.
- Increased access for children and young people – our performance against this metric can be seen in the national metrics section above.
- Productivity of services for children and young people – work is taking place across the Trust to improve productivity across all services whilst continuing to deliver (and improve) high quality and safe services. To support Trust financial viability. For services to work within the financial envelope defined within the establishment reviews, exploring and exploiting opportunities for working differently and effectively. Updates will be provided as this work progresses.
- The Trust does not anticipate further expansion of Mental Health Support Team (MHST) services in 2025/26, aside from continuing to embed the Wave 12 teams following the investment made at the end of 2024/25 and realisation of the full-year effect (FYE) in 2025/26. Efforts will focus on maximising the impact of existing funding to reduce waiting times and improve access to services. This will involve close collaboration with local communities, schools, and healthcare providers to tailor support to local needs. The Trust will also implement digital innovations to enhance service delivery, map workforce requirements to ensure appropriate staffing, and collect and analyse feedback to drive continuous improvement. Ongoing staff training and development will be prioritised, alongside the creation of integrated care pathways to ensure seamless support across services. Additionally, staff wellbeing will remain a key focus to maintain a resilient and effective workforce.
- Expansion of talking therapies service - The ongoing expansion of talking therapies services is progressing in alignment with national expansion targets and the corresponding funding provisions further plans for service development include:
    - Aim to increase performance against reliable recovery and reliable improvement metrics in line with funding and locally agreed targets.
    - Use benchmarking to compare your performance against peers, identify areas of variation, and set measurable goals for improvement.
    - Identify initiatives that aim to reduce missed appointment rates (also known as Did Not Attends (DNAs) reducing overall waiting times and increasing reliable recovery/improvement.
    - Additional focus on improving recovery waits for all communities with a focus on black, Asian and minority ethnic communities and on older people.
    - Ensure our service strategy is aligned with the Long-Term Plan and the Advancing mental health equalities strategy with a focus on improving access, outcomes and experiences for specific populations and under-represented groups.
    - Identifying gaps and opportunities for skill mixing to enhance capacity and efficiency in community services.

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



Current average OPEL level

2.44

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

Children and Young Peoples Mental Health Services

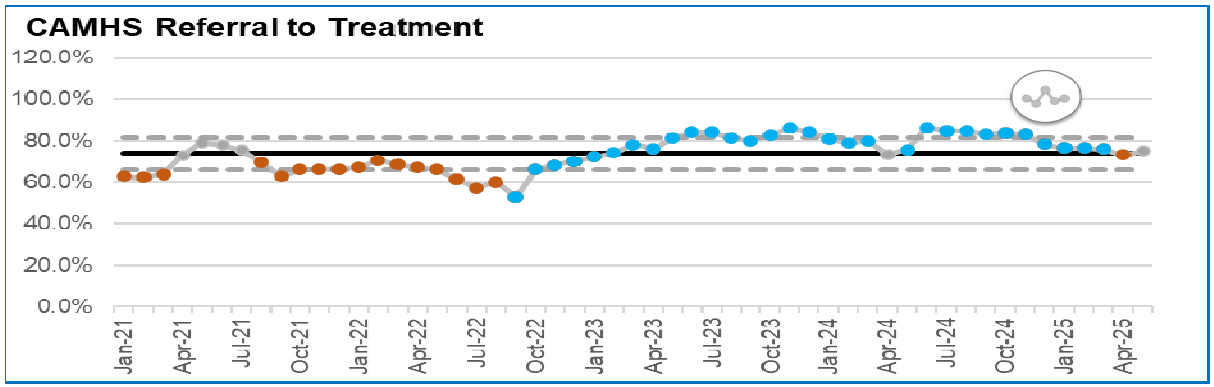
Headlines

Neurodevelopment waits remain a concern and discussions are underway with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support.

Children and Young Peoples Mental Health Services (CAMHS)

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	81.9%	85.0%	86.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	33% (1/3)	0% (0/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	86.6%	83.5%	84.0%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.4%	94.1%	97.6%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.4%	80.1%	82.0%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	59.6%	73.7%	90.9%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	25.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.2%	90.9%	96.5%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.2%	80.8%	79.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.4%	2.8%	2.1%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	349	341	332	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	775	806	907	
Total number of reported incidents	Best Quality	Safe	Trend monitor	55	33	31	

**From April 2024, figures now include children's physical health teams as per the change to the care group structure*



In May 2025, the SPC chart indicates that we have entered a period of common cause variation (no action required), following a recent downward trend in the percentage. See narrative below for further information.

Alert/Action

• Calderdale & Kirklees CAMHS continue to experience increasing waiting lists which are impacted by multiple challenges including staffing levels and referrals into services outstripping capacity, resulting in some teams operating in business continuity.
• Calderdale & Kirklees CAMHS waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees continue to remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register. Commissioners are sighted on these challenges.
• Calderdale & Kirklees CAMHS Keeping Kirklees in Mind (KKiM) mental health support team (MHST) continues to experience significant challenges around recruitment and retention especially with band 5 roles. This appears to be a regional problem. Discussions are ongoing with Kirklees commissioners regarding variations in the service model.
• Capacity and Demand across Community CAMHS Crisis and Eating Disorder teams are being monitored, some teams utilising business continuity measures and rated as red on Risk Register. In Wakefield as temporary staffing cannot be supported via agency, and there are no bank staff with the specialist skills, the team cannot deliver anything beyond the basic core offer.
• Wakefield CAHMS staffing – ReACH Team, Primary Intervention Team (PIT) which is the single point of access (SPA) (including the Eating Disorder Team) all utilising business continuity measures due to low staffing numbers and challenges recruiting to posts. A range of options is being considered and activated, lead by the General Manager.
• Secure CAHMS – Information Technology access of clinical systems and people files needs to be transferred from partner server as part of the Wetherby Youth Offenders Institute mobilisation with access to Trust drives essential. The lack of Trust IM&T infrastructure within the three secure settings continues to provide challenges and risks. This issue has now been added to the risk register due to concerns of the impact that this will have upon service delivery and is rated as red.

Advise

• Calderdale & Kirklees CAMHS- Eating Disorder Service have reopened the Avoidant/Restrictive Food Intake Disorder (ARFID) pathway to referrals following an internal review supported by commissioners. Referral criteria have been updated to support the reduction of inappropriate referrals and workshops for stakeholders on the revised service have been provided. Senior management continue to monitor the situation.
• Calderdale & Kirklees CAMHS- Increased referrals and reduced resources are impacting waiting times for ADHD medication activity. Increased diagnosis of ADHD has led to the Trust receiving an increased number of referrals for medication assessment from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to number of diagnosed assessments undertaken by the ND assessment team in Kirklees, which currently does not utilise RtC.
• Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for children and young people requiring emergency or urgent support. In addition, the Calderdale & Kirklees CAMHS Crisis line receives in the region of 100 calls per month and also a further 25 calls per month from NHS 111.

Assure

• Sickness across the Children and Adolescent mental health care group is consistently below the overall Trust sickness rate of 4.77% at 2.6%. Both long and short term are being managed well
• Appraisal rates across the CAMHS for May is 86% (as of 11.06.25) This is an improvement on April's figure which was 81.25%. There are targeted action plans across the care group in place for those services indicating low appraisal rates
• Mandatory training across the care group is 95% (as of 11.06 25) which is an improvement on Aprils figure of 83.8 % with Data Security (Information Governance IG) standing at 96.2 %. (as of 27.05.25) Again an improvement on the April figure which was 92 1%
• Clinical supervision recording stands at 85.5 % across the care group (as of 16.06.25) and is an improvement from April's performance which was 84.2%
• The Secure Children's Home Aldine House in Sheffield achieved a rating of Good from the Care Quality Commission visit (2 weeks into contract)

Mental Health Care Group

Headlines

The improvement work continues to contribute to an overall reduced reliance on out of area bed use. The Trust is a positive outlier and has shared learning and actions with neighbouring Trusts, whilst still recognising that this is an ongoing challenge.

High acuity and high occupancy on wards is directly linked to the work on reducing reliance on out of area beds, the work underway in the Intensive Home Based Treatment teams to gatekeep admissions and support people at home significantly helps to manage the overall position.

Inpatient services continue to have a high level of sickness. The sickness rate is above the Trust threshold on some wards, 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 and appraisals is being addressed through line management support and oversight and has seen some improvement during the month.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	87.5%	88.4%	90.0%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	72.4%	68.1%	81.8%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	96.7%	97.1%	96.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	14% 1/7	6% 1/16	18% 2/11	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	89.3%	87.6%	89.8%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	83.8%	88.7%	95.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	95.8%	96.0%	96.1%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	94.4%	96.0%	96.5%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.9%	76.6%	78.7%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	From April 2025	92.5%	91.8%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.1%	92.1%	95.6%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	79.1%	81.5%	84.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.2%	3.9%	4.6%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,728	13,722	13,668	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	127	150	129	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	91.6%	96.0%	97.2%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	89.7%	90.1%	96.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	50% 1/2	0% 0/6	0% 0/4	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	88.1%	91.5%	87.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.8%	86.3%	87.1%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.2%	8.8%	9.5%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	From April	83.2%	85.3%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (May)	128	144	148	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	94.6%	96.9%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	12	15	14	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	49	45	41	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	88.4%	88.4%	92.9%	
Restraint incidents	Best Quality	Safe	Trend Monitor	101	95	*96*	
Safer staffing (Overall)	Best Quality	Safe	90%	134.6%	132.1%	128.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	103.8%	104.3%	101.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	5.2%	5.3%	5.6%	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	Best Quality	Safe	From April 25 Apr - 63.1 May 62.5	60.5	55.6	55.0	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	Best Quality	Safe	From April 25 Apr - 63.9 May - 63.3	72.0	61.2	70.8	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	638	672	607	

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• 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.
• There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the Integrated Care Boards through the MADE meetings as well as a weekly Director of Services led challenge meeting with general managers.
• Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout May, acute wards have worked above establishment. This is closely monitored by senior managers on a daily basis with action plans to address.
• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation has become more challenging in May and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
• Intensive Home-Based Treatment teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway. Kirklees had 1 breach for assessment within 4 hours due to staffing pressures (assessed 30mins outside of target timeframe) and did not meet the 90% target in May.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live on 6th January. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and May's compliance is impacted further by ward teams adjusting to the new layout and format of care plans. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. The go live of the new mental health care plan has negatively impacted on this metric reporting, in part due to clinical staff adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme approach (CPA) recording.
• The new care plan metrics for community are now capturing the whole community caseload rather than only individuals on CPA. The care group are working with the performance and business intelligence team to ensure the metric reflects practice. Clinical staff are adapting to the new requirements of where and how to record items adversely impacting on the overall compliance.
• 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 all teams to achieve the target of all staff having an appraisal. System issues are impacting on accuracy of reporting, including exclusion data (e.g. sickness, contract changes) only being updated on electronic staff record (ESR) monthly. Proxy user access not being fully functional has also impacted on recording completed appraisals.
• The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness levels are experiencing a number of long term sickness issues in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• The Single point of access (SPA) teams are prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been challenges with admin vacancies in Calderdale & Kirklees SPA and there has been work focussing on assessing individuals waiting longer than 14days which have both impacted on performance.

Advise

• Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
• 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 and crisis alternatives, trauma informed care and effective intensive home treatment.
• The Talking Therapies recovery rate for May is 54.24% for Kirklees and 52.81% for Barnsley, both achieving the national standard of 50%. In May, Barnsley Talking Therapies achieved the expected national standard of less than 10% for waits to second treatment within 90 days (5.47%). Kirklees is above target at 12.9%. This is measured on completion of treatment and is therefore measuring access some months ago. Data shows that current waits for second treatment are lower.
• Work continues towards meeting expected thresholds where compliance rates are below target for mandatory training (this includes Reducing Restrictive Practice, Cardio-Pulmonary Resuscitation and information Governance). Care Group compliance has improved, particularly in inpatients where the target has been achieved. Work continues with training leads to address priority areas and utilise all training capacity.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on SystmOne. Completeness of equality data is on our data quality improvement action plan.
• There were 8 incidents of prone restraint in May, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by nursing quality and professions team, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.
• The average length of stay metric for South Yorkshire (Barnsley wards) increased in May. This metric counts the average length of stay for people discharged during a rolling three month period. During March, April and May, there were 3 discharges that had had a particularly long length of stay with one of those being clinically ready for discharge since October 2024 but unable to discharge due to availability of suitable placement. The figure reported in April (February, March and April discharges) had discharges that were lower than average lengths of stay and this was due to a number of shorter stays being discharged during the period.

Assure

• Intensive home based treatment teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The use of out of area beds remains low due to continued intensive work as part of the care closer to home workstream

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

Headlines

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
In line with the national picture, ADHD demand continues to exceed commissioned capacity.
Referral rates remain high across both pathways and the service try to minimise waiting times as far as possible.

Learning disability services:
Improvement work on waiting list times in community learning disability services has led to an overall improvement in the number of Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks with the May position achieving 100% and achievement of this standard has consistently been met since November 2024. The learning disability team continue to have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines
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	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.6%	87.3%	88.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/5)	40% (2/5)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	79.6%	75.0%	76.3%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	67.3%	55.4%	49.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.0%	85.1%	81.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	55.7%	90.1%	78.3%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	92.4%	94.8%	94.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	94.2%	91.2%	100.0%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	24	22	19	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	85.8%	87.2%	84.9%	
Safer staffing (Overall)	Best Quality	Safe	90%	172.7%	144.1%	138.5%	
Safer staffing (Registered)	Best Quality	Safe	80%	170.3%	157.4%	179.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.5%	5.1%	4.4%	
Restraint incidents	Best Quality	Safe	Trend Monitor	36	23	*22*	
Average length of stay	Best Quality	Safe	Trend Monitor	35	1015	270	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	71	55	60	

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

Alert/Action

• West Yorkshire Integrated Care Board (WY ICB) Neurodiversity project - The West Yorkshire tender process to increase the number of providers operating in West Yorkshire is underway. The new providers will offer ADHD and Autism assessments across all age groups and must be able to or have plans to offer ADHD medication under shared care too. The launch date has been delayed by 4 weeks to 1st August 2025. At present, this does not affect existing NHS contracts.
• Shared Care agreements for adults with ADHD in Calderdale - have reached an agreement with Calderdale Cares Partnership to be able to offer Shared Care agreements for adults with ADHD in Calderdale. This agreement enables our Service to retain patients on its caseload for automatic reviews, in accordance with national institute of clinical excellence (NICE) Guidelines, following the completion of their titration stage, rather than discharging them to primary care. Progress is already being made with this initiative.

Advise

Consultation
There is a consultation process taking place over the summer to establish how an all-age Neurodiversity hub might work as a first point of contact to offer support to people and potentially divert people from assessments, and to offer triage to the people that do.

Waiting Lists - Screening & Triage
• ADHD Our Service has over 725 people currently waiting for an ADHD triage appointment. This is an innovative new step available to people in Kirklees and Wakefield and is helping to ensure only clinically appropriate cases are added to the waiting lists. Analysis of Wakefield waiting lists shows that monthly waiting list growth has reduced from typically 3.7% to 1.2% per month since this step launched in the summer of 2024.
• Barnsley and Calderdale have not commissioned this, but both have expressed an interest and asked for updated business cases. The Calderdale paper has been shared with the business development team, the Barnsley one is almost complete.
• There are currently over 6400 people waiting for an ADHD assessment and the longest wait is typically around 3 years.
• It is important to note that despite these long waiting lists, the Service is continuing to deliver contracted activity. The service has capacity to assess up to 430 new cases each year and is on track to reach that target. 99 people (23%) have started the assessment process since April 2025.

Autism
• The Adult Autism pathway already includes screening and/or triage in 4 of the 5 Places (the Bradford service is included in this). Where this is in place in Bradford, Wakefield and Kirklees waiting lists are less than 12 weeks.
• Barnsley and Calderdale have expressed a desire to replicate the model.

Assure

• Excellent levels of supervision, appraisal and mandatory training.
• Low level of vacancies.
• Friends and family test results continue to show a sustained improved position but di remain under Trust threshold.
• All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Learning Disability (LD)
• Overall compliance with mandatory training is good with the only information governance training requiring additional focus.
• Appraisals, supervision remain a workforce priority. Slight dip in performance for supervision but appraisal compliance continues to improve.
• Progress being made on the NHS Survey Action Plan.
• ADHD assessments for people with a learning disability continues to be a gap. Whilst commissioners have agreed a business case for additional resource to manage this in principle, there continues to be no additional funding available

Community
• Recent data indicates a continued improvement in waiting list performance across 3 localities, but the service notes a drop in performance in Barnsley which will be addressed once understood..
• Community Teams continue to report high levels of LD service users in crisis.

Assessment & Treatment Unit (ATU)
• The service attended a strategic workshop involving West Yorkshire Providers and commissioners to discuss the current provision of the Assessment and Treatment services across West Yorkshire. Bradford have confirmed experiencing similar pressures re delivery of the service within the financial envelope. All who attended committed to a workstream to explore better use of available beds.
• Acuity remains high with all service users presenting with complex and challenging needs.
• 2 of the service users clinically ready for discharge have placements identified and plans are in place to discharge in June 2025.

Advise

Community
• The recruitment to speech and language therapy posts continues to be a challenge.
• Raising awareness of the Greenlight toolkit across the Trust has noticeably improved communication about individual service users when agreeing service provision or signposting.

Assessment & Treatment Unit (ATU)
• Establishment review to be undertaken.
• Quality Improvement project on advanced choice documentation has been completed.
• LD ATU developed their own feedback process for service users and the last two discharges are now in the process of completing this.

Assure

• Medical recruitment progressing well.
• Annual health checks in all 4 localities have exceeded the 75% threshold.
• Data quality remains good.
• Friends and Family Test – 94%.

Barnsley Physical Health and Wellbeing Care Group

Headlines

Musculoskeletal (MSK) and neurological physiotherapy estate issues continue and now are using alternative accommodation until the end of September 2025 to accommodate forward booking of outpatient activity. This remains on the local risk register. This is having an impact on the full-service offer and may lead to an impact on the 18-week Referral to Treatment target (RTT).

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	86.1%	92.9%	95.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	25% (1/4)	0% (0/2)	0% (0/1)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	96.2%	89.7%	88.9%	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	80.6%	78.6%	72.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.5%	84.2%	86.4%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	93.3%	95.3%	97.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.0%	97.1%	97.2%	
Safer staffing (Overall)	Best Quality	Safe	90%	104.6%	106.2%	102.9%	
Safer staffing (Registered)	Best Quality	Safe	80%	107.8%	113.1%	102.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.8%	4.6%	4.1%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	99%	79.6%	63.2%	49.0%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,821	6,741	7,036	
Total number of reported incidents	Best Quality	Safe	Trend monitor	203	261	223	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Musculo Skeletal (MSK) Service & Neuro Physio - Priory Day Centre remains closed. Remedial works planned will no longer take place as there is no capital funding available. Services affected continue to utilise Priory Campus as temporary alternative accommodation and this arrangement has been extended further until end of September 2025. General Manager is working with both the MSK Service and our Strategic Planning Lead for SWYPFT Estates to explore long term options. This remains on the local risk register. This has had an impact on the full-service offer in terms of group provision and could impact on the 18-week Referral to Treatment Target (RTT) although so far this target continues to be achieved.
• Paediatric Audiology 6-week target for diagnostic procedures has seen a further dip in May from 63.9% to 49% against the target of 99%. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed.

Advise

• Staff receiving supervision - continues to receive focus with a drive to improve recording and increased numbers of trained supervisors. We have seen a small reduction to 72.2% for May which is below compliance. We are seeing an increase into June already at 76.5%.

Assure

• Appraisals - for May the figure has increased again and is exceeding compliance at 95%
• Overall Care Group sickness rates have improved further during May, and the care group continues to meet compliance at 4.1%, with a year-to-date figure of 4.4%.
• Urgent Community Response Service 2-hour target is 91% as at end of May 2025 which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97.21% as at May 2025.
• 88.89% of people dying in their place of choosing in May 2025; this remains consistently above the threshold of 80%.
• Information Governance training has increased, and we have maintained compliance at 97.3%.
• Friends and Family Test (FFT) 96% of people would recommend community services which exceeds the target of 95%.
• CPR training maintains compliance at 86.4% for May.
• Virtual Ward occupancy rate has reduced this month to 82.7% but continues to be above the target of 80%. Numbers have reduced over the last month as the team have been undertaking focused work to address the length of stay on the pathway as Barnsley is currently an outlier.
• Smoking Quit Rates continue to exceed the target of 55% - data is reported retrospectively and for the most recent data available (Quarter 3) this was 71.6%.
• On 14 May our Wound Care drop-in clinic launched. This is targeted at individuals experiencing homelessness / rough sleeping in the central neighbourhood. The clinic is running in conjunction with Waythrough's (Recovery Steps) rough sleeper breakfast club on Wednesdays between 10am and 12 noon at McLintock's Building. Our Advanced Clinical Practitioners (ACPs) and Community Matrons will facilitate the clinic with future support from our Neighbourhood Nursing Service (NNS).
• BBC Radio Sheffield joined the Trust on 22nd May to talk about the 'capturing the seasons' project. This was developed by Creative Minds in collaboration with the Barnsley Integrated Community Stroke Rehabilitation Team and the Stroke Association. Meeting over the course of a year, a group of eight stroke survivors photographed the changing seasons in Locke Park in Barnsley. The artwork is on display at the Cooper Gallery in Barnsley during June and will then be permanently moved to the Stroke Recovery Unit at Kendray.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue in May - hotspot areas can be seen in the ward level breakdown of the report. The People Directorate Business Partner continues to work closely with the care group regarding 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.

Focus remains on ensuring staff have a timely and comprehensive appraisal, although external issues with access to the appraisal system are impacting on reported performance.

Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	85.6%	83.8%	83.2%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	85.6%	85.1%	84.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/0)	0% (0/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.8%	86.2%	83.6%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	99.0%	99.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.3%	79.6%	82.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	Reporting commenced April 2025	33.3%	75.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%		100.0%	100.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	91.8%	92.2%	94.2%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	6	6	3	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	12	13	11	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.8%	85.5%	89.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	14	21	*18*	
Safer staffing (Overall)	Best Quality	Safe	90%	114.0%	116.5%	117.8%	
Safer staffing (Registered)	Best Quality	Safe	80%	105.3%	101.5%	102.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	6.4%	7.2%	7.7%	
Average length of stay	Best Quality	Safe	Trend Monitor	526	985	353	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	181	178	188	

Forensic - West Yorkshire:

Alert/Action

• Bed Occupancy
  • Newton Lodge: 87.71% - Referrals have increased in the male pathway, occupancy is across learning disability (LD) and women's pathways.
  • Bretton Centre: 79.71% - awaiting legal processes to facilitate admissions.
  • Newhaven: 75%
  • Medium secure services are currently experiencing underoccupancy, particularly within LD and women's services, where there are no active waiting lists. However, there has been a recent increase in referrals for male medium secure beds.
• Appraisals remain a key area of focus across the service. The overall appraisal completion rate has shown improvement and currently stands at 84.1%, indicating a positive upward trend.
• Forensic Community Transition Team is not currently funded by the West Yorkshire Provider Collaborative and has not been prioritized for community service funding. The issue has been escalated to the Provider Collaborative, which has advised on the necessary steps for further escalation within their internal processes.
• West Yorkshire Provider Collaborative – have signalled their intention to discuss the male and female pathways within Medium Security.

Advise

• Mandatory training overall compliance: Newton Lodge – 93.7%, Bretton – 94.3%, Newhaven – 94.7%.
Hotspots for Newton Lodge are: information governance with the Bretton Centre being compliant across all mandatory training and Newhaven with hotspots in CPR and IG, plans are in place to address.
• Supervision – levels remain high across the care group with the exception of the Bretton Centre which has reduced due the acuity within the service.
• Sickness absence – remains a focus of attention across the service. There has been a spike in short term seasonal illnesses in Newton Lodge. The service is undertaking a dedicated piece of work to look at sickness absence across the care group. On closer scrutiny the majority of sickness in most teams is long term sickness.
• West Yorkshire Provider Collaborative - The West Yorkshire Provider Collaborative continue to develop future intentions for the Women's pathways and Community Services. The service has met with the Commissioning Hub following two earlier bed modelling workshops to discuss potential areas for exploration in terms of future capacity and demand.
• Turnover – Turnover across the service is much lower than in previous years at 10% or less.
• Forensic Improvement Programme – is well underway with a number of workstreams focusing on improved service user experience and outcomes and improved efficiencies.

Assure

• High levels of data quality across the care group.
• 100% compliance for HCR20 completed within 3 months of admission.
• 25 Hours of meaningful activity 100%.
• % Service Users on care programme approach with a formal review within the previous 12 months –100%

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Mar-25**	**Apr-25**	**May-25**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	78.4%	83.5%	91.5%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	From April	77.3%	73.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/14)	40% (2/5)	50% (1/2)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	82.0%	89.0%	91.0%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%				
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.0%	88.7%	86.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	From April 2025	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%		N/A	N/A	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.0%	94.7%	98.0%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	8	4	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.0%	92.5%	91.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	*5*	
Safer staffing (Overall)	Best Quality	Safe	90%	91.6%	115.5%	123.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	95.7%	96.1%	100.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	3.7%	4.5%	4.0%	
Average length of stay	Best Quality	Safe	Trend Monitor	From April	1015	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	130	138	155	

Forensic - South Yorkshire:

Alert/Action

- Cheswold Park continues to integrate into the Forensic Care Group.
- Admissions remain a priority with 14 service users being admitted since January 2025.
- Establishment review for corporate services continues.
- Quality and safety continues to be monitored internally through a Quality Improvement Group.

Advise

- Priorities have been set for the next 6 months both for the Programme Group and for Clinical and Operational services.
- The service will develop a clear future clinical/operational model.
- Build on relationships with commissioners to determine long term needs of forensic population.
- Future medical workforce business case to be submitted to EMT to support future admissions in accordance with the overall business case.
- Business case regarding pharmacy also in development.
- Future medical workforce business case submitted
- The service is currently reviewing and developing business cases for AHP/Psychology workforce.
- The service continues system policy and procedure alignment in line with Trust, CQC and medium secure standards.
- Ward Manager development programme is underway which will support the role to align to a ward manager role in the wider Trust.
- The service is being supported to develop both internal and external reporting.
- Access to Trust Bank is now in place making staffing of the wards more sustainable.

Assure

- NHS England and the South Yorkshire Provider Collaborative have stepped down the enhanced monitoring.
- Turnover 1.9%.
- Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide on our inpatient wards. A number of key metrics have been identified the wards and performance against these for the past three months is stated. The wards in Cheswold Park Hospital are now incorporated into this report and the monthly data will be added over the financial year so that a three month rolling position is also shown. Figures in bold and italics are provisional and will be refreshed next month.

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

Appraisal
• All 17 wards have achieved the May 88% threshold target, 11 of those wards are at 100% appraisal compliance.
• Matrons continue to work closely with ward managers to ensure outstanding appraisals are booked.

Sickness
• 8 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in May on Melton and Elmdale following the return of staff from long term sickness. Sickness also reduced to below threshold on Poplars following a reduction in the number of short-term sickness episodes.
• Sickness increased to just above threshold on Clark (5.6%) and Ward 19 Female (6.2%). On both wards this is due to short term sickness and one episode of long-term sickness.
• Sickness on Ashdale has increased significantly above threshold to 13.5% in May. This is impacted by long-term sickness with themes of personal and work-related stress.
• Sickness on Stanley, Walton, and Beechdale and has reduced but remains above threshold and continues to be impacted by a combination of long and short-term sickness, no specific themes.
• Nostell (7.9%) and Ward 18 (8.1%) sickness has increased due to a mixture of both long and short-term sickness, no specific themes.
• Sickness on Willow has further increased and is significantly above threshold at 20%. This is impacted by both short and long-term sickness. Themes include pregnancy related absence and work-related absence (including work-related assault).
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness. Timely referrals to occupational health are made but the current time from referral being made to staff having their occupational health appointment is approximately 3-4 weeks.

Supervision
• 14 wards above 80% compliance target, 8 of those wards are at 100% supervision compliance.
• Stanley dropped below compliance threshold in May, but this has improved in June and compliance is currently 86.7% (as of 17/06/25).
• Elmdale dropped just below compliance in May (77.8%). The ward manager is prioritising the staff who haven't received supervision in the last 90 days.
• Beamshaw compliance remains under threshold in May and has been impacted by high clinical acuity with scheduled supervision sessions having to be rearranged. Focused work to prioritise supervision for those staff who haven't received it in the last 90 days has been undertaken and June compliance is 85.7% (as of 17/06/25).

Mandatory Training
Information Governance
• Melton (87.5%) compliance has dropped below threshold in May. June compliance is 92% (as of 19/06/2025) with two staff outstanding, one of whom is long term sick and will be supported to complete on their return to work.
• Walton (88.6%) compliance remains under threshold in May and action continues to be taken by the ward manager, with matron oversight, to drive up improvement. June compliance is 97.1% (as of 19/06/25)
• The 15 remaining wards are above the target of 95%
CPR
• 15 wards are above the CPR training compliance threshold.
• Melton (79.2%) dropped slightly below compliance threshold in May and staff are booked onto future training dates throughout June and July. June compliance is 88% (as of 19/06/25).
• Ward 18 (60.7%) remains below compliance threshold. The majority of Ward 18 staff out of compliance are booked onto future training dates throughout June and July, with remaining staff booked onto August dates.
RRPI
• All 17 wards are above the RRPI training compliance threshold.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
Fire Safety
• 14 wards are above fire safety training compliance threshold.
• Stanley has dropped under compliance (84%) and staff who are non-compliant are booked onto training in June and July. June compliance is at 88.5% (as of 19/06/25).
• Melton (75%) and Walton (82.9%) are also under compliance. Booking of training is being overseen by the ward managers as a priority.

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

Bed Occupancy

• Bed occupancy exceeding the target is reflective of general increased demand for admissions, particularly across working age adults.
• Where the bed occupancy exceeds the target 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.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on several wards:
  • Poplars CRFD is 39.3% in May and is reflective of several service users awaiting placements, five of whom have now been discharged.
  • Clark CRFD (32.2%) and Walton (22.8%) relates to several service users awaiting either placement or suitable accommodation. A service user on Walton is awaiting Ministry of Justice permissions.
  • Willow CRFD is 30.7% in May. This relates to four service users, all of whom were awaiting placement but have recently been discharged.
  • Melton CRFD has increased to 28.3% in May, reflective of two service users who are awaiting funding agreement for placements.
• Nostell CRFD has seen a considerable increase from 6.9% to 17.5% in May. This reflects five service users awaiting care package or suitable accommodation, four of whom have been recently discharged.
• Five other wards are above the threshold for CRFD with Beamshaw, and Ward 19 (male) above 10%. Stanley, Ward 19 (female) and Enfield Down are also above target. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation.
• Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
• There is a weekly check and challenge meeting led by the Director of Service to ensure senior oversight and focus and timely external escalations.

FIRM Risk assessments

• The reporting metric changed as of 1st April to percentage of inpatient risk assessment completed within 24hrs before or after admission.
• Compliance monitoring dashboards have only recently gone live (8th May) and matrons are engaging with ward teams to ensure processes are in place for daily oversight.
• During May Ward 19 (male) had 1 FIRM breach. Ashdale (5), Nostell (5), Ward 18 (3), Stanley (2) had multiple impacted by high number of admissions.
• A deep dive will be conducted by the matron for each breach to identify learning and inform improvement.
• The inpatient team receive a handover of risk prior to admission and at the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Physical violence

• 12 incidents of patient on staff physical violence at Poplars. Incidents relate to specific service users with behavioural and psychological symptoms of dementia. Risk management care plans are in place and the ward psychologist is supporting with psychological formulation. Trust specialist advice from RRPI and safeguarding is also sought as needed.
• Elmdale had 10 incidents of patient-on-staff physical violence throughout May relating to two specific service users with complex needs. Psychological formulation is developed on the wards as required to support management and care of individuals with complex needs.
• Risk specific care plans are in place to support managing incidences of violence with input from trust RRPI specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

• High incident numbers (27) on Walton relates to four individual service users and reflects their presentation, risks of violence and aggression, and need for restraint to safely administer intra-muscular medication to reduce agitation.
• Higher incident number on Elmdale and Nostell is reflective of current patient population and the presentation and risk profile of service users.
• Incident numbers on Poplars correlate with incidents of physical violence as outlined above.

Prone restraint incidents

• There were eight incidents of prone restraint in May, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration.
• All are reflective of individual service user presentation and high risks of violence and aggression.
• The two reasons for prone restraint use were exiting seclusion and the administration of intra-muscular medication. The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite Mar-25	Beamshaw Suite Apr-25	Beamshaw Suite May-25	Clark Suite Mar-25	Clark Suite Apr-25	Clark Suite May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	82.6%	91.3%	100.0%	88.2%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	6.3%	3.8%	2.9%	5.3%	2.2%	5.6%
Supervision	Best place to work and learn	Well led	80%	64.3%	64.3%	64.3%	91.7%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	100.0%	100.0%	100.0%	95.2%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	95.5%	91.3%	95.5%	90.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	86.4%	83.3%	100.0%	100.0%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.9%	91.7%	81.8%	95.2%	100.0%
Bed occupancy**	Best Quality	Safe	85%	99.1%	105.4%	104.6%	99.1%	105.4%	104.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	137	45	90	40	6	97
Safer staffing (Overall)	Best Quality	Safe	90%	163.5%	130.7%	125.3%	105.8%	99.8%	109.9%
Safer staffing (Registered)	Best Quality	Safe	80%	116.0%	115.7%	106.8%	108.1%	115.6%	111.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.1%	10.3%	13.1%	25.8%	28.2%	32.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	2	1	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	4	2	3
Restraint incidents	Best Quality	Safe	Trend Monitor	4	3	*3*	5	2	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	33	11	17	12	6	8

*** Bed occupancy is combined with Clark Suite due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite Mar-25	Melton Suite Apr-25	Melton Suite May-25	Nostell Mar-25	Nostell Apr-25	Nostell May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.9%	92.3%	100.0%	91.3%	87.0%	90.5%
Sickness	Best place to work and learn	Well led	5.0%	8.4%	6.6%	2.6%	7.0%	6.8%	7.9%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	84.6%	68.8%	93.3%	81.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	81.5%	96.2%	87.5%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.3%	100.0%	100.0%	92.6%	88.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	80.8%	79.2%	92.6%	88.0%	87.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.5%	73.1%	75.0%	85.2%	92.0%	95.8%
Bed occupancy	Best Quality	Safe	85%	100.0%	100.6%	106.5%	93.7%	96.9%	98.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	51	N/A	102	48	33	26
Safer staffing (Overall)	Best Quality	Safe	90%	170.8%	130.5%	123.3%	132.5%	168.4%	133.7%
Safer staffing (Registered)	Best Quality	Safe	80%	101.6%	99.8%	98.5%	110.8%	109.8%	100.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.2%	15.9%	28.3%	10.0%	6.9%	17.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	92.9%	58.3%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	0	1	7	4	1
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*2*	14	3	*9*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	28	19	14	14	9	4

*** Bed occupancy is combined with Stanley due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Stanley			Walton		
				Mar-25	Apr-25	May-25	Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.7%	96.0%	100.0%	90.3%	96.8%	93.8%
Sickness	Best place to work and learn	Well led	5.0%	5.7%	9.2%	5.4%	6.7%	10.0%	9.1%
Supervision	Best place to work and learn	Well led	80%	86.7%	86.7%	73.3%	82.4%	94.4%	83.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.9%	100.0%	96.0%	94.6%	88.6%	88.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.6%	88.0%	92.0%	86.5%	88.6%	94.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	84.0%	84.0%	91.9%	85.7%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.5%	92.0%	84.0%	81.1%	82.9%	82.9%
Bed occupancy**	Best Quality	Safe	85%	93.7%	96.9%	98.4%	92.6%	96.4%	97.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	47	43	56	73	141	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	180.7%	125.4%	136.7%	150.4%	157.4%	155.7%
Safer staffing (Registered)	Best Quality	Safe	80%	111.9%	112.1%	105.7%	96.4%	90.7%	90.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.3%	8.5%	6.2%	18.9%	19.5%	22.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	57.1%	85.7%	Reporting Commenced	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	1	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	0	0	3	2	3
Restraint incidents	Best Quality	Safe	Trend Monitor	8	9	*4*	12	16	*27*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*2*	4	5	*3*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	37	15	11	9	6	6

*** Bed occupancy is combined with Nostell due to use of swing beds*

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Mar-25	Ashdale Apr-25	Ashdale May-25	Ward 18 Mar-25	Ward 18 Apr-25	Ward 18 May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	93.8%	96.9%	93.3%	96.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.4%	4.7%	13.5%	11.3%	6.3%	8.1%
Supervision	Best place to work and learn	Well led	80%	100.0%	93.3%	80.0%	75.0%	77.8%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.1%	93.9%	96.8%	81.5%	74.1%	96.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	90.9%	90.3%	88.9%	88.9%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.2%	100.0%	100.0%	74.1%	63.0%	60.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	93.9%	96.8%	81.5%	85.2%	92.9%
Bed occupancy	Best Quality	Safe	85%	100.3%	100.4%	98.4%	97.9%	97.8%	101.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	89	59	51	46	24	34
Safer staffing (Overall)	Best Quality	Safe	90%	132.4%	137.9%	127.9%	99.8%	105.8%	97.4%
Safer staffing (Registered)	Best Quality	Safe	80%	114.6%	114.8%	103.9%	94.8%	92.6%	96.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.9%	2.9%	0.0%	9.8%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	50.0%	68.8%	Reporting Commenced	86.2%	87.5%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	3	2	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	3	5	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	4	6	*7*	8	7	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	*1*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	22	12	8	7	1	2

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	92.0%	96.0%	88.5%
Sickness	Best place to work and learn	Well led	5.0%	3.8%	7.0%	4.4%
Supervision	Best place to work and learn	Well led	80%	83.3%	88.9%	77.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.3%	96.3%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.3%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.6%	96.2%	92.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	83.3%	96.3%	100.0%
Bed occupancy	Best Quality	Safe	85%	92.1%	97.6%	94.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	36	54	56
Safer staffing (Overall)	Best Quality	Safe	90%	121.8%	109.9%	114.0%
Safer staffing (Registered)	Best Quality	Safe	80%	102.4%	96.1%	95.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	7.0%	3.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	91.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	3	10
Restraint incidents	Best Quality	Safe	Trend Monitor	16	3	*14*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	8	10

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Mar-25	Crofton Apr-25	Crofton May-25	Poplars CUE Mar-25	Poplars CUE Apr-25	Poplars CUE May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	87.5%	92.0%	100.0%	90.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.3%	1.9%	1.4%	3.8%	8.1%	4.1%
Supervision	Best place to work and learn	Well led	80%	100.0%	78.6%	100.0%	84.6%	92.3%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.2%	96.2%	100.0%	96.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.7%	91.7%	95.2%	80.0%	86.2%	86.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	70.8%	81.0%	93.3%	89.7%	93.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.5%	88.5%	91.3%	96.9%	93.3%	93.5%
Bed occupancy	Best Quality	Safe	85%	102.2%	94.8%	98.6%	81.9%	79.8%	71.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	57	77	79	115	108	103
Safer staffing (Overall)	Best Quality	Safe	90%	185.7%	201.3%	186.1%	220.5%	230.4%	223.5%
Safer staffing (Registered)	Best Quality	Safe	80%	147.5%	155.5%	154.3%	99.5%	103.0%	110.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	31.2%	31.5%	39.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	90.0%	100.0%	Reporting Commenced	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	2	0	0	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	6	1	13	15	12
Restraint incidents	Best Quality	Safe	Trend Monitor	2	11	*3*	12	11	*10*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	36	33	18	48	31	36

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Mar-25	Willow Apr-25	Willow May-25	Beechdale Mar-25	Beechdale Apr-25	Beechdale May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	81.0%	95.2%	95.0%	100.0%	100.0%	95.5%
Sickness	Best place to work and learn	Well led	5.0%	1.3%	12.5%	20.0%	15.2%	13.2%	9.2%
Supervision	Best place to work and learn	Well led	80%	63.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.5%	100.0%	100.0%	92.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	79.2%	72.7%	85.7%	82.1%	86.4%	90.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	58.3%	100.0%	81.0%	92.6%	100.0%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	83.3%	100.0%	100.0%	85.7%	100.0%	95.2%
Bed occupancy	Best Quality	Safe	85%	83.9%	85.7%	91.0%	101.4%	94.6%	96.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	210	101	132	52	87	85
Safer staffing (Overall)	Best Quality	Safe	90%	129.8%	132.9%	127.7%	130.6%	127.4%	122.7%
Safer staffing (Registered)	Best Quality	Safe	80%	98.2%	100.8%	77.4%	105.8%	95.9%	98.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	7.0%	26.6%	30.7%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	66.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	1	0	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	3	*3*	5	5	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	18	18	13	10	9	5

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male Mar-25	Ward 19 - Male Apr-25	Ward 19 - Male May-25	Ward 19 - Female Mar-25	Ward 19 - Female Apr-25	Ward 19 - Female May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	0.4%	3.2%	1.5%	0.9%	5.0%	6.2%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.3%	100.0%	95.8%	100.0%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	91.7%	91.7%	95.2%	87.5%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	100.0%	100.0%	85.7%	91.7%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	91.7%	95.8%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	96.6%	94.9%	97.0%	93.1%	94.4%	91.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	115	84	121	58	91	89
Safer staffing (Overall)	Best Quality	Safe	90%	100.5%	113.7%	99.6%	88.2%	91.8%	94.7%
Safer staffing (Registered)	Best Quality	Safe	80%	78.7%	86.0%	79.9%	93.2%	90.5%	101.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.3%	18.4%	13.5%	4.5%	6.5%	6.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	80.0%	50.0%	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	3	2	1	3	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	0	1	3	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	10	*3*	2	10	*3*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	2	6	1	1	1

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Mar-25	Enfield Down Apr-25	Enfield Down May-25	Lyndhurst Mar-25	Lyndhurst Apr-25	Lyndhurst May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	97.8%	100.0%	96.6%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.4%	2.6%	3.7%	0.7%	0.4%	0.9%
Supervision	Best place to work and learn	Well led	80%	96.2%	92.3%	81.5%	93.3%	93.8%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.9%	94.0%	100.0%	100.0%	93.1%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	79.6%	85.7%	86.7%	86.2%	86.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.6%	90.9%	95.5%	96.7%	79.3%	96.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.8%	90.0%	88.0%	90.0%	93.1%	96.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	53.4%	54.3%	57.1%	63.6%	52.1%	50.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	910	520	N/A	252	688	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	93.1%	96.2%	100.6%	94.6%	100.5%	113.4%
Safer staffing (Registered)	Best Quality	Safe	80%	98.8%	106.9%	107.9%	89.8%	98.2%	99.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	5.3%	5.2%	9.5%	7.5%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	50.0%	100.0%	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	2	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	2	0	2	1

Inpatients - Forensic West Yorkshire - Medium Secure

Ward Level Headlines - Forensics

Performance for all wards is being addressed through regular performance clinics with ward managers and the general manager. Appraisals remain a key focus for the service with support from the People Business Partner. Improvements in compliance have been noted with Appleton, Bronte, Chippendale, Hepworth and Ryburn achieving 100%. Johnson (95.2%), Waterton (94.7%), Thornhill (96.3%) and Sandal (95.7%) are also now above compliance. Newhaven (78.6%) are below compliance and have two outstanding appraisals that have time booked in to complete. Priestley (65.2%) is also below compliance which is attributed to several staff returning from long term sickness absence with appraisal discussions booked following return to work plans and also some recording issues. Robust plans are in place that are under regular review with the service manager. Staffer staffing reports remain within compliance.

Medium Secure

• Five wards are above supervision compliance (Bronte, Chippendale, Hepworth, Waterton and Johnson). Waterton, has now met compliance following an improving trajectory, evidencing the embedding of plans in implementation by the Ward Manager. Appleton (50%) is under compliance and understood to be a recording issue due to team high acuity. This is an unusual variation for Appleton and plans are in place. Priestley (75%) has reduced compliance and continue to embed new recording systems. There is now an identified lead on the ward who is closely monitoring.
• An increase in sickness absence is noted across the service with Appleton (5.7%), Bronte (8.7%), Chippendale (7.0%), Hepworth (6.2%), Johnson (10.8%) and Waterton (12.1%). This is a combination of both increases in long-term sickness absence and short-term. Individual support plans are in place by Ward Managers with support from our People Directorate.
• The plans in place to improve cardiopulmonary resuscitation compliance have seen improvements with Appleton (81.8%), Bronte (90.9%), Chippendale (81.8%), Hepworth (96.4%), Waterton (86.4%) and Priestley (80%) all above compliance. Improvements are noted on Johnson to 73.3% with close oversight from the Ward Manager. Staff are booked onto this training, and the service will continue to closely monitor, and monitor skill mix across the service.
• Information Governance compliance remains a focus of targeted improvement work, further challenges have been evident in May with a number of staff going out of date. Johnson (96.7), Waterton (95.2%) and Hepworth (96.4%) are within compliance with hotspots identified on Chippendale (90.9%), Priestley (84.6%), Waterton (90.9%) and Appleton (90.9%). The service has a clear plan for addressing with individuals and an improving trajectory is expected on all areas.
• The service includes fire training within the annual security updates. Following some challenges in trainer availability the service has worked with the fire service to support additional training sessions and plans have been in place to address. All wards except for Priestley (76.9%) and Waterton (81.8%) are now within expected targets and continued improvement has been noted. Additional dates continue to be available within the forensic care group and staff are also being supported to book on Trust training.
• Compliance for reducing restrictive physical interventions (RRPI) has notable improvements in compliance across the service with all wards now above compliance.
• Bed occupancy on Appleton (62.5%) is below compliance and due to a reduction in overall learning disability referrals to secure care. Of note the service has seen referrals that are now in process. Bed occupancy in the women's service (Johnson medium secure 73.3%) is also low but has noted a slight improvement and referrals have been received into the service. Neither of these services have a waiting list. Bed occupancy on Bronte (70.5%), although reduced the service users has service users waiting for admission processes to complete. Whilst Priestley and Waterton are red at 100%, this
would be viewed as positive within the forensic pathway as support use of admission beds and
demonstrates appropriate flow through the service.
There were no prone restraints in medium secure and incidents of violence and restraint incidents remains broadly consistent.
• Continued work and increased oversight of Priestley has been in place to understand the challenges in performance and enable focused intervention and support is in place. A gradual, albeit improving trajectory is noted.

Low Secure

• Sickness across all wards monitored closely, and ward managers are working closely with people directorate colleagues. Improvement has been noted on Sandal (2.1%) and Ryburn (3.0%). Newhaven (13.0%) has several staff (4) on long term sickness and some short-term sickness absence. A plan is in place with the People Directorate and additional Occupational Health Support using the CRISSP approach. Thornhill (10.2%) remains a hot spot, albeit some continued gradual improvement noted. Several staff do now have support plans to return to work so improvements are expected.
• Mandatory training compliance remains positive across all areas. A hotspot has been identified in CPR training on Ryburn (66.7%) and Newhaven (73.3%). Positive improvements are noted following review and actions from Ward Manager. There are now 2 staff on Ryburn who both are booked on training. There are 9 staff outstanding on Newhaven, 3 of these are on long term sickness, the others are booked onto training. 2 Newhaven staff on LTS also require data security awareness training, and this will be undertaken on return to work.
•The Inpatient risk assessment completed within 24 hours on Thornhill is a data quality issue, the service user was not admitted but transferred and a risk assessment was in place.
• Bed occupancy is low within low secure services with Thornhill (6£%) and Sandal (91.3%). The service is currently working to support transitions to Thornhill to support capacity on Sandal (admission ward). Ryburn currently has no empty beds. Newhaven (75%) continues to experience lower level of referrals and has no waiting list.
• There have been no prone restraint incidents. A reduction in restraint incidents on Newhaven is also noted and the service have continued to access the support of wider Trust services. RRPI / safeguarding to ensure robust

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Mar-25	Appleton Apr-25	Appleton May-25	Bronte Mar-25	Bronte Apr-25	Bronte May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	1.7%	3.4%	5.7%	2.0%	5.7%	8.7%
Supervision	Best place to work and learn	Well led	80%	93.3%	68.8%	50.0%	100.0%	86.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.7%	90.9%	96.0%	88.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.7%	91.3%	100.0%	88.0%	80.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	82.6%	81.8%	80.0%	88.0%	90.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	91.3%	86.4%	88.0%	92.0%	95.5%
Bed occupancy	Best Quality	Safe	90%	64.9%	68.3%	62.5%	94.9%	78.1%	70.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1856	N/A	N/A	383	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.1%	111.7%	128.6%	98.0%	96.5%	95.9%
Safer staffing (Registered)	Best Quality	Safe	80%	109.3%	104.8%	104.7%	99.7%	101.2%	106.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0	3	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	5	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	11	7	*11*	0	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	15	11	1	6	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale Mar-25	Chippendale Apr-25	Chippendale May-25	Hepworth Mar-25	Hepworth Apr-25	Hepworth May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	96.2%	95.8%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	7.1%	6.9%	7.0%	4.9%	8.0%	6.2%
Supervision	Best place to work and learn	Well led	80%	88.2%	93.8%	81.3%	100.0%	100.0%	94.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	90.0%	90.9%	100.0%	100.0%	96.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	82.6%	90.0%	86.4%	90.6%	88.9%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	80.0%	81.8%	93.8%	88.9%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	95.0%	95.5%	87.5%	100.0%	92.9%
Bed occupancy	Best Quality	Safe	90%	91.7%	89.2%	87.4%	86.2%	93.1%	96.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1329	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	127.6%	113.2%	102.7%	108.7%	91.7%	92.8%
Safer staffing (Registered)	Best Quality	Safe	80%	127.4%	115.6%	120.1%	94.5%	89.9%	91.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	0.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	1	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	13	1	3	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Mar-25	Johnson Apr-25	Johnson May-25	Priestley Mar-25	Priestley Apr-25	Priestley May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	96.3%	96.7%	96.3%	66.7%	66.7%	65.2%
Sickness	Best place to work and learn	Well led	5.4%	0.7%	2.9%	10.8%	3.1%	1.1%	3.1%
Supervision	Best place to work and learn	Well led	80%	93.8%	94.7%	93.3%	80.0%	75.0%	75.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.9%	96.9%	96.7%	89.3%	88.5%	84.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.4%	87.5%	90.0%	77.8%	76.0%	84.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	71.9%	73.3%	74.1%	64.0%	80.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.9%	96.9%	93.3%	78.6%	84.6%	76.9%
Bed occupancy	Best Quality	Safe	90%	80.0%	80.9%	73.3%	94.1%	97.6%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	943	N/A	N/A	898	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	143.1%	156.8%	118.0%	90.0%	89.3%	92.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.0%	107.6%	87.9%	91.2%	92.0%	105.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	0.0%	N/A	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	2	*0*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	33	36	13	4	0	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.2%	94.7%	94.7%
Sickness	Best place to work and learn	Well led	5.4%	11.5%	8.1%	12.1%
Supervision	Best place to work and learn	Well led	80%	76.9%	90.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.0%	95.2%	90.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	90.5%	86.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	85.7%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.5%	81.8%
Bed occupancy	Best Quality	Safe	90%	100.0%	95.4%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1253	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	145.1%	118.4%	124.2%
Safer staffing (Registered)	Best Quality	Safe	80%	102.9%	93.3%	98.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced April 2025	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	16	7	12

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Mar-25	Thornhill Apr-25	Thornhill May-25	Sandal Mar-25	Sandal Apr-25	Sandal May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	96.2%	96.3%	95.8%	95.7%	95.7%
Sickness	Best place to work and learn	Well led	5.4%	15.8%	12.2%	10.2%	3.4%	2.2%	2.1%
Supervision	Best place to work and learn	Well led	80%	84.6%	84.6%	78.6%	94.1%	93.3%	80.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.9%	100.0%	100.0%	96.9%	96.4%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.9%	96.6%	100.0%	96.9%	92.9%	96.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.3%	89.7%	82.8%	84.4%	92.9%	92.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.3%	93.1%	89.7%	93.8%	92.9%	92.6%
Bed occupancy	Best Quality	Safe	85%	79.1%	66.2%	63.0%	89.5%	93.8%	91.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	273	387	98	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	119.8%	115.9%	122.6%	113.0%	144.4%	126.9%
Safer staffing (Registered)	Best Quality	Safe	80%	110.7%	105.2%	105.0%	117.2%	114.7%	104.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	0.0%	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	16	18	20	26	30

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Mar-25	Ryburn Apr-25	Ryburn May-25	Newhaven Mar-25	Newhaven Apr-25	Newhaven May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	86.1%	81.5%	78.6%
Sickness	Best place to work and learn	Well led	5.4%	6.2%	1.7%	3.0%	7.2%	10.3%	13.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	85.7%	100.0%	90.5%	75.0%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.6%	97.0%	94.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	88.9%	86.8%	86.2%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	60.0%	66.7%	81.6%	69.0%	73.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	85.7%	90.9%	94.1%
Bed occupancy	Best Quality	Safe	85%	80.2%	86.7%	88.9%	72.6%	75.0%	75.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	740	N/A	31800.0%	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	98.9%	100.0%	98.4%	110.9%	111.1%	124.9%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	100.0%	100.0%	105.6%	101.6%	97.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	6	10	5
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	10	*4*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	4	12	2

Inpatients - Non-Mental Health

• **Appraisal rate:**
Neuro Rehabilitation Unit (NRU) rate is showing as 86.5% for May which maintains the rate slightly below compliance. Some of this can be attributed to annual leave of Unit Manager.
Stroke Rehabilitation Unit (SRU) rate has increased again to maintain compliance this month at 95.2% for May.

• **Sickness:**
NRU – sickness has slightly increased in May from 7% to 7.2%. One LTS (long term sickness) re hip surgery replacement continues to be off sick due to post operative complications; this will continue until early July. We still have one LTS staff member (anxiety) with their latest sick note running into July (planned return to work on 7.7.25), plus a further LTS where a staff member continues to be on sick leave into June (anxiety) due to a critically ill spouse. An additional sickness absence during May relates to planned surgery; this also continues into June. These are all being managed via HR processes and sickness reviews.
SRU – Sickness for May has significantly decreased from 14.1% to 8.4%. As noted last month, we anticipated an improving picture based on the staff returning to work in early June. This continues to improve, and we expect a further reduction in sickness by the end of June. This is being managed via HR processes and sickness reviews.

• **Supervision:**
NRU has seen a further decrease during May to 39.1%.
Due to the ongoing requirement to ensure safe staffing levels, along with LTS impacting our qualified nursing cohort in particular, patient care has had to be prioritised which has impacted the ability to make progress towards the target again this month. Senior management are aware of significant staffing issues due to sickness and maternity leave which will continue to impact. A new member of staff commenced in post mid-June and further recruitment is ongoing.
SRU figures for May have seen an increase to 70%. We continue to see the figures increase into June to achieve compliance – as at 20.6.25 the figures are showing as 82.9%

• **Information Governance:**
NRU – maintained compliance during May at 97.6%.
SRU – maintained compliance during May at 98.5%.

• **Cardiopulmonary resuscitation (CPR):**
NRU – further improved compliance at 92.3% for May.
SRU – a significant increase during May to achieve compliance at 90.6%.
To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore, there is a potential for up to a 6-week lag before the updated training statistics are showing.

• **Fire Training:**
Both units achieving compliance above 90% following bespoke fire training which took place in early May.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU) Mar-25	Apr-25	May-25	Stroke Rehabilitation Unit (SRU) Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.9%	86.5%	86.5%	85.0%	91.5%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	6.8%	7.0%	7.2%	7.7%	14.1%	8.4%
Supervision	Best place to work and learn	Well led	80%	87.0%	69.6%	39.1%	86.1%	65.8%	70.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	97.6%	97.6%	98.6%	98.5%	98.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.1%	85.0%	92.3%	71.2%	77.8%	90.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	84.8%	90.5%	92.7%	88.6%	89.6%	91.2%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	71.8%	70.3%	63.2%	99.5%	98.3%	90.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	38	46	155	38	39	28
Safer staffing (Overall)	Best Quality	Safe	90%	116.5%	120.4%	116.9%	95.5%	95.3%	92.2%
Safer staffing (Registered)	Best Quality	Safe	80%	94.9%	104.2%	95.0%	119.1%	121.1%	108.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	10	0	0	86

Inpatients - Mental Health - Learning Disability

Headlines

- The service continues to support the provision of appraisal. The service continues to monitor closely and is compliant at 100%.
- The Ward Manager has been undertaking some quality improvement work on supervision, which reflects the improving compliance currently at 100%.
- Mandatory training compliance remains positive, with a hotspot in CPR (68.4%) due to staff requiring updates. Plans are in place to address, and staff are booked onto training.
- Sickness absence has now returned to with compliance levels.
- There are a high number of service users that are clinically ready for discharge. These relate to the ongoing complex packages of care.
- The service has reviewed the risk assessment and has plans in place to support compliance.
- Due to the current acuity and individual needs of service users, the service has required additional staffing, reflected in the overall safer staffing (138.5%) and registered safer staffing (179.7%).
- There was one prone restraint that was a seclusion exit. Training is in place with the RRPI team to support alternative seclusion exit approaches.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	94.1%	94.1%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.6%	5.8%	3.1%
Supervision	Best place to work and learn	Well led	80%	84.2%	90.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.5%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	91.9%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.1%	78.4%	68.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.0%	97.4%	94.1%
Bed occupancy	Best Quality	Safe	N/A	67.3%	55.4%	49.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	1015	270
Safer staffing (Overall)	Best Quality	Safe	90%	172.7%	144.1%	138.5%
Safer staffing (Registered)	Best Quality	Safe	80%	170.3%	157.4%	179.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	55.7%	90.1%	78.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	24	19	19
Restraint incidents	Best Quality	Safe	Trend Monitor	36	23	*22*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	16

Inpatients - Forensic South Yorkshire

Medium Secure

- Supervision compliance is above compliance for Foss and Skipton (100%).
- Appraisal compliance has seen an improvement on both Foss (92.3%) and Skipton (100%).
- Sickness absence is above target for Foss (5.6%) and Skipton (7.6%). This will be closely monitored by the managers.
- Safer staffing on Skipton (Registered 77.1%) is slightly below expected threshold, this has been reviewed by the service manager and has been resolved. Staffing remains to be reviewed daily by the service manager.
- Good compliance against mandatory training is noted across all areas.
- Bed occupancy on Skipton (50%), whilst below usual compliance this is in relation to the mobilisation of CPH and plans are in place.
- There were no prone restraints.
- Risk assessment data is not currently captured as CPH do not currently complete FIRM risk assessments, this is within the improvement plan.

Low Secure

- Supervision compliance is above compliance for Aire (100%), Don (96.2%) and Calder (96.3%). For Esk (66.2%) and Wentbridge (77.3%) this is identified as a recording issue.
- Appraisal compliance across three low secure wards (Esk 75%, Wentbridge 83.8% and Don (72%) remain below expected compliance. A review is underway to understand the challenges within the service.
- Sickness absence is above target for Wentbridge (10.1%). This will be closely monitored by the managers and wellbeing checks have been carried out appropriately.
- Good compliance against mandatory training is noted across all areas with exception of Cardiopulmonary resuscitation (CPR) on Wentbridge (72.7%).
- Bed occupancy on Calder (62.3%), whilst below usual compliance both are in relation to the mobilisation of CPH and plans are in place.
- There were no prone restraints.
- Risk assessment data is not currently captured as CPH do not currently complete FIRM risk assessments, this is within the improvement plan.

				Medium Secure Services Foss		Skipton		Low Secure Services Esk		Wentbridge	
Metrics	Strategic Objective	CQC Domain	Threshold	Apr-25	May-25	Apr-25	May-25	Apr-25	May-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	April 87% May 88%	55.6%	92.3%	77.8%	100.0%	85.0%	75.0%	83.3%	93.2%
Sickness	Best place to work and learn	Well led	5.4%	7.3%	5.6%	6.6%	7.6%	6.3%	5.1%	8.4%	10.1%
Supervision	Best place to work and learn	Well led	80%	87.9%	100.0%	70.4%	100.0%	83.3%	65.2%	91.3%	88.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	90.9%	100.0%	100.0%	95.5%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.6%	93.1%	94.1%	93.5%	100.0%	95.5%	93.2%	93.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.0%	93.1%	93.9%	93.1%	100.0%	95.2%	77.3%	72.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.0%	89.7%	93.9%	100.0%	95.5%	95.5%	88.6%	88.9%
Bed occupancy	Best Quality	Safe	90%	81.7%	85.7%	50.0%	50.0%	85.2%	87.5%	87.5%	87.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1015	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	91.0%	105.2%	108.9%	102.9%	101.7%	114.5%	149.2%	155.7%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	112.9%	83.8%	77.1%	111.0%	105.5%	106.6%	106.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0	6	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	*0*	3	*3*	0	*0*	2	*2*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	*0*	0	*0*	0	*0*	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0	0	0

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Apr-25	Low Secure Services Aire May-25	Don Apr-25	Don May-25	Calder Apr-25	Calder May-25
Appraisal rate	Best place to work and learn	Well led	April 87% May 88%	100.0%	100.0%	95.8%	72.0%	88.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	4.5%	0.9%	0.5%	2.5%	4.6%	3.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	96.2%	88.5%	96.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	97.0%	96.2%	96.4%	95.8%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	84.8%	92.3%	94.6%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.3%	84.8%	84.6%	84.6%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	87.9%	100.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	90.8%	91.4%	98.3%	91.9%	54.8%	62.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	102.3%	110.8%	119.0%	128.9%	94.8%	99.2%
Safer staffing (Registered)	Best Quality	Safe	80%	87.4%	99.7%	82.7%	101.0%	62.5%	75.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	*0*	0	*0*	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	*0*	0	*0*	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0

Overall Financial Performance 2025/26

Executive Summary / Key Performance Indicators

	Performance Indicator	Strategic Objective	CQC Domain	Year to Date	Forecast 2025/26	Narrative
1	Surplus / (Deficit)	Best Value	Well Led	(£1.4m)	£0m	The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) worse than plan. This means that the year to date deficit is £1.4m (£0.2m - 17% worse than plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements.
2	Agency Spend	Best Value	Well Led	£0.7m	£2.9m	Agency worked WTE has continued to reduce in May. However expenditure has increased, £19k more than last month, due to additional charges received relating to previous accounting periods.
3	Bank Spend	Best Value	Well Led	£4.1m	£23.3m	Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However this does remain higher than plan and further actions will continue to be implemented.
4	Corporate Spend	Best Value	Well Led	£11m	£67.3m	National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. This value is total corporate expenditure with the RAG rating as a comparison against plan following agreed budgetary reductions. In May spend is £0.3m less than planned.
5	Financial sustainability and efficiencies	Best Value	Well Led	£2.8m	£28.2m	The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month as April 2025 was £465k behind plan. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.
6	Cash	Best Value	Well Led	£54.6m	£53.3m	Cash continues to be monitored to ensure effective management of the Trust working capital position. At May 2025 this remains better than planned.
7	Capital Spend	Best Value	Well Led	£0.6m	£14.2m	Spend on capital is less than planned in May. This is due to issues with invoices for leased properties which has meant that the annual revaluation has not been possible to calculate. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.
8	Better Payment Practice Code	Best Value	Well Led	96%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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

Appendix 1 - Cheswold Park Hospital

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Trust Threshold	Mar-25	Apr-25	May-25
% of staff receiving supervision within policy guidance	Improving Resources	Well Led	80.0%	82.0%	89.0%	91.0%
Appraisals - rolling 12 months			95%	78.4%	83.5%	91.5%
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	97.0%	97.0%
Mandatory Training - Reducing Restrictive Practice Interventions				93.5%	92.5%	91.5%
Mandatory Training - Cardiopulmonary Resuscitation				90.5%	88.7%	86.8%
Mandatory Training - Clinical Risk				N/A	N/A	N/A
Mandatory Training - Display Screen Equipment				N/A	N/A	N/A
Mandatory Training - Equality & Diversity				98.7%	99.0%	98.3%
Mandatory Training - Fire Safety			>=85%	94.4%	94.7%	94.6%
Mandatory Training - Food Safety			>=80%	100.0%	100.0%	100.0%
Mandatory Training - Freedom To Speak Up (FTSU)				100.0%	100.0%	100.0%
Mandatory Training - Infection Control & Hand Hygiene				95.7%	95.5%	95.6%
Mandatory Training - Information Governance (Data Security)			>=95%	94.5%	94.7%	98.0%
Mandatory Training - Moving & Handling			>=80%	94.4%	94.7%	94.6%
Mandatory Training - Mental Capacity Act/Dols				94.8%	93.4%	93.2%
Mandatory Training - Mental Health Act				94.8%	93.4%	93.2%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				98.7%	98.7%	99.0%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				96.1%	94.4%	95.3%
Mandatory Training - Safeguarding Children				96.1%	94.4%	95.3%

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 2 (2025 / 26)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

	Key Performance Indicator	Year to Date	Forecast 2025 / 26	Narrative
1	Surplus / (Deficit)	(£1.4m)	£0m	The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) worse than plan. This means that the year to date deficit is £1.4m (£0.2m - 17% worse than plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements.
2	Agency Spend	£0.7m	£2.9m	Agency worked WTE has continued to reduce in May. However expenditure has increased, £19k more than last month, due to additional charges received relating to previous accounting periods.
3	Bank Spend	£4.1m	£23.3m	Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However this does remain higher than plan and further actions will continue to be implemented.
4	Corporate Spend	£11m	£67.3m	National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. This value is total corporate expenditure with the RAG rating as a comparison against plan following agreed budgetary reductions. In May spend is £0.3m less than planned.
5	Financial sustainability and efficiencies	£2.8m	£28.2m	The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month as April 2025 was £465k behind plan. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.
6	Cash	£54.6m	£53.3m	Cash continues to be monitored to ensure effective management of the Trust working capital position. At May 2025 this remains better than planned.
7	Capital	£0.6m	£14.2m	Spend on capital is less than planned in May. This is due to issues with invoices for leased properties which has meant that the annual revaluation has not been possible to calculate. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.
8	Better Payment Practice Code	96%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

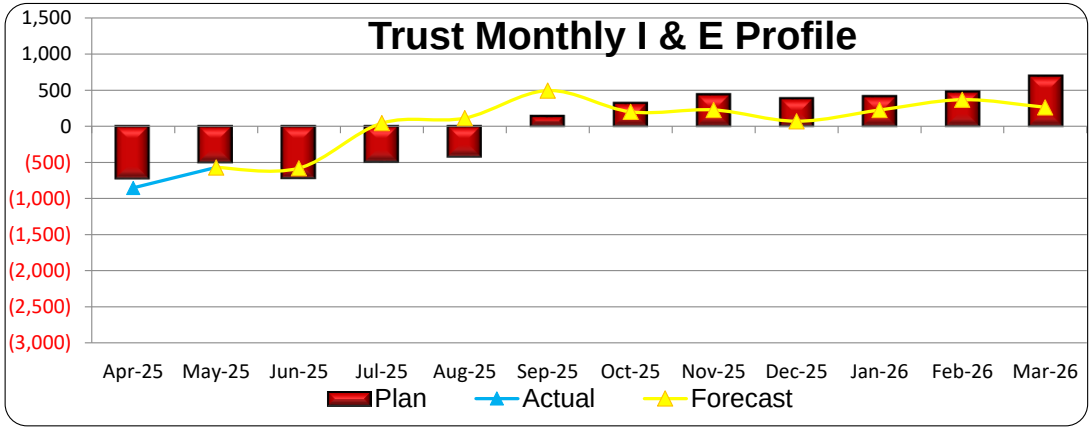
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

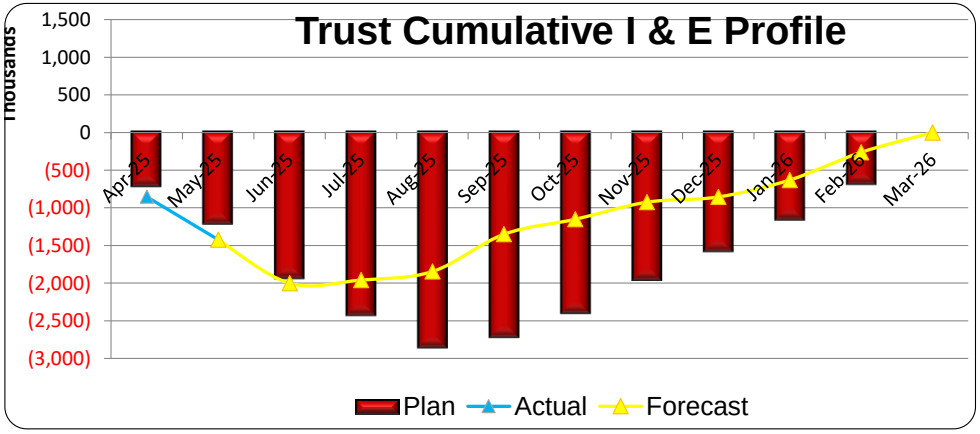
2.0 Income & Expenditure Position 2025 / 26

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, and budgets held centrally, are 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					37,452	37,484	31	74,843	74,770	(73)	450,376	449,822	(554)
Other Operating Revenue					1,294	1,248	(46)	2,527	2,616	90	15,697	15,499	(197)
Total Revenue					**38,746**	**38,732**	**(15)**	**77,370**	**77,386**	**17**	**466,073**	**465,322**	**(751)**
Pay Costs	5,389	5,307	(82)	1.5%	(24,717)	(24,619)	99	(49,527)	(49,521)	5	(296,307)	(294,459)	1,849
Non Pay Costs					(13,730)	(13,891)	(161)	(27,458)	(27,716)	(258)	(159,862)	(161,282)	(1,420)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,389**	**5,307**	**(82)**	**-1.5%**	**(38,447)**	**(38,510)**	**(63)**	**(76,984)**	**(77,237)**	**(253)**	**(456,169)**	**(455,740)**	**429**
EBITDA	**5,389**	**5,307**	**(82)**	**-1.5%**	**299**	**222**	**(78)**	**385**	**149**	**(236)**	**9,904**	**9,582**	**(323)**
Depreciation					(613)	(661)	(48)	(1,225)	(1,322)	(97)	(7,447)	(7,762)	(315)
PDC Paid					(378)	(382)	(4)	(756)	(764)	(8)	(4,534)	(4,584)	(50)
Interest Received					193	251	58	379	514	135	2,077	2,764	687
Surplus / (Deficit) - ICB performance measure	**5,389**	**5,307**	**(82)**	**-1.5%**	**(498)**	**(570)**	**(72)**	**(1,216)**	**(1,423)**	**(206)**	**0**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(17)	(10)	7	(94)	(61)	33
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,389**	**5,307**	**(82)**	**-1.5%**	**(507)**	**(575)**	**(68)**	**(1,234)**	**(1,433)**	**(199)**	**(94)**	**(61)**	**33**





Income & Expenditure Position 2025 / 26

The Trust deficit in May 2025 is £570k.
Actions are required to ensure delivery of the breakeven target.

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2025 / 26. This consciously included an element of unidentified efficiency requirement and will require corrective action in order to achieve this position.

NHS England - monthly submission

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

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. Cheswold Park Hospital, which was purchased in October 2024 and was reported separately during 2024 / 25, has now been consolidated into the Core Trust as business as usual. Previous year comparators have been updated to include this. This is summarised in the table below.

	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
Description	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)	5,366	5,283	(83)	1.6%	(783)	(459)	324	(1,805)	(1,388)	417	(6,632)	(6,006)	625
Provider Collaboratives	23	24	1	4.5%	3	(112)	(115)	4	(56)	(61)	27	90	63
Budgets held centrally	0	0	0	0.0%	283	2	(281)	584	22	(562)	6,605	5,917	(688)
Total - Consolidated position (ICB performance measure)	**5,389**	**5,307**	**(82)**	**-1.5%**	**(498)**	**(570)**	**(72)**	**(1,216)**	**(1,423)**	**(206)**	**0**	**0**	**0**

At month 2 there has been improvement in the Trust (core) financial position. Whilst this remains in a monthly deficit run rate this is £469k less than April 2025. Overall the year to date position is a deficit of £1,388k. The drivers behind the Trust financial performance are considered in detail in the remainder of the report.

Both Adult Secure Provider Collaboratives have reported deficits in month as a result of activity pressures. This will continue to be monitored and mitigation plans developed as required. The financial position for 2025 / 26 for the provider collaboratives which SWYPFT is a partner will be incorporated once known. These are currently assumed to be breakeven.

Budgets held centrally are primarily the targets for value for money and will be allocated as plans progress. As reflected within the value for money analysis schemes are currently behind plan and, hence, the negative impact on the financial position.

2.0 Income & Expenditure Position 2025 / 26

This section focusses on the financial performance of South West Yorkshire Partnership NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives and budgets held centrally which are presented separately. The movement between the total consolidated financial position and the table below is reconciled on the previous page for ease.

To confirm that the individual analysis within this report highlights the Trust only values unless explicitly stated otherwise.

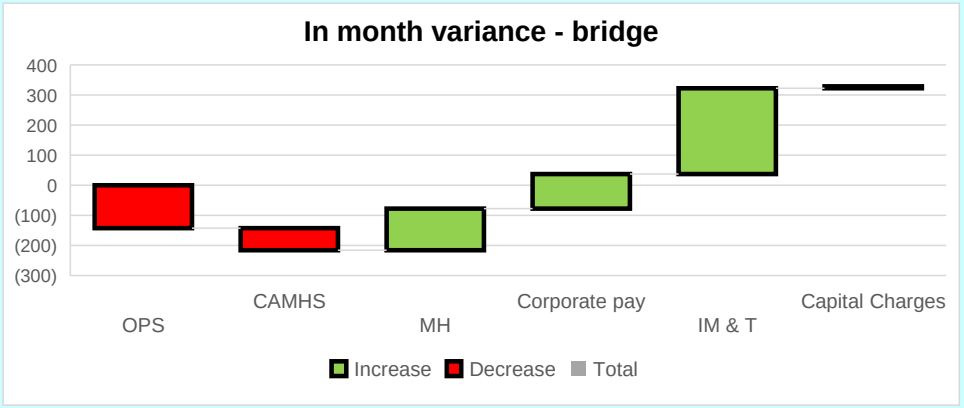
Total Financial Position - Core Trust only

	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
Description / Heading	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					28,246	28,276	30	56,430	56,358	(73)	339,901	339,353	(548)
Other Operating Revenue					1,214	1,175	(39)	2,367	2,468	101	14,741	14,641	(101)
Total Revenue					**29,460**	**29,452**	**(9)**	**58,798**	**58,826**	**28**	**354,642**	**353,994**	**(648)**
Pay Costs	5,366	5,283	(83)	1.6%	(24,492)	(24,463)	29	(49,075)	(49,231)	(157)	(293,599)	(292,786)	814
Non Pay Costs					(4,954)	(4,656)	298	(9,926)	(9,411)	516	(57,771)	(57,633)	137
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,366**	**5,283**	**(83)**	**-1.6%**	**(29,446)**	**(29,119)**	**327**	**(59,001)**	**(58,642)**	**359**	**(351,370)**	**(350,419)**	**951**
EBITDA	**5,366**	**5,283**	**(83)**	**-1.6%**	**14**	**332**	**318**	**(203)**	**184**	**387**	**3,272**	**3,575**	**303**
Depreciation					(613)	(661)	(48)	(1,225)	(1,322)	(97)	(7,447)	(7,762)	(315)
PDC Paid					(378)	(382)	(4)	(756)	(764)	(8)	(4,534)	(4,584)	(50)
Interest Received					193	251	58	379	514	135	2,077	2,764	687
Surplus / (Deficit) - ICB performance measure	**5,366**	**5,283**	**(83)**	**-1.6%**	**(783)**	**(459)**	**324**	**(1,805)**	**(1,388)**	**417**	**(6,632)**	**(6,006)**	**625**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(17)	(10)	7	(94)	(61)	33
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,366**	**5,283**	**(83)**	**-1.6%**	**(792)**	**(464)**	**328**	**(1,822)**	**(1,398)**	**424**	**(6,726)**	**(6,067)**	**658**

The Trust plan for 2025 / 26 is profiled with a deficit in the early part of the year and reducing as value for money schemes have an impact. The budget deficit arises, following a period of small surpluses in the monthly run rate in late 2024 / 25, due to inflationary cost pressures such as pay award assumptions and national insurance changes set by government.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:

	£k
Staffing - Older People (Barnsley and Wakefield). More staff utilised than planned. Primarily bank staffing	(142)
Staffing - CAMHS. Staffing higher than plan. Medical staffing cost pressures	(74)
Staffing - Mental Health care group. Reduction in worked WTE in month	138
Staffing - Corporate pay less than planned. Over and above value for money schemes. Reflected in VFM additional delivery.	116
Support - timing of IM & T purchases	285
Capital charges - interest received higher than planned. Offsetting depreciation charges	6

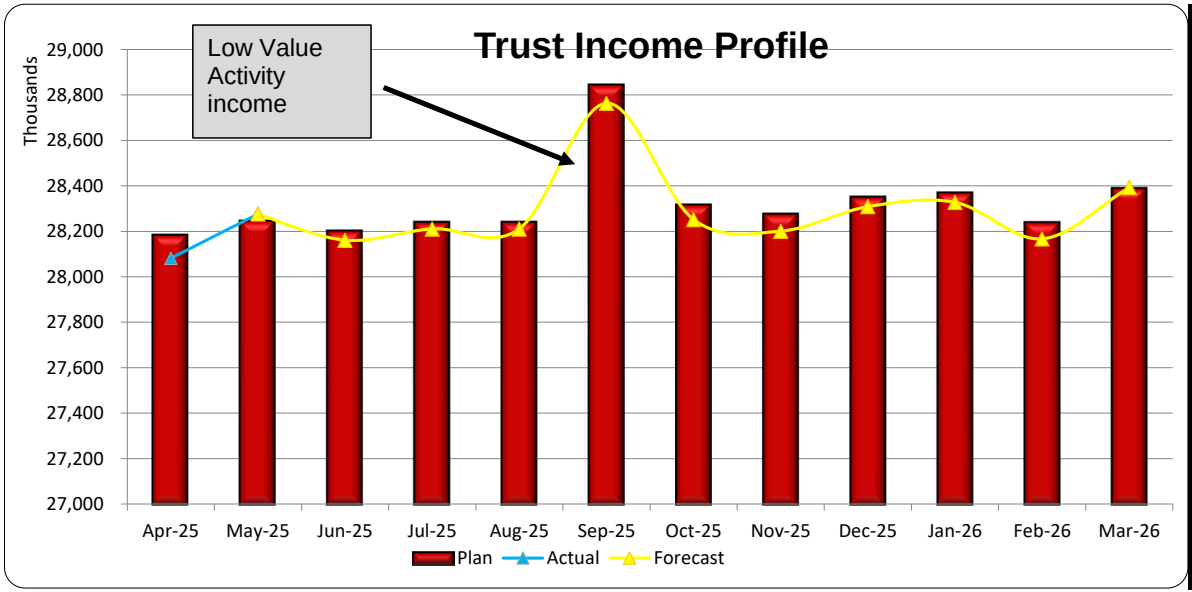


2.1 Income Information

The Trust receives income from it's commissioners in order to deliver healthcare services to meet the defined needs of the local population. The majority of this is in the form of an Aligned Incentive Contract (AIC) with a set value agreed (fixed / block contract value). As such this provides income stability, and financial certainty, to enable the Trust to plan effectively. This is amended to take account of any tariff changes (set nationally) and for agreed changes in service provision (investment and / or disinvestment).

The main table below is the core Trust income and excludes income received for the commissioning role for mental health collaboratives, although this value is noted. The table highlights where income is received from by organisation type. This confirms that the vast majority is received from local Integrated Care Boards (ICB's - both West Yorkshire and South Yorkshire). The Specialist Commissioner includes the SWYPFT contractual element of the Adult Secure Provider Collaborative.

Income source	Total 24/25 £k	Apr-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k	Budget £k	Variance £k
NHS Commissioners	265,839	22,693	22,668	22,676	22,676	22,676	23,279	22,676	22,676	22,676	22,676	22,676	22,722	**272,767**	272,767	0
Specialist Commissioner	36,788	4,697	4,723	4,684	4,726	4,726	4,684	4,726	4,684	4,726	4,726	4,600	4,726	**56,426**	56,881	(455)
Local Authority	5,141	318	465	411	411	411	411	411	411	411	411	411	411	**4,896**	5,232	(337)
Partnerships	2,940	248	251	243	251	251	243	292	282	349	367	332	386	**3,494**	2,958	536
Other Contract Income	1,583	127	168	148	148	148	148	148	148	148	148	148	148	**1,771**	2,063	(291)
Total	**312,292**	**28,082**	**28,276**	**28,161**	**28,211**	**28,211**	**28,764**	**28,252**	**28,201**	**28,309**	**28,328**	**28,167**	**28,393**	**339,353**	**339,901**	**(548)**
2024 / 25		24,752	24,994	25,289	24,997	24,805	24,735	31,570	24,649	26,249	26,177	26,192	27,884	**312,292**		
Provider Collab		9,204	9,207	9,205	9,207	9,207	9,205	9,207	9,205	9,207	9,207	9,199	9,209	**110,469**		
Total	**312,292**	**37,286**	**37,484**	**37,366**	**37,418**	**37,418**	**37,969**	**37,459**	**37,405**	**37,516**	**37,535**	**37,366**	**37,602**	**449,822**		



As identified the majority of income is block / fixed in value. Key variances are noted below. Unless stated the variance in income is offset by an equal variance in pay / non pay with reimbursement based on actual costs incurred.

	Forecast
* Additional roles reimbursement	£268k

Recharge of salary based on staff in post

* Local Authority - Yorkshire Smokefree	£337k

Payment by results on some Smokefree contracts and recharge of actual prescribing costs

* NHS England - patient monies	£22k

Recharge of actual payments made

2.2 Pay Information

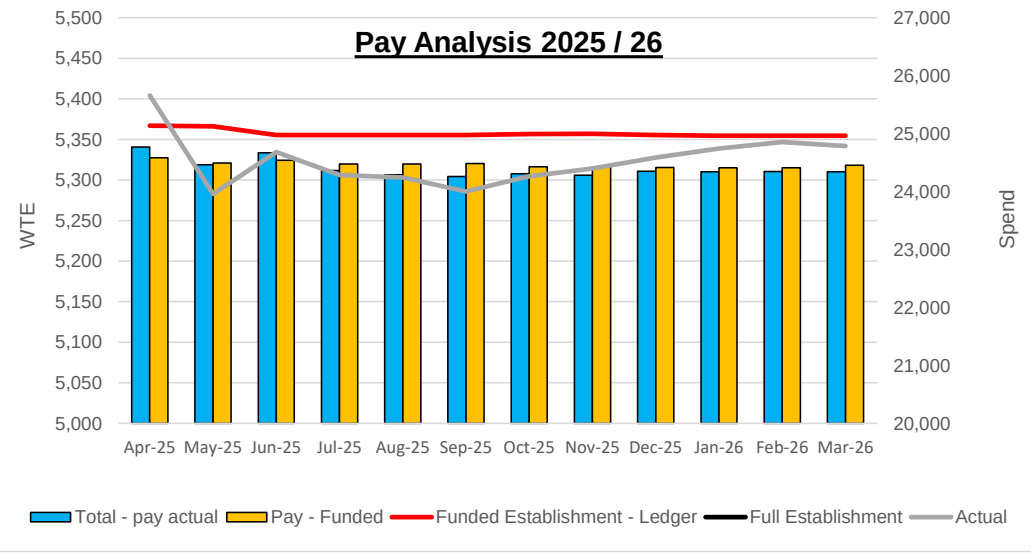
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k
Substantive	22,200	22,182	22,339	22,147	22,118	22,140	22,208	22,225	22,261	22,267	22,293	22,295	**266,674**
Bank & Locum	2,216	1,926	2,018	1,947	1,933	1,913	1,904	1,884	1,909	1,893	1,878	1,860	**23,282**
Agency	352	355	311	268	242	206	196	175	182	181	177	186	**2,830**
Total	**24,768**	**24,463**	**24,669**	**24,362**	**24,293**	**24,259**	**24,308**	**24,284**	**24,352**	**24,341**	**24,348**	**24,341**	**292,786**
24 / 25	21,466	21,360	21,739	21,751	21,275	21,756	27,051	23,069	22,694	22,843	22,707	22,922	**270,633**

Bank as % (in month)	8.9%	7.9%	8.2%	8.0%	8.0%	7.9%	7.8%	7.8%	7.8%	7.8%	7.7%	7.6%	8.0%
Agency as % (in month)	1.4%	1.5%	1.3%	1.1%	1.0%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.8%	1.0%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,837	4,809	4,831	4,830	4,830	4,827	4,843	4,858	4,865	4,877	4,889	4,889	**4,849**
Bank & Locum	528	443	484	461	459	447	452	447	454	451	448	443	**460**
Agency	39	31	20	15	14	12	10	9	9	10	9	9	**16**
Total	**5,404**	**5,283**	**5,335**	**5,306**	**5,303**	**5,286**	**5,305**	**5,314**	**5,328**	**5,339**	**5,347**	**5,342**	**5,324**
24 / 25	5,110	5,034	5,064	5,087	5,092	5,110	5,421	5,434	5,418	5,399	5,425	5,417	**5,251**



In line with national guidance we continue to assume the standard 2.8% pay award within the Trust financial position. We are aware of proposed pay award values for 2025 / 26, differing between medical staff and agenda for change, and these will be included when confirmed. At the same time income will be uplifted.

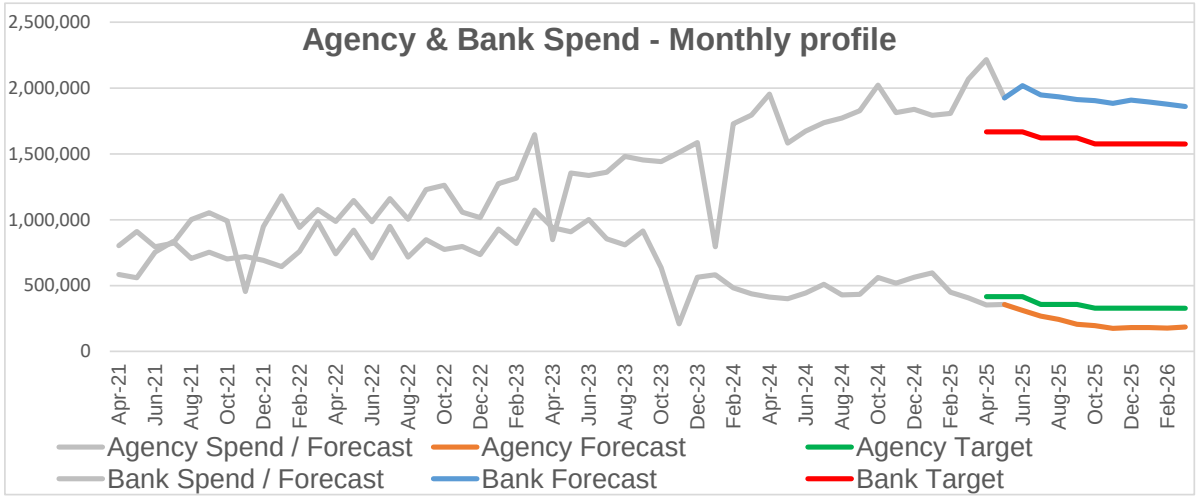
There has been a reduction in all categories in May 2025. The reduction is 28 substantive, 86 bank and 8 agency giving a total reduction of 121 when compared to April 2025. This also means that worked WTE is less than plan in month. Based on detailed forecast information this is expected to be maintained throughout the year.

2.2 Temporary Staffing Focus

Trust spend in May 2025:
Agency £355k
Bank £1,926k

We continue to acknowledge that temporary staffing solutions continue to play an important role in the overall workforce strategy of the Trust. However this must fit within the overall context of ensuring the best possible use of resources and value for money whilst ensuring that operational pressures are effectively managed.

The focus has expanded from purely agency staff to total temporary staffing costs especially those which are paid a premium rate to those paid under normal terms and conditions. This includes agency staff, Trust bank staff and also enhanced payments made to substantive Trust staff for additional hours.



Temporary Staff costs to date - by category			
Category	**Agency**	**Bank**	**Total**
	£k	**£k**	**£k**
Consultant	333	119	**452**
Other Medical	201	78	**280**
Reg Nursing	14	1,017	**1,031**
UnReg Nursing	90	2,617	**2,708**
Other Clinical	66	122	**188**
A & C	3	188	**191**
Other	0	0	**0**
Total	**708**	**4,142**	**4,850**
Lead Provider Collaborative	25	2	**28**
Budgets held centrally			**0**
Total	**733**	**4,144**	**4,877**

In line with national guidance the Trust financial plan for 2025 / 26 included spend reduction targets; 30% reduction in agency and 10% reduction in bank. The target levels of expenditure per month are now shown in the graph above.

Performance measurement of these targets is based upon total consolidated agency and bank expenditure and are reported as part of the Trust value for money programme.

Agency spend continues to be reported as green with expenditure less than plan in both April and May. This is forecast to continue to reduce. The table highlights that the majority of spend relates to medical staff (£534k out of £708k - 75%). Next steps continue to be developed and are reported weekly through the Trust temporary staffing scrutiny and management group.

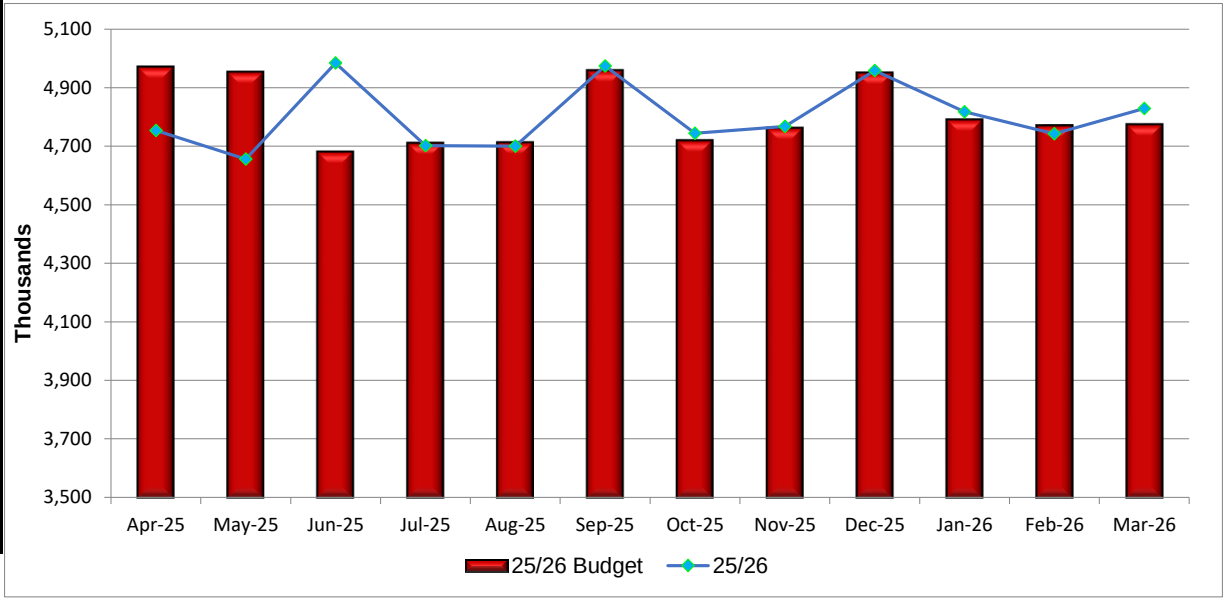
Bank expenditure, however, although reduced in May remains significantly higher than planned level. The reduction of spend in month is £122k with the largest reduction in adult inpatient wards (£101k). Forensics had seen a small increases in month which, in part, is due to additional staffing requirements in response to a specific incident. In all cases a process for break glass is established to ensure that safety is maintained.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust costs, 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. To re-confirm that this also excludes expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k
2025 / 26	4,754	4,656	4,984	4,702	4,701	4,974	4,744	4,768	4,959	4,818	4,743	4,829	**57,633**
2024 / 25	4,286	4,881	4,495	4,134	4,476	4,083	5,026	4,807	4,573	4,729	4,866	5,403	**55,758**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	750	733	(17)
Establishment	1,970	1,566	(404)
Lease & Property Rental	1,496	1,485	(11)
Premises (inc. rates)	918	934	16
Utilities	481	600	120
Purchase of Healthcare	1,099	1,052	(47)
Travel & vehicles	1,076	1,069	(7)
Supplies & Services	1,495	1,396	(99)
Training & Education	96	133	37
Clinical Negligence & Insurance	293	246	(47)
Other non pay	252	196	(56)
Total	**9,926**	**9,411**	**(516)**
Total Excl OOA and Drugs	**8,077**	**7,625**	**(452)**



Key Messages

Within non pay, excluding provider collaboratives and budgets held centrally, most areas are reporting expenditure less than the plan. The largest is establishment which includes a timing delay in purchase of computer equipment. This equates to £286k behind plan for the year to date.

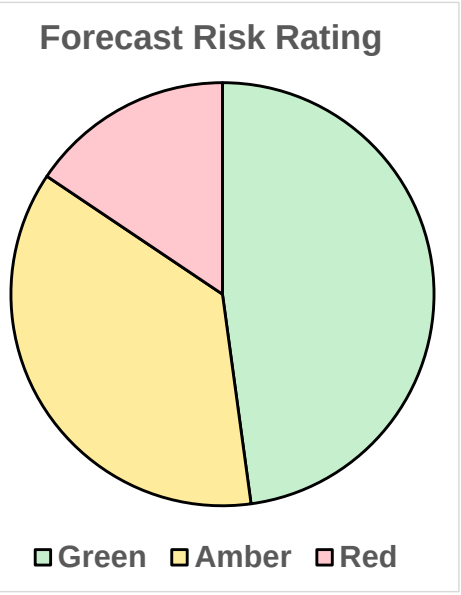
The largest overspend is utilities. The financial position reflects invoices received to date although a number are in query. As such this should be a prudent assessment of the financial risk.

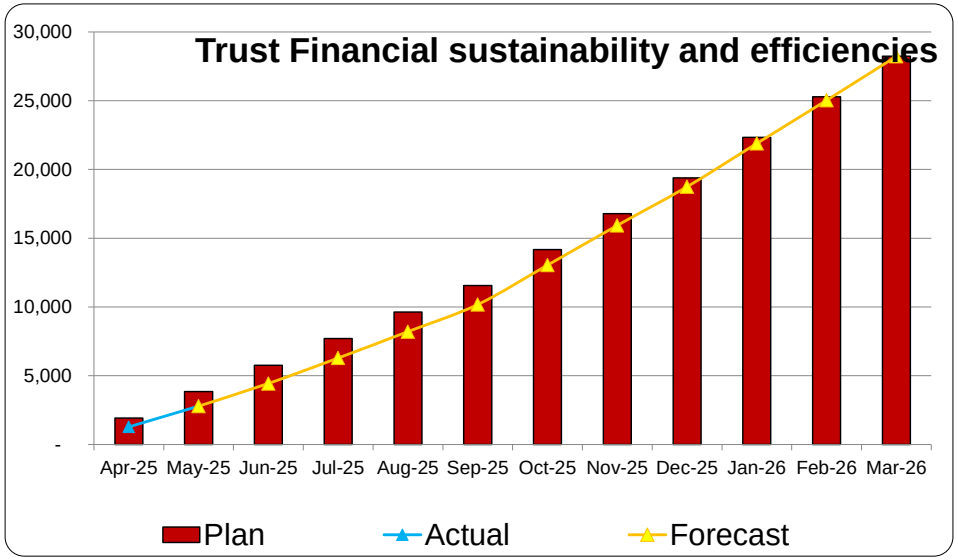
3.0 Value for Money & Financial sustainability

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 2025 / 26 a target of £28.2m has been identified and included within the plan. Additional mitigations will be required if the Trust run rate varies from 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				
Group	Key lines of enquiry	Target £k	Achieved Recurrent £k	Achieved Non Recurrent £k	Variance £k	Target £k	Green £k	Amber £k	Red £k	Variance £k
Pay	Workforce	1,750	0	1,439	(311)	10,500	1,439	7,928		(1,133)
	Unallocated	0	0		0	3,400	0		3,400	0
	Fixed Term Contracts	84	0		(84)	500	0	500		0
	Corp / non clinical	100	311	219	430	2,000	3,056			1,056
	Productivity	0	0		0	1,100	0	1,100		0
	Temporary Staffing	650	98		(552)	3,900	1,430	0		(2,470)
	Difficult Decisions	0	0		0	1,000	0		1,000	0
Non Pay	Non Pay	162	79		(83)	1,130	354	796		20
Other	Corporate Services	284	290		6	1,700	1,745			45
	Provider Collaboratives	250	354		104	1,500	2,121			621
	Bed Sales	0	0		0	500	500			0
	Technical	0	0		0	1,000	2,862			1,862
Total		**3,280**	**1,132**	**1,657**	**(491)**	**28,230**	**13,506**	**10,324**	**4,400**	**0**
Recurrent		1,480	1,132		(348)	16,430	7,854	2,396	4,400	(1,780)
Non Recurrent		1,800		1,657	(143)	11,800	5,652	7,928	0	1,780





At this early stage of the financial year progress is being made on developing and realising schemes. The year to date position is £491k behind plan.

Positive run rate reductions in corporate pay expenditure, and in the provider collaboratives scheme, help to offset those schemes which are currently behind plan. The largest of these is temporary staffing, and as reported elsewhere, is linked to bank usage higher than plan. Bank spend has reduced in month but will require further reductions to realise this scheme. There has been significant reductions on sub sections of this scheme including the reduction of corporate bank spend.

This is reflected in the full year forecast with temporary staffing a key scheme which is forecast to be behind plan and requiring additional mitigations. The actions will be considered by the Value for Money board but are currently rated as green and achievable within this financial year.

The expectation is that as the year progresses we will see a movement of schemes from red to amber and to green reflecting the reduction in financial risk as schemes are realised.

4.0 Statement of Financial Position (SOFP) 2025 / 26

Balance Sheet / Statement of Financial Position (SOFP)	2024 / 2025 £k	Current £k	Note
Non-Current (Fixed) Assets	197,434	195,270	
Current Assets			
Inventories & Work in Progress	248	248	
NHS Trade Receivables (Debtors)	2,453	88	
Non NHS Trade Receivables (Debtors)	989	696	
Prepayments	2,863	5,561	1
Accrued Income	6,235	6,428	2
Cash and Cash Equivalents	55,748	54,593	Pg 15
Total Current Assets	**68,537**	**67,615**	
Current Liabilities			
Trade Payables (Creditors)	(10,899)	(3,292)	3
Capital Payables (Creditors)	(1,551)	(847)	
Tax, NI, Pension Payables, PDC	(9,478)	(10,186)	
Accruals	(14,054)	(18,052)	4
Deferred Income	(644)	(1,444)	5
Other Liabilities (IFRS 16 / leases)	(48,793)	(49,954)	
Total Current Liabilities	**(85,419)**	**(83,776)**	
Net Current Assets/Liabilities	**(16,882)**	**(16,160)**	
Total Assets less Current Liabilities	**180,552**	**179,110**	
Provisions for Liabilities	(3,357)	(3,348)	
Total Net Assets/(Liabilities)	**177,195**	**175,762**	
Taxpayers' Equity			
Public Dividend Capital	76,344	76,344	
Revaluation Reserve	21,306	21,306	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	74,325	72,892	
Total Taxpayers' Equity	**177,195**	**175,762**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2025.

A bridge of cash movements is shown on page 15.

1. Prepayments continue to be higher than year end as charges covering 2025 / 26 have been received and paid. This includes annual charges such as insurance. This value traditionally reduces over the course of a financial year.

2. Accrued income remains high, as it was at year end, and primarily relates to income from NHS England in relation to provider collaboratives. These values have been agreed with commissioners and physical cash payment has been chased. This will be received as a direct cash payment and therefore an invoice has not been raised.

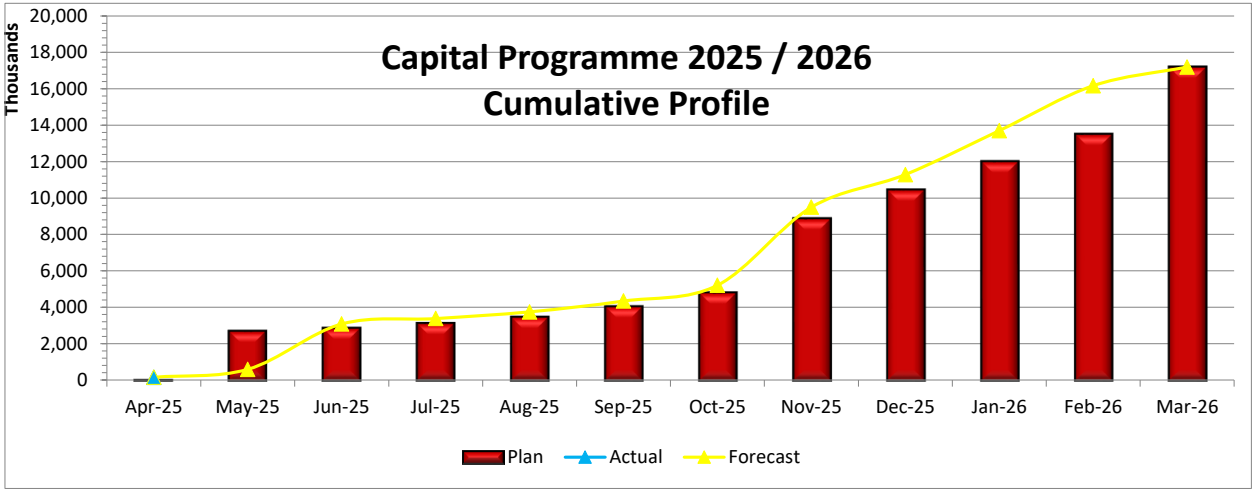
3. As is normal Trade creditors were exceptionally high at year end and have now reduced in April and May 2025. As demonstrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly. Aged creditors are reviewed and actively targeted for resolution. In May creditors older than 30 days are only £17k

4. Accruals continue to be monitored to ensure that they are in line with accounting standards and that issues, or areas of uncertainty, are allowed to build up.

5. Deferred income remains at a relatively low level. The largest element remains the timing of education training funding from NHS England with June 2025 deferred (£684k).

4.1 Capital Programme 2025 / 26

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2024 / 25 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	100	0	(100)	7,425	8,100	675
Estates safety	0	0	0	675	0	(675)
Backlog Maintenance	0	8	8	0	13	13
Other	0	136	136	0	(74)	(74)
Leases (IFRS 16)	2,631	443	(2,188)	6,148	6,210	62
TOTALS	**2,731**	**587**	**(2,144)**	**14,248**	**14,248**	**0**
Additional allocations						
Net Zero (solar funding)	0	0	0	1,952	1,952	0
Cheswold - seclusion room	0	1	1	1,000	1,000	0
Cheswold - Minor Capital	0	0	0	2,082	2,082	0
Cheswold - IM & T	0	0	0			0
TOTALS	**2,731**	**588**	**(2,143)**	**19,282**	**19,282**	**0**



Capital Expenditure 2025 / 26

The table on the left summarises the capital programme for 2025 / 26. The first section is activity as reported against the standard West Yorkshire Integrated Care Board capital allocation. For 2025 / 26 the Trust programme was prioritised against the main older people transformation scheme and the impact of leases.

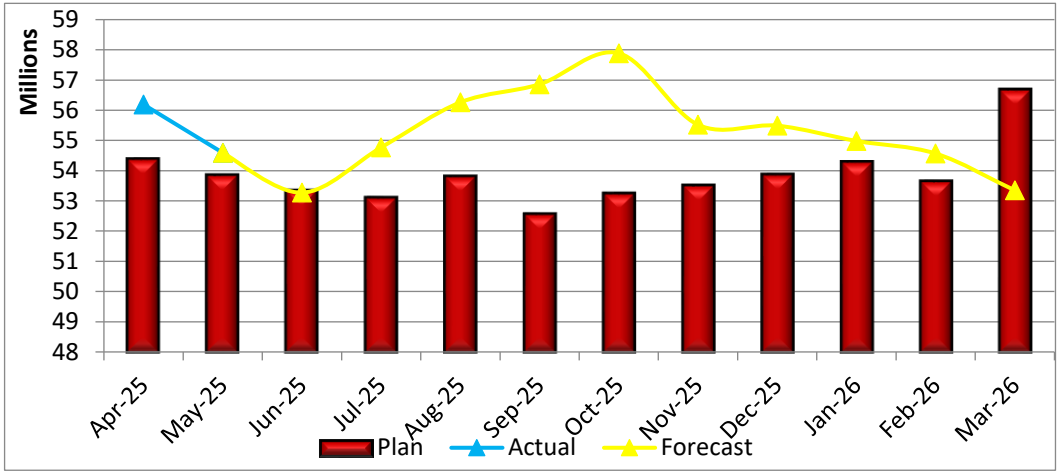
Unlike previous years leases is included within the single allocation value and will need to be managed as such.

Additional funding has been secured either as a result of previous business cases, for example Cheswold investment from South Yorkshire allocations, or external bids in the case of net carbon zero and Cheswold seclusion rooms.

Through national frameworks the Trust has a construction partner and progressing schemes accordingly. As per the profile graph the majority of expenditure is planned for the second half of the financial year.

Whilst the year to date shows a significant variance to plan this is due to invoicing issues in relation to lease renewals. These are expected to be resolved in June 2025.

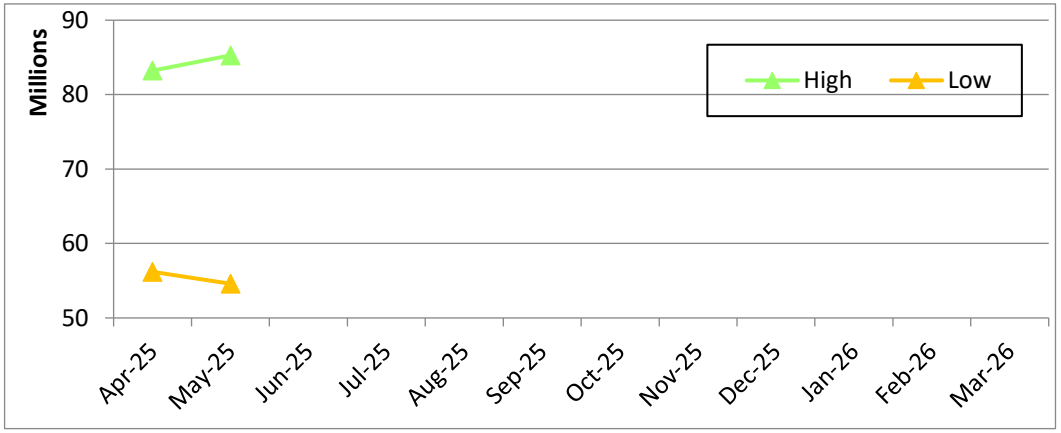
4.2 Cash Flow & Cash Flow Forecast 2025 / 2026



The Trust cashflow forecast remains under review

Whilst current cash balances are higher than plan this is forecast to flucatate over the course of the year based on I & E position and the Trust capital programme.

	Plan £k	Actual £k	Variance £k
Opening Balance	55,839	55,839	
Closing Balance	53,858	54,593	734



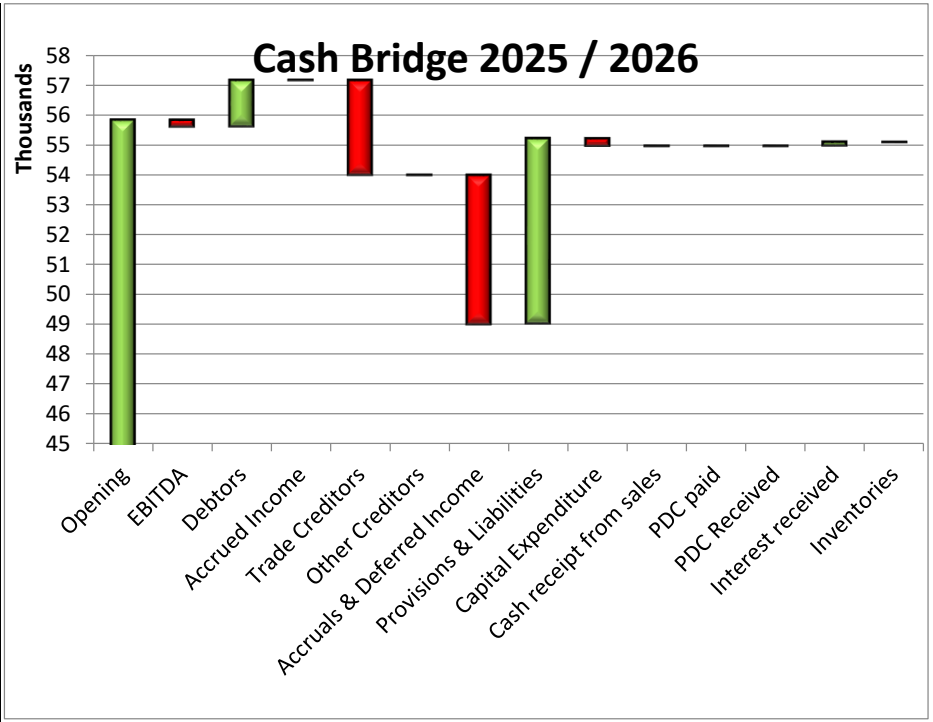
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £85.3m
The lowest balance is: £54.6m

This reflects cash balances built up from historical surpluses.

4.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**55,839**	**55,839**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,906	1,668	(238)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	3,100	4,660	1,560	
Trade Payables (Creditors)	300	(2,859)	(3,159)	
Accruals & Deferred income	0	(4,984)	(4,984)	
Provisions & Liabilities	(5,412)	784	6,196	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(600)	(848)	(248)	
Cash receipts from asset sales	0	0	0	
Leases	(1,654)	(180)	1,474	
PDC Dividends paid	0	0	0	
PDC Dividends received	0	0	0	
Interest (paid)/ received	379	514	135	
Closing Balances	**53,858**	**54,593**	**734**	



The table above summarises the reasons for the movement in the Trust cash position during 2025 / 2026. This is also presented graphically within the cash bridge.

The main headlines are picked out on the previous page.

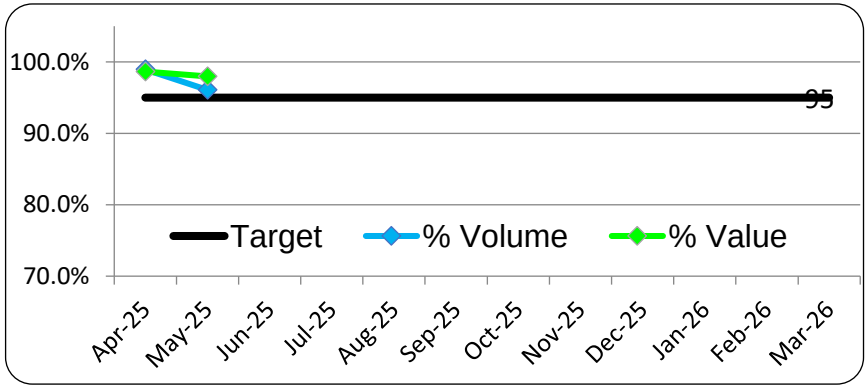
5.0 Better Payment Practice Code

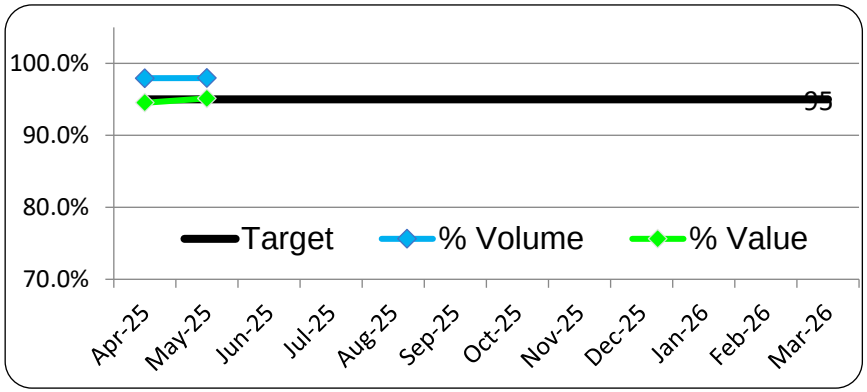
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

NHS	Number %	Value %
In Month	96%	98%
Cumulative Year to Date	98%	98%

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





"

5.1 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 (£)
13-May-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000059072	734,353
07-May-25	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205616	658,717
21-May-25	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205649	658,717
02-May-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400002954	492,999
20-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS58	400,000
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010069	398,935
23-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001620	334,600
21-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS35	240,000
09-May-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 299	226,385
09-May-25	Data Lines	Trustwide	Virgin Media Business Ltd	927686155	224,631
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010066	151,827
13-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS056SN	133,309
07-May-25	IT Services	Trustwide	Wavenet Ltd	1306822	108,300
12-May-25	IT Services	Trustwide	Wavenet Ltd	1331521	108,300
16-May-25	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028577	87,045
27-May-25	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	329711	82,416
20-May-25	Purchase of Healthcare	Trustwide	Diabetes Digital Media Ltd	INV8031	79,156
28-May-25	Computer Software	Trustwide	Patients Know Best Ltd	INV1184	76,893
28-May-25	Drugs	Trustwide	Bradford District Care NHS Foundation Trust	205642	69,444
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800002621	64,358
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800002947	64,358
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800003124	64,358
09-May-25	Purchase of Healthcare	AS Collaborative	Cumbria Northumberland Tyne And Wear NHS Foundation Trust	9810036028	61,832
09-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34029364	56,000
10-May-25	Insurance	Trustwide	Willis Ltd	10958GP25000001PRM	52,601
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	51,572
22-May-25	Computer Software	Barnsley	Pcmis Health Technologies Ltd	144592	50,874
19-May-25	Drugs	Trustwide	NHS Business Services Authority	1000084151	49,715
23-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001621	48,770
07-May-25	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202580012668	47,949

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
16-May-25	Lease Cars	Trustwide	Arval Uk Ltd	RI0013380288	47,374
13-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS056INV	44,835
27-May-25	Drugs	Trustwide	NHS Business Services Authority	1000084466	44,107
08-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34031350	42,770
21-May-25	Utilities	Trustwide	Edf Energy Customers Ltd	000023460710	42,570
28-May-25	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	435	42,433
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	42,354
01-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34030705	40,575
20-May-25	Purchase of Healthcare	Calderdale	Invictus Wellbeing Services Cic	434	39,500
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001349EPC	38,549
08-May-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37443612225	38,487
08-May-25	Insurance	Trustwide	Willis Ltd	11738GP24000002ADP	37,884
20-May-25	Computer Software	Barnsley	Cinnamon Digital Applications Ltd	INV213	36,713
01-May-25	Purchase of Healthcare	Trustwide	Cygnet (Dh) Ltd	HEX0399988	32,085
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	30,157
30-May-25	MFDs	Trustwide	Annodata Ltd	1398002	29,778
14-May-25	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028656	29,490
07-May-25	Drugs	Doncaster	Speeds Healthcare Ltd	INV158453	29,182
19-May-25	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202580009801	28,103
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	28,027
21-May-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37443648525	27,908
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	26,998
13-May-25	Insurance	Trustwide	Aon Uk Ltd	544205062	26,413
19-May-25	Purchase of Healthcare	Trustwide	Nouvita Ltd	13136	26,367
21-May-25	Utilities	Trustwide	Edf Energy Customers Ltd	000023266362	26,118
20-May-25	Rates	Kirklees	Kirklees Council	96951667X2025	25,200
07-May-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90150924	25,019
07-May-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90150926	25,019

5.2 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.

* Value for Money / Cost Savings - The Trust priority of Value For Money is intrinsically linked to the ability to maintain financial sustainability. In addition to value for money this are also called savings, efficiencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase efficiency, reduce expenditure or increase income.

* 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 3 - Statistical Process Control (SPC) Charts Explained

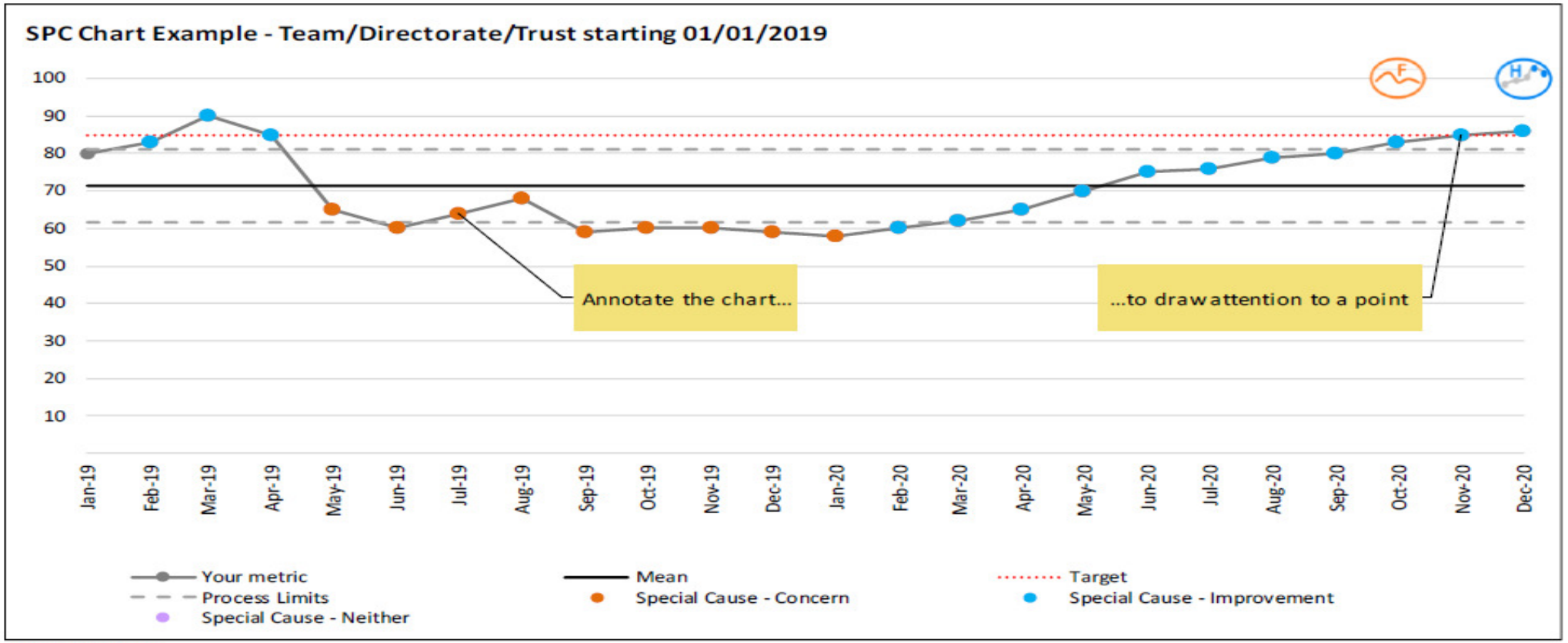
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 3 - 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
1 July 2025
Agenda item 9.2

Private/Public paper:	**Public Paper**
Title:	**Care Group Dashboards: Inpatient Mental Health**
Lead Director	**Adele Fox - Chief Operating Officer**
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in inpatients mental health services contributes towards the Trust's vision to provide outstanding physical, mental and social care in a modern health and care system. The key performance indicators link to all the Trust's values which are: We put the person first and in the centre. We know that families and carers matter. We are respectful, honest, open and transparent. We improve and aim to be outstanding. We are relevant today and ready for tomorrow.
Purpose:	To provide Trust Board members with a summary of the performance in inpatient mental health 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:	Live Our Values ✓ Be the best we can be: • Best quality ✓ • Best partner ✓ • Best value ✓ • Best place to work and learn ✓ Be ambitious ✓
BAF Risk(s):	Monitoring and managing performance in inpatients mental health services contributes to managing all the risks on the Board Assurance Framework and makes a specific contribution to actions to address the following risks: 1.1 Measures are not taken to identify and address discrimination across the T Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience rust resulting in poor patient care and staff experience

With all of us in mind.

	2.3 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. 2.4 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 2.5 -. Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience. 2.8 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. 2.10 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Inpatient mental health services are a key component of care across both South and West Yorkshire. Providing services that are accessible, safe and to a high quality is fundamental to achieving the aims of both of our integrated care systems.
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the Board meetings held in public. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing greater reporting with 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 review and preparation.
Executive summary:	Board is asked to note: Mental health inpatient services have had a focus on performance and sustainability to improve the experience for both staff and service users. Leaders within the inpatient services have had oversight on improvement and dedicated support to train staff and as required, to improve the experience of those we care for and reduce the financial cost. Areas of note: **Appraisal** There has been a strong improvement across the services for completion of appraisals, achieving a 95.6% compliance rate. Seventeen wards have achieved 88% compliance, and eleven have met the 100% compliance mark. Areas that have not achieved these standards have improvement plans that are supported and monitored by the senior team. **Sickness**

	Sickness rates have fluctuated and have been above the threshold. There are no consistent themes across the care group, although some hotspot areas show work-related sickness and pregnancy-related illness as the main reasons for absence. All staff are supported by managers and the critical incident support team. The impact of sickness absence has resulted in increased use of bank staff in some areas, additional staff pressure on the wards, and can result in a poorer experience for our service users due to inconsistent staffing. **Supervision and Mandatory Training** Supervision across the care group overall meets the compliance requirement. Some areas fluctuate with compliance, and these areas have improvement plans to support compliance. Managers provide good oversight by identifying those who have not received supervision and booking dates accordingly. **Information Governance** A focused effort to improve Information Governance (IG) has proved successful, with ten wards achieving compliance above 95%. Other wards are just below compliance standards, and work continues to improve this throughout the care group. **Reducing Restrictive Practice Interventions (RRPI) Training** RRPI Training continues to meet the required training standard above 85%. This improvement is due to ward managers being able to book the training directly and manage rosters effectively. **Cardiopulmonary Resuscitation** Cardiopulmonary Resuscitation training shows a significant improvement, with consistent compliance above 85% across the care group. Fifteen wards have achieved above the threshold, and those below standard have all booked training sessions for the next three months. Ward managers ensure that the wards are safe and staffed with trained personnel. **Fire Training** Fire Training has been a priority this past month, aiming to ensure all staff are trained. Fourteen wards have improved and met the required standards, with others showing improvement. Two wards (Melton and Walton) have an increased focus on improvement, overseen by Ward Managers and Matrons to ensure staff attend training. **Turnover & Recruitment** Staff head count continues to reduce month by month (April 578.4, May 536.5) although there appears to have a small increase in staff turnover. This will be closely monitored to understand the reasons and if any interventions are required. **Financial Performance** Adult in patient units in total are forecast to underspend by £271k but that masks overspend pressures in Wakefield(£513k) and Barnsley (£201k), YTD position is a £108k overspend but there was a significant run rate improvement in M2.

	Older people inpatients are forecast to overspend by £1.1m, this is predominantly driven by a forecast overspend of £1.5m in Wakefield. YTD is £298k over. There are underspends in Calderdale and Kirklees to offset some of these pressures. There has been a reduction in agency use across the inpatient wards, resulting in savings in April and May. Main agency spend is associated with medical cover, however there are plans to recue this over the forthcoming months **Clinically Ready for Discharge (CRFD)** An increased focus on the process has identified patients ready to be discharged therefore seen a rise in numbers reported. The care group managers are working hard to identify people as soon as they are clinically ready and raising this with the relevant partners to support the safe discharge. Improvement work associated with this includes internal and external meetings to escalate barriers to discharge. The care group is part of national and regional improvement programs to support flow initiatives. **FIRM Risk Assessments** The reporting metric changed as of April 1st to the percentage of inpatient risk assessments completed within 24 hours before or after admission, and the compliance dashboard went live on May 8th. Staff have been working hard to adapt to the new documentation with support and monitoring from matrons. All patients admitted have a risk assessment handover and care plan completed, but the new documentation requires additional steps to complete the assessment. To date, compliance has been good, although 14 late completions within 24 hours were noted. These were addressed and rectified, with learning opportunities for individuals to improve. **Incidents & Patient Safety** There is a correlation between physical incidents and restraints, with one patient on Poplars Ward mentally unwell and assaulting staff (12 incidents), requiring physical interventions. Care plans are in place, along with support for both staff and the patient. Elmdale also had a high number of physical violence incidents towards staff (10), related to two patients. The restraints associated with these two wards involved three identified patients. Walton Ward also shows an increase in restraints, related to four patients who presented as unwell and required physical interventions. All wards are supported by the matron and managers of the services.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** and **NOTE** the report**.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Inpatient Mental Health Care Group



April 2025

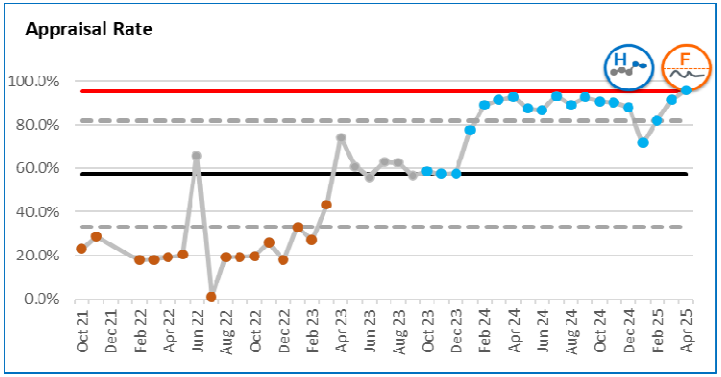
With **all of us** in mind.

Inpatients

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

Workforce

Appraisals

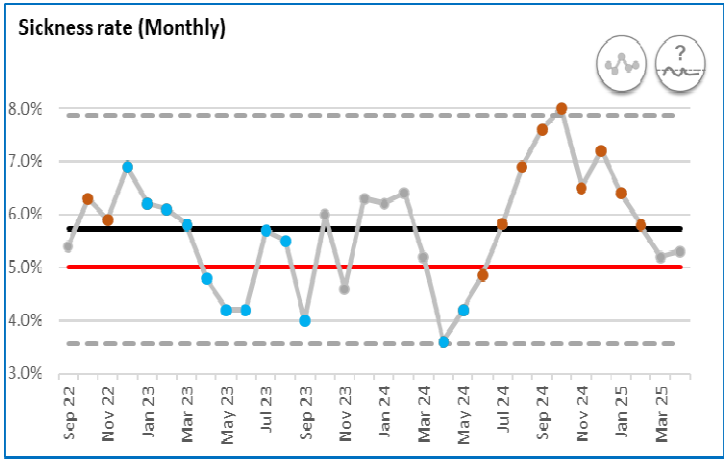


Insights

The strong improvement in appraisal performance since January 2024 has been sustained. The reduction in compliance to below 80% in January 2025 was impacted by the system change from recording via WorkPal to recording on ESR. Mental health inpatient performance for April 2025 is 95.6%

Work is ongoing to maintain appraisal completion. Progress is reviewed by the senior leadership team at the weekly performance meeting. Ward managers, with oversight from matrons, proactively identify appraisals due within the next 30 days and schedule them for completion.

Sickness



Insights

The sickness rate has been above threshold. The increase in sickness is a combination of both short and long term absences. Some long term sickness is linked to work related incidents which have resulted in physical injury and/or impacted on staff members psychological well-being. To support staff teams post serious incident, CRISP (Critical Incident Staff Support Pathway) intervention sessions are arranged through occupational health.

Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made. Matrons review themes and trends related to sickness absence and take action to address any issues identified

There is a continued focus on staff wellbeing within the care group and the MH Inpatient wellbeing plan has recently been refreshed based on feedback from the latest staff survey. A staff engagement exercise is planned for both Crofton and Beamshaw where response scores were consistently low.

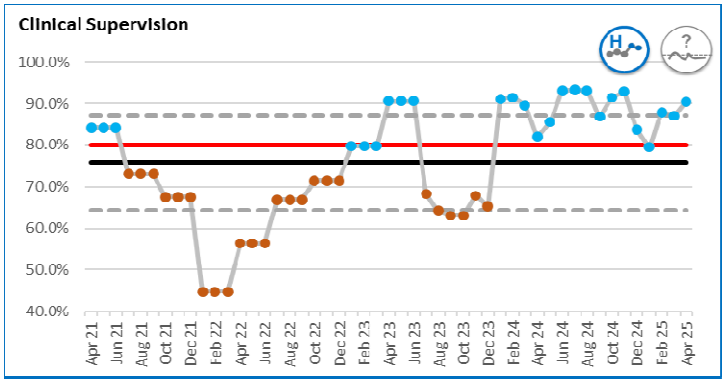
The Inpatient Improvement Programme (IIP) is continuing with a focus on patient pathways and therapeutic engagement workstreams, with actions being taken which will in the long term impact positively on staff wellbeing.

The impact of sickness absence has been increase in bank usage and additional l pressure for those staff working where areas are short of staff or inconsistent staff leading to a poorer experience for our service users.

Inpatients

Workforce

Supervision



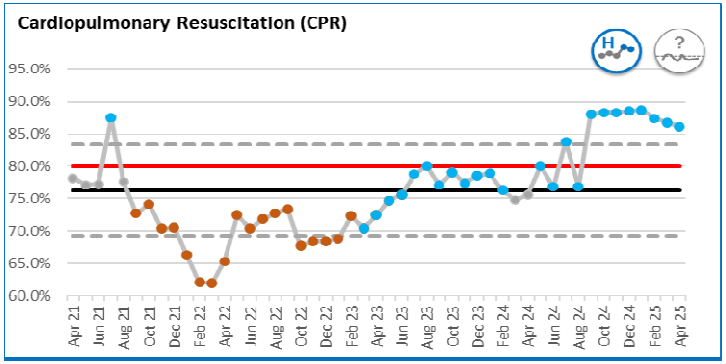
Insights

The SPC (statistical process control) chart indicates special cause improvement with performance consistently above target since December 2023. The care group performance for April 2025 is 90.5%. Oversight is maintained by the senior leadership team at the weekly performance meeting with matrons addressing any identified actions direct with teams.

High acuity and service user distress are significant factors in inpatient services. Clinical supervision provides staff with the opportunity to discuss and improve the care they provide and support them to manage the personal impact of working in a high pressured environment.

The care group is involved in the review of supervision policy and guidance led by Nursing Quality and Professions.

Mandatory Training



Insights

The SPC chart indicates special cause improvement with performance consistently above target since September 2024. Compliance in April 2025 is at 86.1%. The mandatory training dashboard allows ward managers, with oversight from matrons, to closely monitor compliance, identify hot spots and undertake focused actions.

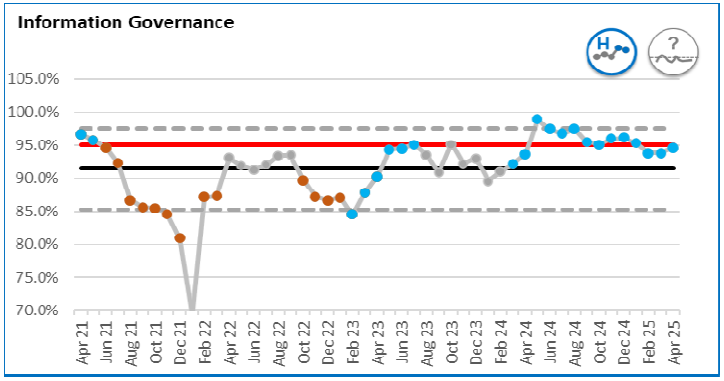
People with a mental health problem are known to experience poorer physical health. Services users can be on high doses of medication and may engage in high risk behaviours. It is essential that staff are trained in cardio-pulmonary resuscitation to be able to respond to emergencies appropriately, before an ambulance arrives to assist. Senior leadership team maintain oversight via the weekly performance meeting. A working group has been established with representatives from the care group, Nursing Quality & Professions and specialist advisors to collaboratively address issues and sustain performance.

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

Inpatients

Workforce

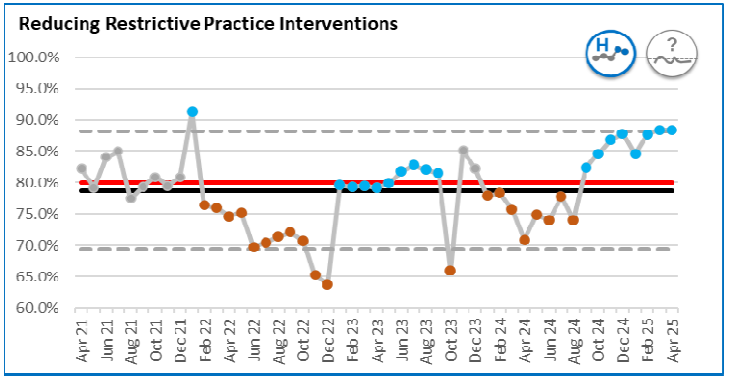
Mandatory Training



Insights

The target for information governance training compliance was just under threshold in April 2025 at 94.6% with 10 wards being above the 95% threshold. The care group have worked hard to minimise the reduction this year and there is a focus on ensuring compliance with Data Security Awareness training with close oversight of compliance at team level via the mandatory training dashboard and weekly performance meeting. Analysis of information governance (IG) incidents has not indicated any correlation with incidents and IG training.

Mandatory Training



Insights

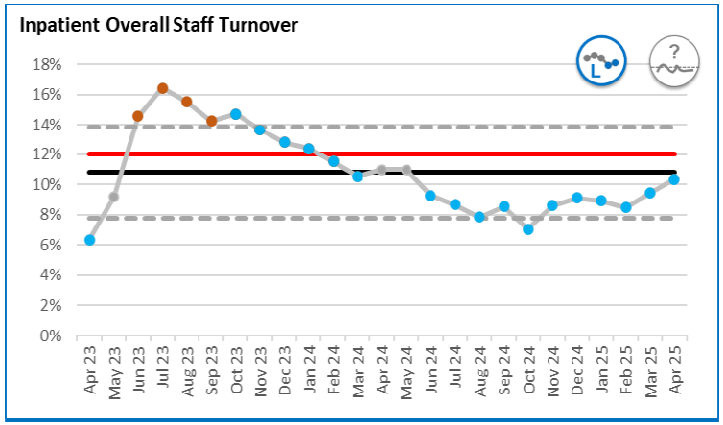
The SPC chart indicates we entered a period of special cause improving variation in September 2024 since when, reducing restrictive practice interventions (RRPI) training has consistently remained above the target of 80% and in April 2025 compliance was at 88.4%. The service has continued to collaborate with colleagues from nursing, quality, and professions to address issues and sustain performance. Prior to March 2025, the booking of staff onto RRPI training was managed centrally by Learning & Development and the RRPI team, however since March 2025 the responsibility for the booking of RRPI training has been handed back to operational services. Ward managers oversee the booking of training for their staff team, supported by use of the mandatory training dashboard. RRPI training compliance is also closely monitored by the Senior Leadership Team at the weekly performance meeting.

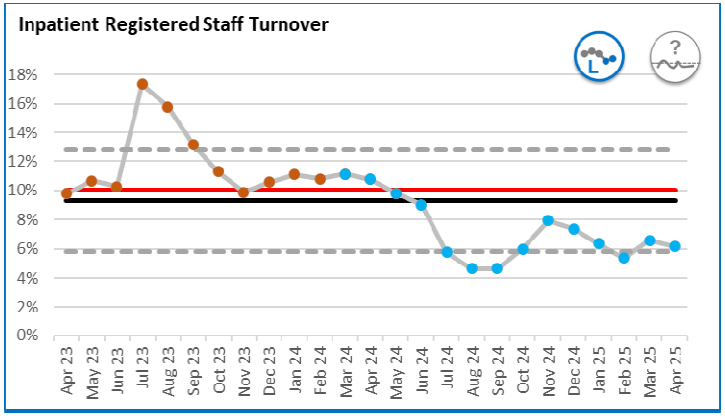
Ward managers conduct regular reviews of staffing to ensure that patient safety needs are met in terms of the reducing restrictive practice interventions competencies of staff on duty. This is overseen and supported by the matron.

Inpatients

Workforce

Turnover





Insights

Staff turnover has been sustained below the Trust threshold of 12% since February 2024. Staff head count continues to reduce month by month (April 2024 578.4, May 2025 536.5) although there appears to have a rise in turnover, this relates to 6.4 WTE leavers.

Good teamwork is essential in providing consistent, safe and effective care. Reducing and stabilising turnover means that staff work with regular team members who know each other, the ward and the service users. The recent Working Age Adult (WAA) establishment review, which has increased baseline staffing numbers on all wards, will further support this through a reduction in use of temporary staff as posts are recruited into. Within the establishment review, there are enrichment roles, including psychology provision to support reflective practice and supervision sessions for staff.

The older people's service (OPS) establishment review is in progress with oversight from the OPS transformation steering group.

Service line staff well-being action plans also support staff retention and initiatives include a deep dive into staff experiences to understand route causes of staff experiencing discrimination from their manager and a specific staff engagement exercise with staff from Crofton and Beamshaw to understand the general negative experience of staff on these wards.

Registered Nurses only.

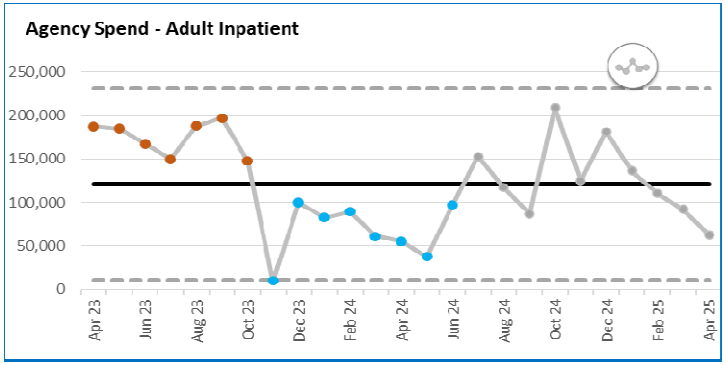
The overall registered nurse turnover for the service has been sustained below the trusts threshold of 10% since May 2024 following successful recruitment of Band 5 nurses, the majority of whom were newly registered and requiring preceptorship.

Clinical lead nurse posts have been substantiated as part of the recent adult inpatient establishment review. These roles support leadership across the inpatient wards and provide clinical role modelling to junior staff. They also offer a clinical career pathway to support the retention of experienced registered staff.

Inpatients

Finance

Agency Spend

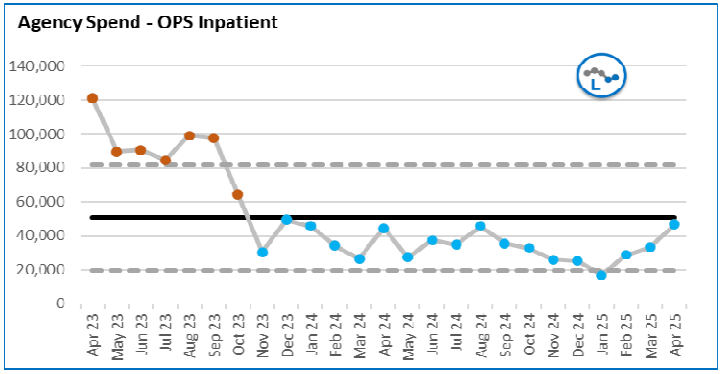


Insights

The SPC charts shows common cause variation since July 2024 and agency spend within adult inpatients was above the mean between October 2024 and January 2025. Agency spend in February, March, and April is below the mean and showing a reducing trend.
Since June 2024 the care group have focused on reviewing and strengthening systems and processes for the governance of rosters to ensure that additional resource is absolutely clinically necessary. Spikes in agency spend are linked to clinical acuity such as increased close observation levels, environmental levels and supporting service users detained to 136 suites.

The recently introduced non-medical agency resourcing authorisation Standard Operating Procedure (SOP) will provide further enhanced scrutiny and assurance that all other staffing options have been explored prior to agency being utilised.

A comprehensive establishment review has recently been completed and all adult inpatient wards have had an uplift in their baseline staffing, reducing the need for agency staff to support clinical acuity. The additional posts require recruitment and the service is engaged with People Directorate colleagues to progress with this.



The SPC chart demonstrates special cause improvement in older people's service inpatient agency spend since October 2023. This has been supported by recruitment and retention into vacant posts.

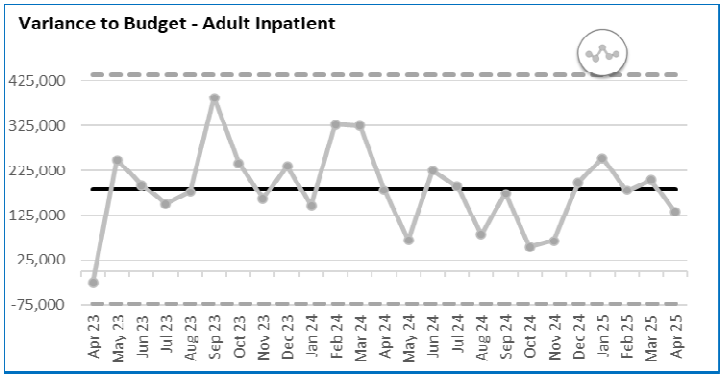
The increase in staffing above baseline numbers, is to maintain patient safety and includes supporting service users with complex needs, managing high numbers of increased observations, and escorting service users transferred to general hospitals. Agency is only considered when options for staff redeployment and use of trust bank have been exhausted, and as outlined above, since June 2024 there has been focused work to review and strengthen systems and processes for the governance of rosters to ensure that additional resource is absolutely clinically necessary.

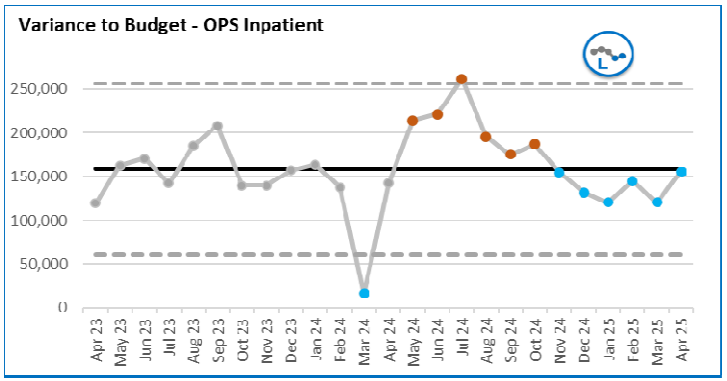
Agency spend in April is also impacted by consultant medic vacancy (Wakefield), HCA vacancies and sickness rates on some wards being significantly above threshold.

Inpatients

Finance

Variance to Budget





Insights

Focused work has been undertaken to understand the continued increased use of temporary staffing across the adult inpatient wards. Primarily additional resource is being used to maintain safety of patients and staff across the inpatient areas.

Reasons for additional resource have been identified as: increased observation levels, patients with complex physical health needs, out of pathway admissions, prolonged escorts to general hospital environments for people detained under MHA, environment levels, S136 suites: daily additional resources, above commissioned levels, allocated to suites to maintain safety; bed pressures, i.e. admissions into non designated beds, non-mandatory training which is not included in headroom.

Since June 2024 the care group, in collaboration with the e-rostering team, have focused on reviewing and strengthening systems and processes for the governance of rosters to ensure e-roster guidance is understood and adhered to.

The service is also engaged in quality improvement work with Nursing, Quality and Professions colleagues with regards to observations in relation to falls, reducing violence & aggression, & transfer of care to general health services.

Focused work has been undertaken to understand the continued increased use of temporary staffing across the older adult wards in Wakefield and Barnsley. Findings have identified the primary reasons for increased resources are: there has been no review of older adults staffing establishments since 2016, increased observation levels, in relation to patients at risk of falls and with frailty and service users with complex dementia diagnoses presenting with increased levels of violence and aggression. This is particularly pertinent for Poplars which is an isolated ward for people with dementia.

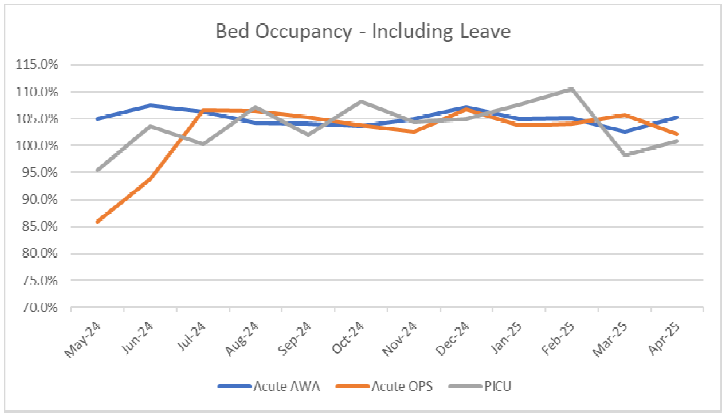
In older adults, patients are frequently being transferred to general hospitals for prolonged stays with staff escorts in numbers to meet the persons needs. This can be several patients at the same time, needing multiple micro teams to support patients.

The special cause improvement from November 2024 is the result of focused improvement in governance in Wakefield and Barnsley OPS ward roster planning.

Inpatients

Access

Bed Occupancy - Including Leave



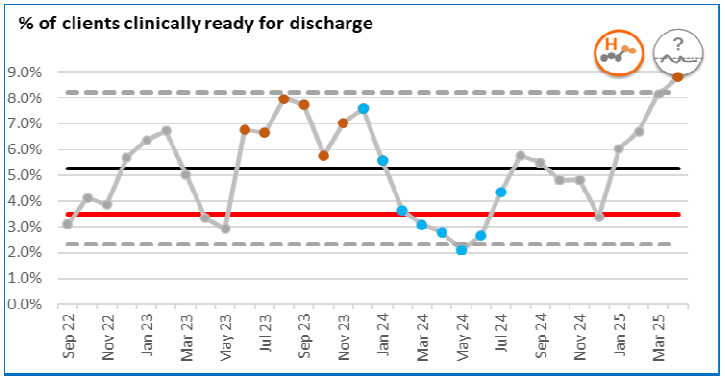
Insights

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

Workstreams within the Inpatient Priority Programme (IPP) include inpatient admission pathways, collaborative care planning for complex needs, and inpatient discharge pathways and are focused on supporting patient flow through the whole system.

Care closer to home improvement work has resulted in a significant reduction in the use of out of area beds. There has been a sustained increase in the use of non-designated beds which has impacted on bed occupancy, especially on the adult inpatient wards in Barnsley. Where this has happened, it is always after all other options to maintain patient safety have been exhausted and protocols are in place which support service users to be moved as soon as is possible to an identified bed. Work is being done to ensure better reporting visibility of use of non-designated beds, and the data will be reviewed within the IPP workstreams. This means our staff are caring for more people on one ward, this adds a complicity with space, leave, observations, increased mediation rounds and clinics amongst other things. For patients this means the wards are noisy, busy and less space and less time with nurses for the therapeutic interventions, which leads to a poorer experience.

Clinically Ready for Discharge (CRFD)



Insights

The percentage of patients clinically ready for discharge in April 2025 is above threshold and upper process limits at 8.8%. There are a number of factors impacting on this increase including refreshed application of the NHSE definition of clinically ready for discharge and improved reporting accuracy. There are also significant challenges in sourcing appropriate placement provision to meet an individual's needs when they leave hospital. Themes also include waiting for appropriate housing, specialist care home placements and Ministry of Justice (MOJ) decisions.

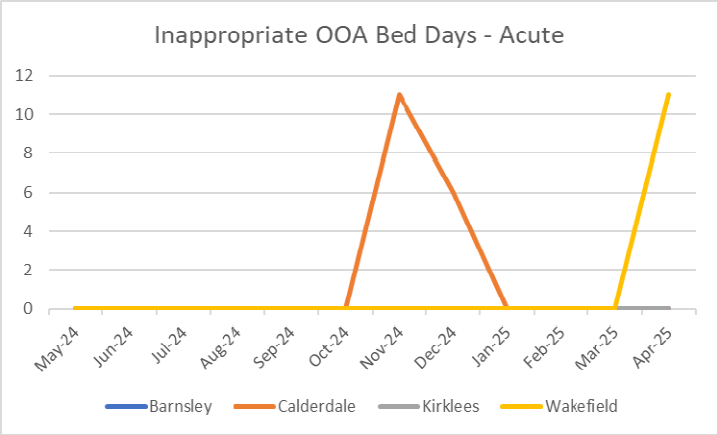
Weekly barriers to discharge meetings continue to focus on actions and accountability for progressing discharge plans and weekly MADE (Multi Agency Discharge Event) meetings remain in place in each locality. Additionally, a weekly CRFD challenge meeting has been established, led by the Director of Service, and attended by both inpatient and community General Managers. This supports timely escalation to external partners.
A dedicated internal workstream has been developed focusing on reviewing inpatient discharge pathways and a monthly discharge oversight group has been established, chaired by the inpatient General Manager. .

Homelessness is proving a significant barrier to discharge planning. The care group is engaged with local authorities, housing providers, and third sector organisations to reduce impact.

Inpatients

Access

Inappropriate Out of Area Placements - Acute



Insights

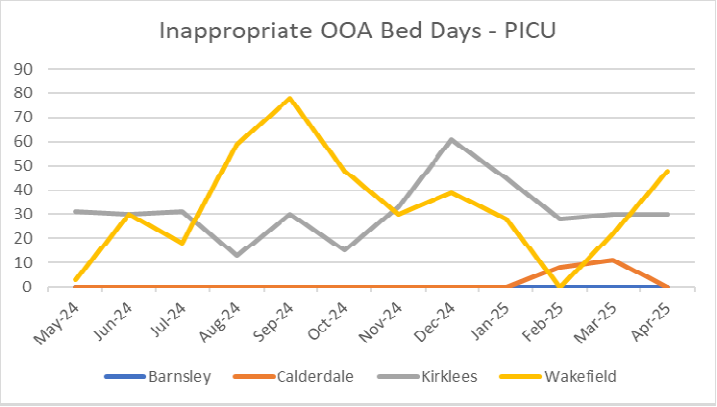
The reduction in the number of out of acute area placements has been sustained. The OOA bed days for Calderdale in November and December represent one service user and the OOA bed days for Wakefield in April also represent one service user.

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

Providing care closer to home has impacted on acuity and occupancy levels in inpatient areas. It has also contributed to the increased need to use temporary staff (e.g. allocation of staff to support service users detained to S136 suites; increased staff to maintain patient safety). As outlined in the finance section, a comprehensive establishment review has recently been completed and all adult inpatient wards have had an uplift in their baseline staffing. The care closer to home oversight group monitors all impacts on staffing through its quality monitoring system.

Monitoring includes analysis of Datix, non designated bed use as well as admissions to the 136 suites; risk monitoring and incidents reports for both concerns related to bed waits, overoccupancy and episodes of violence and aggression. These remain within variance at this point. A triangulation of the above allows us to measure pressure and if this is being transferred to inpatient or community services.

Inappropriate Out of Area Placements - PICU



The reduction in the number of out of area placements for a Psychiatric Intensive Care Unit (PICU) has been sustained. At the time of this report there are five service users placed out of area for PICU beds and this is reflective of the complexity of service user presentations and risk profiles. PICU bed availability is the main reason for people going out of area, as well as gender specific PICU.

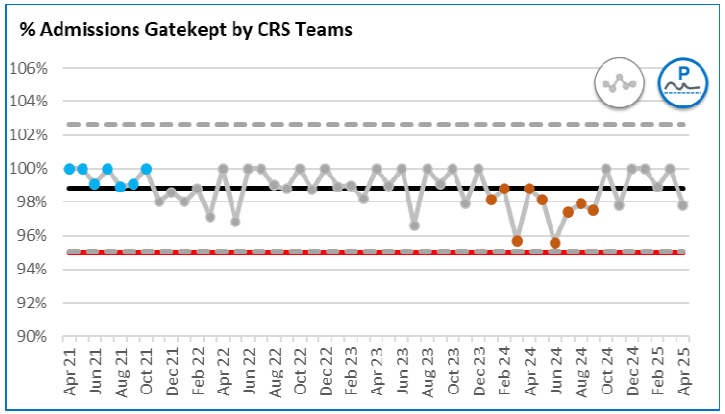
The care closer to home improvement work is having a positive impact on the number and duration of episodes of out of area placements. There is an increased focus on out of area flow alongside developing sustainable systems and implementing creative approaches to avoid out of area admissions. The patient flow dashboard, and the information held within it is used meaningfully to guide decision making.

Demand on services and for inpatient admission remains high and is above commissioned bed base in two localities. There has been sustained pressure within Barnsley specifically and Barnsley Place do not support the use of out of area placements and do not currently provide any safe space facilities like Rest stop in Kirklees, Share in Calderdale and Bond Care in Wakefield, although these discussions are taking place. Patient flow is a live process that can be stepped up to meet specific problems with an increase in frequency of meetings and widening of membership to include key decision makers.

Inpatients

Access

% Admissions gate kept by crisis resolution teams

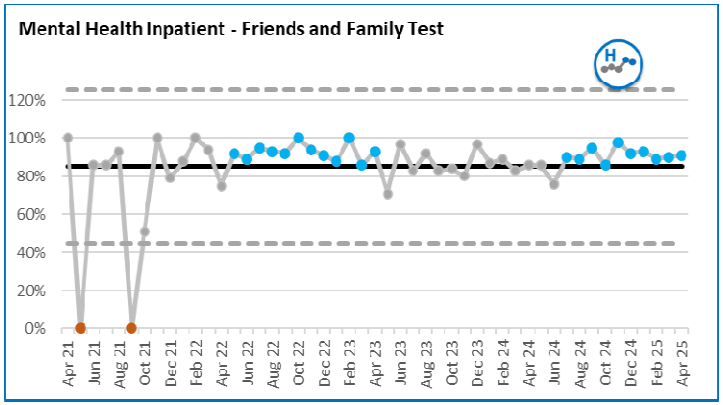


Insights

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

Quality and Safety

Friends and Family Test



Insights

The SPC chart indicates special cause improvement since July 2024 and ratings have consistently been above the mean. Across quarter 4 the average rating was 96% with 124 Friends and Family Test (FFT) returns. Majority of FFT responses were collected as part of the larger patient experience survey. In quarter 4 positive themes included staff, environment, activities offered and food and the only negative themes were staff and food.

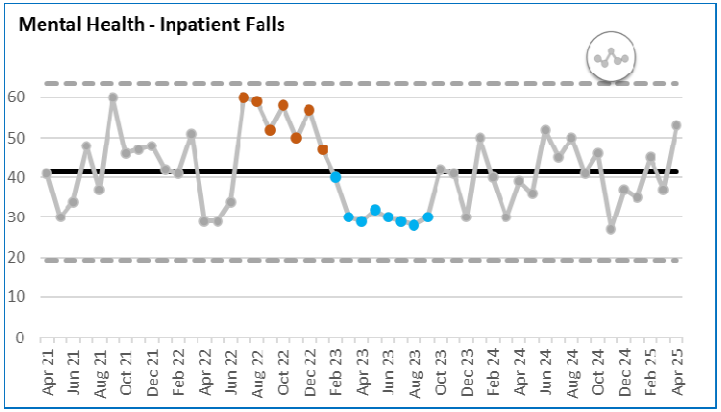
The patient experience survey feedback for quarter 4 highlighted that 99% of service users who responded felt safe during their admission and 98% said they were treated with dignity and respect.

All service user feedback is reviewed quarterly by the Senior Leadership Team in the service's performance meeting.

Inpatients

Quality and Safety

Falls



Insights

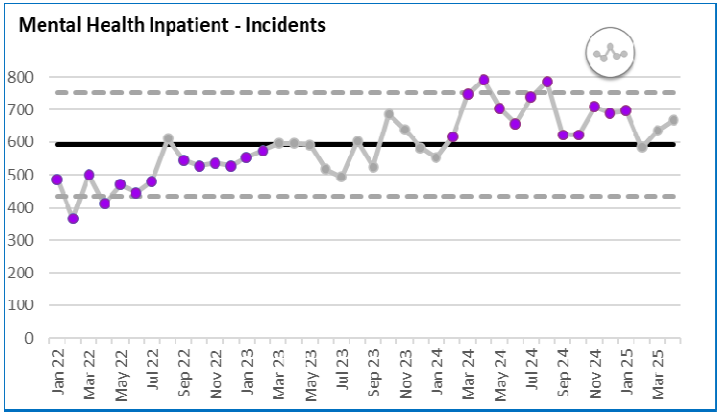
The number of falls in April (58) has increased from February and is above the mean. Falls incidents occurred across both adult and OPS wards and reflects the complex clinical presentation of service users (e.g. dementia, frailty, spatial awareness, long-term physical health conditions).
There has been a 17% reduction in falls related Datix at Ward 19 between April 2024 and March 2025.

Safety huddles are MDT gatherings of 5 to 10 minute duration which highlight and discuss any current safety and risk concerns for patients. Safety huddles have been embedded on OPS wards where falls rates are highest.

Risk assessment processes are supported by the trust falls co-ordinator, who will also support teams to undertake case reviews of service users with identified complex falls risks to inform care planning. The falls co-ordinator also completes a specialist review of all amber falls Datix to identify good practice and inform learning. This informs PSIRF learning responses.

Inpatient physio teams have developed an educational “Reducing the risk of falls in hospital” poster which is displayed across all inpatient areas.

Incidents



Insights

No serious incidents were reported in April 2025.

The service has a positive reporting culture of incidents. All incidents graded amber and above are discussed and reviewed for learning at the weekly care group patient safety oversight group meeting. Additionally, discussions about incidents and themes are held within various governance meetings including local acute care forums and the care group Quality and Governance meeting.

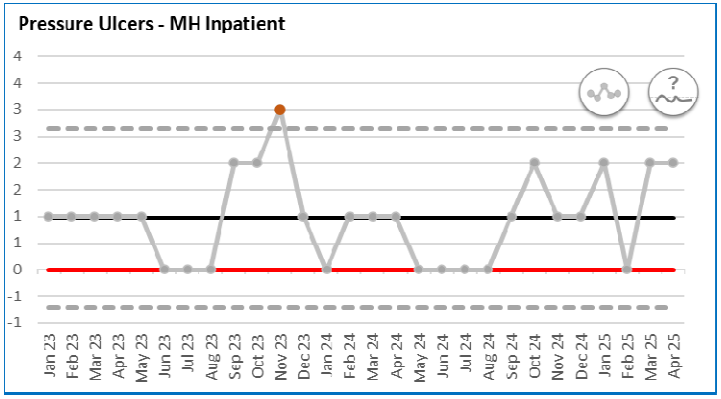
In April, themes of violence and aggression (193) and self-harm (138) remain the most reported incident areas followed by care pathway, clinical, and pressure ulcer incidents (59). This category includes bed management related incidents.

Focused pieces of work are being undertaken promoting reductions in restrictive practices and enhancing trauma informed approaches linked to the therapeutic inpatient care priority programme workstream.

Inpatients

Quality and Safety

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



Insights

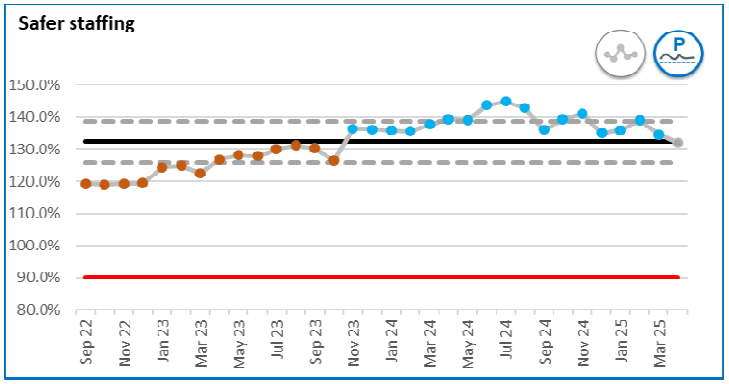
Two pressure ulcer incidents were reported in April across two wards.

Pressure ulcer categories range from 1 (least severe) to 4 (most severe). Both April incidents were category 2 pressure ulcers and degree of harm was low. All reported pressure ulcer incidents are reviewed by Trust tissue viability specialist advisors.

Category 3 pressure ulcers and above which developed under SWYPFT care are graded on DATIX at amber incident severity level triggering a 48hr manager review (which will consider areas of learning and improvement as well as good practice) and discussion at the Patient Safety Oversight Group meeting.

Wards can refer pressure ulcer cases to their local tissue viability service wherever clinically indicated for specialist advice and input.

Safer Staffing



Insights

Safer staffing information provides information of the staff worked against the agreed, funded establishment levels. It does not provide assurance that the staffing numbers were appropriate to meet need at the specific time. Levels reported above 100% means that increased staffing was in place to support service users with complex needs and to maintain patient safety on the wards.

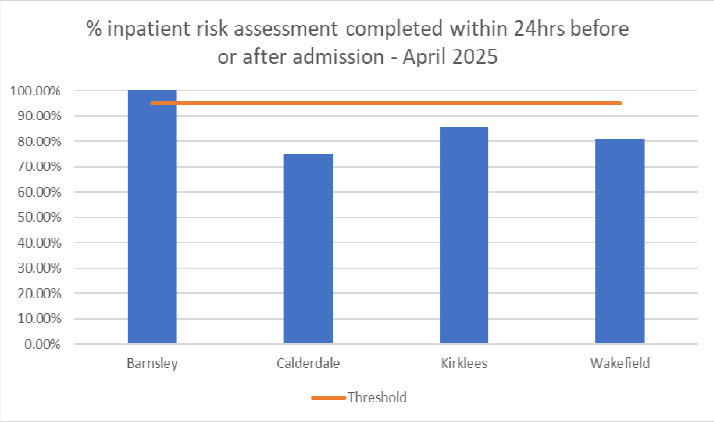
As referenced in the workforce and finance section the recent Working Age Adult (WAA) establishment review has increased baseline staffing numbers on all wards. Staffing currently is not at optimum level compared to the new baseline numbers and an active recruitment program is underway led by Peoples Directorate.

The care group continue with the roll out of safe care. There have been some challenges with safecare compliance but the service is working to resolve these through improving staff understanding of expected benefits which enables better alignment of resources to meet demand. Compliance will be monitored monthly at the inpatient performance meeting.

Inpatients

Quality and Safety

Risk Assessments



Insights

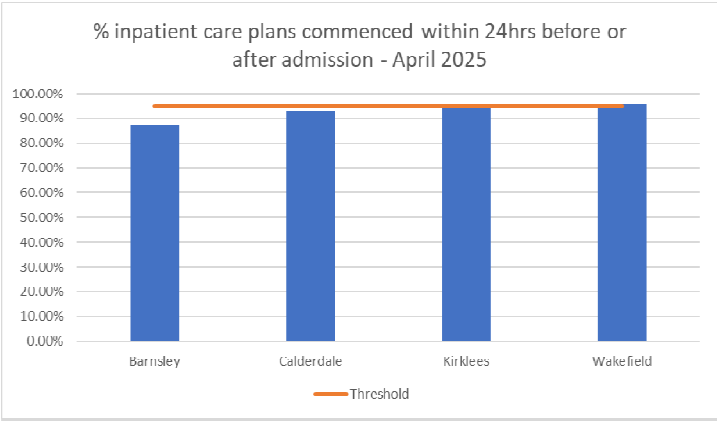
From 1st April 2025 the risk assessment performance metric is the percentage of inpatient risk assessments completed within 24hrs before or after admission, evidenced by the current and historical risk section of FIRM being completed/updated.

Risk assessment performance is 84.2% in April 2025 representing 21 out of 133 assessments not being completed within the target of 24 hours before or after admission target. Compliance within 48hrs increases to 91.5%. Only Barnsley wards are above compliance threshold, achieving 100%.

Compliance monitoring dashboards have recently gone live (8th May) and matrons are engaging with ward teams to ensure processes are in place for daily oversight. The inpatient team receive a handover of risk prior to admission and at the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Inpatient, IHBTT (as gatekeeping service) and patient flow colleagues will collaborate to improve performance, including sharing of learning from ward localities with strong performance (e.g. Barnsley).

Care Plans



Insights

Changes to care plans on Systm One went live on 6th January 2025. Staying Safe plans, which detail the service users identified risks on admission and the interventions to be taken to maintain the service users safety, are now captured as part of the Inpatient My Care and Safety Plan, rather than the FIRM risk assessment, and must be commenced within 24hrs before or after admission.

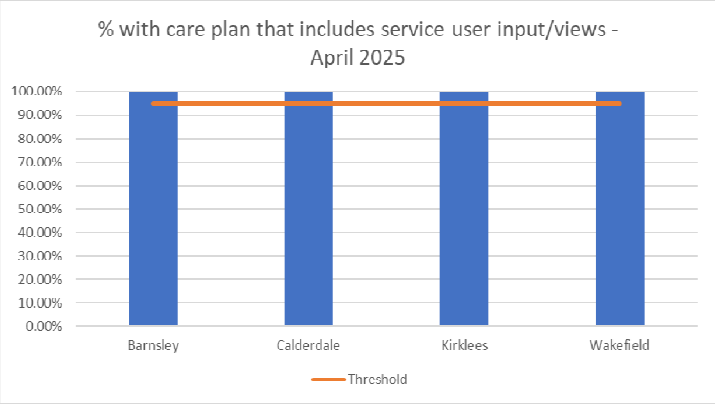
Collective care group performance in April was at 94.7%, just below the 95% threshold. Barnsley, at 87.5%, and Calderdale, at 92.9%, were below threshold and for both localities this represents 2 Staying Safe plans not commenced within 24hrs before or after admission (the different percentage figure reflects a higher number of admissions to Calderdale wards). At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Matrons continue to encourage the inpatient leadership checks (now completed via MS Forms following the end of the contract with Tendable (electronic audit system) on 31st March 2025) which prompts ward leadership teams to undertake an assurance check that new admissions have had their Staying Safe plan completed.

Inpatients

Quality and Safety

Care Plans

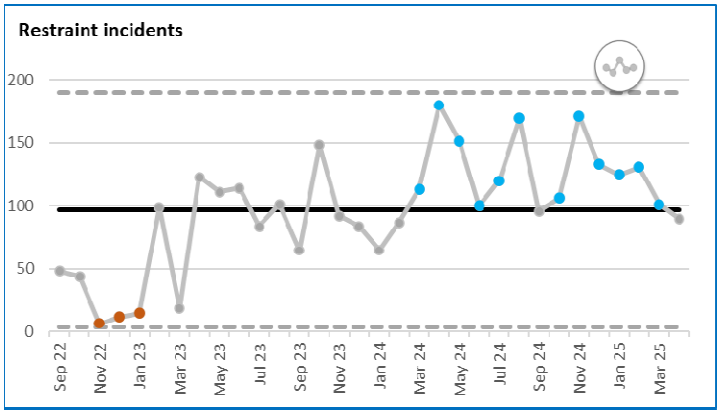


Insights

Good practice is for care plans to be produced collaboratively and in partnership with the service user to ensure they are patient centered, meaningful, and empowering. If a service user lacks capacity, the person-centered approached and collaboration with carers and family should inform care plans.

The percentage of care plans that includes service user input/views was introduced as a performance metric from 1st April 2025 with a compliance threshold of 95%. In April, performance was 100% across all inpatient localities.

Restraint Incidents



Insights

The SPC chart shows common cause variation for restraint incidents, with the number of incidents each month fluctuating. This is to be expected given that restraint incidents are linked to clinical acuity and individual service user presentation and risk. .

Restraint incidents have reduced to below the mean in April. All wards are above the 80% compliance with RRPI training and plans are in place to book all outstanding staff on appropriate courses.

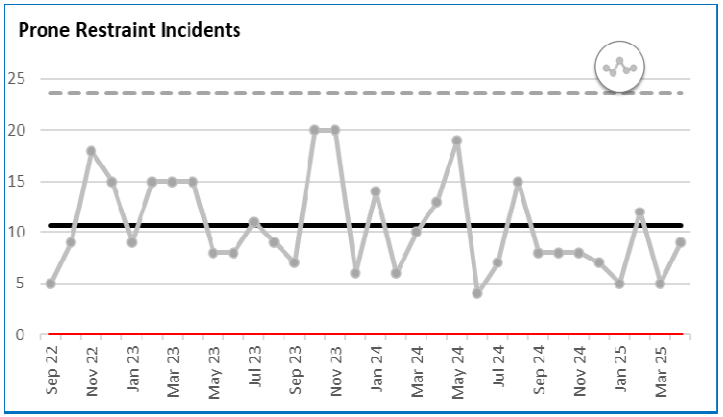
Additional detailed data at locality level will be made available via the reducing restrictive physical interventions (RRPI) Trustwide meeting.

There has been dedicated training to some wards that have seen high resistants, with dedicated care planning for individual Service users (SU). The fluctuation of clinically challenging SU impacts of the safety of the ward, other SU's and the care for everyone on the ward and can increase the need for higher staffing.

Inpatients

Quality and Safety

Prone Restraint Incidents



Insights

Prone restraint (face down restraint) is a form of physical restraint which is to be avoided due to of the severe impact it can have on a person's breathing. There is no nationally agreed measure, however good practice is to have the least number of prone restraints possible, therefore in the Trust we monitor trends from a baseline of 0.

All prone restraints are due to exiting seclusion and/or administration of intramuscular (IM) injections into the gluteal muscle. The service is involved in the trustwide quality improvement work related to reducing prone restraint. The RRPI team continue to roll out training in alternative seclusion exit techniques across inpatient wards and in April 2025 , added these techniques into the 4-day RRPI course (attended by new starters). There is emphasis on training for Walton ward, who have the highest number of prone restraints (linked to them being a 14-bed PICU and high levels of seclusion and rapid tranquilisation due to the presentation and risk profile of the patient population), and local training dates to capture the remaining Walton staff are scheduled in June. The pilot of alternative injection site training was completed on Stanley, with all registered staff being trained in deltoid administration. Following a successful pilot in alternative injection sites on Stanley Ward a blended training package has been developed for injections in alternative sites i.e. deltoid as a means of a least restrictive intervention to administer intramuscular injections in a restraint situation. Trust RRPI training now includes the techniques used to administer IM medication in these sites whilst the service user is supported in the safety pod and safety cushion.

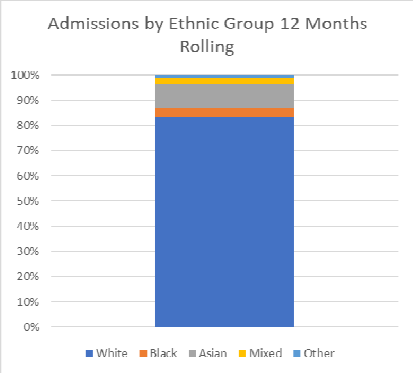
A contributing factor to the reduction in prone restraint to below mean from September 2024, is the purchase and distribution of safety pods by the RRPI team for all seclusion rooms . Safety Pods (a medical device that looks like a bean bag) allow staff to support service users using least restrictive options and a minimal use of force. It is possible to administer IM gluteal injections whilst the service user is seated in a safety pod (subject to levels of violence and aggression). The rise above mean in February is reflective of 7 individual service users and their presentations and high risks of violence and aggression.

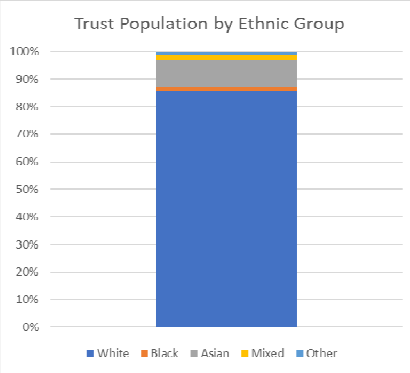
Matrons attend the monthly trustwide restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.

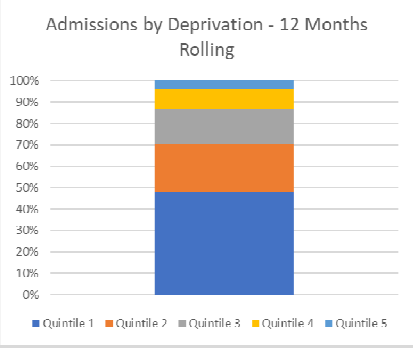
Inpatients

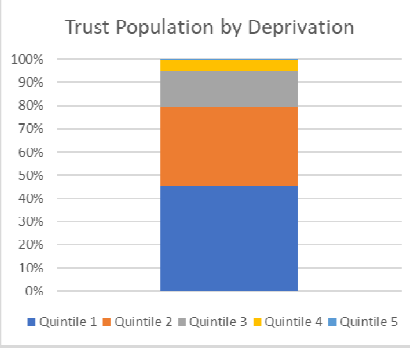
Inequalities

Admissions









Insights

Admissions between May 2024 and April 2025.

Admissions for people from a white and Asian ethnic groups are comparable against the Trust's population. Admissions for people from a black ethnic group are marginally overrepresented. More detailed analysis is required to enable better understanding of this data and actions needed to address it. The care group is involved in the NHS Confederation steering group exploring Mental Health Act (MHA) detentions and inequalities and data findings from this work will feed into our priority programme work.

The service has ensured prioritisation of equality impact assessments (EIAs) over the last 12 months with matrons working with ward managers to facilitate their completion and to ensure that action plans are meaningful.

The care group is involved in the embedding of the NHSE Patient Carer Race Equality Framework (PCREF) and a mapping exercise to identify areas for improvement work and actions is underway. PCREF will inform our equality impact assessments and is a golden thread in our priority programme work.

Admissions between May 2024 and April 2025.

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

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Statistical Process Control (SPC) Charts Explained

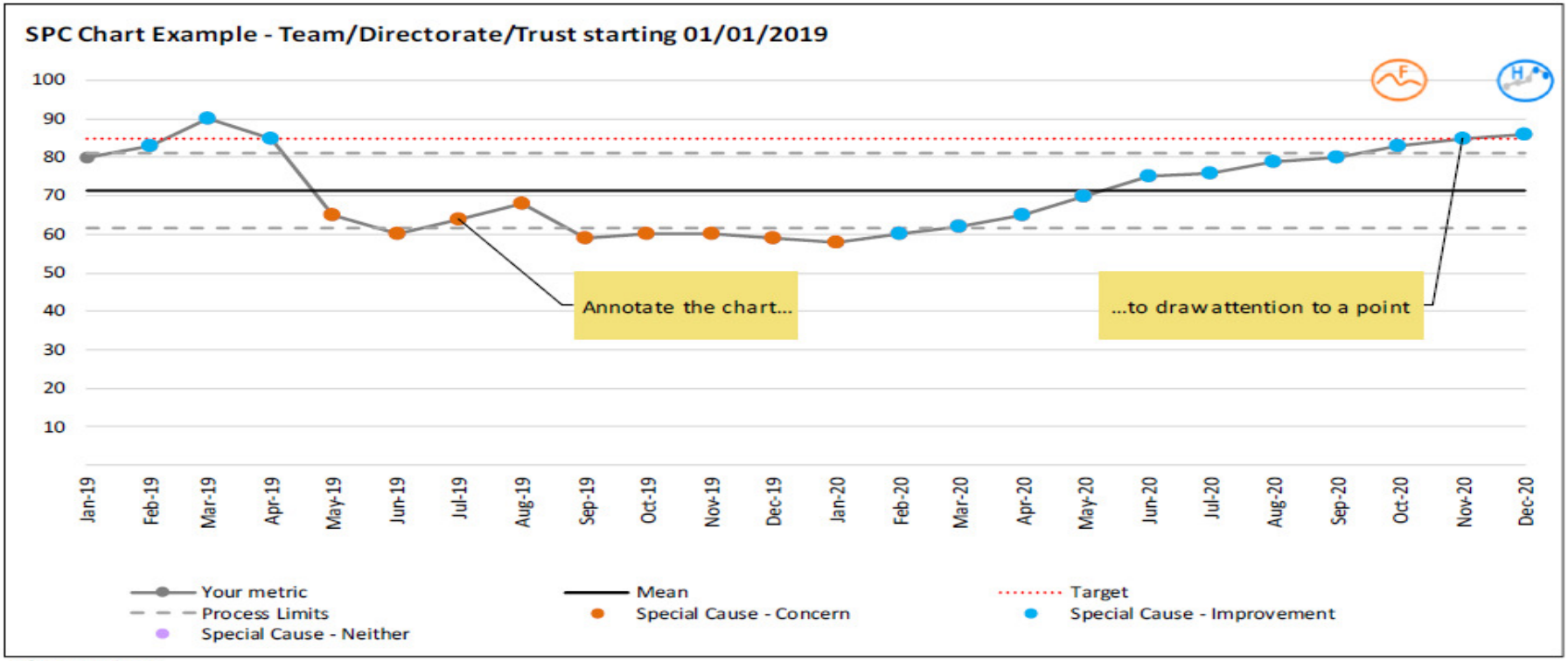
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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
1 July 2025
Agenda item 11.1

Private/Public paper:	Public		
Title:	Patient Safety Oversight Annual Report 2024/25 (including Quarter 4) (formerly the Incident Management Annual Report) incorporating the Learning from Healthcare Deaths Annual Report for 2024/25		
Lead Director:	Darryl Thompson, Chief Nurse / Director of Quality and Professions		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre • We are always improving		
Purpose:	The purpose of this report is to provide assurance and oversight of patient safety activity in South West Yorkshire Partnership NHS Foundation Trust in line with the Patient Safety Incident Response Framework (PSIRF). The report also provides assurance regarding safety incidents overview, emerging themes/trends and learning and improvement and updates on wider patient safety activity. This report replaces the former annual incident management report. It also provides assurance that learning from healthcare deaths arrangements are in place. The learning from healthcare deaths section of this report will be published on the Trust website once approved by Trust Board.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 4.3 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. 6.2 System pressures could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on		

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	opportunities to provide high-quality joined-up care and positive staff experience.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board and Place based partnerships and is a regular feature of our shared objectives and actions. Ensuring there is understanding of the incidents which take place within our services, the impact of these and the learning to ensure future risk or harm can be avoided, or reduced is essential. Sharing learning and best practice, themes, trends and analysis can help to identify opportunities to work together to address concerns or celebrate good practice. Learning from incidents is vital to improve patient safety, staff and service user/carer experience and to provide assurance of good governance and risk management processes.
Any background papers / previously considered by:	Trust Board and Quality and Safety Committee have previously received quarterly and annual incident management reports, learning from healthcare heaths reports and patient safety updates. The content of this report reflects the transition to working under the Patient Safety Incident Response Framework (PSIRF) from 1 December 2023. NHS England PSIRF oversight guidance asks that trusts move towards a focus on learning and improvement. The report is different in approach and will evolve over time as we embed and learn with PSIRF. The learning from healthcare deaths report for 2024/25 is included in Appendix E. This report has been reviewed in the executive management team, and also in the Quality and Safety Committee on 10 June 2025.
Executive summary:	The Trust has robust systems to oversee and learn from patient safety events. We have continued to share learning through our learning systems, including structures to share urgent learning or medication safety issues. The Trust continues to see 'normal' variation in the number of incidents being reported. Between February 2024 and August 2024 there were some higher reporting rates per month, which were explored and related to increases in green no/low harm incidents which is an indication of a positive reporting culture, although these were not outside what could be anticipated. There were no 'Never Events' within the reporting period. In relation to specific patient safety priorities (pages 25 to 35), there are some areas of special cause variation in some of the priority areas (as shown in Appendix A), these have been analysed and explored further. There are no further patterns or trends to report at this point in time, but work continues to develop for how we close the loop and capture outputs/themes/trends. We have continued to see positive progress with a range of patient safety initiatives including the achievement of excellent compliance with Level 1 patient safety training, sharing our patient safety incidents with the national Learn from Patient Safety Events (LFPSE) team and implementation of Patient Safety Incident Response Framework.

	The Trust's Family Liaison Officer (FLO) has continued to support a number of bereaved families and positive feedback continues to be received. **Learning from healthcare deaths** The Trust continues to have robust systems to oversee and learn from deaths. Overall, the Trust continues to see 'normal' variation in the reported number of deaths of people known to us. The mortality review group continues to meet on a quarterly basis and oversees developmental work including updates from regional meetings. The group are considering opportunities of how it can share the learning from deaths wider within the Trust and potentially establishing a forum for reviewing individual cases for mortality and suicide prevention. Attendance is being reviewed to include appropriate care group scrutiny with regards to learning from deaths. **Summary** A key aspect of our patient safety work is the consistent and robust use of data which underpins our assurance. This analysis also supports our improvement work and subsequent monitoring. Use of data is also a key asset in the transition to embedding PSIRF and provides invaluable feedback in relation to supporting a learning and safety culture. We are undertaking further focussed work to ensure patient safety learning is embedded with improvements sustained over the longer term to support an embedded safety culture. As part of the move to PSIRF there is a growing consideration to thinking about systems rather than individuals and how we can strengthen systems to improve safety. Engagement with affected people has improved with some positive feedback received. Teams are valuing being included in reviews and being able to be part of solutions. Communication and collaboration about patient safety is strengthened and patient safety culture is improving. The Trust also has strong networks with partners across the region. **Risk appetite** • Risk identified – the Trust continues to have a good governance system of reporting and learning from incidents. • This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. • The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. • Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6. PSIRF and our incident management processes support the drive to reduce harm and learn from incidents, to reduce risk and prevent recurrence in the future.
Recommendation:	Trust Board members are asked to: • **RECEIVE** the report.

South West Yorkshire Partnership NHS Foundation Trust

Patient Safety Oversight Report

Annual report 2024/25 (1 April 2024 to 31 March 2025, including the Learning from Healthcare Deaths annual Report)

(formerly the Trust-wide Incident Management Annual Report)

Prepared by the patient safety support team

Trust Board - 1 July 2025

With **all of us** in mind.

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1. Introduction

1.1. Purpose of the report and introduction

This report (formerly the Trust-wide Incident Management Report) provides assurance and oversight of patient safety activity in South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in line with the Patient Safety Incident Response Framework (PSIRF). The report also provides assurance regarding safety incidents overview, emerging themes/trends and learning, improvement, updates on wider patient safety activity and learning from healthcare deaths. The report has been renamed to bring the focus of it in line with PSIRF expectations.

The Trust has robust systems to oversee and learn from patient safety events. We have continued to share learning through our learning systems, including structures to share urgent learning or medication safety issues. Incident data is presented in statistical process control chart form in Appendix A of the report to ensure we focus on longer term trend.

The Trust continues to see 'normal' variation in the number of incidents being reported. Between February 2024 and August 2024 there were some higher reporting rates per month, which were explored and related to increases in green no/low harm incidents which is an indication of a positive reporting culture, although these were not outside what could be anticipated.

Discussion about incidents has increased with the introduction of PSIRF during 2024/25 and will, in turn, be encouraging incident reporting by raising awareness. There were no 'Never Events' within the reporting period. In relation to specific patient safety priorities (pages 25 to 35), there are some areas of special cause variation in some of the priority areas (as shown in Appendix A), these have been analysed and explored further. We have continued to see positive progress with a range of patient safety initiatives including the achievement of excellent compliance with level 1 patient safety training and sharing our patient safety incidents with the national Learn from Patient Safety Events (LFPSE) team and implementation of Patient Safety Incident Response Framework.

The patient safety oversight group (PSOG) continues to meet weekly, with attendance from the chief medical officer, chief nurse / director of quality and professions, chief operating officer, all Care Groups and required corporate colleagues. In line with PSIRF principles, we have continued to focus on using our resources proportionately to focus on the areas where we need to understand more detail. Where themes/issues are already known, we use our resources to address these through improvement work rather than keep undertaking individual responses. As such, we have a small number of learning responses, but a bigger focus on improvement work. Recent updates on improvement work are included in Appendix A.

The Trust's Family Liaison Officer (FLO) has continued to work with a number of bereaved families and positive feedback continues to be received. This work was shared by the FLO at October's Quality and Safety Committee. Work is underway with our patient safety partners to gather independent feedback to evaluate the impact of our FLO. Learning and reflections gathered so far, will be incorporated into future approaches as part of the PSIRF review.

The Patient Safety Improvement Group has moved to a monthly frequency to support a cycle of collective reflection and learning, focussed around the patient safety priority areas. This will be developed further during 2025/26. Of note, the data in this report does not include Cheswold Park Hospital who joined the Trust on 1 October 2024. Cheswold Park Hospital transitioned to working under PSIRF from 16 December 2024. Outstanding serious incidents were addressed using PSIRF methodologies and where possible they were themed to cluster responses together.

1.2. Background

The content of this report reflects our transition to working under PSIRF from 1 December 2023. PSIRF oversight guidance asks that trusts move towards a focus on learning and improvement.

Historically, our quarterly reports included specific incident data. However, in line with PSIRF oversight principles and NHS guidance, the Patient Safety Support Team are now reviewing data using statistical process control (SPC) utilising the NHS improvement tool. SPC is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action. PSIRF suggests that trusts should use meaningful data from existing data streams, some of which is included in our Integrated Performance Reports and locally in our clinical risk report to Operational Management Group.

The development of this report is an evolving process and will continue over time. Feedback received on the content will be reviewed for consideration in future reports.

2. Patient Safety Incident Response Framework developments

The Trust's first anniversary of being live with PSIRF was reached on 1 December 2024. Positive feedback has been received through the year from staff involved in learning responses. We are seeing a move to thinking about systems rather than individuals and we can strengthen them to improve safety. Engagement with affected people has improved with some great feedback received. Teams are valuing being included in reviews and being able to be part of solutions. Communication and collaboration about patient safety is strengthened and patient safety culture is improving. Our oversight of patient safety is evolving with new structures, and we have strong networks with partners across the region.

The Trust continues to build on our processes as we [the Trust] learn and develop these collaboratively. PSIRF is a key element of the overall national patient safety strategy. It allows organisations to design and learn from their incidents in line with their local context for patients, families and staff whilst considering local and national safety learning requirements. This is the largest scale national and organisational change in patient safety in the last twenty years and therefore there is not an expectation that these changes will happen rapidly. This change in 'thinking' requires a level of safety maturity, both in culture and expertise, building capability by providing peer support for learning and improvement with a focus on work systems to support our staff to do their best work.

Our patient safety incident response plan and policy are available on our website. These documents include:

- The patient safety incident response plan – which sets out how the Trust will respond to patient safety priorities with a focus on learning and improvement
- The patient safety incident response policy – which describes the systems and processes the Trust will use to learn and improve following a patient safety incident

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key principles:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement

2.1.1. PSIRF interim review

An interim review of the first 15 months of our approach to PSIRF is currently underway framed around the above four PSIRF principles. PSIRF systems analysis tools will be used to reflect on what has worked well and where we can improve going forward. Learning identified form this

review will then be considered as part of updating the Trust PSIRF plan, policy and associated procedures.

This section of the report has been structured around the four key PSIRF principles.

2.2. Compassionate engagement and involvement of those affected by patient safety incidents

2.2.1. Background and progress

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if systems and processes that support compassionate engagement and involvement of those affected by patient safety incidents (patients, families, and staff) are in place.

Compassionate engagement and involvement means working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. When a learning response is undertaken, the Trust meaningfully involves those affected, where they wish to be involved, which is in line with our values. The Patient Safety Support Team have incorporated this into our PSIRF policy and supporting procedures.

The Trust continues to enhance the existing support mechanisms for supporting staff following a patient safety incident. Patient Safety Support Team and occupational health team are working collaboratively together to develop the offer for staff into a working document.

2.2.2. Family liaison officer update

The work of the family liaison officer (FLO) continues with progress now being made in relation to the feedback questionnaire. Following liaison with patient safety partners, some minor changes have been made which require final agreement before the questionnaire is rolled out; with a planned rollout in Quarter 2 in 2025.

Progress continues with the bereavement standard; new members have joined the group and the “bereavement link supporter” role has been finalised. The Trust Communication Team have supported with the development of leaflet and intranet page. The aim is to launch this opportunity to coincide with dying matters week (5th to 11th May 2025), with a day being allocated in Quarter 3 for the first educational support session (options for speakers are currently being explored).

Established links with the trauma informed pathway remain in place with attendance being planned at the newly formed Staff Support and Wellbeing Oversight Group. This fits alongside the work connected to the Trust wide suicide prevention strategy.

Regular connection between the FLO and colleagues in the Trust legal department continue, as do the regular meetings with FLO’s throughout the country to share what is an ever-evolving role. The FLO process is being strengthened through a task and finish group which is due to have its initial meeting on 24th April 2025.

2.3. Application of a range of system-based approaches to learning from patient safety incidents

2.3.1. Background and progress

The PSIRF promotes a range of system-based approaches for learning from patient safety incidents, rather than methods that assume simplistic, linear identification of a single cause.

As a Trust, we have developed our range of systems tools, to help explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement. These are based on NHS England’s toolkit. Although we have called some by different names, the methodology remains the same. This is an evolving process as we learn about what is working well and areas to improve.

The Trust's PSIRF plan includes the circumstances in which we will use our learning response tools but these are summarised in our learning slides (Appendix B).

As the Trust progresses with embedding PSIRF into practice, the Patient Safety Support Team are coaching and supporting care groups with understanding the new tools and PSIRF in general.

2.3.2. Disseminating learning for patient safety across the Trust / PSIRF

Appendix B gives an illustration of our recent learning presentation that brings together some of the learning from 2024/25, including reflections and feedback on the experience of using some of the new learning response tools.

Internally, the full set of slides are available on the Trust's intranet pages for staff in wards and teams, along with previous learning.

2.4. Considered and proportionate responses to patient safety incidents and safety issues

NHS England acknowledge that trusts have finite resources for patient safety incident response. The PSIRF supports trusts to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as never events and deaths thought more likely to be caused by problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a Patient Safety Incident Investigation (PSII) to learn and improve. Some incident types will also require specific reporting and/or review processes to be followed. For SWYPFT, these are detailed in our PSIRF plan.

The PSIRF gives no further rules or thresholds to determine what needs to be learned from to inform improvement. Incident response activity may include a learning response for an individual incident where contributory factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan. It is acceptable **not** to undertake an individual response to an incident – other than to engage with those affected and record that the incident occurred if the Trust and our lead ICB (West Yorkshire Integrated Care Board) are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored. This is set out in our PSIRF plan and expanded below.

2.4.1. PSIRF plan learning responses

Our Patient Safety Incident Response Framework (PSIRF) plan describes our initial patient safety priorities and what improvement work will be undertaken to address the known contributory factors, rather than continuing to do investigations that tell us what is already known. Where cases are identified where understanding is limited, learning response can be used to learn and improve understanding. Our PSIRF plan and priorities were developed through analysis of our historic data including previous learning from serious incidents and actions.

Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong. In fact, the Trust can equally learn from what has gone well and this is something we can develop further and promote at our learning network.

2.4.2. Safety incident overview position across the Trust

Appendix A of this report presents incident data that enables the review of longer-term trends and patterns in line with PSIRF principles in a way that reduces the reactive element to changes.

Incident reporting should not be seen as a single indicator of safety in clinical environments; however, data can provide an early indication of incident change in services, the Trust or even the wider healthcare system.

The Patient Safety Support Team continue to review incident data every month using statistical process control (SPC) charts (see Appendix A), utilising the NHS Improvement Tool to look for changes in data which may require further exploration to understand fluctuations that fall outside the normal variation anticipated based on previous data. Commentary has been provided for each SPC, with further information including ethnicity data, where relevant, reflections on learning response activity and where improvement work is in place.
Although there are some areas of special cause variation in the data shown in Appendix A under the patient safety priorities, these are usually related to small numbers of individuals and their clinical presentation or data quality changes. These outlier areas have been explored with specialists and care groups, who are best placed to understand changes in light of other factors. They also ensure we are doing everything we can to support individuals to minimise patient safety incidents. There are no particular patterns or trends to report at this point in time but work to improve the capture of outputs will continue in 2025/26.

Discussion about patient safety incidents has been held through the year at the Patient Safety Improvement Group to aid understanding. During 2025/26, we will be adapting our Patient safety improvement group to focus discussion on the patient safety priorities in our PSIRF plan and this will include considering triangulating data, intelligence from incidents/feedback, local and national learning, and our related improvement work. (as in Appendix A). We will also include looking at emerging patient safety areas not currently in our priorities. We hope to facilitate discussion to explore any hotspots and reasons why there may be changes, consider wider intelligence from other sources including input from care groups and specialist advisors, any national guidance/reports, and what our learning responses and improvement work are telling us. We envisage this will help with being able to provide assurance. The first meeting in the revised format will be in June 2025. This work will continue to develop using a Plan, Do, Study, Act (PDSA) approach.

2.4.3. Ethnicity data

There is a national legislative requirement that Trust Boards routinely review patient safety incidents and near misses through an ethnicity lens, involving experts by experience.

This report contains patient safety data using SPC (see Appendix A). Breakdown of patient safety incident data by ethnicity of those affected has been analysed. Patient safety incident data is shared with our Patient Safety Improvement Group which has patient safety partners so we can consider through an ethnicity lens.

During 2024/25, we have continued to review incidents to ensure that any equality issues are highlighted. All incidents which identify hate/abuse based on ethnicity and other protected characteristics are reviewed at the weekly at care group and Trust Patient Safety Oversight Groups, to ensure any themes are identified early and ensure support is provided.

In line with the Equality Impact Assessments in the incident reporting, management and learning response procedures, the patient safety support team provide data for all incidents occurring during 2024/2025 to care groups (available separately). This is to aid discussion in care groups to give insight into improvement opportunities. Further detail is available from patient safety support team or on Datix at local level. In addition, incident data is shared with policy leads to ensure equality data related to incidents is considered when reviewing policies and procedures.

Data relating to a limited number of protected characteristics for individuals involved in incidents (age, gender, ethnicity, sexuality) is available on Datix for reported incidents. In addition, information is held for restraint incidents in line with the Use of Force Act. It should be noted that each person linked to an incident will have some level of demographic data recorded, but for the purposes of the data, this focusses on the person affected. NHS England (NHSE) have developed the Learn from

Patient Safety Events system (LFPSE) that brings together patient safety incident reporting across England. This is a voluntary scheme and is in development, with work continuing to strengthen data collection in a standardised format across the NHS. The collection of equality data cannot be mandated locally on Datix because information on any protected characteristics of the patients or staff involved in an incident may not be immediately available to the reporter (as identified by NHSE). Making its collection mandatory could act as a barrier to reporting and lead to fewer incidents being reported. As with the national position, we consider it is more important to collect incomplete information about risks to patients and staff than to potentially block reporting of that information by mandating the inclusion of information that reporters may not have or may have to record inaccurately.

Data should always be checked at the managerial review stage of adverse events rather than incident reporting stage. Guidance has been produced to support managers with reviewing the demographic data for those linked to incidents, to ensure accuracy as data pulls through to future incidents

In the coming year, the Patient Safety Support Team will:

- Explore how data can be interrogated by care groups and specialists that will assist with understanding types of incidents to team level including the review of ethnicity data of those affected to aid discussion and give insight into incident data for the populations we serve. Work is planned to explore options about how incident data could be considered in light of population information. Work will also continue in Quarter 1 2025/26 with the Trust's Intelligence Change Partner and Business Intelligence Team.
- Undertake a procurement process for the Trust's risk management system. Datix is currently the system used by the Trust, however there are other systems on the market. This process will consider how system providers (including Datix) can support the collection and reporting of equality data.

2.4.4. Improvement work

Our improvement work continues to develop as the Trust learns about using PSIRF in practice. This includes now we align intelligence from incidents with improvement activity and this will be considered further in our ongoing PSIRF review. It should be noted that in line with advice from NHS England, we shouldn't expect to see the output of improvement activity for some time. NHS England suggest that PSIRF plans are reviewed fully in at around four-year post implementation, as improvement work can take a long time to embed and to see change played out in data trends.

As we develop our Patient Safety Improvement Group further during 2025, we will shift the focus of discussion to the patient safety priority areas which will include improvement work. An overview of progress during the year are included under the relevant PSIRF improvement area in Appendix A.

2.4.5. Learning from our learning response process

As anticipated, there have been fewer learning responses than under the previous Serious Incident Framework. The use of debrief has been well used by teams to support team reflection, engagement and support and focus on learning. The Manager's Rapid Review (48-hour review) is a learning response that helps us understand more, as it includes questions around systems thinking to help managers reflect more widely about what happened, however on reflection, this is a decision-making tool rather than a learning response which will be reflected in our PSIRF review.

The Patient Safety Support Team have spent time supporting team managers and Care Groups to learn about PSIRF and systems thinking and when they may need to consider undertaking a learning response and understanding wider patient safety processes. This is to encourage confidence in talking about and understanding system thinking and learning. Positive outputs are being seen in teams supported with increases incident reporting as recognition improves along with quality of content and decision making. Some care groups are beginning to lead some learning responses with support from the Patient Safety Support Team.

Teams who have been involved in a learning response have shared feedback, much of which has been positive (Appendix B) and this will be considered in our PSIRF review.

2.4.6. Learning response outputs

A selection of outputs from learning responses have been provided in Appendix B. From some completed learning responses, some of the feedback and learning has centred around the culture within teams. Actions have been identified and brought back into the Care Group governance processes. Some care groups are starting to lead learning responses with support from Patient Safety Support Team. Feedback from care groups has been positive and they find Patient Safety Support Team facilitated learning responses helpful.

Individual Patient Safety Incident Investigation (PSII)

An individual Patient Safety Incident Investigation (PSII) is undertaken when a patient safety event meets the national or local criteria as set out in the Trust's PSIRF plan, and numbers are expected to be low in number. This may include a death where we have established through other review processes that there were potential problems in care that need to be investigated further to understand their impact on the incident. PSIIs use systems thinking methodology to review the identified issues to seek new learning, improvement and where needed, develop safety actions.

There have been three PSIIs reported since April 2024 where we seek to find more understanding about the issues identified in the early stages of review.

PSII Thematic projects

The three PSII thematic improvement projects were identified in our patient safety incident response plan; updates are given below:

- **Formulation informed risk management (FIRM) –** this project was identified through PSIRF as an improvement project because of the number of Serious Incident actions related to FIRM risk assessment. However, there has been separate work underway around care planning and risk assessment, with the primary focus being on care planning and embedding risk assessment more robustly into that process. Work was also undertaken to develop a generic audit tool; however, it didn't appear to have been embedded in practice. To avoid duplication of work, the PSII project lead held some initial meetings to explore further with staff. A survey was developed with the aim of seeking an understanding of front-line colleagues' experience of FIRM in practice, including the barriers and reflections; 72 responses were received. Analysis of the results and learning has given a deeper understanding of insights. A report concluding the work has been shared with the Care Planning and Risk Assessment working group, this has been closed at the Patient Safety Improvement Group.
- **Pressure Ulcer clinical documentation** – This thematic project arose through analysis of Serious Incident actions over a number of years, which could be related back to pressure ulcer clinical documentation. A group process mapping day took place on the 6 November 2024 with front line clinicians, team leaders, managers, specialists, SystmOne (the Trust's electronic care record system), data and patient safety specialists. The group used quality improvement methods to map work as done to help identify areas for improvement. It was identified that the use of care plans required review for scheduling and allocation of work, and that a new wound care template on SystmOne would support consolidation of all existing wound care documentation. This aims to reduce time and duplication of work by creating leaner effective systems for documentation and eliminate the need for routine Datix reports for each pressure ulcer and the time taken to process each incident report. It is hoped the template will improve the personalisation of care and see improved quality documentation. A report has been drafted and outputs from the day are being taken forward in a task and finish improvement group within Barnsley Physical Health and Wellbeing Care Group.
- **Inpatient Suicide/self-harm** – this thematic work involves the review of all historical incidents of inpatient apparent suicides. Due to delays in completion, it was agreed that 2024

data of apparent inpatient suicides would also be included. Two multi-professional meetings have taken place and lines of enquiry established and alignment with existing workstreams. A draft report is being prepared.

2.4.7. Cross system working

In the last year, the Patient Safety Support Team have been strengthening our relationships with colleagues in patient safety teams in other local trusts. An increase has been seen in 'service to service' enquiries as issues are identified and shared with other agencies and then back into the Trust. This is to ensure local review and learning opportunities. The table below shows the breakdown by provider:

SWYPFT to external organisation service to service requests sent	**2024/25**
Barnsley Hospital NHS Foundation Trust (BHNFT)	43
Calderdale and Huddersfield NHS Foundation Trust (CHFT)	12
Mid Yorkshire Hospital NHS Foundation Trust	13
Yorkshire Ambulance Service (YAS)	6
Sheffield Teaching Hospitals (STH)	4
GP surgeries	2
Cygnet Hospital	1
Sheffield Health and Social Care Trust	1
Total	**82**

Table 1: Service to Service enquiries raised by SWYPFT patient safety team with other providers

The number of service to service requests the Trust has raised with Barnsley Hospital (43 in Table 1) primarily relates to pressure ulcers we have identified during our visits that originated in the acute hospital.

In addition to service-to-service enquiries that SWYPFT have sent to other providers, other organisations contact the Trust for further information/exploration of patient safety issues they have brought to our attention. These are shown in Table 2 by provider.

Service to Service - External organisation to SWYPFT requests received	**2024/25**
Learn From Patient Safety Events reporting (LFPSE)	98
Mid Yorkshire Hospital NHS Foundation Trust	9
Calderdale and Huddersfield (CHFT)	9
Barnsley Hospital NHS Foundation Trust (BHNFT)	8
Yorkshire Ambulance Service (YAS)	4
Sheffield Teaching Hospitals (STH)	2
South Yorkshire Integrated Care Board (ICB)	1
Total	**131**

Table 2: Service to Service enquiries received in SWYPFT from other providers for further review

In addition to the number of requests we have raised with Barnsley hospital above, we received 8 requests from Barnsley Hospital, related to a range of care settings including pressure ulcer care.

This includes a high number of patient safety incidents reported via the LFPSE system which have been reported by staff in neighbouring acute hospitals about SWYPFT care and treatment. However, on exploration of the limited information available to us, many of these are not related to SWYPFT care and treatment, and a different provider should have been selected. Work is underway to resolve this with the relevant acute hospital patient safety team. The table overleaf shows the total number of service-to-service enquiries received.

The Patient Safety Support Team have been working with each of the three local acute trusts to discuss shared learning opportunities and to review memorandum of understanding arrangements so there are agreed ways of working on shared patient safety incidents.

2.4.8. Cross system PSIIs

PSIRF encourages cross system/multi-agency responses to patient safety incidents where appropriate. We are working with two acute hospital trusts on individual PSIIs they have reported which link with our services.

2.4.9. Historic outstanding serious incidents

Four historical serious incident investigations have been concluded during 2024/25. No Serious Incident investigations remain open.

2.5. Supportive oversight focused on strengthening response system functioning and improvement

2.5.1. Background

NHS England advises there must be openness with information relating to patient safety incidents and findings from learning responses to support continuous development of an effective incident response system. The development of our internal structures that support patient safety oversight are described as follows:

2.5.2. Patient safety oversight developments

Patient Safety Oversight Group developments
During 2024/25, we have continued with our weekly Patient Safety Oversight Group (PSOG) where patient safety risks are discussed. During the year, each care group have continued to develop their own patient safety oversight groups that feed into the Trustwide group.

Patient Safety Improvement Group
The Trust Patient Safety Improvement Group moved to a monthly frequency during 2024/25 which has been useful, receiving highlight reports from care groups and improvement leads. However, we have identified we need to streamline further during 2025/26.

Moving forwards the patient safety improvement group agenda will focus primarily on the patient safety priorities in our PSIRF plan and Trustwide actions, this will include considering the data (as in Appendix A) and will also include emerging patient safety areas not currently in our priorities. We hope to facilitate discussion around each priority to look at the data as a group, explore any hotspots and reasons why there may be changes, consider wider intelligence from other sources including input from care groups and specialist advisors, any national guidance/reports, and what our learning responses and improvement work are telling us. We envisage this will help with being able to provide assurance. The first meeting in the revised format will be in June 2025. We will continue to use a Plan, Do, Study, Act (PDSA) approach to revise our approach over time. The terms of reference will be updated for discussion in the meetings. This work aligns with the ongoing wider PSIRF review.

3. Other patient safety activity

Throughout 2024/25, we have continued to make good progress with our patient safety workstreams in line with national priorities and local developments. This section of the report provides updates on other patient safety work the Patient Safety Support Team and patient safety specialists have been working on.

3.1. Patient Safety specialists

We have expanded our patient safety specialist role to include other colleagues whose roles link to patient safety leadership and delivery. One of the patient safety specialists completed NHS England's ergonomics and human factors training provided by the University of Loughborough in December 2024. The course is accredited by the Chartered Institute of Ergonomics & Human Factors (CIEHF).

3.2. Safety Incident Response Accreditation Network (SIRAN)

During 2024/25, the Patient Safety Support Team have been undertaking the Royal College of Psychiatrists Safety Incident Response Accreditation Network (SIRAN) process for our patient safety and incident response processes.

This has involved a three-month period of self-assessment and feedback from involved parties. Numerous pieces of evidence were submitted alongside narrative for each of the 59 standards. Early feedback will be incorporated into the PSIRF review that is currently underway. The evidence will be presented to the SIRAN accreditation committee in early May. The outcome of the accreditation process will be reported in future reports when available.

3.3. National reports and guidance

The patient safety support team monitor patient safety reports issued by the Health Services Safety Investigations Body (HSSIB) and share these with the appropriate leads/groups in the Trust for consideration of any local learning or action required. There have been 16 reports published during 2024/25 (see Appendix C). These are available to staff on the patient safety intranet pages.

In December 2024, the government published the Williams Memorandum of Understanding (MoU) that sets out how healthcare organisations, regulatory bodies, investigatory bodies and prosecutorial bodies in England will work together in cases where there is suspected criminal activity on the part of an individual in relation to the provision of clinical care or care decision making. Information has been added to our patient safety intranet pages for staff, and this will be included in future versions of policies and procedures.

During 2024/25, the Patient Safety Commissioner launched their Patient Safety Principles which provide a framework for decision making, planning and collaborative working with patients as partners in a just and learning culture and are for everyone working in the healthcare system. They also act as a guide for leaders at all levels on how to design and deliver safer care for patients and reduce avoidable harm in a just and learning culture. We have shared the principles on our patient safety intranet pages for staff.

3.4. Learn from Patient Safety Events (LFPSE)

The Trust went live with learn from patient safety events (LFPSE) in February 2024.

LFPSE is part of NHS England's developments to improve patient safety. It is a national database for patient safety learning and improvement and replaces the national reporting and learning system (NRLS) and the system used for reporting serious incidents. It captures a range of patient safety events that happen, including patient safety incidents, near misses, never events and good care.

- LFPSE data collection fields and functionality has been incorporated into our Datix incident reporting system and was approved by NHS England as compliant
- Reporting to LFPSE now occurs automatically when a patient safety incident is identified and entered in Datix, with the record updating to LFPSE every time it is updated (saved)

A review of reporting has taken place during 2024/25 which identified some areas for improvement which will be delivered in 2025/26. This includes raising awareness of what a patient safety incident

is and what is reportable to LFPSE alongside strengthening our data collection methods and monitoring processes.

3.5. External reporting of patient safety incidents

The Trust uploaded patient safety incidents[1] (which are a subset of all incidents reported) during 2024/2025 to national reporting systems. The national systems share patient safety incidents with the Care Quality Commission (CQC), who may 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 externally as the harm was not to a patient.

In 2024/25, a total of 9,379 patient safety incidents were reported on our Local Risk Management System (LRMS), Datixweb, with 48 resulting severe harm and patient safety related death incidents. We ask staff to over-estimate the actual harm where this is not confirmed, and this will be reflected in this figure.

As the 2024/2025 period reflected the above transition between systems and processes, data is not comparable with previous years.

95% of the 9,379 patient safety incidents resulted in no harm or low harm. Nationally (NHS 2021), it is believed that organisations that report more incidents usually have a better and more effective safety culture. If we understand what our incidents are, we can learn and improve our services.

The Trust considers that this data is as described for the following reasons:

- The Trust transitioned to Learn from Patient Safety Events (LFPSE) on 14/2/2024
- LFPSE is a new national database where patient safety incidents stream direct from our local system into the national LFPSE system
- The LFPSE national team have advised that the data presented in the LFPSE dataset is based on information recorded on a largely voluntary basis. This is a new data collection system and so is likely to show different patterns of recording behaviour as organisations transition from the old NRLS to LFPSE service. Patterns of recording during this transition phase may not be comparable to previous patterns and care must be taken to avoid basing conclusions about the safety of care on changes in recording patterns during this period. It is anticipated that volumes of recording will increase over time
- LFPSE data that has been submitted to NHS England is currently being validated and therefore cannot be used for patient safety incident planning or official statistics
- As staff become more familiar with LFPSE requirements figures are expected to increase
- Reporting to LFPSE has been in development through 2024/2025 since implementation in February 2024, therefore our data is based on what we believe in the Trust to be a patient safety incident.
- We have included the figure of all our patient safety incidents reported on our Local Risk Management System (LMRS) and the percentages have been taken from this figure.

The implementation of the patient safety incident response framework (PSIRF) in the Trust from 1 December 2023 continues to support our strong focus on learning for improvement.

3.6. Cheswold Park Hospital

Cheswold Park Hospital transferred to the Trust from 1 October 2024, and they continued to use their existing risk management system, Ulysses until 13 January 2025 when the transition to

[1] 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.

Datixweb was implemented. This involved the introduction of incident reporting and feedback recording on Datixweb. The service commenced working under the Patient Safety Incident Response Framework from 16 December 2024.

As an independent provider, Cheswold Park were not required to report patient safety incidents to the national system. After transition to Datix reporting, the patient safety team have configured the system so that reporting to the national Learn from patient safety events system could commence. Until this came into effect, incidents were manually reported to LFPSE team by the Patient Safety Support Team. Patient Safety Incidents that resulted in severe harm or death are shared with the Care Quality Commission via LFPSE.

3.7. Developments on Datix

During 2024/2025, the focus of Patient Safety Support Team development work has included:

- The patient safety support team have continued to develop and improve the recording and management of learning responses under PSIRF in the Datix system
- New Care Group for Children's, Young People and Families added to Datix and changes to the team structures completed
- Delivery of Datix training sessions for managers on promoting incident reporting and reviewing incidents
- Planning and implementation of incident reporting processes at Cheswold Park Hospital from 1 October 2024
- Manually inputted incidents into Datix from Cheswold Park Hospital Ulysses system from 1 October 2024 until mid-January 2025 to ensure complete record in one system.
- Recoding of incidents relating to the use of intra-muscular medication to manage aggression which were previously recorded as Medication incidents, now recorded as Violence and Aggression incidents. All historical incidents back updated to the new categorisation.
- Reviewed and updated the process for rejected incidents.
- Worked with colleagues in Performance and Business Intelligence on the automation of Datix IPR metrics.
- Implemented processes for validation of LFPSE data in line with NHS England guidelines.
- New search form created on Datix to make searching for incidents easier.
- Amendments made to the Feedback module to improve data collection for service user protected characteristics.
- Refreshed and updated Datix Business Continuity Plan.

3.8. Responding to national patient safety alerts

The Patient Safety Support Team continue to distribute and respond to national patient safety alerts along with other types of alerts.

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. If the alert is applicable to the Trust, the alert is circulated to quality and governance leads who then cascade to ward/team level managers via Datix. Responses are collated via Datix with a care group final response. Responses are monitored by the Patient Safety Support Team and reminders are sent via Datix to ensure the Trust meet the deadlines set. Information is reported into the medical device and safety alert group on a monthly basis and to operational management meeting. The patient safety alerts received and actioned during 2024/25 are available in Appendix D.

Although many alerts are not applicable to the Trust, they go through the same level of scrutiny. For example, alert NatPSA/2024/007/DHSC which was issued in May and updated in xxx, is not prescribed by the Trust, however this has been circulated for information because some of our service users would be prescribed it through other sources, and if so, it could have a big impact.

3.9. Improving patient safety education and training

Progress continues to be made with the various levels of patient safety training:

- Patient safety training Level 1 e-learning for all staff became mandatory in November 2023. Data from the electronic staff record (to end of March 2025) shows:
    - Level 1a – Patient safety essentials for all staff – 98.7%
    - Level 1b – Patient safety for senior managers and board members – 91%
- Level 3 and 4 training for patient safety specialists is a 12-month programme led by the University of Loughborough. One of the Trust's Patient safety specialists has completed the course in December 2024.

3.10. Patient safety partners (PSP)

In December 2023, the Trust welcomed three patient safety partners (PSPs), in line with NHS England guidance who contribute alongside our staff, patients, families and carers to improve and influence patient safety across our range of services. The Trust sees their role as a true partnership, drawing on their experience and having an active role in highlighting good practice and challenging where care, treatment or our processes need changes to ensure that the patient voice is heard throughout.

So far, our patient safety partners have been supporting pieces of work including:

- Supporting evaluation of the family liaison officer service with bereaved families and carers in the development of a survey.
- Attended quality walkarounds in different services
- Attending our Patient Safety Improvement Group
- Planned and contributed to the World Patient Safety Day learning network event including talking about the role
- Reviewing and providing feedback on the quarterly report and learning journeys that as an organisation we have undertaken.

A staged plan is being developed to look at how we can develop the role of the PSP's due to patient safety crossing multiple agendas, this includes supporting reducing restrictive practice work and support with our investigators' meeting when reviewing learning responses.

We are looking at recruitment of further PSPs within the Trust and using the PSP meetings to support further development of their role and how we are able to show the effectiveness of their contributions to our Trust.

3.11. Implementing medical examiners

The national requirement to report inpatient deaths to medical examiner's office came into effect on 9 September 2024.
The Trust does not have its own medical examiners but instead will utilise those available from Mid Yorkshire Hospitals Teaching NHS Trust, irrespective of where the death has occurred within the Trust, with the exception of Cheswold Park Hospital, which will be considered separately for the time being as systems and processes develop.

Information has been shared on the Trust internal intranet pages. All medical staff have been informed about how and when to contact the Medical Examiner's Office.

3.12. Improving safety culture

In 2024/25, 96% of all incidents reported resulted in no or low harm or were not related to care provided by the Trust. The number of incidents resulting in moderate or severe harm or patient

safety related deaths are small. We look for opportunities to learn from any incident, whether it results in harm or is a near miss (free lesson). Incident reporting themes and trends are monitored at various levels in the Trust, including team, patient safety team, care group, operational management group and through the integrated performance report. Our patient safety improvement group focusses discussion on the patient safety priorities in our PSIRF plan, to examine themes and trends in patient safety intelligence and where required, plan further thematic analysis. As this group develops further with the themed focus, it is envisaged that emerging risks and areas for attention will be included in this report. The Trust continues to work to increase overall incident and near miss reporting as part of safety culture work.

This year there has been an increase in incident reporting, with a 6.1% increase on the previous year. There has not been an increase in harm levels which we believe indicates a positive reporting culture, where staff feel able to report incidents and near misses. This figure excludes data for Cheswold Park Hospital who joined the Trust in October 2024. When including Cheswold Park Hospital data, the increase is noted to be a 13 % increase on 2023/24. The harm level overall remains at 96%.

3.13. Learning from healthcare deaths

The Trust's annual learning from health care deaths report is available in Appendix E. Once approved this will be published separately on the Trust website.

3.14. Other patient safety work

During 2024/25, we have continued to:

- Develop our Family liaison officer role supporting bereaved families
- Developed our patient safety oversight group structures to align with PSIRF
- Delivered sessions for care groups on understanding Notifiable Safety Incidents and when Duty of Candour applies
- Continued the implementation of electronic prescribing system to aid medication safety
- Established a new structure for the patient safety improvement group to fit with wider patient safety activity
- We have provided the Quality and Safety Committee and Trust Board with new style reports that reflect PSIRF changes and reported on a range of patient safety activity throughout the year. The reports now include our Learning Journey presentation and the Learning from Healthcare Deaths report. The learning reports are shared on the Trust website
- Continued to share learning through our systems
- Continued to progress work related to our suicide prevention strategy
- Celebrated World Patient Safety Day on 17 September 2024 by:
    - Holding a face-to-face learning network at Fieldhead. The learning network had a special focus around patient safety and falls prevention
    - Staff completed patient safety pledges
    - The team supported Creative Minds to hold activities for patients on some wards with a patient safety focus

4. Conclusion and next steps

The content of this report reflects the transition to working under the Patient Safety Incident Response Framework (PSIRF) from 1 December 2023 to 31 March 2025. The report continues to evolve over time as we embed and learn with PSIRF. Below is a summary of the highlights in the report and next steps.

The continued development of the Patient safety improvement group will see a shift in focus to the patient safety priority areas, with discussion around themes and trends involving a range of stakeholders, examining the output from learning responses, and feedback from those affected. This aims to identify further areas where improvement work may be beneficial.

In relation to specific patient safety priorities (pages 25 to 35), there are some areas of special cause variation in some of the priority areas (as shown in Appendix A), these have been analysed and explored further. In relation to self-harm, the exception relates to a period of data cleansing where some incidents were re-coded adding to an increase in number. This has now settled. Areas for inpatient falls were shown to relate to one specific ward, with a small number of patients with a number of falls; the care and treatment of each individual was examined and appropriate care plans, risk assessments and actions were in place to prevent future falls.

There has been a fall in medication administration errors which relates to a change in the recording of the *use of intra-muscular medication to manage aggression*, which has transferred to be recorded under violence and aggression. Patient on patient physical violence (priority), pressure ulcers, absent without leave incidents remain in normal variation range. Each month this data is reviewed and discussed with specialists and care groups to ensure we understand and are doing everything we can to minimise patient safety incidents. There are no further patterns or trends to report at this point in time, but work continues to develop for how we close the loop and capture outputs / themes / trends.

The weekly patient safety oversight group (PSOG) ensures timely and detailed review of all incidents rated amber or red for potential harm or risk, staffing incidents, plus all incidents, however rated, that relate to protected characteristics and prone restraint. We have continued to develop the group through the year and hope this will continue to evolve during 2025/26.

In relation to PSIRF, positive feedback has been received through the year from staff involved in learning responses. Staff are valuing being included in reviews and being able to be part of the solutions. They report finding the processes to be inclusive, and enabling supportive, open conversations focussed on learning and improvement (See Appendix B). In addition, the discussions reflect a move to thinking about systems rather than individuals and where we can strengthen systems to improve safety.

Discussion about the engagement and involvement of affected people has increased as a result of PSIRF during the year. There have been areas of positive practice, but also revealed some areas for further improvement, which will be addressed through our PSIRF review. Communication and collaboration about patient safety has been strengthened and as a result we hope our patient safety culture is improving. Our oversight of patient safety is evolving with new structures, and we continue to invest in our relationships with partners across the region.

Over the next 6-12 months, the Patient Safety Support Team will be focused on the following priority areas:

Priority development area	**Activity includes**
Review of Patient Safety Incident Response Framework (PSIRF)	• Reviewing PSIRF journey including reflections on our experiences • Revised PSIRF plan, policy and procedures • Understanding our improvement activity • Engagement and involvement of those affected by patient safety incidents • Incorporating feedback from the Royal College of Psychiatrists Safety Incident Response Accreditation Network (SIRAN) assessment • Continue to evolve our Patient Safety Oversight Group, Patient Safety Improvement Group and learning systems • Working with our patient safety partners to support the review

Continue to embed patient safety workstreams	• Reflecting on our patient safety specialists' team and ensuring they are appropriately changed and the role defined • Reviewing our approach to Patient Safety Partners including related processes, exploring further recruitment, and working towards attendance at Quality and Safety Committee
Data quality and information management to enhance recording of themes, trends and analysis	• Embedding actions from our review of reporting to Learn from Patient Safety Events (LFPSE) • Exploring the recording of good care examples (Safety II thinking – learning from what has gone well) • Establishing a real time surveillance group for apparent suicides to review data at an early stage • Continue to develop ways to review patient safety data to help monitor trends including through an ethnicity lens • Continue to work with colleagues at Cheswold Park Hospital as they integrate into Trust policies and procedures. • Improve how we close the loop at the end of learning responses
Procurement process for our risk management system	• Work with procurement team and other corporate teams to undertake a procurement process to explore options for a replacement risk management system to ensure best value for money, user experience, and quality information

Helen Roberts
Patient Safety Specialist
May 2025

Appendix A Statistical process charts of incidents reported

Rolling 24-month data to 31 March 2025.

This Appendix shows statistical process charts (SPC) for the following incident data:

- Part A - All incidents reported Trust wide
- Part B - Patient safety incidents - the data in this section of the report will focus around patient safety priority areas identified in the Trust's Patient Safety Incident Response Plan. SPC data will be displayed where possible along with any relevant updates from improvement work and/or learning response activity.

Statistical process control - summary icons key

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS

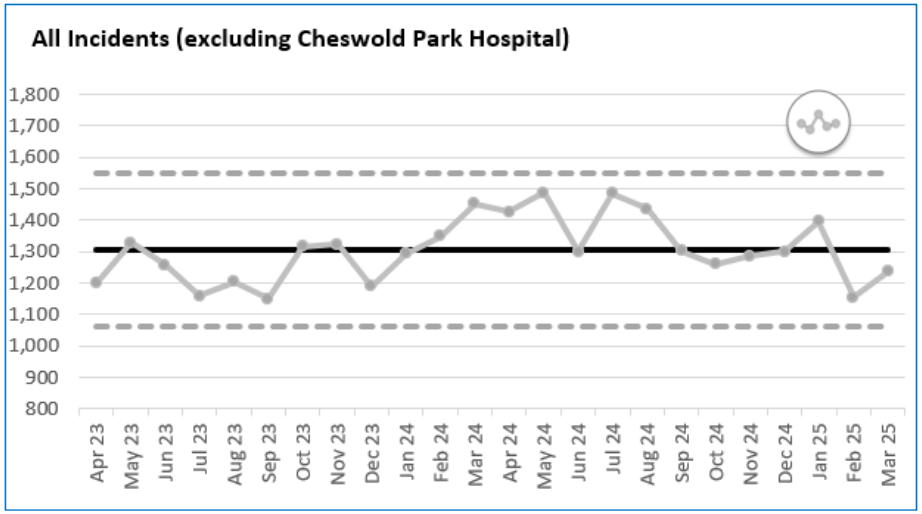
	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart, you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers, but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers, but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers, and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers, and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

3

Note:
This section does not include Cheswold Park Hospital data

Note:
Percentage figures stated may not total 100% due to rounding

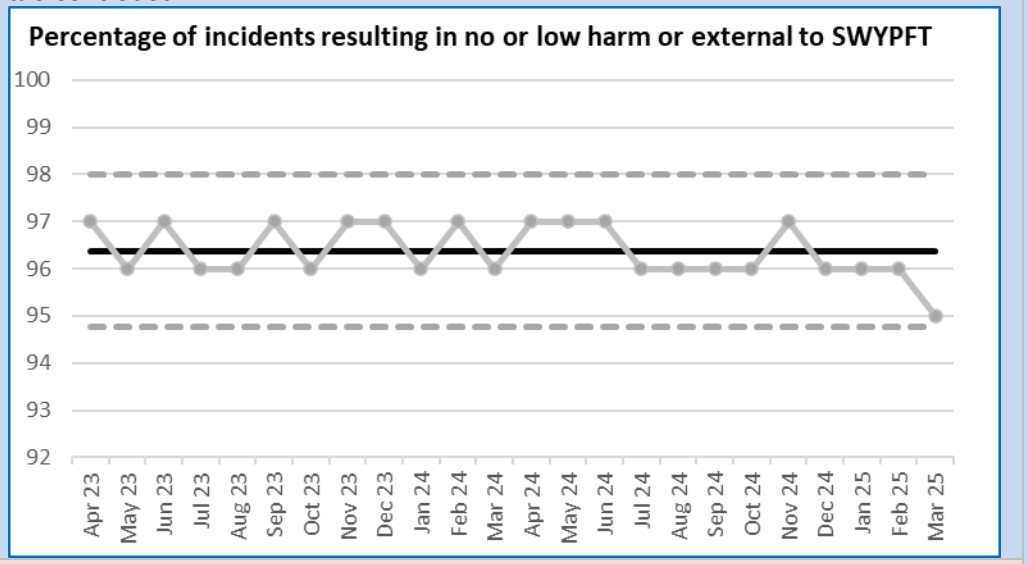
Part A All incident data

All incidents reported Trust wide		**Comment** The Trust continues to see 'normal' variation in the number of incidents being reported. Between February and August there were some higher reporting rates per month, which were explored and related to increases in green no/low harm incidents which is an indication of a positive reporting culture. The Patient Safety Support Team will continue to monitor data. There were no 'Never Events' reported in this period.

Percentage of all incidents resulting in no or low harm or which were external to SWYPFT care

This SPC chart shows the percentage of incidents each month which resulted in no or low harm, or which were external to the Trust's care (e.g. reported for good practice/ awareness) against all incidents up to 28 February 2025. Overall, this is 96%.

At the time of reporting, more recent months data is often still under review. This can result in the appearance of a lower percentage of no/low harm /external incidents however, when analysis has been done, this often increases overtime as reviews are concluded.



Improvement work

The initial review by the Patient Safety Support Team (PSST) has revealed that at the point of the team review of incidents (ward/team and PSST), harm levels are not always confirmed, and due to the volume of incidents to work through, the opportunity to revisit harm levels is not available routinely, which may result in some cases remaining with an upwardly biased harm level which is not accurate. The Patient Safety Support Team reviewed the degree of harm over the past year to ensure accuracy in harm levels as far as possible.

Data analysis

In analysing the impact of the percentage difference of a potential increase in moderate harm or above, staff are encouraged to initially upwardly report the harm level where this is not confirmed at the time of reporting, to ensure the appropriate response is made. This can then be revised as further information is known and historic data is routinely refreshed.

As a result of the introduction of Learn from Patient Safety Events (LFPSE), incidents which result in harm (moderate and above) now includes prolonged psychological harm (>=28 days). This may account for a small change in the percentage as the combined harm levels increased overall. LFPSE was introduced in the Trust in February 2024.

Where harm is moderate or above, it includes harm to staff members as well as patients.

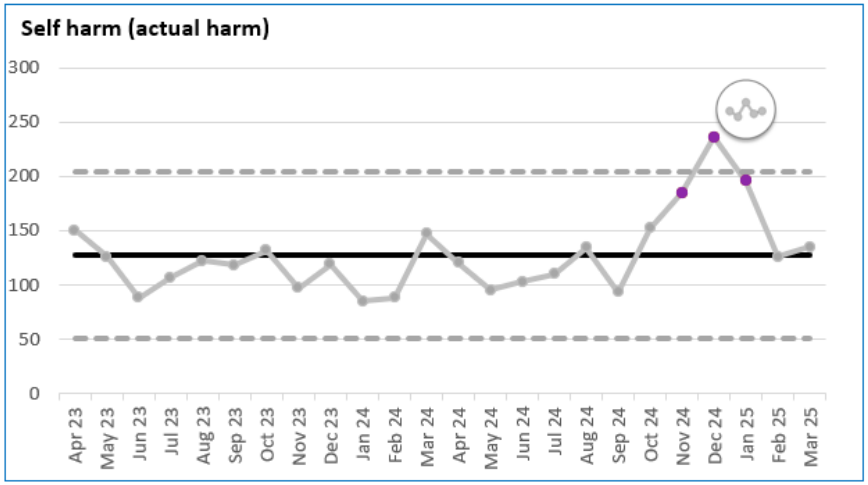
The top 3 types of incidents resulting in higher levels of harm are pressure ulcers (which can fluctuate), violence and aggression (physical contact against staff is highest) and self-harm (actual harm). Moderate harm often reflects attendance at A&E for treatment.

The top 3 types of incidents resulting in higher levels of harm are also categories explored further in Part B.

Part B Patient safety incidents

Notes:
This section of the report includes SPC charts over 24 months and reflections on related improvement work and/or learning response activity covers the period since PSIRF went live from 1 December 2023. The data aligns with the PSIRF plan and may not be the same as data in other reports. For example, the falls data below is in inpatient settings only; other reports may contain data on all falls. Care should be taken not to compare with data from other sources.

*Ethnicity - person affected may be more than one for each incident
Not all percentages may total 100% due to rounding.

Patient safety priority	Statistical Process Control chart (where available)	Comments on data and PSIRF work
Self-harm **PSIRF plan focus:** • Inpatient – self harm associated with ligatures or swallowing objects • Community – overdose of prescribed medication		**Data analysis** The Trust saw a period of special cause variation in the number of self-harm incidents between November 2024 and January 2025. These data points have been explored and the peak in December corresponds with the data cleansing for attempted self-harm and these being re-coded to actual self-harm. Of these incidents 96% resulted in no harm/low harm or unrelated to SWYPFT care and 4% resulted in moderate harm. In 2024/25: <u>MH inpatient</u> 88% of incidents occurred in mental health inpatient setting. 74% of these resulted in no/low harm or were unrelated to SWYPFT care. 21% resulted in moderate harm requiring acute hospital treatment. 5% resulted in severe harm. 89% of these incidents recorded the person/s affected as being from a White - English/Welsh/Scottish/Northern Irish/British or other white background ethnicity. 8% data was not recorded/not stated. <u>MH community</u> 12% of incidents were reported by mental health community teams. 97% of these resulted in no/low harm or were unrelated to SWYPFT care. 3% resulted in moderate harm. 77% of incidents recorded the person/s affected as being from a White - English/Welsh/Scottish/Northern Irish/British or other white background ethnicity. 14% data was not recorded/not stated. 5% were recorded as Asian/Asian British and 3% were recorded as Mixed/multiple ethnic groups - white and black Caribbean.

Improvement work
This is a joint plan for self-harm and suicide prevention. Update included under the Suicide prevention section.

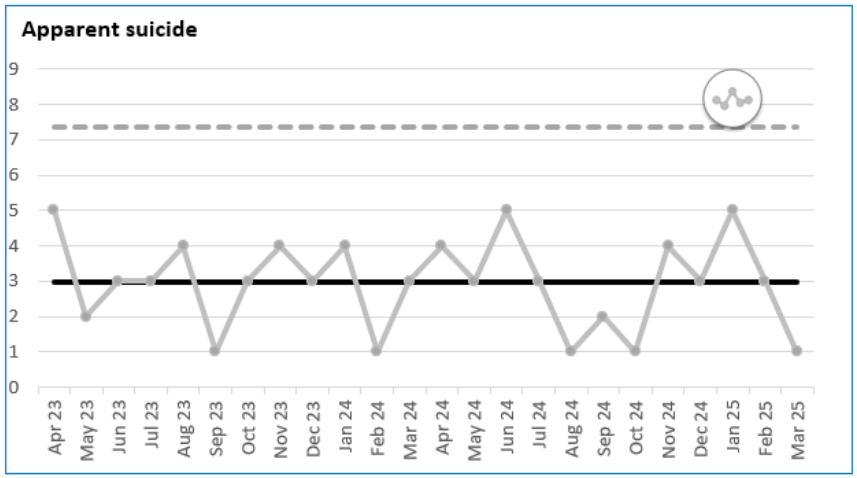
Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review	115
Debriefs	136
After Action Review	0
Specialist Learning Review	1
Case Note Review	2

Sharing learning During 2024/25, learning relating to self-harm risks/methods have been shared with all staff including 13 Bluelight alerts and 2 learning summaries regarding self-harm risk from specific issues.

Apparent suicides

PSIRF plan:
Focus on suicide prevention at team level



Improvement plan for suicide prevention and self-harm
During 2024/25 the following improvement work has been undertaken:

- PSII thematic work involves the review of all historical incidents of inpatient apparent suicides. Due to delays in completion, it was agreed that 2024 data of apparent inpatient suicides would also be included. Two multi-professional meetings have taken place and lines of enquiry established and alignment with existing workstreams. A draft report is being prepared.
- Removing access to means guidance updated to align with national workstreams
- Updated SBAR which provides staff insights and awareness of removal of access to means including embedding online harms training on ESR
- SafeTALK training delivery
- Ongoing ASSIST training delivery
- Suicide prevention in the workplace
  Development of the suicide prevention work plan
  Apparent suicide reports completed for 2022/23 and 2023/24.

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review	76
Debriefs	27
After Action Review	4
Specialist Learning Review	1
Case Note Review	11
Structured Judgement Review	4
Patient Safety Incident Investigation	2

Data analysis
This graph includes all apparent suicides reported on Datix in line with the Learning from Deaths policy. This data includes deaths that appear to be suicides of service users under the Trust's recent care. Apparent suicide does not indicate the coroner's conclusion. Records will be updated as further information comes to light, e.g., if coroner's conclusion is natural causes or confirms suicide. Data may change over time. This graph uses the incident date.

91% of the apparent suicides in 2024/25 occurred in community mental health settings.

8% (3) of the apparent suicides in 2024/25 were recorded by inpatient mental health services. Of these deaths, all occurred in the community or non-mental health inpatient settings (e.g. whilst on leave from the ward).

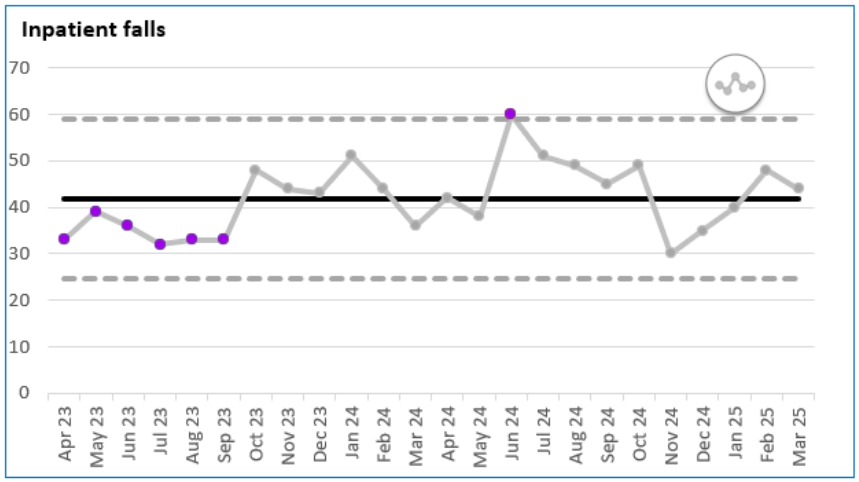
78% of those who died had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 4% had a recorded ethnicity of Asian/Asian British – Indian. 4% had a recorded ethnicity of Mixed/multiple ethnic groups - other mixed or multiple ethnic groups.10% data was not recorded/not stated.

SPC data is monitored monthly at the operational management group.

Inpatient falls

PSIRF Plan:

- Learning from well managed incidents and/or near misses
- Priority area covered by Improvement plan
- Learning response by exception only



Improvement plan updates 2024/25

- We maintained falls rates per 1000 bed days under the National average, and falls related patient safety events accounted for only 4% of all Datix events reported Trust wide
- Falls education - 78% of staff working on wards experiencing higher falls rates have received falls education, and shared staff learning and focus on falls supports ongoing education
- Cheswold Park Hospital staff have received training to use the falls risk screening, and Post falls Protocol. Their patient group is meeting NICE guidelines for falls, and will be monitored
- Safety Huddles – are taking place regularly on some wards. These wards have reported positive outcomes including improved communication, and reduced patient safety events linked with falls and violence & aggression
- Falls awareness week – working alongside the Barnsley Integrated Team, Comms Team and Patient Safety Support Team we ran several initiatives including patient education, Creative Minds session, stalls at Barnsley Market and a half day conference
- FRAT-18: this has been fully reviewed and is now live on SystmOne. Feedback from staff has been positive.
- Bone Health Screening: this is a Trust developed tool to support staff in understanding if the patient is at risk of osteoporosis and gives some guidance around treatment options.

Data analysis

The Trust saw a point of special cause variation in June 2024 for inpatient falls. This was attributed to an increase in falls on Poplars with a small number of patients who had multiple falls. The falls attributed to these patients resulted in no harm or low harm. Care for each patient was reviewed to ensure that all actions to prevent falls was in place.

The Falls coordinator promotes the reporting of falls incidents including where no harm occurred and raised awareness of the importance of reporting no harm events and impacts on the number of green fall incidents from which we can learn.

In 2024/25:
95% occurred in mental health inpatient wards and 5% in general community wards.
83% had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British or other white background. 3% had a recorded ethnicity as Asian/Asian British – Indian. 3% had a recorded ethnicity as Asian/Asian British – Pakistani. 9% of data was not recorded/not stated.

60% of these resulted in no harm, 35% resulted in low harm, 4% resulted in moderate harm and <1% resulted in severe harm requiring acute hospital treatment (typically fractures).

More detailed information is discussed at the Falls prevention and bone health group.

Future work

- Robust governance and review of falls related patient safety events to ensure we continue to provide high quality patient assessment and intervention to reduce falls risks. This work supports identification of any potential learning through horizon scanning review
- To ensure we are offering multifactorial assessment to optimise safe activity and mobility planning to meet the new Nationally led guidance from the Royal College of Physicians, National Audit of Inpatient Falls (NAIF) and NICE quality standards
- To review the use of post falls checks prior to a patient being moved, supporting staff with decision making in emergencies
- To review bone health screening, and developing a governance pathway
- eFalls pilot study, making sure we are relevant today and ready tomorrow

Sharing learning

During 2024/25, learning relating to falls risks have been shared with all staff including a learning summary regarding confusion and falls, and a case study following an inpatient fall involving a medical device brought in from home.

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

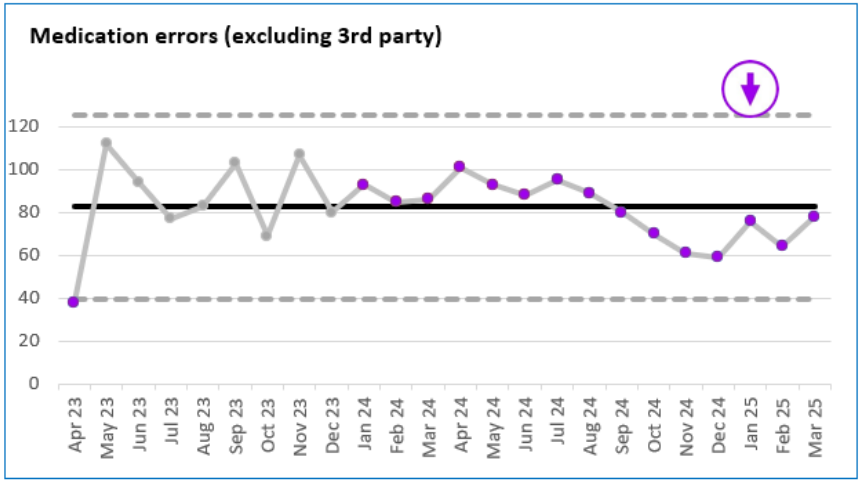
Because of extensive improvement work, we did not identify any instances in our PSIRF plan where we would routinely conduct a learning response although this can be done by exception. However, some tools have been used for identifying local learning and for reflection:

Managers 48-hour review	16
Debriefs	33
After Action Review	1
Specialist Learning Review	1
Case Note Review	

Medication errors

PSIRF plan:

- Administration of insulin
- Medication storage (fridges/clinic rooms)



Improvement plan

Through 2024-25 work has included:

- Continued to share learning/updates through Greenlight alerts
- Implemented Electronic Prescribing Medication (EPMA) and reporting starting to be shared
- Out of hours leave training package completed
- Common stock list implemented and embedded – further review to ensure effectiveness
- Discharge medicines service KPI performance above national average
- SystmOne Clozapine template implemented
- SystmOne Lithium template implemented
- Unity Centre project rolled out across wards
- AdIoS system completed
- Green bag project rolled out across the Trust
- STOMP rolled out across the Trust

Future work:

- Working with the nursing directorate on:
  - EPMA reporting
  - Addressing administration error themes

Data analysis

The Trust continues to see 'normal' variation in the number of medication errors with a downward trend in incidents through 2024/25. This can be attributed to the removal of incidents that were previously recorded under medication errors for the ***use of intra-muscular medication to manage aggression*** which was recategorized (in Q3) to a violence and aggression category by RRPI TAG. These types of incidents are now excluded from the SPC chart for medication errors.

In 2024/25:
68% occurred in mental health inpatient wards
20% occurred in mental health community
11% occurred in general community
1% occurred in general community inpatient wards

66% of medication errors in inpatient settings had a recorded ethnicity of White - English/Welsh/Scottish/ Northern Irish/British or other white background. 6% had a recorded ethnicity of Asian/Asian British – Pakistani, 4% were recorded as Black/African/Caribbean/Black British – African. 7% were from ten other minority ethnic groups.18% of ethnicity data was not recorded/not stated.

In community settings, 76% of medication errors affecting patients had a recorded ethnicity of White - English/Welsh/Scottish /Northern Irish/British. 7% were from a wide range of other ethnic groups. 16% data was not recorded/not stated.

In all settings 92% of medication incidents resulted in no harm, 7% with low harm and <1% resulted in moderate harm.

More detailed information is discussed at the Safe medicines practice group.

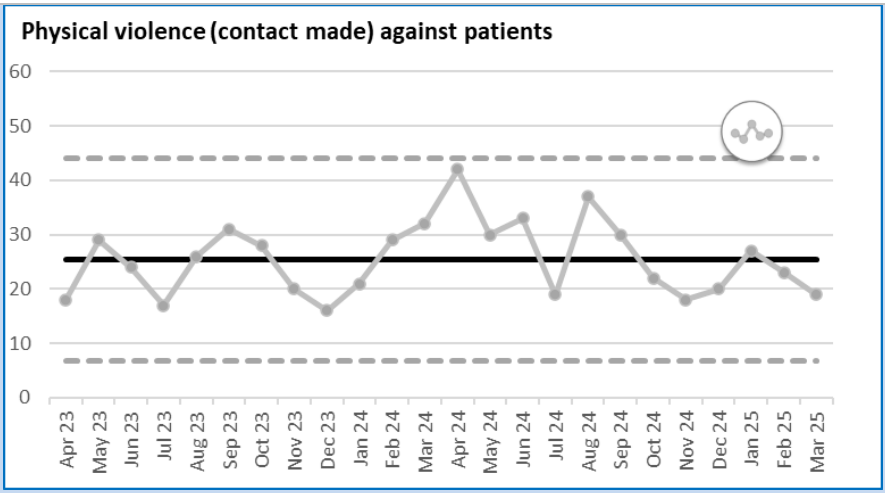
Sharing learning
During 2024/25, learning relating to medication safety have been shared with relevant staff through Greenlight alerts. These include monitoring Olanzapine 3 hours post injection, rescue medications and some regarding prescribing promethazine hydrochloride, clonazepam and prescribing on EPMA.

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review	56
Debriefs	99
After Action Review	1
Specialist Learning Review	2
Case Note Review	1

Violence and aggression against patients

- Violence resulting in moderate harm or above
- Incidents involving use of force resulting in moderate harm or above
- Incidents where system issue identified



Data analysis
The Trust continues to see 'normal' variation in the data.

95% of incidents occurred in MH inpatient settings. 4% of incidents occurred in MH community settings and <1% occurred in general community settings.

74% of physical violence against patients in inpatient settings had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British or other white background.
7% had a recorded ethnicity of Asian/Asian British - Pakistani. 3% had a recorded ethnicity of Black/African/Caribbean/Black British – African. 7% were from a wide range of other ethnic groups. 7% data was not recorded/not stated.

59% of violence against patient incidents resulted in no harm, 36% with low harm and 4% resulted in moderate harm. <1% resulted in prolonged psychological harm.

More detailed information is discussed at the Reducing restrictive physical intervention group.

Improvement plan
Our improvement plan for reducing restrictive physical interventions sits with the Reducing Restrictive Physical Intervention (RRPI) team. Achievements during 2024/25 include:

- Maintained RRN accreditation
- Achieved RRN accreditation in mechanical restraint
- The band 3's in the team were successful at achieving teaching qualifications
- The team have increased training compliance achieving the Trust target of over 80% currently sits at 86%
- Started the in-reach work for the Trust ambition of zero prone
- Continuing to reduce the use of prone restraint[2]
- Continuing to reduce the incidences of seclusion[3]

Further detail on the above is available in the Quality Account report or separate reports.

Sharing learning
During 2024/25, a learning summary has been circulated regarding recording data on Datix for an incident of Violence and Aggression

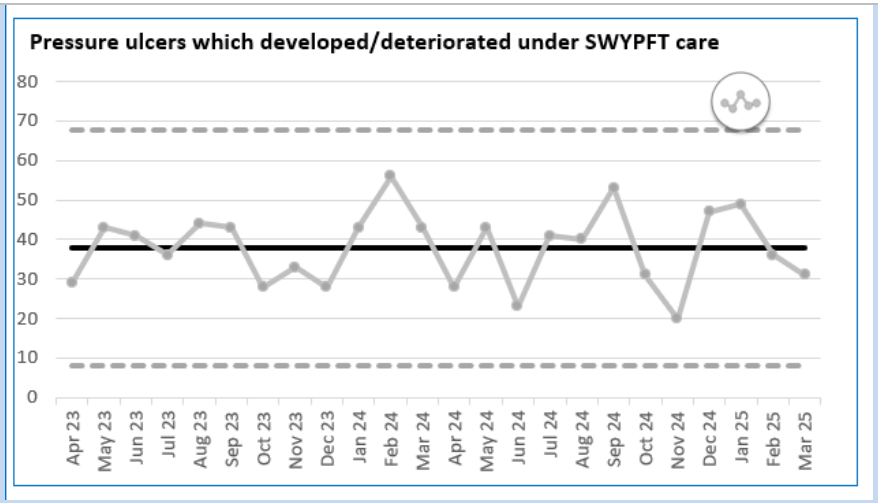
Learning responses used for decision making and reflection (01/12/2023 – 31/3/2025)

Managers 48-hour review	17
Debriefs	37

[2] Prone restraint is a type of restraint which involves holding a person chest down, whether the service user has placed themselves in this position or not, and whether the person is face down or has their face on the side) across inpatient services
[3] seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient 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- Mental Health Act (MHA) Code of Practice) across inpatient services.

Pressure ulcers

- Category 2 resulting in learning not covered in existing improvement work.
- Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life)
- Clinical documentation including Waterlow risk assessment



Data analysis

The Trust continues to see 'normal' variation in the number of pressure ulcers category 2, 3 or 4 which developed / deteriorated under SWYPFT care.

The majority of incidents (98%) in 2024/25 were reported by Barnsley physical health services, however there were 8 incidents reported by Mental Health Care Group (Inpatient) and 1 incident reported by general community inpatient ward.

95% of incidents had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 5% data was not recorded/not stated.

50% of pressure ulcers resulted in low harm (typically Category 2), 46% with moderate harm (typically Category 3) and 4% were recorded as severe harm (typically Category 4). This is based on the pressure ulcer severity, rather than any identified problems in care.

Improvement work - through 2024-25 we have:

- ✓ Implemented a foot wound pathway, which sets out the process for podiatry undertaking first assessments for people with foot wounds
- ✓ Phase 1 PURPOSE- T roll out, which is a tool for assessing risk of pressure damage
- ✓ Trial on reducing frequency on completing wound care assessment template (release clinical time)
- ✓ Carried out process mapping of pressure ulcer clinical documentation (as reported in section 2.3.6) and developed new template that is ready for testing
- ✓ Moved to 48-hour manager review and stopped RCA process (release clinical time)

Future work:

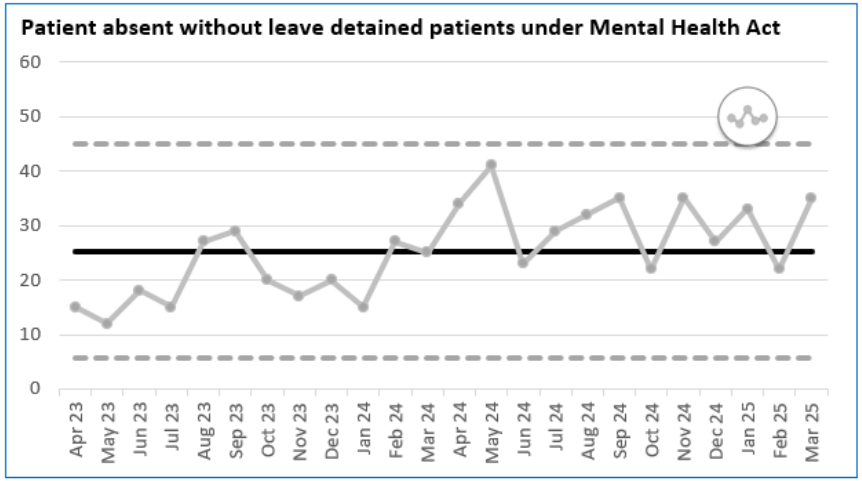
- Ongoing roll out of PURPOSE- T
- Implementation of the new wound care template
- Collection of pressure ulcer data will be captured by clinical record system and flowed into community services data set, but will allow for local analysis
- Pressure ulcer will only be reported through Datix when a patient safety incident has occurred
- Pressure ulcer report
- Updating the wound care policy
- DHSC safeguarding and pressure ulcer tool to be rolled out

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review (completed since May 2024 instead of the historic RCA tool).	231
Debriefs	8
After Action Review	1
Specialist Learning Review	1

Patients absent without leave (AWOL)

- Escape and attempted escapes from the fabric of the building
- Developing new intelligence



Improvement plan

During year one of our PSIRF plan we intended to gather intelligence that would inform future improvement planning. During 2024/25, we have:

- Reviewed the Absent without Leave policy
- Developed information to support staff with the Right Care, Right Person
- Clinical Environment Safety Group continue to review incident data on escapes from inpatient units. They have undertaken specific review of incidents relating to patients leaving The Dales.
- Gardens/courtyards in all inpatient areas have been assessed to reduce risks
- Continued monitoring and review of AWOL incident data to identify themes and trends where further improvement work could be undertaken

Learning responses to understand, review and reflect (01/12/2023 – 31/3/2025)

Managers 48-hour review	56
Debriefs	36

71% of incidents had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 12% had a recorded ethnicity of Asian/Asian British – Pakistani. 8% of incidents had a range of other ethnic groups recorded. 8% data was not recorded/not stated.

Data analysis

Incidents are within normal variation.

Analysis shows that the majority of AWOL incidents resulted in no harm (93%). The remaining incidents (7%) resulted in low harm.

There was one patient who was AWOL from escorted leave to the general hospital which resulted in death due to suicide. This incident is included in the apparent suicide figures above.

Of the incidents in 2024/25:

48% failed to return from planned leave, 32% absconded from staff on escorted leave 9% escaped from inpatient units, 5% attempted escapes that were prevented, 3% were unauthorised leave e.g. in excess of S17 arrangements, 2% absconded for other reasons e.g. from acute hospital, from family whilst on leave. 1% of incidents were recorded as AWOL – other. Work has been carried out in 24/25 to improve recording of AWOL incidents.

Of those who did not return to the ward as planned, the below details how they returned to the ward:

How did the patient return to the ward	%
Returned voluntarily	36
Returned by police	31
Returned by hospital or other staff	15
Not completed	7
Returned by family member	6
Other (please specify in description) See below breakdown:	5
Not stated in description	3
Returned with ambulance staff	1
Returned by staff	0.4
Returned by friend	0.4
Returned by taxi	0.4

Physical health/mental health • Deteriorating physical health of mental health patients • Issues with medical devices	SPC data is not currently available. This is due to the range of categories of incidents which may fit these criteria, with some issues being contributory in other incidents.	

Improvement plan

Throughout 2024/25 we have:

- Implemented training and education for staff to have deeper understanding of holistic patient care, embracing mental health / learning disability and physical health. The trust has invested in clinical skill facilitators and other specialist teams e.g. speech and language, that support clinical team with physical health, providing programmes of hands-on training to services and care groups: e.g.: Physical health, NEWS2, A-E assessment, GCS/head injury observations monitoring, Falls and post falls assessment, Dysphagia, Sepsis, Long term condition management, Palliative and end of life care, ReSPECT, Compression bandaging and competencies, for staff where needed.
- Implemented Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) within the Trust, now embedding into practice
- Improved Tissue viability referrals and support for inpatients
- Developed head injury and A-E procedures & tools to support effective patient management
- Established a new Physical Health Operational Steering Group
- Developed a physical health in mental health and learning disabilities strategy
- A Bluelight alert around choking has been reissued, along with promotion of training. Datix incidents continue to be reviewed. Care plans have improved and referrals to Speech and Language Therapists have supported care planning

Future work

- Embed the new Physical Health Operational Steering Group, as a collaborative forum to improve patient physical health and share practice
- Review inpatient wound care management training and formulary. This will support with effective choice of dressing, reduce antimicrobial prescribing, cost improvement and sustainability
- Review potential digital recording of clinical observations

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review	55
Debriefs	57
Case Note Review	2
Structured Judgement Review	1

Sharing learning

During 2024/25, learning summaries have been circulated regarding staff purchasing their own medical devices to be used in clinical settings, analysis of incident involving a medical device and advice regarding urinary retention. A case study following an inpatient fall involving a medical device brought in from home was also shared.

Transitions in care

- Issues with transitions between:
- inpatient and community teams
- between community teams

SPC data is not currently available. This is due to the range of categories of incidents which may fit these criteria, with some issues being contributory in other incidents.

Although we said we would not undertake improvement work during 24/25, some progress has taken place around transfer of care protocols:

- ✓ Reviewed the transfer of care protocols which are in place between SWYFT and Barnsley Hospital NHS Trust and Calderdale and Huddersfield Hospital (separate protocols with the two hospitals)
- ✓ Liaison with colleagues at the Acute Trusts to understand their experience of following the transfer of care protocols
- ✓ Liaison with Trust colleagues from mental health inpatients, including medics and ward managers to understand their experiences of using the protocols
- ✓ Changes made to the protocols through this engagement work and incorporating the learning from patient safety incidents
- ✓ Gathering of learning from patient safety incidents and learning reviews which have been completed

Future work:

- Continue to engage with acute Trust colleagues to complete updated protocols
- Ensure this is well communicated to staff within the Trust who can utilise this protocol
- Increase knowledge of RightCare Barnsley to support the transfer of care of service users to Barnsley Hospital
- Undertake work to understand the effectiveness of the updated protocols once in place and review and amend as necessary, in collaboration with all relevant parties.

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Managers 48-hour review	19
Debriefs	9
Thematic review*	1

*Thematic review – a thematic analysis was completed as part of the development of a case study on transitions in care. Data was analysed and this will inform future improvement work.

Sharing learning

During 2024/25, a learning summary was shared regarding transitions between CAMHS and primary care services.

Healthcare acquired infections	Four incidents between 1/12/2023 and 31/3/2025 therefore no SPC chart provided.

Improvement plan
Our infection prevention and control (IPC) team continue to deliver on improvement work with services to reduce and manage IPC incidents and improvement workstreams. Throughout 2024/25 this has included:

- Trust's Infection prevention and control (IPC) annual programme outlines the IPC priorities, objectives and quality improvement actions and sits alongside the day-to-day preventative and reactive workings, inclusive of healthcare associated infections (HCAI's) of the IPC service
- Give high priority to surveillance of alert organisms and other infectious organisms. Post infection review (PIR) process for alert organisms with partner healthcare organisations routinely performed by IPC team with learning reported to IPC TAG and shared with Clinical governance groups and Care group clinical governance groups.
- Continue to maintain over 80% compliance with IPC and Hand hygiene training
- Above average result on PLACE

Future work:

- Improve FFP3 Fit testing compliance for the Trust
- Increase season vaccination rates
- Embrace and support antimicrobial resistance and stewardship plans

Learning responses to understand, reflect and learn (01/12/2023 – 31/3/2025)

Case Note Review	2

Sharing learning

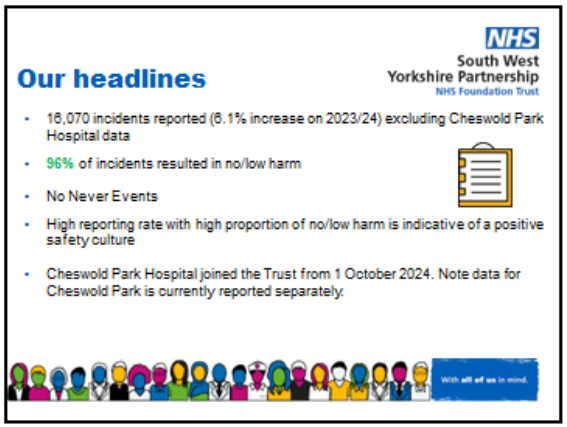
During 2024/25, a Bluelight alert was circulated to all staff regarding risks with Biozoon Air.

Appendix B Learning from experience slides

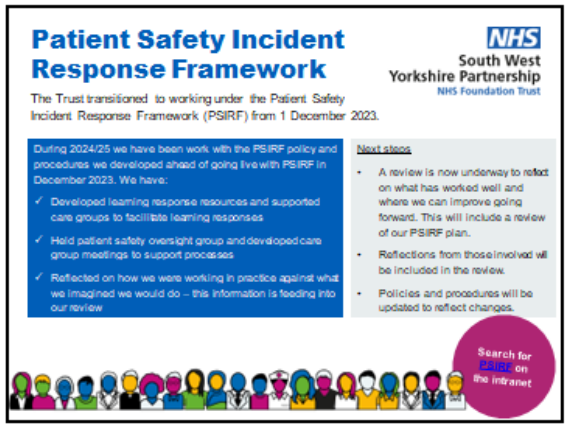
Below is an illustration of our Learning journey presentation that brings together learning through the year 2024/25.



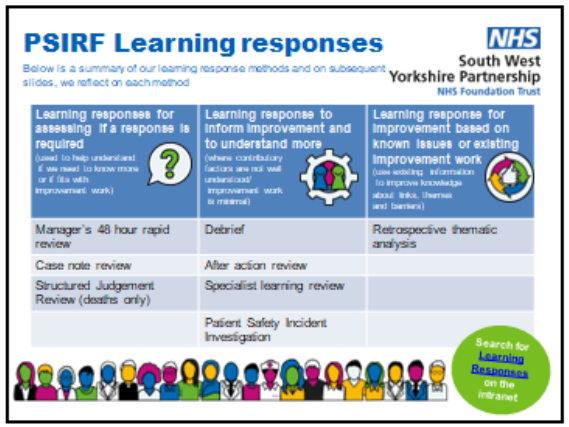
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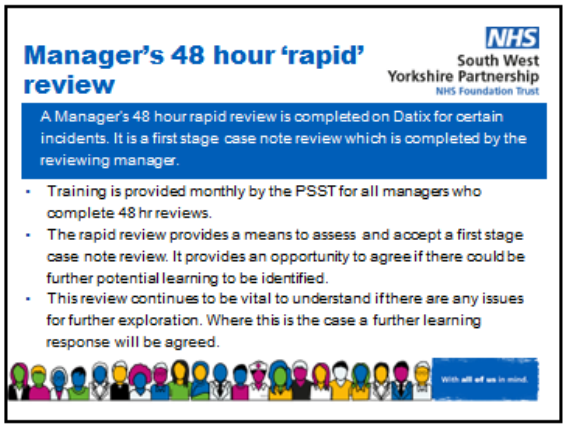
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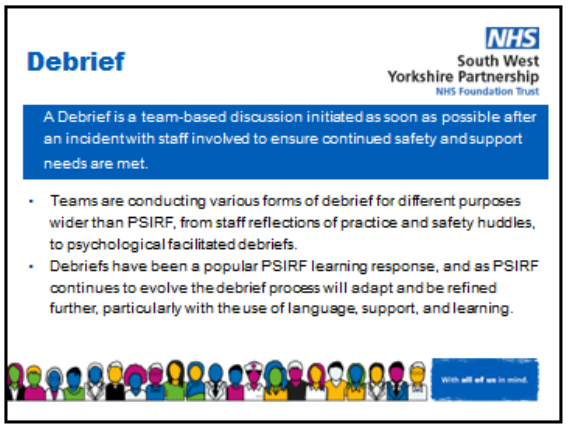
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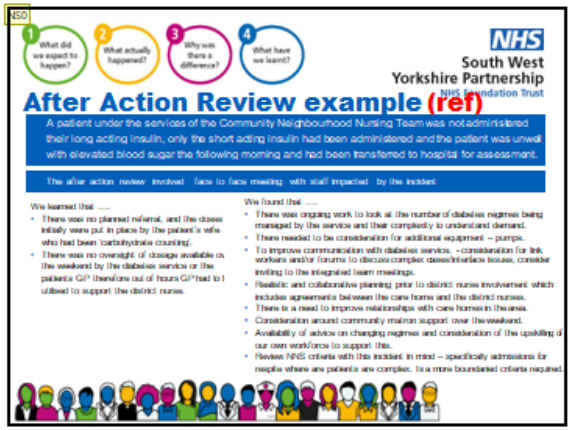
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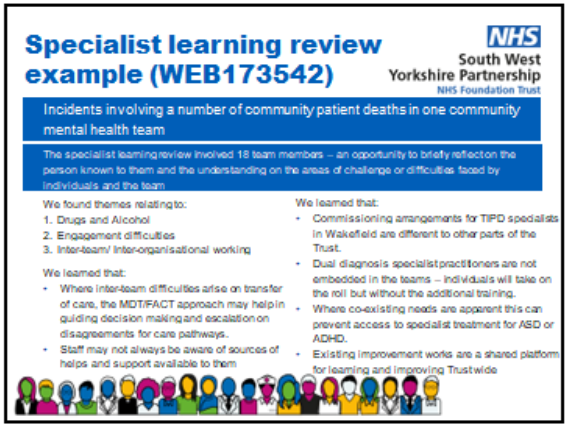
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Debrief themes
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Debrief completed within Early Interventions community team following the death of a service user
Debriefs have involved staff directly and indirectly affected by the incident
Common themes have found the process:
✓ Gives staff time and space to stop and reflect
✓ Ensure staff wellbeing is checked and support arranged
✓ Ensure FLO is linked if indicated
Learning points noted from above incidents:
• Understanding and reflecting on the incident enables reflection on individual and team processes around record keeping
• Manager and lead clinician contact with the family face to face following the death was well-received.
• Involvement and engagement from FLO to help signpost for support for young family members and those who live further afield
• Ensuring that information sharing packs for families have full contact details and direct to duty in staff absence.
With all of us in mind.

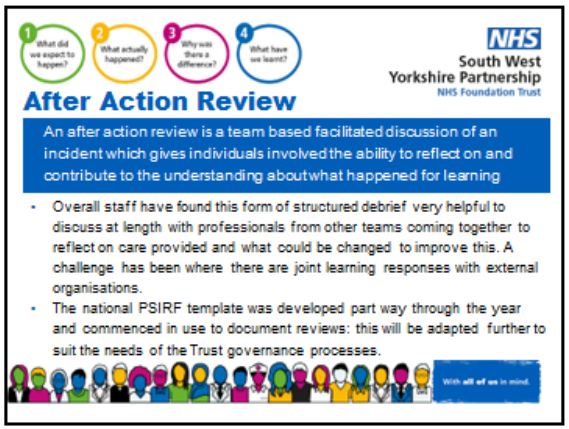
7


1 What did we expect to happen?
2 What actually happened?
3 Why was there a difference?
4 What have we learnt?
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
After Action Review example (ref)
A patient under the services of the Community Neighbourhood Nursing Team was not administered their long acting insulin, only the short acting insulin had been administered and the patient was unwell with elevated blood sugar the following morning and had been transferred to hospital for assessment.
The after action review involved face to face meeting with staff impacted by the incident
We learned that .....
• There was no planned referral, and the doses initially were put in place by the patient's wife who had been 'carbohydrate counting'.
• There was no oversight of dosage available on the weekend by the diabetes service or the patients GP therefore out of hours GP had to t utilised to support the district nurses.
We found that .....
• There was ongoing work to look at the number of diabetes regimes being managed by the service and their complexity to understand demand.
• There needed to be consideration for additional equipment – pumps.
• To improve communication with diabetes services. - consideration for link workers and/or forums to discuss complex cases/interface issues, consider inviting to the integrated team meetings.
• Realistic and collaborative planning prior to district nurse involvement which includes agreements between the care home and the district nurses.
• There is a need to improve relationships with care homes in the area.
• Consideration around community matron support over the weekend.
• Availability of advice on changing regimes and consideration of the upskilling of our own workforce to support this.
• Review NHS criteria with this incident in mind – specifically admissions for people where are patients are complex. Is a more boundaried criteria required.

9


Specialist learning review example (WEB173542)
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
Incidents involving a number of community patient deaths in one community mental health team
The specialist learning review involved 18 team members – an opportunity to briefly reflect on the person known to them and the understanding on the areas of challenge or difficulties faced by individuals and the team
We found themes relating to:
1. Drugs and Alcohol
2. Engagement difficulties
3. Inter-team/ Inter-organisational working
We learned that:
• Where inter-team difficulties arise on transfer of care, the MDT/FACT approach may help in guiding decision making and escalation on disagreements for care pathways.
• Staff may not always be aware of sources of helps and support available to them
We learned that:
• Commissioning arrangements for TIPD specialists in Wakefield are different to other parts of the Trust.
• Dual diagnosis specialist practitioners are not embedded in the teams – individuals will take on the roll but without the additional training.
• Where co-existing needs are apparent this can prevent access to specialist treatment for ASD or ADHD.
• Existing improvement works are a shared platform for learning and improving Trust wide

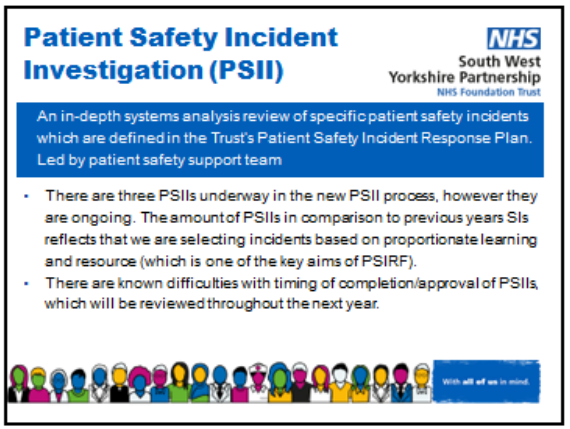
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1 What did we expect to happen?
2 What actually happened?
3 Why was there a difference?
4 What have we learnt?
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
After Action Review
An after action review is a team based facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened for learning
• Overall staff have found this form of structured debrief very helpful to discuss at length with professionals from other teams coming together to reflect on care provided and what could be changed to improve this. A challenge has been where there are joint learning responses with external organisations.
• The national PSIRF template was developed part way through the year and commenced in use to document reviews: this will be adapted further to suit the needs of the Trust governance processes.
With all of us in mind.

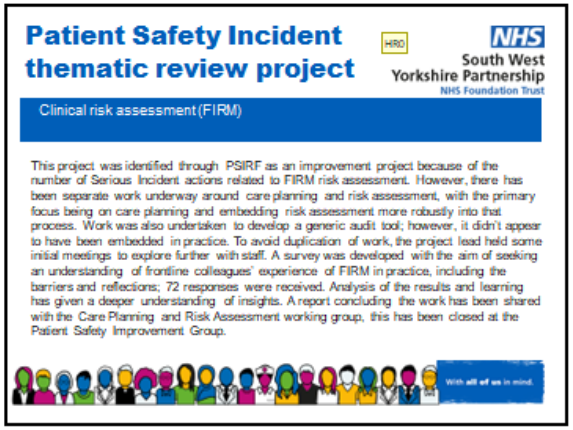
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Specialist learning review
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
A specialist learning review is used to identify learning from multiple patient safety incidents and explore a safety theme, pathway and process
• Gaining feedback forms after the event does prove challenging and so asking for feedback at the time would be advantageous. The majority of people in attendance report some positives from the experience, there are still some difficulties in adapting to the changes and ensuring staff fully understand the process – managing expectations of large numbers of people, ensuring all have a voice and systems analysis is championed in the experience remains of importance.
• Where there is discussion on areas of learning it is important to consider if an action should be documented and carried into an action plan in Datix to map better outcomes and any solutions created.
• A new and revised approach to sharing updates and learning from patient safety related incidents would be an advantage, staff report not always being aware of the release of learning summaries.

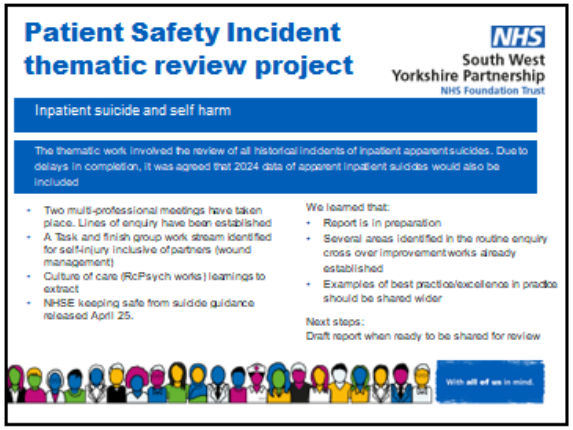
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Patient Safety Incident Investigation (PSII)
NHS
South West
Yorkshire Partnership
NHS Foundation Trust
An in-depth systems analysis review of specific patient safety incidents which are defined in the Trust's Patient Safety Incident Response Plan. Led by patient safety support team
• There are three PSIIs underway in the new PSII process, however they are ongoing. The amount of PSIIs in comparison to previous years SIs reflects that we are selecting incidents based on proportionate learning and resource (which is one of the key aims of PSIRF).
• There are known difficulties with timing of completion/approval of PSIIs, which will be reviewed throughout the next year.
With all of us in mind.

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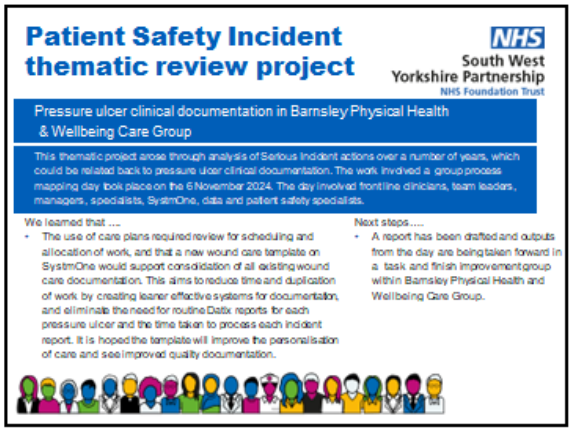
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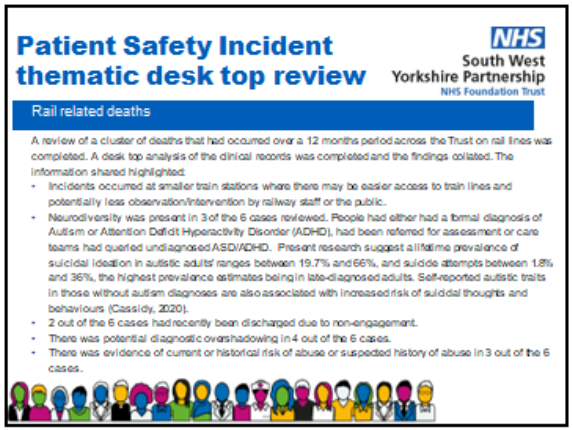
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Mental Health Inpatient Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- AAR on another ward highlighted gaps in the understanding of the responsibilities of nurse in charge role, including oversight of tasks being completed or delegated with clear leadership by nurse in charge which will remove any assumptions around completion of tasks. Handover processes have been reviewed and training delivered to appropriate staff.
- SLR completed identified areas of improvement around food and fluid charts and record keeping along with access to skilled dietetic advice particularly if associated with unfamiliar challenges such as ARFID. This work is picked up through the dietetic leads
- Inpatient wards analysis of amber incidents has highlighted challenges on access to means, had linked to a review of restricted and or banned items works. This had been picked up as a task and finish group and work is ongoing.
- Transfer and discharge incidents have highlighted issues relating to communication between referring teams to the admitting teams, where handover of information has been minimal, leading to delays in recognising complications, and involvement of family. It has also highlighted good practice around robust NEWS monitoring and escalation of physical health needs.



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Mental Health Inpatient Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- Service users absconding from the fabric of ward/buildings have been highlighted to the Clinical Environmental Safety Group to review potential workable solutions. There have been actions taken reviewing ward environments, alarms, anti-climb surfaces, locks etc from an estate perspective, and communication to staff on numerous occasions to ensure doors are locked before walking away (to prevent tailgating). Supervision and reflective practice held to reiterate the importance of environmental safety and vigilance on ward environments. Staff awareness of the pre leave protocol.
- Risk assessments and staying safe plans are in a place when service users are admitted which identify immediate risks, and mitigating circumstances are put in place to manage. If the risk of absconding is immediately flagged, restrictions are put in place e.g. access to courtyard, while the team continue to assess individual risks. Another environmental solution being explored would be to introduce airlocks.



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Mental Health Community Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- Weekly incident monitoring groups are well established and run independently. Dashboards have been created to enable review of amber and red incidents. Cluster incidents lower in other colour coding reviewed, incident are being linked in the background to aid review.
- Learning has been identified on the barriers apparent for inter-team communications and transfers of service users in a timely manner. Some positive examples in other areas where teams have been working with highly complex and unpredictable service user risks, demonstrate multi-agency, partnership working across local authorities and with local police to support management and mitigation of risks. Effective care planning with the inclusion and presence of patient safety representative and or other directorate specialists which have enhanced team supported decision making, care planning and risk management.
- Following a case note review completed, a contrasting situation was noted on responses from IHBTT teams when service users are calling on several occasions for support but this is not activated at the time of the calls – there is learning in ensuring that relapse plans are explored and that involvement of family or another trusted person is explored in ensuring safety plans are stable and being followed.



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Mental Health Community Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- An amber IHBTT incident had raised a query over whether assessment of risk to suicide in someone with ASD needs a more direct approach, although not a suggested area of learning as there was no direct cause and effect this individual factor did raise internal team discussion
- There was learning identified following the death of a community service user through suicide, the review identified the need for early care planning at the point of transition from inpatient services. There are existing improvement workstreams in place to improve clinical record keeping standards, care planning and safety planning.
- In some case where there has been a deterioration in service user health which had been felt to contribute to difficult or challenging patient presentation leading to incidents, the reviews have identified areas where a more assertive approach to engagement with mental health teams may have been of benefit. Work is ongoing on care planning and safety planning Trust wide, new keeping safe and keeping well plans are now in use that ensure a personalised approach and identified supportive other engagement.
- There have been a number of incidents relating to self-harm or death where the theme emerging from manager rapid reviews are identifying challenges with co-existing substance misuse. Noted learnings and actions captured within review on improving partner organisation working and where possible presence of Specialist Dual Diagnosis leads in key meetings to guide on care and risk management.



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Mental Health Community Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- There was learning noted within one incident as to the awareness of staff and teams on the support that can be provided for gambling harms – gam care. This local level learning was shared within the team.
- Within one community team a theme on reporting safeguarding concerns in adults had been noted/ improving knowledge, adding to Datix and follow up on outcomes were noted as areas of learning
- For another community team it was noted their main concern was to engage with the service user, which lead to delay in referring to PIPOT and the Safeguarding team. Learning identified that raising concerns must be prioritised over concerns around therapeutic rupture.
- There have been considerations as to whether there were missed opportunities to conduct further face-to-face assessments/visits to establish potential risks and to improve clinical decision making.
- There was learning identified following a violence and aggressive incident whilst an IHBTT team were conducting a home visit. Staff did not have their lone working device on with them to use, to alert police quickly. Following this, the team reflected how unpredictable IHBTT work can be and started to use their lone worker devices.



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Children, Young People and Families Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Themes and trends/Local improvement work

Patient safety service improvement plan has been developed for all CAMHS services to provide evidence and assurance against. The plan has actions to be undertaken over a six-monthly period, and is not limited to;

- Sustained use of the Consent tool & ensuring the child is consulted about the care and discharge
- Recording if a child was seen alone
- Discharge planning and letters being addressed to the person
- FIRM risk assessment

IG incidents across community CAMHS led to a briefing being shared with the teams via CAMHS CGG. All services provided assurance against the points of learning.

CAMHS have implemented a service wide PSOG and local PSOG's to discuss and agree incidents and a range of learning responses, which are subsequently managed timely in completion and actions for improvement are identified.



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Children, Young People and Families Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Themes and trends – lower-level incidents

- Staff experience verbal aggression, often by telephone and often associated with waiting times. A piece of work is underway to develop a letter to families around verbal aggression & the support of customer services will be sought.
- To consider the reporting of self-harm in community settings as the agenda for suicide prevention develops to establish patterns of escalating risk.

Areas of concerns/risks

- More recently Datix staffing levels and demand in Crisis & Eating Disorder teams has led to the Risk Register severity rating being increased.
- Increased Datix under category of Care Pathways associated with capacity and demand.
- There have been delays in taking forward repeated learning that requires Trust level guidance, and this gives rise to concern given the reoccurring themes . E.g. medical Care plan standards / FIRM guidance.



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Children, Young People and Families Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning identified

- Continued SBAR's shared with staff (see Learning Library slides).
- There is an SBAR underway evaluating the level of information being shared with a school following an IG breach where there was information sent to an incorrect school which has led to secondary considerations about the custom and practice of sending full reports to schools.
- Following an audit of discharge letters, work has been undertaken to develop letters and ensure the voice of the child is sought, considered and documented in consultation pathways (and the use of FIRM risk assessment on these pathways).
- An SBAR was drafted (in collaboration with the staff member) following threats of harm to a member of staff and the support plan included Trust security staff who were very helpful. Staff were reminded to submit Datix.

Learning responses being used

- 48 hour rapid reviews
- Debrief – are not always completed, highlighting a potential need to progress this over the next year.
- After action reviews
- Weekly learning from Team PSOGs



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Forensic Services Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Themes and trends

- Quality of observation and engagement, and a QI project has been initiated linking with Cheswold with similar incidents.
- Policy and practice
- Environment and security
- Violence and aggression
- Physical illness

Areas of concerns/risks

- Observation & engagement, environment and security

Learning identified

- The importance of monitoring mental state and ensuring adequate staffing on all areas of the wards.
- Awareness of the risks that can not always be predicted or expected whilst a patient is accessing leave.
- Better understanding of the support available from specialist advisers in the safeguarding team.



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Forensic Services Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

- There are ongoing challenges around RCRP and navigating recalls with support in the community when presenting circumstances are risky to staff.
- Ensuring seclusion checks are completed regularly, to check for damage.
- Importance of communication between professional network and sharing of information.
- Staff need to remain vigilant and ensure care plans/ risk handover are up to date to ensure all staff are aware of his current risk.
- The team have reflected on how to keep themselves safe and reviewed the lone worker responsibilities and care plans. This includes where visits take place, lone worker instructions and clear care planning.

Local improvement work

- Bluelight development, debrief sessions, action plan & quality improvement work, including Dip samples to improve awareness and implementation of policy

Learning responses being used

- 48hr rapid review
- Debrief, planned quality improvement work
- Sharing learning through Bluelight alerts



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Learning Disability and ASD/ADHD Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Themes and trends

- Violence and aggression (physical contact made and aggressive episodes, mainly at Horizon centre).
- Medication
- Information Governance
- Deaths reported to LeDeR

Areas of concerns/risks

- Injuries following restraints
- Transitions in care

Learning identified

- Environmental factors in relation to location of restraints within the Horizon centre (limited space).
- Availability and use of PPE bite jackets and hand protectors at the Horizon centre.
- Gender requests for more male staff to cover bank shifts at Horizon centre.
- To communicate more widely (within the team- to relevant professionals) the risks and mitigating strategies that would be helpful to clients with known risks when attending appointments; and that when someone is coming in for outpatient appointments with known challenging behaviours, the team should make a plan regarding proactive and reactive risk management strategies to support the clinic to ensure best possible outcomes.



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Learning Disability and ASD/ADHD Care Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Learning identified continued....

- The importance of risk assessments and reviewing patients in their home setting as well as day care.
- The importance of sharing information between colleagues and with external agencies.
- Timely communication within teams in relation to sharing information e.g. safeguarding referrals, to avoid delay.
- Being proactive with using information gained from out of area services in relation to clients.
- Lone working devices are used and switched on during home visits.

Local improvement work

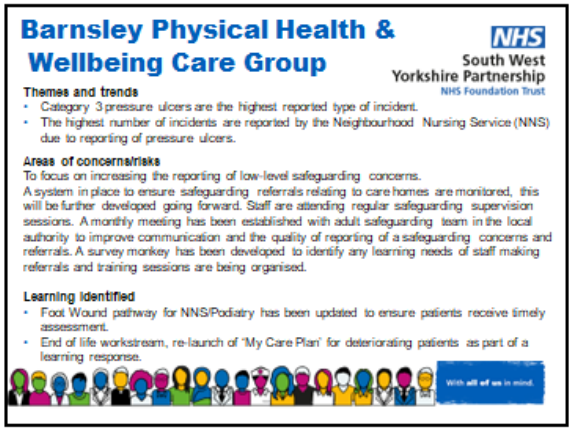
- Transitions in care through MDT meetings between services to identify and manage presenting risk.
- Completion of risk assessments and MDT support.
- To improve working relationships with mainstream mental health services for supporting clients with personality disorders.
- Gender requests for more male staff to cover bank shifts at horizon.

Learning responses being used

- 48 hour rapid reviews and debrief (safety huddle).



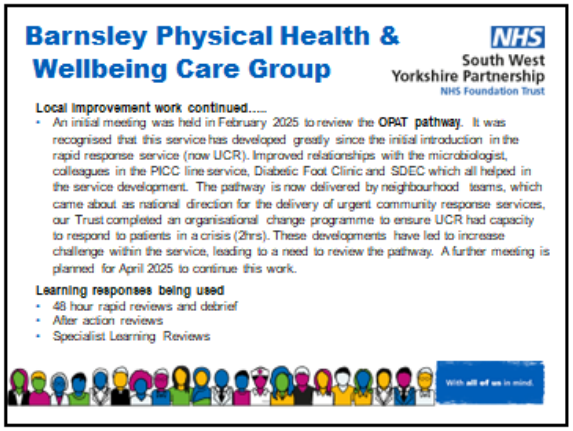
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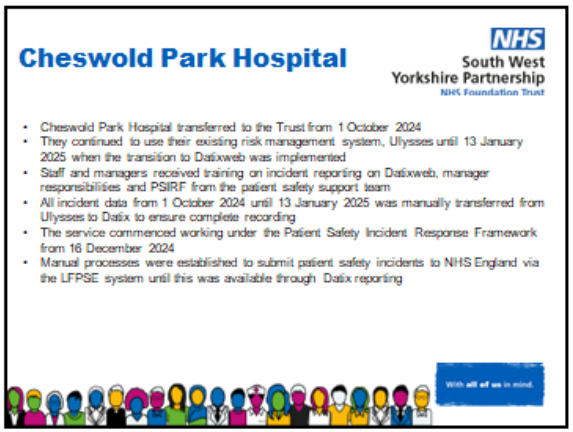
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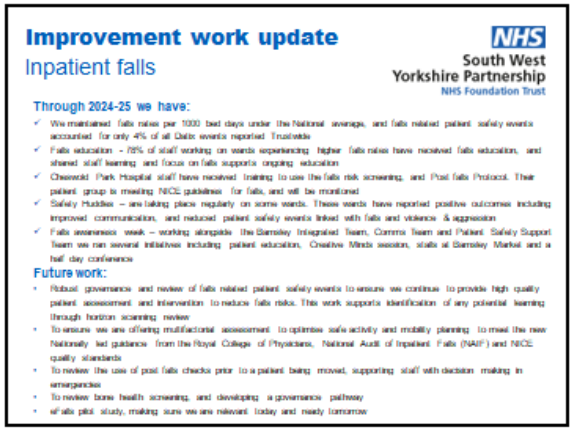
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Improvement work update

Pressure Ulcers

South West Yorkshire Partnership NHS Foundation Trust

Through 2024-25 we have:

- ✓ Implemented a foot wound pathway, which sets out the process for podiatry undertaking first assessments for people with foot wounds
- ✓ Phase 1 PURPOSE- T roll out, which is a tool for assessing risk of pressure damage
- ✓ Trial on reducing frequency on completing wound care assessment template (release clinical time)
- ✓ Carried out process mapping of pressure ulcer documentation
- ✓ Developed new template that is ready for testing
- ✓ Moved to 48 hour manager review and stopped RCA process (release clinical time)

Future work:

- Ongoing roll out of PURPOSE- T
- Implementation of the new wound care template
- Collection of pressure ulcer data will be captured by clinical record system and flowed into community services data set, but will allow for local analysis
- Pressure ulcer will only be reported through Datix when a patient safety incident has occurred
- Pressure ulcer report
- Updating the wound care policy
- DHSC safeguarding and pressure ulcer tool to be rolled out

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Improvement work update

Healthcare Acquired Infections

South West Yorkshire Partnership NHS Foundation Trust

Through 2024-25 we have:

- ✓ Trust's Infection prevention and control (IPC) annual programme outlines the IPC priorities, objectives and quality improvement actions and sits alongside the day-to-day preventative and reactive workings, inclusive of Healthcare associated infections (HCAI's), of the IPC service
- ✓ Give high priority to surveillance of alert organisms and other infectious organisms. Post infection review (PIR) process for alert organisms with partner healthcare organisations routinely performed by IPC team with learning reported to IPC TAG and shared with Clinical governance groups and Care group clinical governance groups.
- ✓ Continue to maintain over 80% compliance with IPC and Hand hygiene training
- ✓ Above average result on PLACE

Learning responses have helped identify that ....

- We need to help staff become more aware of how to treat hypoglycaemia and the escalations.
- We need to routinely review NEWS2 to ensure quality of completion and clinical record keeping on all clinical observations to ensure timely documentation and include O2 saturation recording.
- Staff must be proactive with hydration management and in physical health interventions to include weight management
- Where there are equipment challenges these need escalating to the appropriate department to prevent delays and increase risk to patient safety related incidents
- There have been delays in referrals to SALT and Dietetics in some incidents, staff understanding on early referral is required
- Ensuring that information is shared on the management of infectious outbreaks and what testing is required.
- collecting of samples, in blood or sputum have not been accurate, leading to some delays in obtaining results and delays in treatment
- We need to ensure where possible to promote vaccination and if declined ensure this is clearly documented.

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Improvement work update

Physical Health (one health approach)

South West Yorkshire Partnership

Through 2024-25 we have:

- ✓ Implement training and education for staff to have deeper understanding of holistic patient care, embracing mental health/ LD and physical health. The trust as invested in clinical skill facilitators and other specialist teams e.g. speech and language, that support clinical team with physical health, providing programmes of hands-on training to services and care groups: e.g.: Physical health, NEWS2, A-E assessment, GCS/head injury observations monitoring, Falls and post falls assessment, Dysphagia, Sepsis, Long term condition management, Palliative and end of life care, ReSPECT, Compression bandaging and competencies, for staff where needed.
- ✓ Implemented ReSPECT within the Trust: now embedding into practice
- ✓ Improved Tissue viability referrals and support for inpatients
- ✓ Developed head injury and A-E procedures & tools to support effective patient management
- ✓ Established a new Physical Health Operational Steering Group
- ✓ Developed a physical health in mental health and learning disabilities strategy
- ✓ A Bluelight alert around choking has been reissued, along with promotion of training. Datix incidents continue to be reviewed. Care plans have improved and referrals to Speech and Language Therapists have supported care planning

Future work:

- Embed the new Physical Health Operational Steering Group, as a collaborative forum to improve patient physical health and share practice
- Review inpatient wound care management training and formulary. This will support with effective choice of dressing, reduce antimicrobial prescribing, cost improvement and sustainability
- Review potential digital recording of clinical observations

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Improvement work update

Medication administration

South West Yorkshire Partnership NHS Foundation Trust

Through 2024-25 we have:

- ✓ Continued to share learning/updates through Greenflight alerts
- ✓ Implemented Electronic Prescribing Medication (EPMA) and reporting starting to be shared
- ✓ Out of hours leave training package completed
- ✓ Common stock list implemented and embedded – further review to ensure effectiveness
- ✓ Discharge medicines service KPI performance above national average
- ✓ SystmOne Clozapine template implemented
- ✓ SystmOne Lithium template implemented
- ✓ Unity Centre project rolled out across wards
- ✓ AdlaS system completed
- ✓ Green bag project rolled out across the Trust
- ✓ STOMP rolled out across the Trust

Future work:

Working with the nursing directorate on:

- EPMA reporting
- Addressing administration error themes

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Serous Incidents concluded in 2024/25

South West Yorkshire Partnership NHS Foundation Trust

There were four serious incident investigations concluded, these involved;

- A 52-year-old gentlemen who accessed older people's intensive care services and in-patient services who sadly died of physical health concerns following a diagnosis of early onset dementia and contracting Covid-19.
- A 65-year-old gentlemen who also accessed older people's intensive care services and in-patient services who sadly died whilst being absent without leave from the ward, full detail of circumstances of death are not known to the Trust.
- A 74-year-old gentlemen who accessed older people's outreach services and in-patient services and also had an admission to a working aged adult ward who sadly died from asphyxiation following placing a plastic bag over his head.
- A 41-year-old gentleman who accessed early intervention services, core services and enhanced mental health services who was found hanging in a public area by passers-by and sadly died from his injuries in hospital.

The Serious Incident investigations involved 9 different services and 20 team members – they were all given an opportunity to reflect on the person known to them and the care they received as well as an understanding on the areas of challenge or difficulties faced by individuals and the teams.



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Serous Incidents concluded in 2024/25

South West Yorkshire Partnership NHS Foundation Trust

We learned that ....

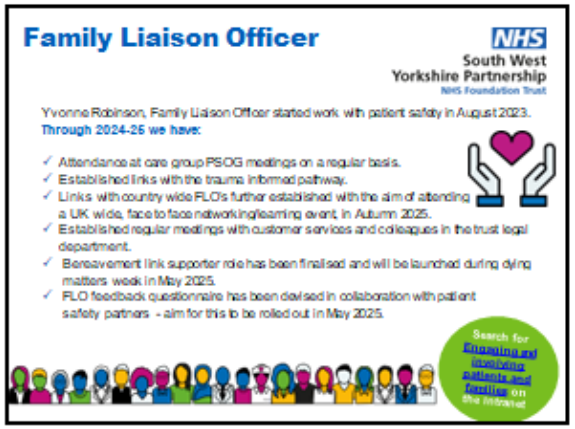
- NEWS2 scores were not always recorded as per policy.
- Care planning was not always documented as it should be.
- Clinical recording was not always as detailed as it could be.
- Risk assessments were not always completed as they should be.
- Carrier bags were being treated as prohibited items, which required risk assessment for service users to keep, rather than banned items on some in-patient areas.
- Contact with family/carers may not always be taking place when informing safety planning and carers assessments were not always considered.
- Communication within and across teams occasionally lacked detail in relation to service user risk and safety planning.
- There was limited joint working between the Trust and partner organisation.

We found.....

- Audit completed by Resuscitation Lead found that daily charts were completed correctly.
- Improvement workstreams were already in place in respect of families/carers and their involvement and support.
- Improvement workstreams were already in place in respect of care planning, risk assessment and record keeping.
- Improvement work had already been undertaken in relation to the use of plastic bags within in-patient areas.



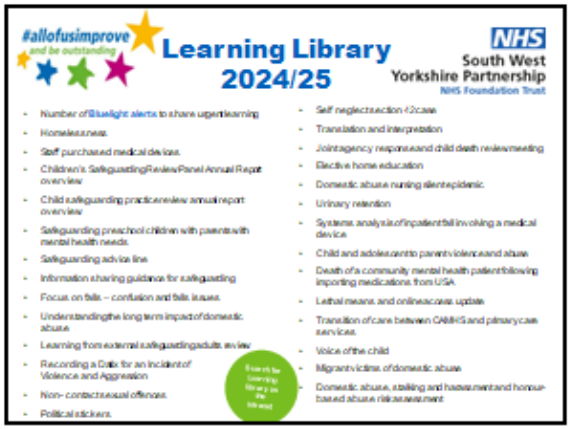
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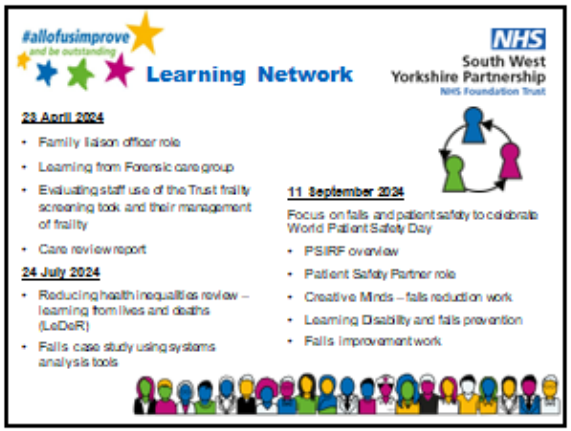
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Appendix C Healthcare Services Safety Investigation Branch reports 2024/25

Information has been shared with specialist leads for consideration of any impact for the Trust services

Topic	Date published
Pre-hospital interpretation of electrocardiograms (ECG) in ambulance services	March 2025
Medication not given anticoagulation before and after a procedure	March 2025
Safety management: accountability across organisational boundaries	February 2025
Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge	January 2025
Mental health inpatient settings: Creating conditions for the delivery of safe and therapeutic care to adults	January 2025
Medication not given administration of time critical medication in the emergency department	December 2024
Mental health inpatient settings: Supporting safe care	December 2024
Medication related harm	December 2024
Investigation report: Mental health inpatient settings - out of area placements	November 2024
Healthcare provision in prisons: continuity of care	November 2024
Sexual safety: the implications for patient safety	October 2024
Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare	September 2024
Healthcare provision in prisons	August 2024
Keeping children and young people with mental health needs safe: the design of the paediatric ward	May 2024
Patients at risk of self-harm: continuous observation	May 2024
Nutrition management of acutely unwell patients in acute medical units	April 2024

Appendix D Patient safety alerts received and actioned during 2024/25

Reference	Title	Date issued by agency	Alert applicable?	Comments
NatPSA/2024/004/MHRA	Reducing risks for transfusion-associated circulatory overload	04/04/2024	No - alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/005/MVA	Shortage of Erelzi® (etanercept) 50mg solution for injection in pre-filled pen	03/05/2024	No - alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/006/DHSC	Shortage of Orencia® ClickJectTM (abatacept) 125mg/1ml solution for injection pre-filled pens	23/05/2024	No - alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/007/DHSC	Shortage Of Pancreatic Enzyme Replacement Therapy (Pert)	24/05/2024	Yes - circulated for information	The alert was issued to prescribers for action. Discussed at drugs and therapeutics committee.
NatPSA/2024/008/DHSC	Shortage of Kay-Cee-L® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup	26/07/2024	No - alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/009/DHSC	Shortage Of Human Albumin 4.5% And 5% Dose Vials NatPSA/2024/009/DHSC	30/07/2024	No - alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/011/DHSC	UPDATE: Discontinuation of Kay-Cee-L® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup	21/10/2024	Disseminated to relevant staff	Only applicable in a small number of cases. Pharmacy will manage where this is prescribed
NatPSA/2024/012/DHSC	Shortage Of Molybdenum-99/Technetium99m Generators	25/10/2024	Alert not applicable to trust	Alert not applicable to trust
NatPSA/2024/013/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT) – Additional actions	11/12/2024	Disseminated to relevant staff	This was an update on a previous alert from May 2024. The alert was issued to prescribers for information.
NatPSA/2025/001/DHSC	Discontinuation of Promixin® (colistimethate) 1-million-unit powder for nebuliser solution unit dose vials	17/03/2025	Alert not applicable to trust	Alert not applicable to trust

South West Yorkshire Partnership NHS Foundation Trust

Appendix E Learning from healthcare deaths annual report 2024/2025

Covering the period 1/4/2024 – 31/3/2025

Background context

Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy which sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different, and they receive poor quality care for several 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 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.

Of note, a quarterly learning from healthcare deaths report was previously an appendix to the Incident Management reports. As part of the transition to the Patient Safety Oversight Report, this report was not included as an appendix for Quarters 1 and 2. Going forward, the quarterly Learning from Healthcare Deaths paper will be an appendix to the quarterly Patient Safety Oversight Report that is submitted to Committee and Trust Board.

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's 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.

For core reporting principles, the Trust is deemed the main provider of care, if at the time of death, the patient was subject to:

1. An episode of inpatient care within our service.
2. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.

3. A Community Treatment Order.
4. A conditional discharge.
5. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
6. Guardianship
7. Deprivation of Liberties legislation (DOLS)
8. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.

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. In some cases, we may only be aware that death was certified (or reported to the coroner), without any information about the specific cause of death.
2	Case record review	Includes: (1) Managers 48-hour review (2) Structured Judgement Review (3) Case note review
3	Investigation (learning responses)	From 1/12/2023, the Trust commenced working under the Patient Safety Incident Response Framework and our learning response processes include: • After Action Review • Specialist Learning Review • Patient Safety Incident Investigation (PSII) • Learning from Life and Death Reviews (LeDeR) (learning disability and autism deaths) • Safeguarding review

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.

Annual Cumulative Dashboard[4] Report 2024/2025 covering the period 01/04/2024 – 31/03/2025

Figure 1 Summary of 2024/2025 Annual Death reporting by financial quarter to 31/03/2025

Reporting criteria		2023/ 2024 total	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	2024/ 2025 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[5]	2127	530	501	612	507	2150
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	409	121	94	95	117	427
3	Total Number of deaths which were in scope	285	78	71	60	73	282
4	Total Number of deaths reported on Datix that were not in the Trust's scope	124	43	23	35	44	145

Figure 2 Statistical Process Control Report of all deaths reported 01/01/2023 – 31/03/2025 by date reported

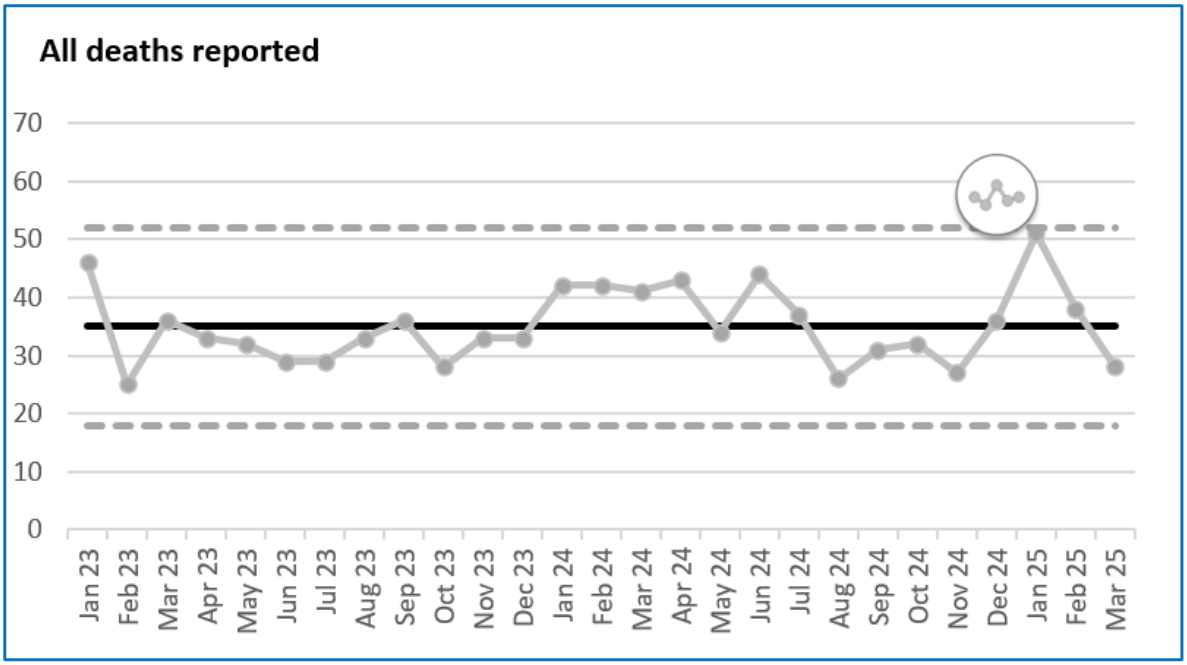


Figure 2 shows a Statistical Process Control chart of all reported deaths (by reported date) between 01/01/2023 - 30/03/2025. There is natural variation in the data relating to those who have died who were known to us. In January 2025 there has been an increase in the number of deaths reported, however there are no areas of special cause variation that require further exploration at this time.

[4] Dashboard format and content as agreed by Northern Alliance group.
[5] Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

Figure 3 Breakdown of the total number of in scope deaths reviewed in 2024/2025 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Adults and Older People Mental Health Care Group (Community)	Adults and Older People Mental Health Care Group (Inpatient)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Children Young People and Families Care Group	Total
2024/2025 Q1	2	60	4	11	0	1	78
2024/2025 Q2	0	48	3	17	0	3	71
2024/2025 Q3	1	37	5	14	1	2	60
2024/2025 Q4	0	52	5	15	0	1	73
Total	**3**	**197**	**17**	**57**	**1**	**7**	**282**

Figure 4 Summary of total number of all in scope deaths in 2024/2025 to the end of Quarter 4 by the respective level of mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response					Total
	Certification of death	Manager's 48-hour review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patent Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	
2024/2025 Q1	11	45	5	0	1	2	1	13	0	78
2024/2025 Q2	12	31	3	2	0	2	1	20	0	71
2024/2025 Q3	13	29	1	1	0	0	0	16	0	60
2024/2025 Q4	23	30	1	2	1	0	0	16	0	73
Total	**59**	**135**	**10**	**5**	**2**	**4**	**2**	**65**	**0**	**282**

Figure 4 above shows the total number of all in scope deaths in 2024/2025 to date. The majority of mortality reviews are undertaken through case record review (a Manager's 48 hour rapid review, Structured Judgement Review and case note review) or the Learning Disability Death (LeDeR) process. In line with the national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figures 5 and 6 below provide this breakdown.

Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to LeDeR[6]. It should be noted that the figures may not tally with the numbers by care group (in figure 3 above). This is because we identify Learning Disability and Autism not just through the reporting

[6] Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

team, but by a field on Datix to determine if any patient who died had a learning disability or autism irrespective of where they were cared for.

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

Figure 5 Summary of total number of in scope deaths in 2024/2025 by the Review process (including people with Learning Disability and/or Autism deaths)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2024/2025 Q1	12	1	0	13
2024/2025 Q2	19	1	1	21
2024/2025 Q3	16	0	0	16
2024/2025 Q4	16	0	0	16
Total	**63**	**2**	**1**	**66**

Of the sixteen Learning Disability/Autism deaths which were reported to LeDeR, all had the Manager's 48-hour review completed.

LeDeR learning identified

Feedback is received routinely from LeDeR focussed reviews from across the region. The key highlights received to date were overall positive:

- Positive practice received from family.
- Good evidence of joint working between learning disability and mental health services in the coordination and management of the service user's needs.
- Record keeping of both physical and mental health symptoms for service users referred to eating disorder clinics. This learning has been shared with local service areas for reflection and subsequent action.

When the next annual report from Learning from Life and Death Reviews national team is received, this will be reviewed, and a summary and response will be shared separately with Trust Board.

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not having a learning disability and what level of review was completed. All deaths reported have the Manager's 48 hour review completed to ensure the care and treatment leading up to a death was considered, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 6 Summary of total number of in scope deaths in 2024/2025 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response			
	Certification of death	Manager's 48-hour review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patient Safety Incident Investigation (PSII)	Total
2024/2025 Q1	11	45	5	0	1	2	1	65
2024/2025 Q2	12	30	3	2	0	2	1	50
2024/2025 Q3	13	29	1	1	0	0	0	44
2024/2025 Q4	23	30	1	2	1	0	0	57
Total	**59**	**134**	**10**	**5**	**2**	**4**	**2**	**216**

Inpatient deaths

Figure 7 below shows that over the year 2024/25 to date there have been 19 inpatient deaths. All inpatient deaths are considered for the most appropriate level of review, and reported to LeDeR where necessary.

Figure 7 Trust wide Inpatient deaths in 2024/2025 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2024/2025 Q1	2024/2025 Q2	2024/2025 Q3	2024/2025 Q4	
Adults and Older People Mental Health Care Group (Inpatient)	Acute Inpatient (adult)	Ashdale	0	1	0	0	1
		Elmdale	0	0	1	0	1
		Stanley	2	0	0	0	2
		Ward 18	0	1	0	1	2
	Older People Inpatient	Beechdale	0	1	1	1	3
		Crofton	0	0	1	0	1
		Poplars	1	0	0	1	2
		Ward 19	0	0	2	2	4
		Willow	1	0	0	0	1
Forensic Services Care Group	Low secure Learning disability	Newhaven	0	0	1	0	1
Barnsley Physical Health and Wellbeing Care Group	General community inpatient wards	Stroke unit, Barnsley	0	0	1	0	1
Total			**4**	**3**	**7**	**5**	**19**

Of these deaths, the below table provides detail on whether the deaths were expected or unexpected/natural or un-natural, by inpatient ward.

Expected or Unexpected death	Total
Unexpected natural death eg cardiac arrest, stroke, Road Traffic Collision	**7**
Beechdale Ward, The Dales, Calderdale	1
Elmdale Ward, The Dales, Calderdale	1
Poplars Unit, Wakefield	1
Ward 19 (OPS), Priestley Unit, Kirklees	4
Expected natural death eg terminal illness	**5**
Beechdale Ward, The Dales, Calderdale	1
Integrated Stroke and Early Support Discharge (ESD) Team, Barnsley	1
Newhaven Forensic Learning Disabilities Unit	1
Poplars Unit, Wakefield	1
Willow Ward - Barnsley	1
Unexpected un-natural death eg suicide, homicide, abuse, neglect	**4**
Beechdale Ward, The Dales, Calderdale	1
Stanley Ward, Wakefield	2
Ward 18, Priestley Unit, Kirklees	1
Expected natural death eg cancer, but sooner than expected	**1**
Crofton Ward (OPS), Wakefield	1
Unexpected natural death eg alcohol dependency or where there are care concerns	1
Ward 18, Priestley Unit, Kirklees	1
Unknown/unclear	**1**
Ashdale Ward, The Dales, Calderdale	1
Total	19

Location of deaths

Figure 8 below shows the locations where patients died (where this was recorded). Acute/general hospital is the highest noted location at 31%.

Figure 8 Location of deaths that were reported during 2024/25

	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total
Acute Trust / General Hospital	30	25	26	30	**111**
Patient's home	27	22	16	20	**85**
Care/Residential Home	7	10	8	8	**33**
Public place	5	4	0	8	**17**
Unknown	3	3	3	5	**14**
Hospice	2	4	3	2	**11**
Inpatient facility (SWYPFT)	0	0	3	0	**3**
Family or friends' home	2	1	0	0	**3**
Other country	0	2	0	0	**2**
Other mental health provider (not SWYPFT)	2	0	1	0	**3**
Total	**78**	**71**	**60**	**73**	**282**

Where the location of death is unknown, this is often because we identify a patient has died from a third-party update on the clinical record.

Causes of death

In terms of causes of death, figure 9 below shows the broad cause of death for the 282 patients who died. The highest types of cause of death recorded was from physical causes, which will include expected and unexpected deaths. Where possible, records where end of life/palliative care was noted have been captured separately.

Figure 9 Causes of death for in scope deaths recorded during 2024/25 by care group area

Cause of Death (themed)	Barnsley Physical Health & Wellbeing Care Group	Adults and Older People Mental Health Care Group (Community)	Adults and Older People Mental Health Care Group (Inpatient)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Children Young People and Families Care Group	Total
Respiratory	0	8	1	4	0	0	**13**
Apparent suicide suspected	0	28	3	0	0	3	**34**
Unknown/unclear	0	21	3	4	0	1	**29**
Unascertainable	0	1	0	0	0	0	**1**
Cancer	0	16	0	4	1	0	**21**
Haemorrhage	0	2	0	1	0	0	**3**
Drowning	0	0	0	1	0	0	**1**
Stroke	0	1	0	1	0	0	**2**
Alzheimer's	0	3	0	0	0	0	**3**
Pneumonia	0	18	2	14	0	0	**34**
Physical cause suspected	1	8	1	3	0	1	**14**
Dementia	0	6	0	4	0	0	**10**
Pulmonary embolism	0	5	0	0	0	0	**5**
Renal failure	0	4	0	2	0	0	**6**
Physical cause suspected - end of life	0	11	1	3	0	0	**15**
Sepsis	1	11	0	4	0	0	**16**
Overdose	0	2	0	0	0	0	**2**
Accidental death	0	1	0	0	0	0	**1**
Frailty of old age	0	6	0	1	0	0	**7**
Suspected carbon monoxide poisoning	0	0	0	1	0	0	**1**
Multi-organ failure	1	1	0	0	0	0	**2**
Sudden death	0	0	0	1	0	0	**1**
Physical cause suspected	0	2	1	0	0	1	**4**
Covid	0	1	2	0	0	0	**3**
Hypoglycaemia	0	1	0	0	0	0	**1**
Necrotic bowel	0	1	0	1	0	0	**2**
Asphyxia	0	1	0	1	0	0	**2**
Cardiac related	0	32	2	7	0	0	**41**
Drug/alcohol related	0	6	1	0	0	1	**8**
Total	**3**	**197**	**17**	**57**	**1**	**7**	**282**

Apparent suicides

The apparent suicides will be reported on further in the Apparent Suicide annual report which will be available separately. The figures will be based on the live data, so may not match figures in this report.

Learning from Structured Judgement Reviews (SJRs)

Positive practice identified

- Arrangements and plans for transfer of care between different teams and joint visits, with the service users being made aware.
- Regular medication reviews and monitoring which involve service users, taking into consideration their views and agreement on changes collaboratively.
- Good treatment for service users with complex disabilities.
- Evidence of service users being listened to and their concerns being followed up accordingly.
- There was evidence of building good rapport with service users, and following several failed contact attempts with a service user (including named emergency contacts) a home visit was undertaken in accordance with DNA protocol.
- Discharge pathway was identified within 48 hours admission to the team following the case management review meeting and identified as Core. This supports the working model of beginning the discharge process at point of admission.
- One overall review of care highlighted evidence of good risk assessment, risk formulation and planning: all reflective of current need and demonstrated good risk recognition which informed safe, sound clinical decisions.

Areas of Improvement identified

- FIRM (formulation informed risk management) risk assessments are not always updated following changes in service user risks. Information is often added to progress notes but is not transferred to the FIRM/risk assessment. This intelligence has been provided to the Care planning and clinical risk assessment group for consideration in ongoing improvement work.

Progress to note from the Mortality Review Group

- The internal Mortality Review Group has met several times during the year. The next meeting is scheduled for 9 July 2025.
- Care groups continue to review SJR outcomes and create actions plans for identified areas of concern.
- SJR training sessions were relaunched in March 2025, which have been positive and supports the pool of trained reviewers within the Trust. Further training continues scheduled in May, July and October 2025.
- The Bereavement Link Supporter role job description has been finalised, and it is hoped the role will be launched to coincide with the ‘Dying Matters’ week commencing on 5 May 2025.
- Three Postvention Assisting those Bereaved by Suicide (PABBS) training sessions are being rolled out this year. The first session has taken place at the end of March 2025 in Barnsley with two more sessions scheduled in May 2025 at Fieldhead hospital and Folly Hall. Early feedback has been very positive (similar to the sessions held last year).
- A family liaison officer questionnaire has been developed and consulted on with Patient Safety Partners and the Quality Governance team and will be shared for final approval before it can be implemented in practice.
- A task and finish group began in April 2025 to look at the governance process in responding to questions from families. This group will link with care groups, legal services and possibly customer services.
- A generic LeDeR email address has been set up and a staff guide develop to help improve LeDeR reporting and that requests for information received from LeDeR are assessed and information shared appropriately, in line with Trust policy.

- Barnsley Physical Health and Wellbeing Care Group are in regular contact with the Medical Examiner's officers and have been acting on their feedback which has been largely positive. A leaflet has been produced in collaboration with the Lead Medical Examiner for Barnsley Hospital, for community staff within Neighbourhood Nursing teams and Urgent Care Response team in Barnsley to distribute to families/carers following an expected death. This will follow following the verification of death taking place first. The leaflet explains the process in more detail following the advent of the Medical Examiner's role. This is currently in draft format and will be submitted to the Care Group's Clinical Governance Group for their approval and has been suggested that the leaflet could be used by the Bereavement Link Supporter role.
- The Regional Mortality group (hosted by the Improvement Academy) have continued to meet during 2024/25. The group asks for information to be shared across providers to support identification of common themes from around the region.
- The Northern Alliance Group (mental health and learning disability Trusts) have met during 2024/25. A Microsoft Teams channel has been set up for discussion and sharing information amongst the group. The next meeting is scheduled to take place on the 14 May 2025.

Next Steps

Our work to support learning from deaths continues, and annual review provides an opportunity for reflection, therefore over the coming year the mortality review group will undertake a review and refresh of its purpose to provide an opportunity to refocus how we learn from deaths and identify problems in care. It will consider changes made with the introduction of PSIRF and take opportunities to identify learning themes from learning responses to widen the scope. This will be in relationship with the Patient Safety Improvement Group (PSIG).

Alison Lennox
Lead Patient Safety Investigator
On behalf of the Mortality Review Group
May 2025

Appendix F Suicide prevention

Alert:

NHSE released safety from suicide guidance on 4th April 2025 – Power point presentation has been created for easy sharing across care teams to review, reflect and identify actions to take forward. This is still with Darryl Thompson and Amy Hartley and was awaiting a briefing to support roll out which was with Mark Brooks for review.

Recent changes across the regional ICB's and NHSE has impacted on suicide prevention aims and objectives in West Yorkshire.

The strategy has been reviewed, and key priority areas have been highlighted for continued investment

- Bereavement by Suicide – reinvestment until 2026
- Near to real time Surveillance – to be led on a co-chair approach by PH leads across the Calderdale, Kirklees, Wakefield patch.
- Previously agreed that NHS secondary services comms (including SWYPFT comms team) would support the updates and maintenance of the regional West Yorkshire web page
- Target training in organisations – ICB championed being one of the first organisations to make suicide prevention training mandatory – note this is not for clinicians and was bespoke created for each team to ensure relevance.

The supporting staff following critical or traumatic incident working guidance has been in development for 2+ years. Sent to director for people's directorate to acknowledge and approve and to add name in support of information sharing. Also carefully shared with staff side representative who hoped to create a short paragraph of support offer.

There is now an urgent need for this document to be visible across all care teams given changes in approach to incident investigations since PSIRF. There is an indication that there needs to be more done to ensure that staff are getting the right support as per operational guidance.

Bereavement link support role – rolling programme of recruitments – needs the continued visibility but this role also essential in ensuring that actions are taken to support staff as per best practice guidance.

PSST team need to review what information is being shared and when to support the staff and wider teams.

Task and finish group to be formed to review responding to staff suicide. Naomi Sutcliffe to action a reach out email for volunteers.

Task and finish group is underway in responding to Mental Health inpatient Wound Management – includes partners across Mid Yorkshire Hospitals NHS Trust, Calderdale and Huddersfield NHS Foundation Trust (CHFT), Yorkshire Ambulance Service (YAS) involvement and engagement from physical health governance pathway in SWYPFT – very positive first meeting.

Advise:

- West Yorkshire ICB championing suicide prevention training as mandatory – this alert had been shared with Darryl Thompson, LNA and training directory for all Trust Suicide Prevention Training is ongoing work – challenges are present refunding to pay for trainers.
- Suicide Specific Supervision model of approach is due to go live in the next 2 months. Action to add names of volunteers to the supervision platform is to be taken. Most have had the opportunity to access PABBS training to support their role with staff. Will also have a half-day session with MIND to support the role and the importance of specific support – links to the third victim there is an action for Naomi Sutcliffe to also seek input from leads in Bradford Institute to also feed in to this principled approach.
- Early discussions have begun on Autism and ADHD and the aims for the Trust Suicide Prevention Strategy 2025-2028, positive response from many interested parties – a call out to be a part of a task and finish group will take place as the next stage.

Approved

- The apparent suicide report (2023/24) was approved at board and shared in EMT, PowerPoint presentation for easy highlights is completed, report will be added to the intranet pages and communicated out across care groups.
- Suicide prevention drop-in learning sessions – successful turn out for postvention – bereaved by suicide, guest speakers from Amparo, Leeds Mind and FLO SWYPFT – dates up and coming, drugs and alcohol and prevention of suicide, guest speaker Tom Fitzsimmons from Change Grow Live (lived experience community support peer). With learning from SWYPFT Dual Diagnosis Specialise advisors. 9th July – impact of social media and online harms – guest speakers Papyrus, R;ipple and the Mollie Rose foundation – aimed at our professionals working with young people, opportunity to attend will also be shared with educators linked to CAMHS teams. September – Men and Suicide, champions have indicated a request for an Autism specific focussed session – all are co-ordinated by Naomi Sutcliffe at present.

Assurance:

- Any Inpatient suicides have had near to real time suicide surveillance forms submitted to NCISH
- Public Health leads across the West have picked up the baton for the areas of works that were highlighted as key to continued investment in suicide prevention ICB strategic Objectives.
- Near real time suicide surveillance in the West have met again recently – Naomi Sutcliffe is to support the review on the ISA's that had been previously designed
- The Trust suicide prevention lead is exploring internally run and ISA supported near to real time suicide surveillance meeting to support with upstream data collection to inform organisational aims and ambitions for the prevention of loss of life to suicide.



QSC - national suicide prevention im

- Review of National strategy against SWYPFT strategy has been completed
- Work is ongoing for the PSII inpatient suicide and self-harm; challenges have been apparent in release of time to compile the findings.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	**Quality Commission CQC action plan update**		
Lead Director:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Mission/values:	The report demonstrates commitment to all of the Trust values, which are fundamental to delivering safe and effective 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 Trust Board with an update and assurance regarding the Trust approach to CQC concerns, inspections and our own internal process for assuring ourselves that the identified actions are being responded to in an improvement focused and timely manner.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.1 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. 2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.		

With all of us in mind.

	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience. 4.1 Financial pressures in our systems could result in less focus on mental health, learning disability and autism, community services and/or Place. 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 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
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider Trust within the Integrated Care System is governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to 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. The progress described in this report and the completion of these actions contributes directly to the quality and safety objectives of the integrated care systems.
Any background papers / previously considered by:	Previous versions of this paper have been shared with the Quality and Safety Committee, Executive Management Team and Trust Board.
Executive summary:	On Wednesday 6 December 2023, following inspection visits, the Care Quality Commission (CQC) published the reports 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 'should do' actions are being approached with a clear expectation of completion. 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. Of note, this is a live document under a process of continual review and update.

	There are a number of Trust-wide issues which are outlined within the report, and these are being approached on a Trust-wide basis rather than solely at Care Group level. These include: • Monitoring of essential to job role training. • Oliver McGowan training, for staff working with people with a learning disability and autistic people, and access to the webinar to complete Level 1 of the training. • Appraisal recording given the system changes. • Roll out of alternative exit to seclusion and use of alternative injection sites, as part of the ambition of zero use of prone restraint. • Supervision of courtyards/outside spaces. • Checking of emergency equipment/defibrillators. All of these actions are addressed through workstreams collaboratively with colleagues from Care Groups and the Nursing, Quality and Professions directorate. **Current progress** **Sixteen Acute and PICU MUST and SHOULD DO actions:** • 11 must do actions are now complete. • Two are complete but awaiting further evidence from the Care Group to enable them to be signed off. • Two actions are now amber as they are off track for completion. There are some Trus-wide actions which will support the completion of these actions. • There were 12 Should do actions, all of these are now complete. • Trajectories have been identified for all actions yet to be completed, which will be agreed by EMT and the Quality and Safety Committee. **Seven Forensic service MUST and SHOULD DO actions:** • Five are now complete. • One is complete but awaiting further evidence from the Care Group to enable it to be signed off. • Once action is off track, this is related to the checking of emergency equipment. Action has been escalated with an enhanced focus on this in the Care Group. • There were seven should do actions. Six of these are complete. One action is off track, this relates to the use of blanket restrictions and outside spaces. This has been reviewed actions taken wherever possible and Trust-wide response where limitations to access remains is under development. • Trajectories have been identified for all actions yet to be completed which will be agreed by EMT and the Quality and Safety Committee. In addition to the above inspections Cheswold Park Hospital was inspected by the CQC prior to becoming part of the Trust on 1 October 2024. Work has commenced with supporting the senior leadership team on site to address the must and should dos within the report that was received by the previous

	provider. There are 16 must do and three should do actions. At the time of reporting the actions taken to date give a position of: • Seven complete must do actions • Two must do actions are complete but awaiting further evidence from the Forensic Care Group to enable them to be signed off • Seven must do actions are in progress and on track. Of the three should do actions, two of these are complete and one action is in progress and on track. The Trust continues to take an improvement focused approach to these actions, with prioritisation around completion where there were clear safety concerns. The evidence sign-off process is underpinned by both a review of the evidence, and a review of the plan to embed going forward, and the commitment to embed these improvements into practice, with a clear governance process to oversee as business as usual in the longer term. Of note, it has been agreed at the Executive Management Team and in Quality and Safety Committee that, subject to agreement by Board, an abridged version of this report will be submitted going forward, only including those actions that are not yet complete. This will include the Trust's progress around prone restraint reduction. Trajectories for completion of outstanding actions will be discussed and agreed by EMT and the Quality and Safety Committee.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions. • **AGREE** the recommendation for future reports to focus on incomplete actions only.

Care Quality Commission (CQC) Inspection Reports
Action plan update for Must and Should Do Actions
Trust Board- 1 July 2025

Executive Summary

This paper provides an updated position on progress against the Must and Should Do actions which were highlighted within the two CQC inspection reports, published on 6 December 2023 (acute mental health wards and forensic wards). It also includes monitoring arrangements to ensure that any actions are embedded in practice going forward.

The Cheswold Park Hospital action plan is also now included within this report.

Review meetings of outstanding actions and evidence took place on 12 May 2025 with the three Care Group action plan leads.

Subject to agreement by Board, an abridged version of this report will be submitted going forward, only including those actions that are not yet complete. This will include the Trust's progress around prone restraint reduction. Trajectories for completion of outstanding actions will be discussed and agreed by EMT and the Quality and Safety Committee.

Acute/Psychiatric intensive care unit (PICU)

There were 16 Must do actions, of which 11 are now complete. Three are complete but awaiting further evidence from the Care Group to enable them to be signed off. Two actions are now amber as they are off track for completion. There are some Trust-wide actions which will support the completion of these actions**.**

There were 12 Should do actions, all of these are now complete.

Forensic and secure services

There were seven Must do actions, of which five are now complete. One is complete but awaiting further evidence from the Care Group to enable it to be signed off. One action is off track, which is related to the checking of emergency equipment, work has taken place to address this action and it remains open to ensure all wards are able to provide evidence that actions are fully embedded.

There were seven Should do actions. Six of these are complete. One action is off track, this relates to the use of blanket restrictions and outside spaces. This is being reviewed and discussed more widely.

Cheswold Park Hospital

When Cheswold Park Hospital was owned by Riverside Healthcare, the CQC inspection reported resulted in 16 Must do actions, of which five are now complete. Four are complete but awaiting further evidence from the Care Group to enable them to be signed off. Seven actions are in progress and on track. There were three Should do actions. Two of these are complete and one action is in progress and on track. The Trust is responding to these actions to ensure all learning is captured and addressed from before we were the provider.

1. Purpose of the paper

This paper provides an updated position on progress against the Must and Should Do actions which were highlighted within the two CQC inspection reports, published on 6 December 2024 (acute wards and forensic wards). It also includes monitoring arrangements to ensure that any actions are embedded in practice going forward. The Cheswold Park Hospital action plan is also now included within this report.

Of note, this is a live document. Later versions of this report are in development and will be reviewed by the Executive Management Team and the Quality and Safety Committee prior to submission to Trust Board. Therefore, some dates due for completion might be in the past tense in the data in this report. Face to face meetings to review the evidence that underpins progress continue to be held regularly, chaired by the Chief Nurse / Director of Quality and Professions. The most recent review of action progress took place on 12 May 2025.

2. Background

Following receipt of the initial feedback from the inspections in May 2023 and on receipt of the draft reports in September 2023 the Care Groups (Acute and psychiatric intensive care units (PICU) and Forensic Services) several improvement actions were put into place. Some of these actions were already in progress in existing improvement work and others were added to plans.

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 plans to address the Must Do actions / regulatory breaches, along with timescales and action owners. (See Appendix 1 of this paper to see the action plans in full).

Within the inspection reports are the following:

Forensic service – seven MUST DO and seven SHOULD DO actions

Acute and PICU service – sixteen MUST DO and twelve SHOULD DO actions

When the Trust acquired Cheswold Park Hospital in October 2024, the hospitals CQC action plan became redundant due to the actions being applied to the provider at the time (Riverside Healthcare). However, the Trust is treating the action plan as live and following the same process of evidence collection, review and sign off.

Cheswold Park Hospital – sixteen MUST DO and three SHOULD DO actions

3. Action plans, oversight and assurance

The overarching Trust wide action plan and detail is summarised below. This report is updated during monthly update and assurance meetings and is also used to provide updates to our Trust CQC inspector at monthly local engagement meetings.

The CQC actions and progress against them is being overseen and assured in the following way:



4. Sign off of actions

- Forensic actions

This is completed in line with a detailed process within the Forensic care group process, with explicit governance arrangements.

- Acute/PICU actions

Sign off of the actions for acute/PICU is through the inpatient performance and quality oversight meeting with Director of Service approval.
Monthly assurance meetings

- Cheswold Park Hospital

This is completed by the leadership team at Cheswold Park Hospital and reported via the Quality Improvement Group (Quality Assurance System – Intensive Level, chaired by a Non-Executive Director)

Bi-monthly assurance meetings are chaired by the Chief Nurse (Darryl Thompson). Progress against actions is shared as part of the meetings, following which final sign off takes place once actions are completed and evidence embedded.

A SharePoint site captures changes and information which provides assurance around completion of actions and embedding of these actions into practice. Evidence is uploaded and reviewed as part of the meetings with the Chief Nurse. The Quality Governance Manager (Liam Redican) is meeting regularly with each Care Group to review and add any additional evidence onto SharePoint.

- Evidence review meetings

In addition to the meetings with Care Group leads that have been taking place to receive updates around progress against actions, from August 2024, face to face meetings have taken place with the Chief Nurse / Director of Quality and Professions and other colleagues from the nursing, quality and professions (NQ&P) directorate, to review in detail the evidence which has been submitted to SharePoint, to provide assurance against completion of the actions.

The purpose of these evidence review meetings is:

- To review the uploaded evidence against the actions and to decide whether it provides robust assurance of action completion
- To review where further work is needed or further evidence required to provide required assurance
- To agree where actions cannot be completed or where there is Trust wide improvement work which is in progress or is needed to support delivery of the action (see below for examples)

Any escalations will be shared through EMT and Quality and Safety Committee.

5. Monitoring of the embedding of changes and improvements as a result of actions

Action completion is being monitored through the above process. There is a need to ensure that any changes or improvements made as a result of actions are embedded into practice long term and any learning shared more widely if required.

Alongside the review of the actions and evidence, an additional column has been added to the main table in Appendix 1, which outlines where reporting and monitoring is held as actions become business as usual. This column is still being completed and is designed to provide oversight of ensuring that improvements continue to be monitored.

6. Trust wide developments

There are several CQC actions which are supported by Trust wide programmes of work. Whilst there are specific actions for each Care Group, detailed in the tables below, some actions are progressing on a larger scale. These actions cover several 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 and the introduction of a new care plan from January 2025
- Regulation 17 – good governance
  - Use of e-seclusion

Reporting of progress of these larger scale improvement plans occurs regularly through the Quality and Safety Committee, operational management group and executive management team.

7. Care Group action plan oversight and summary

The progress of actions is measured using a blue, red, amber, green (BRAG) key. These are defined as the following:

Blue	Action complete and assurance of improvement
Blue Green	Action reported as complete by Care Group, awaiting evidence sign off
Red	Action not started
Amber	In progress but off track from expected
Green	On track for completion by date

Full details of action pans can be seen in Appendix 1. Below is a high-level summary which outlines where there are outstanding actions to be competed against the actions.

Acute/PICU

Sixteen Must do actions

Blue	11
Blue Green	3
Green	0

Amber	2
Red	0

CQC requirement	Status	Outstanding actions
9.1 and 9.2- person centred care – care planning and service user and carer voice in care planning (2 actions)		Review of data for 7 months. This will be reviewed in July 25 and reported in August update. • Slippage due to roll out of new care plans.
12.1 – safe care and treatment – prone restraint reduction		Prone restraint has reduced within care group since inspection in 2022 and there are several Trust-wide workstreams to support further reduction: • Alternative staff seclusion exit training -standalone training offered to all inpatient areas and introduced to 4-day full reducing restrictive physical interventions training • Options paper being developed for Executive Management Team (EMT) to reconfigure 2 -day refresher training to include alternative seclusion exit training • Alternative injection site training • Individualised care planning, including exploration of alternatives, where people may request prone position is used either for physical health reasons or because of previous trauma. Given the Trust's ambition for zero prone restraint, Trustwide work continues to be reported to the Quality and Safety Committee and within the integrated performance report to Trust Board.
12.2 and 12.3 – safe care and treatment		
15.1 – premises and equipment		
15.2 and 15.3 – premises and equipment		
17.1 and 17.2 – good governance		
17.3 – good governance – reviews when a person is in seclusion		• Processes in place and improvements made • Will continue to monitor for 7 months, review in July and report in August 2025

18.1 – staffing – sufficient numbers of appropriately qualified staff		
18.2 - staffing		
18.3 – staffing – use of bank and agency (reducing this)		• Interim establishment review completed and agreed which will support the reduction in use of bank and agency. • There is a significant reduction in agency use. The use of Trust bank staff is expected to reduce given the current focus on the recruitment of Healthcare Support Workers . • Rolling programme of healthcare support worker recruitment events in place until March 2026. • Expected final sign off will therefore be March 2026.
18.4 and 18.5 – staffing		

Twelve Should do actions

Blue	12
Blue Green	0
Green	0
Amber	0
Red	0

CQC action	Status	Outstanding actions
Training on door top alarms		
Information for agency staff on medicines management		
Records of medicines management training		
Records of when section 17 leave has been cancelled due to staffing		
Access to medical care as quickly as possible		
Physical health monitoring following medication start		

Blanket restrictions around access to certain areas of the wards	
Care plans for those at risk of deliberate self harm	
Planning meals which take into account dietary and cultural needs of patients	
Access to hot and cold drinks and snacks at all times	
Consider amending the cleaning records or The dales and Priestley unit	
Making the seclusion policy more accessible for staff to use in practice	

Forensics

Seven Must do actions

Blue	5
Blue / Green	1
Green	0
Amber	1
Red	0

CQC regulation	Status	Outstanding actions
09 – person centred care – people who require them have positive behavioural support plans		• Awaiting seven data points on primary nursing audit • Next audit will be reviewed for sign off in August 2025
10 – dignity and respect		
12 – safe care and treatment – Part 1	This is one action with the action below. This part is complete.	

12 – safe care and treatment – Part 2 – checking of emergency equipment		• Emergency equipment checks now rated as amber. Progress being made but not yet 100% each week of all wards, as is expected. Action being undertaken and escalation within the Care Group and to the Chief Nurse / Director of Quality and Professions • Next review date August 2025, with expected sign off as complete by September 2025.
13 – safeguarding service users from abuse and improper treatment – proportionate use of restraint, and use of prone restraint only as a last resort		
17 – good governance		
20 – duty of candour		
18 – staffing		

Seven Should do actions

Blue	6
Blue Green	0
Green	0
Amber	1
Red	0

CQC action	Status	Outstanding actions
Range of activities across wards		
Section 17 leave supported, particularly when attending medical appointments		
Consider options for improving the provision of food for patients		
Staff wearing scrubs when escorting patients on leave		
One page profiles are easily accessible for staff		
Involvement of carers in loved one's care		

Restrictions should be individually assessed and that restrictions are proportionate to the risks posed		• A Trust-wide audit of restrictions across mental health and secure wards has been completed. All wards compliant with expected practice, aside from variance around access to outside space on some wards. Results to be discussed at the Operational Management Group. Rationale for any blanket restrictions being reviewed within Care Groups, updated position to be presented to the executive management team in October 2025.

8. Summary

The CQC actions, outlined above, 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. Monthly meetings with the Care Group leads are established and challenge is provided where required.

Monitoring of the sustainability of improvements will be monitored through Care Group processes and through clinical governance group on a six-monthly basis. 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. Cheswold Park Hospital CQC Action Plan:

Sixteen Must do actions

Blue	5
Blue / Green	4
Green	7
Amber	0
Red	0

CQC requirement	Status	Outstanding actions
9.1 Access to appropriate and meaningful activities		• Implement 25 hours structured activity and associated recording on SystmOne
9.1 Community meetings		• Evidence reviewed and signed off 03/06/2025

12.1 Prescribing and administration of controlled drugs		• EPMA to address issues. However, due to being high risk, a position statement has been requested
13.4 Section 17 leave		
14.4 Access to drinking water		
15.1 Keepmoat and Lakeside seclusion rooms		• Development of a SOP for using the rooms if required
15.1 Door observation panels		• To be overseen as part of the door replacement programme, with timescales reported to the executive management team. Propose to close this as an action and progress as part of the planned estates work.
16.1 Complaints handling		
17.1 Blanket restrictions		
17.1 Clinical record keeping part 1 system fit for purpose		
17.1 Clinical record keeping part 2 records complete and up to date		• Audit data being reviewed for assurance and action.
17.1 Clinical record keeping part 3 risk assessments		• Audit data being reviewed for assurance and action.
17.1 Clinical record keeping part 4 PBS plans		• Audit data being reviewed for assurance and action.
17.1 MCA audits and training		• Audit data being reviewed for assurance and action.
17.1 Ligature audits		• All audits complete. Next step is planned review of evidence for sign off
17.1 Policies		• Program of policy introduction underway, overseen within the senior leadership team
18.1 Staffing part 1 enough staff		• Continue with staffing initiatives in line with Trust standards and new admission schedule
18.1 Staffing part 1 staff required knowledge and experience		• Learning needs analysis for entire staff group planned
18.2 Training, support, supervision and appraisal		• Transition to wider Trust systems
20.1 Debriefs		

Three Should do actions

Blue	2

Blue	Green	0
Green		1
Amber		0
Red		0

CQC action	Status	Outstanding actions
Hiring processes		
Windows not obscured in nurse stations		
Family and carer involvement		• Continue to develop system and processes in line with wider Trust and Triangle of Care principles

The Cheswold Park Hospital leadership team continue to focus on the CQC report and action plan through internal governance meetings. The introduction of Trust policies will further support the improvement of patient care and family and carer involvement. This is overseen and monitored by the Quality Improvement Group.

Appendix 1: Full detail and updates

Acute and PICU MUST DO actions (evidence reviewed on 12 May 2025)

16 Must do actions

- 11 must do actions are complete (signed off in evidence review meetings)
- 3 must do actions have been reported as complete by the Care Group, and are awaiting evidence sign off
- 2 must do actions are off track due to passing the proposed initial completion date
- Evidence is regularly uploaded to SharePoint to provide assurance about action progress and completion

Regulation	How the regulation was not being met	Person responsible	Action completion date	Evidence	Status (BRAG)	Further evidence requested	Ongoing monitoring
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 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))	Care group senior leadership team the nursing, quality and professions (NQ&P) directorate	In line with Care plan and risk assessment improvement group and priority programme	4/3/25 – Care Plan programme (trust wide). New care plan now implemented from beginning of Jan. For 12 months – consistently over 90%. In Jan 25 – dip to 87.3%, due to changes in Care plan and roll out of new care plans. Feb – increase to 92% Metric on Tendable – considers care plan after 7 days. 1st person – service user voice.		Review of data for 7 months. This will be reviewed in July 25 and reported in August update	KPI within Care Group – through performance meeting. IPR monitoring.
09 - Person centred care	9.2 The Trust must ensure that people (and, where relevant	Care Group senior leadership team and	In line with care plan and risk assessment	KPI moving forward 25/26 – questions about how the care plan has been		Similar to above action.	

	their relatives and/or carers) have the opportunity to be meaningfully involved in their care, are supported to access independent advocacy and are offered a copy of their care plans, unless this is not possible due to the person's individual circumstances (Regulation 9(1) and (3))	NQ&P directorate	improvement group workstream	developed collaboratively. Quality dip sample through the matron checks. Carer champions on the wards. New care plan monitoring and recording as above. Evidence: Benchmarking for Triangle of Care (ToC) and action plan Carers newsletter Advocacy monitoring on inpatient whiteboard and Tendable checks – weekly results Completion of the carer Friends and Family Testt Care planning – as above with patient voice and involvement. Copy of care plan – on SystmOne – recent Business Intelligence dashboard and working on embedding. Compliance increasing – to embed over next 6 months.		Increase in compliance on SystmOne on sharing of care plans Review of data for 7 months.	

				Delivered preceptorship training and a specific session about care planning.			
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 best practice guidance (Regulation 12(2)(b))	Care Group senior team and NQ&P directorate	September 2024	Training being rolled out on wards regarding seclusion exit and injection sites. RRPI team to visit wards to deliver training. This will be picked up by nursing team around trajectory and working closely with wards to deliver training locally. Evidence received shows stabilisation of data and reduction in prone restraint. Awaiting evidence review			
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	Care Group senior team and NQ&P directorate	October 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. Posters displayed in seclusion			

	tranquilisation and when patients are secluded (Regulation 12(2)(b))			A-E document re-vamped Exploring using NEWS2 for rapid tranquilisation monitoring Metrics: Tendable Compliance audits for May, June, July – completed and demonstrated considerable improvement.			
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))	Care Group senior team and NQ&P directorate	September 2024 with interim dates to submit progress against specific actions	CPR and RRPI training figures. Care group performance dashboards for monitoring. Metrics – overall performance for the care group Ward compliance RRPI – 83.5% overall in September Resus – ILS – 90.9% BLS – 90.2%			
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	Care Group Senior Leadership Team, Estates Team, Executive Management Team (EMT) (capital		Evidence paper submitted. Local operating procedure. Clear governance process in place, including comms to SU, oversight by senior manager, ensuring risk assessments, ligature			Normal routine business as usual. Robust processes and monitored through CCTH and

	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))	allocation and sign off)		risks, privacy and dignity.			Care group reporting and monitoring.
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	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)		Clear dates for work completion to be determined and monitored until completion.			

	restrictions on their freedom of movement within the ward (Regulation 15(1)(c))						
15 - Premises and equipment	15.3 The Trust must ensure that the care environment on all wards supports patients' privacy and dignity, particularly when wards are overlooked by areas accessed by patients of another gender or the general public (Regulation 15(1)(c))	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)	June 2024	Evidence review complete. This includes: Confirmation of installation of Integrated Blinds and statement regarding care planning when necessary to utilise specific bedrooms and Trust-wide bed base if required			
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	Care Group Senior Leadership Team, Mental Health Act (MHA) Team, Directorate of Nursing, Quality and Professions		Tendable shows capacity assessments for individual decisions (finance etc.) Data collected by MHA office around capacity assessment completion. 2 metrics: • Consent to treatment – MHA colleagues –			

	the outcome is kept within their care records (Regulation 17(2)(c))			metrics reported in MHA Committee • Decision specific capacity assessments A manual audit has been completed and demonstrates assurance >90% that both capacity to consent to treatment and decision specific capacity assessments are undertaken and recorded. Routine monitoring is part of the weekly Matron Tendable check which includes a question about decision specific capacity assessments being documented if clinically indicated			
17 - Good governance	17.2 The Trust must ensure that record keeping in relation to environmental risks is kept up to date and is available for ward staff to refer to when needed. (Regulation 17(2)(b))	Care Group Senior Leadership Team, MHA Team, Directorate of Nursing, Quality and Professions	March 2024	Tendable data demonstrates 100% compliance in April and May.			
17 - Good governance	17.3 The Trust must ensure	Care Group Senior	October 2024 in line with e-	Audits completed – good compliance.		Process implemented.	Monitored by care

	that, when patients are secluded, they receive observations and medical, nursing and multi-disciplinary team 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))	Leadership Team, MHA Team, Directorate of Nursing, Quality and Professions	seclusion developments	Junior medics within 1 hour completed. Independent review led by a medic – considerable improvement following discussions and training. Now sits with medical secretaries who organise independent review. E-seclusion audit.		Now evidencing embedding – until July. Data for Feb. Non-compliance with independent review but showing improvements (Jan and Feb). Will continue to review until July – for review in Aug	group performance meeting.
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	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	Evidence enough staff to facilitate leave – since May 24, <1% of cancelled leave due to staffing. Therapeutic activities – Sept-Jan – 13% Sept cancelled due to staffing, reducing month on month and Jan 3.5%. Reflecting successful recruitment into posts and improved staffing on wards.	12/5/25		

	hospital if the patient is granted leave (Regulation 18(1))						
18 - Staffing	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))	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	Monthly summary regarding safer staffing. Last 6 months data– shows meeting staffing rations for RN's. Trust target 80% - consistent over 80%.			Monitored through IPR monthly. Quality and performance meeting.
18 - Staffing	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	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	Continued use of bank staffing due to acuity. Establishment review completed and agreed which will support the reduction in use of bank and agency.		Number of bank and agency staff used per month, since inspection (May 23)	Weekly assurance meeting around use of bank and agency.

	impact on the quality of patient care (Regulation 18(1))						
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))	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	August 2024	Now migrated across to ESR. Working on new process for documenting. Target threshold being reviewed to reduce to 90%. Ward level data through Care group dashboards. Not consistently >95% Alert system in place. Monitored through performance oversight 3 months of appraisal data to provide assurance.			Trust wide action now – not for the Care Group. Appraisals monitored through OMG, IPR and Care Group performance group.
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))	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	New completion date of March 2025 in line with Oliver McGowan training programme	Continue to sustain e-learning element of Level 1 now above 80% compliance for all wards. Awaiting rollout of webinar element of Level 1			

Acute and PICU SHOULD DO actions:

Blue and complete = 12

The Should Do action	Person responsible	Action completion date	Evidence	Status (BRAG)	Ongoing monitoring and oversight
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	Care group leadership team	May 2024	Plan for door top alarm go live Implementation of door top alarm sign off		
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	Care group leadership team	May 2024			
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	Directorate of NQ&P, Pharmacy	31/03/24	4/3 – using e-rostering to record when staff have done medicines with respect oral and IM. This allows a report to be pulled and monitored. Face to face training.		Monitor quarterly in Quality and performance meeting. Dashboard development around essential to job role training – review of training – mandatory training.
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	Directorate of NQ&P	31/07/24	Data for monitoring of completion of section 17 leave and record of any		

that action is taken to address any concerns identified from this data			cancelled leave and reasons		
The Trust should ensure that patients are able to access medical care as quickly as possible when this is needed, including out of hours	Care group leadership team	31/07/24	Ongoing process of monitoring incidents.		
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	Care group leadership team, Pharmacy	31/12/24	Specific high dose anti-psych monitoring form. On tenable as a question. Data June-Oct 100% physical health monitoring. Monitoring and oversight added.		
The Trust should ensure that the restrictions on patients' access to certain areas of the wards at Kendray Hospital are kept under review and kept to the minimum level of restriction necessary to keep people safe from avoidable harm	Care group leadership team	30/09/24	Completion of works related to Clark ward		
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	Care group leadership team	30/04/24	Good practice guide. Weekly matron checks. Data for 7 months demonstrates good compliance. New care plan will enhance this.		
The Trust should ensure that patient feedback on the availability of food to meet dietary and	Catering Team	30/09/24	Terms of reference for nutrition steering group.		

cultural needs is taken into account when menus are planned for all wards			Patient experience feedback on food Community meeting minutes where food was discussed.		
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	Care group leadership team	30/09/24	Confirmation of access to hot and cold drinks and snacks on acute wards		
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	31/12/24	Cleaning reports from The Dales and Priestley unit		
The Trust should consider reviewing the seclusion policy to make this more accessible for staff to use in practice	Care group leadership team, Directorate of NQ&P	31/12/24	Update to seclusion policy which has been agreed at clinical policy group. Full review of policy due in 2025.		

Forensic service MUST DO actions (evidence reviewed 12 May 2025)

7 Must do actions

- 5 must do actions are complete (signed off in evidence review meetings)
- 1 must do action has been reported as complete by the Care Group, and is awaiting evidence sign off
- 1 must do action is off track due to passing the proposed initial completion date
- Evidence is regularly uploaded to SharePoint to provide assurance about action progress and completion

Regulation	How the regulation was not being met	Person responsible	Action Completion date	Evidence	Current status (BRAG)	Further evidence requested
09 - person-centred care	The Trust must ensure patients, who require them, have relevant behavioural support plans that enable staff to meet their needs and provide person centred care. Regulation 9 (3)(a)(b)	Clinical manager, lead matron and NQ&P directorate	August 2024	PBS Pathway Service Delivery document now operational. Screening Tool live on SystmOne. Clarity on roles and responsibilities. Monitored on primary nursing audit (quarterly), overseen by the care groups quality governance leads		7 data points on primary nursing audit
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)	Senior estates manager Forensic care group managers	January 2024	Uploaded to SharePoint: • One email thread around the strips being completed and any improvement noted • One email around increasing staff vigilance to areas where confidential information can be heard. • Copy of revised environment check paperwork • Audit work completed to check for noises in confidential spaces.		
	The Trust must ensure ligature	Clinical lead for security	March 2024	Uploaded to SharePoint:		

12 – safe care and treatment 12- safe care and treatment **part 2**	risk assessments are up to date and accessible for all staff Regulation12(d)(e)	Ward managers/governance team Clinical environment safety group		• QI Action plan • Risk summary document • Ligature photos • All induction checklists • Bank leaflet • Risk handover document • Security update slide set • Ligature audit • Copy of yellow folder		
	That all equipment used has been checked to ensure it is safe to use.	As above	As above	Audits show some wards consistently achieving 100% compliance. Performance held for last 6 months, confidence required across all wards (96.5% correct checks across all wards, last 6 months). 100% required. Will be reviewed in 3 months (August 2025) Further work required on consistency across the care group. Will be escalated to Care Group Governance Group for discussion and next steps.		Requires 7 months evidence of compliance. Processes in place for oversight and monitoring of this. Wider work looking at the policy and when checks are completed.

				Ward Managers only to undertake checks on Mondays		
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 restraint. The Trust must also ensure prone restraint is only used as a last resort and is carried out safely. Regulation 13 (4)(b)	Care Group leadership team and NQ&P directorate	September 2024	Low prone Uploaded to SharePoint: • Blank highlight report • FISC March agenda • FISC March presentation • FISC March minutes - draft • Analysis of highlight reports so we can develop a report of themes at the end of July and end of September.		
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	Senior managers NQ&P directorate	September 2024, with interim dates to submit progress against specific actions	Uploaded to SharePoint: • Inpatient highlight report template • FISC Minutes Jan, March & May 2024 • FISC March presentation		

	managing this appropriately. Regulation 17(1)			• FCG Governance framework • Forensic management structure • TOR for security committee. • TOR for inpatient governance. • Flow of FISC minutes into FCG - agenda		
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	Lead Matron	December 2023	Uploaded to SharePoint: • Inpatient quality governance report template • Incident monitoring agenda • DoC incidents Jan-May 24		
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	Senior management team NQ&P directorate	March 2024 New completion data: March 2025 – in line with target completion date for OM training	Uploaded to SharePoint: • Highlight report template, • Minutes from management team meeting, • 2 x Oliver McGowan training compliance • Copy of dashboard to show uptake and stats. • 23-24 Q4 commissioner		

	disability and autistic people. 18(2)a			highlight report (adult secure inpatient) • Supervision and training stats from dashboard		

Forensic service SHOULD DO actions

- Seven should do actions
- Blue and complete = six
- Amber and off track = one

The Should Do action	Person responsible	Completion date	Evidence	Status (BRAG)	Embedded by date
The Trust should ensure that patients are able to engage in a range of activities across all wards	Care group leadership team	31/10/24	25 hours activity. 100% compliance for few years. Activities on board, record who has taken part and who has declined. IT training on induction.		Forensic KPI – reported to commissioners.
The Trust should ensure patients are supported to take Section 17 leave, particularly when this involves patients attending medical appointments	Care group leadership team	31/07/24	Section 17 leave recording of completed and cancelled leave		
The Trust should consider its options for improving the provision of food for patients	Care group leadership team and Catering Team	31/10/24	Catering meeting minutes Forensic care group process You said we did poster		

The Trust should ensure patients privacy and dignity is considered when staff accompany them on section 17 leave in relation to wearing of scrubs	Care group leadership team	31/10/24	Auditing of staff escorting service users whilst wearing scrubs June and September 24		
The Trust should ensure that all patient's one-page profiles are easily accessible for all staff	Care group leadership team	30/04/24	One page profile template and review of completed profiles		
The Trust should ensure where appropriate carers have opportunities to be involved in their loved one's support	Care group leadership team	30/09/24 S1 template to record carer involvement.	Carers bags Carers involvement Carers noticeboard Triangle of care action plan Audit of carer involvement		To send data.
The Trust should ensure that restrictions are individually assessed and blanket restrictions are a proportionate response to risks posed	Care group leadership team	4/3 – review of blanket restrictions and how these are recorded. Including a review of the use of restrictions in courtyard/outside spaces. For discussion at EMT. Blanket restrictions are reviewed monthly. Review dates being updated to add into recording template. Patients are individually risk assessed 30/09/24 Evidence uploaded to SharePoint A Trust-wide audit of restrictions across mental health and secure wards has been completed. All wards compliant with expected practice, aside from variance around access to outside space on some wards. Results to be discussed at the Operational Management Group. Rationale for any blanket restrictions being reviewed within Care Groups, updated position to be presented to the executive management team in October 2025.	Forensic blanket restrictions information and community meeting minutes		Updated target date 31 10 25.

Cheswold Park Hospital MUST DO actions (evidence reviewed 12 May 2025)

The service received 16 MUST DO actions:

- 5 must do actions are complete (signed off in evidence review meetings)
- 4 must do actions have been reported as complete by the Care Group, and are awaiting evidence sign off
- 7 must do actions are in progress and on track
- Evidence is regularly uploaded to SharePoint to provide assurance about action progress and completion

Regulation	How the regulation was not being met	Person responsible	Action completion date	Evidence	Status (BRAG)	Further evidence requested
09 – Person Centred Care	The provider must ensure that patients have access to appropriate and meaningful activities 7 days a week, on and off the ward and that this is documented (9.1)	Associate Director of Nursing, Quality and Professions (EC)	November 2025	Activities are offered daily Continued review of the variety of activities available and access to external support through Creative Minds		Implement 25 hours structured activity and associated recording on SystmOne
09 – Person Centred Care	The provider must ensure that all wards at the hospital hold regular ward community meetings with the patients and they are documented (9.1)	Service Manager (EB)	June 2025	All community meetings now minuted, and minutes are submitted for assurance purposes You said, we did in place Acknowledged in most recent CQC report Evidence reviewed and signed off 03/06/2025		Example minutes saved to folder
12 – Safe care and treatment	The provider must ensure that all regulations relating	Associate Director of Nursing,	March 2026	High risk, ongoing issue QI task and finish group commenced Dec 24		Need a position statement on action currently

	to the prescribing and administration of controlled drugs are followed (12.1)	Quality and Professions (EC) / Chief Pharmacist (KD) / Clinical Lead (JP)		Meeting held with Speeds Pharmacy 31/1/25 All learning from medication incidents to be shared at the newly formed Patient Safety and Quality forum from Feb 25 EPMA to address (likely October) Position has improved with strong leadership oversight (quality and medical)		being taken whilst awaiting implementation of EPMA
13 – Safeguarding	The provider must ensure that all Section 17 leave is based on patient need as required by the MHA Code of Practice (13.4)	Associate Director of Nursing, Quality and Professions (EC)		Very low numbers of S17 leave cancelled Recorded as an incident on Datix if necessary	18/3/25	
14 – Nutrition and Hydration	The provider must ensure that patients always have free access to drinking water (14.4)	Associate Director of Nursing, Quality and Professions (EC)		Water fountains moved following inspection	18/3/25	
15 – Premises and Equipment	The provider must ensure that the Keepmoat and Lakeside seclusion suites are fit for purpose and maintain the privacy and dignity of patients (15.1)	Associate Director of Nursing, Quality and Professions (EC) / Head of Estates (NP)	June 2025 for mitigation statement Longer term regarding estate changes	Audit of the seclusion environments undertaken in Feb 2025 using the new CQC Brief Guide. Update report to be provided to the executive management team in line with estates timescales in September 2025.		A SOP to be developed

15 – Premises and Equipment	The provider must ensure that all doors in rooms used by patients have observation panels with integrated blinds/obscuring mechanisms (15.1)	Associate Director of Nursing, Quality and Professions (EC) / Senior Planning Manager (SI)	Being reviewed in line with the broader door replacement programme.	Door replacement works underway which include integrated observation panels		
16 – Complaints	The provider must ensure that their complaints process and accompanying processes and policies are fit for purpose and ensure all complaints can be reviewed appropriately (16.1)	Associate Director of Nursing, Quality and Professions (EC) and (SW)	May 2025	CPH policy reviewed as part of the due diligence process and continued review with a plan to introduce the Trust process from April 2025 All complaints to be back dated to recorded on Datix (1/10/24 to present date) Oversight of complaints now with the Associate Director of Nursing, and Service Director		
17 – Good governance	The provider must ensure that all blanket restrictions are reviewed and documented whilst complying with the MHA (17.1)	Associate Director of Nursing, Quality and Professions (EC)	May 2025 for the audit, align with Trustwide work regarding blanket restrictions	The blanket restrictions have been reviewed and updated CPH will transfer to Trust policy Q1 25/26		
17 – Good governance The provider must ensure that: the hospitals care record system is fit for purpose and all	The provider must ensure that the hospitals care record system is fit for purpose	Associate Director of Nursing, Quality and Professions (EC) / Head of Nursing (AB)		SystmOne introduced in April 2025		

patient care records, risk assessments and positive behaviour plans are completed and updated as needed (17.1)	all patient care records are completed and updated as needed	Associate Director of Nursing, Quality and Professions (EC)	December 2025	Record keeping training and the Trust care plan and risk assessment training will be introduced in Q1 25/26			Evidence from audits
	risk assessments are completed and updated as needed	Associate Director of Nursing, Quality and Professions (EC)	December 2025	Record keeping training and the Trust care plan and risk assessment training will be introduced in Q1 25/26			Evidence from audits
	positive behaviour plans are completed and updated as needed	Associate Director of Nursing, Quality and Professions (EC)	December 2025	Record keeping training and the Trust care plan and risk assessment training will be introduced in Q1 25/26			Evidence from audits
17 – Good governance	The provider must ensure that the use of the MCA is audited, and staff are provided with effective training on its use (17.1)	Associate Director of Operations (ER)	December 2025	The Trusts MHA team provide support to CPH including a review of systems, processes and roles Training remains with CPH with 99% compliance rate Plan to introduce Trust training and policies in 25/26			Training in line with Trust standards MCA audit results
17 – Good governance	The provider must ensure that all hospital areas have up to date ligature risk assessments in place (17.1)	Associate Director of Nursing, Quality and Professions (EC)	July 2025	All wards complete. Awaiting two seclusion rooms currently occupied (will be audited ASAP)			All complete, require evidence
17 – Good governance	The provider must ensure that all policies relating to	Associate Director of Nursing,	March 2026	All clinical policies reviewed as part of the due diligence			Program of policy

	the safe care and treatment of patients have been reviewed and updated as required (17.1)	Quality and Professions (EC) / Associate Director of Operations (ER)		A trajectory of the introduction of Trust Policies is to be presented to EMT 20/2/25			introduction saved to folder
18 – Staffing The provider must ensure that there is enough staff, with the required knowledge and experience, to keep patients and staff safe (18.1)	The provider must ensure that there is enough staff	Associate Director of Operations (ER)	October 2025	Implemented MHOST Staffing RAG tool Escalation procedure in place Transitioned to e-rostering to support more robust planning and to ensure oversight of skill mix Utilising Trust-wide bank			
	with the required knowledge and experience, to keep patients and staff safe	Associate Director of Operations (ER)	October 2025	A scheduled learning needs analysis for whole staff group is planned There is a programme of work for ward manager development underway All staff to transition to Trust mandatory training to ensure a competent and well-informed workforce			
18 – Staffing	The provider must ensure that all staff receive appropriate training, support, supervision and appraisal in line with the providers policy (18.2)	Associate Director of Nursing, Quality and Professions (EC) / Associate Director of Operations (ER)	March 2026	Training figures good (99% compliance on mandatory) Supervision figures good Appraisal figures good Introducing Trust mandatory training Planned introduction of Trust Supervision Policy			

				Review of supervision structure underway Planned move to the Trust appraisal process		
20 – Duty of Candour	The provider must ensure that all staff and patients receive appropriate debriefs following incidents and that these are recorded (20.1)	Associate Director of Nursing, Quality and Professions (EC) / Head of Nursing (AB)	May 2025	Improved and further strengthened following the introduction of PSIRF and Datix Overseen by Local Patient Safety Oversight Group		

Cheswold Park Hospital SHOULD DO actions:

The service received 3 SHOULD DO actions, alongside the MUST DO actions:

- two actions are complete
- one action are in progress and on track

The Should Do action	Current position as at March 2025	Person responsible	Action to be taken	Completion date	Status (BRAG)
The provider should consider reviewing the hiring processes of the hospital to ensure newly employed staff have the knowledge and experience to complete their roles effectively	The Trust recruitment processes have been introduced to CPH	Associate Director of Operations (ER)			
The provider should ensure that windows are not obscured in the nurses' station on each ward	Removed at the time of inspection and continues to be monitored in the environmental checks	Associate Director of Nursing, Quality and Professions (EC)			
The provider should ensure that they consider the needs of patients' families and carers and involve them in the patients care where possible	The Trust values have been introduced and collaboration with family and carers in the	Associate Director of Nursing, Quality and		March 2026	

	patients care is communicated in leadership meetings The social work team and the family liaison lead are currently reviewing the family and carer leaflet and introducing the FFT Designated family and carer role and links to the wider Trust offer Beginning to explore Triangle of Care	Professions (EC) / Social Worker (LM)			

11. Understanding the impact of changes

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

Sarah Whiterod – Associate Director of Nursing, Quality and Professions

Liam Redican – Quality Governance Manager

Glossary of terms

Acronym	Full version
BLS	Basic Life Support Training
BRAG	Blue Red Amber Green
CC2H	Care Closer to Home
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
DoC	Duty of Candour
EMT	Executive Management Team
EPMA	Electronic Prescribing and Medicines Administration
FISC	Forensic Inpatient Security Committee
FCG	Forensic Care Group
ILS	Immediate life support training
LD	Learning Disability
MCA	Mental Capacity Act
MHA	Mental Health Act
NEWS2	National Early Warning Score 2 – a tool to identify physical health deterioration
NQ&P	Nursing, Quality and Professions
OM	Oliver McGowan training for people with a learning disability and autistic people
OMG	Operational Management Group
OPP	One Page Plan
PBS	Positive Behaviour Support planning (a therapeutic approach for learning disability)
PICU	Psychiatric Intensive Care Unit
PSOG	Patient Safety Oversight Group
RRPI	Reducing Restrictive Physical Interventions
SOP	Standard Operating Procedure
SPC	Statistical Process Control
TBC	To Be Confirmed
ToC	Triangle of Care
ToR	Terms of Reference
QI	Quality Improvement

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.3

Private/Public paper:	**Public**		
Title:	**Patient Experience (including complaints) Annual Report 2024/25.**		
Lead Director:	**Darryl Thompson, Chief Nurse and Director of Quality and Professions**		
Mission/values:	The report demonstrates 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 present the Patient Experience (including complaints) Annual Report for 2024/25. This annual report includes customer services (complaints, compliments, concerns and comments), friends and family test and service line patient experience survey information. Also included are additional areas where patient experience is gathered, including catering, patient-led assessments of the care environment (PLACE), Insight and mental health inpatient weekly and monthly audits.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	The patient experience annual report 2024/25 supports a number of BAF risks, including: 1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.		

With all of us in mind.

	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider Trust within the ICS is 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. Understanding the quality of care and the feedback from the people who use our services, their families and carers is integral to enabling our services to grow and develop. It supports collaborative working across our partnerships and our contribution to system wide discussions and developments in a meaningful way.
Any background papers / previously considered by:	The previous Patient Experience Annual report for 2023/24 was shared with Quality and Safety Committee and Trust Board in June 2024. The Quality and Safety Committee and executive management team receive quarterly updates on patient experience. This report has been reviewed by the executive management team, and in the Quality and Safety Committee on 10 June 2025 it was recommended to submit the report to Trust Board.
Executive summary:	The Patient Experience Annual Report brings together information and data intelligence from customer services (complaints, compliments, concerns and comments), friends and family test and patient experience surveys. In addition, for 2024/25 other areas where patient experience is gathered are included, such as patient-led assessment of the care environment (PLACE) audits, inpatient weekly and monthly audits, catering and insight. Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. The patient experience headlines for 2024/25 are as follows: • During 2024/25 the Trust received 11,556 pieces of feedback (customer services, friends and family test and patient experience surveys). • We have seen an increase in formal complaints (26%) which have been received and investigated by the Trust. • 82% of complaints closed in the year were resolved within the six-month target. • There has been a notable increase in the number of reopened complaints, suggesting complainants are more dissatisfied with the response they receive. • There has been an increase in compliments, and these are spread across services. • The friends and family test (FFT) feedback shows an increase in satisfaction across the Trust. The qualitative data received through FFT has improved and this supports improvements. • This increased satisfaction is also reflected in service line patient experience surveys. • Themes, both positive and negative, across patient experience, are largely consistent with previous years, and it is the specifics

	from these themes that supports improvement of quality, safety and culture within individual services and teams.
	• The main positive themes from the feedback related to staff, communication, admission and discharge and access and waiting times.
	• The main negative themes from the feedback relate to access and waiting times, staff and communication.
	• Some additional themes have been noted and these include:
	  ○ Food, food choice and quality. Improvement work has led to improvement in overall satisfaction on mental health inpatient wards.
	  ○ Family involvement. Some positive feedback and improvements noted, however some feedback suggests there is more to do in this area.
	• Some people providing feedback do not wish to supply any equality or personal data. Where this data was available 2,548 service users, 503 carers and 307 parents were identified as providing feedback.
	• Where identifiable, the majority of feedback received was from people of a working age and equality data suggests feedback was from a broad range of groups who access our services. Work has been done during 2024/25 to capture equality data, and this is used to support our understanding of patient experience for all people.
	• A number of key improvements were made during the year including:
	  ○ Improvement in the number of complaint responses sent within the six-month statutory target, from 43% during 2023/24 to 82% responded to within six months during 2024/25.
	  ○ Increase in overall satisfaction rates through the friends and family test.
	  ○ Volunteers are working within both customer services and patient experience teams and this role will expand further over the coming year.
	• The report also sets out action and development plans for the next 12 months including:
	  ○ Capturing, reviewing and actioning feedback from complaints.
	  ○ Launching patient experience surveys across remaining service lines and triangulating the feedback.
	  ○ Using the themes identified within this report to support improvement work, identify good practice and utilise the feedback to demonstrate where improvements have been made.
	• In addition, the patient experience agenda will continue to support the implementation of the patient and carer race equality framework (PCREF) and the triangle of care workstreams, enable feedback into priority programmes of work, and support the quality assurance system in providing quality oversight and quality improvement.

Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the Patient Experience Annual report 2024/25.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Patient Experience Annual Report 2024/25

With **all of us** in mind.

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1. Introduction

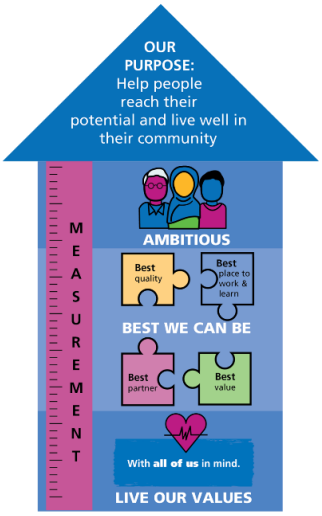
1.1. What is patient experience?

Patient experience is regarded as one of the key indicators of quality in healthcare provision and is closely intertwined with the two other key aspects: clinical effectiveness and patient safety. Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. We also know that positive staff experience is fundamental for ensuring good patient experience.

The measurement of patient experience feedback is used to identify strengths and weaknesses of healthcare delivery, drive-quality improvement, inform commissioning and promote patient choice. Of note, for the purpose of this report we will use the term patient to also cover the term service user, a more usual term in reports within the Trust.



Across the Trust live our values and are working towards achieving our priorities which are visualised in the image below.



Patient experience is a key element of all the work we do across the Trust, which ensures that we put the person first and, in the centre, and hear the voices of families and carers. Understanding the experience of our patients and their carers and families allows for improvements to be made

as we move towards being an outstanding organisation and providing outstanding care and outcomes.

1.2. Gathering patient experience

There are several ways in which patient experience is captured across the Trust and this report will share information, themes, and outputs from these different methods. Alongside this, the information gathered will be triangulated and the report will provide an overall picture of the experience of our patients, their carers, and families and how this information has been used to drive forward improvements in the quality of care.

This report will cover the following:

- Customer services contact, including complaints, concerns and compliments.
- Friends and family test results.
- Patient experience surveys.

In addition, this year there is a spotlight on some of the other key areas which provide an insight into patient experience. These are:

- Food related patient experience.
- Patient-led assessments of the care environment (PLACE).
- Insight from external organisations and sources.
- Matron monthly inspection on mental health inpatient wards.

2. Patient experience as a pillar of quality

The National Quality Board's (NQB) single view of quality and the delivery of high-quality, personalised, and equitable care for all is defined in the infographic below:



Experience can be understood in the following ways:

- What the person experiences when they receive care or treatment
    - The interactions between the person receiving care and the person providing the care, e.g. how the person providing care communicates with the person receiving care
    - The process the person is involved in, such as booking an appointment
- How the person's interaction with a staff member, care provision, or services made them feel

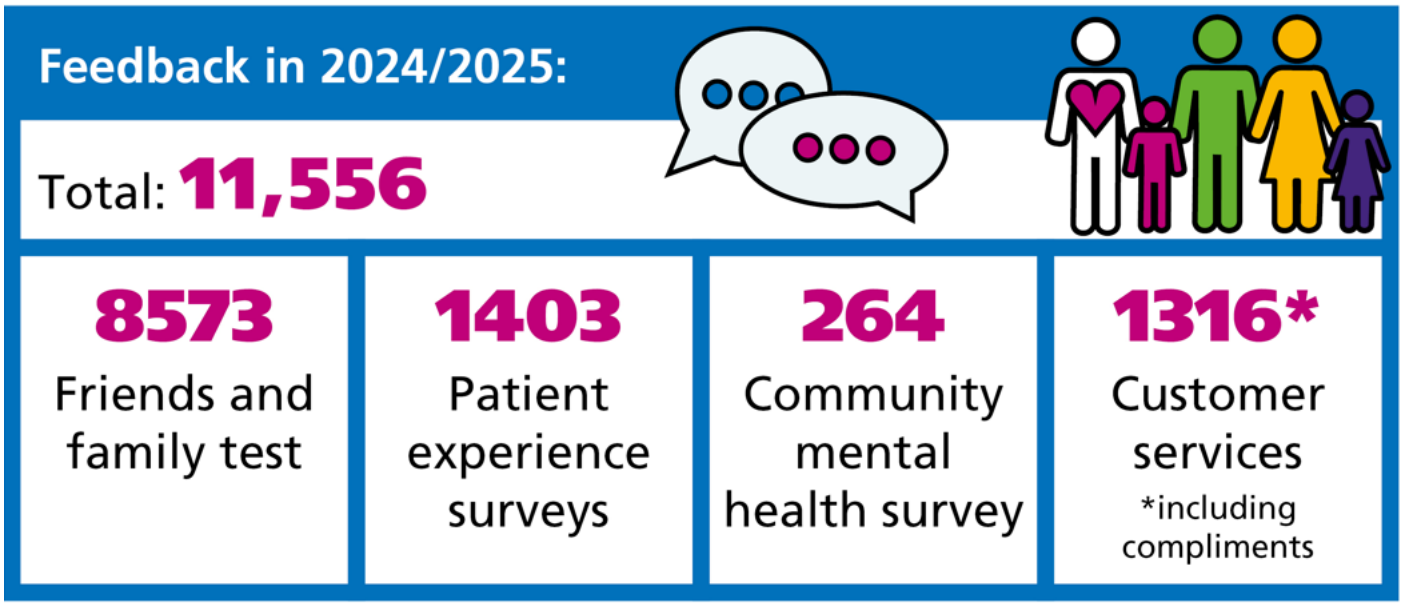
There are three key areas an organisation should consider when planning for improvement:

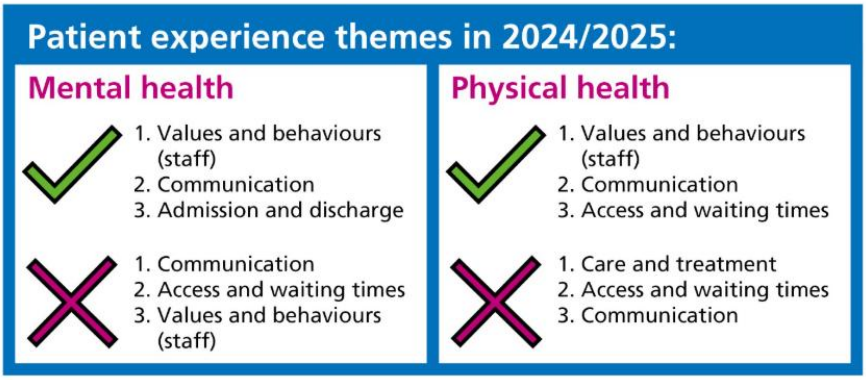
1. Co-production
2. Using insight and feedback
3. Improving experience of care at the core of priority programmes of work

In line with the Trust Quality Strategy and the current three quality priorities, patient experience is a key part of driving forward improvements.

3. Key facts and findings

3.1. Overview of feedback received





The patient experience themes above combine customer services, friends and family test and patient experience survey information. The themes are predominantly the same regardless of how feedback is collected.

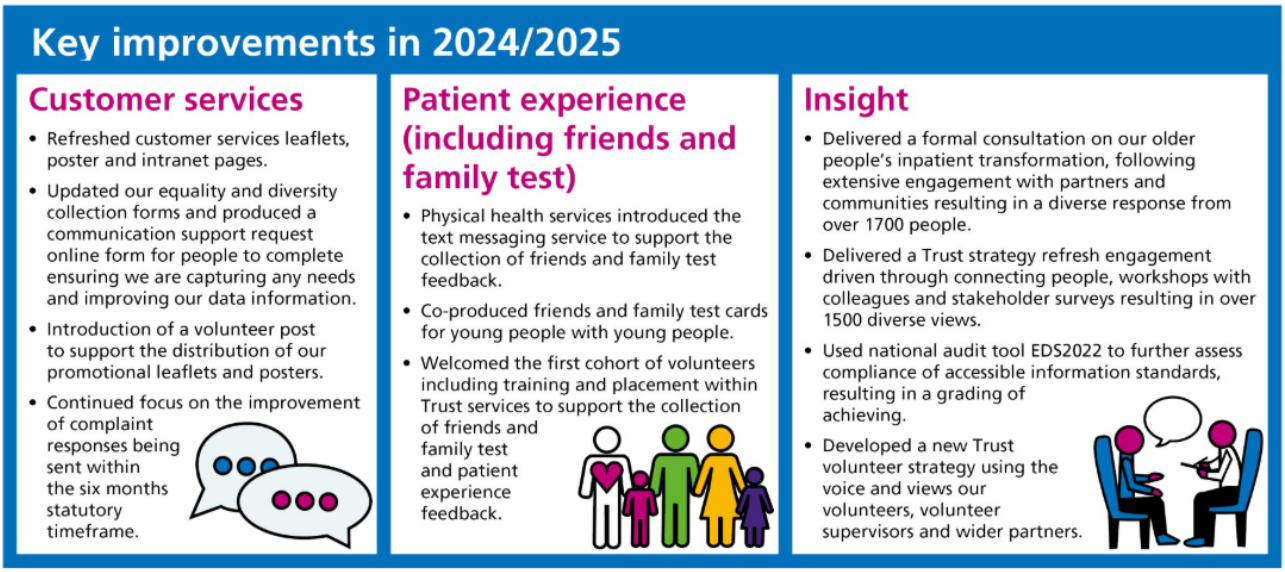
Additional triangulation of feedback related to patient experience has also identified some additional themes. These include:

- Food, food quality and food choice in inpatient settings. Within mental health inpatient wards, satisfaction rates have improved over the last 3 years, with a 95% rate identified during 2024/25. Patient experience surveys also provide good oversight of a high satisfaction rate with food in inpatient settings. Satisfaction with

food quality and choices within forensic inpatients remains low, and changes and additions to catering staffing is working to improve this satisfaction. A spotlight on food related feedback Appendix 13.

- Long waiting times for assessment and treatment. Insight information and complaint themes identify this as an area of concern, especially within children and young people services and attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD) services.
- Family involvement in a service users care has mixed feedback, with some positive areas and some less positive areas.

3.2. Key improvements made in 2024/25



3.3. Who gave us feedback in 2024/25

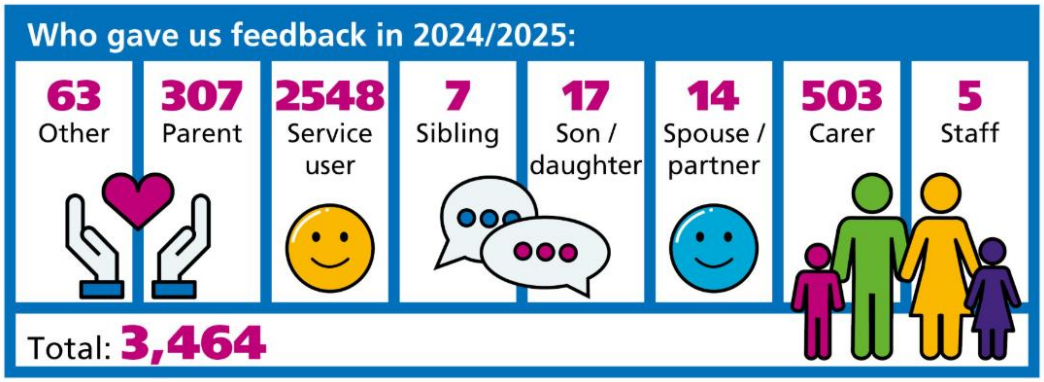
The information below is related to customer services, patient experience surveys and friends and family test and is detailed within the relevant sections. Not all respondents during 2024/25 provided equality data, therefore the figures shown below are lower than the overall number of returns for patient experience in section 3.1. In addition, some people may engage in more than one feedback mechanism.

During 2024/25 (of those who provided the information) 71% of the feedback received came directly from patients (service users) themselves, with 17% from a carer/relative or friend and 9% from a parent.

The equality data for ALL feedback is contained within Appendix 2.

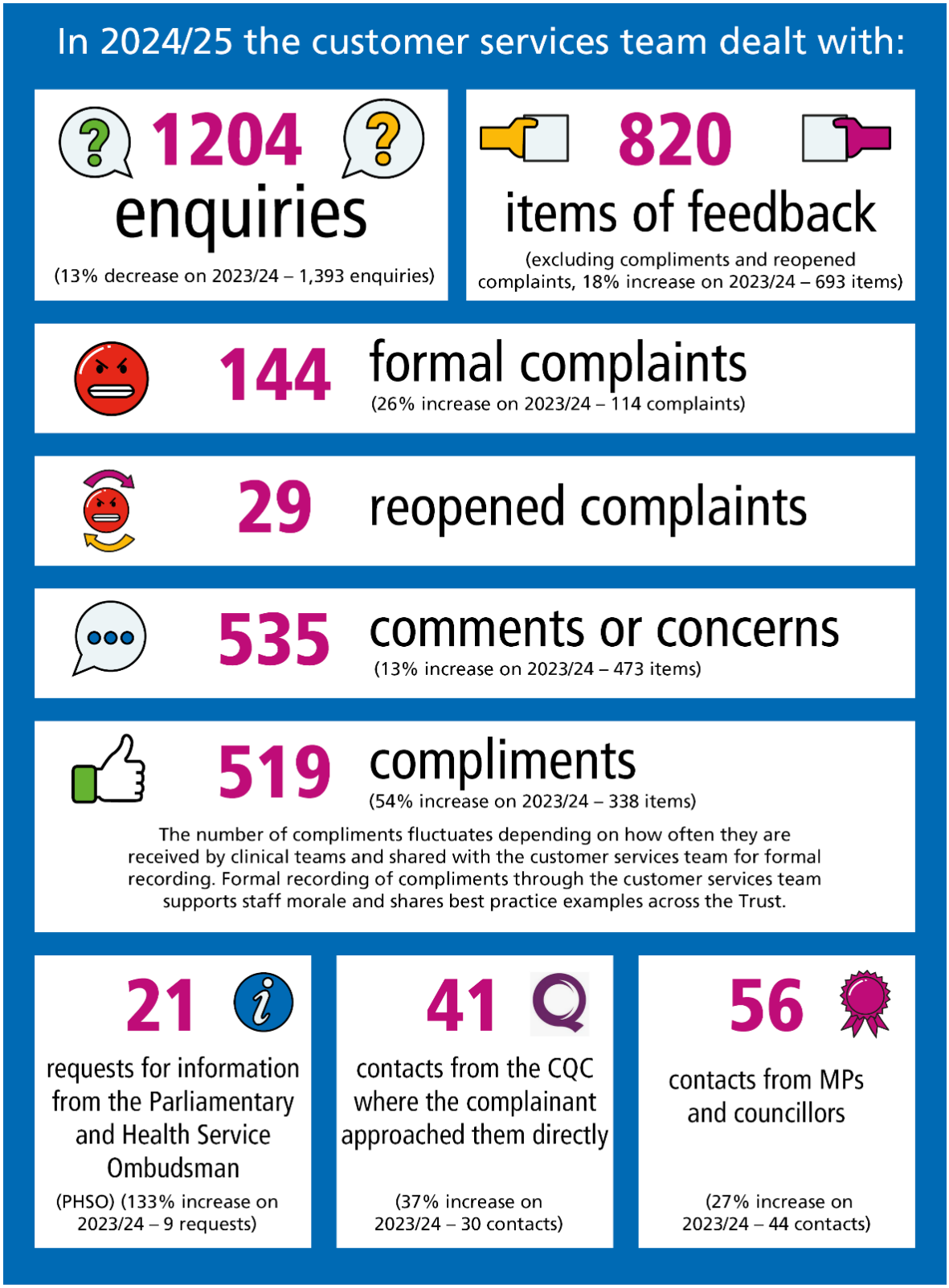
The data suggests that feedback is received from a wide range of people who access Trust services. The majority of feedback is received from working age adults (65%), with 35% being from people over 60. This is an improvement on the previous year in terms of older adults providing feedback.

65% of feedback received is people who are female, and 35% from males. 74% of feedback is from people of a white English/Welsh/Scottish/northern Irish background, with 18% white and Asian and 2.3% from Asian/Asian British people.



Development in enhancing data collection and using it to help drive improvements will form part of the Patient and Carer Race Equality Framework (PCREF).

4. Customer Services



4.1. Overview

Trust Board monitors complaints via the integrated performance report (IPR). The quality and safety committee (QSC) and executive management team (EMT) also receive assurance reports regarding customer service key performance indicators and quarterly reports are shared with the West Yorkshire Integrated Care Board (ICB) as part of the Trust contract.

This report includes the annual data related to complaints, in line with the Trust's aim to learn from concerns/complaints raised, improve patient experience, and ensure Trust Board oversight of the compliance against our registration with the Care Quality Commission (CQC) in relation to complaints management. This includes:

- The monitoring arrangements for complaints handing in the Trust;
- Trends in complaints themes; and
- The Parliamentary and Health Service Ombudsman (PHSO) status

Themes from feedback are used to support quality improvement across our services and enable patient, carer, and staff experience to be captured within the work we do and the care we provide every day.

The Customer Services team deals with the following types of feedback:

Enquiries	When an individual is seeking information and does not wish to raise a concern about their treatment. This can also include signposting to other organisations.
Comments	A comment is a matter that is not about an individual's care and treatment. It is something that is a cause for concern to the person, e.g., they may be unhappy with parking arrangements at the service, or someone leaving lights on when a building is empty.
Compliments	Positive feedback received regarding care, generally from service users, their relatives and/or carers. Compliments are also sometimes received from other health care professionals, services or external partners.
Informal concerns	A concern is a matter which an individual wishes to be considered on an informal basis. This can be done by the complainant directly with the service and should be resolved to the individual's satisfaction within two working days (in line with NHS complaint regulations). All staff are expected, on a routine and daily basis, to deal with patient concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational/clinical areas, allowing for timely and informal resolution of the concern.
Formal complaints	An expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply: • Action or activity by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer. • The complainant believes that a mistake or error occurred and that this has detrimentally affected them. • The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

During 2024/25 the customer services team:

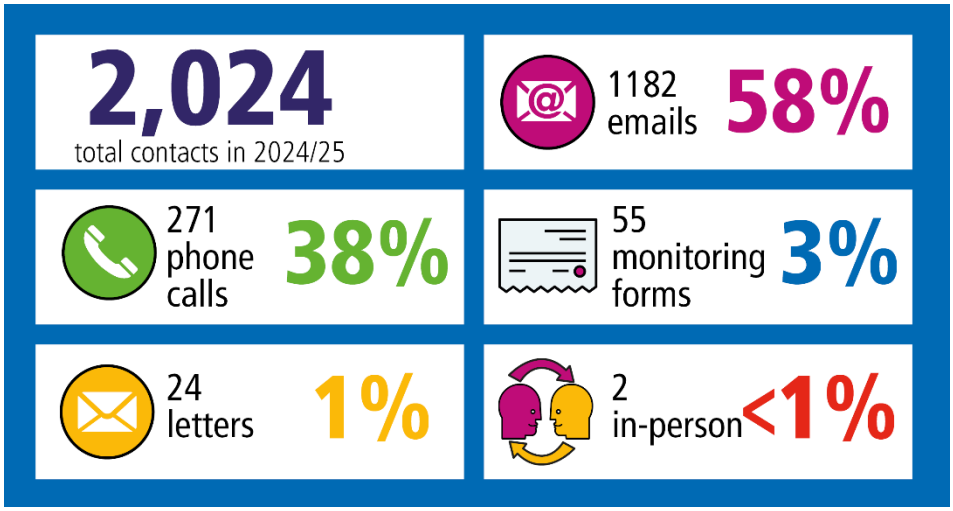
- Dealt with 1,204 enquiries regarding information about the services we provide, the complaints process and signposting to other organisations.
- Received 820 items of feedback, which consisted of formal complaints, informal concerns, and comments, and breaks down as follows:
    - 285 were formal complaints, which is a 26% increase from the previous year (223 in 2023/24). Of these:

- 144 (of the 285) (51%) are proceeding as formal complaints (these are complaints where consent has been received from the complainant and the scope of the investigation agreed to enable an investigation to begin i.e. timescales start). This compares with 114 (26% increase) from the previous year.
- 22 (of the 285) (8%) are awaiting consent to be returned.
- 22 (of the 285) (8%) are agreeing the scope of investigation with their complaint handler.
- 97 (of the 285) (34%) formal complaints raised did not proceed to investigation, either through the complainant not returning the requested consent, inability to agree a scope for the complaint or no further contact being received from the individual.

- Work to identify barriers to proceeding with a formal complaint has been identified and will be started during 2025/26.

4.2. Recording feedback – a summary

Feedback is received into the customer services team by email, letter, by a staff member, online form from the website, monitoring form (from the customer services leaflet), or by a phone call.



Signposting and responding effectively to both the public and staff is a fundamental part of our role in customer services. As part of this role, we receive a wide variety of enquiries from both the public and staff. These can range from straightforward service queries to more complex concerns that require time to fully understand and respond to. Often, the initial contact doesn't clearly outline the issue or may relate to services outside of our Trust's remit, which means additional steps are needed to clarify the ask and identify the appropriate route for support.

Many of the queries we receive are not easily resolved. They may involve sensitive issues, multiple organisations, or historic concerns, all of which require careful handling and clear communication. Our administrative team consistently go above and beyond to support this process responding with empathy, gathering information, signposting where appropriate, and ensuring each individual feels heard. Their dedication is central to ensuring a positive experience for those reaching out to us, reinforcing that we are a responsive, accessible, and compassionate service. By being open, transparent, and accessible, we demonstrate that we are here to listen, and that no door is ever closed. This approach shows we are committed to making it as easy as possible for people to reach the right support, and that we take every concern or query seriously.

Information about the numbers of comments and compliments are also detailed within this report.

Initially concerns are managed informally, where possible, with the relevant service or team reviewing and if appropriate, contacting the complainant for an initial discussion about their concerns. As such several concerns do not progress through a formal complaint process as they are able to be resolved informally.

Where the complainant requests for them to be managed as a formal complaint from the outset, or those where an informal resolution has not been possible, these will then be managed through the Trust's formal process for the handling of complaints. This report provides data on both feedback resolved informally and those which are managed through a formal process. Complaint themes are outlined on a Trust wide basis and reported at service level.

Complaints which are received by the customer services team are risk assessed using the Trust's risk matrix. This is undertaken by the customer services manager and shared with clinical services to assess and action any immediate risks. Any complex or high-risk complaints are discussed at the monthly complex complaint cases panel and/or raised at the weekly patient safety oversight group (PSOG). PSOG is attended by the Executive Trio which includes the Chief Operating Officer, Chief Nurse and Director of Quality and Professions and the Chief Medical Officer. Any complaint graded as red is presented at PSOG. This also provides assurance that actions relating to the most serious Trust complaints are fully implemented into clinical services.

4.3. The customer services team

The customer services team is made up of staff trained in the management of NHS complaints who are specialists in complaint handling and investigation. Throughout 2024/25 the team were able to improve the flow of complaints and concerns through the process, leading to improvements in response time for complaints. Further information and data are contained later in this report.

4.4. Volunteer contribution and future role in service improvement

Over the past year, the customer services team has welcomed a dedicated volunteer whose primary focus has been to ensure the accessibility and accuracy of our customer service materials. The volunteer has worked diligently to update our new customer service leaflets, reflecting the local changes to advocacy services, and has distributed these materials along with our posters, across all service areas within our Trust.

Looking ahead, our volunteer will take on an important role in gathering feedback from a broad range of stakeholders. They will be responsible for distributing satisfaction forms to complainants, staff involved in resolving feedback, staff named in feedback, other NHS organisations, local authorities, and advocacy services. This proactive approach will enable us to gain valuable insights into how our team supports stakeholders through the feedback process.

By analysing the responses we receive, we will be able to identify areas for improvement and highlight best practices, ultimately leading to meaningful service enhancements. Our volunteer's contribution will not only strengthen our feedback processes but will also help us foster a culture of continuous improvement and learning.

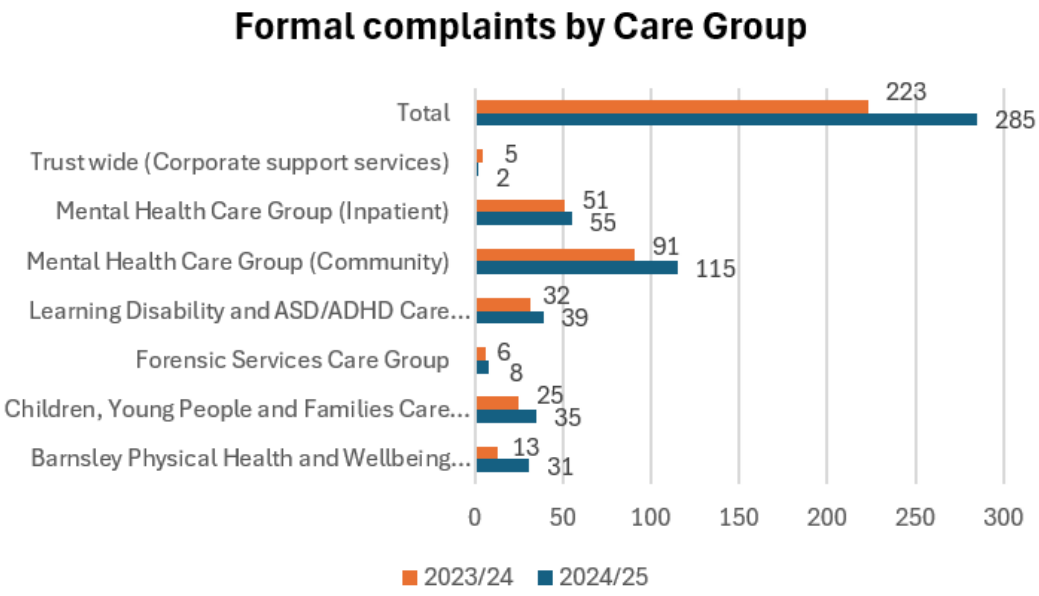
Our volunteer plays a valuable role in supporting our commitment to enhancing the quality of our service and we are grateful for her time, dedication and commitment.

4.5. Managing complex complaints

Complaints are often complex and longstanding in nature. Complainants' expectations of what can be achieved through the complaints process may be unachievable and individuals often require support to understand the potential outcomes available through the complaint's procedure.

In addition, there are a small number of people where the frequency of their contact with the Trust, or their individual behaviour, hinders consideration of their own and/or other people's complaints. This is defined as persistent or unreasonable behaviour. A section in the: *Customer services policy: supporting the management of complaints, concerns, comments and compliments (September 2023)* supports the customer services team and the Trust in supporting individuals who are defined in this way. This includes letters which have been developed to explain the process to the person. These letters have been reviewed through a trauma informed lens and by a person with lived experience.

4.6. Formal complaints



The bar chart above shows a comparison for the total number of formal complaints received by each Care Group across the Trust in 2023/24 and 2024/25. The graph above demonstrates that there has been a 26% increase in complaints received compared to 2023/24.

In 2024/25, adults and older peoples' services (OPS) mental health (community) service line received the highest number of complaints (n=115) which is consistent with the previous year, followed by adults and OPS inpatient services (n=55). Detail about the themes for complaints is contained further down within this report.

The majority of complaints for the learning disability Care Group related to autistic spectrum disorder and attention deficit hyperactivity disorder (ASD/ADHD) services (n=33). These often related to waiting times and assessment outcome and prescribing of ADHD medication. As a result of this feedback the customer services team are supporting ADHD services by providing additional audit information to identify areas of focus, such as sharing clearer information ahead of diagnostic assessments to enable service users to understand the process and empowering service users and carers to get the best out of their appointment.

Whilst the graph demonstrates the spread of complaints across different Care Groups and service lines, it is important to note that these areas are not comparable, due to differing service user groups and the numbers of people who are supported by each service. The

opportunity for learning and improvement does not always equate to the Care Groups with the most complaints.

4.7. Responding in a timely manner

In line with the NHS Complaints (England) Regulations (2009) and the Trust's customer service standard, all complaints are expected to be acknowledged within three working days and a formal written response provided, and the complaint closed within six months of receipt.

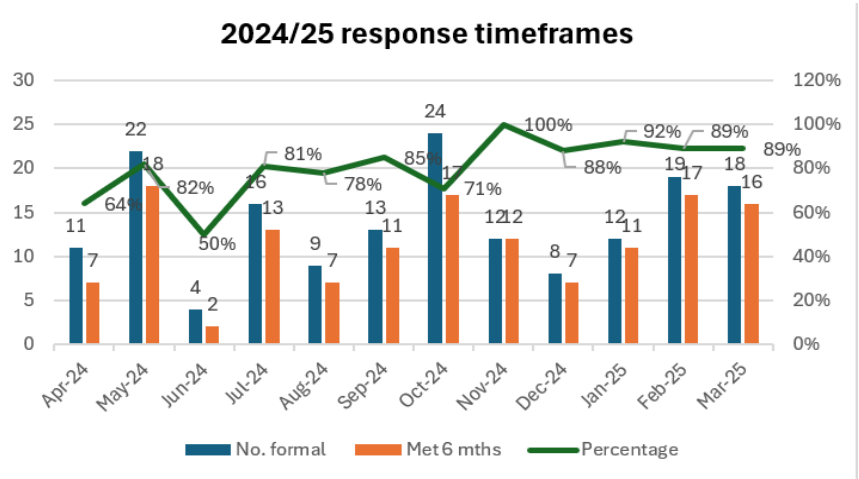
4.7.1. Acknowledgement within three working days

- During 2024/25, 99% (n=283) of formal complaints met this target which is an improvement from 92% in the previous year.
- Of the two that missed the target, this was due to human factors and human error. This has been addressed with the individual to ensure learning and improvement. The error did not result in a delay for the complainants.

Timescales for responding to a complaint are negotiated on an individual basis (but remain within regulatory requirements), with each complainant offered regular updates on the progress of their complaint until the issues are resolved to their satisfaction or a full explanation has been provided. A complaint investigation should be proportionate to the concerns raised. The target for when a complainant can expect to receive a formal response is agreed between the customer services officer and the complainant.

All complaints are dealt with as quickly as possible. Directors of services and general managers across services are kept updated on the progress of complaint investigations. The customer services team works with individual services to support the identification of lead investigators who have capacity and dedicated time for conducting the investigations.

4.7.2. Responding and closing complaints within six months



- During 2024/25, 168 formal complaints were closed and 82% (138/168) of these were closed within the six-month target. This is a significant and sustained improvement on the performance during 2023/24 when 43% of formal complaints were closed within the six-month target (175 complaints closed).
- The significant gains reflect the fact that complaints are now allocated and investigated in real time since the waiting list was eliminated in October 2023.

- Close working between the customer services team, Care Groups and directors involved in oversight and sign off of complaints is also reflected in this improved performance.
- On occasion there are delays in responding to complaints and the reasons for this can be multi-faceted. These can include:
    - delays obtaining valid consent to enable the investigation to proceed.
    - delays agreeing the scope of investigation with the complainant.
    - availability of a lead investigator in the Care Group.
    - timely completion of the complaint toolkit.
    - complaints progressing through the stages of the sign off process.

Further detail about complaint responses timeframes by Care Group can be found in Appendix 1.

4.8. Reopened complaints

During 2024/25, a total of 29 formal complaints were reopened (reactivated) following the completion of the initial investigation and the issuing of an outcome letter to the complainant. This represents 17% of all formal complaints closed during the year (29 out of 168), which is a notable increase compared to the previous year, where only 5% (8 out of 175) of complaints were reopened.

This upward trend indicates a rise in the number of complainants who are not fully satisfied with the response they receive. However, this increase contrasts with the findings of a recent independent 360 assurance audit, which reviewed 12 final written responses. The audit found that each response addressed all the issues raised and included compassionate, meaningful apologies, demonstrating good practice in complaint handling and communication.

There is a notable increase in the complexity of the issues which are raised by complainants, and these often involve multiple services, clinical decision making, or historical concerns. In addition, complainants' expectations continue to evolve, with some seeking more detailed explanations or assurances about actions taken in response to their concerns.

4.9. Themes from complaints

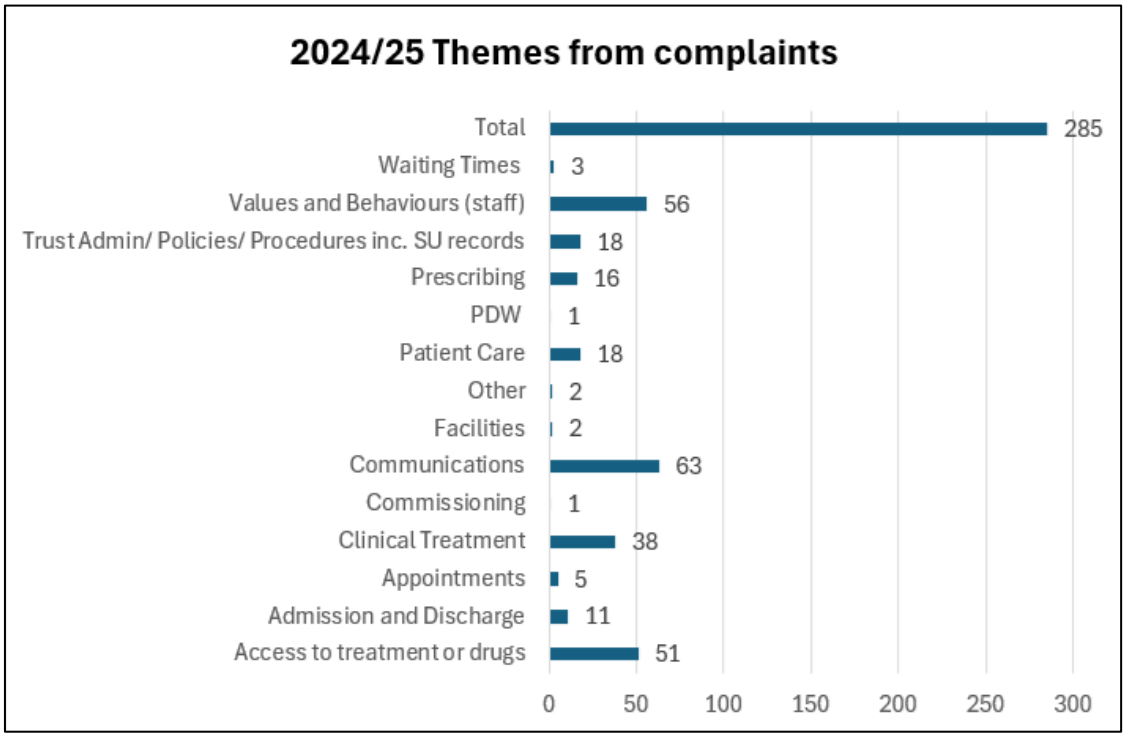


Complaints typically contain multiple themes/issues and in 2024/25, the primary subject of each complaint were themed into 14 categories. The themes are the primary reason the person is complaining and do not reflect the findings from our investigation. Therefore, the themes do not demonstrate an actual failing or proven issue although they do reflect the complainant's perception.

The themes for complaints are based on NHS Digital's categorisation and many different sub-categories sit within each overarching theme. Further information can be found here.

- Communications (n=63, 22%) is the top primary subject for complaints in 2024/25, which is consistent with 2023/24. This includes sub-categories such as communication failure between departments, delay in receiving results, patient not feeling listened to.
- Values and behaviours (staff) were the second most common theme for complaints in 2024/25 (n=56, 20%) compared to clinical treatment in 2023/24. This theme continues to be reported within the integrated performance report and can relate to staff attitude, breach of confidentiality, rudeness or uniform issues (amongst others).
- Access to treatment or drugs was the third most common theme (n=51, 18%) for complaints in 2024/25 which is consistent with 2023/24. This theme includes access to services, funding of treatment, length of waiting list and treatment delayed.

Breakdown of complaints by theme:



[PDW – privacy, dignity, wishes]

Throughout 2024/25, the Customer Services team has continued to play a central role in supporting Care Groups to monitor, review, and embed learning from complaints and feedback. Our approach is focused on ensuring that concerns raised by service users and their representatives are not only addressed individually but are used to inform continuous improvement at every level of care delivery.

Themes and learning identified through complaints are routinely shared with Care Group clinical governance meetings, where they inform local improvement plans and contribute to wider Trust priorities. This includes alignment with Trust-wide initiatives such as the Care planning and risk assessment improvement group and the accessible information standards programme. Feedback from complaints has also been instrumental in shaping the review of the Trust's discharge and transfer of care policy, highlighting the importance of joined-up learning across multiple service areas.

During this period, we strengthened our support for Care Groups by focusing on how learning is cascaded and implemented at the team, service, and directorate level. This work is designed to help ensure that identified learning is not only acknowledged but acted upon, improving the experience of future and existing service users; their families and carers and supporting safer, more responsive care.

To achieve this, each Care Group has been assigned a named member of the customer services team. These complaint handlers provide tailored, ongoing support, including monthly feedback reports outlining trends, themes, and the status of all open and recently closed complaints. This closer collaboration enables Care Groups to have timely oversight and to take ownership of actions required.

As we move into 2025/26, supporting the effective use of learning from complaints remains a key priority. Planned developments include:

- Strengthening feedback loops: working with Care Groups to develop clearer processes for evidencing and confirming that actions arising from complaints have been implemented.
- Trust-Wide learning and thematic reviews: enhancing the identification of cross-cutting themes that require Trust-wide action and ensuring these are escalated through the appropriate governance channels.
- Improving visibility of learning: continuing to align complaint learning with clinical and operational improvement workstreams to ensure the insights from feedback are embedded into the Trust's wider quality and safety agenda.
- Enhancing local ownership: supporting Care Groups to develop internal processes for sharing learning with frontline teams, including 'You Said, We Did' communications and learning summaries and learning library.

Through these actions, the customer services team remains committed to ensuring that every piece of feedback contributes to a culture of openness, learning, and continuous improvement across the organisation.

4.10. Learning from complaints

Themes emerging from patient, carer, and staff feedback are regularly shared with Care Groups for review. Where necessary, actions are implemented to support service improvement and ensure that learning is embedded across the organisation. This process helps drive quality improvement and ensures that the lived experiences of patients, carers, and staff inform both our strategic priorities and the delivery of day-to-day care.

A key expectation of those raising complaints is a clear and thorough explanation to the issues that they have raised. As part of the Trust's response to complaints, all complainants receive a detailed and personalised reply addressing the specific issues raised, alongside a formal apology acknowledging their experience.

Several themes identified through complaints align with ongoing quality improvement initiatives, supporting a culture of continuous learning and service development. These are summarised below, with further detail contained within Appendix 12.

We know that families and carers matter**:**

- Staff to ensure they inform families about cover arrangements and emergency contacts.
- Staff to ensure they invite carers/relatives to ward rounds when appropriate.
- Carers/relatives made aware that they are able to contact teams and inform them of any concerns they should consider in future care and treatment planning, in line with triangle of care principles.

We are respectful, open, honest and transparent:

- Review of discharge processes to ensure that patients are fully informed regarding the discharge plan and reasons for discharge.
- Provide transparent information about assessments and medication decisions.
- Work to improve communication regarding test results.
- Ensure communication around safeguarding protocols and concerns are completed and patients made aware of suicide risk assessments (where relevant).
- Ensure patients are informed about the sharing of information with external organisations.

We improve and aim to be outstanding:

- Referral processes updated, including referral forms.
- Review of assessment processes to include underlying diagnoses, such as dementia.
- Review of process for repeat prescriptions.
- Reminders shared around property disclaimer forms on wards.
- Commitment to improve documentation delays.
- Tier 3 service scope clarified from first appointment, with focus on improved initial communication.
- Review of discharge practices to avoid patients feeling dismissed.

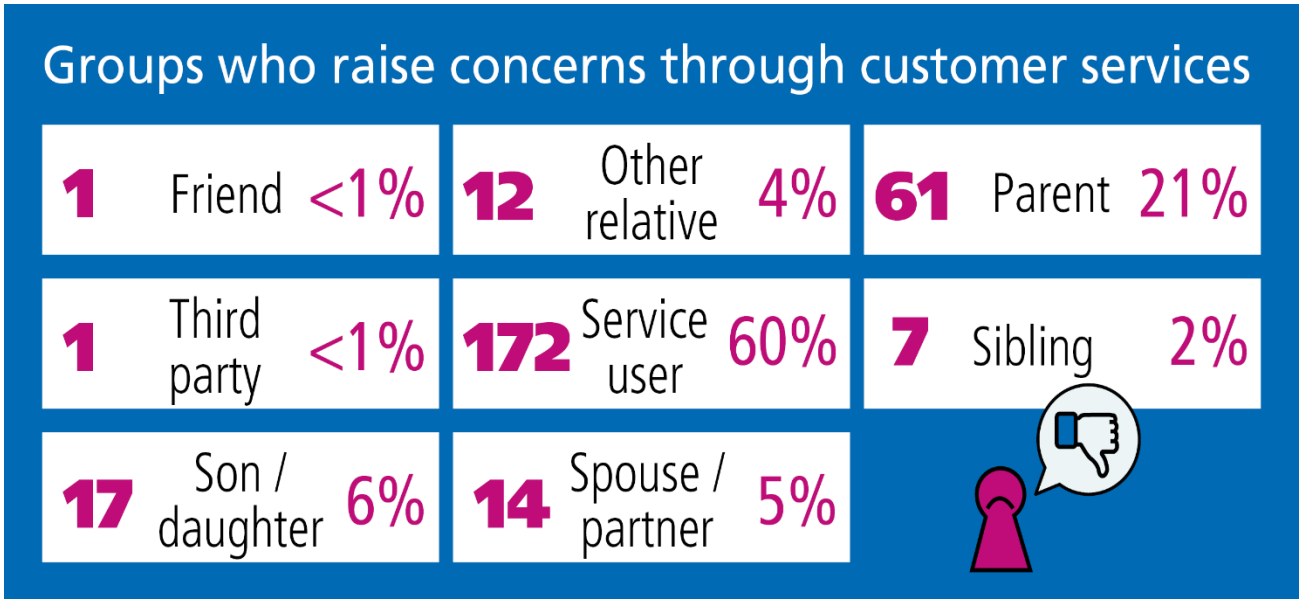
We put the person first and in the centre:

- Doctors encouraged to involve patients in care planning collaboratively.
- Preferred communication method recorded in records.
- Reaffirmed importance of explaining working diagnoses and checking understanding with the patient.
- Changes to treatment criteria for electro-convulsive therapy (ECT) to make it more person centred.
- Improve communication around use of the mental health act and informing patients of their rights..
- Reassurance about Oviva weight-loss support service and guidance for access.

We are relevant today and ready for tomorrow

- Clarification and updates provided on scan results, ensuring referrals are appropriate.
- Trust working to expand weight-loss service capacity and reduce delays.
- Trust wide learning about what documents services can provide without a subject access request (SAR).
- Mental Health Act training for Band 4–6 staff to improve future patient communication and practice.

4.11. Equality and protected characteristics – who's making complaints?



Equality data is crucial for understanding who accesses the formal complaints process and who might be using the process less. Equality data can also help the Trust to understand if people with protected characteristics feel unfairly treated within services or if there are themes from complaints which support improvements across the Trust and within specific services.

Equality data related to the complainant, when consent was provided and when the service user is not the complainant can be found in Appendix 3 and 4.

4.11.1. Develop a deeper understanding of equality data during 2025/26

In 2025/26, a more in-depth analysis will be conducted to gain a deeper understanding and identify areas needing specific focus and support for people to make complaints and understanding who the complaint is about. We are exploring ways to:

- Raise awareness of the importance of providing equality and diversity information when submitting a complaint.
- Provide clearer prompts and explanations on consent and data collection forms.
- Ensure staff are confident in asking for and recording this information sensitively and appropriately.
- Review communications to ensure they are inclusive and encourage participation from all communities.
- Triangulate equality data from complaints with other feedback provided to the Trust to identify an overall picture of the experience from ethnic minority groups, people with protected characteristics and marginalised communities.

Continued collection and analysis will help ensure we are identifying any patterns or inequalities in access, experience, or outcomes and tailoring our service and support to meet diverse needs more effectively.

4.11.2. Complaints related to a protected characteristic

The following table outlines a small number of complaints received within the year which relate to a protected characteristic. This highlights how these complaints have been managed and the outcome for the complainant.

Protected characteristic	Issue	Resolution
Race and religion	A service user felt racially discriminated against due to being allowed fewer personal belongings than others on the ward.	We clarified that some patients have accumulated items over time. The ward is now reviewing and managing excess property, including options such as collection by relatives, paid storage, charity donations, or disposal. We also confirmed that mobile smartphones are restricted for all patients and can only be used off the ward with approved leave. Our policies are applied equally, regardless of ethnicity.
Carer (s)	Family members felt their concerns were not listened to, and staff were too busy to engage with them.	We now ensure that, with patient consent, family members can attend outpatient appointments and have a designated contact person to raise any concerns.
Pregnancy	A safeguarding referral during dialectical behaviour therapy (DBT) sessions caused you additional distress.	The referral was made following a disclosure that you were early in pregnancy and had expressed thoughts of harming yourself and the baby. We sought advice from the safeguarding team, who recommended a referral to the Multi-Agency Screening Team (MAST) to ensure your safety and wellbeing. As a result of you raising your concern, staff will speak with patients where possible and explain when and why referrals are made to outside agencies.
Race and religion	You believed you were being detained unlawfully and that this was due to your race.	Staff spoke with you and acknowledged how distressing this experience can be. We explained that the Mental Health Act provides the legal framework for assessment and treatment, which is applied equally to support recovery for all individuals.
Disability	A consultant was rude and failed to consider your disability when lowering a chair, which could have led to a fall.	We apologised for not informing you beforehand. While the chair includes armrests to prevent falls, staff have been reminded to always check with patients before adjusting chairs to ensure safety and comfort.
Race and religion	You experienced issues with a telephone appointment.	The service manager contacted you to explain the process. You were advised to request a new referral from your GP and informed that an interpreter can be arranged.
Gender	A service user with complex post-traumatic stress disorder (PTSD) was moved from an all-female ward to a mixed ward with aggressive male patients, which worsened her mental health.	Clinical staff met with the service user, acknowledged her needs were not fully considered, and apologised. She has since been moved to an all-female ward.

4.12. Regulation: Parliamentary and Health Service Ombudsman (PHSO)

During 2024/25, 21 cases were escalated to the PHSO, out of the 168 formal complaints closed by the Trust. This equates to 13% of all formal complaints closed. This is a notable increase compared to 5% of complaints which were escalated to the PHSO during 2023/24.

- The Trust has not yet received an outcome from the PHSO for 17 of the cases (81%) we have been asked to provide information for.
- The PHSO has returned an outcome for 4 cases (19%) and none of these involved recommendations/actions for the Trust to take.

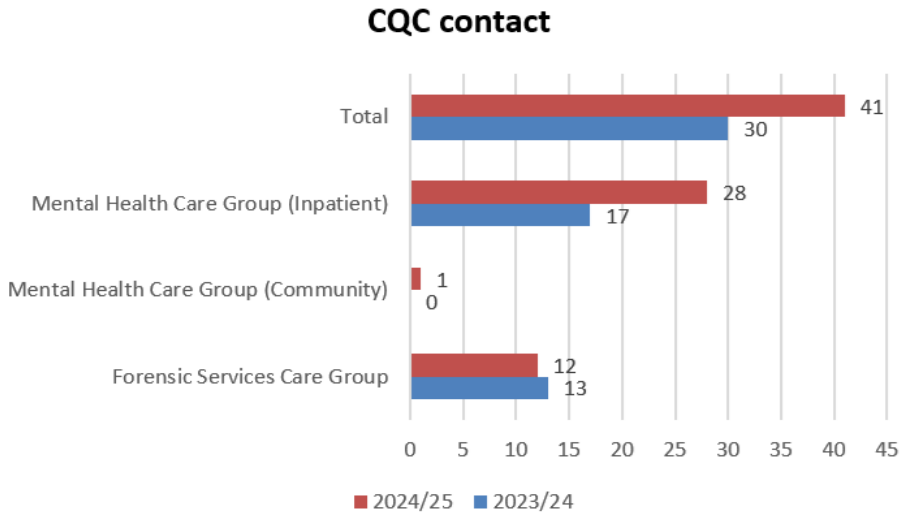
There are no identified themes for the complaints which have been escalated to the PHSO. Moving forward to 2025/26 the PHSO have advised that they will be focussing on cases relating to ADHD/ASD services.

4.13. Care Quality Commission (CQC) complaints

During 2024/25 the customer services team received 41 contacts from the CQC whereby the complainant had approached them directly. This compares to 30 CQC contacts in 2023/24.

In 2024/25, the CQC contacts related to three Care Groups: adults and OPS mental health (inpatients), adults and OPS mental health (community) and forensic services. There are common themes across Care Groups such as dissatisfaction with Section 17 (Mental Health Act) leave arrangements, disputes about diagnosis and concerns about care and treatment.

The graph below demonstrates that the increase in CQC contacts for adults and OPS mental health (inpatients) mainly accounts for the overall increase in CQC contacts compared to the previous year.



When a complaint is received via the CQC, the customer services team triangulate information with the quality governance team and the safeguarding team to identify if other contact has been received from the service user/complainant. This ensures that investigations and responses are consistent.

Customer services provide regular progress reports to the CQC's Mental Health Act complaints department on complaints they have shared or raised with us. The updates contain information including if the complaint has been concluded and if a response has been sent to the complainant. If a complaint is still under investigation, customer services will provide an update and an estimated timeframe of when a response will be provided. A copy of the response letter sent to the complainant is also shared with the CQC for their information.

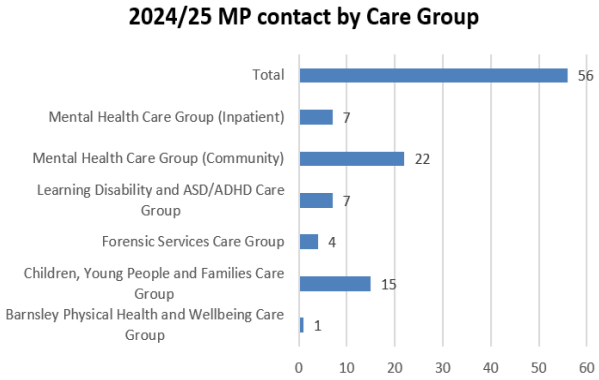
4.14. Member of Parliament (MP) contacts

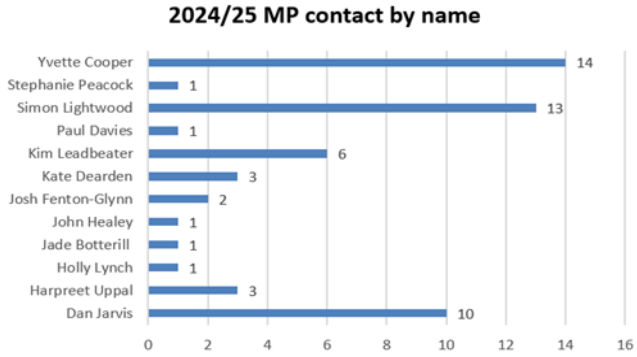
During 2024/25, the customer services team received 56 MP contacts which is a 27% increase from 44 in 2023/24. Yvette Cooper (Pontefract, Castleford & Knottingley) submitted the majority (n=14, 25%) of MP contacts in 2024/25 which is consistent with 2023/24. This was followed by Simon Lightwood (Wakefield & Rothwell) at 23% and Dan Jarvis (Barnsley North) at 18%.

Adults and OPS Mental Health Care Group (Community) continued to receive the most MP contacts in 2024/25 at 39%. These often involve complex issues regarding multiple services, for example challenges with benefits, housing and immigration and the associated impact on mental health.

Family members often contact their MP when they are concerned about the support being provided to their loved one which involves additional complexities around consent and the information the Trust can share.

Children, young people and families Care Group received the second highest MP contact at 27%, the majority of this feedback related to access to treatment for children and young people and waiting times.





4.15. Joint working 2024/25

National guidance around complaint management emphasises the importance of organisations working jointly where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single coordinated response.

Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaint process when this involves more than one organisation and improve accessibility for users of health and social care service.

There has been a 30% increase in complaints requiring joint working in 2024/25 compared to 2023/24 (n=96). The following table outlines where we have worked jointly with another organisation to resolve a complaint.

Organisation	Formal complaint	Reopened complaint	Informal concern	Service issue (comment)	Total
Barnsley Hospital NHS Foundation Trust	2	2	2	1	7
Barnsley Metropolitan Borough Council	1	1	0	0	2

Care Quality Commission	21	0	20	0	41
Member of Parliament	12	1	41	2	56
Mid Yorkshire Hospital NHS Trust	3	0	0	0	3
NHS Bradford Districts ICB	0	0	1	0	1
NHS Calderdale CCG	1	0	0	0	1
NHS Wakefield CCG	2	0	0	0	2
Other	3	0	0	1	4
Sheffield Teaching Hospital	1	0	0	0	1
Wakefield Metropolitan District Council	1	0	0	0	2
Yorkshire Ambulance Service NHS Trust	1	0	0	4	5
Total	**48**	**4**	**65**	**8**	**125**

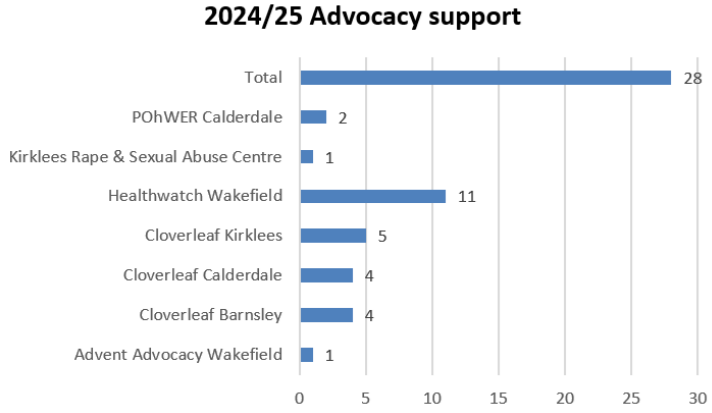
4.16. Independent Complaints Advocacy Services (ICAS)

The NHS complaints advocacy services provide practical support and information for those wishing to make a complaint about care and treatment within the NHS which they, or someone they know, has received. Advocates are independent from the Trust.

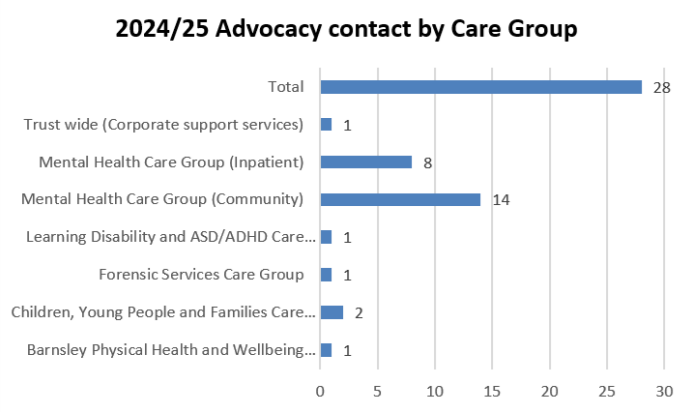
The customer services team provides all complainants with details of local advocacy services when the formal acknowledgement information pack is issued.

Advocates covering all areas of the Trust have attended customer services team meetings (virtually) in recent years to foster positive working relationships and enable them to provide feedback to support service improvements. During 2024/25 there were 28 complaints raised with/by an advocate compared with 12 during 2023/24 which is an increase of 133%. This increase could demonstrate that complainants are becoming more aware of the role of an advocate in supporting them to raise feedback.

Advocacy support was provided by the following advocacy services with the highest number of contacts from Healthwatch Wakefield (n=11, 39%):



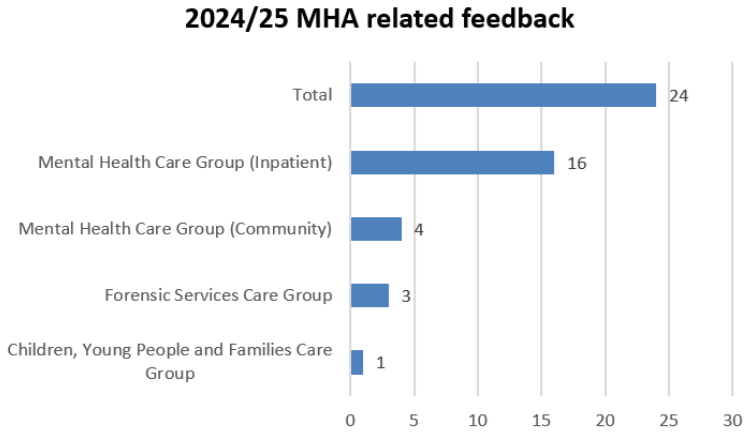
Mental health (community) received the highest number of complaints with advocacy support (n=14, 50%) followed by mental health (inpatient) (n=8, 29%)



4.17. Mental Health Act complaints

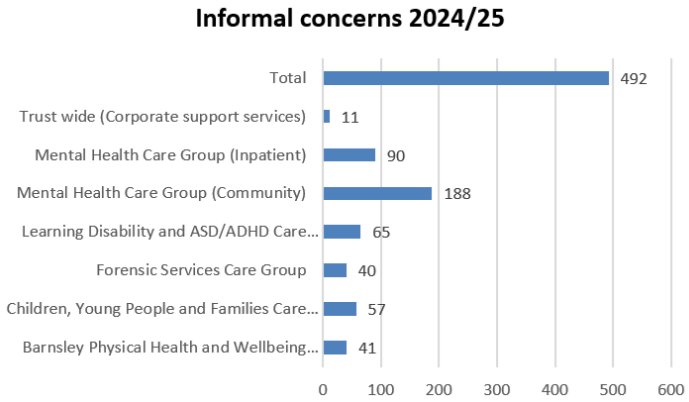
Information on the numbers of complaints/concerns regarding application of the Mental Health Act (MHA) is routinely reported to the Mental Health Act sub-committee of the Trust Board. In 2024/25 there were 24 pieces of feedback which included the MHA as one of the subjects/themes, which is an increase from 13 in 2023/24.

The majority of feedback related to the MHA is for the mental health inpatient setting as this is the service where the MHA is applied.



4.18. Number of informal concerns made into customer services

The Trust received 492 informal concerns in 2024/25, compared to 433 in 2023/24, which is a 14% increase. Adults and older peoples' mental health Care Group (community) received the most (n=188) informal concerns with 54% for Calderdale and Kirklees, 28% for Wakefield and 18% for Barnsley. These are concerns which are resolved by the service without the need for a complaint to be investigated formally and a written response provided.



Adults and older peoples' mental health care group (inpatient) received the second highest (n=90) informal concerns in 2024/25 with the majority for Calderdale and Kirklees, then Wakefield, with the fewest for Barnsley.

Learning disability and ASD/ADHD care group received the third highest number (n=65) of informal concerns in 2024/25, the majority, 85% (n=55) were for the adult ASD/ADHD service. These related waiting times and diagnosis outcomes.

4.18.1. Response times for informal concerns

The Trust's complaints process supports local resolution in the first instance and contact with the service provider to resolve concerns directly at source. The customer services team works closely with clinical services to ensure that informal concerns are responded to by services within 2 working days. However, with agreement from the complainant, this statutory timeframe can be extended.

Of the 492 informal concerns dealt with in 2024/25, 47% (n=232) were closed within 2 working days. Of the 492 informal concerns, 166 (34%) exceeded the 2 working days target although a resolution was provided by services. 94 informal concerns (19%) did not have a resolution communicated to customer services. Collaborative work between the customer services team and clinical services is underway to ensure the process for sharing feedback is robust. The ongoing work involves gathering feedback from our services, analysing themes and trends, and sharing best practice and resolution plans across the entire organisation.

Some examples of informal concerns received by customer services, and responded to by services:



4.19.

Compliments

During 2024/25, 519 compliments were recorded in total which is an increase of 54% compared to 338 in 2023/24. Details of compliments, broken down by Care Group are contained within Appendix 11. This includes some specific examples.

Below are some examples of compliments received into the Trust during 2024/25:

Children and families care group, CAMHS

"We just wanted to express our gratitude with the support you have provided since being involved in our child's care. That first time you met them in a distressed state in hospital, you immediately brought some calmness to the situation, and you communicated with them so sensitively, in a way that he understood, which allowed him to open up to you. Never forget how amazing you are and the difference you make. Forever grateful."

Forensic services, low secure

"After spending two months here and experiencing other wards, I believe I have witnessed exemplary best practices at the ward."

Forensic services, specialist community forensic team (SCFT)

"I just want to say that I shall eternally remain grateful to the specialist team for supporting me on my prodigious first placement. I am so thankful for the learning."

Children and families care group

"I wanted to write and acknowledge how wonderful my daughter's epilepsy nurse specialist is. As a family we have been under the nurse's care for over 4 years. Over time as my knowledge and understanding of my daughter and her complicated health has progressed, so has the support from her. She has become a real advocate for us as a family, helping us to get the right medication, referrals and very recently a hospital admission to have a procedure which has truly changed our lives. I genuinely believe that her role is more than just a job to her. She truly cares for her patients and their families. Going above and beyond when she can to try and make lives better. I wish it were possible to bottle even half of her dedication, compassion and understanding for her patients. The world would be a much better place with more people like her. Keep a tight hold of her please, I'm not sure how we would cope without her."

Learning disability and ASD/ADHD care group

"I wanted to thank the dedicated team who have supported me in finding the support I've clearly needed for a long time. I am now at a point where my life has improved drastically, with the help of medication and a deeper understanding of my ADHD."

Barnsley physical health and wellbeing care group

"I wanted to express the upmost gratitude and thanks to the nurse regarding her exceptional care and support. She went above and beyond when she first met my uncle to ensure he was cared for. She expressed that this is just 'her job', however to me this was so much more, she went above and beyond her job role to give me comfort. She was kind, caring, compassionate and extremely professional. She is an absolute credit to the people she is caring for and to your service and I feel privileged that my uncle is receiving the best care possible from her and the rest of your staff. I don't think she will ever grasp how much it meant to us and to my uncle that he now has the care in place for him and he can have his last wish to die at home due to the care and dignity given."

Mental health care group (Community), older people's services

"I just wanted to say what an absolutely fantastic worker the nurse is. He has consistently shown great care, compassion, kindness & the upmost professional attitude towards our family. I honestly do not know where we would be now if he had not continued to support us. A reliable, trustworthy and extremely dedicated worker, that the older people's mental health team are very lucky to have. Nothing was ever too much trouble and I want to thank him for his dedication and commitment to our family."

Mental health care group (inpatient), older people's services

"I would like to thank each and every one of you for the care I received. You all went above and over your call of duty."

Mental health care group (community)

"Thank you and your team for looking after my sister. I truly worry about her, and you were amazing, setting my mind at rest."

Mental health care group (inpatient)

"I wanted to take a moment to extend my deepest gratitude to each and every one of you for the outstanding care and support you provided. Your dedication, compassion, and professionalism made a significant difference in my journey towards healing and recovery."

Trust wide (corporate support services), customer Services team

"Thank you so much you have been so helpful, and I really appreciate it."

Trust wide (corporate support services), Mental Health Act

Reports and evidence given in the hearing from all professionals was greatly appreciated. It showed that the professionals had a very high level of understanding of the patient's needs, care and initiative and had confidence that they were certainly working hard to identify future needs for a successful discharge pathway.

4.20. Number of comments made into customer services

Comments are unrelated to care and treatment provision, and customer services received 43 comments in 2024/25, compared to 40 in 2023/24.

Examples of comments which were made into the customer services team included:

You raised	We responded
Washing machine on an inpatient ward isn't working. This has been the case for a few weeks. The issue was raised following a petition from 15 patients.	Services have secured funding to replace the washing machine.
Friend of service user trying to help him to find his car keys which went missing during ward transfer and had been handed in for safekeeping.	Car keys couldn't be located following admission to extra care area (ECA) and ward authorised ex-gratia payment for replacement. Customer services communicated this outcome and ensured payment was issued and provided an explanation and apology.
Member of the public querying the steps the Trust is taking to support military veterans in the community.	Confirmed we have been a Veteran Aware Trust since 2019 when we committed to the Armed Forces Covenant and became a member of the Veterans Covenant Healthcare Alliance. The Trust has an Armed Forces Covenant Champion in place, who is a member of staff and an army veteran with 24 years regular service, who ensures that we are in line with the Veterans Covenant Healthcare Alliance Reaccreditation. The staff member also chairs the Military Covenant and Veterans Steering Group which meets on a quarterly basis.

4.21. Key improvements during 2024/25

During 2024/25, the Trust continued to strengthen its approach to managing and learning from complaints, concerns, comments, and compliments. Several key developments and improvements were successfully implemented, aimed at enhancing the quality, transparency, and accessibility of the feedback process.

Quality improvement in complaint handling

- Regular thematic reviews of reopened complaints were introduced to better understand the reasons for dissatisfaction, with a focus on improving clarity, tone, and demonstration of learning in responses.
- A new quality assurance step was implemented to ensure all complaint responses undergo a second review before final sign-off, improving consistency and compassion in communications.
- The investigation toolkit was refreshed to better support the identification and articulation of lessons learned, and actions taken.
- Each investigator is now supported by a dedicated customer services officer to provide guidance throughout the complaint process and ensure follow-through on identified learning.

Governance and performance monitoring

- A significant and sustained improvement in responding to complaint within the statutory six-month target has been made during the year.

- Key performance indicators were updated, with complaint data now reported monthly via the integrated performance report (IPR) and shared with Care Groups to support local governance and accountability.
- The timeframe for complaint closure is now tracked in working days, allowing for more precise monitoring of progress against the statutory six-month requirement.
- A Trust-wide complaints intelligence dashboard was developed on DATIX, streamlining reporting and enhancing visibility of complaint trends and outcomes.
- Collaborative working across Care Groups and support services, including information governance, legal, safeguarding, patient safety and quality governance to ensure feedback is triangulated and learning is disseminated.

Policy and process enhancements

- The customer services policy was fully reviewed and updated, with strengthened guidance on managing persistent and unreasonable behaviours while ensuring compassionate communication remains central.
- Updates were made to the Trust website, intranet, leaflets, and posters to ensure all customer service information is current, accessible, and easy to understand.

Equality, diversity and inclusion

- Equality and diversity data collection forms were revised to include veteran status and preferred names, improving the personalisation and inclusivity of the feedback process.
- Analysis of this data will inform future improvement planning and help identify where engagement efforts should be focused.
- Specific attention is being given to understanding feedback from those with protected characteristics and to increasing accessibility for less-heard groups.

Involvement and volunteer support

- A volunteer has now started working in the customer services team. The volunteer has been updating the customer services leaflets and has distributed these internally. Moving forward, this role is also supporting the co-ordination of evaluated feedback from complainants, third parties, and staff to identify areas where the process can be further improved.

Independent review and assurance

- A 360 Assurance Audit was completed and provided a moderate level of assurance. It found strong alignment with NHS complaints regulations and the PHSO Complaint Standards (2022), with a clear governance structure in place.
- Four actions were agreed as part of the audit findings (one medium, three low risk), with a key recommendation being to strengthen the tracking and evidence of completed actions to better support organisational learning. The audit also found that from the 12 complaint response letters they reviewed, each response addressed all the issues raised and included compassionate, meaningful apologies, demonstrating good practice in complaint handling and communication.

4.22. Customer service team priorities for 2025/26

1 Learning from care groups and promoting feedback
Ensuring feedback is captured, reviewed and actioned



- **Capturing, reviewing, and actioning feedback**
  Working closely with our care groups to identify and monitor learning and actions we can take from the feedback we receive.
- **Aligning with larger learning projects**
  Incorporate learning from feedback into existing Trust wide learning projects, fostering a culture of continuous learning and ensuring we are working on the same goal together.
- **Showcasing outcomes on intranet and website**
  Design and promote a 'learning from feedback' page on the customer services intranet and website demonstrating transparency, how feedback is valued and influences change to the people who use or are interested in the Trust services we provide.

2 Maintaining focus on response timeframes
Ensuring timely resolution of complaints



- **Improving 100% compliance with 6-month statutory timeframe**
  Ensure all formal complaints meet the statutory response timeframe, and maintain 100% compliance with the statutory timeframe that formal complaints must be acknowledged within 3 working days.
- **Improving response rates for formal complaints**
  Continuously enhance response efficiency to improve satisfaction and trust in the complaint resolution process.
- **Enhancing timeframes for resolving informal concerns**
  Develop better tracking and resolution mechanisms for informal concerns to prevent escalation.

3 Incorporating 360 assurance audit feedback
Strengthening policies, training and risk assessments



- **Updating the customer services policy**
  Revise policy to reflect handling of reopened complaints and best practices for learning from feedback processes from the audit review.
- **Implementing Trust wide customer services training**
  Develop and implement training across the Trust to standardise complaint investigation and resolution processes. Ensuring staff feel supported, skilled and confident when responding to feedback
- **Strengthening the clinical risk rating process**
  Strengthen and ensure formal complaints receive accurate clinical risk assessments when they are received in collaboration with care groups.

4 Accessibility monitoring and service improvements
Enhancing access to customer services



- **Understanding insights from accessibility data**
  Analyse feedback and monitoring data to identify barriers in accessing our service.
- **Improving ways for people to access our service**
  Implement changes so that ALL users can easily access our service.
- **Continuous monitoring and adaptation**
  Regularly review accessibility measures and make necessary improvements based on feedback.

5 Using insight, satisfaction and equality data for improvement
Enhancing service quality through data



- **Gathering and analysing satisfaction data from all stakeholders**
  Collect satisfaction data from people who provide feedback: complainants, advocates, staff and other NHS/partner organisations, so we can identify improvements to our processes and highlight what we do well.
- **Acting on equality and protected characteristics data**
  Analyse and act on protected characteristics data to improve inclusivity.
- **Identifying and addressing areas needing targeted support**
  Use data insights to enhance our service for underrepresented groups.

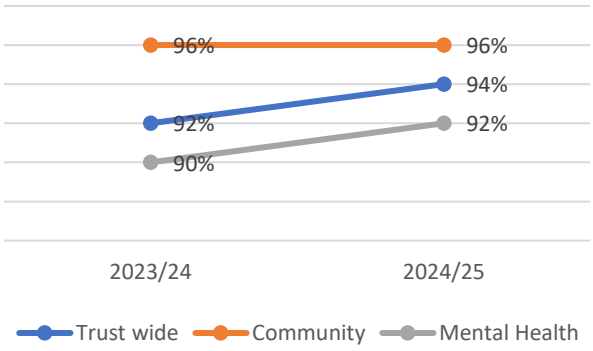
The customer services function remains committed to continuously improving how feedback is received, handled, and acted upon. In the year ahead, we will continue to embed improvements, particularly focusing on increasing satisfaction, ensuring accessibility for all service users, and improving how learning is shared and evidenced across the organisation.

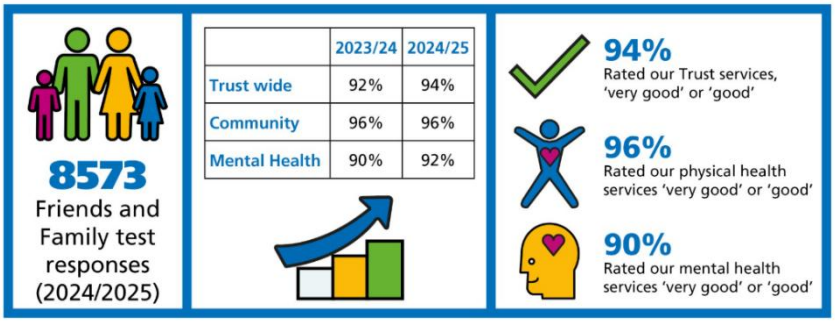
5. Friends and Family Test (FFT)

The FFT was launched in April 2013 by NHS England and is an important feedback tool to support service users and carers to provide feedback on the service. FFT asks people to rate the service *'very good'* to *'very poor'* with a supplementary free text question asking why they gave that answer.

In 2024/25 the Trust saw an increase percentage of people that rated Trust wide and mental health services as 'very good and good'. Physical health services remained the same.

The graph shows the improvement for responses that rated services as 'good' or 'very good', when compared with 2023/24.





In 2024/25 the Trust received 8573 FFT responses. This was a 3% decline in number of responses received compared with 2023/24 (8851). Following a review of the feedback we are unable to account for the lower returns, however this is still a good amount of feedback which enables us to understand the experience of people using our services. The Trust will continue to look at methods of increasing friends and family test feedback in 2025/26.

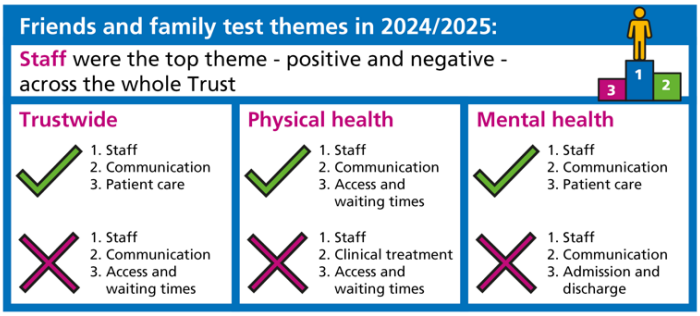
The Trust has 223 services registered to collect friends and family test feedback. In 2024/25 197 services received feedback. In 2025/26 the Trust will identify and work with the 26 services who have not received any friends and family test feedback.

During 2024/25:

- 94% of all respondents rated Trust services as 'very good' and 'good'.
- 96% of respondents rated physical health services as 'very good' and 'good'
- 92% of respondents from mental health services rated services as 'very good' and 'good'

The overall rating across the Trust has increased since 2023/24.

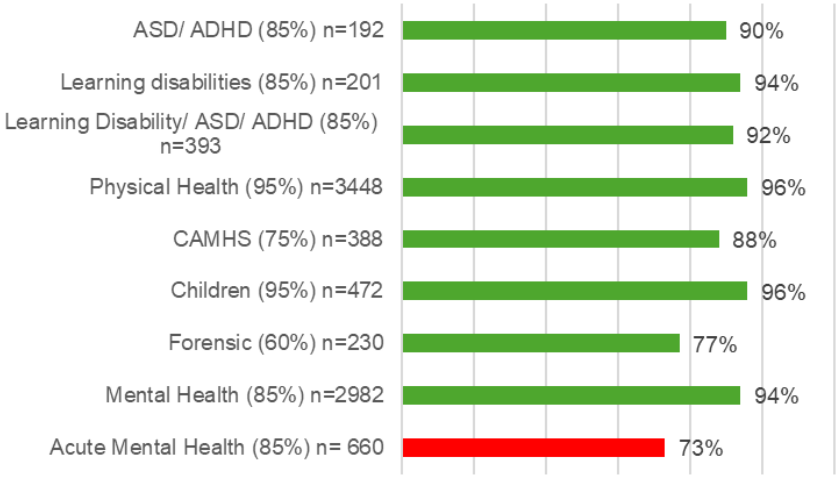
5.1. Themes from FFT feedback



Themes from FFT feedback have remained consistent over the reporting period. Staff, communication, and patient care being the most consistent themes for both positive and negative feedback.

5.2 Care Group FFT results

Each Care Group has a target satisfaction rate. The graph below highlights that most service lines consistently achieve the target satisfaction rate, except for acute mental health (mental health inpatients).



A detailed breakdown of ratings can be found in Appendix 6.



Poplars:

Poplars received no friends and family test feedback in 2023/24 and struggled to engage service users in completing patient experience surveys on the ward. This is due to service user's being diagnosed with dementia and they struggled to provide feedback.

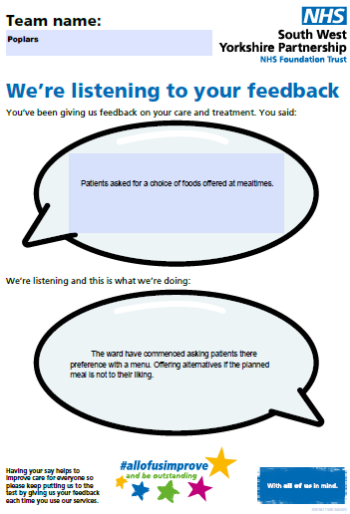
To increase feedback a number of actions were taken during 2024/25, which included:

- ✓ The activity co-ordinator supported service users to complete friends and family test cards.
- ✓ The discharge co-ordinator worked with families on discharge to increase family engagement with the process and collect feedback.
- ✓ It was agreed that the survey could be split and each week a couple of questions from the survey could be asked, to support the collection of patients experience.
- ✓ Friends and family test promotional items refreshed throughout the ward, including, posters, leaflets and a new feedback box.
- ✓ Staff focussed on promoting and collecting friend and family test feedback.

Throughout 2024/25, Poplars received friends and family test feedback from 19 carers and 10 service users and received 6 completed patient experience surveys. The wards overall rating was

76% and staff continue to review feedback to identify areas of improvement and share and celebrate the good comments received.

In 2025/26, Poplars will review feedback to identify trends and themes and keep service users, their carers and families involved in the process, by sharing improvements through 'you said, we did'. The quality governance team will be working with Poplars to develop a dementia friendly survey to improve accessibility and increase feedback from service users with a cognitive disability.

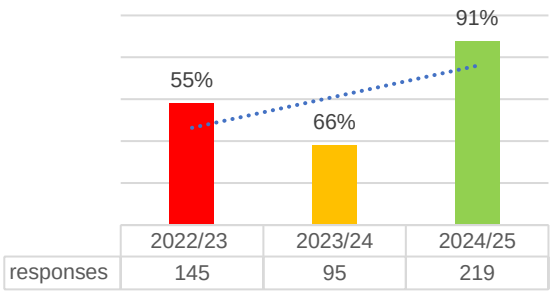




Attention Deficit Hyperactivity Disorder (ADHD) and Autism Service:

ADHD and Autism Services increased their responses by 130% in 2024/25 and their overall rating increased by 25%, continuing the good practice embedded during 2023/24. The service rotates their CHATpad (a computer tablet to facilitate feedback) between clinics, updates staff monthly regarding returns and shares feedback. Collecting feedback has become part of the culture within the team and is demonstrated with the increase in feedback and rating for the service.

Responses/ rating



	2022/23	2023/24	2024/25
responses	145	95	219

Actions taken by ADHD and Autism service to improve service user experience based on feedback, included:

- Access and waiting times
  - ✓ Development of an autism referral screening clinic to improve service user experience and an ADHD triage clinic to determine if an assessment is appropriate. This is helping to manage waiting lists. This is now commissioned in some areas and is proving to be effective.
  - ✓ Information relating to waiting times following referral for assessment of ADHD and / or Autism is detailed on the services internet pages and are updated regularly.
  - ✓ Long waiting times are typical across the country. The service is also working with colleagues across organisations in West Yorkshire and South Yorkshire Integrated Care Boards to review and establish safe quality pathways across children's and adult services for both ADHD and autism.
  - ✓ The service has made changes to working administrative practices that has created additional clinic space at Manygates in Wakefield. This invaluable space has facilitated an increase in appointment opportunities.

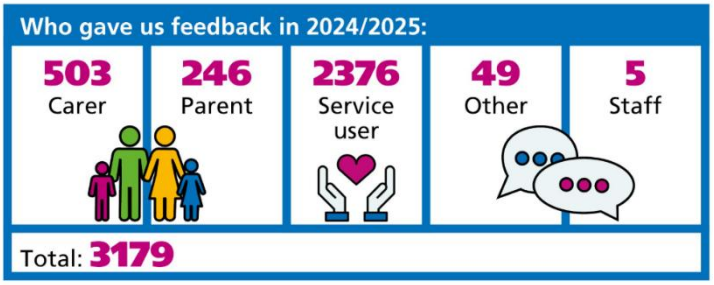
- Communication
  - ✓ Website has been updated to include information about what to expect at your appointment, the process and information regarding services.
  - ✓ All relevant clinical staff have attended bespoke communications training to help support difficult conversations when delivering assessment outcome feedback.
  - ✓ All feedback received is shared with individuals and at whole team level.

- ✓ The service is working with facilities to procure a new telephone system to improve access.

- Consistency of staff
  - ✓ The service strives to maintain consistency in medication titration appointments and ensure there are no interruptions or delays in treatment. In the event of planned or unplanned staff absences, appointments will be offered with an alternative clinician who has full access to the individual's notes and care plans. This means people will be reviewed and receive prescriptions at the right time and avoid a delay in the optimisation of their treatment. Additionally, this means people can flow through the pathway more efficiently and help reduce waiting times.

- Availability of ADHD medication
  - ✓ The service has also worked with pharmacy colleagues to develop a safe process to distribute prescriptions for controlled medication from the base in Wakefield.

5.3. Who's providing FFT feedback across the Trust?



Not all those who provided equality data provided data for all the characteristics, which causes limitation on how the Trust can analyse the data. However, we have seen a significant increase in equality data being provided by respondents, which helps the Trust to identify groups that may require additional support to provide feedback or where there is a difference in experience than from other groups.

From the equality data provided the Trust identified 92% of respondents were from a white background, 67% identified as female, 82% of respondents recorded having a disability. 58% of respondents were between the age 21-60. The equality data collected does not identify any groups having a different experience of the care and service they receive.

The collection of equality data will continue to be a focus for 2025/26. The data shows that the Trust continues to see diversity in people providing feedback through FFT and although the data is not directly comparable to the overall Trust population, a review of the data suggests that the focus for 2025/26 should include that methods of feedback are accessible for children and young people and service users from minority ethnic groups.

Equality data from feedback will routinely be shared with services on an annual basis to support equality impact assessments and to identify gaps in feedback from less represented groups.

A full breakdown of equality data for the FFT can be found in Appendix 5.

6. Patient Experience Surveys

6.1. Local Surveys

The Trust began to introduce patient experience surveys across service lines in 2021/22. This was to increase the opportunity for service users and their families to provide feedback to help identify areas of good practice across the Trust and areas that require improvement as the Trust had decided to withdraw from the national mental health inpatient survey, to concentrate on a more localised and focused survey. As a result, this had led to richer and more useable feedback being received.

Surveys are now embedded across forensic inpatients, mental health inpatients and physical health services. A carers' survey has also been developed, which supports the Triangle of Care (ToC) that is being implemented across the Trust. Children and young people and ADHD and Autism survey will be deployed in quarter 1 of 2025/26. The launch of these surveys was delayed due to feedback from service users, carers, their families and staff regarding the accessibility of the questions. The survey has been reviewed with help from the Wakefield learning disability patient experience group and questions have been rewritten to ensure they are in an easy read format. These rewritten questions will also be updated within current surveys throughout 2025/26.

All surveys contain a core set of questions that score the Trust on key themes around service user experience of Trust services, including feeling safe, feeling involved, feeling listened to, being treated with dignity and respect, and knowing how to raise concerns. These also align to the CQC five lines of enquiry.

The Trust received feedback from 1,403 patients and carers through patient experience surveys in 2024/25. Service users and carers across the Trust reported:

- feeling safe
- feeling treated with dignity and respect,
- feeling listened to
- knowing how to raise concerns
- being involved in their care and treatment.

Trust wide (n=1403)	%
feeling safe	98%
service user feeling involved	91%
carer being involved	82%
feeling listened to	97%
being treated with dignity & respect	98%
knowing how to raise concerns	92%

There was a slight decline in the service users feeling involved (2023/24 95%), knowing how to raise concerns (2023/24 90%) and feeling treated with dignity and respect (2023/24 99%).

Respondents also did not feel that their carers, or those who are carers, were involved as much as they wanted. This feedback score has declined from 91% in 2023/24 to 80% in 2024/25, which could be due to the raised awareness of the work being undertaken through the Triangle of Care (ToC), and service users and staff being more aware of the carer offer. This feedback is aligned to the ToC work and feeds into the ToC steering group to support developments.

Staff and patient care were consistent themes raised in patient experience surveys for both positive and negative comments.

Reporting on patient experience surveys is provided to services routinely. A detailed breakdown is provided on questions and response, including a comparison of the previous reporting periods results. Free text information is provided including thematic analysis.

Action plans are included on reporting for the forensic inpatient and mental health patient experience survey. Physical health reporting is being developed and will form part of the Trust's patient experience objectives for 2025/26.

Forensic Inpatients:

- 👎 **Lack of activities on the ward.**
- ✓ Feedback is sought from service users through activity provision sheets, including ideas for new activities.



- 👎 **Poor choice and quality of food.**
- ✓ A new catering manager has been appointed, and catering meetings have restarted. Choice and quality of food remains a focus for service users, and the catering manager reviews feedback regularly and takes actions where possible.

Equipment and Adaptations Service:

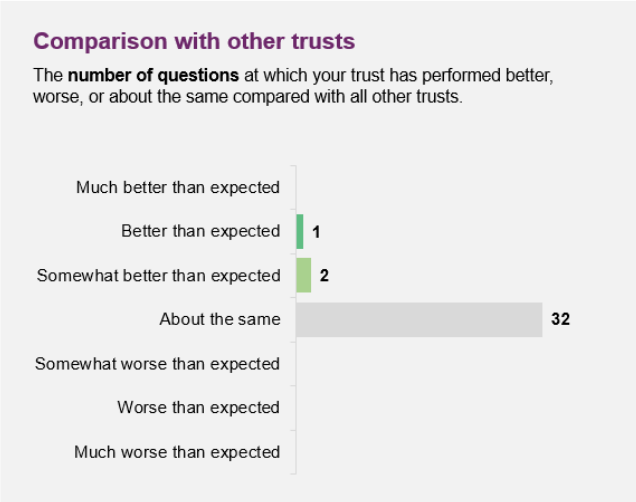
- 👎 **Service users did not know how to raise concerns about the service.**
- ✓ Customer services details were added to the service referral letters.



Community Palliative Care

- 👎 **Lack of responses to the patient experience survey.**
- ✓ The service created a schedule for which member of staff would be using the CHATpad, paper copies of the patient experience survey was added to information packs on bright coloured paper and they have also been placed in the relative's room.

6.2. Community Mental Health Survey 2024



The table is taken from the IQVIA management report.

The community mental health survey is a mandated survey conducted each year by an external provider on behalf of the CQC. The survey looks at the experience of people receiving care in community mental health services.

People aged 16 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen between 1 April and 31 May 2024, however, questions

relating specifically to transition questions for young people were removed due to low number of responses received last year.

Fieldwork took place between August 2024 and November 2024.

Compared to other similar Trusts, our results show that the Trust has performed 'better than expected' in one question, 'somewhat better than expected' for two questions and 'about the same' for 32 questions.

When compared with the national average, 19 questions scored for the Trust were in the top 20%, 16 scores were in the intermediate 60%, and none were in the lower 20% range compared with the national results.

Based on a comparison to the national average, results for the Trust are as follows:

Where service user care **is best:**

- ✓ **Crisis care access:** length of time taken to get through to the crisis team
- ✓ **Feedback:** NHS mental health services asking service users for their views on the quality of their care
- ✓ **Crisis care support:** NHS mental health team provided support to family/carer when service users had a crisis
- ✓ **Support while waiting:** service users offered support while waiting
- ✓ **Medication:** what will happen if they stop taking medication being discussed with service users

Where service user experience **could improve:**

- ○ **Support with other areas of life:** service users being given help or advice with finding support for finding or keeping work
- ○ **Support with other areas of life:** service users' family/someone close to them being involved in their care as much as they like
- ○ **Support while waiting:** service users offered appropriate support while waiting
- ○ **Planning care:** service users had a care review meeting in the last 12 months
- ○ **Medication:** NHS mental health team checking how service users are getting on with medication

The top three themes identified from 135 positive comments were staff (n=82), communication (n=17) and patient care (n=12). 26 members of staff were named as giving good care and treatment and having effective communication skills.

The top three themes identified from 119 negative comments were access and waiting times (n=20), access (n=21) and communication (n=20).

The recommendations outlined in the report provide by IQVIA on behalf of the CQC included the following:

- Medication review
- Advice and resources for finding and keeping work
- Support while waiting
- Involvement of family/carers
- Being treated with dignity and respect.

Further detail on these recommendations is below:

- **Your Treatment:** Assess arrangements for the regular review of how service users are getting on with their medication. Ensure mental health care teams address if the medication is effective, any positive or negative side effects, if service users are taking the medication as prescribed, and if they have any concerns.
- **Support and Wellbeing**: Ensure mental health teams regularly offer advice and resources to service users to support them to find or keep work. Review the materials that are available to service users and how information from external sources is signposted.
- **Accessing Care and Treatment:** Review the resources provided to service users to support their mental health while they are waiting for their first appointment for treatment to ensure they address a range of service users' needs. Examine the data to determine if any

particular groups tended to feel the support was not appropriate for their mental health needs.

- **Support and Wellbeing**: Ensure mental health service providers determine if service users would like to involve any family members and/or friends in their care or treatment. Direct service providers to determine the extent they would like them to be involved.
- **Overall:** Consider why some service users do not feel they are treated with respect and dignity by NHS mental health services. Communication is often key so consider any training needs in topics such as unconscious bias to enable mental health professionals to respect all aspects of the patient's background, views and needs.

Further analysis is being undertaken locally to identify areas of good practice and areas that require improvement, which will form part of the priorities and developments for 2025/26.

A detailed breakdown of the community mental health survey results, including data on who took part in the survey, can be found in Appendix 9.

6.3. How patient experience feedback is gathered

A number of different methods are used across the Trust to collect FFT and patient experience surveys. Electronic collection methods from both FFT and patient experience surveys remain the most popular collection method. Online links and QR codes are used within services which are also available on the Trust website. Online surveys provide tools such as read aloud, screen mask and enlarged print to support service users and carers in providing feedback. Surveys and FFT cards are available in paper format in either standard or easy read version. Posters and leaflets are displayed in Trust settings, and staff are encouraged to offer opportunities to provide feedback throughout a service user's care and treatment.

6.4. Using feedback for learning and improvements

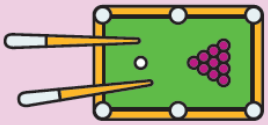
Feedback is shared with services monthly for them to review, to share with their team and service users, identify good practice and take the appropriate action where necessary. FFT results are displayed, where possible, within services along with 'you said, we did' posters, sharing learning with service users, and their carers. Feedback is also used and supports other projects across the Trust such as consultations, quality walkarounds and CQC inspections to ensure that experience of those accessing Trust services is included. Patient experience survey results are also shared with support services to identify any wider actions.

Specific examples of where feedback has led to improvements can be found in Appendix 8.

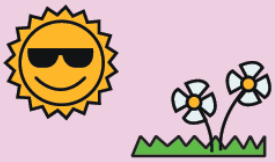
YOU SAID:



You said that the TV signal can be very poor at times.



You told us that you enjoyed the activities on the ward and would like more regular access to the pool table.



You told us that when the weather allows, you enjoy spending time in the garden.

WE DID:



We have passed this feedback onto our estates team and will continue to work to improve this.



We are working hard to make sure that activities are available each day and welcome the continued suggestions.



We are working hard to increase our outdoor activity range and will make full use of these when the weather improves.

Team Name:

Calderdale Neurodevelopmental Assessment Service

NHS South West Yorkshire Partnership NHS Foundation Trust

We're listening to your feedback

We wanted to understand the experiences of parents and carers who have supported their child through our assessment pathway.

We interviewed parents to gain insight into how they felt before, during and after their child's assessment, and have used that feedback to make improvements to our service...

You said...

Our initial letters did not provide enough information about the assessment and who would be completing it.

You felt that being invited to a 'feedback appointment' did not reflect the importance of the meeting.

You wanted something to take away from the final appointment to support your understanding of the diagnosis.

We did...

More information has been added to the first appointment letter, along with staff team pictures.

We have changed the wording we use for this final appointment to 'outcome appointment'.

If the report is ready in time for your outcome appointment, you will receive a physical copy of this to take away that day.

#allofusimprove and be outstanding

With **all of us** in mind.

Wakefield Recovery and Wellbeing College
Home of the Discovery College



NHS South West Yorkshire Partnership NHS Foundation Trust

You said...	We did...
You weren't sure why we offer telephone appointments and thought these might not be of as much value as a face to face appointment.	We put a piece in our newsletter and on our website explaining why we offer telephone appointments, online courses and other non-face-to-face interventions.
You'd like more advanced craft courses.	We're introducing a craft course covering more advanced crafts, like card making.
You told us some of our venues weren't very private and you were concerned about talking openly.	We picked this up with the venues and in our communications - our groups now have dedicated space.
You were unable to carry out some activities in craft sessions due to dexterity issues.	We added a category in our ILPs to determine any dexterity issues, ensuring craft activities work for all.
You couldn't find Prosper House!	We added What Three Words to our directions, a photo of the building and new signage to the front of the building.
Cancelled courses were having a negative impact on your wellbeing.	We introduced a robust checking system before courses to confirm attendance earlier, worked heavily on promotion and reviewed the frequency of sessions to align with demand.
You asked us why some courses were only being held on certain days.	We agreed! So we've started offering more variety, with a range of different tutors.

6.5 Cheswold Park Hospital - NEW

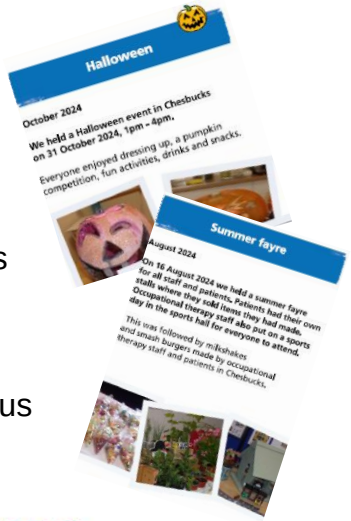
The Trust stepped in to become the provider at Cheswold Park Hospital in Doncaster on 1 October 2024. Cheswold Park Hospital is new to the Trust's processes, including the NHS friends and family test (FFT) and the Forensic inpatient patient experience survey.

The implementation of the friends and family test is expected to start during Quarter 1 2025/26. The Forensic inpatient patient experience survey is scheduled for completion in Quarter 3 2025/26.

Cheswold Park Hospital has also introduced an annual family and patient involvement newsletter. This publication details past events and provides information on upcoming activities, which is shared with service users, their carers, and families.

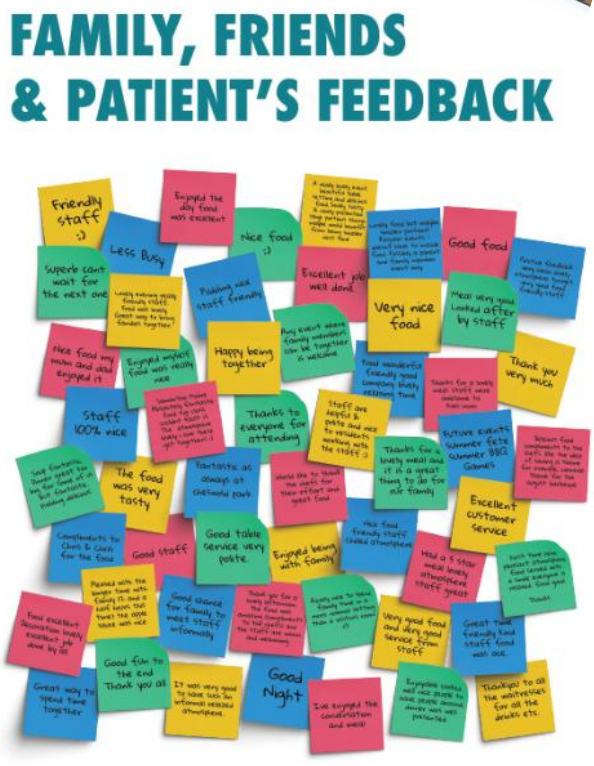
Throughout 2024/25, a series of patient involvement events were conducted, including:

- Two patients delivering reducing restrictive practice (RRP) training to all new starters.
- Service users participating in the induction process for new admissions by providing tours of the hospital.
- A service user presenting their personal self-harm experiences to fellow service users, their carers, and families.
- A service user producing a monthly newsletter to provide updates on hospital events.
- Monthly patient engagement councils offering service users the opportunity to share ideas and ask questions.
- Monthly catering meetings allowing service users to discuss menus with staff.



Following an Easter event in 2024, the following feedback was received from service users, their carers and friends.

''A big Thank you for a really lovely afternoon yesterday. So nice to have a festive buffet together with other families and some fun activities. You and all of the other staff have worked so hard to give us all a very nice Christmas Party and it is much appreciated. I also loved seeing some of the Recovery college students and to have a chat with them. I have honestly missed teaching the classes and seeing the students so much. Hope you have a Very Happy Christmas and all the best for 2025."



6.6. Patient and carer race equality framework (PCREF) – NEW

PCREF is an anti-racism, race equity and accountability framework, supporting mental health Trusts and mental health service providers to demonstrate how they are meeting their core legislative requirements and how they can improve the cultural competence of their organisation. This cultural shift aids improved access, experience, and outcomes for racialised and ethnically and culturally diverse communities. It will also help the Trust to move towards becoming an anti-racism organisation. At its core the PCREF is a participatory anti racism framework to drive service improvements for racialised communities.

Patient experience can support this work by:

- Ensuring patient experience data is used, monitored and flowed to national datasets to enable bench- marking, lesson-sharing and service improvement.
- Ensuring outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.
- Agreeing approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

The Trust has assessed itself against the framework and the following actions have been identified to be addressed through patient experience surveys:

- Equality data is collected for friends and family test and patient experience surveys. This is not routinely analysed or shared at present, but actions are being taken in 2025/26 to improve this.
- All future patient experience surveys will ask the accessible information standard (AIS) question as part of the core questions.
- Questions around advocacy and knowing how to raise concerns will be included in the appropriate patient experience surveys currently under development.
- Review and analyse equality data and review the experience of service users by ethnicity across service lines.
- Continue to develop volunteers within the quality governance team throughout 2025/26 to support collection of real-time patient experience feedback.

6.7. Achievements and improvements for patient experience during 2024/25

Throughout 2024/25 there have been a number of improvements made relating to the patient experience agenda. Specific details can be found in Appendix 8. The high-level themes of these improvements include:

- Volunteers
- Use of ChatPads in community services
- Expanding the use text message to improve responses within physical health services.
- Working with services where FFT responses are low.
- Capturing the voice of children and young people admitted to an adult mental health ward.
- Acting on community mental health survey actions.
- Working with the was not bought programme within CAMHS.
- Triangulation of patient experience feedback from across the Trust.
- Continue to develop service line patient experience surveys.
- Work with children's service to develop age appropriate FFT cards.

6.8. Priorities and developments for 2025/26

Throughout 2025/26, the Trust will continue to:

- expand the volunteer role within patient experience.
- work with services not meeting their targets and identify quality improvement work.
- develop the was not brought workstream with colleagues across the Trust.
- develop tools to support and encourage children and young people to provide feedback.
- develop the patient experience surveys across the remaining service lines.
- develop a dementia patient experience survey.
- identify areas for improvements from the community mental health survey and work with clinical colleagues to identify actions.

The Trust will also:

- work with colleagues to complete patient and carer race equality framework (PCREF) actions.
- work with colleagues to develop experience, equality and involvement forums.
- review and implement the experience of care framework.
- review feedback numbers over the past two years to identify any trends or themes as to why feedback is lower than previous years.
- carryout and audit of Trust main locations to review information available to service users, carers and their families on how to provide feedback and identify areas for improvement.
- develop a patient experience newsletter.

7. Additional patient experience captured across the Trust

Patient experience is captured in many ways and daily in the work teams are services do. In addition to Customer Services and the Patient experience (FFT and service line patient experience surveys) detail has been included (full detail in Appendix 13):

- patient experience related to food. This includes feedback on inpatient meals and changes and improvements within dining rooms at both Fieldhead hospital and Kendray hospital. Feedback has supported improvements and continues to be sought. The Trust Nutrition Steering Group receives this feedback on a regular basis.
- Patient-led assessments of the care environment (PLACE) audits which are completed annually and provide excellent insight into non-clinical aspects of care.
- Insight information at quarterly intervals from people who use our services, staff, partners, and communities.
- Matron Weekly and monthly audits on inpatient wards, using the Tendable app.

8. Next steps

There are a number of areas of focus for 2025/26 which are outlined within this report. In addition to these, the main areas for gathering patient experience feedback (customer services, friends and family test and insight) will work together to continue to understand and support improvements in patient experience. This will include:

- Capturing, reviewing and actioning feedback from complaints.
- Launching patient experience surveys across remaining service lines and triangulating the feedback.

- Using the themes identified within this report to support improvement work, identify good practice and utilise the feedback to demonstrate where improvements have been made.

In addition, the patient experience agenda will continue to support the implementation of PCREF and the triangle of care workstreams, enable feedback into priority programmes of work and support the quality assurance system in providing quality oversight and quality improvement.

9. Conclusion

Patient experience is a key indicator of quality in healthcare and good patient experience is associated with improved clinical outcomes.

Throughout this report, feedback on the experience of patients, their families/carers and other people in our communities has been used to provide us with a picture of satisfaction and areas for improvement. The data provided demonstrates that the Trust receives feedback from a wide range of patients and service users, from across the communities we serve.

During 2024/25 we have seen an increase in formal complaints (26%) which have been received and investigated by the Trust, and 82% of complaints closed in the year were resolved within the six-month target. There has been a significant increase in the number of reopened complaints, suggesting complainants are more dissatisfied with the response they receive. We have also seen an increase in compliments, and these are spread across services.

The FFT feedback shows an increase in satisfaction across the Trust and specifically within Care Groups. The qualitative data received through FFT has improved and this supports improvements. This is also reflected in service line patient experience surveys, which have been further expanded during the year and will continue to develop during 2025/26.

Themes, both positive and negative are largely consistent with previous years, and it is the specifics from these themes that support improvement of quality, safety and culture within individual services and teams. In addition, some further areas which provide an insight into patient experience, such as PLACE audits, inpatient audits and catering and food improvements provide a more thorough picture.

This report demonstrates that feedback into the Trust is robust and provides us with rich information which the Trust as a whole, and Care Groups and services can take forward into improvement work and sharing good practice.

It is through the triangulation of patient experience feedback with other measures of quality, such as freedom to speak up, performance dashboards/measures, CQC cases and patient safety incident response framework (PSIRF) incidents that a robust picture of patient satisfaction will be formed, and this work will develop further during 2025/26.

A number of areas have been identified for focus during 2025/26, and these will form the basis of teamwork plans and targets for the coming 12 months. There will be a focus on supporting improvement across the Trust in the key areas of communication, access and waiting times, staff and communication, alongside celebrating positive feedback and improvements.

Appendix 1 – Complaint response time by Care Group

The following chart breaks down complaint responses within six months by Care Group. It is worth noting that whilst the performance below is by Care Group, the reason there is a delay in responding is not solely within the gift of the Care Group. The Care Group is responsible for timely allocation of an investigator; timely return of the completed investigation toolkit and Care Group sign off of the complaint response as part of the governance process. Therefore, it is not always reflective of Care Group performance when there is a delay in a complaint response being sent.

Care Group	Total	< 6 months	> 6 months
Adults and OPS (Community)	72	57	15
Adults and OPS (Inpatient)	35	23	12
Barnsley Physical Health and Wellbeing	9	9	0
Children, Young People and Families	16	14	2
Forensic Services	3	3	0
Learning Disability and ASD/ADHD	31	30	1
Trust wide (Corporate support services)	2	2	0
Total	168	138	30

In 2024/25, the Barnsley Physical Health and Wellbeing, Forensic Services, and Trust-wide (Corporate support services) Care Groups achieved 100% compliance with the six-month target for complaint resolution. These areas also received a lower volume of complaints, which may have supported timely responses.

The Learning Disability and ASD/ADHD Care Group also performed strongly, achieving 97% compliance, with 30 out of 31 complaints resolved within the target timeframe.

Adults and Older People's Services (Inpatient and Community) had lower compliance rates - 66% and 79% respectively. However, these Care Groups continue to manage a significantly higher number of complaints, and several cases were impacted by factors such as delays in obtaining consent or agreeing the scope of the investigation. In a few instances, internal delays, such as returning toolkits or sign-off processes, also contributed.

To support improvement, we are working with these Care Groups to identify and address barriers to timely resolution where delays are within their control. Actions include providing additional guidance around consent processes, streamlining internal steps such as toolkit reviews, and strengthening oversight during the sign-off stage. The aim is to build consistency across all services while recognising the unique pressures faced by different teams.

Appendix 2 - ALL feedback equality data

Age	Total	Percentage
0-16	149	3%
17-20	147	3%
21-30	434	10%
31-40	779	17%
41-50	686	15%
51-60	735	16%
61-70	686	15%
71-80	622	14%
81+	296	7%
Total	**4534**	**100%**



Sexuality	Total	Percentage
Heterosexual	714	78%
Prefers not to say	154	17%
Bisexual	22	2%
Lesbian	10	1%
Gay	6	1%
Other	6	1%
Information requested	4	0%
Total	**916**	**100%**



Gender	Total	Percentage
Female	2886	64.8%
Male	1521	34.2%
Prefers not to say	3	0.1%
Transgender	9	0.2%
You live and work permanently in a gender other than that assigned at birth	13	0.3%
Other	10	0.2%
Non-binary	8	0.2%
Androgynous	1	0.0%
Gender fluid	1	0.0%
Neutral	1	0.0%
Total	**4453**	**100%**



Marital status	Total	Percentage
Married / civil partnership	446	48%
Single	220	24%
Widowed / surviving civil partner	93	10%
Co-habiting	87	9%
Divorced / person whose civil partnership had been dissolved	48	5%
Separated	27	3%
Prefers not to say	9	1%
Total	**930**	**100%**



Disability	Total	Percentage
Mental health condition	1021	33%
I do not have a disability	608	20%
Long standing illness	434	14%
Physical impairment	271	9%
Multiple disabilities	173	6%
I prefer not to say	157	5%
Learning disability	141	5%
Cognitive impairment	135	4%
Other	95	3%
Speech impairment	29	1%
Total	**3064**	**100%**



Caring responsibilties	Total	Percentage
No	747	78%
Yes	197	21%
Information requested	8	1%
Prefers not to say	3	0%
Total	**955**	**100%**



Religion	Total	Percentage
Christian (including Church of England, catholic, protestant and all other Christian denominations)	495	53.1%
None	319	34.2%
Prefers not to say	49	5.3%
Agnostic	27	2.9%
Any other religion/ belief	15	1.6%
Muslim	10	1.1%
Information requested	3	0.3%
Buddhist	3	0.3%
Spiritual	2	0.2%
Orthodox	2	0.2%
Jewish	2	0.2%
Anglican	1	0.1%
Hindu	1	0.1%
Italian	1	0.1%
Methodist	1	0.1%
Pagan	1	0.1%
Sikh	1	0.1%
Total	**933**	**100%**



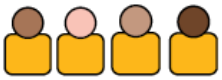
Providing feedback	Total	Percentage
Service user / patient	2140	71.4%
Carer / relative / friend	503	16.8%
Parent	280	9.3%
Other	36	1.2%
Son / daughter	9	0.3%
Spouse / partner	9	0.3%
Other relative	5	0.2%
Sibling	5	0.2%
Staff	5	0.2%
Non service user	3	0.1%
Raised by third party - unable to collect data	1	0.0%
Guardian	1	0.0%
Prisoner	1	0.0%
Total	**2998**	**100%**



Pregnant / children	Total	Percentage
No	761	90%
Yes	71	8%
Information requested	9	1%
Prefers not to say	3	0%
Total	**844**	**100%**



Ethnicity	Total	Percentage
White English / Welsh / Scottish / Northern Irish / British	3316	73.8%
White and Asian	809	18.0%
Asian / Asian British	104	2.3%
White - any other	59	1.3%
Any other ethnic group	53	1.2%
Mixed / multiple ethnic groups	40	0.9%
Black / African / Caribbean / Black British	35	0.8%
Pakistani	24	0.5%
Indian	11	0.2%
Any other mixed background	9	0.2%
White and Black Caribbean	8	0.2%
White and Black African	7	0.2%
Any other Asian background	6	0.1%
Prefers not to say	6	0.1%
Any other Black background	4	0.1%
Other ethnic group	2	0.0%
Information requested	2	0.0%
Chinese	1	0.0%
Total	**4496**	**100%**



Appendix 3 - Customer services equality data

Ethnicity

		Service users	
Ethnic group	**Complaints**	**Number**	**%**
White – British & Irish	67%	86,985	82%
White - other	4%	2,530	2%
Mixed group	5%	982	1%
Asian & Asian British	7%	4,268	4%
Black & Black British	2%	1,798	2%
Other	1%	2,003	2%
Not recorded	14%	8,104	8%
Total	**100%**	**106,670**	**100%**

Disability

		Service users	
	Complaints	**Number**	**%**
Not disabled	7%	39,528	37%
Registered disabled	51%	6,151	6%
Disability not otherwise specified	3%	3,784	4%
Not recorded	39%	57,207	54%
Total	**100%**	**106,670**	**100%**

Gender

		Service users	
	Complaints	**Number**	**%**
Male	33%	49,474	46%
Female	64%	57,123	54%
Indeterminate	0%	10	0%
Transgender	1%	-	-
Unknown	2%	63	0%
Total	**100%**	**106,670**	**100%**

Age

		Service users	
Age group	**Complaints**	**Number**	**%**
0-6 years old	0%	3,592	3%
6-17 years old	1%	16,065	15%
18-25 years old	4%	8,552	8%
26-55 years old	71%	37,133	35%
56-64 years old	10%	11,404	11%
65-74 years old	8%	10,655	10%
75 years and over	2%	19,269	18%
Unknown	4%	0	0%
Total	**100%**	**106,670**	**100%**

Appendix 4 – Analysis of equality data for Customer Services

Equality data related to the complainant

The customer services team capture equality data from the complainant - the person raising the complaint. Whenever possible, data is collected either when the complaint is made or when the equality form is returned later. Complainants are informed about the importance of this data for ensuring equal access to the complaints process.

The equality form includes nine protected characteristics: age, disability, gender reassignment, ethnicity, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. Additionally, we ask if the complainant is a carer and if they are registered with their General Practitioner (GP) as one. This aligns with the services we offer, and the Trust considers this additional characteristic as important as the nine protected characteristics. This enables the customer services team to ensure that complainants are fully supported based on their needs.

The team continues to explore best practices for capturing equality data, both internally and externally, incorporating any learnings into routine processes.

The Trust's equality and diversity managers review all complaints and feedback where concerns are raised about possible less favourable treatment due to a protected characteristic. This ensures that any trends or patterns of harassment are identified and addressed appropriately.

Comparing the data suggests that those raising concerns and complaints are representative of our service user population. Although this data is not directly comparable as complaint equality data is for all complainants, rather than just service users, a large proportion (n=172, 60%) are from the service user.

A review of the age profile of complainants in 2024/25 shows that 66% of formal complaints (n=188) were submitted by individuals aged between 26 and 55. In contrast, only 8% (n=22) were received from people aged over 65.

This disparity suggests there may be barriers, perceived or actual, that make it more difficult for older individuals to access or engage with the complaints process. While it is likely that some older service users rely on family members or carers to raise concerns on their behalf, we recognise the importance of ensuring that the complaints process is inclusive, accessible, and user-friendly for all age groups

As part of our commitment to ensuring equity and accessibility within our complaints process, we conducted a focused review in 2024/25 to better understand the lower representation of older adults, particularly those aged 65 and over, among complainants.

We analysed complaints submitted by third parties, primarily family members and carers, on behalf of individuals accessing older people's services. The findings highlighted that the concerns raised were often not from the older person themselves but rather reflected the experiences and frustrations of family members. Key themes included feeling excluded from care planning, a lack of clarity around discharge processes, and insufficient communication regarding treatment decisions. These insights suggest that families and carers may feel disconnected from the care being delivered and are using the complaints process to voice concerns on behalf of their loved ones.

Alongside this, we carried out a review of our complaints and feedback materials to assess their suitability for older adults. This included evaluating the clarity, tone, and accessibility of written

materials, as well as how easily the information could be accessed in both print and digital formats. While some good practices were identified, the review also highlighted opportunities to improve how we present and share information, particularly for those with visual impairments or limited digital access.

Based on these findings, we are developing clearer and more accessible feedback materials, increasing awareness of advocacy and support services more frequently accessed by older populations, such as community groups, GP practices, and care homes, and ensuring staff are equipped to support older individuals and their families when concerns arise. These actions form part of our wider commitment to promoting equitable access to the complaints process for all service users.

Equality data when consent was provided

The equality form, described above, captures where the complaint is coming from, and this enables identification of when the complainant is the service user. Customer services can only collate more detailed equality data when the consent form is returned, and the following breakdown relates only to those cases (n=166) where consent was provided.

The data shows that most complaints come from people who are of a working age, between 26-55 (71%) and 66% class themselves as white British. 62% of complaints were raised by the service user. 64% of complainants are female and 33% are male. There is a spread across other ethnic groups which falls broadly in line with our service user population. Data suggests that people from ethnic minority groups appear to be proportionate to those accessing our services. Notably, 67% of complainants identify as white British/Irish, which is significantly less than the Trust's service user population of 91%. However, it should also be noted that 14% (n=24) either did not provide ethnicity details or stated that they preferred not to say.

Complaints are received from people with a wide range of disabilities and for those who returned the equality form (n=166), 17% declared a mental health condition or a mental health condition plus another type of impairment (8%). Most people who provided information about their sexual orientation (n=113) are heterosexual (68%), with a small proportion (7%) who are representatives of the LGBTQ community. Notably, 25% of complainants (n=41) declined to provide information about their sexual orientation.

It was previously only possible to identify the equality data for service users who are the complainant, rather than for all people the complaints relate to. The consent form was amended on 9 September 2024 and where possible, we also collect equality data from the service user when a complaint has been raised on their behalf by a third party.

Equality data when the service user is not the complainant

During 2024/25, 63 of the 166 complaints received with returned consent were raised by a third party on behalf of a service user. This reflects the important role that families, carers, and advocates continue to play in supporting individuals to raise concerns.

From September 2024, an update to the Datix system enabled us to begin collecting equality and diversity information for service users in cases where they are not the complainant. While this dataset is still developing, a review of the first 33 applicable complaints received from September provides useful insight into the demographics of the service users for whom complaints were raised.

Demographic highlights from the first 33 third-party complaints:

Age of service users:

- 33% were aged 26–55 years, 30% were aged 6–17 years, 21% were aged 75 years and over.
- 6% each were aged 18–25 and 56–64 years and 3% were aged 65–74 years.

This spread highlights that third-party complaints are most commonly raised for adults of working age and children or young people, with a notable number relating to older adults.

Gender identity:

- 55% of service users were male, 39% were female, 3% identified as transgender and 3% declined to disclose gender.

Ethnicity and language (based on 27 living service users):

- 67% identified as White British, 3% Pakistani and 3% White and Black African and 9% did not provide ethnicity data.
- 81% reported English as their main language, 4% stated Punjabi and 15% declined to disclose language.

Additionally, 18% of these third-party complaints (n=6) were raised in relation to deceased individuals. In these cases, only limited demographic data such as age and gender are collected, out of respect and to minimise intrusion.

This early analysis highlights the potential value of collecting and analysing demographic data in third-party complaints. However, with a relatively small dataset, we recognise the need to further improve the completeness and consistency of this information.

Appendix 5 - Friends and family test equality data

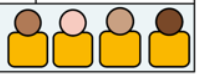
Disability	Number	%
Mental health condition	889	41
I do not have a disability	345	16
Long standing illness	333	15
Physical impairment	181	8
Cognitive impairment	131	6
Learning disability	131	6
I prefer not to say	88	4
Other	64	3
Speech impairment	26	1
Total	**2188**	



Age	Number	%
0-16	136	4
17-20	131	4
21-30	344	10
31-40	493	15
41-50	534	16
51-60	558	17
61-70	474	14
71-80	427	13
81+	202	6
Total	**3299**	



Ethnicity	Number	%
White English/Welsh/Scottish/Northern Irish/British	2870	90
Asian/Asian British	90	3
White - Any other	59	2
Any other ethnic group	51	2
Mixed/multiple ethnics groups	38	1
Black/ African/ Caribbean / Black British	33	1
Pakistani	18	1
Any other mixed background	8	0
Indian	5	0
White and Asia	5	0
Any other Asian background	4	0
Any other Black background	2	0
Other ethnic group	2	0
White and Black African	2	0
White and Black Caribbean	2	0
Chinese	1	0
Total	**3190**	



Gender	Number	%
Female	2196	67
Male	1055	32
You live and work permanently in a gender other than that assigned at birth.	12	0
Other	10	0
non-binary	8	0
Transwoman	4	0
Androgynous	1	0
Gender fluid	1	0
Neutral	1	0
Total	**3288**	



Appendix 6 - Friends and family test breakdown by Care Group/ service line/ area

Care Group	Number	Percentage
(Acute Mental Health (85%)	**484/660**	**73%**
Barnsley	29/47	61%
Calderdale	60/82	75%
Kirklees	260/378	69%
Wakefield	135/153	88%
Mental Health (85%)	**2798/ 2982**	**94%**
Barnsley	1566/1633	96%
Calderdale & Kirklees	874/967	90%
Wakefield	358/382	94%
Forensic (60%)	**176/230**	**77%**
All age community	46/70	66%
Low	28/31	905%
Medium	102/129	795%
CAMHS & Children	**796/860**	**93%**
Children (95%)	455/472	96%
CAMHS (75%)	341/388	88%
Physical Health (95%)	**3315/3448**	**96%**
Inpatient	32/32	100%
Nursing	95/110	86%
Long term conditions	576/595	97%
Health & wellbeing	1239/1266	98%
Therapy / primary care & prevention	1373/1445	95%
Learning Disability/ ASD/ ADHD (85%)	**362/393**	**92%**
Learning disabilities	189/201	94%
ASD/ ADHD	173/192	90%

Number = (good & very good/ number of responses received)

Appendix 7- Friends and Family Test Feedback Method Breakdown by Care Group/ service line/ area

Care Group	Card %	Kiosk (CHATpad) %	Online Link %
Acute Mental Health	13%	12%	75%
Barnsley	34%	13%	53%
Calderdale	26%		74%
Kirklees	6%		94%
Wakefield	19%	48%	33%
Mental Health	32%	5%	63%
Barnsley	34%		66%
Calderdale & Kirklees	26%		74%
Wakefield	38%	1%	61%
Forensic	25%	26%	49%
All age community	1%	1%	19%
Low			100%
Medium	2%	46%	53%
Children and Families	17%	11%	72%
Children	21%	8%	71%
CAMHS	13%	15%	71%
Physical Health	10%	7%	83%
Inpatient	25%	38%	38%
Nursing	3%	22%	75%
Long term conditions	4%	20%	76%
Health & wellbeing	3%		97%
Therapy	17%	4%	79%
Learning Disability/ ASD/ ADHD	59%	1%	40%
Learning disabilities	47%		53%
ASD/ ADHD	72%	4%	24%

Appendix 8 – Learning and improvements from patient experience

The table below outlines some of the changes and improvement made as a result of feedback received:

You Said	We Did	Location
You said our initial letters did not provide enough information about the assessment and who would be completing it.	More information has been added to the first appointment letter, along with staff team pictures.	Calderdale Neurodevelopmental Assessment Service
You wanted something to take away from the final appointment to support your understanding of the diagnosis.	If the report is ready in time for your outcome appointment, you will receive a physical copy of this to take away that day.	Calderdale Neurodevelopmental Assessment Service
You asked for a choice of foods offered at mealtimes.	The ward has commenced asking patients for their preference with a menu, offering alternatives if the planned meal is not to their liking.	Poplars
You didn't feel that you were included in next steps planning.	Managers discuss education and explanation to patients at team meeting.	Musculoskeletal Service
You did not know how to raise a complaint.	A customer services leaflet has been added to referral letter.	Equipment, Adaptations and Sensory Impairment Services
You told us that you enjoyed the activities on the ward and would like more regular access to the pool table.	Ward staff are working hard to make sure that activities are available each day and welcome the continued suggestions.	Ward 19
You are unhappy about the access and waiting times to the service.	The service is developing a referral screening clinic to assess clinical appropriateness of referral.	ADHS and ASD services
You requested shorter waiting times.	The service has implemented the following strategies, scheduling and confirmation calls/ text messages, clear communication of appointment times and dates, automated reminders and early check-in and streamlined intake process and waitlist management.	Tissue Viability service
You wanted, better options for food, including: • **healthier choices of supper snack i.e. oat/ fruit cake or biscuits, small cereal bar, seasonal fruit** • **improvement in finger foods i.e. crumpets, pizza, veg sticks** • **can we have some different items i.e. cottage cheese?**	The catering team have: • created a 'Mix & Match' range of out of hour food items to reflect diverse needs i.e. healthier eating and finger foods oat fruit biscuits, cereal bar, flapjack bar. • created a trial of 8-week Wed summer seasonal menu i.e. seasonal fruit, cottage cheese, pizza.	Kendray Catering serving wards at Kendray & Priestley Unit
You said there was a lack of communication regarding process and what to expect.	The services website currently been updated to reflect information and processes and will include what to expect at your appointments.	ADHD & ASD services

You said, you wanted: • **more choice of pizza - only seasonal, Poor fruit & veg variety** • **enough portion size, over fed wouldn't eat all these meals, amount of waste** • **more cultural options, chips are cold/under cooked**	The catering team: • will carry out quality checks on chips. • our food offering aims to support a mix a match approach for individual choice selection, wide diverse nutrition requirements & reduce food waste. • seasonal options are opportunities for new items - Cultural Halal/ Caribbean menu/Jacket potato, fruit (apples, oranges, banana) & veg (salad, broccoli, peas, carrots, swede) are available daily.	Kendray Catering CPU Beamshaw Community Food
You asked for better signposting to be able to get here as you couldn't find any yellow signs and had to ask the GP receptionist.	The service has requested the sign on the reception desk is replaced with a yellow sign.	Tissue Viability service
You asked for timely consultations and appointments.	The service has implemented the following strategies including, scheduling and confirmation calls/ text messages, clear communication of appointment times and dates, automated reminders and early check-in and streamlined intake process and waitlist management.	Cancer Related Lymphoedema service

Volunteers: The Quality Governance Team has successfully trained three volunteers. Two of these volunteers will commence their placements within the ADHD & ASD service and the Wakefield Learning Disability Team in Quarter 1 2025/26. The next cohort of volunteers is scheduled to undergo training in May 2025.

- **Use of CHATpads in community services:** Volunteers are being trained to use CHATpads within their roles, with the training including technical support for the device. Volunteers are being deployed across the Trust to assist in the collection of Friends and Family Test and patient experience feedback to increase qualitative data to support service improvements.

- **Expand the FFT text message function across physical health services to increase FFT responses:** Text messaging was implemented across Physical Health and Wellbeing services, with the exception of those services not utilising SystmOne and certain units where text messaging is deemed inappropriate, such as the Neurological Rehabilitation Unit (NRU) and Stroke Rehabilitation Unit (SRU). Since its launch in January, there has been a 60% increase in responses to the online survey and a 67% increase in overall feedback for Barnsley Physical Health and Wellbeing Care Group.

- **Continue to work with service's not meeting targets and identify quality improvement work:** Throughout the year, 29 advice surgeries were conducted with various services to review their friends and family test feedback, including feedback ratings, return rates, and return methods. These sessions provided an opportunity for services to evaluate the accessibility of their feedback methods for service users, carers, and families. Additionally, bi-monthly friends and family test drop-in sessions are available to staff to support the collection of feedback. These sessions cover the history and purpose of the friends and family test, as well as collection and reporting methods, and emphasises the use of feedback for quality improvement.

- **Capturing the experience of children and young people admitted to adult mental health wards:** A survey and process have been developed to capture the experiences of young people admitted to adult mental health wards. Post-discharge feedback will be collected by the CAMHS care coordinator within the community. Once the survey results are compiled, they will be shared with the relevant inpatient wards for review, enabling the identification of key areas for improvement and the implementation of appropriate actions based on the feedback received. Reporting will be conducted either bi-annually or annually, depending on the number of returns, to analyse themes and trends from the feedback.

- **Review equality data:** Due to capacity constraints within the Quality Governance Team, there was a delay in analysing the equality data for 2023/24. This data will be shared with Care Groups in May 2025, alongside the 2024/25 data. Moving forward, this process will continue on an annual basis.

- **Undertake a review of patient experience across the Trust using NHS England's experience of care framework:** **NHS England » Experience of care improvement framework**.
  The framework was launched by NHS England in early 2025. It serves as a tool to enhance outcomes and experiences for service users, unpaid carers, staff, volunteers, and the wider community. Reviewing this framework will be a key objective for the Trust in 2025/26.

- **Community mental health survey actions:** Following analysis of the 2023 community mental health results, local actions were identified, and an action plan has been created, this includes:
    - Development of a leaflet to provide service users, their carers, and their families with the appropriate local information to support service users in all areas of their life that effect their mental health, including:
        - Benefits and financial advice
        - Cost of living
        - Who to contact in a crisis
        - Finding work
    - Reminder to staff to explain to service users, their carers and families, why they may, on occasions, have to repeat information to staff.
    - Accessible information to be added to patient experience surveys to identify if service users, their carers and families are offered information in the format they request.
    - Promote the Triangle of Care within community services to encourage the involvement of carers and families in services users care where appropriate.

- **Continue to work with CAMHS on Was Not Brought project:** A multidisciplinary project group has been established, comprising of colleagues from CAMHS, safeguarding, equality and involvement, and the quality governance team. This group is dedicated to analysing existing data, enhancing data quality, and reviewing policies, including definitions. The objective is to improve data collection processes to better support young people, their carers, and families in attending appointments. Additionally, the group aims to identify individuals facing financial difficulties and explore how the Trust can provide effective support. This will be an ongoing objective throughout 2025/26.

- **Continue to work with other support services to triangulate patient experience feedback:** Discussions are currently underway with the equality and involvement team to explore the development of the existing equality and involvement forums across the Trust into a more integrated experience, equality, and involvement forum. This new forum will include colleagues from customer services and patient experience, aiming to support Care Groups and triangulate data from various feedback methods. The goal is to ensure that the voice of the service user is heard across all channels of feedback, fostering a more integrated approach to improving care. This will be ongoing objective throughout 2025/26.

  The children and young people experience, equality and involvement action group and the physical health and wellbeing action groups will remain active. Additionally, the project group for ADHD and ASD will continue to operate until the new experience, equality, and involvement forum is established.

- **Continue to work with Trust charity to promote the use of charitable bids:** Colleagues from the Trust charity, Ey Up, are invited to all patient experience group meetings and will remain a standing item on the agenda for all patient experience discussions. This includes the forthcoming experience, equality, and involvement forums once they are established, ensuring ongoing collaboration and integration of charitable support into the patient experience process.

- **Continue to develop patient experience surveys across the remaining service lines:** These have continued to develop and feedback provided has helped shape the surveys for ADHD, autism and learning disabilities, which will be launched in Quarter 1 of 2025/26, with

the CAMHS service launching in Quarter 2 and the mental health community survey in Quarter 3.

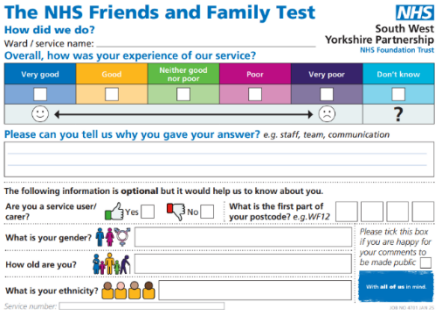
Current surveys are being used to benchmark patient experience across service lines and support service improvement. Further information can be found under section 6.1. Local Surveys.

The Trust would like to thank the Wakefield Learning Disability Patient Experience Group for their support with this piece of work.

- **Develop a communications plan to promote FFT and patient experience feedback methods:** An annual communication plan has been developed to identify key activities throughout the year, such as Carers Week, which promotes the carers patient experience survey to encourage feedback. The plan also includes regular reminders for the friends and family test, including requests for stationery, the use of QR codes on social media, and links. Additionally, the communication plan includes adhoc items such as openings for volunteer roles.

- **Work with Care Groups to collate actions taken as a result of feedback:** Developments include:
  - Feedback forms for actions identified from patient experience surveys, completed quarterly by services and submitted to the quality governance team.
  - Along with the form, services will also submit, where appropriate, 'You Said, We Did' posters to highlight changes made based on feedback. These forms and posters are then collated and shared locally as well as on social media to promote transparency and accountability.
  - Reminders are provided throughout experience, equality, and involvement groups, Care Group meetings, and through internal communications.

- **Work with children's service to develop accessible age-appropriate friends and family cards**: Two groups of connectors were established and engaged with children and young people to review the friends and family test cards to help us redesign them. Following the review, feedback was viewed and categorised into what the Trust could and couldn't change. The design team were asked to design the cards base on feedback, this included:


The NHS Friends and Family Test
How did we do?
Ward / service name:
South West Yorkshire Partnership NHS Foundation Trust
Overall, how was your experience of our service?
Very good | Good | Neither good nor poor | Poor | Very poor | Don't know
Please can you tell us why you gave your answer? e.g. staff, team, communication
The following information is optional but it would help us to know about you.
Are you a service user/ carer? Yes No
What is the first part of your postcode? e.g.WF12
What is your gender?
How old are you?
What is your ethnicity?
Please tick this box if you are happy for your comments to be made public
With all of us in mind

- Use of colour
- Lines to write on in comment box
- Make 'optional' stand out
- Removing orange and blue areas
- Prompts in text box

Feedback from the young people involved in the project also identified:

- Only 16/ 21 young people knew what the friends and family test was.
- Only 2/16 young people had completed a friends and family card.

An action plan has been developed to address these issues and will form part of the priorities for patient experience for 2025/26. This includes:

- Continuing to work with services to increase visibility of friends and family test.
- Using social media to raise profile of friends and family test to children and young people.
- Reviewing supporting documents for friend and family test for children and young people.
- Creating a video for the screens in the CAMHS waiting areas to explain:
    - What the friends and family test is.
    - Why it's important to for children and young people to provide feedback.
    - How children and young people can provide feedback.
    - What happens to the feedback provided from children and young people.



The Trust would like to thank the young people from Newsome School and Woodland School who participated in this project.

Appendix 9 - Community Mental Health Survey Results 2023 – Infographic

Community mental health survey results for 2023

South West Yorkshire Partnership NHS Foundation Trust

Introduction and background

The community mental health survey is mandatory and is conducted on behalf of the Care Quality Commission (CQC). It explores the experience of people receiving support from community mental health services. The survey involves 53 providers of NHS community mental health services in England.

Our Trust received 247 responses out of 1250, which was a 20% increase in responses from the 2022 survey.

Comparison with other Trusts

When compared to other Trusts, our Trust's scores were comparable to those of other similar Trusts.

Our Trust has performed:

Much better than expected in one question.
How long it took get through to their contact (Q29).

Better than expected in five questions.
Service users' medication being reviewed (Q22).

Somewhat better than expected for five questions.
Service users' getting the help they needed in crisis (Q30).

About the same for 22 questions.

Themes

The top three themes identified from **99 positive comments** were staff (90), patient care (31) and communication (17). 27 members of staff were named as giving good care and treatment and having effective communication skills.

The top three themes identified from **105 negative comments** were access and waiting times (61), patient care (20) and staff (13).

So what?

The findings and results have been shared with the quality governance leads (QGL) for distribution among the team, and an action plan has been developed in collaboration with the quality governance leads, which combines the received recommendations along with local analysis. The elements of this plan are emphasised by the areas needing improvement and the actions implemented for each aspect.

Area for improvement:	Action:
Nationally identified action: Direct mental health teams to regularly check in with service users to offer resources and advice and support them with cost of living expenses. Review the materials that are available to service users and how information from external sources is sign posted.	Development of a leaflet to provide service users, their carers, and their families with the appropriate local information.
Q32b: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work? **(-28%)**	
Q32c: In the last 12 months, did NHS mental health services give you help or advice with finding support for financial advice or benefits? **(-23%)**	
Q26: Would you know who to contact out of the office hours within the NHS if you had a crisis? **(-5%)**	
Q11: Did you have to repeat your mental health history to your mental health team? **(-16%)**	It is important to remind staff to provide an explanation to service users, their carers and family regarding the necessity of repeating information to: • Clarify information recorded. • Support staff understanding of situation. • Ensure service users, their carers and families understand information.
Q10: Did your NHS mental health team consider how areas of your life impact your mental health? **(-19%)**	Work has already been undertaken to address these areas. Personalised care and support plans have been developed. This includes the use of DIALOGUE+. DIALOG+ is a patient led outcomes scale whereby people entering secondary mental health services are asked to rate their satisfaction around quality of life and needs for care.
Q17: Has your mental health team supported you to make decisions about your care and treatment? **(-18%)**	
Q21c: Were the side effects of your medication discussed with you? **(-13%)**	This is monitored as part of the quality audit and feedback to practitioners by the team manager.
Q33: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like? **(-9%)**	Promote Triangle of Care (TOC) by: • Completing staff carers awareness training. • Promotion of carers assessments: » recording carers information on SystmOne, » providing carers passports (Carer confident)

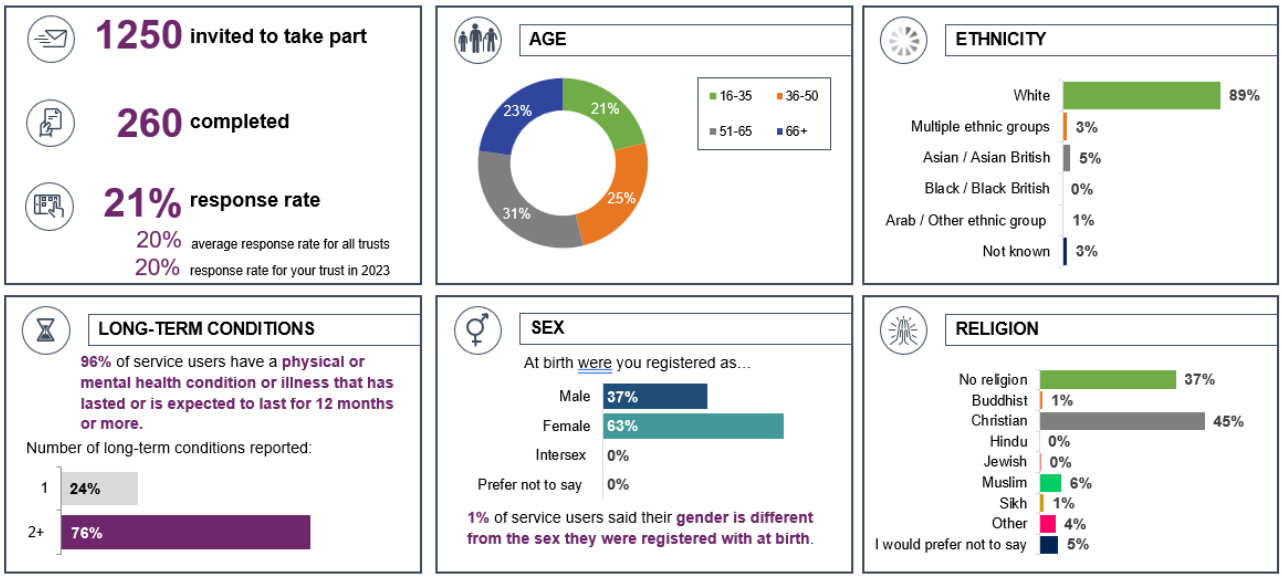
If you require a copy of this information in any other format or language please contact the Trust.

With **all of us** in mind.

Appendix 10 - Community Mental Health Survey Results 2024

Who took part in the survey?

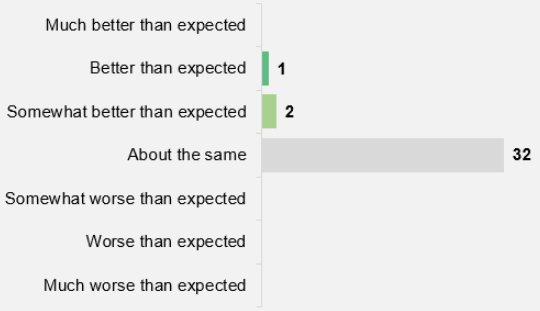
This slide is included to help you interpret responses and to provide information about the population of service users who took part in the survey.



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.



Section Scores

This section of the report summarises the overall score for each survey section. Section scores are based on the average across all scored questions in the section.

Section	Trust	All
Accessing Care and Treatment	6.94	6.53
Your Mental Health Team	6.75	6.48
Your Care	6.55	6.16
Your Treatment	7.31	6.95
Crisis Care	6.59	5.94
Support and Wellbeing	4.04	3.84
Overall	6.19	5.77

Community Mental Health 2024 local comparison with the previous year

Overall Trust percentage by question with previous year comparison.

Heading	Number 2023	Question	2021	2022	2023	2024	change
Your mental health team	11	Did your NHS mental health team consider how areas of your life impact your mental health? *(yes, definitely & yes, to some extent)*	88%	86%	67%	82%	15%
Your care	15	To what extent did your NHS mental health team involve you in agreeing your care plan? *(very large, large and some extent)*	-	78%	82%	91%	9%
Your treatment	22c	Have any of the following been discussed with you about your medication? Side effects of medication? *(yes, definitely & yes, to some extent)*	75%	80%	67%	74%	7%
Your treatment	25	How do you feel about the length of time you waited between your assessment with the NHS mental health team and your first therapy appointment? (The waiting time was appropriate; I did not have to wait)	-	-	52%	58%	6%
Your treatment	22d	Have any of the following been discussed with you about your mediation? What will happen if I stop taking my medication. *(yes, definitely & yes, to some extent)*	-	-	66%	66%	0%
Crisis care	27	Would you know who to contact out of the office hours within the NHS if you had a crisis? *(no)*	30%	29%	24%	15%	-9%
Your care	17	In the last 12 months, have you had a care review meeting with your NHS mental health teams to discuss how your care is working? *(yes)*	67%	59%	56%	55%	-1%
Your care	18	Has your mental health team supported you to make decisions about your care and treatment? *(yes, definitely & yes, to some extent)*	94%	97%	79%	78%	-1%
Support and wellbeing	33c	In the last 12 months, did NHS mental health services give you help or advice with finding support for financial advice or benefits? *(yes, definitely & yes, to some extent)*	55%	49%	26%	25%	-1%
Support and wellbeing	33d	In the last 12 months, did your NHS mental health team give you any help or advice with finding support for cost of living. *(yes, definitely & yes, to some extent)*	-	-	18%	16%	-2%
Accessing care and treatment	4	How did you feel about the length of time you waited between the assessment with the NHS mental health team and your first appointment for treatment. *(the waiting time was appropriate)*	-	-	53%	51%	-2%
Your treatment	26	Thinking about the last time you received therapy; did you have enough privacy to talk comfortably?	-	-	97%	95%	-2%

Overall	39	Overall, in the last 12 months, how was your experience of using the NHS mental health services? *(rating 6 - 10)*	71%	73%	76%	74%	-2%
Your treatment	22a	Have any of the following be discussed with you about your medication? Purpose of medication? *(yes, definitely & yes, to some extent)*	97%	93%	92%	90%	-2%
Your treatment	22b	Have any of the following been discussed with you about your medication? Benefits of medication. *(yes, definitely & yes, to some extent)*	-	-	90%	88%	-2%
Support and wellbeing	38	Do you feel the support provided meets your needs? *(yes, definitely & yes, to some extent)*	-	-	71%	68%	-3%
Your mental health team	12	Did you have to repeat your mental health history to your mental health team? *(yes, often & yes, sometimes)*	90%	89%	73%	70%	-3%
Overall	41	Aside from this questionnaire, in the past 12 months, have you been asked by NHS mental health services to give your views on the quality of your care? *(yes)*	18%	24%	32%	29%	-3%
Accessing care and treatment	5	While waiting, between your assessment with the NHS mental health team and your first appointment, did you experience any change in your mental health? *(yes, my mental health got worse)*	-	-	40%	44%	-4%
Your mental health team	8	Were you given enough time to discuss your needs and treatment? *(yes, definitely & yes, to some extent)*	87%	85%	89%	85%	-4%
Your mental health team	10	Did you get the help you needed? *(yes, definitely & yes, to some extent)*	-	95%	86%	81%	-5%
Your mental health team	13	Did your NHS mental health team treat you with care and compassion? *(yes, often & yes, sometimes)*	-	-	94%	89%	-5%
Overall	40	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? *(yes, always & yes, sometimes)*	93%	94%	95%	90%	-5%
Accessing care and treatment	7	Was the support offered appropriate for your mental health needs? *(yes, completely & yes, to some extent)*	-	-	94%	87%	-7%
Crisis care	30	Thinking about the last time you contacted this person or team; how do you feel about the length of time it took you to get through to them? *(I got through straight away)*		-	60%	53%	-7%
Support and wellbeing	33a	In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Joining a group or taking part in an activity (e.g. art, sport etc)	-	-	60%	53%	-7%

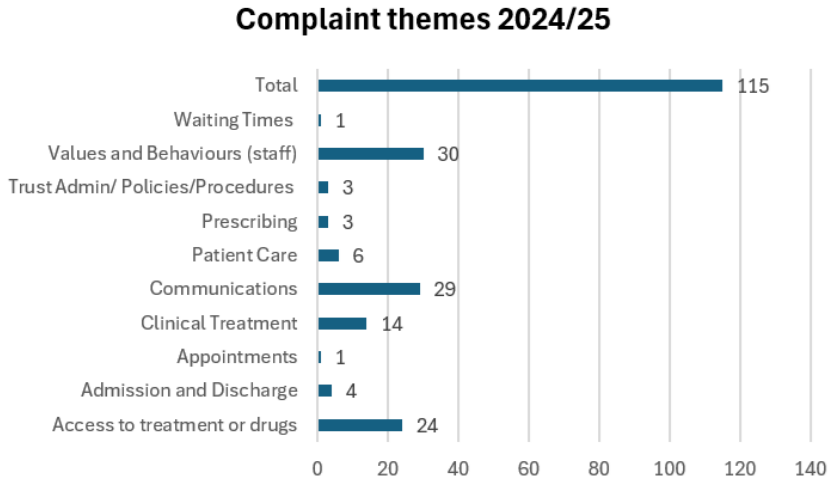
Accessing care and treatment	6	While waiting, between your assessment with the NHS mental health team and your first appointment for treatment, were you offered support with your mental health? *(yes)*	-	-	64%	57%	-7%
Accessing care and treatment	3	How long did you wait between your assessment with the NHS mental health team and your first appointment for treatment? *(less than three weeks)*	-	-	42%	34%	-8%
Your care	14	Do you have a care plan? *(yes)*	-	-	64%	55%	-9%
Support and wellbeing	33b	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work? *(yes, definitely & yes, to some extent)*	51%	52%	24%	15%	-9%
Your treatment	24	In the last 12 months, have you received any therapies for your mental health needs?	-	-	44%	35%	-9%
Support and wellbeing	35	Has the NHS mental health team asked if you need support to access your care and treatment? *(yes)*	-	-	46%	36%	-10%
Crisis care	29	Thinking about the last time you tried to contact this person or team; did you get the help needed? *(yes, definitely & yes, to some extent)*	80%	87%	85%	74%	-11%
Crisis care	31	Did the NHS mental health team give your family or carer support whilst you were in crisis?	-	-	65%	54%	-11%
Your care	19	Do you feel in control of your care? *(yes, definitely & yes, to some extent)*	-	-	78%	66%	-12%
Your treatment	23	In the last 12 months, has your NHS mental health team asked you how you are getting on with your medication?	73%	72%	84%	71%	-13%
Support and wellbeing	36	Do you need support to access your care and treatment? *(yes)*	-	-	46%	29%	-17%
Support and wellbeing	34	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like? *(yes, definitely & yes, to some extent)*	80%	82%	73%	52%	-21%
Support and wellbeing	32	In the last 12 months, has your NHS mental health team supported you with your physical health needs? *(yes definitely, to some extent ?)*	63%	60%	66%	43%	-23%
Your mental health team	9	Did you feel your NHS mental health team listened to what you had to say?	-	-	-	85%	
Your care	16	Were you given a choice on how your care and treatment would be delivered?				57%	

KEY	2024
improved	5
declined	33
stayed the same	1
New	2

KEY
Highlights those questions that have declined over the past three years.
Highlights those questions that have improved across the last three years.

Appendix 11 - Customer services feedback by Care Group

Adults and Older People Mental Health Care Group (Community)



Top three complaint themes

1. Values & behaviours (staff)
2. Communications
3. Access to treatment or drugs

During 2024/25 Adults and OPS Mental Health Care Group (Community) received 115 complaints and 86 compliments

Complaint examples

1. Service user unhappy about an appointment she had with a psychiatrist. She felt she was patronised and dismissed by the consultant.
2. Service user been discharged unknowingly and having trouble with medication.
3. Service user concerned that a letter with personal information regarding her mental health condition and support from services was posted to the wrong address.

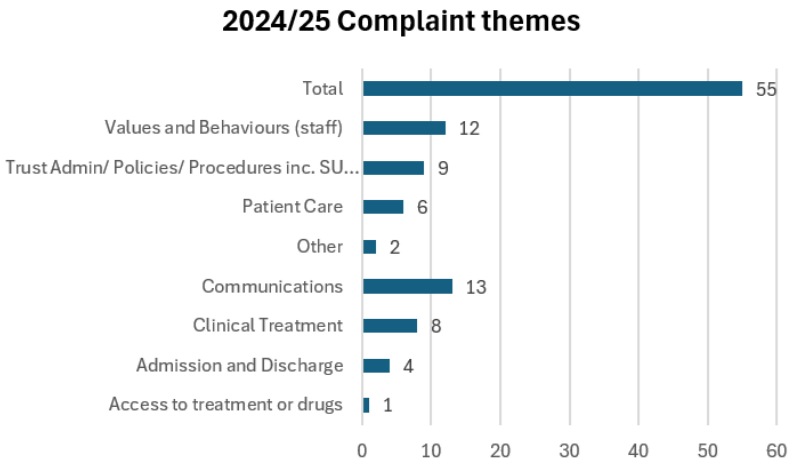
Compliment examples

1. She was very kind, professional and helpful and always has been. Nothing is ever too much trouble for her and when she says she is going to sort something she definitely does and also contacts you to let you know.
2. You have helped me and been there every step of the way.
3. Words truly can't express my gratitude to you for the level of personalised and exceptional care and compassion shown. I thank you for such patience and kindness.

Adults and Older People Mental Health Care Group (Inpatient)

Top three complaint themes

1. Communications
2. Values & behaviours (staff)
3. Trust Admin/ Policies/ Procedures inc. SU records



During 2024/25 Adults and OPS Mental Health Care Group (Inpatient) received 55 complaints and 53 compliments

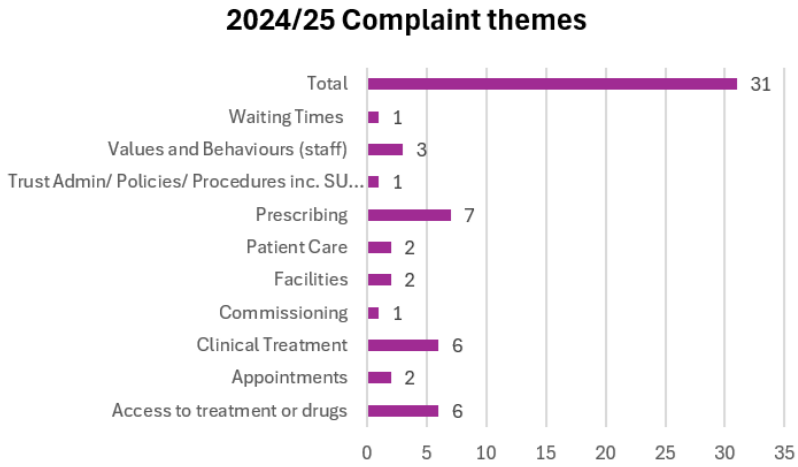
Complaint examples

1. Service user believes they were falsely diagnosed, given unlawful medication and was threatened by staff while they were an inpatient.
2. Daughter is disputing that her mother needs an inpatient admission and wants her discharging from her section.
3. Service user is currently an inpatient but there is no bed available for him, so he is having to stay in communal areas and has no privacy. This is not helpful for his recovery.

Compliment examples

1. I would like to thank all the staff on the ward for their care and attention. I would also like to thank them for their friendship and support to me on my visits to the ward.
2. I wanted to extend my deepest gratitude to each and every one of you for the outstanding care and support you provided during my time on the ward. Your dedication, compassion, and professionalism made a significant difference in my journey towards healing and recovery. Being in a psychiatric hospital can be an incredibly challenging and vulnerable experience, but thanks to your unwavering commitment to patient care, I felt safe, supported, and understood throughout my stay.
3. Thank you for the time you and other staff were able to offer to both my mum and me during our visit today. It really is much appreciated and also reassuring to see how you are all working so hard to look after my dad. Thank you again.

Barnsley Physical Health and Wellbeing Care Group



Top three complaint themes

1. Prescribing
2. Clinical treatment
3. Access to treatment or drugs

During 2024/25 Barnsley Physical Health and Wellbeing Care Group received 31 complaints and 133 compliments

Complaint examples

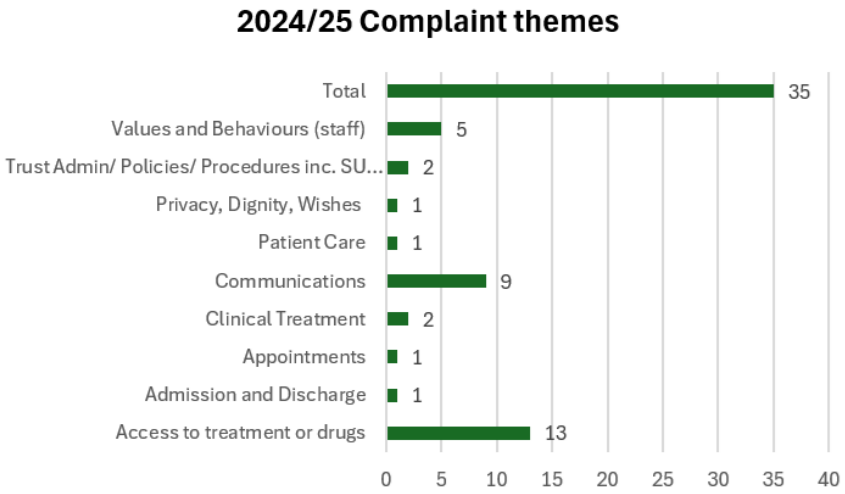
1. Granddaughter of service user upset that district nurse was rude and abrupt with her grandmother when she asked district nurse about overnight care for her husband, who is end of life.
2. Service user's daughter advised that a tourniquet was left on her mother's arm following routine bloods. This wasn't noticed for days or so until her mother began to complain about the feeling in her arm (she has dementia).
3. Service user was prescribed weight management medication by injection, which was delivered by another Trust. The other Trust is now declining to provide the medication. This is having a negative impact on their mental health as they were making progress and had been able to start IVF treatment.

Compliment examples

1. We wouldn't have had such a perfect ending to such a perfect life if it wasn't for all of you.
2. Thank you for everything you have done for me, without your wonderful care I wouldn't be where I am today.
3. Thank you for putting up with me and making my leg better.

Children, Young People and Families Care Group

Children, Young People and Families Care Group received 35 complaints in 2024/25 and 143 compliments



Compliment examples

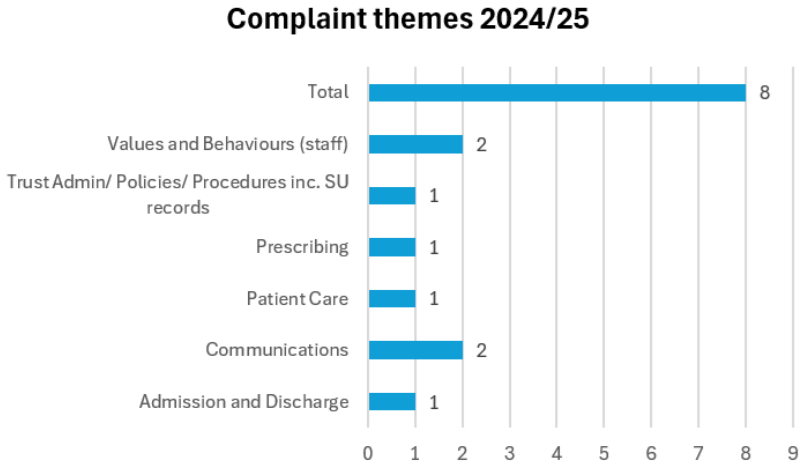
1. I felt so safe and comfortable; it has helped me so much with my mental health. I was able to share so much with you that I had not before and it has helped me process so much of what has happened in my life, even from childhood. Thank you so much! You are so kind and have helped me so much
2. Thank you for all you have done for our child and for us as a family
3. We are so grateful of your help, words aren't enough! You and the whole team have saved our daughter and our family.

Complaint examples

1. Mother concerned regarding the assessment and decisions reached regarding her son's situation.
2. Parents not happy that their child with additional needs received vaccine without them being present. Parents had confirmed that they wanted to be there at the time to support and HPV vaccination was administered against their wishes.
3. Mother of young person unhappy with the alleged conduct of their lead healthcare professional. Also believes they failed to stop her from becoming so unwell that an inpatient admission was required.

Forensic Services Care Group

Forensic Services Care Group received 8 complaints and 26 compliments in 2024/25



Complaint examples

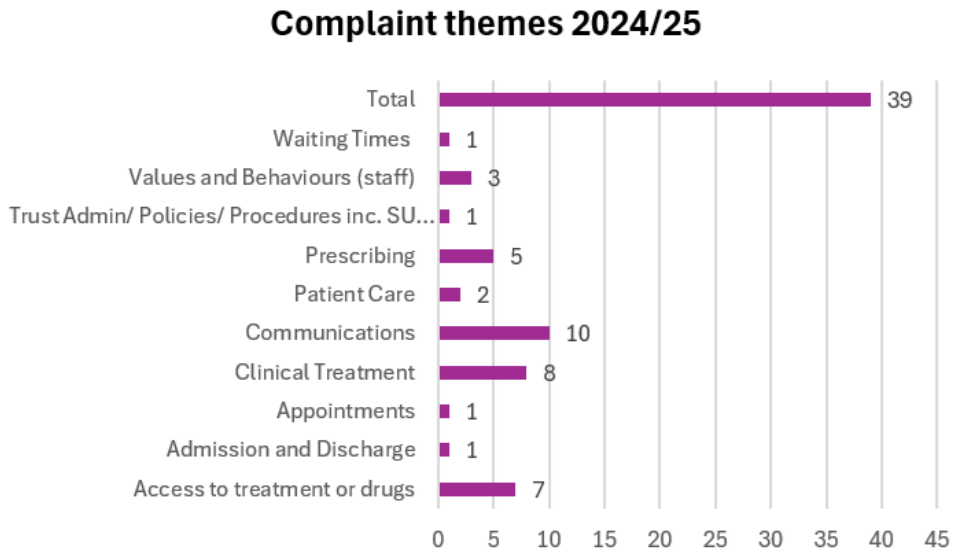
1. Service user unhappy with communication about transfer and rationale for this.
2. Service user believes the hospital are using electrodes through smoke detectors and he is getting harmed by these and his ears are red raw. When he mentions it to staff, they say it's his schizophrenia.
3. Service user's sister concerned about the attitude of a member of staff and comments made.

Compliment examples

1. Mother of service user wanted to acknowledge the good facilities, particularly the grounds, the herb garden and potting sheds and cafes. She is also impressed with how the staff have supported her as a parent, as well as her son as a patient. She is also pleased that she has met and shook hands with other patients.
2. You have been able to use your great leadership skills to build a professional team, pulling everyone's unique strengths to complement and support each other which has had a positive impacted on the ward. I have learnt and understand the importance of teamwork. I have been able to acquire valuable skills on the ward which are a great asset.
3. I shall eternally remain grateful to the team for supporting me on my prodigious first placement. I am so thankful for the learning.

Learning Disability and ASD/ADHD Care Group

Learning Disability and ASD/ADHD Care Group received 39 complaints and 59 compliments in 2024/25



Complaint examples

1. Service user's autism referral has been refused. Service user is unhappy with the service and feels like he is not being heard.
2. Mother of young adult upset and concerned as following diagnosis last year, has now been told adult services do not acknowledge condition that was diagnosed and will not prescribe medication. This is despite young person stating that medication has been life changing.
3. Mother of service user unhappy about the quality of care and support for her son and the quality of communication from services over decisions, including a transfer out of area.

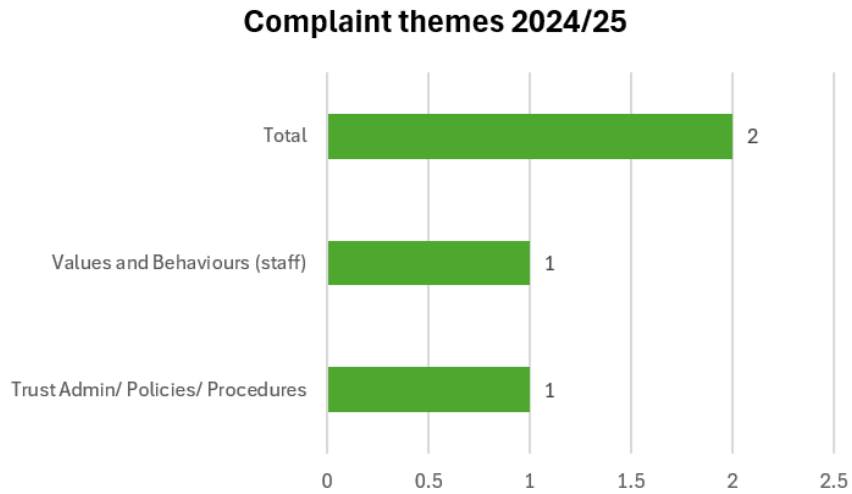
Compliment examples

1. I wanted to thank the dedicated team who have supported me in finding the support I've clearly needed for a long time. I am now at a point where my life has improved drastically, with the help of medication and a deeper understanding of my ADHD.
2. The placement has clearly enabled the students to flourish, and this does not just happen without a positive learning culture and good staff support.
3. I spoke to one of the students today and she told me what an enriching experience she has had on placement, so much so that she would like to work with you, despite never having worked on a ward before. She explained that this is because of the support that she received to develop there; and talked about the patient-centred approaches of the staff team and how you all role-modelled excellence in teamwork.

Trust wide (Corporate support services)

It is not possible to meaningfully analyse complaint themes for Trust wide (Corporate support services) due to the low number received

Trust wide (Corporate support services) received 2 complaints and 39 compliments in 2024/25



Complaint examples

1. Service user concerned about the attitude of customer services staff towards her, saying they have been rude.
2. Husband of service user unhappy he is unable to access his wife's healthcare records.

Compliment examples

1. I wish to compliment a staff member from the payroll department. I'm having some brain/functioning issues and had an issue around my annual leave and time owing. The staff member listened to my concerns, took lots of time explaining what I needed to do to show the correct information and took me through all my taken and booked leave.
2. You have been so polite and helpful. You are a diamond.
3. I've had only positive experience with the library. As a new starter, I have been introduced to the systems, all my questions have always been addressed. The librarians were continuously helpful regarding my research requests. Thank you for all that you do!

Appendix 12 – Learning and actions taken following complaints

You told us	We responded and acted on:
You were unhappy that your care coordinator had been changed without any prior notice	As a result of feedback staff have been reminded that any temporary or permanent changes to cover of works that are put in place should be communicated in advance and contact numbers provided so that support is not interrupted, and families know who to approach in the event of an emergency for example.
You were unhappy with issues relating to son's assessment	As a result of feedback, it has been highlighted to the wider team the requirement and importance that all new referrals to the team have the correct referral form completed and uploaded to the clinical record.
You were unhappy with circumstances around being discharged.	Following a review by a senior manager and the updated clinical information provided; a decision was made to schedule an appointment in the community clinic. This decision reflects our commitment to addressing concerns and providing the necessary support and care. A further outpatient appointment can be made with a different consultant following the community clinic if this is required
You were unhappy with the decision made to transfer your dads end of life care to a nursing home.	As a result of feedback, we have reviewed our assessment process and revised it to include underlying diagnoses such as dementia, beyond the presenting palliative/end of life care needs.
You were unhappy that information regarding safety had not been placed on the service users record.	In response to the issues raised regarding documentation of concerns about safety, this will be added to the clinical record and will be completed at the persons next appointment in the community clinic to ensure that the concerns are accurately reflected in their healthcare records.
You were unhappy that your referral for access to physiotherapy was declined.	It has been highlighted with the wider team as part of their learning, to ensure that comprehensive explanations are provided to service users when referrals are declined so that they can understand the clinical rationale for any decisions.
You were not happy with services sending letters to your family address despite requesting email contact only.	As a result of raising this issue, preferred communication method of email has been recorded on the persons healthcare records and an apology provided.
You were unhappy with your recent contact with services and lack of support given. You felt that your working diagnosis had not been explained to you at the time.	All staff are regularly reminded of the importance of clearly explaining information around a service user’s working diagnosis and to check their understanding of this.

You were unhappy that you were informed that you had to make a subject access request (SAR) by the team to access the letter sent to your GP following your appointment.	A discussion within the team has occurred and in terms of what services can send out without the need for a SAR request. Wider learning for all services has been highlighted as an action to take forward.
You were unhappy that you were not informed prior to your appointment that a trainee staff member would also be in attendance.	Staff have been reminded to check with patients that they are comfortable with another practitioner attending the appointment and gain consent before they meet.
You were dissatisfied with your diagnosis, no one had spoken to you about it and what it means for you.	As a result of feedback doctors have been encouraged to involve patients in care decisions and share care plans so that they can be updated and worked on in collaboration.
You felt that services didn't listen to your concerns about your wife, and this led to a serious incident at your home.	We explained that procedures were followed, and there were no immediate concerns requiring hospitalisation for your wife. However, the complainant remained dissatisfied and the General Manager met with them which gave the opportunity to listen to his experience, and they provided an apology on behalf of the service.
You are not happy with the care and treatment you've received by Trust services and your named worker.	You felt your current worker had provided inappropriate support by speaking to you in an abrupt manner, calling you disrespectful, and accusing you of having an "attitude." The service has reassured you that the mental health worker's conduct will be addressed in clinical supervision, and a different mental health worker will be allocated to you in the future.
You are unhappy that services did not advise you for nearly a month that your brother had been admitted, despite having the necessary contact information from a previous admission.	The service apologised for not informing you in a timely manner that your brother had been detained under the MHA and explained the Section 2 detention process that had been followed.
You are unhappy that your child's mental health has been dismissed on the premise that they are autistic and have gender dysmorphia. You are also unhappy that a CAMHS worker consistently misgendered your child.	The service has accepted that young person was not addressed using their preferred pronouns. The approach taken to explore self-harming behaviours, and the handling of diagnosis discussions was not helpful. The service has apologised for the staff member's conduct and has assured the mother that the worker will receive additional training and clinical supervision to address these concerns.
You are unhappy that you will have to wait 6.5 years for the recommended treatment to support your weight loss.	Weight loss injections can only be prescribed by a specialist consultant, leading to long wait times. The Trust is addressing these concerns by working with partners to increase capacity and improve support, including ensuring psychological referrals are offered, which were missed initially in this case. Tier 3 guidelines require patients to undergo diet and lifestyle changes before injectable therapies, contributing to extended wait times.

	The Trust is committed to streamlining access, improving communication, and reducing delays in service provision.
You are concerned about the effectiveness of the assessment and discharge process you experienced when you had problems with your shoulder.	The service explained that protocols were followed during the assessment process and apologised that this was not fully communicated. They clarified that the first scan focused on the neck and nerves, while the arthrogram was specifically targeted at the shoulder joint, which accounts for the differing results. A referral to Orthopaedics was made once all non-surgical treatment options had been exhausted. The service apologised that the discharge process made you feel dismissed and assured you that they would review and improve how discharges are handled in the future.
You are unhappy that a private diagnosis and Shared Care Agreement has not been recognised, and service user is left without treatment that had been extremely beneficial.	Response outlined the comprehensive assessment process, highlighting inconsistencies in reported symptoms and objective findings. It explained the rationale for medication discontinuation and clarified that the decision regarding the shared care agreement rested with the GP, who prioritised patient safety and evidence-based care.
Service user experienced delays and problems resolving property issues from two years ago since they were transferred.	All ward staff have been reminded of the importance of ensuring that a property disclaimer form/list is completed in full when a person arrives on the ward and to check this again if the person is transferred to another ward or hospital. Staff should also ensure that the form is scanned onto the person's electronic healthcare record and a copy provided to them.
Daughter of service user was distressed that staff recorded the wrong details on her mother's end of life care plan and death certificate, resulting in them needing to unnecessarily approach other services as part of the process for registering her mother's death.	The service apologised and committed to: - Feedback to general hospital for their part in the errors. - Internal improvements, including enhanced communication, prioritised referrals, system changes, and staff training.
Service user concerned about access to her medical records and information being shared with a third party.	Reassurance provided and confirmed that staff did not breach confidentiality.
Son of service user raising concerns about mother's care and treatment.	The Trust has formally responded to issues raised by CQC on behalf of complainant. However, the care coordinator has spoken with service user who confirmed she does not want her son to raise complaints on her behalf or for information to be shared with him.
Service user unhappy with information disclosed to GP regarding their diagnosis following contact with service that they disagree with.	The importance of obtaining and checking a person's understanding and views of any known or recorded mental health diagnoses, has been reiterated to all staff. This ensures a better understanding of how the service can best support someone by signposting them to the most appropriate service to provide any ongoing support identified.

Service user feels that he's not been supported by a consultant since transferring into the care of the older people service.	Investigation identified that the service user's care experience fell short of expected standards. Sincere apologies were extended to the service user for the lapses in their care.
Service user unhappy with care and treatment they are receiving as an inpatient and has referred these to CQC.	Confirmed process by which service user came to be detained after attending A&E with family members and assessed as experiencing relapse in mental ill-health. Rationales for the service's response to the person's needs during the admission were provided.
Disappointed and frustrated with the lack of support and help for obesity issues. After a high blood pressure and months of waiting for support, friends bought them a weight loss injection. They have been buying this since April 2024 and the service user has lost approximately 3 stones in weight with very few negative side effects. They were hoping that they could have this prescribed from Trust as it is costly to self-fund, particularly as they are hoping to retire soon. Have been told in support phone calls that they are on a waiting list, but it is unlikely to ever happen, but they can be offered bariatric surgery.	The NHS has commissioned an alternative weight loss programme which includes assessment for injectable medications. This service is called Oviva, and service user has been identified as eligible for this. Advice provided that the Health and Wellbeing Coach at GP Practice should have been in contact with service user to discuss this as an option for her.

Appendix 13 – Other patient experience feedback

Food related patient experience from the catering team

(Source: SE108 24/25 Patient Mealtime and Staff Dining Room Experience conducted by Daniel French, Catering Manager and Elaine Lane, Trust Senior Catering Dietician)

Hospital food across NHS Trusts often receives low feedback scores due to several inherent challenges. Many patients find the food unappetising and lacking in variety, which can be attributed to budget constraints and the need to cater to diverse dietary requirements on a large scale. Additionally, the quality and freshness of ingredients can be compromised due to logistical issues and the mass production nature of hospital catering. Reports have highlighted that hospital food is not always prioritised, leading to inconsistent standards and dissatisfaction among patients. These factors collectively contribute to the perception that hospital food is inherently bad, resulting in consistently low feedback scores.

However, feedback from the mental health inpatient patient experience survey identified the Trust rating for food across inpatients has remained above an 80% satisfaction rate since 2022/23 and has seen a steady improvement over the past two years, with 2023/24 showing a satisfaction rate of 90% and in 2024/25 of 95%. However, the food rating for the Trust Forensic service remains under 50%. This is being addressed through action plans and discussions with the catering managers on a regular basis at community meetings.

Across the Trust, catering is provided to service users, staff and visitors in the ward areas and in dining rooms. In order to evaluate the service, develop and improve the food offering, feedback forms were devised and introduced into wards at Kendray Hospital and dining rooms at Kendray Hospital and Fieldhead Hospital by the catering teams during 2024. The aim of gathering this feedback was to improve the standard and variation of food items within the dining rooms. Feedback forms allowed for meals to be rated and people were asked whether they would choose a specific item again. A free text field was provided for additional comments.

32 people, service users and staff, provided feedback on the seasonal menus which had been introduced in inpatient wards at Kendray Hospital. The key findings were:

- In June 2024, a seasonal summer menu was devised for service users and ward staff. This was trialled for three months.
    - 22 people provided feedback on the menu and majority of the respondents enjoyed the menu,
    - Only two options received negative feedback *(chicken burger and cheese and tomato pizza)*.
    - Overall, 64% of respondents agreed that the meals were appropriate summer options, and the quality of the food was good.
    - Additional comments included requests for larger portions, options to be available all the time and menus to identify spicy food.

- In September 2024 a seasonal autumnal menu was devised for service users and ward staff. This was trialled for three months and again feedback forms were available for patients and staff to complete.
    - 10 people provided feedback, and mixed reviews were received about the menu with seven of the options receiving positive feedback
    - Four options received negative feedback *(including watercress, cucumber & radish salad and horseradish sauce and yoghurt pot).*
    - Overall, 80% of people agreed the meals were appropriate seasonal options and the quality of the food was good.

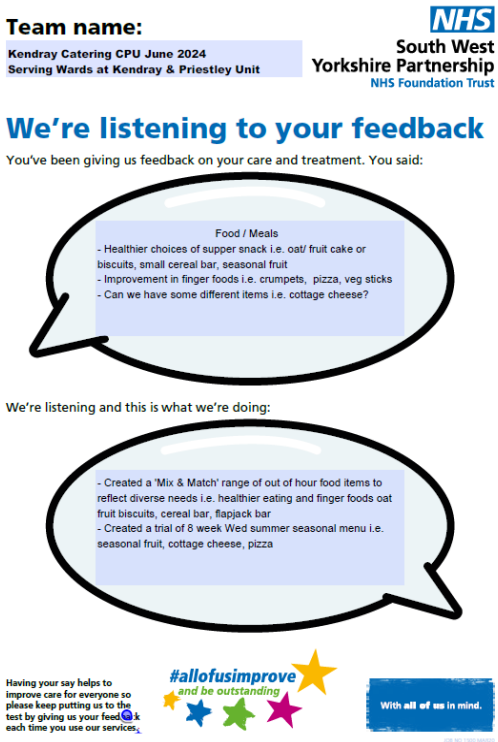
- Additional comments included the food being described as tasty, preferred the normal menu and warm pilchards.

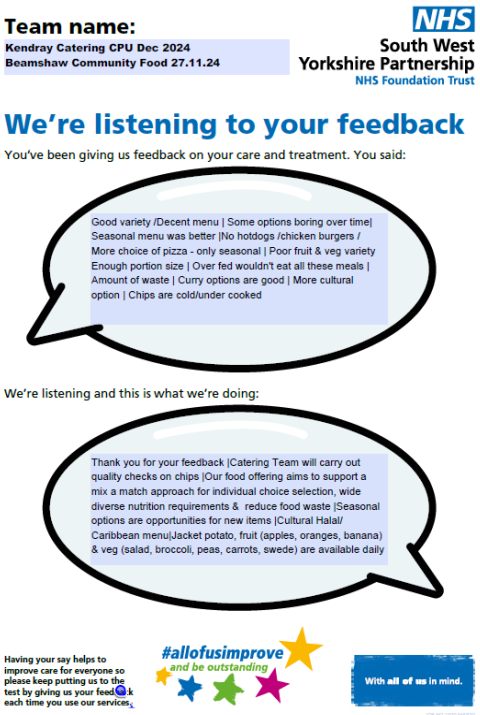
Feedback forms were provided in both Kendray Hospital and Fieldhead Hospital dining rooms for visitors and staff to complete. This included rating the meal purchased, and if the meal would be purchased again. A free text field was also provided for suggestions on what meals could be featured on the menu in future. Key findings were:

- 15 responses were received for Kendray Hospital,
  - of which 86% rated their meal very good
  - and 87% would definitely choose the meal again.
  - Suggestions for future meal choices included dairy free options, paninis/ toasties and toad in the hole.
  - Additional comments included praise for the food and value for money and that food always seems to run out by 12:30.

- Fieldhead Hospital received 29 responses,
  - of which 73% rated their meal very good
  - and 79% would definitely choose the meal again.
  - Suggestions for future meal choices included gammon and chips, chicken curry and traditional Italian meatballs.
  - Additional comments included praise for the staff and the quality of food and more jacket potato fillings.

The Catering Manager and Trust Senior Catering Dietitian reviewed the feedback with catering colleagues and where possible amendments were made to the menus on the ward and in dining rooms. Feedback forms will continue to be collected and reviewed to identify improvements.





Patient-Led Assessments of the Care Environment (PLACE)

Patient-Led Assessments of the Care Environment (PLACE) in the NHS are annual evaluations conducted by teams that include patients, known as patient assessors. These assessments focus on non-clinical aspects of healthcare settings, such as cleanliness, food quality, privacy, dignity, and the suitability of facilities for patients with dementia or disabilities. The primary merit of PLACE assessments is that they provide direct feedback from patients, ensuring that their perspectives are central to improving the care environment. This patient involvement motivates healthcare providers to enhance their services and maintain high standards, fostering a compassionate and dignified care experience. Additionally, the results are published, allowing hospitals to benchmark their performance against national standards and other similar institutions. A full report on the Trust results is available separately.

The following domains are assessed:

- Cleanliness
- Combined food and hydration (based on all organisational food and ward food assessments)
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients with dementia are met
- Disability: how well the needs of patients with a disability are met

In 2024, the Trust assessment team consisted of:

- PPI (Patient Public Involvement) representatives
- Healthwatch England - Wakefield, Barnsley and Calderdale teams
- Trust Governors
- IPC (Infection, Prevention and Control)
- Estates
- Facilities
- Ward managers and staff

Overall, the Trust results for 2024 were positive, with all domains scoring higher than the national average, with three domains improving since 2023. These domains were combined food, privacy and dignity and dementia.

The results are also broken down into Trust inpatient areas, as follows:

- Fieldhead
- Newton Lodge
- Kendray
- Priestley Unit
- The Dales
- Poplars
- Enfield Down

Highlight results:

- **Cleanliness** – for the second year running, five inpatient units scored a maximum of 100%, with two areas just under 100%. This compares with 68% satisfaction within patient experience survey feedback.
- **Food** – all but one area scored higher than the national average (91.32%), with an overall score of 95.28%. Poplars scored 90.77% This compares with 80% satisfaction from patient experience survey feedback and 95% within catering feedback.

- **Privacy, dignity and wellbeing** – all areas scored above the national average. Patient experience surveys showed 98% satisfaction for dignity and respect.
- **Condition, appearance and maintenance** – all areas scored above the national average. Flooring was noted as needing improvement.
- **Dementia** – of the five applicable areas, all scored above the national average and have achieved higher scores than the previous year.
- **Disability** – the Trust remains well above the national average of 85.2%, with a score of 92.85%. However, five areas show a decrease on the previous year, with a requirement to complete an access audit. In the Dales, the score in 2023 was 88.11% and this has increased to 92% in 2024.

Overall, the PLACE results demonstrate positive practice across the Trust in meeting the needs of patients, in the non-clinical aspects of healthcare and assurance in the provision of high-quality care.

All qualitative and quantitative information captured as part of PLACE is utilised in the development of action/improvement plans alongside sharing good practice and improvements.

Insight

Our organisation captures feedback throughout the financial year, at quarterly intervals from people who use our services, staff, partners, and communities.

To support this approach the engagement and equality team have set up a dedicated inbox involvingpeople@swyt.nhs.uk where any form of insight can be shared.

The insight is triangulated with insight from workforce, current service users and carers and performance data to help ensure our approaches and services remain inclusive and equitable so we can continue to **improve and aim to be outstanding**. We will remain relevant to the communities and stakeholders we serve by working in partnership to co-create solutions and the right conditions, ensuring **families and carers matter.**

We will demonstrate **respectful, honest, open, and transparent** communication and information by reflecting in the report the things people have told us. By working this way, the Trust can be assured that we remain connected to our communities, develop positive relationships with stakeholders and remain **relevant today and ready for tomorrow.**

The insight gathered is reported each quarter. The aim of the quarterly insight report is to capture all the involvement feedback the Trust has received directly or indirectly and identify any key themes or learning which may be used to identify any actions or service improvements.

This is shared with our executive management team (EMT), operational management group (OMG) and Care Groups. The triangulation of this insight means that the Trust can identify any patterns or key themes that may require collective approaches or action.

A ‘you told us; we listened’ website page acknowledges this insight with assurance that this has been picked up through the usual resolution channels.

The information below provides an overview of last year’s 2024-25 most reported service areas and highlights the key themes using governor or Healthwatch insight as well as any engagement activities delivered by community groups and/or partners. Further information is available at: You told us, we listened - South West Yorkshire Partnership NHS Foundation Trust

Key themes from across the reports in 2024/25 include:

- Overuse of medication instead of considering different treatment options.

- Long waiting times and difficulty getting appointments especially in children and young people services.
- Concerns in continuity of support for gender transition.
- Poor experience of workforce; staff attitudes and quality of treatment / care.
- Lack of learning disability provision in Barnsley CAMHS service.
- Lack of nurse support around neurodivergence diagnosis, treatment and medication.
- Services not working together (mental health/housing).

The Trust will continue to report quarterly on community insight and share with senior teams and services.

To support our approach to capturing the voice and views of people we have:

- ✓ Continued to embed and deliver on our Trust wide approach to involvement 'Connecting People' in partnership with leads from Calderdale and Kirklees and building relationships in Barnsley.
- ✓ Delivered a formal consultation on our older people inpatient transformation, following extensive engagement with partners and communities resulting in a diverse response from over 1,700 people.
- ✓ Delivered a Trust Strategy refresh engagement driven through connecting people, workshops with colleagues and stakeholder surveys resulting in over 1,500 diverse views.
- ✓ Maintained a Trust wide approach to developing surveys which now all include equality monitoring as standard.
- ✓ Produced quarterly insight reports to executive management team (EMT) which capture the voice and views of people with contributions from our Governors, Healthwatch and partners. 'You told us, we listened' information is published quarterly on our website.
- ✓ Developed a 'what we already know' insight report to feed into the Trust Strategy refresh and shared with the University of Huddersfield for wider research baseline intelligence.
- ✓ Developed a new Trust Volunteer Strategy using the voice and views our volunteers, volunteer supervisors and wider partners.
- ✓ Involved key stakeholders in the Trust in the volunteer service accreditation which was renewed in Spring 2024.
- ✓ Continued to work in partnership with the Third sector to co-design and develop our service offers in each place.
- ✓ Deliver the accessible information standard using a dedicated intranet page, training offer and good practice guidance.
- ✓ Used national audit tool EDS2022 to further assess compliance of accessible information standards (AIS), resulting in a grading of achieving.

Matron monthly inspections – insight and learning

Tendable (an app-based audit tool) was used to record audits and gather patient feedback across mental health inpatient wards in 2024/25. This is generally completed on a weekly and/or monthly basis and results are used to support improvements.

On a monthly basis, a discussion with patients takes place, and a number of questions are asked which provide insight into a patient's experience of their care and treatment. There are 15 questions and throughout the year the results summarise in the following way:

- Three questions scored amber (70-90%) and these included 'how would you describe the care on the ward', being involved in writing their care plan and being given a copy of their care plan. Amber is not necessarily indicative of a poor performance. The Tendable system gives options of 'excellent', 'good', 'ok' and 'poor' and when a response of 'good' is provided, Tendable records this as amber.
- 12 questions scored green (above 90%), and these included family being involved, knowing who to speak to if they need to raise concerns or a complaint and service users feeling able to discuss their needs in ward rounds.

These results are produced on a monthly basis and discussed within the Care Group and within the individual wards. A 'you said, we did' approach is adopted and improvement plans put into place to support improving care and treatment.

Although there is some variation in the results between the audits and the patient experience survey core question, the majority of questions scores are consistent. These variations could be for a number of reasons including service users having a preference to remain anonymous when provided feedback through a patient experience survey or wanting to discuss concerns with a member of staff during the audit.

Question	Audit	Survey
feeling safe	98%	98%
service user feeling involved	89%	94%
carer being involved	100%	89%
feeling listened to	100%	99%
being treated with dignity & respect	98%	99%
knowing how to raise concerns	100%	95%

A number of areas identified for improvement are supported through wider improvement work, such as care planning and risk assessment improvement group and implementing the triangle of care standards to ensure carers are supported and involved in their loved one's care. In addition, these results feed into ward-based improvement work, priority programmes of work and support staff development.

The Mental Health Care Group are developing ways of recording sharing copies of care plans, using SystmOne (clinical record system) and having oversight within the Care Group governance meetings to monitor improvement. These are also part of the feedback and actions received from the CQC inspection from 2023.

Moving forwards and through 2025/26 this feedback will be triangulated with other information, data and intelligence which will support the quality assurance system and in identifying hot spot areas, areas requiring improvement and areas of good practice.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.4

Private/Public paper:	**Public**		
Title:	**Bi-annual safer staffing report**		
Lead Director:	**Darryl Thompson, Chief Nurse and Director of Quality and Professions**		
Mission/values:	The report demonstrates commitment to all of the Trust values, which are fundamental to delivering safe and effective care. - We put the person first and in the centre - We know that families and carers matter - We are respectful, honest, open and transparent - We improve and aim to be outstanding - We are relevant today and ready for tomorrow		
Purpose:	The purpose of this report is to update Trust Board on safer staffing in the Trust. This includes ensuring we have the right staff, with right skills, in the right place. To achieve this, updates are shared in relation to establishment reviews, workforce planning, new and developing roles and recruitment and retention priorities in line with the NHS England developing workforce safeguards policy (2018). The report provides assurance in relation to the safer staffing agenda and outlines work in progress and plans in place to ensure that our clinical areas are appropriately staffed and can deliver safe and effective care		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best value • Best place to work and learn	 ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.2 The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives 2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents 2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes 3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience		

With all of us in mind.

	4.3 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 5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision 6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust collaborates closely with partners across integrated care systems and colleagues at NHS England around the safer staffing agenda. Learning and good practice is shared through both formal and informal networks and trusts are working collaboratively. An example of this is the work is the development of the collaborative bank resource in partnership with two neighbouring trusts.
Any background papers / previously considered by:	The previous bi-annual safer staffing report was submitted to Trust Board and the Quality and Safety Committee in January 2025. This report has been reviewed in the executive management team, and also in the Quality and Safety Committee on 10 June 2025.
Executive summary:	The paper provides an update on current safer staffing developments taking place in the Trust, including the commencement of establishment reviews and the continued roll-out of e-roster and SafeCare systems to support the effective deployment of resources within services. The paper reviews the Trust's current safer staffing position for the reporting period (October 2024 to March 2025) through analysis of workforce and rostering performance, along with patient and staff outcome measures that can be triangulated to identify potential risks. Data from Cheswold Park Hospital is used within incident reporting analysis, however workforce and rostering information was not available at the time of this report. The service will be fully integrated into the next bi-annual safer staffing report. **Key highlights:** **Assure**

	- A full programme of establishment reviews has been developed and is now in progress - The Trust achieved a total fill rate of over 90% against both funded and clinically required staffing (above the national safer staffing benchmark) - Registered nurse fill rates exceeded 100% for both funded and clinically required staffing - The flexible staffing resource (bank/agency) continue to meet the additional staffing demand, achieving a 92.9% fill rate of all requests - Episodes of one registered nurse on duty reduced by 43.8% compared to the previous reporting period - Cancelled Section 17 leave episodes due to staffing remain low (0.4% mental health inpatients, 2.7% forensic inpatients) - The Trust stability rate continues to exceed 90%, indicating a strong position around staff retention - Appraisal, mandatory training and supervision rates continue to improve - CQC action plans against regulatory staffing breaches continue to progress **Alert** - 18 out of 31 inpatient wards had a total fill rate of over 120% against funded establishments, impacting financially and indicating that baseline staffing levels are potentially insufficient to meet clinical demand - The Horizon inpatient service deployed 58% more registered nursing staffing than set within their baseline budget. Crofton and Chippendale wards exceeded 120% registered nursing fill rates - Although overall registered nurse staffing fill rates were maintained, seven wards dropped below the 80% threshold during day shifts - With regards to additional whole time equivalent (WTE) staff, 215.56 were deployed on average each week in the Trust. This includes The Poplars (24.24), Horizon Centre (22.64) and Melton Ward (16.91), who recorded the highest in the Trust - Ten inpatient wards fell below the funded baselines for registered Care Hours Per Patient Day (CHPPD), with particular pressure points within working age acute, older people's and psychiatric intensive care unit (PICU) wards - Safer staffing reported incidents increased by 32.7%. This could be linked to an improving incident reporting culture and the inclusion of Cheswold Park Hospital - There was a slight increase in turnover and vacancy rates - There will be no recruitment to trainee nurse associate or registered nurse degree apprenticeships throughout 2025/26. This could impact on both staff wellbeing and staff retention **Advise** - A new monthly report is currently being developed to triangulate safer staffing and workforce data with patient and staff outcome measures

	- Several new outcome measures are now being incorporated into safer staffing analysis including patient feedback and cancelled staffing breaks - A safer staffing dashboard powered by business intelligence is being developed within the Trust to provide ward/team-based trend analysis The Trust continues to make significant process to align safer staffing governance with national policy and best practice, supported by the assistant director of nursing, quality, and professions, who is currently undertaking the NHS England chief nursing officer safer staffing fellowship. Establishment reviews will continue to be undertaken as a rolling programme, triangulating workforce data with a patient and staff outcome measures to ensure that we continuously review whether our staffing meets the needs of our patients and supports the wellbeing of our staff. Overall, the Trust is maintaining safer staffing levels, however across all Care Groups, there are wards that are particularly challenged to maintain safer staffing at all times. Embedding SafeCare across all inpatient areas will effectively support deployment of resources to meet these challenges and the introduction of the new monthly safer staffing report will ensure that safer staffing risks are identified and acted upon appropriately.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** this report.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Safer Staffing Bi-Annual Report

September 2024 – March 2025

With **all of us** in mind.

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Bi-Annual Safer Staffing Report
June 2025

1. Introduction

The purpose of this report is to provide updates and assurance the Quality and Safety Committee and Trust Board in relation to safer staffing. Safer staffing principles ensure that we have the right staff, with the right skills, in the right place to meet service user need and maintain the wellbeing of Trust staff.

This report provides oversight in relation to safer staffing performance for the period October 2024 to March 2025, including analysis of quality measures and safer staffing incidents. It also provides updates in relation to establishment reviews, workforce planning, new and developing roles, and recruitment and retention strategies, in line with the National Quality Board (NQB) 'Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time' (2016). This report also provides information on future safer staffing developments, to ensure our clinical areas are appropriately staffed and can deliver safe and effective services, resulting in positive outcomes and a positive experience for service users and carers, alongside positive staff experience.

The report covers the points within the NQB Trust Board Safer Staffing Checklist (see Appendix 1), to enable Committee and Board members to have the information required to assure themselves that the Trust continues to have the staff in place to deliver safe and effective care. Reference to the plans to continually develop safer staffing reporting, in line with the on-going review of the wider safer staffing agenda are included.

The report is structured around key indicators for safer staffing analysis, utilising data that measures:

- Demand, capacity and resourcing
- Patient outcomes
- Staff outcomes
- Workforce development

In line with national safer staffing policy, the Trust has commenced a programme of establishment reviews across inpatient services. Once inpatient reviews are complete, the safer staffing reviews will be rolled out across all community services. Any identified themes and trends or areas of concern identified from safer staffing reviews will also be shared across Care Groups and with the Quality Governance Team, to ensure this information is triangulated with broader intelligence used within the Trust's Quality Assurance System (QAS). In addition, this report demonstrates that there are processes in place to mitigate safer staffing risks and identifies the safer staffing developments being deployed within the Trust to strengthen safer staffing governance at a Trust, Care Group and team level.

2. Background

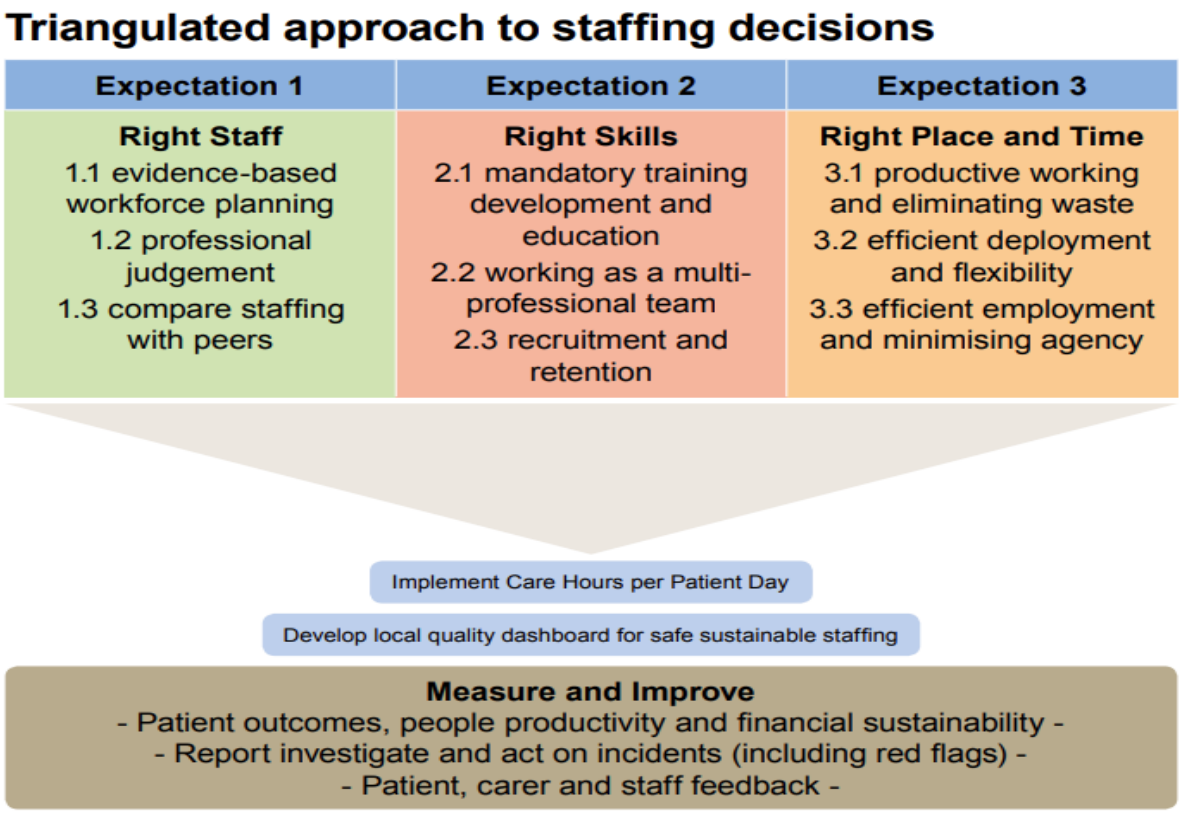
NHS England's Developing Workforce Safeguards (2018) outlines the expectations in relation to safe and sustainable staffing in order to improve health outcomes. It provides a clear governance and oversight framework alongside recommended evidence-based tools and resources to support NHS providers in delivering safe patient care and through this achieve the best possible outcomes for their patients. Mental Health Staffing: A Practical

Guide (NHS England, 2016) (available here) states that all Trust Boards must take full responsibility for the quality of care provided to patients and as a key to quality take full and collaborative responsibility for nursing and care staffing, care, and capabilities.

Six-monthly reports on safer staffing are presented to Committee and Trust Board, and the Trust reports monthly on safer staffing through the integrated performance report (IPR) and other reporting mechanisms related to quality of care, and service user and staff experience. This report builds upon the safer staffing paper presented to the Committee and Trust Board in January 2025.

Safer staffing remains a priority for the Trust, and this requires complex decision making on a regular basis by registered clinical and operational colleagues, as well as specialist advisors. This work is overseen by the executive management team.

The NQB recommendations for safer staffing follow a triangulated approach. The flow chart overleaf supports providers of NHS services with the delivery of the right staff, with the right skills, in the right place at the right time (National Quality Board, 2016).



Safer Staffing Triangulated Approach NQB (2016)

3. Establishment reviews

National safer staffing policy requires organisations to undertake annual strategic staffing reviews using a triangulated approach as detailed below:



There are three evidence-based tools that can be used within the Trust to inform establishment review setting. The mental health optimal staffing tool (MHOST) is used within mental health inpatient services, including forensic settings. In January 2025, over 30 staff were trained to use the tool. The tool categorises patient acuity into five levels, and these are measured each day across a 20–30-day period. Scores are entered into the Trust's unique MHOST template containing formulae that calculate optimal staffing levels for each ward. However, suggested staffing levels should not be applied in isolation. The evidence from acuity tools must be triangulated with professional judgement and patient and staff outcome measures. Professional judgement can be used as a bespoke safer staffing model, with guided questions to understand safe staffing requirements.

For services where there is no current evidence-based model e.g. the Horizon centre learning disability assessment and treatment unit, this would be the primary method of undertaking an establishment review. Where evidence-based tools do exist, professional judgement is applied during the establishment review meetings to gather the views of those who lead the service about how staffing feels on the ward. Professional judgement is vital to understand factors that could affect staffing requirements that a safer staffing tool would overlook. For example, the need to have a corridor monitor at all times due to environmental risks due to the layout of a particular ward.

Outcome measures form an integral part of safer staffing assurance and are both patient and staff related. For the purposes of this report the following outcome measures are considered:

- patient outcome measures including cancelled Section 17 leave, patient safety incidents and patient experience ratings
- staff outcome measures have included training, supervision and sickness rates and will soon incorporate cancelled breaks due to staffing.

3.1 Establishment review process

The Trust has commenced a programme of establishment reviews, with the aim to review all clinical establishments within 12 months. The draft establishment review timetable is available at appendix 17. Workforce data, patient and staff outcome measures and results from evidence-based tools are reviewed at every establishment review meeting attended by the chief nurse or deputy chief nurse, safer staffing leads, service leads, finance and human resources representatives. When using evidence-based tools, no changes should be made

to establishments until two periods of data collection has taken place to account for any unusual variations within the data.

3.2 Acute and PICU working age adult mental health inpatient services

The working age adult inpatient service undertook an interim establishment review in 2023, that was agreed by Executive Management Team (EMT) in March 2025. The recommendations from the review were:

- an overall increase of 63.15 staff (nurses and health care assistants) to meet safer staffing levels and reduce the number of bank and agency workers
- addition of support roles to enhance patient care and reduce administrative burden on clinical roles for example, associate psychologists and ward management assistants

This has created a several vacancies that are currently being recruited to as detailed below (of note, WTE relates to workforce whole time equivalents of 37.5 hours per week):

- Band 6 vacancies – 3.85 WTE
- Band 5 vacancies – 7.8 WTE
- Band 4 vacancies – 2 WTE
- Band 3 vacancies – 112 WTE

The increase in substantive workforce will significantly decrease the use of bank and agency with the aim to maintain staffing levels within agreed budgets.

In line with the current programme of establishment reviews, these commenced for the working age adult and PICU mental health wards in December 2024 and were completed in February 2025. Data using the MHOST has been collated and is currently being analysed. Once the MHOST data has been collated, the establishments will require a further review to consider any additional recommendations to staffing. The service will undertake their second MHOST data collection in Q3 2025/26.

3.3 Older people's mental health inpatient services

The older people's mental health inpatient service establishments were reviewed within the wider transformation of older people's inpatient services. The service has now undertaken acuity dependency data collections using the MHOST tool, and provisionally, establishments are planned to be reviewed in Q2 2025/26.

3.4 Mental health rehabilitation services

The mental health rehabilitation inpatient service establishments are planned to be reviewed in June 2025. The service has collected acuity data using the MHOST tool.

3.5 Mental health community services

Mental health community service establishments are due to be reviewed in Q3 2025/26. As there is no evidence-based tool available for this clinical area, establishment reviews will focus on a professional judgement model, triangulating this with patient and staff outcome measures and a review of workforce and activity data. It will also be guided by the feedback from the recent externally commissioned review of activity in community mental health teams.

3.6 Forensic inpatient services

Forensic inpatient establishment reviews were undertaken during May 2025. Due to the timescale of this review, the service have not used an evidenced based tool as part of these reviews. The draft establishment review recommendations are currently awaiting costing and will then be reviewed by the Care Group and the executive management team.

The service plan to commence the MHOST data collection in June 2025. A further review of establishments will take place once the outcome of the MHOST data collection is complete. In 2024, the adult provider collaborative provided additional funding to support Johnson, Thornhill and Waterton wards in relation to the additional staffing being used to meet clinical need. This will be reflected within the staffing templates from June 2025 and will show a reduction in the number of additional shifts being created above baseline establishments.

3.7 Learning disability services (community and inpatients)

Learning disability services establishments are due to be reviewed in Q3 2025/26. As there is no evidence-based tool available for these clinical areas, establishment reviews will focus on a professional judgement model, triangulating this with patient and staff outcome measures and a review of workforce and activity data.

3.8 Barnsley physical health inpatient services

The neurological rehabilitation unit (NRU) and stroke rehabilitation unit (SRU) establishments are due to be reviewed in June, taking into consideration both nursing and allied health professional (AHP) staffing. A paper was approved by EMT last year to uplift NRU staffing by two whole time equivalent nursing staff in line with the safer staffing levels recommended by the UK rehabilitation outcomes collaborative (UK ROC).

The stroke rehabilitation unit is part of the South Yorkshire integrated stroke network, and repatriates patients from hyper acute stroke units for ongoing rehabilitation. The network was created in 2018 and a major review of stroke services in South Yorkshire took place, including a full establishment review to meet the needs of the service. Similar to NRU, high dependency levels frequently require increased staffing to maintain patient safety.

To support the establishment reviews, NHS England have been requested to provide ‘train the trainer’ training for the Safer Nursing Care Tool, used for these wards similarly to the MHOST tool for mental health as detailed above.

3.9 Barnsley physical health community

Options are currently being explored to determine the appropriateness of using the community nursing safer staffing evidence-based tool. Once this is determined, planning will commence to undertake establishment reviews of all services within the 2025/26 financial year.

3.10 Cheswold Park Hospital

Establishment reviews at Cheswold Park Hospital are due to commence in Q2 2025/26. A meeting has been planned to determine the terms of reference for the review, noting that to use the MHOST acuity tool, additional training will need to be delivered to staff.

4. E-rostering

The e-rostering rollout continues, with over 75% of clinical services now using the system. Rollout was paused briefly to prioritise Cheswold Park Hospital's (CPH) integration onto e-rostering due to their existing staffing systems and the risks associated with these.

An updated rollout plan will be developed and published in June to accelerate the program, ensuring that all clinicians are on the system with non-clinical staff to follow. The e-roster team continue to offer individual support to services who are reviewing establishment templates and staffing models.

Performance data from e-roster reports continues to be shared with Care Group colleagues through the e-rostering steering group. This enables a review of roster trends and patterns to highlight concerns and share good practice. Examples of this include annual leave allocation, staffing availability and flexible staffing use. Operational managers are supplied with rostering data from the previous week and for the following seven days (see appendix 16), allowing for identification of any areas for improvement and enabling any previously unidentified issues to be addressed.

5. SafeCare

SafeCare is software that is widely used throughout the NHS to enable real time staff deployments based upon resources and acuity within clinical areas. It provides a position of whether a ward has enough staff to meet service need for a shift and subsequently ensuring efficiencies within staffing. Effective use of SafeCare allows the continued development of patient outcome measures to contribute to safer staffing analysis, SafeCare provides a unique opportunity to record significant incidents through a 'red flag' function. By embedding SafeCare successfully, the quality of patient safety data will be more in-depth, allowing for a greater understanding of the safer staffing position within each inpatient area. SafeCare has now been rolled out to all inpatient wards across the Trust, however, there remain challenges regarding embedding the use of SafeCare consistently across all wards.

SafeCare is due to be relaunched within the Wakefield mental health inpatient services in June and will then be rolled out across stroke and neurological rehabilitation wards (the final inpatient areas to be introduced to SafeCare). This will provide a live picture across all wards of both staff on duty (capacity), patient acuity (demand) and alerts to any areas where capacity is insufficient to meet clinical demand.

6. Fill rates

Reporting of safer staffing fill rates has been mandatory since 2014 whereby trusts are required to report their actual fill rate against planned staffing. There are two ways in which trusts report this due to different interpretations of planned staffing. Some trusts use budgeted establishment as planned and others use clinically required as planned. Historically, the Trust has reported fill rates against budgeted establishments. Whilst this gives a clear indication of performance against baseline staffing establishments, it does not identify the proportion of clinically required shifts that were filled. As such, a ward could have a fill rate of over 100% but still have insufficient staffing to meet clinical need. By measuring clinically required fill rates, the Trust can be assured of the safer staffing position in relation to clinical need and demand.

There are four main factors that influence fill rate levels:

- Acuity: the ward/team require more staff than funded within their establishment to manage the increased care needs of patients
- Unavailability: When staff are unable to work due to reasons including sickness, training, parental leave or annual leave (above headroom allowance)
- Vacancies: when posts within the core establishment have not been recruited to
- Baseline establishment: the staffing establishment may no longer be appropriate to meet the needs of the service

6.1 Fill rate measure

To determine whether safe staffing fill rates have been achieved, nationally recognised baselines are used to compare Trust data. These are 90% for total staffing and 80% for registered staffing. An additional measure is used to highlight fill rates above 120% as this indicates that baseline establishments are not currently sufficient to meet clinical demand.

6.2 Total inpatient staffing fill rates (October 2024 – March 2025)

The graph below shows that for the reporting period, total staffing fill rates were above the 90% threshold when measured against both baseline funded establishment and clinically required staffing, indicating that overall, Trust-wide inpatient services were safely staffed and remain in a period of special cause variation (high) (See Appendix 2). This was however at cost, with an additional 32% staffing utilised above the funded baseline templates, indicating that current funded establishments, are not sufficient to meet clinical need. Of note, with regards to the table below, the orange line indicates how we were staffed against what was clinically required. The blue line indicates how this staffing is measured as a fill rate against the current funded establishment. Clinically required staffing is calculated by considering how many additional staff have been requested, with the fill rate being our success in filling those requested roles.

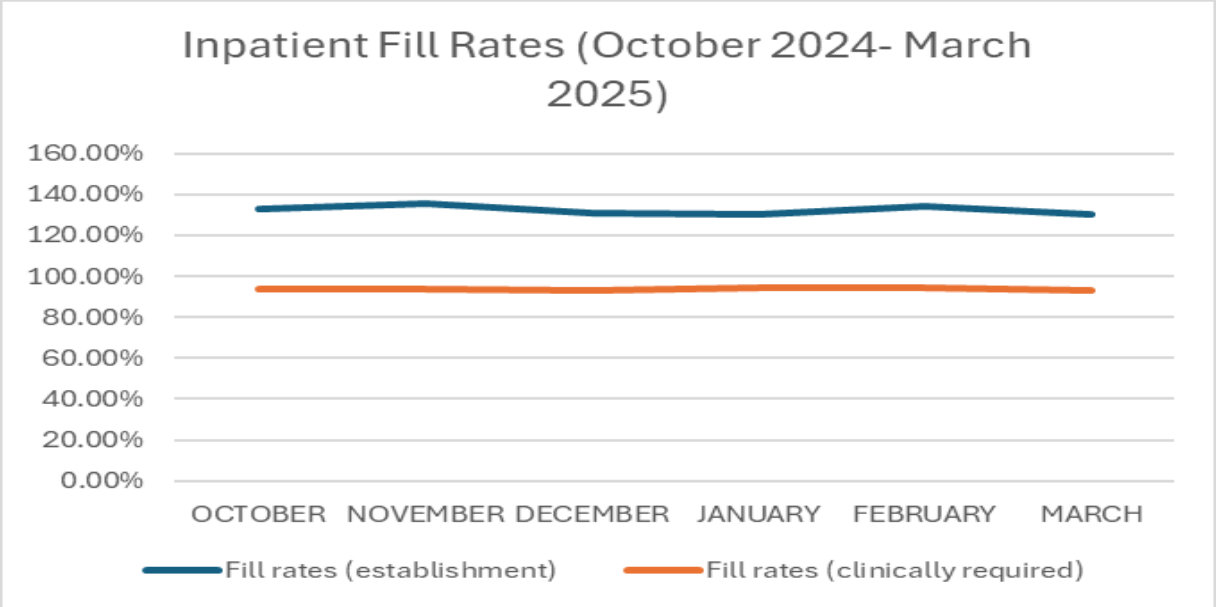


Table 2: Total fill rates October 2024- March 2025

6.3 Service specific staffing fill rates

Reporting of aggregated safer staffing data at trust level has been identified as a contributing factor to healthcare failings, for example the Mid-Staffordshire enquiry. In response, the Trust now reviews safer staffing data at service and ward level. The table below shows the service specific fill rates for the reporting period.

Service	Fill rate (funded establishment)	Fill rate (clinically required)
Trust Total	132.04%	93.58%
Learning Disability (Horizon)	172.72%	93.79%
PICU	158.20%	94.69%
Older Peoples	154.85%	90.95%
Working Age Acute	138.63%	94.19%
Medium Secure	117.33%	94.68%
Low Secure	114.45%	95.48%
Barnsley Physical Health Inpatients	106.15%	88.78%
Mental Health Rehabilitation	96.27%	95.80%

Table 3: Service specific total fill rates

- As displayed in the table above, all service areas achieved the 90% fill rate against both funded establishment and clinically required except for Barnsley physical health inpatient services (clinically required fill rate was 88.78%). Currently, fill rate reporting does not include allied health professionals (AHPs) who work directly within ward establishments, therefore the care interventions of AHPs will have mitigated any risks associated with a lower fill rate
- The areas highlighted in blue, reflect fill rates above the 120% current budgeted establishments. The higher the percentage, the greater the financial impact. Consistently high fill rates above baseline templates indicates that the current establishment is insufficient to meet the clinical needs of the service
- Appendix three provides a detailed ward specific breakdown. This identifies three wards falling just below the clinically required fill rate benchmark of 90% (Willow Ward, Ward 19 female and the stroke rehabilitation unit (SRU)). Willow Ward and Ward 19 female mitigated risks through redeployment of staff within their own localities, and the role of ward based AHPs supported care provision on the SRU
- 18 out of 31 inpatient wards had a total fill rate above 120% for the six-month reporting period, supporting the need to review ward establishments as described above. Although clinically required fill rates were maintained overall, this has been reliant on temporary staffing at cost both financially to the Trust and in terms of ward productivity. Additionally, there is a strong evidence base that high use of temporary staffing is associated with poorer patient experience and staff wellbeing
- Current monthly safer staffing reporting does not include clinically required fill rates, however this will be included from July 2025 to support safer staffing assurance.

6.4 Total inpatient registered staffing fill rates

Registered nurse staffing levels are reported in addition to total fill rates due to the specific role and responsibilities of this workforce group. Registered nurse staffing includes both

registered nurse and registered nursing associates, who account for around 10% of the registered workforce staffing (see Appendix 4) The table below highlights both the funded establishment and clinically required fill rates for registered staff.

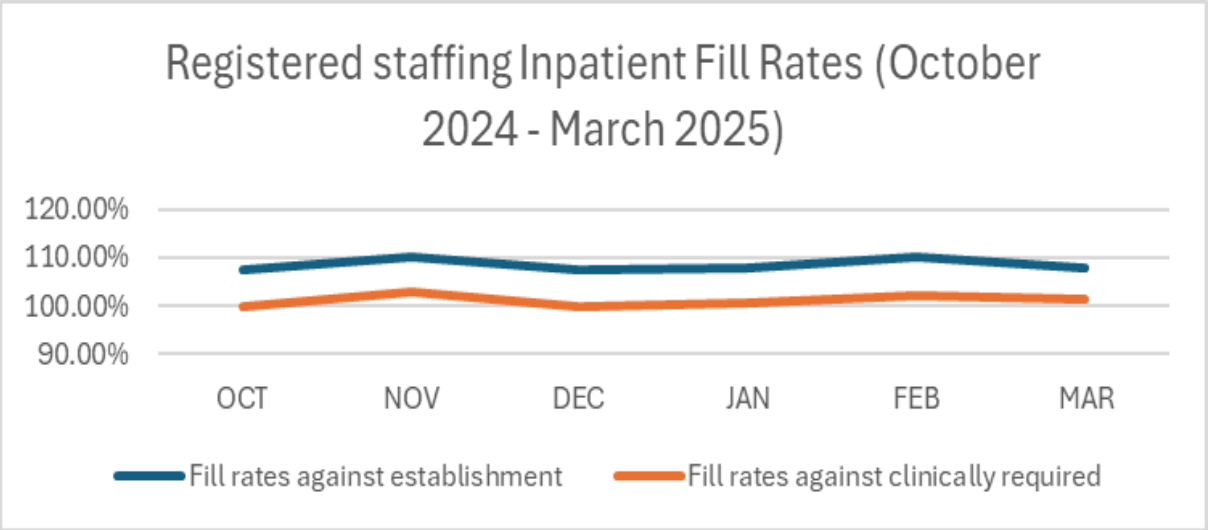


Table 4: Registered staff fill rates

In the reporting period, registered staffing fill rates were significantly above the 80% benchmark, both against funded establishment (108.32%) and clinically required (101.04%) remaining in a period of special cause variation (high), see appendix five. Achieving over a 100% clinically required fill rate indicates that a small percentage of health care support worker (HCSW) shifts were filled by registered staff, either due to areas being over established for registered nurses, or when vacant HCSW shifts remained unfilled.

6.5 Service specific registered staffing fill rates

Service	Fill rate (funded establishment)	Fill rates (clinically required)
Trust Total	108.32%	101.04%
Learning Disability (Horizon)	158.30%	98.28%
Older Peoples	114.63%	98.41%
Working Age Acute	108.68%	107.43%
Low Secure	108.27%	105.80%
Barnsley Physical Health Inpatients	107.00%	93.42%
Medium Secure	103.95%	97.58%
Mental Health Rehab	100.68%	99.93%
PICU	97.18%	96.23%

Table 5: Registered staffing fill rates by service

- When broken down by service type, no service exceeded the 120% threshold for registered clinically required fill rates, however learning disability (Horizon) exceeded their funded establishment for registered staffing by 58.3%. Horizon support bespoke care packages therefore establishment requirements fluctuate more than any other service in the Trust

- In addition to Horizon, Crofton and Chippendale wards exceeded 120% fill rates against funded establishment. This was to meet clinical demand and again supports the need to review baseline funded establishments, currently in progress (A ward specific breakdown is provided in Appendix 6).

When reviewing fill rates, it is useful to determine any difference between day and night staffing. Appendix 7 details the daytime fill rates (against funded establishment) for registered nurse staffing. Unlike night shifts that exceeded 100% fill rates, several wards fell below the threshold for registered nurse staffing. This can be as a result of vacancies, rostering practice, service redeployment, service redesign, sickness/absence and training. Overall staffing levels were maintained as a result of HCSW staff filling the vacant registered shifts. Closer oversight of this will be maintained through the development of the new monthly safer staffing report.

6.6 Average weekly whole time equivalent (WTE) staffing above funded establishment
To understand the extent of the additional staffing resource required to meet service demand and the associated financial impact, the table below breaks down the average weekly additional WTE staffing used above funded establishments.

Ward	All	Registered	Unregistered
Trust Total	215.56	23.67	191.88
Working Age Acute	71.96	6.38	65.58
Older Peoples	58.08	6.96	51.12
PICU	28.70	-0.63	29.33
Learning Disability (Horizon)	22.64	3.90	18.74
Medium Secure	19.68	2.25	17.43
Low Secure	13.96	3.39	10.56
Barnsley Physical Health Inpatients	2.22	1.28	0.94
Mental Health Rehabilitation	-1.68	0.12	-1.18

Table 6: Average weekly WTE above funded establishments

- For the reporting period, an average of 215 additional WTE posts were used each week to meet service demand, 89% of which was using the unregistered temporary workforce
- Working age adult acute and older people's wards accounted for over 60% of the additional staffing to meet service demand. A ward specific breakdown is presented in appendix 8
- The importance of being able to drill down to ward level is evident as two of the three wards with the highest additional WTE use (Horizon Centre and Melton PICU) sit outside of the working age adult acute and older people's services
- The Poplars has the highest additional WTE per week (24.24). This is particularly impacted by high fill rates at night. The Poplars' current budgeted establishment is for three staff on nights and due to the high levels of acuity, staffing levels can exceed 400% fill rate
- The Horizon Centre staffing required an additional 22.64 WTE per week. This is attributed to the bespoke care packages offered by the service. Three service users have recently been discharged following protracted delays in their discharge. It is anticipated that this will reduce current requirements for high levels of additional staffing

- Melton psychiatric intensive care unit (PICU) required an additional 16.91 WTE staffing per week. The unit is relatively small (6 beds) caring for patients with high dependency needs, therefore staffing has regularly exceeded funded establishment to meet clinical demand
- During the reporting period, the executive management team has supported the recommendations from an establishment review undertaken in 2023 for the acute and PICU working age adult wards. The associated uplift in staffing will be reflected within the staffing templates during the next reporting period, anticipating that this will lead to a reduction in fill rates against funded establishments. This will also apply to Johnson, Thornhill and Waterton wards within forensic services who received uplifts in their templates from the provider collaborative in 2024.
- Appendix 9 provides a ward breakdown of the ten wards creating the highest number of additional shifts during the reporting period

7. Temporary staffing (bank and agency use)

The Trust continues to rely on the use of the temporary staffing workforce. During the reporting period, 35,212 vacant shifts were made available to temporary staffing, of which 32,701 were filled (92.9%).

Following the introduction of the flexible staffing scrutiny group and significant work within Care Groups, agency use continues to reduce from 4.62% at the end of the previous reporting period to 3.72% in March as evident in the table below, comparing the percentage of shifts filled by substantive, bank and agency staffing.

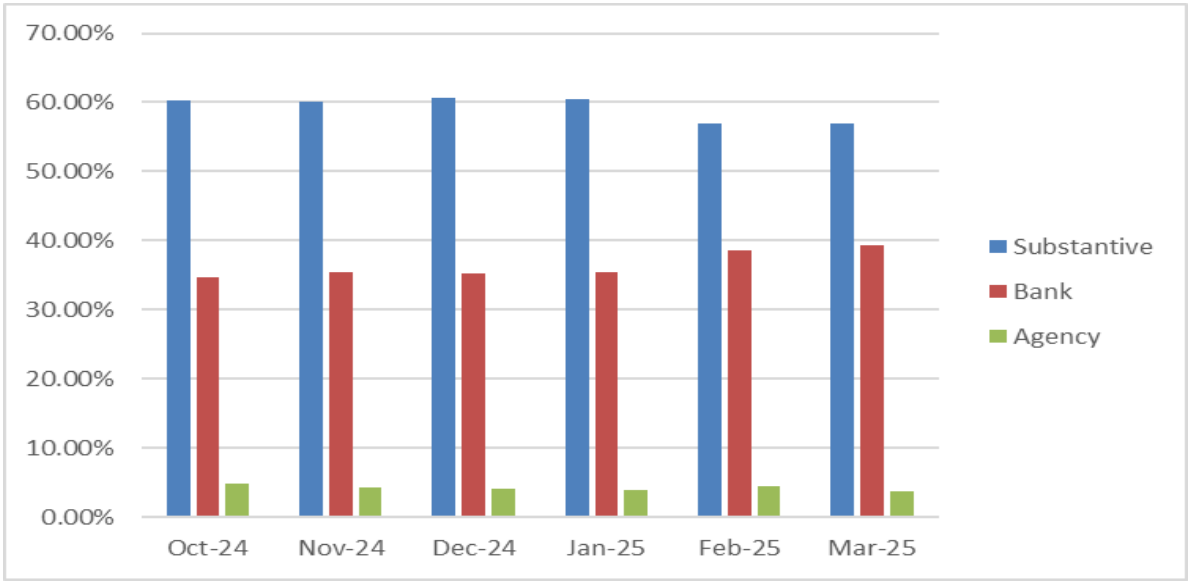


Table 7: Comparison of substantive, bank and agency shift fill rates

During March, which historically shows an increase in flexible staffing due to annual leave being taken prior to the end of the financial year, bank and agency staff worked 961 RN shifts within inpatient services compared to 805 in September 2024, an increase of 156. During the same period, bank and agency staff worked 4,832 unregistered shifts in March 2025, compared to 4,573 unregistered nursing shifts in September 2024, an increase 259. Annual leave planning reports are now circulated to ward managers each week and

performance reviewed within the e-rostering steering group with senior inpatient leadership representation.

It is worth noting that there has been minimal fluctuation in total flexible staffing however toward the end of the financial year there has been an increase in the usage of bank staff. This should be offset with a recruitment drive for substantive unregistered staff, currently in progress. Appendix 10 provides a comparison of staffing costs broken down by the substantive, bank and agency workforce for October 2024 and March 2025.

The number of overall unfilled shifts within inpatient areas has risen in the last three months from 359 to 578. This has again been driven by the increase in flexible staffing requirements due to acuity, and the reduction in staff availability due to annual leave.

The Trust's bank staff collaboration with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust continues. Staff expressing an interest to join the collaborative bank has remained high, however the number joining the collaborative bank is low in comparison. The Trust continues to clear more staff to work in the other two trusts than vice versa and this has led to only 41 shifts being worked in SWYPT through the collaborative bank.

The Trust continues to explore ways of reducing agency use, in line with national priorities for eliminating agency use, particularly within the unregistered workforce. The Trust has entered the North of England Commercial Procurement Collaborative (NOEPC) to support any use of locum allied health professionals (AHPs) ensuring that the Trust remains on framework agreements, at or below the capped rates. We will also be exploring a master vendor option for our medical locum requirements. The Trust also continues to ensure appropriate representation within the national performance advisory group for safer temporary staffing. This will ensure that we remain updated on national changes and continue to be involved in developments around safer staffing and use of a temporary workforce.

8. Care Hours Per Patient Day (CHPPD)

The Trust has been required to publicly declare care hours per patient day (CHPPD) for each inpatient area since July 2018. CHPPD is the amount of care hours delivered to patients by the clinical workforce each day and is calculated by dividing the hours worked by clinical staff with the number of patients occupying beds at midnight. It is split into registered and unregistered nursing staff. Following advice from NHS England, the baseline CHPPD figure is calculated using 100% occupancy, rather than those occupancy levels commissioned (85-90%). The Trust continues to compare trends within the data at ward, regional and national level. CHPPD should not be used in isolation, but as one of several measures / quality indicators of safer staffing. CHPPD averages are impacted by the staff to patient ratio. They can be negatively impacted by shortfalls in staffing, or higher occupancy levels. For the first time, statistical process control (SPC) analysis has been undertaken to present Trust CHPPD data as detailed in the tables below:

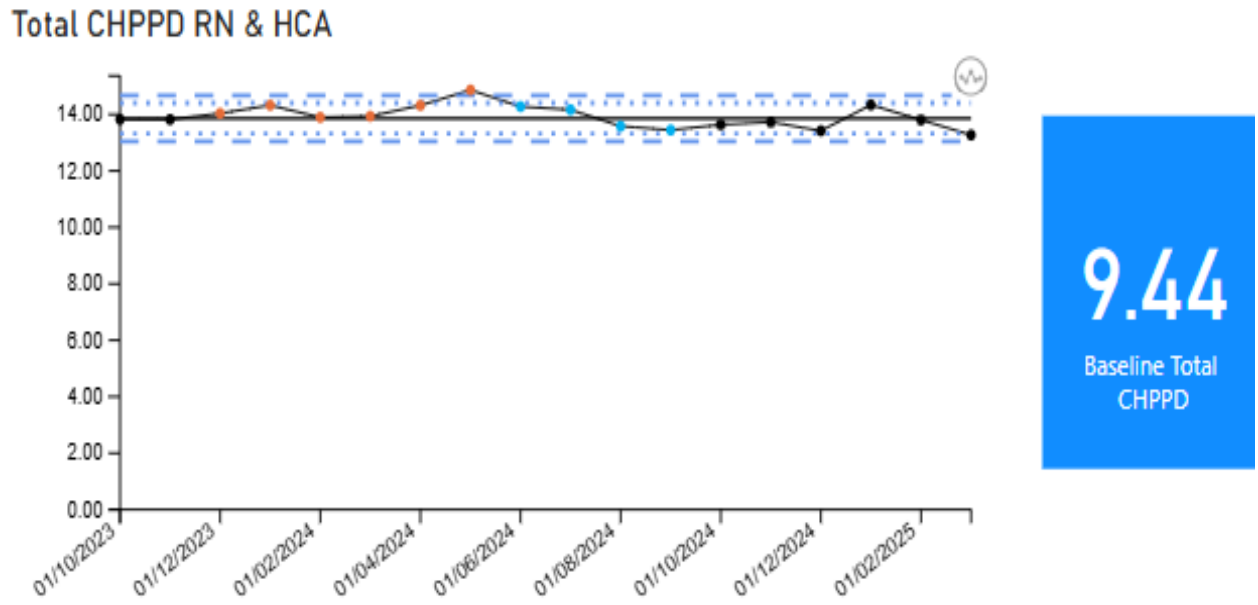


Table 8: Total Care Hours Per Patient Day (CHPPD)

- As demonstrated in the data above, over the reporting period CHPPD has continued to fluctuate within process limits and above the baseline total CHPDD (calculated by dividing the funded establishment hours by an assumption of 100% occupancy)
- When compared nationally and benchmarked against organisations rated as 'outstanding' by the Care Quality Commission (CQC), the Trust is achieving a higher rate of CHPPD than the provider median in recent months, but typically lower than trusts rated as 'outstanding' (see table 7 overleaf)

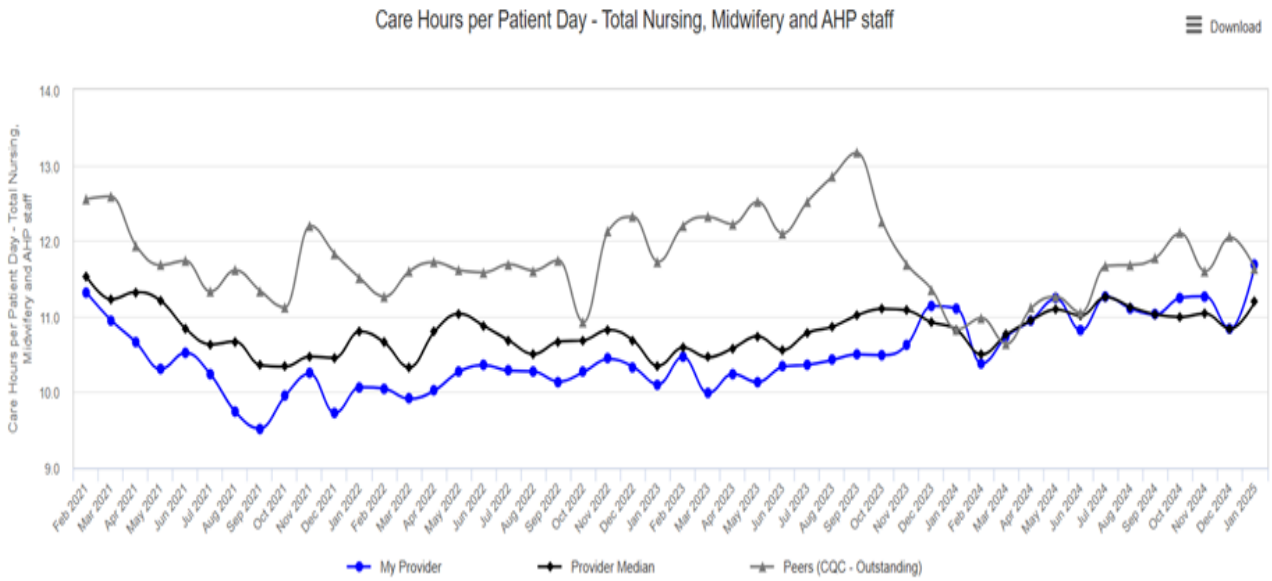


Table 9: Trust CHPPD comparison with provider median and CQC rated 'outstanding' organisations

The CHPPD can be further broken down to CHPPD for both registered and unregistered staff, this is an important quality matrix for understanding the time available to care for

registered nurses. The table below demonstrates registered nurse CHPPD during the reporting period:

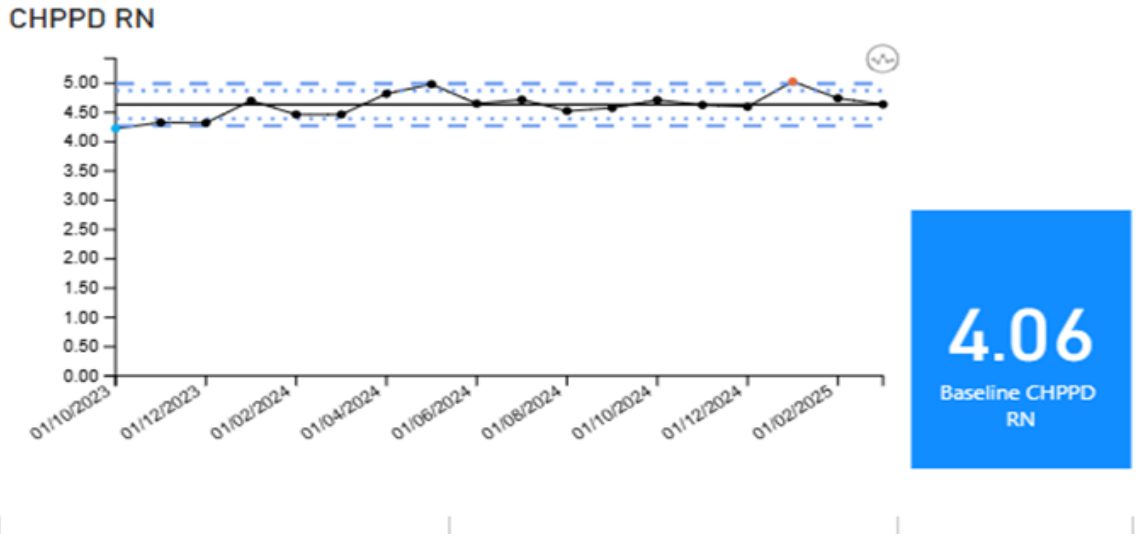


Table 10: Total registered CHPPD

Registered CHHPD has remained relatively stable throughout the reporting period and above baseline establishment. There was one month just above the upper process limit of 4.99 in February (5.03). There was no specific theme identified for this marginal variance

The table below demonstrates unregistered nursing staff CHPPD during the reporting period:

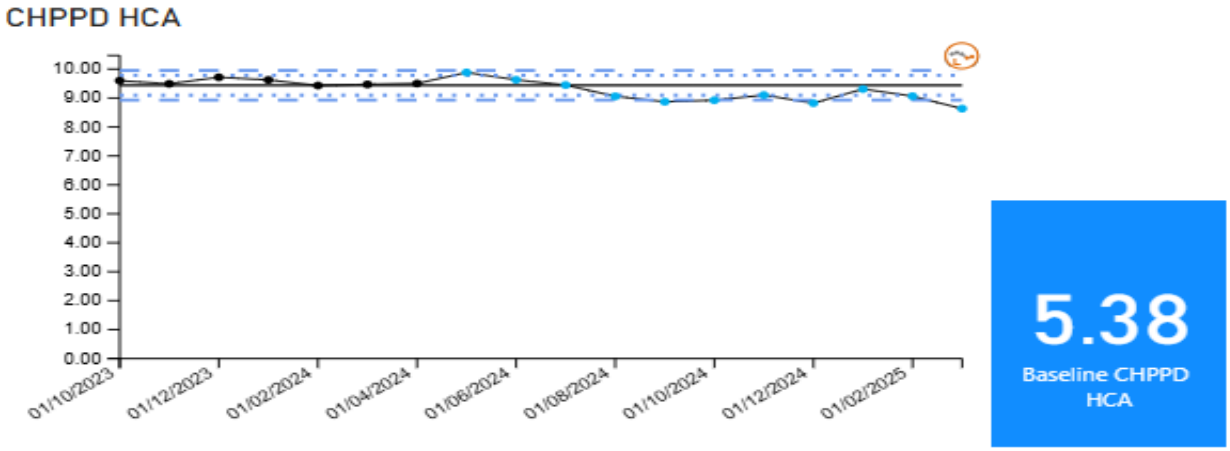


Table 11: Total unregistered CHPPD

- Unregistered CHPPD continues to present within a period of special cause variation (reducing)
- The reduction is attributed to vacant registered posts being filled, reducing the reliance on the unregistered temporary workforce
- Baselines are calculated based on current funded templates, therefore any uplift in staffing following the establishment reviews will increase the baseline figure

CHPPD provides the actual amount of care that was available per patient based on fill rates achieved. The table below provides a comparison of the baseline funded CHPPD for the total,

registered and unregistered workforce, against the CHPPD achieved. Data in red highlights where the CHPPD achieved fell below the funded baseline.

Service	CHPPD total baseline	CHPPD Average	CHPPD registered baseline	CHPPD registered average	CHPPD unregistered baseline	CHPPD unregistered average
Trust total	9.44	18.39	4.06	5.56	5.38	12.83
Learning Disability (Horizon)	21.13	57.28	4.63	11.46	16.5	45.82
PICU	18.52	25.79	7.81	6.23	10.72	19.58
Barnsley Physical Health Inpatients	10.98	11.21	4.09	6.08	6.89	5.13
Low secure	8.51	12.8	3.75	5.52	4.76	7.28
Medium Secure	8.42	10.8	4.4	4.97	4.02	5.83
WAA	8.33	9.87	3.13	3.10	5.2	6.76
OPS	8.02	10.72	3.9	3.5	4.12	7.23
Mental health Rehab	6.76	8.67	2.78	3.66	3.99	5.01

Table 12: Service specific CHPPD

- All service areas achieved above total CHPPD baselines, however working age adult, PICU and older people's services were below the expected care hours provided by registered staff. To understand this in more detail, a ward breakdown is required, available at appendix 11
- Barnsley physical health inpatient services were below their baseline for unregistered CHPPD, however any shortfalls were addressed through registered staffing hours
- Five out of 31 inpatient wards were below their total expected CHPPD, three within older people's service and two within working age adults, 10 wards were below the expected CHPPD for registered staffing, and two for unregistered staffing
- There are particular risks associated with wards who do not achieve their baseline registered CHPPD target, both in terms of impact on patient outcomes and satisfaction, and the impact on staff wellbeing, particularly the registered workforce given their additional responsibilities
- The older people's wards within Calderdale and Kirklees localities were below expected CHPPD across total and registered staffing, however their baseline target (based on their establishment) is higher than the other older people's wards in Barnsley and Wakefield. This further supports the need for the planned review of ward establishments enabling comparisons across peer groups
- CHPPD trends will be monitored within the new monthly safer staffing report

9. Outcome measures

9.1 One Registered Nurse on Duty (when unplanned)

Incidents of one registered nurse on duty when unplanned can impact on quality, patient safety, patient experience and staff wellbeing. The table below presents data over the last 12 months when there has been one registered nurse on duty when the staffing establishment is planned for more:

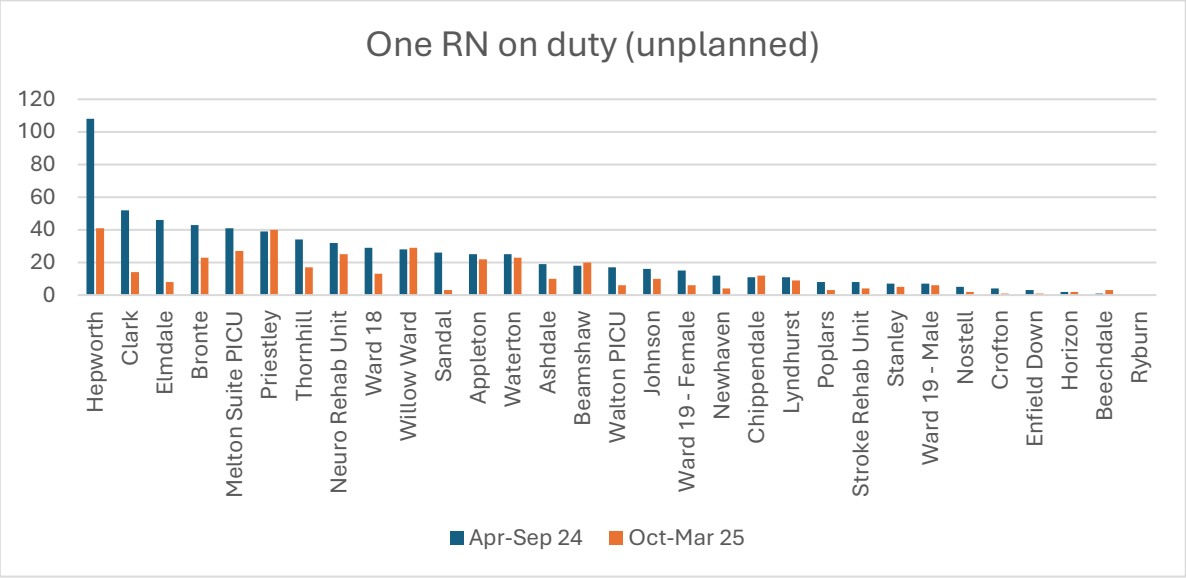


Table 13: One Registered Nurse on Duty

- During the reporting period, there has been a significant reduction in the number of shifts with just one unplanned registered nurse on duty from 692 to 389 (43.8%)
- The improvement can be attributed to the number of newly registered nurses now in post

If a registered nurse is left to work alone when unplanned, services will implement interventions to mitigate against potential risks, for example seeking additional support through redeployment of staff, creation of additional shifts or reassigning duties of senior staff to support clinical service delivery, for example ward managers and lead nurses working within clinical numbers. This will now be monitored and reported at ward level during the monthly safer staffing reporting.

9.2 Cancelled Section 17 Leave

Cancelled Section 17 leave is an important quality indicator for patient experience and can be significantly impacted by staffing levels. Formal monitoring of cancelled Section 17 leave now takes place across the mental health and forensic inpatient services. The data for Quarter 3 2024/5 is presented in the table overleaf:

Care Group	Total episodes of leave requested	% of leave facilitated	Total episodes of leave cancelled	Percentage of leave cancelled due to staffing
Mental Health	5389	99%	48	0.4%
Forensics	912	89.8%	93	2.7%

Table 14: Episodes of Cancelled Section 17 Leave Q3

- The data shows that a high proportion of escorted leave was successfully facilitated, with minimal cancellations due to staffing (23 in the Mental Health Care Group and 25 in the Forensic Care Group). A breakdown of cancelled leave for each ward is available (appendix 12)
- Other reasons for cancelled leave may be due to clinical risk assessment, changes in the service user's presentation or other clinical factors.
- A review of current reporting processes will be undertaken to determine whether the data can be reported monthly, and expanded to include learning disability services

9.3 Patient related incident reporting by Care Group (Oct 24 – Mar 25)

Patient related incident reporting was introduced in the previous bi-annual safer staffing report and forms a critical part of safer staffing analysis. The table overleaf represents incidents from within the inpatient services for each Care Group to identify current themes or trends that may influence or be influenced by staffing levels.

	Barnsley Physical Health and Wellbeing Care Group	Forensic Services Care Group	Learning Disability and ASD/ADHD Care Group	Cheswold Park Hospital	Mental Health Care Group	Total
Care Pathway, Clinical and Pressure Ulcer Incidents	5	20	0	32	176	233
Medication	8	65	4	147	219	443
Missing/absent service users	0	7	0	4	182	193
Safeguarding Adults	0	19	0	8	36	63
Safeguarding Children	0	2	0	0	3	5
Safer Staffing	1	19	2	22	70	114

Security Breaches	0	97	2	45	202	204
Self-Harm	0	88	3	173	937	1201
Sexual Safety incident	0	12	0	24	56	92
Slips, Trips and Falls	4	23	1	3	226	257
Violence and Aggression	0	379	225	204	1107	1915
Grand Total	**18**	**731**	**237**	**662**	**3072**	**4483**

Table 15: Incidents by Care Group

Incidents of violence and aggression (1,915) remain the most common Datix incident theme, although these reduced by 7.6% from the previous reporting period. Self-harm incidents (1,201) increased by 52.1% in the reporting period, the second highest incident type. Of note, the figures in the previous reporting period did not include Cheswold Park Hospital. The mental health Care Group continue to experience more incidents than any other Care Group (3,072) representing 68.5% of all reported incidents.

Datix themes are now being analysed using statistical process control (SPC) charts and will be incorporated into the new monthly safer staffing report. During the reporting period, self-harm was identified to be in special cause variation (high) within working age adult and forensic inpatient services.

The table below highlights the wards with the three highest number of reported incidents across key incident types.

Incident Category	**Wards with the highest number of incidents (Oct 24 – Mar 25)**
Violence and aggression	Horizon (225), Elmdale (139), Ward 18 (134)
Self-harm	Elmdale (209), Nostell (208), Ward 18 (181)
Falls	Beechdale (48), Ward 19 (46), Poplars (31)
Sexual safety incidents	Ward 18 (29), Esk (12), Ashdale (9)
Medication management incidents	Skipton (41), Beamshaw (29), Ward 18 (27)
Absent without leave (AWOL)	Ashdale (30), Nostell (29), Ward 18 (26)
Safer staffing incidents	Nostell (40), Wentbridge (7), Poplars (6)

Table 16: Datix incident categories- highest wards with incident type

- Ward 18 feature in the top three of the seven incident categories, Nostell, three and Ashdale, Elmdale and Poplars two. This is a further indication of the acuity experienced within these areas and data will be triangulated with wider safer staffing measures in the monthly safer staffing report

9.4 Safer Staffing Incidents

The table below shows the number of safer staffing reported incidents in the reporting period. This includes incidents across the Trust, recognising that safer staffing can impact

across all Trust services. Inpatients accounted for 92.2% of the 128 safer staffing incidents reported. This was an increase of 55 from the last report.

Service/area	Number of safer staffing incidents
Working Age Adult Acute Inpatients	52
Cheswold Park Hospital	22
Older Peoples Inpatients	12
Medium Secure Inpatients	11
Children Young People and Families	10
Low Secure Inpatients	8
Mental Health Care Group (other)	8
Psychiatric Intensive Care Units (PICU)	6
Forensic Services (other)	5
LD inpatients	2
Barnsley Physical Health Inpatients	1
Barnsley Physical Health (other)	1

Table 17: Safer staffing incidents by service type

- The mental health Care Group continue to report the highest number of safer staffing incidents (52 within the inpatient service, 40 of which were on Nostell Ward)
- Following the introduction of Cheswold Park Hospital into Datix incident reporting, incidents reported here were second highest (22)
- A detailed monthly breakdown of safer staffing incidents by team is available (appendix 13)

Safer staffing incidents are primarily reported when staffing levels are insufficient to meet clinical demand, either due to high acuity or sickness/absence. Other incidents include preceptee only cover, being unable to facilitate leave, and delays or cancellations of visits in community services. Staff are encouraged to report safer staffing incidents. In addition, utilisation of SafeCare's 'red flag' alerts will provide a more comprehensive analysis of safer staffing incidents when fully embedded within the Trust.

All safer staffing incidents reported on Datix are monitored through the Trust's weekly patient safety oversight group and reviewed during the monthly safer staffing meeting, with a focus on the impact on patient safety and quality of care. The Quality Governance Team continue to monitor safer staffing incidents as part of data triangulation under the quality assurance system.

9.5 Complaints and concerns

The Trust collects data on both formal and informal concerns and complaints via the customer service team. Concerns are recorded in relation to insufficient staff, lack of suitably trained staff, staffing levels, staffing ratios and other related staffing issues. In the reporting period, there have been no formal or informal complaints or concerns raised about safer staffing. This has been consistent for the last 12 months.

Analysing concerns and complaints forms a key part of safer staffing governance. When wards have insufficient staffing to meet clinical need, or the wrong skill mix to deliver

effective care, the number of concerns and complaints reported can increase. The following table overleaf highlights the number of complaints received across the inpatient service during the reporting period.

Area	Total	Formal complaints	Informal complaints / concerns	Complaints relating to safer staffing
Trust total	109	38	71	0
WAA	66	25	41	0
OPS	13	6	7	0
Medium Secure	11	3	8	0
Low secure	10	2	8	0
PICU	7	1	6	0
Barnsley Physical Health	2	1	1	0
MH Rehab	0	0	0	0
Learning Disability (Horizon)	0	0	0	0

Table 18: Inpatient concerns and complaints October 2024- March 2025

- Over half of the total concerns / complaints occurred within five working age adult acute wards: Ward 18 (17), Elmdale (11), Beamshaw (10), Clark (10), Stanley (10)
- The new approach to triangulating safer staffing data has identified that three of these wards (Ward 18, Elmdale and Stanley) were all below baseline CHPPD for registered staffing, suggesting a possible correlation between patient experience and registered staffing levels. This will now be monitored during the monthly safer staffing reporting to identify any emerging patterns within the data, and taking appropriate action where necessary
- A full breakdown of ward concerns and complaints is available (see Appendix 14)

9.6 Medication Omissions

High numbers of medication omissions (without clinical reason) can indicate patient safety concerns that may be influenced by staffing, particularly where there is one registered nurse on duty. Data omissions are obtained from the Electronic Prescribing Medication Administration (EPMA) system. The data below highlights the number of medication omissions (without clinical reason) across all inpatient services over the last 12 months since reporting commenced.

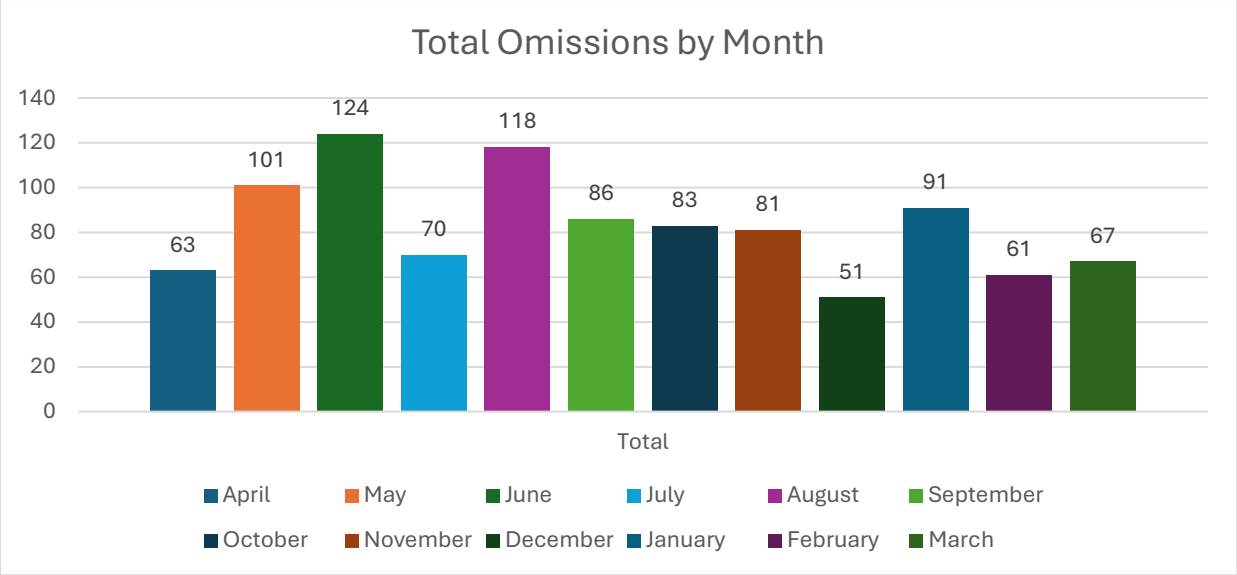


Table 19: Monthly Medication Omissions Trust-wide (April 2024- March 2025)

- Overall, there has been a 23% reduction in medication omissions over the last six months
- EPMA continues to be embedded in practice therefore further assurance is being explored to determine if the incidents reported are actual medication omissions or attributable to record keeping issues. Ward incidents will be reported each month within the safer staffing report, allowing for trend analysis and to facilitate an on-going review of data quality. A ward breakdown of incidents over the last 12 months is displayed in the following table:

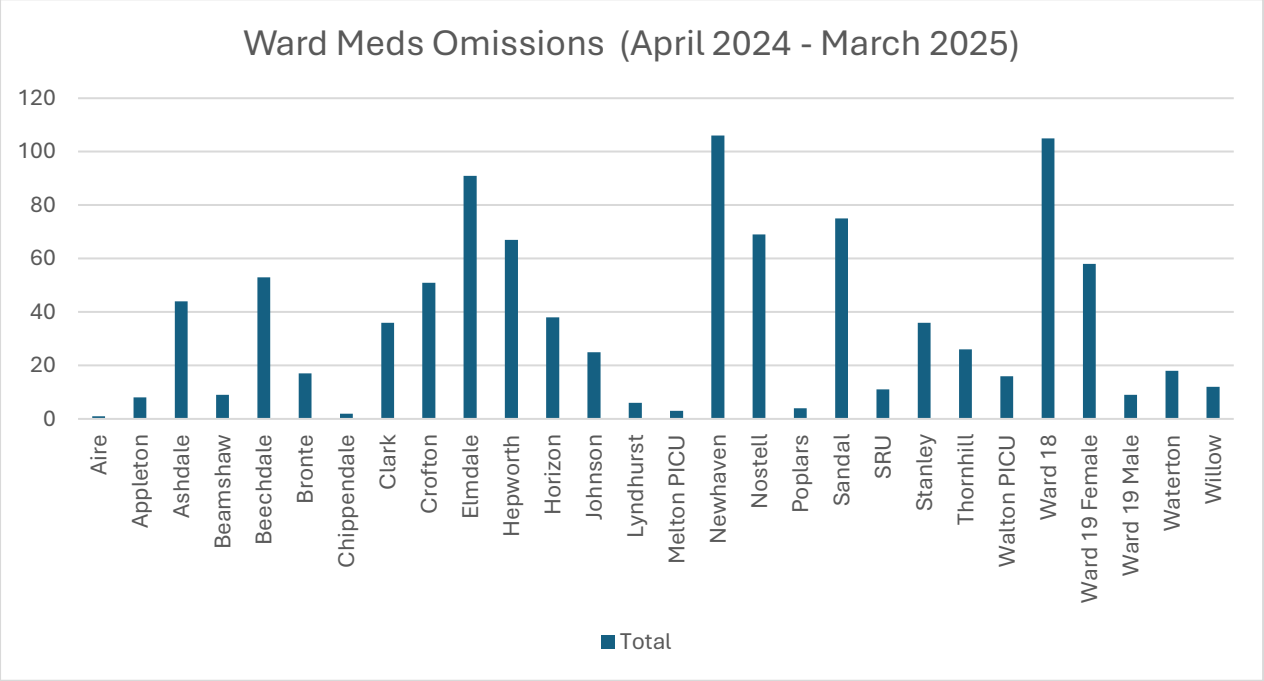


Table 20: Medication Omissions by Ward (April 2024- March 2025)

- Newhaven, Ward 18 and Elmdale have the highest recorded number of medication omissions over the last 12 months
- The higher rate of omissions for Ward 18 and Elmdale could be associated with the CHPPD for registered staffing being below the funded baseline, although it is difficult to determine this without a deeper dive into the incidents that occurred
- The new monthly safer staffing report will triangulate this data, allowing for Care Groups to review any identified patterns within the data and take appropriate action to mitigate any identified risks

9.7 Patient feedback/ friends and family test (FFT)

Patient feedback using the friends and family test is included within the report for the first time. It is nationally recognised as a patient outcome measure that should be used in the analysis of safer staffing. The table overleaf shows the average monthly score for each ward from the friends and family test during the reporting period. Patients are asked to score their care from 1-5 as detailed in the key below. The lower the score, the higher the care was rated.

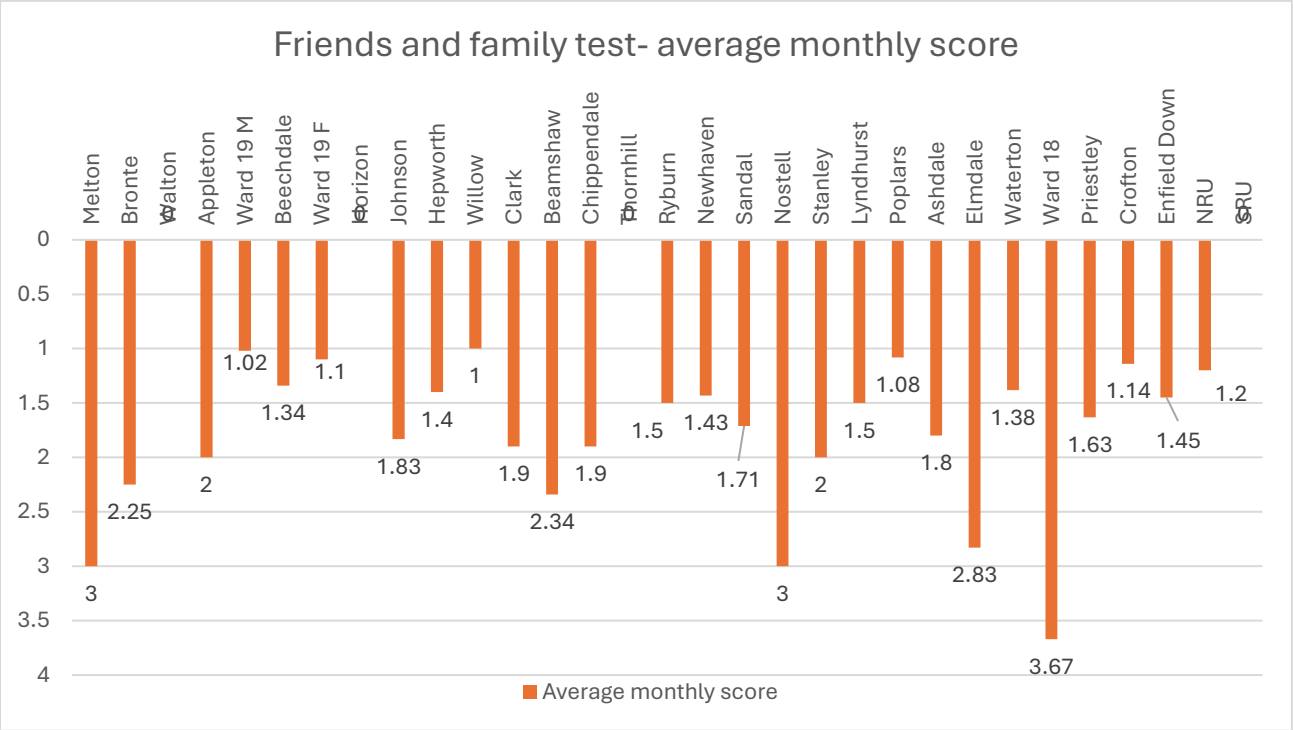


Table 21: Average monthly ward score, friends and family test

- Ward 18, Nostell, Melton, Elmdale and Beamshaw scored the lowest within the FFT test data, however this must be interpreted with caution due to the limited responses received from these wards and how this can impact on the average scoring
- Appendix 15 shows the number of responses received from each ward. To make this data meaningful, Care Groups need to review their processes for collecting this information
- Ward scores will now be reported each month, supporting safer staffing analysis and identifying areas with poor response rates, to look at how these can be improved
- These scores will also be part of the data reviewed for the Quality Assurance System

10. CQC 2023 Inspections: Regulation 18 'Staffing' Breaches

Following the 2023 CQC unannounced inspections, the working age adult and psychiatric intensive care mental health inpatient services received five actions and forensic services received two actions in relation to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An update of the action taken and current position is displayed below:

Working age adult and PICU inpatient services	
Action	**Progress**
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	The action was signed off as complete in May 2025.
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	The action is signed off as complete
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	The action is in progress. The Establishment review has been completed and recommendations signed off. This will support the reduction in use of bank and agency staff
The Trust must ensure that staff receive regular appraisals in line with the requirements of the trust's appraisal policy	The action is signed off as complete
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	The action is signed off as complete
Additional actions taken by the Care Group	
Continued implementation of the workforce initiatives from the inpatient improvement programme, including the focus on recruitment, retention, induction of staff (including bank and agency), building a competent and confident workforce through continual professional development	
Continuation of Care Group retention and wellbeing plans. The service are regularly achieving a 90% fill rate for substantive registered staff following successful recruitment to substantive roles	
The Care Groups have undertaken work to improve completion of appraisals, and this continues to be closely monitored. In addition, a review of the appraisal system is being undertaken to ensure that it is reflective of locally recorded data. Care groups are consistently achieving between 85-95% compliance	
Following the rollout of the Oliver McGowan mandatory training on learning disability and autism, the mental health Care Group have now achieved over 90% compliance for the e-	

learning module; level one. A trajectory is being created for completion of the webinar, taking into consideration the challenges in accessing training and the impact on staffing levels across the Care Group of supporting this attendance	
Forensic inpatient services	
Action	**Progress**
The Trust must ensure all staff are receiving the required level of supervision and training in accordance with trust policy	The action is signed off as complete
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	The action is signed off as complete
Additional actions taken by the Care Group	
Supervision performance is now reported within the Trust's integrated performance report	
The supervision database has been refined to allow for easier monitoring of performance	
The service are consistency exceeding the 80% target for clinical supervision (91.7% within low secure and 90.3% within medium secure at the end of March 2025)	
The service have increased oversight of performance, and all forensic inpatient services were above the 80% target for mandatory training across all months for the reporting period	
Following the rollout of the Oliver McGowan training, the service have now achieved over 90% compliance for the e-learning module; level one. A trajectory is being created for completion of the webinar to meet full level one expectations, taking into consideration the impact on staffing levels across the Care Group of supporting attendance	
These actions continue to be monitored, reviewed, and closed as part of CQC Action Planning Group and progress against the actions is reported to the executive management team, the Quality and Safety Committee and Trust Board	

Table 22: CQC regulatory actions

11. Workforce Planning and Recruitment

Vacancy rates across the Trust increased during the reporting period, particularly within inpatient services. The vacancy rate as of March 2025 was 15% compared to 14.4% at the end of Quarter 2 2024/25. The turnover rate increased slightly to 8.6% (from 8.2% at the end of Quarter 2). There has been a continued focus on retention of the clinical workforce particularly newly registered nurses. Interventions to support the internationally educated nurses (IEN) continue to be reviewed, with prioritisation to support a small minority who have not yet completed their preceptorship programme. This will continue to be reviewed within the IEN steering group, chaired by the chief nurse.

Since September 2024, the Trust have recruited 272.2 WTE new starters with 260.6 leaving their posts. During the current fiscal year, the Trust's stability rate (workforce turnover and growth) remained above 90%. When benchmarked regionally against other mental health providers, the Trust are amongst the highest for workforce stability and the lowest for turnover rate.

There continues to be vacancies within our unregistered nursing workforce. The recent approval of the acute working age mental health inpatient service establishment review has created additional vacancies that will be advertised imminently. A working group to review the development of our non-registered workforce has recommended a competency framework to be introduced that will enable progression of unregistered staff working at band

two level to develop into band three roles. This has been agreed with staff side colleagues and has commenced within mental health inpatient services, with a view to rolling this out Trust-wide, including bank only employees.

Vacancy recruitment panels continue within Care Groups and at Trust level, strengthening governance processes and decision-making regarding recruitment. Further strategic planning is underway regarding workforce development led by colleagues in the people directorate. Safer staffing establishment reviews will form a key part of future planning.

11.1 Growing from within – Training and Education

- 40 staff are currently undertaking registered nurse degree apprenticeships. Of these, 27 are enrolled on the four-year registered nurse degree apprenticeship (RNDA) and 11 are undertaking the two-year RNDA top-up from band four nursing associate posts. Two employees are undertaking an RNDA master's course
- Six staff are due to complete their RNDA apprenticeship at the end of November 2025 and 11 of the NA top up degree staff are due to complete their training by the end of August 2025
- The nursing associate programme has continued to embed and at present, there are 25 Trainee Nursing Associates in post across the Trust
- Of these, six are due to complete at the end of June 2025 and five are due to complete at the end of December 2025
- There has been no recruitment to trainee nursing associate posts this year. This is a Care Group decision based on the absence of registered nurse vacancies
- There are 18 staff enrolled on the three-year AHP degree apprentice course (10 occupational therapy, four physiotherapy, one speech and language therapy, one dietetics and two podiatry). Of these, nine are due to complete their apprenticeship at the end of October 2025. Recruitment is under way for a 2025 cohort of AHP apprentices
- The Trust has supported the development of Advanced Clinical Practitioner (ACP) roles in line with the NHS long-term workforce plan. ACP courses are funded by NHS England with an additional £10,200 funding provided each year to support the learning needs of each student. During 2024, Care Groups did not support any applications for funding, as there are no current vacancies their workforce plans
- New roles continue to be considered where sustained challenges with recruitment are identified. The Trust's new roles governance group review any proposed changes to skill mix, to ensure care can be delivered safely and effectively using a quality impact assessment process

12. Workforce Performance

It is widely acknowledged that the clinical workforce must be supported to have the right skills and are enabled to maintain their own wellbeing to deliver safe and effective care to patients. Four key indicators of this are staff sickness, appraisal rates, supervision, and mandatory training compliance. As detailed in the table below, at the end of March 2025, the overall sickness rate within inpatient services was just above the Trust target of 4.4% at 4.6%, appraisal rate was 86.0% (against 95% target) and overall mandatory training rates were above the Trust target for all Care Groups.

March 2025	Trust Overall	Forensic	Mental Health	Learning Disability and Adult ASD and ADHD	Barnsley Integrated Services	Cheswold Park Hospital	Trust Target
Staff sickness rate	4.6%	6.2%	4.7%	4.7%	4.5%	2.2%	4.4%
Appraisals	86%	85.3%	87.1%	88.6%	86.2%	Not included	95%
Supervision	86.1%	91.8%	88.1%	79.6%	80.6%	Not included	80%
Mandatory Training	93.4%	93.2%	93.0%	94.9%	94.4%	Not included	80%

Table 23: Trust sickness, appraisal, and mandatory training by Care Group- March 2025

12.1 Staff sickness

- Sickness absence continues to be monitored at Care Group level and within the operational management group (OMG) monthly performance meeting
- Sickness has increased from the previous reporting period with October and December recording the highest rates within the reporting period
- Focussed work is taking place within Care Groups to support long term sickness absence, supported by people directorate business partners

12.2 Appraisals

- Although below Trust target, appraisal rates have continued to improve over the reporting period
- Appraisal performance is closely monitored within Care Groups and via the Trust Integrated Performance Report (IPR)

12.3 Mandatory Training

- Mandatory training compliance is a key indicator of safe staffing, ensuring that staff have the right skills to complete their role to a high standard
- The Trust have prioritised two key areas of mandatory training to address ‘must do’ actions following the 2023 CQC unannounced inspection to inpatient services. These are reducing restrictive physical intervention (RRPI) training and cardiopulmonary resuscitation (CPR)
- RRPI training has continued to improve. At the end of April 2025, 88.3% of all staff requiring this competence were in date
- Cardiopulmonary Resuscitation training has continued to improve. Basic life support levels one and two and intermediate life support were all above the 80% compliance threshold at the end of April 2025

12.4 Supervision

- All Care Groups have maintained compliance with the 80% target for clinical supervision, with the exception of the learning disability service
- Currently, supervision reporting only applies to registered staff at Band 4 and above. The supervision policy has recently been updated and is out for consultation. Changes to the policy include the inclusion of all non-medical clinical staff within reporting, and requirements for the frequency of supervision have been changed from six hours per year for clinical and managerial supervision to supervision taking place at least every 60 days. This will ensure supervision takes place more frequently and will provide assurance that the unregistered workforce are also being appropriately supported and supervised
- As part of the Trust's clinical supervision offer, a number of nursing staff have undertaken Professional Nurse Advocate (PNA) training to deliver restorative supervision. The restorative approach 'promotes reflection of personal emotions and practice, has a positive impact on emotional wellbeing, provides a strategy to mitigate workplace stress, enhances retention and assists with the management of personal and professional demands' (Royal College of Nursing 2021). The Trust has allocated continuing professional development (CPD) monies to secure a further 60 PNA training places to meet contractual requirements of having one PNA for every 20 registered nurses in the Trust. Cohorts are in place throughout June, September and January 2026

12.5 Staff Wellbeing

- Following improvements in the staff survey result for wellbeing (2023), Care Groups are currently reviewing the 2024 results and developing appropriate action plans to further support areas of improvement
- Systems remain in place to continue to gather and monitor data and intelligence, to help the Trust understand existing pressure points, and where things are working well to share learning and act accordingly
- Our occupational health service provides a range of tailored support programmes to colleagues including stress management, fast track physiotherapy, counselling, moving and handling support, physical health screening and rehabilitation as part of returning to work from absence
- As part of the Trust's ambition to be a trauma informed organisation, a staff support and wellbeing steering group has been established to look at the wellbeing offer within the organisation

Report produced by:
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(Specialist Advisor for Safer Staffing)

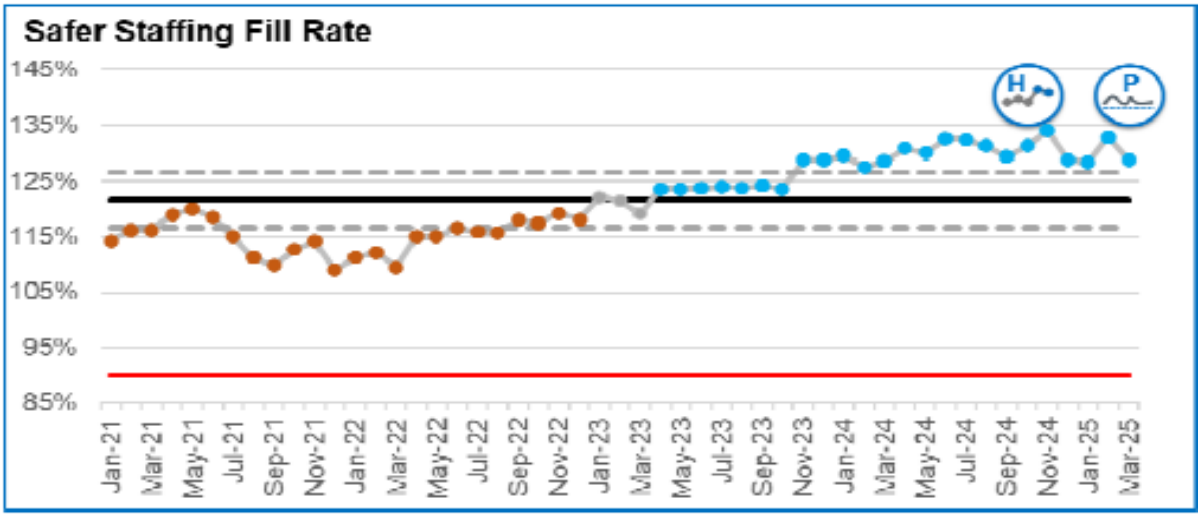
Appendix 1

Trust Board Safer Staffing Checklist

1. **Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?**
   Board receives regular presentations on staffing (e.g., IPR reports, regular assurance visits from Board members to the wards/departments to learn about and understand the services better (e.g., quality walkarounds and executive trio visits).
2. **Are there processes for escalating issues identified by staff, patients, or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services?** Acuity is regularly and routinely monitored on wards including need for 1:1 observation. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system and regular reporting to safer staffing group.
3. **Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence-based approach? How can the calculator tools be best deployed in delivering this?**
   Originally the Trust has developed a bespoke decision support tool which was used to decide on the original staffing templates. We have moved to using the most up to date evidence tool available which has been used in staff reviews to date and will be for the Trust-wide inpatient establishment review. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.
4. **What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?**
   Managers are empowered to use a range of interventions (e.g., use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement. Specialist Advisor for Safer Staffing is available to offer advice and support as required.
5. **How are the needs of Mental Health service users incorporated in staffing?**
   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.
6. **As well as staffing measures outlined by the NQB are their measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?**
   Complex benchmarking and performance data is widely available throughout the organisation and drills down to Team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.
7. **How this ward staffing information might be presented differently within a Mental Health setting where the ward-based Team is not the only valuable resource available?**
   Monthly reporting on Trust website and safer staffing exception report shared with all services monthly and summary information provided in IPR.

8. **How are the challenges of filling specific Mental Health roles managed e.g., recruitment training etc.?**
   We have particularly good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. We attend national recruitment events and are lead providers in a regional collaboration looking at international recruitment. Training needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.
9. **How is the commissioner kept informed about best practice in Mental Health so that informed commissioning decisions are made?**
   Local Place Quality Boards receive updates on how the organisation is performing in relation to safer staffing, within the externally available integrated performance report.

Appendix 2
Trust total safer staffing fill rate



- The table above demonstrates that overall, Trust fill rate measured against budgeted establishment, remains in a period of special cause variation (high)

Appendix 3
Ward specific total fill rates

Service	Fill rate (establishment)	Fill rate (clinically required)
POPLARS	228.19%	91.51%
CROFTON	176.59%	92.51%
MELTON	174.80%	92.10%
HORIZON	172.72%	93.79%
WILLOW	161.21%	88.89%
NOSTELL	156.02%	94.12%
CLARK	155.85%	91.71%
BEAMSHAW	148.95%	92.50%
STANLEY	145.89%	94.43%
SANDAL	140.32%	96.07%
BEECHDALE	136.39%	93.39%
JOHNSON	133.69%	95.95%
WALTON	133.31%	95.43%
ASHDALE	131.01%	95.70%
CHIPPENDALE	130.57%	92.76%
ELMDALE	130.49%	96.66%
WATERTON	127.29%	95.41%
NEURO-REHAB	126.28%	94.24%
WARD 19 MALE	118.15%	90.58%
NEWHAVEN	110.70%	94.79%
BRONTE	110.27%	96.14%
WARD 18	109.94%	94.21%
THORNHILL	106.08%	95.83%
HEPWORTH	105.82%	94.48%
WARD 19 FEMALE	100.47%	86.92%
RYBURN	99.54%	99.42%
APPLETON	98.09%	92.82%
LYNDHURST	97.07%	96.89%

ENFIELD DOWN	95.75%	95.08%
PRIESTLEY	93.88%	92.36%
STROKE REHAB	91.82%	84.00%

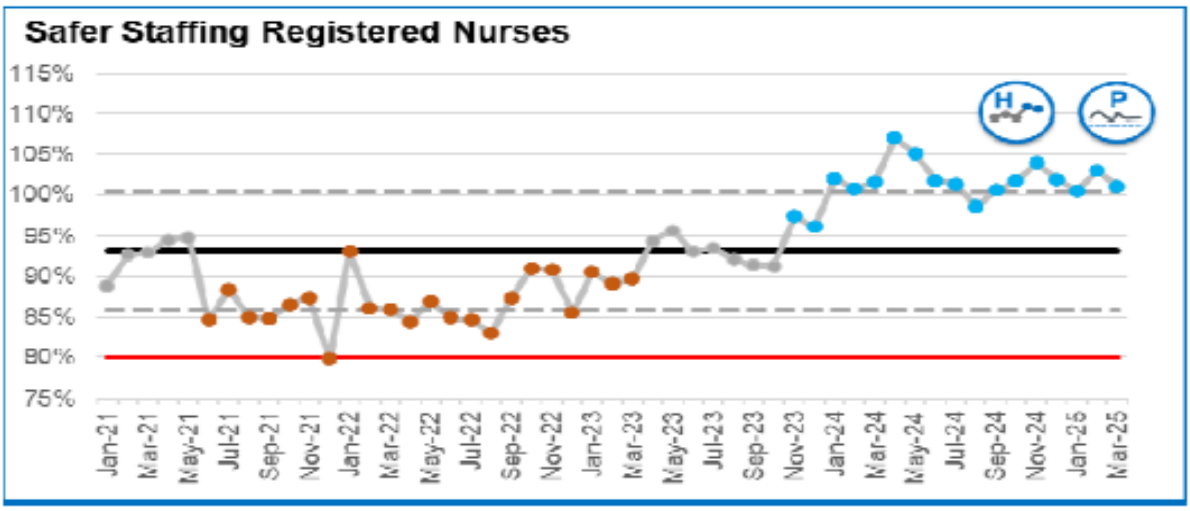
Appendix 4

Registered nurse staffing fill rate split (registered nurses and nurse associates)

	Days		Nights	
Month	**RN**	**NA**	**RN**	**NA**
October	**91%**	**9%**	**89.4%**	**10.6%**
November	**91.9%**	**8.1%**	**92.1%**	**7.9%**
December	**90.6%**	**9.4%**	**92.5%**	**7.5%**
January	**90.5%**	**9.5%**	**87.7%**	**12.3%**
February	88.8%	11.2%	87.3%	12.7%
March	**87.3%**	**12.7%**	**88.2%**	**11.8%**
Total	**88.7%**	**11.3%**	**88.3%**	**11.7%**

Appendix 5

Total registered staffing fill rates



- The table above demonstrates that overall, Trust fill rates for registered staffing measured against budgeted establishment remains in a period of special cause variation (high)

Appendix 6
Ward specific registered fill rates

Service	Fill rate (establishment)	Fill rate (clinically required)
HORIZON	158.30%	98.28%
CROFTON	144.12%	106.86%
CHIPPENDALE	133.45%	101.96%
WARD 19 FEMALE	119.51%	114.89%
ASHDALE	118.45%	117.31%
SANDAL	118.14%	115.14%
BEAMSHAW	117.02%	116.00%
NEURO-REHAB	112.58%	96.22%

BRONTE	111.00%	104.78%
BEECHDALE	110.79%	93.11%
CLARK	110.75%	108.73%
NOSTELL	110.01%	109.10%
POPLARS	108.37%	99.90%
WATERTON	108.07%	107.03%
NEWHAVEN	107.45%	106.77%
APPLETON	106.12%	103.52%
THORNHILL	105.59%	100.84%
STANLEY	105.38%	102.52%
ELMDALE	105.25%	105.01%
WILLOW	104.49%	84.45%
STROKE REHAB	102.15%	90.89%
ENFIELD DOWN	102.05%	100.87%
RYBURN	100.02%	100.02%
WARD 19 MALE	99.99%	90.58%
MELTON	99.04%	97.90%
LYNDHURST	98.30%	98.30%
JOHNSON	97.39%	96.41%
WALTON	95.87%	95.05%
WARD 18	95.18%	94.74%
PRIESTLEY	91.83%	89.63%
HEPWORTH	90.49%	87.81%

Appendix 7

Registered nurse day fill rates

The table below reflects the percentage of registered nurse day shifts filled, measured against the current establishment across the reporting period

Registered Day Rate	Month-Year					
Unit	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Appleton	90%	84%	84%	89%	91%	94%
Ashdale	119%	126%	116%	123%	118%	124%
Beamshaw	119%	114%	124%	115%	126%	126%
Beechdale	102%	101%	94%	99%	114%	107%
Bronte	95%	117%	113%	102%	89%	98%
Chippendale	103%	96%	99%	110%	103%	90%
Clark	117%	114%	103%	107%	111%	108%
Elmdale	93%	101%	94%	91%	94%	100%
Enfield Down	85%	103%	94%	95%	100%	88%
Hepworth	72%	68%	86%	87%	86%	91%
Johnson	89%	91%	80%	76%	89%	91%
Lyndhurst	79%	79%	77%	80%	80%	85%
Melton Suite PICU	108%	103%	98%	95%	93%	103%
Neuro Rehab Unit	123%	122%	123%	122%	116%	110%
Newhaven	100%	112%	102%	96%	103%	104%
Poplars	111%	119%	100%	103%	100%	93%
Priestley	64%	71%	63%	68%	75%	74%
Ryburn	100%	101%	100%	100%	100%	99%
Sandal	117%	141%	124%	120%	124%	126%
Stanley	107%	107%	96%	109%	112%	120%
Stroke Rehab Unit	147%	142%	135%	144%	156%	113%
Thornhill	92%	102%	106%	98%	119%	109%
Ward 18	82%	80%	69%	79%	88%	90%
Waterton	96%	107%	90%	84%	80%	89%
Willow Ward	98%	82%	82%	96%	94%	93%
Ward 19 - Female	92%	106%	89%	86%	88%	79%
Ward 19 - Male	78%	97%	100%	87%	77%	72%
Nostell	107%	119%	104%	104%	107%	110%
Crofton	139%	124%	120%	111%	130%	127%
Walton PICU	98%	95%	90%	90%	92%	95%
Horizon	125%	127%	127%	130%	138%	139%
Overall Shift Fill Rate	**100%**	**104%**	**98%**	**99%**	**102%**	**101%**

Appendix 8

Average WTE above establishment (Per week)

Ward	All	Registered	Unregistered
Poplars	24.24	0.65	23.59
Horizon	22.64	3.90	18.74
Melton	16.91	-0.09	17.00
Nostell	15.89	1.16	14.73
Crofton	14.54	3.44	11.10
Clark	12.68	1.00	11.68
Stanley	11.99	0.62	11.37
Walton	11.79	-0.54	12.33
Beamshaw	11.20	1.61	9.59

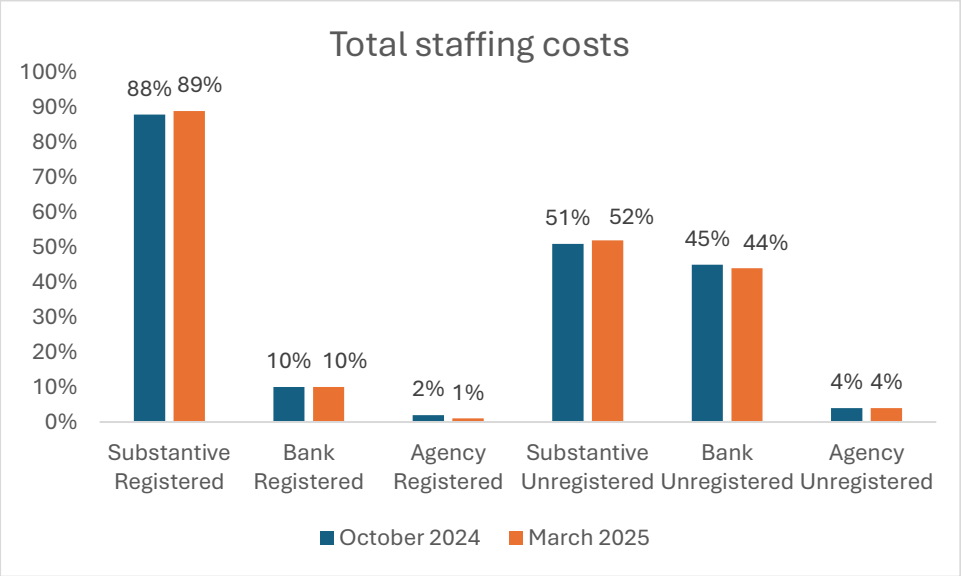
Sandal	10.51	1.63	8.88
Willow	9.59	0.30	9.29
Ashdale	8.66	1.95	6.71
Elmdale	8.52	0.55	7.97
Johnson	7.18	-0.32	8.20
Beechdale	6.51	0.96	5.55
Chippendale	5.10	2.58	2.51
Waterton	4.55	0.62	3.93
NRU	3.94	1.07	2.87
Ward19 Male	3.12	0.00	3.12
Ward 18	3.01	-0.51	3.52
Newhaven	2.50	0.74	1.76
Bronte	1.94	1.10	0.85
Thornhill	1.31	0.56	0.75
Hepworth	1.23	-1.10	2.34
Ward19 Female	0.08	1.61	-1.53
Ryburn	-0.04	0.00	-0.04
Appleton	-0.32	0.47	-0.79
Lyndhurst	-0.52	-0.11	-0.41
Priestley	-1.02	-0.63	-0.39
Enfield Down	-1.16	0.24	-1.40
SRU	-1.73	0.21	-1.94

Appendix 9

Highest number of additional clinical duties created (October 2024- March 2025)

Ward	No of Additional Duties
Poplars	2257
Horizon	2136
Melton PICU	1465
Nostell	1400
Crofton	1348
Clark	1125
Walton PICU	1083
Stanley	1056
Beamshaw	999
Waterton	873

Appendix 10
Percentage of total staffing costs (substantive, bank and agency)



Appendix 11
Ward specific CHPPD

Ward	CHPPD Baseline	CHPPD Average	CHPPD registered	CHPPD registered average	CHPPD unregistered	CHPPD unregistered average
Melton	21.18	34.38	9.18	7.91	12	26.47
Horizon	21.13	57.28	4.63	11.46	16.5	45.82
Walton	15.86	17.24	6.43	4.55	9.43	12.69
Bronte	15.55	17.15	8.69	9.20	6.86	7.95
SRU	14.8	10.58	4.37	6.18	10.43	4.40
Appleton	11.44	17.70	5.44	9.02	6	8.69
Clark	9	12.98	3.88	3.91	5.14	9.07
Beamshaw	9	12.01	3.86	3.91	5.14	8.09
Ward 19 M	8.96	7.31	5.4	2.96	3.56	4.34
Sandal	8.72	14.31	3	4.13	5.72	10.18
Willow	8.7	13.67	3.9	3.88	4.8	9.78
Johnson	8.5	14.70	4.5	5.68	4	9.02
Beechdale	8.47	7.89	5.14	3.38	3.33	4.51
Nostell	8.45	11.75	3	3.42	5.45	8.33
Stanley	8.45	8.26	3	2.65	5.45	5.61
Ward 19 F	8.12	6.19	4.92	3.51	3.2	2.68
Ward 18	7.91	7.77	2.69	2.34	5.22	5.43
Newhaven	7.83	12.37	3.33	5.11	4.5	7.26
Ashdale	7.75	8.20	2.75	2.92	5	5.28
Elmdale	7.75	8.09	2.75	2.55	5	5.54
Thornhill	7.7	11.53	3.56	5.28	4.14	6.24
Hepworth	7.67	9.43	4.24	4.40	3.43	5.03
Chippendale	7.59	10.13	3.59	4.84	4	5.29
Lyndhurst	7.29	8.89	3	3.41	4.29	5.48
NRU	7.15	11.83	3.8	5.97	3.35	5.86
Ryburn	6.86	8.07	3.43	4.05	3.43	4.01
Poplars	6.76	18.70	2.76	3.64	4	15.07
Crofton	6.6	10.58	2.58	3.60	4.02	6.98
Enfield Down	6.23	8.44	2.55	3.90	3.68	4.54
Waterton	5.72	7.62	2.72	3.07	3	4.56
Priestley	5.48	5.77	2.66	2.65	2.82	3.13

Appendix 12
Cancelled section 17 leave (due to staffing) Q3; 2024/25
Working Age Adult Care Group

Ward	Number of leave episodes planned	Percentage of leave cancelled due to staffing
Clark	254	3.5% (9)

Beamshaw	144	1.4% (2)
Melton Suite	151	0%
Willow	139	1.4% (2)
Nostell	73	0%
Stanley	306	1.6% (5)
Walton	840	0.1% (1)
Crofton	51	3.9% (2)
Poplars	22	9.1% (2)
Ward 19 Male	33	0%
Ward 19 Female	28	0%
Ward 18	735	0%
Beechdale	150	0%
Enfield Down	226	0%
Lyndhurst	81	0%
Elmdale	794	0%
Ashdale	1197	0%

Forensic Care Group

Ward	Number of leave episodes planned	Percentage of leave cancelled due to staffing
Appleton	14	0%
Bronte	1	0%
Chippendale	64	0%
Hepworth	14	0%
Johnson	86	7.0% (6 episodes)
Priestley	109	0.9% (1 episode)
Waterton	159	0%
Ryburn	3	0%
Sandal	190	8.9% (17 episodes)
Thornhill	186	0% (1 episode)
Newhaven	86	0%

Appendix 13

Safer staffing incidents by ward/team

Ward/Team	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	Total
Nostell Ward, Wakefield	14	8	4	6	1	7	40
CAMHS - Kirklees	3	1	0	1	1	2	8
Wentbridge ward	0	3	0	0	1	3	7
Poplars	1	2	0	1	1	1	6
Appleton	0	0	0	0	1	4	5
Hepworth Ward	0	0	1	0	1	3	5
Foss ward	0	0	1	1	1	2	5

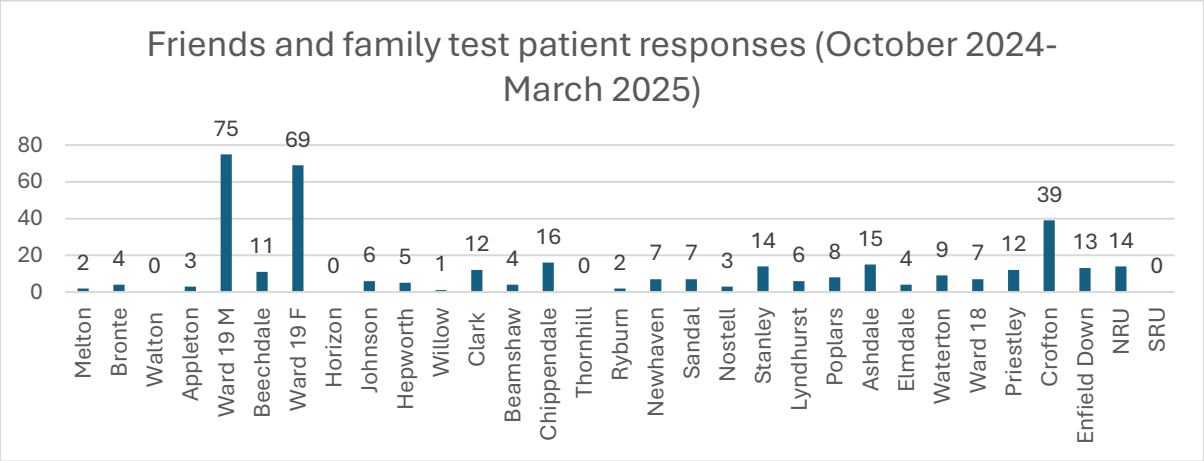
Don ward	0	0	0	1	0	4	5
Specialist Community Forensic Team	0	1	1	1	2	0	5
Ashdale Ward	0	3	0	1	0	0	4
Clark Ward	2	0	0	0	1	1	4
Priestley Ward	1	1	0	0	0	2	4
Willow Ward	0	0	0	0	3	1	4
Enhanced Team West - Kendray, Barnsley	2	1	0	0	0	0	3
Melton PICU	0	2	0	1	0	0	3
Stanley Ward	0	2	1	0	0	0	3
Walton PICU	1	0	0	0	1	1	3
CAMHS - Calderdale	2	0	0	0	0	0	2
Crofton Ward (OPS)	0	0	0	1	0	1	2
Horizon	0	0	0	0	1	1	2
Intensive Home Based Treatment Team (IHBTT) - Barnsley	0	0	1	1	0	0	2
Thornhill Ward	0	1	0	1	0	0	2
Skipton ward	0	1	0	0	0	1	2
Calder ward	0	0	0	1	0	1	2
Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale	0	0	1	0	0	0	1
Beamshaw Ward	1	0	0	0	0	0	1
ECT - Calderdale	0	0	0	0	0	1	1
Johnson Ward	0	0	0	0	0	1	1
Mental Health Inpatient management team	1	0	0	0	0	0	1
Neuro Rehab Unit	1	0	0	0	0	0	1
Newhaven	0	0	0	0	0	1	1

Urgent Crisis Response Service- Barnsley	0	0	0	1	0	0	1
Waterton Ward	0	0	0	0	1	0	1
Aire ward	0	0	0	0	0	1	1
Total	29	26	10	18	16	39	

Appendix 14
Complaints by ward

Ward	Total complaints	Formal complaints	Informal Complaints/ concerns	Complaints relating to safer staffing
Ward 18	17	6	11	0
Elmdale	11	3	8	0
Beamshaw	10	4	6	0
Clark	10	5	5	0
Stanley	10	4	6	0
Thornhill	5	2	3	0
Beechdale	5	2	3	0
Walton	5	0	5	0
Nostell	5	2	3	0
Hepworth	4	2	2	0
Ward 19	4	2	2	0
Ryburn	3	0	3	0
Johnson	3	0	3	0
Ashdale	3	1	2	0
Sandal	2	0	2	0
Waterton	2	1	1	0
SRU	2	1	1	0
Melton	2	1	1	0
Willow	2	2	0	0
Chippendale	1	0	1	0
Priestley	1	0	1	0
Crofton	1	0	1	0
Poplars	1	0	1	0
Horizon	0	0	0	0
Appleton	0	0	0	0
Newhaven	0	0	0	0
Enfield Down	0	0	0	0
Lyndhurst	0	0	0	0
Bronte	0	0	0	0
NRU	0	0	0	0

Appendix 15
Friends and family test; ward responses



Appendix 16

Weekly E-roster management information report example

Allocate RosterPerform 11 Overview

Org.Units/Metrics	Unfilled Roster %	Additional Duties	Wrong Grade Type	Bank / Agency Use %	Agency Usage - Hours %	Overtime Hours	Net Hours Balance	Total Unavailability %	Annual Leave %	Sickness %	Parenting %	Study Day %	Working Day %	Other Leave %
Appleton	8.64%	22	8	48.39%	0.00%	0	125.98	37.95%	22.73%	5.45%	5.68%	2.27%	0.00%	1.82%
Ashdale	3.46%	17	7	28.47%	0.00%	0	156.83	22.07%	10.36%	8.34%	0.00%	0.00%	3.36%	0.00%
Beamshaw	5.43%	23	3	61.17%	0.00%	0	103.22	41.89%	19.27%	10.56%	0.00%	4.11%	3.97%	3.97%
Beechdale	6.48%	26	1	30.13%	0.00%	0	56.77	20.50%	15.00%	4.17%	0.00%	1.33%	0.00%	0.00%
Bronte	7.16%	0	9	16.30%	0.00%	0	-4.72	31.57%	2.86%	13.06%	0.00%	9.21%	6.44%	0.00%
Chippendale	9.26%	10	8	16.10%	0.00%	0	131.93	16.86%	0.00%	7.69%	4.81%	4.36%	0.00%	0.00%
Clark	2.12%	0	6	36.67%	0.00%	0	-31.1	28.73%	7.83%	7.83%	9.78%	2.61%	0.00%	0.68%
Crofton	4.48%	59	8	52.08%	1.56%	0	15.22	19.13%	12.98%	0.00%	4.73%	0.95%	0.00%	0.48%
Elmdale	7.30%	15	2	49.99%	0.97%	0	23.93	28.17%	21.45%	0.00%	0.00%	2.43%	0.12%	4.17%
Enfield Down	11.34%	6	5	19.78%	0.00%	0	59.92	28.29%	11.41%	8.38%	2.62%	2.09%	3.79%	0.00%
Hepworth	9.80%	1	2	21.02%	0.00%	0	124.03	31.83%	15.43%	4.26%	0.00%	2.66%	4.43%	5.05%
Horizon	8.34%	52	1	31.86%	2.28%	0	-84.63	15.33%	6.03%	1.01%	6.28%	1.01%	0.00%	1.01%
Johnson	3.84%	21	5	38.71%	0.00%	0	54.38	36.58%	13.15%	7.95%	6.71%	0.68%	7.95%	0.14%
Lyndhurst	3.43%	7	7	16.87%	0.00%	0	64.32	18.18%	14.71%	1.38%	0.00%	0.46%	0.23%	1.38%
Melton Suite PICU	4.31%	10	2	27.41%	0.00%	0	121.27	21.09%	12.41%	2.76%	0.00%	1.67%	4.25%	0.00%
Neuro Rehab Unit	4.77%	22	1	18.75%	0.00%	7.5	-319.33	35.38%	19.43%	7.69%	3.24%	0.97%	4.05%	0.00%
Newhaven	1.50%	23	1	50.98%	0.00%	0	149.18	46.10%	11.93%	21.65%	0.00%	2.80%	9.72%	0.00%
Nostell	2.97%	33	0	55.62%	4.22%	0	97.88	33.43%	14.46%	6.09%	7.61%	1.52%	1.22%	2.54%
Poplars	4.66%	90	5	56.31%	6.77%	0	-14.7	22.40%	16.43%	5.16%	0.00%	0.47%	0.00%	0.34%
Priestley	12.11%	0	6	8.66%	0.00%	0	167.95	26.56%	15.27%	0.00%	0.00%	4.14%	5.09%	2.05%
Ryburn	0.00%	0	0	21.56%	0.00%	0	47.15	21.71%	7.34%	11.47%	0.00%	2.91%	0.00%	0.00%
Sandal	5.93%	44	5	56.27%	0.00%	0	222.22	39.59%	13.72%	3.39%	7.07%	10.61%	0.71%	4.09%
Stanley	4.45%	41	6	55.24%	5.35%	0	-53.05	31.82%	16.42%	9.32%	4.11%	0.00%	0.33%	1.64%
Stroke Rehab Unit	31.23%	34	0	2.06%	0.00%	0	7.77	25.31%	13.93%	10.87%	0.00%	0.00%	0.00%	0.52%
Thornhill	6.09%	16	7	27.39%	0.00%	0	267.8	29.60%	4.81%	10.39%	2.08%	7.14%	3.98%	1.20%
Walton PICU	1.60%	91	0	63.74%	5.08%	0	-65.4	30.22%	11.14%	10.32%	4.64%	2.90%	0.00%	1.22%
Ward 18	6.09%	2	9	51.79%	1.03%	0	80.77	39.71%	12.05%	10.99%	3.77%	2.26%	3.01%	7.63%
Ward 19 - Female	13.72%	5	3	1.79%	0.00%	0	97.78	23.25%	14.12%	6.94%	0.00%	2.19%	0.00%	0.00%
Ward 19 - Male	18.46%	9	2	8.97%	0.00%	0	38.5	21.66%	10.85%	4.18%	0.00%	1.66%	4.98%	0.00%
Waterton	10.38%	12	2	37.83%	0.00%	0	306.03	26.20%	5.42%	5.76%	5.14%	3.09%	6.79%	0.00%
Willow Ward	8.59%	26	0	50.09%	0.00%	0	252.1	41.51%	17.17%	18.11%	0.00%	0.00%	4.72%	1.51%

Allocate RosterPerform 11 Overview

Org.Units/Metrics	Unfilled Roster %	Additional Duties	Wrong Grade Type	Bank / Agency Use %	Agency Usage - Hours %	Overtime Hours %	Net Hours Balance	Total Unavailability %	Annual Leave %	Other Leave %	Parenting %	Sickness %	Study Day %	Working Day %
Appleton	7.45%	1	6	21.05%	0.00%	0.00%	130.48	24.32%	1.82%	0.00%	5.68%	5.45%	3.41%	7.95%
Ashdale	4.95%	15	6	39.42%	0.96%	0.00%	161.08	31.76%	15.61%	0.00%	0.00%	9.42%	0.00%	6.73%
Beamshaw	3.56%	11	3	41.36%	1.15%	0.00%	95.72	19.87%	12.91%	0.00%	0.00%	0.00%	1.99%	4.97%
Beechdale	5.25%	8	0	15.74%	0.00%	0.00%	118.27	14.67%	9.67%	0.00%	0.00%	4.17%	0.83%	0.00%
Bronte	6.83%	0	4	10.48%	0.00%	0.00%	-90.22	33.99%	13.60%	0.00%	0.00%	5.90%	8.05%	6.44%
Chippendale	6.90%	2	3	15.79%	0.00%	0.00%	158.93	25.42%	8.91%	0.00%	4.64%	2.97%	2.78%	6.12%
Clark	2.25%	0	4	41.06%	0.00%	0.00%	-20.35	33.43%	13.11%	0.00%	9.78%	6.26%	4.27%	0.00%
Crofton	5.12%	43	13	52.64%	2.09%	0.00%	4.72	32.70%	24.76%	0.00%	4.73%	1.51%	1.70%	0.00%
Elmdale	2.87%	10	3	45.89%	0.00%	0.00%	39.02	27.35%	18.27%	1.35%	0.00%	0.00%	3.50%	4.23%
Enfield Down	7.57%	0	10	5.93%	0.00%	0.00%	56.58	17.16%	7.54%	0.00%	2.62%	0.00%	3.21%	3.79%
Hepworth	11.56%	0	6	14.98%	0.00%	0.00%	187.03	17.91%	10.28%	0.00%	0.00%	0.00%	4.08%	3.55%
Horizon	6.24%	49	3	44.02%	0.00%	0.00%	-29.47	22.52%	6.94%	0.00%	6.28%	4.02%	1.26%	4.02%
Johnson	5.81%	13	5	38.66%	0.00%	0.00%	22.17	42.94%	11.51%	0.00%	6.71%	11.57%	1.37%	11.78%
Lyndhurst	1.70%	2	7	9.69%	0.00%	0.00%	77.65	21.06%	16.50%	0.00%	0.00%	0.00%	0.29%	4.27%
Melton Suite PICU	5.20%	3	0	22.73%	2.67%	0.00%	93.77	23.45%	16.55%	0.00%	0.00%	0.00%	3.45%	3.45%
Neuro Rehab Unit	14.35%	27	2	22.84%	0.00%	1.02%	-260.08	32.87%	17.81%	0.00%	3.24%	6.48%	0.00%	5.34%
Newhaven	4.62%	6	3	43.15%	0.00%	0.00%	164.05	41.81%	12.52%	0.00%	0.00%	15.02%	5.30%	8.96%
Nostell	10.28%	5	0	40.32%	0.00%	0.00%	98.38	33.08%	10.65%	0.71%	7.61%	7.46%	4.36%	2.28%
Poplars	6.33%	75	5	51.42%	0.80%	0.00%	-37.2	21.88%	13.19%	0.00%	0.00%	4.23%	4.45%	0.00%
Priestley	6.00%	0	14	0.00%	0.00%	0.00%	209.95	9.37%	0.00%	1.22%	0.00%	0.00%	3.06%	5.09%
Ryburn	0.00%	0	0	10.34%	0.00%	0.00%	29.15	13.76%	6.88%	0.00%	0.00%	0.00%	4.59%	2.29%
Sandal	6.41%	30	4	48.62%	0.00%	0.00%	190.72	38.19%	10.61%	3.54%	7.07%	0.00%	16.27%	0.71%
Stanley	2.28%	13	7	41.72%	3.29%	0.00%	-73.55	32.51%	18.88%	0.82%	4.11%	6.57%	0.11%	2.03%
Stroke Rehab Unit	32.59%	37	7	1.38%	0.00%	0.00%	50.52	23.38%	15.89%	1.55%	0.00%	5.95%	0.00%	0.00%
Thornhill	1.52%	14	0	24.15%	0.00%	0.00%	243.8	36.36%	19.48%	0.00%	2.08%	3.77%	7.79%	3.25%
Walton PICU	2.90%	28	0	50.47%	2.65%	0.00%	-77.9	31.63%	17.63%	0.00%	4.64%	5.57%	3.21%	0.58%
Ward 18	0.00%	0	4	38.36%	0.00%	0.00%	101.77	23.34%	3.77%	2.01%	3.77%	7.23%	3.56%	3.01%
Ward 19 - Female	14.59%	7	8	0.00%	0.00%	0.00%	116.62	16.55%	2.85%	0.00%	0.00%	4.27%	7.18%	2.25%
Ward 19 - Male	17.50%	4	0	0.00%	0.00%	0.00%	65.75	11.01%	4.78%	0.00%	0.00%	0.00%	1.26%	4.98%
Waterton	2.89%	15	5	36.88%	0.00%	0.00%	343.53	25.72%	8.44%	0.00%	5.14%	0.00%	3.09%	9.05%
Willow Ward	12.04%	16	1	34.81%	0.00%	0.00%	286.6	36.30%	15.47%	0.14%	0.00%	15.97%	0.00%	4.72%

Appendix 17

Draft establishment review timetable

Month	Service Line	Data Collection	Report Due	Lead
March 25	MH WAA &OA Inpatients	March 25	April 25	CH, TM &KB
April 25	Easter -Data collection not recommended			
May 25	Forensic Services (excluding Cheswold Park)	May 25	June 25	TM, CH & JB/ST
June 25	NRU/SRU/Rehab & Horizon	June 25	July 25	Tm, CH & Service Leads TBC
July 25	Cheswold wards	July 25	August 25	TM, CH & ER
August 25	Community teams planning -data collection not recommended -plan for rest of year 25/26			
September 25	MH WAA &OA Inpatients	September 25	October 25	TM, CH & TBC
October 25	Community	October 25	November 25	TM, CH & TBC
November 25	Forensic Services (excl Cheswold Park)	November 25	December 25	TM, CH & TBC
December 25	Planning for 2025/26- Data collection not recommended			
January 26	Community &NRU/SRU/Rehab & Horizon	January 26	February 26	TM, CH & TBC
February 26	Community & Cheswold wards	February 26	March 26	TM, CH & TBC
March 26	Community	March 26	April 26	TM, CH & TBC

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.5

Private/Public paper:	**Public**		
Title:	**Quality Account 2024/25**		
Lead Director:	**Darryl Thompson, Chief Nurse/Director of Quality and Professions**		
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 Board with a final version of the Trust's Quality Account 2024/25. By the date of Trust Board, the plan is that it will have been uploaded onto the Trust's website, and therefore published, by the expected date of 30 June 2025.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	The Quality Account content is aligned with all areas of BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider trust within an Integrated Care System is governed by regulatory bodies, and production of a Quality Account is a formal requirement of each trust. It is important that regulatory activity is monitored, learning is taken from feedback and action is taken to remedy any findings. Quality of care is a key priority for our Integrated Care Boards and the places within which we work. The information provided in the Quality Account supports and describes the delivery of quality care and the improvements made across services over the last 12 months.		

With all of us in mind.

Any background papers / previously considered by:	Trust Board members received and approved the Trust's Quality Account for 2023/24 and previous years. The final draft version of the Quality Account for 2024/25 was shared with the Quality and Safety Committee prior to it being shared with partners as part of the required consultation. Drafts were also shared with the executive management team in March 2025 and with Members Council Quality Group in April 2025. By the time of this Trust Board, the Quality Account will have been reviewed for approval by the Chair and Chief Executive, who have delegated authority from Trust Board.
Executive summary:	Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. The Trust's Quality Account is required to be published for the previous financial year by 30 June. The Quality Account is produced annually and in line with the guidance from NHS England, focuses on the quality of services by looking at: • Patient safety • Clinical effectiveness • Patient experience A description of future areas for improvement and achievements against previous year's quality priorities is included in Part 2 of the Quality Account. Part 3 covers a review of quality performance and also looks back at historic performance to identify any trends. Examples have been included as required in line with the three bullet points above. The final draft of the Trust's Quality Account for 2024/25 was reviewed in detail in the Quality and Safety Committee in May 2025, and in response to timeline challenges, needed to be shared with stakeholders (with minimal changes) prior to the June Committee to ensure the required consultation period. The final draft, including the feedback comments from stakeholders, has been shared with Quality and Safety Committee members outside of the meeting structure for completeness. This feedback from partners is in Appendix 2. Where this feedback has included detail about a Care Group, this has been shared with that Care Group. Other feedback will be used to guide us in the development of next year's Quality Account. Overall, the feedback is very positive from partners, that the report is an accurate reflection of their experience of the Trust. The Quality Account meets the statutory requirements set out by NHS England, provides a view of quality across the Trust for 2024/25 and the plan is that by the time of this Trust Board it will have been published on the Trust website as required by 30 June 2025.
Recommendation:	**Trust Board members are asked to:** **RECEIVE** the Quality Account for 2024/25.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Quality report

2024/25

With **all of us** in mind.

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Part 1:
Chief executive and chair's welcome

Welcome to our 2024/25 quality account. We are delighted to introduce this reflection of our services outlining our performance and priorities for improvement.

In what has been a challenging year for the NHS nationally, where we've seen increased acuity and demand alongside significant financial pressures, we have proudly retained a focus on the quality of our care.

Our aim is to be outstanding. This is all underpinned by our work on #allofusimprove and our golden threads: recovery focused and trauma informed recovery, social responsibility and sustainability, and equality, involvement and addressing inequalities.

#allofusimprove is the Trust's approach to quality improvement across the Trust. We have a dedicated improvement team made up of colleagues with specialist quality improvement skills and knowledge. The #allofusimprove team provides support, advice and guidance to individuals, teams and whole Care Groups wanting to carry out improvements in their work area.

We encourage quality improvement at all levels and all our staff have access to a range of tools. This includes the model for improvement toolkit used to design, test and implement changes for low-level improvements and the six-step quality improvement project toolkit used to manage larger-scale quality improvement projects.

In May, the Trust presented #allofusimprove as a case study to the NHS Providers Quality Improvement Conference. This was a fantastic opportunity to learn, share, and spread the word about the work we are doing as a Trust to other NHS organisations.

Some of these successes include the roll out of electronic prescribing and medication administration (EPMA). EPMA replaces paper medication charts with an electronic medication chart in SystmOne. It has led to some fantastic benefits, especially improvements in patient safety and reducing incidents, service delivery, quality of data and financial benefits for the organisation. EPMA is now live across all our inpatient wards (over 450 beds).

The Trust's Barnsley pulmonary rehabilitation service was also recognised nationally for good practice in supporting people with long-term lung conditions. The team were highlighted as a positive example by the Royal College of Physicians' National Respiratory Audit Programme (NRAP) after 100% of patients were able to start pulmonary rehabilitation within 90 days of their referral.

Our Triangle of Care journey is an important part of our ongoing commitment to including carers at every stage of a person's care. In 2024/25 we reached a milestone in that journey with 100% of our inpatient wards and crisis teams having completed self-assessments, which are a vital way of looking at how each service currently supports carers. It also helps us see how we can support our teams and services to improve the experience of carers and ensure they are an equitable part of service users' care.

Rates per 100,000 smokers showed that all five of our Yorkshire Smokefree services were actively performing well and supporting many smokers to make a quit attempt in 2024/25. The services' figures are the highest in Yorkshire and Humber and are outperforming England figures.

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. One example is our partnership work in Calderdale on health checks for people with a serious mental illness (SMI), which has seen uptake increase from 14% to 71%.

The Trust was asked by NHS England to step in to be the provider of services at Cheswold Park Hospital, a low and medium secure mental health hospital based in Doncaster. Our Trust has significant experience in providing low and medium secure services at scale and is the largest NHS provider of medium secure services across Yorkshire. In October 2024, Cheswold Park Hospital transferred to the Trust and work is underway to transition services fully into the Trust.

Our friends and family test responses also paint a positive picture of quality care. In November 2024, 96% of respondents in the friends and family test rated our physical health services either good or very good; 94% in our mental health services, 93% for child and adolescent mental health services (CAMHS), 100% for learning disability services, 100% for attention deficit hyperactivity disorder (ADHD) and 100% for forensic services.

We have our own internal processes to ensure the quality of our services. Our quality walkarounds focus on open and transparent communication. They enable service users, staff and others to work together to identify areas of good practice and potential improvements.

Our Horizon Centre in Wakefield had a positive and successful Trust quality walk around in 2024. One of the stand-out improvements was the reduction from the previous performance of around 32 seclusion incidents in a month down to zero seclusions. All carers were positive about the care their family member was receiving and the experience of their interactions with the staff on the unit.

We also encourage our teams to complete a quality impact assessment (QIA). A QIA is a continuous process which helps to ensure that changes initiated as a consequence of service delivery or efficiency decisions made by the Trust are fully assessed for their impact on quality and safety. The QIA process is an enabler and a supportive tool which supports change and development. Completing QIAs ensures that any potential consequences on quality are considered, and any necessary mitigating actions are outlined early and in a consistent way.

In 2024/25 we refreshed our Trust strategy – our medium to long term plan that describes what we are going to do in the next five years. This includes how we can improve things for our workforce, services and support families and carers. What is clear is that quality underpins everything we do to ensure safe, supportive and person-centred care.

Statement of assurance

This quality report has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and NHS Improvement, the independent regulator of foundation trusts. The Board of Directors has reviewed the quality report and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.



Chief executive: Mark Brooks



Chair: Marie Burnham

Part 2:
Priorities for improvement and statements of assurance by the Board

Part 2.1 – Priorities for improvement

In Part 2 of our quality report, we outline our planned improvement priorities for 2025/26. We give an overview of our approach to quality improvement and our approach to quality governance.

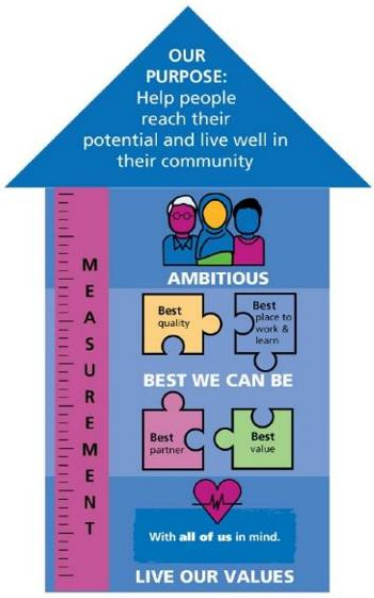
Trust Strategy 2024-2030

In early 2024 we commenced a refresh of our Trust strategy. This involved three strands:

- Comprehensive strategic analysis.
- Trust wide equality impact assessment.
- Extensive engagement with nearly 25% of our workforce, 1,500 members of the community and partners from across the areas we cover.

Our new strategy for 2024-2030 was approved at Trust Board in October 2024. It sets out our plans up to 2030 to deliver our purpose as an organisation.

A summary of the strategy is set out in the infographic below.



Our strategic aims:

1. We will live our values
2. We will be the best we can be
3. We will be ambitious

Our purpose was developed through previous extensive co-creation. It is to:

Help people reach their potential and live well in their community

Our purpose has not changed. Our extensive, inclusive #allofus engagement has confirmed that this statement is recognised widely and fully embraced by all, and it is therefore restated as part of this refreshed strategy as our collective purpose.

Our strategy describes our role within our neighbourhoods, communities and places. It sets out how we will work and what we will achieve together. As our overall Trust strategy, it informs all of our other strategies and plans and provides a way for us to be clear about our focus and direction.

Our strategic aims allow us to consider particular areas so that we can collectively focus our efforts to make the most difference.

From our analysis and extensive engagement, we have identified three strategic aims:

- **Strategic aim one: We will live our values**
- **Strategic aim two: We will be the best we can be**
- **Strategic aim three: We will be ambitious**

For each strategic aim, using the evidence from our engagement and analysis, we have

- Set out our strategic objectives and what this means we will do
- Set out what we will see if we are getting it right
- Identified how we will measure progress

This work means that we have a strong line of sight from our strategy through to what we do, and the measures which will enable us to be very clear whether we are achieving what we have set out to do.

Strategic aim two: We will be the best we can be
Our strategic aim two is to be the best we can possibly be. We will do this every day and for every contact we have with those we serve and those colleagues we work with. For this strategic aim we have identified **four best statements** which we have used to theme our strategic objectives.



Best quality
To provide the best quality we can we have identified four strategic objectives. These are set out below, and within the strategy there are statements about how we will know if we are getting it right and examples of the measures and metrics we will use:

- We will ensure equitable access, experience and outcomes for all.
- We will ensure our services are consistently safe, responsive, personalised and effective.
- We will ensure continuous inclusive improvement is integral to developing and delivering creative and innovative services.
- We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation.

Strategic improvement programmes

We have developed our strategic improvement priorities for 2025/26 by using our annual planning processes and aligning priorities to the Trust strategy. Once we had a long list of the areas for improvement we paused and considered the changing context and where this means we should add particular focus. At this point we concluded

- We have a clear, coherent strategic direction that we have tested to make sure it is current
- We have a clear understanding of our external environment (our PESTLE analysis)
- We have a clear understanding of our internal capabilities (our SWOT)

Given that the world is changing around us, we still know where we are wanting to go but we need to think about the focus and pace of the different elements in our strategy and make choices about where we put our effort first and what might wait

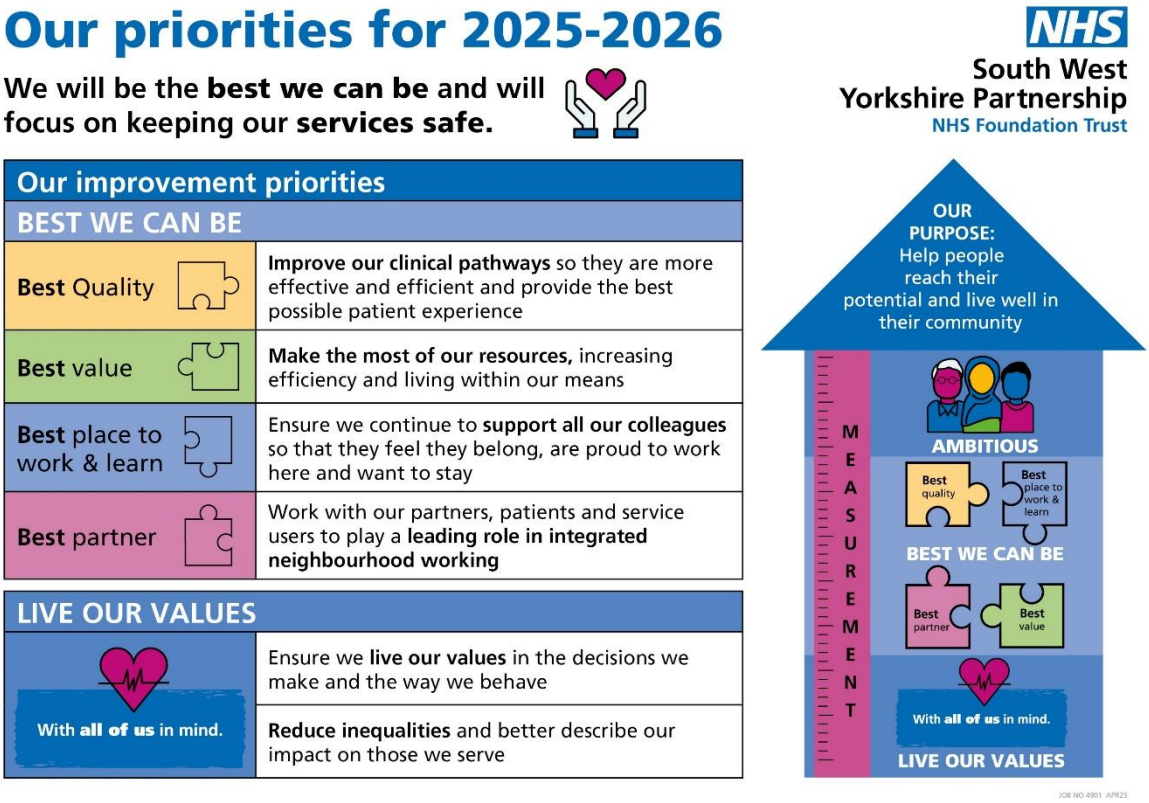
Consequently, we identified the following areas of focus:

- We must always focus on safety – this is part of how we operate and deliver every day. It is a given.
- For the next 12 months we must focus our improvement energy and resources on making the most of our resources and deliver this at pace with all of us working collectively to achieve this. For this we need to consider:
    - What will make the biggest impact on our use of resources?
    - What are we working on that does not have a financial impact? Can we risk assess what will happen if we do not focus on these now? Will they wait?

In line with our strategy, we need to make sure that our focus on making the most of our resources is done in a way which ensures we are:

- Living our values,
- Supporting our colleagues in challenging times
- Keeping a strong focus on addressing inequalities and delivering high quality, safe services.

Our strategic improvement programmes for 2025/26 are therefore set out in the infographic below. These are our priority areas of work where we will focus our resources to make sure we make the improvement we set out to do. Further to the high level of engagement of our service users, carers, colleagues and members of our population, these are also our Quality Priorities for 2025/26.



There are specific areas of quality improvement work that sit underneath these strategic improvement priorities that focus on particular areas of concern, based on the data currently available to us. Best Quality will include examples such as:

- Responding to clinical demand, capacity, resources, patient flow
- Reducing length of stay in inpatient areas
- Productivity
- Undertaking evidence-based establishment reviews
- continuing the focus on reducing restrictive practice
- improving clinical record keeping
- ensuring we continue to do all we can to provide mental health inpatient care close to a person's home

Quality priorities 2024/25

The quality priorities are seen as those which will have the greatest and most direct impact on improving the quality of care for service users and describe areas of focus for our clinical services. Quality improvement programmes within each priority are defined at a Care Group level to ensure that meaningful and place-based programmes are developed and led by colleagues working across our services. We explore these areas with teams across the organisation to help staff identify specific areas of good practice to share and areas for improvement to address using quality improvement approaches.

The quality priorities for the 2024/25 quality account remained consistent with the previous quality account and these were as follows:

- Safe and responsive care
- Equality, inclusion and equity
- Health, wellbeing and experience of staff

Looking ahead to 2025/26 our quality priorities focus are as outlined above.

Bolstering safer staffing in community adult and older adult community mental health teams

The community mental health establishment review has begun. These have focused on a range of things including:

- Caseload management - demand and capacity, including effective contact management and caseload allocation and tools to ensure balanced workloads.
- Digital enablers of productivity (including digital dictation, electronic communication (rather than postage), effective roster of community visits to minimise travel), use of Artificial Intelligence, automation to streamline processes and improve patient access.
- Effective pathways to maximise use of resource – e.g. MDT/ team meeting approaches, lead health care practitioner role in Core, group work versus individual clinics, etc

Pre-requisites / core enablers of this workstream include:

- Improving data management.
- exploring how well our interfaces work, aiming to identify any issues, what they are and work out what we need to do to understand the opportunities more fully so that we can define and scope activity.

Areas of focus:

- Inter-team pathways
- Single point of access (SPA) and primary care network interface and optimisation, including VCSE offer and how we work with other partners,
- Integrated Neighbourhood development
- Local authority integration
- Specialist pathways

Summary of our progress against the 2024/25 quality priorities

Below are a number of examples which demonstrate our improvement across the Trust, and which align to our quality priorities.

Additional improvement and innovative work which aligns to the quality domains (patient safety, clinical effectiveness and patient experience) can be found in Part 3 of this report.

Safe and responsive care: to deliver quality improvements to support clinical safety and reduce risk; to empower, support and enable people to make safe choices; and provide a positive experience which is personalised and shaped by what matters to people.

Learning disability services improvements
What we prioritised

- Reducing the longest waits in community services to under 18 weeks and preventing further breaches for service users waiting over 18 weeks.
- To continue to support GPs with annual health checks (AHCs) for people with a learning disability as well as working with them to improve the quality of AHCs and health action plans (HAP).
- To embed new locality trio and senior clinician model in community teams.
- To continue to progress the Horizon Centre assessment and treatment unit (ATU) improvement action plan.
- To commence delivery of the community improvement plan.
- To establish greenlight toolkit principles across the Trust (an audit to check how well mental health services support people with a learning disability and/or autism, which then helps to improve those services).
- To improve Stopping over medication of people with a learning disability and autistic people (STOMP) approach in each community locality.
- To ensure learning from deaths reviews of people with a learning disability and autistic people (LeDeR) outcomes are shared and understood.
- To embed the out of hours pathway for people with a learning disability.

What we did

The Trust delivers community services to people with a learning disability in four different geographical areas and runs a specialist in-patient assessment and treatment unit called the Horizon Centre. Each community service has a multidisciplinary model for routine care, and intensive support and psychiatry, which offers an immediate response to people who are experiencing a crisis. The service also operates an out-of-hours provision which ensures people in crisis have access to specialist learning disability advice and support.

The evidence tells us that people with a learning disability were significantly and adversely impacted during the COVID-19 pandemic. Dynamic support registers are used for people assessed as being at high risk and welfare calls were implemented whilst people were waiting to be seen. This has allowed teams to assess and respond to need, fast-tracking people for support where required. Post pandemic, the service has retained and improved waiting lists to reduce the length of wait overall.

During 2024/25, all four community teams have consistently strengthened the service offer by:

- Actively promoting the friends and family test within learning disability services, to increase the amount of service user/carer feedback received and using this to guide improvements.
- Significantly reducing longest waits to under 18 weeks. Whilst some discipline specific challenges remain, this has progressed well and the performance for preventing further 18-week breaches is now exceeding the 90% target.
- Implemented a new waiting well/waiting fairly approach to support improvements in waiting lists and enhance the previous welfare contact process for when people are waiting.
- Embedding the out of hours service, which went live in November 2023. In the out of hours service colleagues predominantly work alongside intensive home-based treatment teams to provide advice and support on reasonable adjustments. This team supports anyone with a learning disability and or autism regardless of the level of learning disability.
- Continuing to support GPs to complete AHCs for people with a learning disability as well as improve the quality of check.

- Operating a greenlight champion group which has in excess of 50 champions across Trust services. This group meets bi-monthly where the learning disability service delivers awareness raising training in a number of areas including environment, sensory needs, communication, learning disability clinical tools etc. Each champion has access to a learning disability specialist should they need any specific support and advice.
- Embedding a new clinical support layer of leadership which makes up the locality trio of clinical leadership, quality and governance support and operational delivery. This will strengthen clinical leadership and case decision making locally as well as improved support and communication in locality community teams.
- Embedding a range of champions across each service including wellbeing, Triangle of Care, and staff network groups. These champions meet regularly to share information back to the rest of the team and support improvements specific to their role where needed.
- Establishing a reducing health inequalities group. This group shares learning and raises awareness on a range of activities including LeDeR, AHCs, supporting people with reasonable adjustments.
- Progressing 'activity in the community' improvement programme including review of duty processes, improved activity for LeDeR (learning from lives and deaths – people with a learning disability and autistic people), improving clinical pathways and reducing health inequalities.
- Reviewing and improving a referral form for access to the service. This will ensure the right information is received in order to deliver more timely response.
- Embedding locality trio and senior clinicians' models to improve clinical escalation in locality teams. This has now been reviewed and has improved communication and support within teams.
- Establishing a weekly safety huddle chaired by the learning disability trio, where clinicians can bring discussions about service users who are heading into crisis to ensure more timely and proactive advice and support is accessible. This huddle is also attended by the ATU and out of hours service so that everyone is aware of service users struggling in the community and available to support where needed.
- STOMP pathway strengthened and implemented across all four community teams.

During 2024/25, the Horizon Centre has strengthened the service offer by:

- Successfully progressing actions set out in the Horizon improvement programme and embedded into business as usual.
- Embedding multi-disciplinary leadership team.
- Improving substantive recruitment with all posts now recruited to.
- Improving staff communication with regular team newsletters, team meetings, improved performance with supervision and appraisals and daily safety huddles.
- Introducing and embedding a range of champions (as above).
- Disseminating priority training, including the Oliver McGowan mandatory training on learning disability and autism, positive behaviour support (PBS) for people with behaviours that challenge, respiratory conditions, autism awareness and trauma informed care.
- Significantly improving clinical documentation.
- Ensuring all service users have meaningful engagement and activity plans in place.
- Improving learning from incidents via safety huddles, management oversight, handovers and de-briefs.
- Improving discharge pathways.

What next?

- We will complete the community improvement plan monitored through the Care Group clinical governance group.
- We will sustain improvements on the Horizon ward and continue to improve.
- Our priorities for 2025/26 include:
    - Continuing to improve waiting lists so that all waits remain under 18 weeks.
    - Focusing on resolving speech and language therapy (SLT) recruitment challenges.
    - Continuing to improve Trust understanding and approach of the greenlight toolkit principles.
    - Continuing to support the completion of annual health checks.
    - Increasing support and advice for duty officers to ensure consistency of delivery at access point.
    - Embedding improved clinical pathways including behaviour, transition, dementia pathways.
    - Continuing to proactively support people who are heading into crisis.
    - Reducing the length of time for people ready for discharge in the ATU to being discharged back into the community.
    - Reviewing establishment, delivery and finance on the ATU to ensure further efficiencies are made and the unit is financially viable.

Urgent Community Response – out of hours integration with Barnsley Metropolitan Borough Council night service

What we prioritised

- Developing an integrated crisis/urgent intervention team for out of hours support, including key urgent response teams including IHeart 365, urgent community response (UCR), assisted living team and night service.
- Co-location and a single integrated point of access and contact for referrers, service users/families/carers and those with alarming, assisted living devices.
- Reviewing pathways and access criteria.
- Utilisation of pathways and teams to prevent escalation or place of safety placements, if safe and applicable to do so.

What we did

- Relocated UCR to work alongside IHeart 365 (Barnsley Healthcare Federation BHF), the GP out of hours service at the BHF Priory Centre.
- Worked alongside Barnsley council reablement colleagues to pilot relocation of the night service support workers out of hours; whilst still allowing them to prioritise their fast-track referrals which they are funded to deliver.
- Developed pathways for the Trust's neighbourhood teams to refer into the night service support worker provision in the event this would support a patient in terms of:
    - personal cares and welfare checks.
    - visits that would reduce the risk of admission to hospital/care home, e.g. turning for pressure care/pushing fluid intake/safety check.
    - saving a UCR nurse visit for tasks that do not require a nurse, which they have been undertaking during the out of hours period, such as personal cares/safety check
    - bridging a gap whilst other services are mobilised e.g. supportive care at home whilst continuing healthcare (CHC) fast track being processed.

    - ensuring pathways are in place for the night service staff to escalate concerns to a trained UCR staff member.
- Assisted living team (ALT) training delivered to UCR staff in terms of device installation and referral for assisted living devices to prevent escalation.
- Review of pathways with the assisted living team in the event they need to escalate patients to UCR.

A feedback session was held during March 25 and during this session evaluation data was shared, patient case studies were discussed and outcomes shared. Any change that needed to be made were discussed and agreed. Feedback on the pilot is largely positive.

What next?

- The initial evaluation data at the three month point of the pilot outlines the benefits to joint working in terms of patient and system outcomes. We are continuing to collect this and undertake a further review and recommendation based on the six-month data point, e.g. to extend the pilot further or recommend it becomes business as usual.
- Point of care blood testing devices are now in place and have been utilised across crisis pathways in and out of hours. The UCR clinical lead is linking with BHF/iHeart 365 to explain the offer and ensure there are pathways in place to refer into UCR for this provision, which will help inform clinical decision making.
- Point of care blood testing devices were received in February 2025 to further expand the urgent point of care testing (POCT) within UCR teams in and out of hours which again could be requested out of hours via iHeart 365 to support escalating patients who need rapid bloods reporting.

Kirklees 0-18 Children and Young People Primary Care Network service

What we prioritised

- Early intervention for children and young people (CYP), supporting General Practitioners (GPs) in their management.
- Working in surgeries across all Kirklees Primary Care Network's (PCN).
- Clinical lead is a qualified advanced clinical practitioner and is supported by Band 7 and Band 6 registrants.
- Service provides assessment and can provide short-term low-level interventions.
- The service can signpost to alternative support providers and directly in Kirklees child and adolescent mental health service (CAMHS), including the crisis team.
- This initiative is to support admission avoidance programmes.
- Alongside social prescribing and mental health support teams (MHST) they will provide a combination of early intervention, with the plan to reduce referrals to CAMHS.

What we did

- Worked with commissioners to identify workforce requirements.
- Worked with PCNs and commissioners in identifying initial 'pilot' PCNs to roll out the service and this has now spread to all PCNs within the Kirklees borough.
- Worked with GP practices to utilise existing technology to book appointments via GP integrated systems.

- Reviewed initial feedback from 'pilot' PCNs and further developed the service to improve efficiency and ensure wider coverage.
- Met regularly with commissioner and the Trust's contracting teams to ensure that the service specification was fit for practice.

What next?

- Continue to monitor feedback to support service improvement and development.
- Identify and support further development of the current workforce to ensure they are equipped to meet clinical need within the service.
- Review management structure with a plan to support with a team manager, whose duties are currently being managed by the clinical lead.
- Use the Kirklees model to influence the development of 0-18 CYP PCN services in other areas.

Electronic prescribing and medicines administration (EPMA)

What we prioritised

- Digitalising medicines prescribing and administration.

What we did

Multidisciplinary and multi-professional project teams were established involving clinical, and information management and technology (IM&T) colleagues who have worked together on the design and preparation for implementation of electronic prescribing and medicines administration in different services and settings.

EPMA was implemented on the neurological and stroke rehabilitation physical health inpatient wards in June 2024, bringing with it the benefits already realised within mental health inpatient settings.

Services that access the Integrated Neighbourhood Teams (INTs) SystmOne unit went live with e-prescribing in early December 2024. This means that V300 and V150 (training qualifications) prescribers are able to electronically raise prescriptions that can be automatically sent to the patient's community pharmacy of choice for them to collect.

This included the following services:

- Breathe respiratory service
- Community matron service
- Heart failure service
- Neighbourhood nursing
- Neighbourhood rehabilitation
- Palliative care
- Parkinson's team
- Podiatry
- Tissue viability
- Urgent community response

EPMA is being piloted within Kirklees intensive home-based treatment team (IHBTT) from March to April 2025, using the inpatient medication chart functionality in this setting, before further training and rollout is commenced in other IHBTTs.

A broad range of benefits have been identified from the use of electronic prescribing in different settings, which are linked to the Trust's values, strategic objectives and priorities. These include:

- Legible and complete prescriptions.
- Improved medicine administration (timely and appropriate).
- Reduced medication incidents reported.
- Providing a single and comprehensive view of a service user's current and historical medication.
- Ability to view a service user's medication wherever a clinician or service user may be located.
- Enhanced patient experience with the electronic transmission of prescriptions improving access and convenience for service users.
- Reducing the risk of lost and stolen prescription pads.

What next?

Mental health
Within inpatient settings continued optimisation of EPMA functionality for inpatient wards and the development of reporting to support patient safety improvements.

Further implementation into other locality intensive home-based treatment teams and 136 suites within Barnsley, Calderdale and Wakefield and Cheswold Park forensic inpatients.

Community physical and mental health teams
Continued scoping, prioritisation and implementation planning for all remaining community teams that are in scope for the implementation of electronic prescribing once secondary care hospital prescribing functionality is available.

Personalised Care and Support Planning for adults and older adults' community mental health services (Moving on from the Care Programme Approach)

What we prioritised

- Development of practice guidance in relation to new roles and new model of care planning.
- Engaged with teams to co-produce practice guidance.
- Amalgamated workstreams to the wider transformation e.g. Triangle of Care, community mental health transformation, care planning quality group, to streamline the need for meetings, and in encouraging collaboration and reducing duplication.
- Maintained involvement with regional and national forums supported by NHSE to share learning and common challenges.

What we did
Working in alignment with five key NHS England principles:

i) ***"A shift from generic care co-ordination to meaningful intervention-based care*** *and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care.*

ii) ***A named key worker for all service users with a clearer multidisciplinary team (MDT) approach*** *to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.*

iii) ***High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community****: a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (e.g. Section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.*

iv) ***Better support for and involvement of carers*** *as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.*

v) ***A much more accessible, responsive and flexible system*** *in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time".*

Principle 1. This has been incorporated alongside discussions within Principle 2, focusing on key worker/MDT approach.

Principle 2. A set of draft principles that details key worker/multidisciplinary team approach has been consulted with at team level and agreed. Progress has been paused due to awaiting community care standards following intensive and assertive community mental health guidance, which impacts responsibilities of key worker/MDT.

Principle 3. Patient reported outcome measures (PROMs) guidance document developed. Dialog domain is now embedded into care plans on SystmOne, and digital interface for service users is being developed. Training for the new care plan is ongoing.

Principle 4. This work is encompassed within the Triangle of Care Group. The Trust has achieved Triangle of Care Star 1 after having held an external peer review of the work undertaken to date, including assessing all inpatient and crisis teams and demonstrating commitment to delivering the six triage of care standards. The model is being rolled out in inpatient units and community teams.

Principle 5. This work has been undertaken by the community mental health transformation priority programme in aligning all aspects of these principles within the review of care pathways and touch points within the Trust.

What next?

Principles 1 and 2:

- Develop policy group to update policy for CAMHS and Forensics.
- Create new policy for adult and older people mental health and to incorporate practice guidance documents (personalised care and support, key worker & MDT/care planning and risk assessment guidance).
- Review current guidance based on incoming new community care standards.

Principle 3.

- Further values-based training is to be developed to focus on personalisation and co-production.

Principle 4.

- Continued work through the triangle of care group.

Principle 5.

- Continued work within the Community mental health services priority programme improvement group (CMHSPPIG).
- Re-invigorate previous keyworker and MDT workstream when external guidance is received, and it is anticipated this in turn will then become a workstream focused on policy and training in the future.
- Involvement with the national and regional forums will also continue.

Quality assurance system

What we prioritised

The quality assurance system (QAS) has been designed to provide the Trust with a robust system for monitoring and assuring the quality of services and to support early identification of increasing or persistent risks, allowing actions to be put into place to prevent further deterioration.

Through the routine monitoring of the quality of care, any increasing risk to quality will be able to be identified early. A service, where quality concerns have been identified, can be stepped up to enhanced monitoring and supported to take steps to improve. A further level, intensive monitoring, is available should adequate assurance not be received at the enhanced monitoring level. This system aims to minimise the risk of surprises from regulators and commissioner inspections and will support the Trust on its journey to being an outstanding provider of healthcare.

A number of tools have been developed to support the quality assurance system.

What we did

- The Quality Assurance System (QAS) is a framework that provides oversight of quality and culture across Trust services. This system will utilise the six-step process for improvement.
- The ambition for the QAS is to work in clear partnership with front line clinical services, to support best practice, share excellence, and bring clear awareness up to Board level of teams where additional support is needed. This awareness will be directly informed by triangulated data, generated from a range of digital sources, alongside qualitative feedback and experience metrics.

Principles of the QAS

- Facilitated by the nursing, quality and professions directorate, however, a key principle of the system is a collaborative working approach with clinical and operational teams, senior leaders and other identified stakeholders, including the integrated change team, people directorate, and other support services (infection prevention and control (IPC) team / reducing restrictive physical interventions (RRPI) team / safeguarding team).
- Enables early identification of where additional resources are required to support a service where improvements are needed using a quality improvement methodology.
- Allows for assurance to be provided to the ward/service through to Trust Board and to other parties, such as the Care Quality Commission (CQC) and commissioners in an open and transparent way (as required).
- Utilises available data in real time, which provides a view of quality of care. This will be both quantitative (numerical) and qualitative (textual) data and identify good practice, exceptional areas and where improvements have been made and sustained.
- Provides a clear rationale for when services will move from routine monitoring, to enhanced and, in exceptional circumstances, onto intensive monitoring.
- Supports governance oversight and reporting on services which are on enhanced and intensive monitoring.

The QAS consists of three distinct levels:

Level 1: Routine monitoring

This is the default position for all services across the Trust. Monitoring of the quality of care through the quality metrics is the responsibility of the Care Group and Operational Management Group (OMG) and support services as per the current oversight processes.

Level 2: Enhanced monitoring

A service will be stepped up to enhanced monitoring where there are increasing or persistent concerns about the quality of care, identified through the quality concerns trigger tool (see below). A number of actions will be taken at this stage, including a rapid quality review meeting, deep dive, enhanced quality walkaround and action plan development, including identification of additional support required. Teams will return to routine monitoring after an agreed time period when improvements are able to be demonstrated.

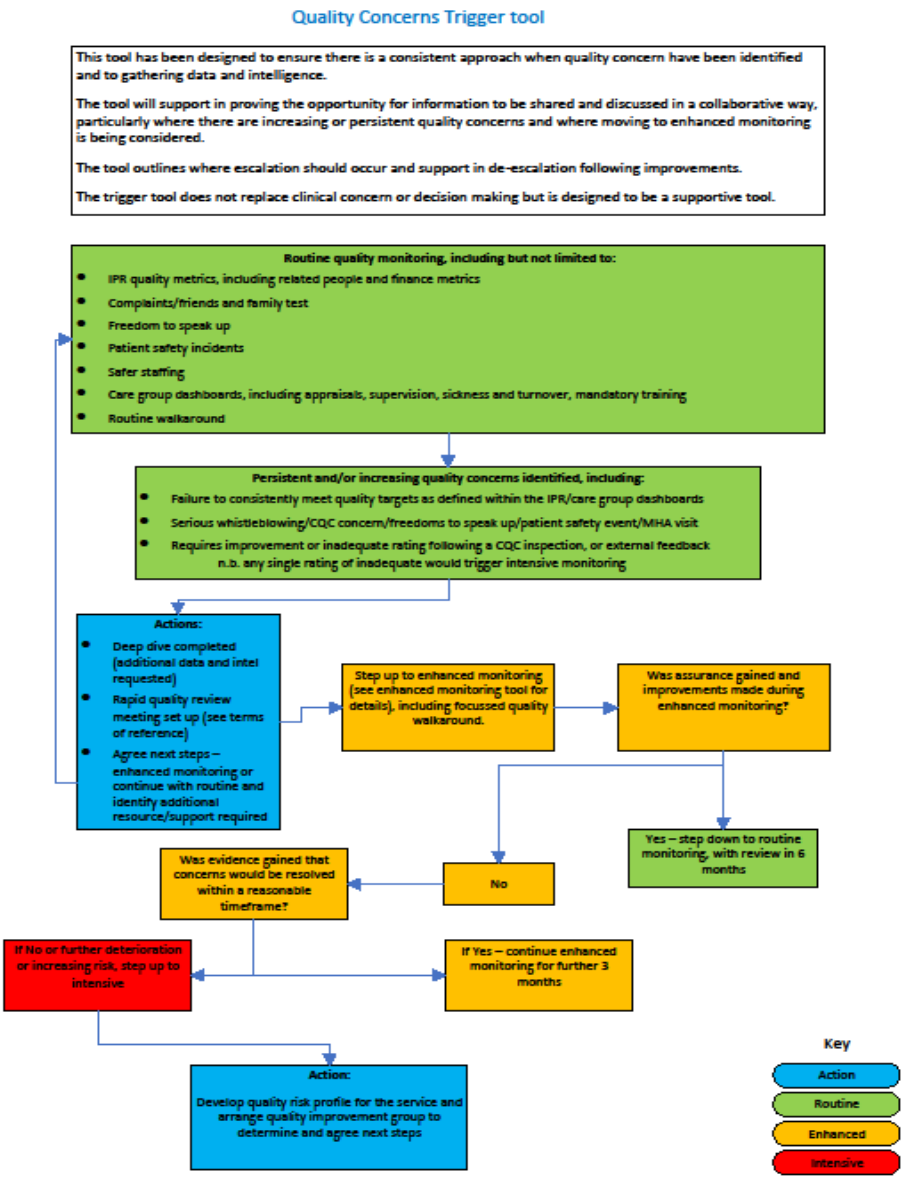
Level 3: Intensive monitoring

Where a service fails to show adequate improvement and provide assurance after 3-6 months on enhanced monitoring they may be stepped up to intensive monitoring. It is likely this will be in exceptional circumstances only. A number of actions will be taken at this stage, including setting up a quality improvement group, an intensive quality walkaround and completion of a quality risk profile (see below).

Quality concerns trigger tool

This tool has been designed to ensure there is a consistent approach when quality concerns have been identified and to gather data and intelligence.

The tool will support in providing the opportunity for information to be shared and discussed in a collaborative way, particularly where there are increasing or persistent quality concerns and where moving to enhanced monitoring is being considered. The tool outlines where escalation should occur and support in de-escalation following improvements.



Quality Risk Profile

A quality risk profile (QRP) is a tool that brings together a range of information to understand the quality of a service and to capture, in a systematic way, the current and known risks to quality of care at a point in time.

The QRP combines both quantitative and qualitative information. Each type of service (e.g. mental health inpatients) has their own set of metrics depending on the service provided, however there will be a number of core metrics that are applicable to every service.

The completion of a QRP will be triggered when a service on enhance monitoring does not show signs of improvement or quality deteriorates after a defined period of time.

The QRP uses common principles of risk:

Current risk score = consequence score x likelihood score
Consequence score – represents the potential consequences or severity of a risk event if it were to occur.

Likelihood score – reflection of how likely it is that the consequence described will occur with controls in place.

Once the individual quality risk scores are agreed, an overall quality risk score will be calculated. This will be the basis for targeted support and assurance.

What next?

- Launch the developmental quality assurance system toolkit across the Trust following February/March Trust Board approval- April 2025.
- Develop implementation group with key operational teams.
- Automate and test the toolkit with close involvement from the integrated change team.
- Review how we celebrate success.
- Share learning and improve.

Finalise and publish the toolkit - March 2026.

Clinical record keeping

What we prioritised
To improve record keeping, specifically clinical risk assessment and care planning.

What we did
Following the work started as part of the 2022 priority programme refresh which involved a focus on improving co-production of care plans and risk assessments, the current Trust strategy objectives state we will ensure services are safe, responsive, personalised and effective, involving service users in care planning.

Phase One – now complete, involved the development of a structured quality improvement methodology. The care planning and risk assessment improvement group was established and a series of workshops held to fully understand the problem and collectively identify what was needed to promote co-produced care planning and risk assessment and improved record keeping overall.

Phase Two – the quality improvement methodology was applied to an improvement programme on co-production of care plans and risk assessments, and improved clinical record keeping was facilitated, including the development of new appropriate metrics. Driver diagrams demonstrated the areas where changes were required and allowed the group to focus on identifying and developing solutions.

Phase three - the early change ideas, including the development of the new care plan on SystmOne, best practice in care planning guidance and the updated guidance on clinical record keeping have been implemented and are demonstrating positive impact. We are now in a position to implement the remaining changes identified and ensure these are adopted Trust-wide. When these have been developed in draft form, further check and challenge sessions will be held in each Care Group and place, as well as with service users and carers, to ensure it meets the ask and needs of all.

Data and improvements

Improve Care					
Metrics	Threshold	Dec-24	Jan-25	Feb-25	Variation/ Assurance
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory for Community - Jul/Aug 80% Sept 82.5% Oct 85% Nov 87.5% Dec 90% Jan 92.5%	94.9%	87.3%	*92.3%*	
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		74.2%	67.1%	*76.3%*	
% Service users on care programme approach with a plan of care developed collaboratively	85%	99.7%	99.7%	99.7%	

The above data demonstrates that a very high proportion of care plans are developed collaboratively which is excellent progress and is above the threashold of 95%. There is still work to do on ensuring the target for the risk assessment and safety plan (staying safe/staying well plans) are completed in a timely manner.

What next?

- The care planning and risk assessment improvement group will continue to meet regularly to progress, sense check and contribute to the implementation of the agreed improvements.
- Promote the continued improvement in care plan performance.
- Care planning training is in development and the agreement from the group was to record the training as a video that is accessible to staff on the learning platform. Representatives from Care Groups have been asked to contribute case studies to make the video applicable to all fields of care provision.
- To understand and continue to address the performance with regards to clinical risk assessments.
- Refresh the clinical risk assessment policy in line with national developments and changes to the personalised care and support and community mental health care agenda.
- Improve quality of clinical record keeping (ongoing), offering clinical record keeping training to staff (commenced in Autumn 2024).
- Improve quality of clinical record keeping, care planning and risk assessments, using clinical audit to benchmark and review and inform training development.
- Development of a Trust-wide audit on clinical record keeping to use across the organisation and with all teams annually.
- Develop confidence and competency frameworks: to be used for new staff, preceptees and those where competency requires assurance.
- Monitor the impact of changes and outcomes through the Trust suicide prevention group and clinical governance group.
- Share best practice from areas of higher performance, showcasing to encourage wider learning and improvement.

Equality, inclusion and equity: to deliver high-quality care which is accessible to everyone, and which achieves high quality outcomes; deliver care which is designed to improve the health and wellbeing of the population we serve. Also, to deliver care which is inclusive and addresses inequalities and provides a positive experience which is personalised and shaped by what matters to people.

Culture of Care

What we prioritised

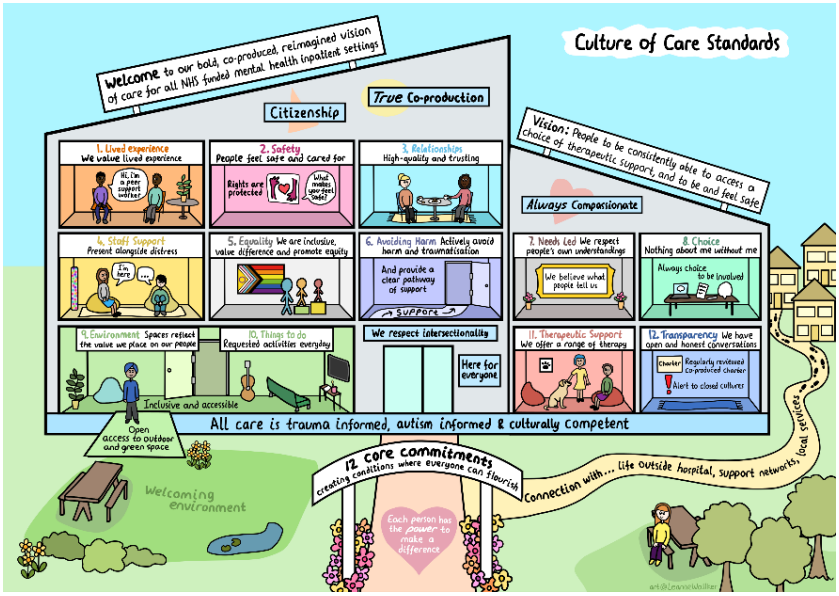
Working with NHS England and other organisations on a quality improvement project regarding Culture of Care (CoC).
To develop a clear governance structure to manage the different components of the programme, specifically:

- Quality improvement: a culture of care
- Ward manager development
- Staff care and development

What we did

In 2023, NHS England convened a group with strong representation from the sector, lived experience leadership and involvement and people who experience inequality in accessing and using mental health services, to develop a set of Culture of Care standards.

These standards form the basis of the programme and underpin all of our design and delivery.



Aligned throughout the CoC programme standards are the following guiding principles:

Guiding principles

Our approaches — Anti racism, trauma-informed, autism-informed

Lived experience
Leadership, mentoring, coaching, support and challenge

We are currently working with NHS England and other organisations on a quality improvement project regarding Culture of Care. This includes:

1. Quality improvement (QI)
    a. **Ward level QI coaching**. This is a pilot over the next two years on four of our wards – Melton, Beamshaw, Sandal and Enfield Down. A benchmarking tool has been completed

with each ward, and this benchmarks how the ward and the organisation currently align with the 76 standards across the CoC programme. The outcomes are supporting the development of QI projects across the wards. Each ward has a project team with key colleagues and designated lived experience support aligned with the teams.

b. **Organisational QI coaching** – this is still in development with the national programme team and will commence in June 2025
c. **Direct coaching and mentoring with executive teams**. Across England 103 executives will be coached by leadership coaches from the national programme. Each organisation has been allocated a coach who brings lived experience and a coach who brings board-level leadership and improvement experience. Coaching will be focused on supporting wards to improve their culture.
d. **Support for organisations to move away from risk stratification and provide a more personalised approach to safety**. This stage is still in development awaiting feedback from four pilot sites within the National Culture of Care Program.
e. Network meetings. We are part of network 4 with other Trusts – Leeds and York partnership NHS Trust, Tees Esk and Wear Valleys, Bradford District Care Trust and Humber and the Priory and hold joint sessions with network 7.

2. **Ward manager development**
   Nominated ward managers are undertaking the Foundation of Nursing Studies (FoNS). The programme will support individuals to develop knowledge, skills and confidence in leading and facilitating person-centred culture of care, engaging with people with lived experience and inspiring teams.
3. **Staff care and development**
   The Public Service Consultants (The PSC) and Virginia Mason Institute (VMI) - alongside InHealth Associates, ImROC (Implementing Recovery through Organisational Change) and the Institute of Group Analysis (IGA) - will offer a co-produced support package for ward staff to develop team cultures and systems so that people on the ward feel safe and cared for.
   PSC will focus on high quality relational care, positive informal interactions on the ward, and psychologically safe environment. We are currently supporting staff to engage with the different training provided.

An example of quality improvement work - Developing an autism informed approach

Through the benchmarking with the NHS England toolkit across the pilot wards, it was clear that we have interventions in place to address our approach to becoming a trauma-informed organisation and our approach to put anti-racism at the heart of the organisation.

Our vision for adopting an autism informed approach required more focus and it was agreed to co-produce an away day for ward staff and other key stakeholders with six central workstreams of focus:

- Staff/service user feedback
- Service user experience
- Positive behaviour plan approaches
- Promotional materials
- Training
- Environmental auditing

The away day was very positive and understanding and confidence of participants increased during the day. Outcomes included:

- Challenge as no sensory or quiet areas on wards

- Development of awareness boards
- Could we build some internal resources to support staff?
- Face to face sessions with people with lived experience valuable
- Build into staff supervision
- Produce a 'working with autistic people' resource

The outcome from the away day will support the CoC work on developing an autism informed approach.

Next steps

1. Continue the QI work in collaboration with National Collaborating Centre for Mental Health (NCCMH):
    a. This is minimum monthly catch ups with NCCMH representative.
    b. Test the ward specific change ideas currently in place and adapt and adopt as appropriate.
    c. Take forward the organisational change ideas, including:
        i. Review with the estates team the identified doors within the ward environment that cause sensory distress to service users through the closure system
        ii. Review the approach to observation times with patient safety, focusing initially on the rehabilitation ward (Enfield Down)
        iii. Review the blanket restrictions approach within the Trust with the patient safety team
        iv. Develop the Autism informed approach ideas, such as the promotional materials
        v. Continue to develop the Trauma informed approach in line with the Trust's approach through the inpatient programme
        vi. Continue to align work with the Anti-racist approach in line with the Trust's patient and carer race equality framework (PCREF) actions
2. Continue to learn from the Ward Manager Development program and feed back good learning experiences into the Trust Ward Leadership program
3. Align the lived experience approach within the inpatient wards with that of the Trust volunteering services:
    a. Development of the lived experience community of practice.
4. Continue the governance framework for sharing change ideas and escalating issues.
5. Continue to work with the national networks on sharing good practice.

Equality, Inclusion and Involvement

What we prioritised

To deliver the objectives within the equality, involvement, communication and membership strategy in 2024/25.

What we did

The Trust has an 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. The strategy identifies the processes already in place to support equality and inclusion and the

breadth of insight and intelligence that already exists. The Trust's 2020-2024 equality, involvement, communication and membership strategy can be found here: equality and involvement - South West Yorkshire Partnership NHS Foundation Trust. The strategy has undergone a refresh, with new title of Equality, Diversity and Inclusion strategy. The updated version has very recently been agreed at Trust Board in April 2025 and a published version is being worked on.

Using the principle of involvement to underpin everything we do; we continue to drive the equality and inclusion agenda. The Trust strategy sets out the core components that enable us to deliver a clear and comprehensive approach to meaningful involvement and inclusion, underpinned by communication and supported and driven by our members.

Embedded in these principles and a golden thread throughout is our continuing duty to ensure that the Trust demonstrate due regard to the Equality Act 2010, Public Sector Equality Duty (PSED).

The Trusts executive management team, and the equality, inclusion and involvement committee (EIIC) of the Trust Board oversee the implementation of the strategy so it can improve access, experience, and outcomes for people from all backgrounds and communities. In addition, the committee has delegated responsibility for signing off annual action plans, acting on behalf of the Board to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

Summary of our progress

The Trust develops an equality, diversity and inclusion annual report which sets out our progress. The full report can be found here equality and involvement - South West Yorkshire Partnership NHS Foundation Trust. Below is a summary of our progress, highlighting key areas in this report.

To support the collection of insight and data we have:

- Updated a Trust wide mental health equality impact assessment (EIA) and toolkit.
- Developed a Trust wide EIA to support a shared understanding on each protected group.
- Maintained a resources library for equality publications and data and shared with care groups and teams.
- Progressed the ‘All of You’ campaign which continues to maintain data recording for ethnicity over 95% and increasing sexual orientation and disability data.
- Maintained a dedicated intranet page for staff to access resources and materials ‘All of you’ on equality strands.
- Continued to use our health inequalities dashboard metrics at a service level to identify any anomalies or patterns that identify service improvement.
- Improved equality data collection of our linked charities ‘Creative Minds’ and ‘EYUP’ (Trust charity).
- Continued to focus on our service equality impact assessments (EIAs) and action plans which are now part of our performance reporting and demonstrate delivery of our public sector equality duty.
- Maintained a literature bank, census, service and workforce data through an intranet platform.

To support our approach to capturing the voice and views of people we have:

- Continued to embed and deliver on our Trust wide approach to involvement ‘Connecting People’ in partnership with leads from Calderdale and Kirklees and building relationship in Barnsley.
- Delivered a formal consultation on our older people inpatient transformation, following extensive engagement with partners and communities resulting in a diverse response from over 1700 people.

- Delivered a Trust Strategy refresh engagement driven through connecting people, workshops with colleagues and stakeholder surveys resulting in over 1500 diverse views.
- Maintained a Trust wide approach to developing surveys which now all include equality monitoring as standard.
- Provided quarterly insight reports to the executive management team (EMT) which capture the voice and views of people with contributions from our Governors, Healthwatch and partners are developed quarterly with you told us, we listened published on our website.
- Developed a 'what we already know' insight report to feed into the Trust Strategy refresh and shared with the University of Huddersfield for wider research baseline intelligence.
- Developed a new Trust Volunteer Strategy using the voice of views our volunteers, volunteer supervisors and wider partners.
- Involved key stakeholders in the Trust in the volunteer service accreditation which was renewed in Spring 2024.
- Continued to work in partnership with the Third sector to co-design and develop our service offers in each place.

To support our approach to our workforce we have:

- Ensured our workforce are compliant with equality and diversity mandatory training.
- Delivered enhanced equality and inclusion training for all leaders and managers.
- Delivered a series of monthly lunch box talks using films created by our community with an equality theme.
- Continued to support our international nurses with pastoral care and buddying.
- Developed an animation to communicate the culture of our Trust with accompanying self-reflection tools.
- Co-designed and published a micro-aggression guide.
- Continued to progress the work of 'All of you: Race Forward' which identifies how we will tackle racial abuse and harassment of staff by people who use our services.
- Developed guidance to support incident reporting – with a particular focus on how to manage hate crime, racial abuse and harassment.
- Rolled out Triangle of Care (TOC) through the training and development of our workforce and identifying carers champions.
- Delivered training on equality impact assessments and created a resource bank of literature.
- Continued to develop, grow and support all our staff networks.

To support our approach to improving outcomes and experience for specific groups protected under the equality act, including carers, we have:

- Continued to support a 'DisAbility' Staff Network which includes long term conditions.
- Continued to monitor and develop actions because of Workforce Disability Equality Standard (WDES).
- Updated the Disability policy and plan on a page to highlight key actions required by each service.
- Embedded health checks for people with a learning disability.
- Supported the roll out of Serious mental illness (SMI) checks in each area, delivered in partnership with our places.
- Supported the work around the green light toolkit for people with a Learning Disability and the roll out and recruitment of over 80 champions across the Trust.

- Developed the STOMP and STAMP (supporting treatment and appropriate medication in autistic children and children and young people with a learning disability) approach to reduce over medication of people with a learning disability and autistic people.
- Improved disability awareness through visual stories and campaigns throughout the year
- Worked with creative interventions through our linked charity 'Creative Minds.'
- Delivered the accessible information standard using a dedicated intranet page, training offer and good practice guidance.
- Continued with the Race Equality and Cultural Heritage (REACH) Staff network
- Helped to develop a dedicated leadership programme.
- Monitored and developed actions because of Workforce Race Equality Standard (WRES)
- Identified a dedicated lead to deliver (WRES).
- Supported the delivery of a Forensic service culturally competent care action plan.
- Developed and tested cultural competency training.
- Continued to report on improvements to race equality data using our equality dashboard.
- Attended the Asian Professional Network Association (APNA) annual event with clinicians. Last year it led to clinical involvement in programmes and training.
- Celebrated South Asian heritage month with stories and cultural cuisine in our canteen and onwards.
- Reduced hate crime and incidents by working in partnership with local crime prevention officers to host several sessions for staff in each place location.
- Proudly supported, in partnership, the 'Root out Racism' campaign.
- Supported specific cultural creative activities on our wards and in communities.
- Used the 'Translation and interpretation service' training with over 200 staff trained.
- Developed the new translation and information policy.
- Celebrated women through International Day of Women using media, stories, and events.
- Continued to develop creative and recovery interventions with a gender focus through 'Creative Minds'.
- Celebrated international men's health day using media, stories, and events.
- Developed a menopause staff support group.
- Raised awareness of preferred pronouns, using badges, and a film to raise awareness developed by young people has been shared with staff.
- Progressed on our commitment to add pronouns to staff signatures.
- Celebrated trans gender awareness day in March with a staff development session led by a panel who answered openly any questions people had.
- Celebrated Annual 'Pride' month by attending community events, sharing stories, media campaign and screen savers.
- Supported the Rainbow badge pledge.
- Updated the Transgender policy guidance and a quick guide and tips for staff.
- Continued investment in 'Trans-Barnsley' a group hosted by our Recovery College, with a visible identify and presence.
- Set up a dedicated working group and action plan to deliver the national LGBT+ good practice framework.
- Widened our faith connection in each of our places to ensure we can support people in our services.
- Set up a pastoral care talk line.
- Rolled out a befriender service in all inpatient services.

- Improved prayer facilities by introducing Friday prayers through a volunteer Imam at our Fieldhead hospital site – open to all.
- Improved our ablution facilities for prayer by adding a facility at Fieldhead hospital Wakefield in Summer 2024.
- Shared guidance for fasting and a prayer pack training to support staff and service users.
- Achieved star 1 in triangle of care (TOC).
- Used charitable funding for carers which has enabled day trips and activities for carers of people who use services and a staff retreat.
- Improved identifying carers and recording of carer status for people who use services.
- Improved identifying carers and recording of carer status for our workforce.
- Continued to roll out the 'carers passport'.
- Held carers week celebrations including a community film, social; media stories and a celebration event.
- Achieved Carer Confident status Level 1 and 2 (a national benchmarking scheme to assist employers to build a supportive and inclusive workplace for staff who are, or will become, carers and to make the most of the talents that carers can bring to the workplace).

What next?

In October 2024 the Trust agreed its organisation strategy to take us to 2030, supported once again by a clear set of values and behaviours that put people at the heart of everything we do. From this we know that addressing inequalities in health remains a key priority and barriers to accessing services will remain in focus.

Our overall Trust strategy sets out a range of aims and objectives to help us achieve our purpose. Our refreshed Equality, Diversity and Inclusion strategy, agreed at Trust Board in April 2025, considers how we make sure that all of these elements are woven through everything we do and are embedded into our ways of working. This will ensure that all of us can reach our full potential, and that our Trust is the best place to receive care, as well as the best place to work and learn. We have developed this strategy to focus on the actions we will take and how we will demonstrate the positive and real difference that we will make.

This strategy replaces the equality, involvement, communication and membership strategy which was approved in September 2020. Membership is an essential part of being a Foundation Trust and therefore it is a key component for all trust strategies. How we work with our members is an important part of our inclusion approach which is described in this strategy. Communication is a key enabler for the strategy and is part of our deployment approach and plan which we are developing to make this strategy real. Our Equality, Diversity and Inclusion strategy sets out our strategic intent and development for equality, diversity and inclusion. This new strategy has been developed through, extensive engagement, comprehensive analysis and clear alignment to our overall Trust strategy.

There are nine protected characteristics identified within the Equality Act (2010). In addition, the Trust has added a tenth protected characteristic for carers. This reflects our values and our shared belief that 'families and carers matter.'

We were clear that we needed to consider three different, interrelated areas to ensure that we developed a refreshed strategy that was based on evidence, what we already know, and what our colleagues, local communities and partners wanted to tell us. It is important that our strategy reflects the voice of the people we serve and work with. This included:

1. A full strategic analysis to develop a comprehensive picture of our strategic context.

2. The development and use of a comprehensive Trust wide equality impact assessment.
3. An extensive, inclusive engagement exercise.

The richness of our analysis and extensive engagement has helped us to identify the areas of focus for our refreshed strategy. We have done this by triangulating the information from what people have told us, with the equality impact assessment and our strategic analysis. These have been used to develop the aims and objectives set out in our strategy.

From our analysis and extensive engagement, we have identified six strategic aims.

Strengthen our approach to Equality, Inclusion and Involvement

We will strengthen our approach and weave equality, inclusion and involvement through everything that we do, so it is easier to do the right thing.

Embrace Equality

Consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health.

Recognise Diversity

We will ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and as the basis for our decisions.

Deliver Inclusivity

We will ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay.

We will truly listen to all our communities and demonstrate the difference we make to those we serve.

Deployment of our EDI strategy is as important as its development. It is how we 'hard wire' the delivery of the strategy and make it real. It is also how we demonstrate our commitment to deliver inclusivity. Deployment is a management process that connects and aligns the way we will function with our strategic aims and objectives.

We already have a range of metrics and measurement in place around the EDI agenda. We have commenced work to clarify the measures we will use to see how well we are delivering what we set out to do and where we need to put more or different effort. We are very aware that finalisation of these example measures will require further engagement and co- creation with a variety of different people if they are going to accurately demonstrate impact for people. This will be undertaken as part of the deployment and ongoing delivery of the strategy and will be aligned to the measurement work being done to demonstrate delivery of the Trust strategy.

The Trust also has an agreed anti-racist statement with an agreed approach to becoming a truly anti racist organisation. We have included a strategic objective in our EDI strategy which includes following the NHS England anti racist framework, namely The North West BAME Framework as a mechanism to assess our progress in becoming a truly anti racist organisation and implementing the patient carer race equality framework (PCREF).

Embedding a trauma informed approach (April 2024 – March 2025)
What we did

Trauma informed practice is about realising that trauma can affect individuals, groups and communities, recognising the signs, symptoms and widespread impact of trauma and working to prevent re-traumatisation. “Being trauma informed is a duty of care for the whole organisation and requires a whole cultural change in how we operate. A trauma informed approach must be embraced in all aspects; as well as in direct therapeutic interventions, it should be integrated into leadership, estates services, human resources, research and strategic priorities.” *(www.candi.nhs.uk, 2023)*

What we prioritised

- Trust-wide implementation of the trauma informed framework.

The chief psychological professions officer is the trauma informed lead for the Trust.

There has been a three-year plan underway to deliver across five trauma informed organisation workstreams:

1. Developing a Trust-wide system framework in line with West Yorkshire Integrated Care Board (ICB); testing and evaluation of framework and devising a Trust wide implementation plan (year 1).
2. Trust wide implementation of the framework and beginning identification of the Trust as being trauma-informed (year 2).
3. Supporting sustainable changes to behaviours and practice (year 3 and beyond).

We are now coming to the end of **phase 3** with a focus on continuing the operationalisation of the evaluated framework and ensuring that the shared understanding about what it means to be trauma informed (underpinned by key principles: safety, trust, collaboration, choice, empowerment, culture) is woven throughout everything we do. Being trauma informed is embedded throughout the Trust strategy and the clinical strategy meaning the ‘golden thread’ will continue to be a priority for the next five years and beyond. This aligns to West Yorkshire ICB priorities and strategic direction. There is increased interest across SY ICB. Establishing monitoring and reporting structures and evaluating outcomes is under discussion.

Workstream updates:

WS1: *Community of Practice forum* – monthly facilitated and evaluated sessions regularly attended by 40-70 staff. A recent session had 100+ attendees. Focus alternately on staff support and clinical teams.

WS2: *Identify, test and evaluate a self-assessment tool to identify trauma informed maturity in Teams* - ROOTS (a reflective framework) continues to be facilitated with teams and services. Action plans have been co-produced and reviewed with demonstrable change. Children and young people (CYP) ROOTS tool is being developed and also adapted for people with a learning disability.

WS3: *Building on existing practice to facilitate trauma informed clinical teams and approaches - w*ork continues on developing a baseline of trauma informed approaches / interventions as part of a broader Trust-wide mapping exercise. This work will align with the clinical strategy and link with the Trust psychological professions priority plan.

WS4: *Training* - the e-learning package is complete and due to go live. This is mandatory (with exception) for all staff to complete. Monthly face-to-face training sessions will continue to be delivered to support those staff unable to complete the e-learning package. These will be facilitated by staff and experts with experience who have undertaken the ‘train the trainer’ training. Trauma informed leadership

training has been delivered to the Trust Board and is being rolled out across other directorates / Care Groups and professional groups. Training has been completed with older people's services (OPS), estates and facilities, stroke and neurological rehabilitation units (NRU/SRU) and CAMHS. Pre and post evaluation documentation continues to be obtained as part of ongoing evaluation of each of the training sessions.

WS5: *Staff Support and Wellbeing* - baseline of existing staff support and wellbeing offers across the Trust is being finalised. Trust-wide audit and evaluation of preventative offers (reflective practice) is nearly complete. This will highlight strengths and any gaps in provision considering inclusivity and equity of access for **all staff** that are in both patient-facing and non-patient facing roles. Restorative supervision is also being considered.

What next?

- Continuing to embed a trauma informed approach across all services and teams using a quality improvement approach.
- Launch of trauma informed e-learning.
- Monthly community of practice sessions to continue.
- Staff support and wellbeing oversight group to take a Trust wide view of all staff support offers.
- A Trust trauma informed celebration and learning event is taking place on 13th May.
- All to support the organisation to help shape the Trust's goal to become a trauma informed organisation by 2030.

Health, wellbeing and experience of staff: Working in partnership with leaders to shape a values-led culture of engagement, wellbeing and effectiveness to drive sustainable organisational performance and deliver high quality care. We provide inclusive learning opportunities which support personal and professional growth, skill development and career progression. We aim to build a culture of psychological safety where staff feel confident to speak up when they have concerns and are supported afterwards.

Staff survey improvements

What we prioritised

To improve staff experience and wellbeing, using our NHS staff survey feedback.

What we did

The Trust is committed to the prevention of ill health as well as providing a comprehensive wellbeing support offer when colleagues experience illness. We have an in-house occupational health and wellbeing service providing a range of services as well as our own staff counselling service (see wellbeing section below).

During 2024/25 we have been taking a number of actions to improve staff experience.

Workplace wellbeing remains a key priority. We have focused on promoting and communicating our wellbeing at work offer, updating, and simplifying our wellbeing intranet pages and developing our wellbeing champion network.

We use data from a variety of sources, including the NHS staff survey, to understand the challenges colleagues are facing in different parts of our organisation, with support of the Board where this data is routinely reported.

During 2024/25, we have made considerable progress in implementing our people plan and best place to work and learn priorities. We have:

- Continued to develop the Trust's wellbeing and occupational health offer.
- Worked to ensure our wellbeing offer is trauma informed.
- Worked with partners in Wakefield, Kirklees and Calderdale, to implement Schwartz rounds to support staff to deal with the emotional demands of their role.
- Continued to promote and support our staff networks.
- Improved our uptake of appraisal.
- Developed our support offer to teams.
- Supported services and teams with their service development activity.
- Roll out of our leadership and management development offer.
- Continued to adopt a resolution approach to managing disciplinary cases which has seen a reduction in formal disciplinary processes.
- Supported our leadership teams to review and agree action plans following the NHS staff survey feedback.

NHS staff survey results 2024

The NHS staff survey is conducted annually. The questions within the survey align to the seven elements of the NHS 'people promise', retaining two previous themes of engagement and morale. All people theme scores are based on a scale between 0 and 10. A higher score indicates a more positive result.

The response rate for the 2024 survey among Trust staff was 57%, an increase from 51% in 2023. Scores for each indicator together with that of the survey benchmarking group of community, mental health and learning disability trusts are presented below.

Indicators ('People Promise' elements and themes 2023)	Trust score 2024 0-10	2024 Benchmarking group score	2023 Trust score 0-10
We are compassionate and inclusive	7.69	7.55	7.72
We are recognised and rewarded	6.55	6.35	6.56
We each have a voice that counts	7.09	6.94	7.10
We are safe and healthy	6.61	6.40	6.60
We are always learning	5.90	5.93	5.86

We work flexibly	6.99	6.83	6.99
We are a team	7.26	7.15	7.28
Staff Engagement	7.19	7.07	7.25
Morale	6.48	6.20	6.48

Our results compare positively to other provider Trusts across both West and South Yorkshire and with Trusts across the region. We have the best scores across our region for 'we are a team,' 'staff engagement' and 'morale'.

The 2024 results show that eight of the nine theme results are better than the national average compared to similar provider organisations:

- 'We are compassionate and inclusive'
- 'We each have a voice that counts'
- 'We are recognised and rewarded'
- 'We are safe and healthy'
- 'We work flexibly'
- 'We are a team'
- 'Staff engagement'
- 'Morale'

The 'we are always learning' theme score is slightly below average, but this has improved since 2023.

The NHS England report confirms there are no changes in people theme scores since 2023, which are statistically significant.

What next?

- Take action to ensure the Trust is inclusive and diverse, where discrimination, violence and bullying do not occur. Working with our workforce race equality leads and staff networks.
- Continue to prioritise the health, wellbeing and safety of our colleagues, including access to flexible working opportunities.
- Ensure we make effective use of the full range of colleagues' skills and experiences.
- Continue to engage and listen to staff to understand what's important to them and how we can further improve staff experience.
- Continue roll out of our leadership and management development offer.
- Work with the sexual safety group to encourage staff to raise concerns when necessary.
- Further develop our support offer to teams.

Staff wellbeing

What we prioritised

To continue to develop our wellbeing offer.

What we did:

Additional to the standard staff health and wellbeing offer (above) is a response to the needs of the service staff health and wellbeing champions; the below led by the people experience team in collaboration with other key stakeholders i.e. learning and development, estates, trauma informed lead.

Understanding NHS staff survey [NSS] and how it relates to staff health and wellbeing
Supporting staff health and wellbeing groups to understand the people promise and their NSS data for them to be able to focus on areas of need that are meaningful to their service; including them taking shared ownership for wellbeing.

Fostering understanding through racial trauma education
We want to highlight the important work done in co-designing and delivering a vital learning session on racial trauma. This initiative invites meaningful dialogue about the experiences that shape our colleagues' lives, fostering a culture of understanding, empathy, and support.

Leading well for wellbeing
A new programme aims to equip leaders with the skills needed to prioritise team wellbeing through self-awareness and emotional intelligence. This initiative empowers leaders to foster connections, open communication, and a supportive environment where everyone feels valued.

The podcast: real talk with real people
Real talk with real people is exactly that; it is a series that captures the real and unscripted stories of our people. The series is about hearing about people's experiences from across the Trust,
covering everything from hot topics of interest, asking questions we may not always feel comfortable asking; and learning about different people and their roles.

Real talk with real people: men's mental health
A men's health podcast has been co-created to address important topics in an engaging way, including personal stories. This initiative also includes a Knowledge Café and a trauma-informed community of practice, encouraging open dialogue about health and wellness.

Real talk with real people: exploring belonging and curiosity
Another podcast project centres on belonging, encouraging curiosity about others and nurturing different perspectives. Collaborations aim to explore what belonging means and how to cultivate it within our workplace culture.

Real talk with real people: impact of bereavement
A heartfelt podcast shares a personal bereavement story, highlighting the importance of community support during challenging times. This initiative reinforces the value of compassion and wellbeing within our organisation.

A culture of realness and encouragement
These initiatives embody a spirit of realness and encouragement, fostering a culture where vulnerability is celebrated, and support is prioritised. They demonstrate the power of collaboration and the shared values that unite us all.

Trauma Informed Community of Practice (TI CoP)
We visited the real talk with real people topics as a community of practice covering men's mental health and navigating bereavement in the workplace is coming up; other TI CoP include reflections on racial

trauma session, occupational health and wellbeing and thinking about psychological safety and human factors.

Knowledge cafes
As part of the real talk with real people podcast and TI CoP, we explored this through a knowledge café; first looking at men's mental health and in the pipeline bereavement and other topics.

Sense of belonging in the workplace
We came together Trust-wide to explore what belonging is for us, sharing stories about how others have created a sense of belonging for us and identified how we may help create a sense of belonging for others.

Intranet pages
There is a page dedicated to staff health and wellbeing champions that contains all they need to know about the role, network, learning and development and what's new; we also have built a leading well for wellbeing page that highlights what is expected of our leaders when it comes to wellbeing, support for them and what learning and development is available.

Wellbeing conversation training
NHS England wellbeing conversation training is available via e-learning, communication messages in place to promote across Trust footprint, session development around behaviours to support effective wellbeing conversations is due to commence in 2025.

Call to action
We encourage everyone to engage with these initiatives and participate in the conversations they inspire. Together, we can build a stronger, more connected community that prioritises the wellbeing of every individual.

We continue to:
- Develop sessions to build self-awareness, emotional intelligence and psychology safety to support effective wellbeing conversations.
- Review and develop leadership development pathway: Leading well for wellbeing.
- Work with the Trust's trauma informed lead in working towards a trauma informed organisation i.e. having trauma informed wellbeing conversations, applying trauma-informed lens to challenging situations to be explored in the community of practice.
- Support the design, development and delivery of sexual safety guidance and training.
- Continue to support staff health and wellbeing champions.
- Develop an annual communication and engagement plan to include the above including awareness days, working towards involvement/input from other directories/services i.e. strategy and change, occupational health.
- Review and build resources on staff health and wellbeing champion and leading well for wellbeing intranet pages.
- Monthly reviews of the content take place to update and edit as needed.
- Monitor wellbeing domains analytics on intranet monthly to understand total number of views across each of the four sections of the wellbeing resources (mental health is most frequently visited over physical, financial and social health and wellbeing).
- Build staff health and wellbeing champion network, identify gaps for areas of focus.
- Build learning and development (L&D) wellbeing offering i.e. mental health first aid (MHFA) training.

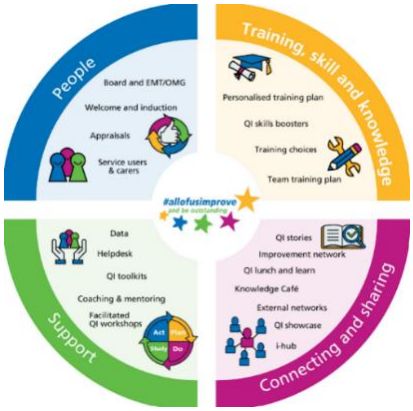
What next?

- Development of MHFA network (launched 13 March 2025).
- Looking at data to inform wellbeing needs of service i.e. NSS, well-led report (leavers, sickness), staff networks and other anecdotal data collected throughout the year; occupational health data which will soon be available through their newly installed system.

Our approach to quality improvement

#allofusimprove is the Trust's approach to quality improvement, it is **the adopted consistent and systematic approach to quality improvement** across the Trust.

Quality improvement is weaved throughout the Trust's new strategy with our shared vision and purpose to be the best we can be and to ensure systematic and sustained improvement is happening across the Trust and is making a difference.



The narrative across the Trust is that quality improvement is everyone's business. No matter who, where or what role a colleague has within the Trust they have a role and responsibility to help us continually improve.

The Trust has a dedicated team, made up of colleagues with specialist quality improvement skills and knowledge. The team provides support, advice and guidance to individuals, teams and Care Groups wanting to carry out improvements in their work area.

All individuals and teams have the opportunity to access a wide range of tools. This includes the model for improvement toolkit used to design, test and implement changes for low level improvements; and the six-step quality improvement project toolkit used to manage larger scale quality improvement projects. This covers each step of our bespoke six-stage process from identification of the challenge faced, using QI tools to help understand the problems, generating and testing ideas, right through to implementation and sharing of stories.



Our quality improvement model aligns to the five pillars of NHS Impact and our offer to all colleagues across the organisation spans the four quadrants of:

- People
- Training
- Skills and knowledge
- Support and connecting and sharing

Our people are at the heart of the model, and it is important to us that we have **effective leadership for improvement.**

This year we have continued to ensure we have an **organisational focus on data and measurement** to ensure the work we do is making a difference.

Creating a workplace culture that supports quality improvement is vital to ensuring our systematic approach to improvement is embedded across the Trust.

The team work alongside colleagues within the Trust's learning and development team to ensure that quality improvement is built into the fabric of colleagues one to one discussions, supervision sessions and appraisals.

The Trust offers a variety of mechanisms to **build improvement skills from senior leaders through to frontline staff** as our training offer is open to anyone who has an interest in quality improvement.

This year we have had successes using our quality improvement processes including the redesign of our care plans and processes, the embedding of culture and care onto our inpatient settings, improvements to our forensic pathways and improvements to accessing our services which has taken a data led quality improvement approach.

As a Trust we are proud of our #allofusimprove approach and offer to our staff. Our approach to quality improvement is a vital part of our values to improve and aim to be outstanding.

Our approach to quality governance

Our executive lead for quality improvement and quality governance is the chief nurse and director of quality and professions.

Central to our approach to governance of quality and improvement is the quality and safety committee (QSC), which is a sub-committee of the Trust Board. Reporting into the QSC is the Trust's clinical governance group, which is responsible for assuring quality based on linking directly with Care Group quality and governance colleagues. During 2024/25 work was completed to ensure that reporting via clinical governance groups from key Trust action groups, Care Group governance groups and escalation of concerns into quality and safety committee was enhanced. Clinical governance group focusses on horizon and risk scanning, interpretation and reporting of national/local quality and safety directives, critical consideration of organisational quality and safety improvements, information sharing, planning, and monitoring implementation. The members' council quality group also supports and oversees the Trust in its approach to quality governance.

Governance and quality assurance play a key role in managing quality. At executive, Care Group and service-level, our trio model of clinical, operational and governance roles provides leadership for quality.

We routinely track quality indicators in our integrated performance report (IPR), which can be viewed by team, service, Trust-wide and externally on the Trust's website. Quality indicators include the NHS friends

and family test (FFT), infection prevention and control performance, patient safety incident response framework (PSIRF), safer staffing, pressure ulcers, restrictive interventions, and complaints. Each of these have specific targets that reflects our ambition to continuously improve. The report is considered at the executive management team (EMT), Trust Board and its committees, and the members' council quality group.

We learn through a clinical audit programme and participate in research and development with links to universities and the academic health sciences network (AHSN). We also contribute to and learn from external benchmarking and reporting initiatives, including the national confidential inquiry into suicide and homicide (NCISH), mental health benchmarking and workforce capacity and demand.

To maintain an operational focus on quality, an enhanced clinical risk performance report is presented to the operational management group (OMG). A new quality assurance system (QAS) has been recently developed and is being launched across the Trust. This QAS includes a programme of quality walkarounds, which enable oversight of quality and culture within services, through using a collaborative approach and identifying good practice and areas for improvement.

Quality oversight is also a core aspect of quality and governance meetings at Care Group level, with escalation to the clinical governance group and on to the executive management team and QSC as required.

Cheswold Park Hospital

Of note, on 1 October 2024 the Trust took over the provision of services at Cheswold Park Hospital. Cheswold Park Hospital is a 112 bedded low and medium secure mental health hospital in Doncaster. Our Trust has significant experience of providing low and medium secure services and is the largest NHS provider of these secure services across Yorkshire.

During the latter part of 2024 welcome events were held for Cheswold Park staff to share information about the Trust and to learn more about the people working at Cheswold Park.

The Trust established a programme board, responsible for the transition of Cheswold Park into the Trust and key leadership positions were implemented to support this work. The key workstreams for the programme board included:

- People development
- Clinical and operational
- Quality and safety
- Estates and facilities
- Communication and involvement
- Finance, contracting and procurement
- IMT and reporting

The focus on quality and safety has included some significant developments, including a transition to DATIX, the incident reporting system used by the rest of the Trust; a review of staffing, nursing, allied health professionals and medical; integration into the Trust medication reporting processed, completion of ligature audits, review of water quality safety issues and the roll out of SystmOne clinical record system.

Progress has been made and a focussed review of the actions from the CQC inspection of Cheswold Park hospital in 2023 (given to the previous owner, Riverside Healthcare) enables us to ensure these are complete and align with the clinical and quality work which is underway.

Part 2.2 – Statements of assurance from the Board

This section is a series of statements from the Board for which the format and information required is set out in regulations and therefore it is set out verbatim.

1	During 2024/25 South West Yorkshire Partnership NHS Foundation Trust provided and/or subcontracted 187 relevant health services (93 service types relating to 187 individual service provided/sub-contracted).

1.1	The South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 187 of these relevant health services.

1.2	The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2024/25.

Participation in clinical audits and national confidential enquiries

2	During 2024/25 14 national clinical audits and one national confidential enquiry covered relevant health services that South West Yorkshire Partnership NHS Foundation Trust provides.

2.1	During that period South West Yorkshire Partnership NHS Foundation Trust participated in 93% (13) of the national clinical audits and 100% of the national confidential enquiries that we were eligible to participate in.

2.2	The national clinical audits that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2024/25 are as follows: 1. National audit of care at the end-of-life mental health spotlight (NAT02) 2. National audit of cardiac rehabilitation (NAT05) 3. National respiratory audit programme (NRAP) (NAT06) 4. Sentinel stroke national audit programme (NAT08) 5. Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) (NAT10) 6. National audit of dementia 2025-27 (NAT12) 7. National audit of seizures and epilepsies for children and young people (Epilepsy 12) (NAT13) 8. National clinical audit of psychosis (NCAP) early intervention in psychosis (EIP) audit (NAT16) 9. Learning disabilities improvement standards (NAT17) 10. Prescribing Observatory for Mental Health (POMH) topic 21b: the use of melatonin (NAT19) 11. National audit of inpatient falls (NAT26) 12. Prescribing Observatory for Mental Health (POMH) topic 16c: rapid tranquilisation (NAT27) 13. Prescribing Observatory for Mental Health (POMH) topic 24a: opioid medication in mental health services (NAT29) 14. National audit of eating disorders (NAT31)

2.3 The national confidential inquiry that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2024/25 is as follows:

- Mental health clinical outcome review programme - national confidential inquiry into suicide and safety in mental health (NCISH) (NAT11)

The national confidential inquiry that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2024/25 is listed below alongside the number of cases submitted to the inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
Mental health clinical outcome review programme - national confidential inquiry into suicide and safety in mental health (NCISH) (NAT11)	44	25 (57%)	19 questionnaires still to complete

2.4 The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2024/25 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified in most cases. This is because the audits we participate in do not specify a minimum number in their sampling framework criteria.

	National Clinical Audits **2024/25**	Cases submitted ***(If applicable)***
1.	National audit of care at the end-of-life mental health spotlight (NAT02)	Continuous data collection January 2025 – January 2026.
2.	National audit for cardiac rehabilitation (NAT05)	Continuous clinical audit. In total 155 cases submitted based on eligible criteria during 2024/25.
3.	National respiratory audit programme (NRAP) (NAT06)	Continuous clinical audit. In total 71 cases submitted during 2024/25.
4.	Sentinel stroke national audit programme (SSNAP) (NAT08)	Continuous clinical audit. SSNAP produces an annual report published in November each year.
5.	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) (NAT10)	Continuous data collection model.

6.	National audit of dementia 2025-27 (NAT12)	Service mapping exercise underway. No patient-level data collection in diagnostic services this year. Report to be published late 2025.
7.	National audit of seizures and epilepsies in children and young people (Epilepsy 12) (NAT13)	Continuous data collection model.
8.	National clinical audit of psychosis (NCAP) early intervention in psychosis (EIP) audit (NAT16)	NCAP has been transitioning to using routinely collected data from NHS England Mental Health Services Data Set (MHSDS) and are currently piloting this. Report to be published late 2025.
9.	Learning disabilities improvement standards (NAT17)	Results not yet published: NHS England » The learning disability improvement standards for NHS trusts
10.	Prescribing Observatory for Mental Health (POMH) topic 21b: the use of melatonin (NAT19)	N/A – the Trust did not participate, due to delays in the development of a new pathway and shared care guideline with the ICB and GPs
11.	National audit of inpatient falls (NAT26)	Continuous data collection model.
12.	Prescribing Observatory for Mental Health (POMH) topic 16c: rapid tranquilisation (NAT27)	32 cases, 91% of eligible cases submitted to POMH
13.	Prescribing Observatory for Mental Health (POMH) topic 24a: opioid medication in mental health services (NAT29)	Seven cases, 88% of eligible cases submitted to POMH. Report expected April 2025.
14.	National audit of eating disorders (NAT31)	Data collection in progress for service mapping November 2024 – November 2025.

2.5/ 2.6

National clinical audit

The reports of 14 national clinical audits and one national confidential enquiry were reviewed by the provider in 2024/25 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

- Each clinical audit has a project lead that is responsible for presenting the audit results to their Care Group
- Each audit enables identification of areas for improvement and an action plan is developed to enable improvements following audits.
- Any immediate areas of concern are highlighted to the relevant Care Group
- Following development and completion of an action plan, re-measurement/re-audit is planned to assess progress.
- The prioritised clinical audit programme has Trust Board oversight, to ensure that the audit cycle is complete and that there is organisation oversight and support to improvements.

	Implementation of the action plan is monitored by the Care Group as part of their governance systems

2.7/ 2.8	**Local clinical audit** The reports of 31 local clinical audits were reviewed by the provider in 2024/25 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: • Each clinical audit has a project lead that is responsible for presenting the audit results to their Care Group. • Each audit enables identification of areas for improvement and an action plan is developed to enable improvements following audits. • Any immediate areas of concern are highlighted to the relevant Care Group. • Following development and completion of an action plan, re-measurement/re-audit is planned to assess progress. • The prioritised clinical audit programme has Trust Board oversight, to ensure that the audit cycle is complete and that there is organisation oversight and support to improvements. • Implementation of the action plan is monitored by the Care Group as part of their governance systems.

3.0	**Participation in clinical research** The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2024/25, that were recruited by the research department to participate in research that had been approved by a research ethics committee is **633** *(Please note this figure excludes staff participation and any participant recruits which have been allocated to regional public health or primary care studies which would take this figure to over **700+**).* The Trust has successfully achieved its annual recruitment target (525) and is one of only two mental health providers within the Yorkshire and Humber region to have exceeded its higher level recruitment target (625) set by the National Institute for Health Research (NIHR) Regional Research Delivery Network (RRDN). With over 40 research studies active throughout the year the research and development (R&D) team has successfully curated the development of a structured pipeline of studies which: • Is balanced in its complexity i.e. 26 studies are regarded as interventional / randomised control trials (with one commercial study active during this period) and the reminder 14 observational studies. • Is balanced in its engagement and participation across our geography and across the care groups/clinical specialties i.e. studies are recruiting from CAMHS, Working Age and Older Adult services, Physical Health, Learning Disabilities, inpatient and community services within all four place areas. • Has provided the opportunity for service users, carers and clinical colleagues to lead, participate and co-produce research activity within the Trust.

The R&D dept. continues to deliver and operationalise key aspirations of the Trust Research Strategy (which was approved in December 2022) and has specifically within 2024/25:

- Enhanced the profile and contribution of research and development to wider Trust corporate and clinical activity by becoming an enabling tool in the development of the Trust strategy refresh, clinical strategy and digital strategy development as well as a key partner in the bid to become a teaching trust.
- Utilised the research & innovation group (TRIG) to create a clearer pathway between corporate services supporting service evaluation, involvement, engagement and quality improvement to enhance the Trust's support offer.
- Enhanced the profile of the research and development department as a vehicle in enabling service users, carers to become 'community connectors' - peer support workers, volunteers and lived experience practitioners within the trust i.e. the dept. has recruited over 35 volunteers, peer support workers and patient public involvement workers.
- The department has also hosted 10 students from different clinical and academic backgrounds, providing them with an introduction into research and development and research governance.
- The department is a key convener of the projects and discussions which are reviewing the implications, processes and management of artificial intelligence (AI), data, and data science research within the Trust.

As part of the wider strategic development of research capacity within the Trust, the research department continues to mentor and support over 35 clinical colleagues to submit funding applications and research bids to funding bodies including the National Institute for Health Research (NIHR). The department has supported the publication and development of 15 peer reviewed journal articles and has supported the development of a poetry anthology (as part of a research collaboration with the national poetry centre in Leeds).

The department was successfully awarded £1.2m of infrastructure money from the NIHR to develop a modular dedicated research resource unit at the Fieldhead site. The addition of this resource would further significantly develop the Trust's capacity to be a leader within mental health research across the region.

The research department continues to work closely with higher education institutes and has working agreements and collaborations with the following institutions: University of Huddersfield, University of Durham, University of Leeds, University of Sheffield, University of York, University of Manchester & Leeds Beckett University, University of Bradford, University of Newcastle, University of Birmingham, Sheffield Hallam University and University of Oxford. Through these partnerships the Trust is listed as a key delivery partner and co-applicant on three major programme grant applications worth over £15 million, with research activity extending between five and nine years.

As a key partner within the regional research delivery network (RRDN) and respective integrated care board structures, the research department is actively contributing to place based research collaborations within Kirklees, Calderdale, Wakefield and Barnsley; and is providing direct support and recruiting to public health and physical health studies in primary and acute settings - where recruitment for these studies is allocated to the region. We continue to explore new and innovative ways to support engagement with communities and develop research champions and research

	ambassadors throughout our places, ensuring that our research activities are reflective of the population that we serve.

4.0	**Commissioning for quality and innovation payment framework (CQUIN)** The mandatory CQUIN scheme has been paused for 2024/25, therefore no information is available.

5.0/ 5.1	**Care Quality Commission** South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities: • Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and screening procedures • Treatment of disease, disorder or injury There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on, at, or from. South West Yorkshire Partnership NHS Foundation Trust's conditions of registration state that the three regulated activities listed above can only be carried out at the following locations: • Fieldhead hospital (Wakefield) • The Dales (Calderdale Royal Hospital) • Kendray hospital (Barnsley) • The Priestley Unit (Dewsbury District Hospital) • Lyndhurst (Halifax) • Enfield Down (Huddersfield) • The Poplars (Hemsworth) • Cheswold Park Hospital (Doncaster) The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2024/25.

6.0/ 6.1	Removed from the legislation by the 2011 amendments
7.0/ 7.1	South West Yorkshire Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2024/25.

8.0/ 8.1	**NHS Number and General Medical Practice Code Validity** South West Yorkshire Partnership NHS Foundation Trust submitted records during 2024/25 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data.

	The percentage of records in the published data which included the patient's valid NHS number was: • 100% for admitted patient care. The percentage of records in the published data which included the patient's valid general medical practice code was: • 99.5% for admitted patient care.
9.0	**Data security and protection toolkit** South West Yorkshire Partnership NHS Foundation Trust achieved a status of 'standards exceeded' for the 2023/24 toolkit assessment and will be submitting the toolkit again this year, by 30 June 2025. A toolkit audit is currently being undertaken (May 2025).

10./ 10.1	**Clinical coding accuracy** South West Yorkshire Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

11.	**Quality of Data** Improving data quality remains one of South West Yorkshire Partnership NHS Foundation Trust's key priorities. There was continued focus in 2024/25 on improving the quality of clinical record keeping. With a number of areas routinely reported and monitored to the Trust's improving clinical information group. This underpins the delivery of safe effective care and assures the executive management team, the quality and safety committee and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust. South West Yorkshire Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

Data Quality	Actions
Bringing clarity to quality	• Continue to improve the training, guidance and support available to help staff and services to understand and improve data quality. • A dedicated resource to work on data quality alongside working with operational staff was identified during 2024/25.
Measuring quality	• Continue to develop a wide range of team, service line, Care Group and Trust level operational and performance reports, and monitor these reports in appropriate forums. • Service line reporting and electronic dashboards will include key performance indicators and will enable users to look at performance at team, service line, Care Group and Trust levels.

		• Team dashboards are available via the Trust intranet and will continue to be developed and further rolled out across all service areas. • Internal and external benchmarking will be incorporated in dashboards. The Trust has established a benchmarking group to review benchmarking data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers.
	Publishing quality	• Continue to publish its data to the secondary uses service, NHS England, the CQC, the Department of Health and Social Care, commissioners and partners and to the Members Council.
	Partnership for quality	• Continue to work with partner organisations to ensure that all our respective quality and performance requirements are met, and that duplication of data collection and inputting is minimized.
	Leadership for quality	• The improving clinical information group will oversee the development and delivery of the data quality improvement programme and will provide a quarterly progress update to the executive management team. • Care Groups will ensure the development, monitoring and delivery of the individual Care Group level improvement plans.
	Innovation for quality	• The Trust continues to work to ensure innovation for quality is embedded within this as part of the continued development of the system. • The Trust continues to exploit new technology to make these systems easy to access and use. Particular use of digital solutions for non-face-to-face activity was implemented during the Covid-19 pandemic which allowed continued service delivery in a challenging environment. This continues to be utilised where appropriate.
	Safeguarding quality	• The Trust's executive management team will ensure essential standards of safety and quality are maintained and monitored and will take action where data quality issues arise.

Learning from deaths

27.1	**The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.** During 2024/25, 2,150 of South West Yorkshire Partnership NHS Foundation Trust patients died. This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. six months) prior to death, identified from our clinical systems. This includes services such as end of life care, district nursing and care home liaison services. There is a delay in information being updated from the national system, particularly for quarter four, and therefore the total figure is likely to increase as records are refreshed. The following number of deaths occurred in each quarter of that reporting period:

Quarter	Deaths
One	530
Two	501
Three	612
Four	507

27.2 **The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.**

By 7 April 2025, 142 case record reviews (includes initial team level case note review or structured judgement review) and 70 investigations have been carried out in relation to 212 of the deaths included in item 27.1.

In 70 cases a death was subjected to both an initial case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Deaths reviewed/ investigated
One	63
Two	56
Three	45
Four	48

The figures for 2024/25 are not comparable with 2023/24 due to the introduction of Patient Safety Incident Response Framework and use of different tools to help understand if there were problems in care

27.3 **An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.**

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

Quarter	Deaths reviewed/ investigated found to be due to problems in care
One	0 (0%)
Two	0 (0%)
Three	0 (0%)
Four	0 (0%)

	Of the 212 case record reviews or learning response/review in the reporting period, none identified 'a problem in care which resulted in death'. This is the wording used in the national Patient Safety Incident Response Framework (PSIRF) and Learning from Healthcare deaths policy. Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. These numbers have been estimated using the methodology below: Our structured judgement reviews are conducted by trained reviewers from a clinical background (such as medicine, nursing, allied health professional and social workers) who work outside the clinical area where the death occurred. The reviewer scrutinises the clinical records to review the care and treatment the individual received leading up to their death. They record their findings in a template under specific phases of care. Each phase of care is rated with a supporting narrative. The reviewer also makes a judgement about whether the death was due to problems in care that resulted in harm. All completed reviews are discussed at Care Group governance groups to agree on the next steps, which may include areas for improvement or further investigation. Since 1 December 2023, the Trust has been working under the patient safety incident response framework (PSIRF). In the event that a problem in care was identified that led to a death occurring, we would undertake a patient safety incident investigation in line with national guidance. Up until transitioning to work under PSIRF on 1 December 2023, we had local level investigations through to serious incident investigations. These involved a review of the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period of time. The focus of all investigations is on human factors, systems, and processes. They also examine if any issue can be identified which led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring. The quality account asks for deaths which have been reviewed through case note review or investigation. The term investigation is no longer used in the Trust due to PSIRF. Learning response is now the term used. Under PSIRF, we have a range of learning responses we can use to review deaths. This includes a manager's 48-hour rapid review, case note review, structured judgement review, patient safety incident investigation, learning from lives and deaths review (LeDeR). These review methods involve a review of the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period. The focus is on human factors, systems, and processes. They will also examine if any issue led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring. In addition, we also use after action review and specialist learning review as team approaches to reflecting on individual cases or themes to explore what went well and where there are areas where we can learn and improve. We have included these reviews in our figures.

27.4	**A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.** Not applicable

27.5	**A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).** Not applicable

27.6	**An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.** Not applicable

27.7	**The number of case record reviews or investigations finished in the reporting period (2024/25) which related to deaths during the previous reporting period (2023/24) but were not included in item 27.2 in the relevant document for that previous reporting period.** 10 case record reviews and 9 investigations were completed during 2024/25 which related to deaths which took place before the start of the reporting period.

27.8	**An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.** 0 representing 0% of the patient deaths in 2023/24, completed in 2024/25, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust mortality review processes described above in 27.3.

27.9	**A revised estimate of the number of deaths during the previous reporting period (2022/23) stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.** 0 representing 0% of the patient deaths in 2023/24, completed in 2024/25, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2.3 – Reporting against core indicators

South West Yorkshire Partnership NHS Foundation Trust is required to report performance against a core set of indicators using data made available to the Trust by NHS England. For each indicator, South West Yorkshire Partnership NHS Foundation Trust must also make assurance statements for which the format and information required is set out in regulations and therefore it is set out verbatim.

12. **Not applicable**

13. **The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care (N.B. this metric has replaced follow up within 7 days)**

As set out nationally South West Yorkshire Partnership NHS Foundation Trust is moving away from the care programme approach (CPA) as set out in the CPA position statement from NHS England. As such we are no longer required to report on data related to CPA. The Trust is working towards developing an approach which is based on the five broad principles within the position statement. Therefore, this data relates instead to all service users under adult mental illness specialties.

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership Foundation Trust NHS Digital data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care **Performance indicator is 80%**	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions	2024/25	91.4%	92.3%	92.4%	89.3%	90.1%
		2023/24	92.6%	91.6%	90.9%	90.9%	91.5%
		2022/23	86.2%	89.2%	88.7%	87.8%	88.0%
		2021/22	85.8%	82.7%	83.6%	84.3%	84.1%
		2020/21	82.7%	81.0%	83.9%	84.6%	83.0%

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system.
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.
- Data is clinically validated before it is submitted to NHS England.

- Performance data is reviewed monthly by the executive management team and also reviewed regularly by the Trust Board.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage and therefore the quality of its services:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to focus on the quality of clinical data.
- Each Care Group has developed a robust process to improve the quality of their clinical data.
- Each Care Group is provided with performance and quality reports monthly. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent deterioration in quality.

14 - 16. **Not applicable**

17. **Percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper**

Indicator	NHS Outcomes Framework Domain	NHS Digital South West Yorkshire Partnership NHS Foundation Trust performance data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period **Performance target is 95%**	2: Enhancing quality of life for people with long-term conditions	2024/25	97.5%	97.2%	99.2%	99.6%	98.3%
		2023/24	99.7%	98.6%	99.3%	97.5%	98.8%
		2022/23	96.2%	99.3%	99.6%	98.7%	99.0%
		2021/22	99.7%	99.4%	98.3%	97.8%	98.8%
		2020/21	100%	96.1%	98.7%	99.4%	98.9%
		2019/20	99.7%	100%	99.7%	97.9% *(local data)*	98.4% *(local data)*
		2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		2017/18	98.4%	96.9%	96.9%	99.6%	98%
		2016/17	96.9%	99.3%	99.3%	99.3%	
		2015/16	95.81%	97.29%	96.04%	98.32%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system.
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.
- We have two specific gatekeeping activity codes that are used for all gatekept admissions - this information can be extracted directly from the electronic record system.
- Data is clinically validated before it is submitted to NHS England.
- Performance data is reviewed monthly by the executive management team.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to ensure a focus on the quality of clinical data.
- Each Care Group has developed a robust process to improve the quality of their clinical data.
- We undertake a weekly audit of our gate kept admissions to validate the gate keeping function.
- Each Care Group is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

18. **Not applicable**

19. **Readmission rates**

The data made available by NHS England with regard to the percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital, which forms part of the Trust, within 28 days of being discharged from a hospital during the reporting period.

	NHS Outcomes Framework Domain	Indicator Readmission rates by age										
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2020/21	2021/22	2022/23	2023/24	2024/25
0-15	3: Helping people to recover from episodes of ill	0	0	0	0	0	0	0	0	0	0	0
16 and over		7.02%	8.7%	9.7%	9.8%	9.8%	9.1%	5.2%	4.5%	3.7%	4.3%	2.6%

	health or following injury											

South West Yorkshire Partnership NHS Foundation Trust had no readmissions for patients aged 0-15 during this period. All data applies to people aged 16 or over.

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- 97.4% of people were not readmitted in 2024/25.
- This information is taken from the electronic clinical record system.
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.
- Data is clinically validated before it is submitted to NHS England.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to ensure a focus on the quality of clinical data.
- Each Care Group has developed a robust process to improve the quality of their clinical data.

Each Care Group is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

20-21	**Not applicable**

22.	**The Trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period**

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership NHS Foundation Trust score	National score
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's	2: Enhancing quality of life for people with long-term conditions	2023 score	National 2023 score
			National comparison
		7.2	About the same as other trusts nationally (CQC website)

		“Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period	4: Ensuring that people have a positive experience of care	2022 score	National 2022 score	
					National comparison	
				7.2	About the same as other trusts nationally (CQC website)	
				2021 score	National 2021 score	
					National comparison	
				5.8	About the same as other trusts nationally (CQC website)	
				2020 score	National 2020 score	
					National comparison	
				7.0	About the same as other trusts nationally (CQC website)	
				2019 score	National 2019 score	
					National comparison	
				7.0	About the same as other trusts nationally (CQC website)	
				2018 score	National 2018 score	
					National comparison	
				6.7	About the same as other trusts nationally (CQC website)	
				2017 score	National 2017 score	
					National comparison	
				7.9	About the same as other trusts nationally (CQC website)	
				2016 score	National 2016 score	
					Highest trust score	Lowest trust score

			7.5	8.5	6.8
			2015 score	National 2015 score	
				Highest trust score	Lowest trust score
			8.00	8.2	6.8
			2014 score	National 2014 score	
				Highest trust score	Lowest trust score
			7.9	8.4	7.3

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

- This information was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and using anonymous information.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services:

- This information will be triangulated with other sources of patient and staff experience feedback so that we can successfully focus our improvement action.

23-24. **Not applicable**

25. **The number and percentage of such patient safety incidents that resulted in severe harm or death**

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Financial Year	Number of patient safety incidents (at 01/04/25)	Number of patient safety incidents reported on LFPSE (at 01/04/25)	Severe harm	% severe	Death	% death
2024/25	9,379	3,912	32	0.3%	16	0.17%

The Trust considers that this data is as described for the following reasons:

- The Trust transitioned to Learn from Patient Safety Events (LFPSE) on 14 February 2024.
- LFPSE is a new national database where patient safety incidents stream direct from our local system into the national LFPSE system.
- The LFPSE national team have advised that the data presented in the LFPSE dataset is based on information recorded on a largely voluntary basis. This is a new data collection system and so is likely to show different patterns of recording behaviour as organisations transition from the old national reporting and learning system (NRLS) to LFPSE service. Patterns of recording during this transition phase may not be comparable to previous patterns and care must be taken to avoid basing conclusions about the safety of care on changes in recording patterns during this period. It is anticipated that volumes of recording will increase over time.
- LFPSE data that has been submitted to NHS England is currently being validated and therefore cannot be used for patient safety incident planning or official statistics.
- As staff become more familiar with LFPSE requirements figures are expected to increase
- Reporting to LFPSE has been in development through 2024/25 since implementation in February 2024, therefore our data is based on what we believe in the Trust to be a patient safety incident.
- We have included the figures of all our patient safety incidents reported on our Local Risk Management System (LMRS) and the percentages have been taken from this figure.

In 2024/25, a total of 9,379 patient safety incidents were reported on our LRMS, Datixweb, with 48 resulting in severe harm and patient safety related death incidents. We ask staff to over-estimate the actual harm where this is not confirmed and this will be reflected in this figure.

As the 2024/25 period reflected the above transition between systems and processes, data is not comparable with previous years.

95% of the 9,379 patient safety incidents resulted in no harm or low harm. Nationally (NHS 2021), it is believed that organisations that report more incidents usually have a better and more effective safety culture. If we understand what our incidents are, we can learn and improve our services.

The implementation of the patient safety incident response framework (PSIRF) in the Trust from 1 December 2023 continues to support our strong focus on learning for improvement.

We have multiple methods of sharing learning from incidents including a learning library, Bluelight Alerts for sharing urgent learning and a learning network. Teams also share learning through Care Groups.

Plans in place to improve reporting to LFPSE during 2025/26

- Staff education to raise awareness of patient safety incidents and what is reportable to LFPSE.
- Strengthening the monitoring of incidents reportable to LFPSE to identify and address any gaps.
- Work on Datix to map patient safety incidents by type, category and subcategory to show the mandatory LFPSE questions for completion.

26. **Guardian of safe working hours**

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from working excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The new contract introduced the role of guardian of safe working hours who is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The introduction of a new contract for doctors in training impacted on the Trust in February 2017, with new employees moving onto the contract at that point. The Trust appointed a senior medical representative as the guardian of safe working and their 2024/25 annual report and quarterly reports, highlighted the following:

- The number of exception reports has remained low during this period which is in line with the majority of Trusts providing mental health care (table below). The most common issue has been pressure of work on inpatient areas, especially during colleagues' absence. Trainees have been encouraged to complete exception reports if they do stay late or miss breaks or educational opportunities. Trainees have raised concerns about not receiving their rota in a timely way and there being barriers to arranging annual or study leave. Work is on-going to try to resolve these issues.

Exception Reports by Area				
Area/BDU	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	11	11	0
Calderdale	0	0	0	0
Kirklees	0	3	3	0
Wakefield	0	4	4	0
Forensic	0	1	1	0
Total	**0**	**19**	**19**	**0**

- Rota gaps remain high, with 568 or 22% of first tier shifts vacant. The main reasons include vacancies, less than full-time trainees placed in full-time slots, and occupational health recommendations for trainees to come off the on-call rota. The industrial action taken by trainee doctors has been another factor. There were 3 shifts where it was not possible to obtain junior doctor cover. Where there is a rota gap, the rota co-ordinators will seek to find someone to cover via the medical bank resource. When this has not been possible senior doctors have acted down to cover
- Rota coordinators managing the Trust medical bank, with the support of the trainees have done fantastic work to maintain the service despite these challenges
- There has been improved recruitment to core training in psychiatry, with an expansion of training numbers. There have been a number of vacancies across all schemes providing trainees to the Trust, although there were fewer vacancies from February.
- The Guardian of Safe Working Hours continues to have sessions with all new trainees at induction to offer support and encourage trainees to raise any concerns that they may

	have. The guardian of safe working hours also meets trainees at the quarterly junior doctors' forum.

Part 3: An overview of quality of care in 2024/25

This section of the quality account will be used to present an overview of the quality of care offered by South West Yorkshire Partnership NHS Foundation Trust in 2024/25.

Performance against indicators set out in the national metrics (previously the systems oversight framework)

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the national metrics.

Indicator		South West Yorkshire Partnership NHS Foundation Trust data				
	Target	2020/21	2021/22	2022/23	2023/24	2024/25
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral	60%	89.5%	89.0%	89.1%	88.7%	92.3%
NHS Talking Therapies (Formerly improving access to psychological therapies (IAPT)): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	50%	52.2%	53.5%	52.2%	52.3%	52.8%
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	75%	94.0%	94.0%	97.1%	98.7%	99.0%
ii. within 18 weeks of referral	95%	99.4%	99.8%	99.9%	99.8%	99.9%
Admissions to adult facilities of patients under 16 years old	0	1	1	2	0	2
Inappropriate out-of-area placements for adult mental health services	494	1691 bed days	3216 bed days	4982 bed days	3132 bed days	1358 bed days

The initiatives we undertake to improve quality of care change from year to year, which means we are not always able to make a direct comparison of our performance against each priority each year. Where we can make comparisons across the years we have done so. We make these changes to continually strive to improve the quality of our care.

The Health and Care Act (2022) introduced statutory Integrated Care Boards (ICBs) and Integrated Care Systems (ICSs) in July 2022. This has meant that there are changes in how services are required to work together, and the metrics that providers should deliver against.

Our Trust provides a wide range of services across several communities. These services are commissioned by two separate ICBs and we work across four place-based partnerships:

- West Yorkshire Health and Care Partnership
    - Kirklees place
    - Calderdale place
    - Wakefield place
- South Yorkshire Integrated Care Partnership
    - Barnsley place

Some of the Trust's specialist services such as the forensic mental health services are commissioned under specialist commissioning which comes directly from NHS England.

Our Trust is a compassionate and innovative organisation with equality, co-production, recovery and creativity at its heart. We aim to help people reach their potential and live well in their community and to provide outstanding physical mental and social care in a modern health care system.

Part 3 of the quality account will also showcase examples of quality improvement from across the organisation that have been initiated within individual services or areas of the Trust. Our annual Excellence Awards showcase the achievements of both individuals and teams who have continued to innovate and improve the quality of services during these challenging times. They also demonstrate how, as a Trust we have improved services with hybrid working that meets the changing needs of people within our communities.

The following presents an overview of the quality of care we offer against the three indicators:

- Patient safety
- Clinical effectiveness
- Patient experience

These are in addition to the improvement work outlined in Part 2.

Patient safety

Safe means services delivered in a way that minimises things going wrong and maximises things going right; continuously reducing risk, empowering and enabling people to make safe choices and protecting people from harm, neglect, abuse and breaches of their human rights; and ensuring improvements are made when problems occur.

Quality initiatives in 2024/25

The quality initiatives prioritised for action in 2024/25 as part of the quality account process were as follows:

- Patient safety
- Suicide prevention
- Reducing restrictive practice interventions
- Ligature audits

Patient safety
What we prioritised • To continue to work towards delivery of priority patient safety workstreams.
What we did Throughout 2024/25, we have continued to make progress with our patient safety workstreams in line with national priorities and local developments. We have expanded our patient safety specialist role to include other colleagues whose roles link to patient safety leadership and delivery. One of the patient safety specialists completed NHS England's ergonomics and human factors training provided by the University of Loughborough in December 2024. The course is accredited by the Chartered Institute of Ergonomics & Human Factors (CIEHF). Another patient safety specialist will conclude their training in 2025. Patient safety work, led by our patient safety specialists and colleagues in the patient safety support team, has focused on delivery of national priorities as summarised below: **Improving safety culture** In 2024/25, 96% of all incidents reported resulted in no or low harm or were not related to care provided by the Trust. The number of incidents resulting in moderate or severe harm or patient safety related deaths are small and are detailed earlier in this report. We look for opportunities to learn from any incident, whether it results in harm or is a near miss (free lesson). This year there has been an increase in incident reporting, with a 6.1% increase on the previous year. This demonstrates a positive reporting culture, where staff feel able to report incidents and near misses. This figure excludes data for Cheswold Park Hospital who joined the Trust in October 2024, to ensure year on year comparability. Analysis of the data has shown that harm levels have not increased significantly, despite the overall increase in numbers reported. This may, in some part, be due to the promotion of incident reporting through the implementation of the patient safety incident reporting framework (PSIRF), learn from patient safety events (LFPSE), and learning sessions that have been delivered. In addition, we have continued to promote our freedom to speak up guardians and training. **Learn from patient safety events (LFPSE) implemented** The Trust went live with learn from patient safety events (LFPSE) in February 2024.

LFPSE is part of NHS England's developments to improve patient safety. It is a new national database for patient safety learning and improvement and replaces the national reporting and learning system (NRLS) and the system used for reporting serious incidents. It captures a range of patient safety events that happen, including patient safety incidents, near misses, never events and good care. LFPSE data collection fields and functionality has been incorporated into our Datix incident reporting system.

A review of reporting has taken place during 2024/25 which identified some areas for improvement and will be delivered in 2025/26. This includes raising awareness of what a patient safety incident is and what is reportable to LFPSE alongside strengthening our data collection methods and monitoring processes.

Cheswold Park Hospital
Cheswold Park Hospital (CPH) transferred to the Trust from 1 October 2024. Since this time we have implemented PSIRF within CPH, this went live from 16 December 2024 and we have also transitioned the reporting of incidents and complaints on Datixweb from mid-January 2025.

Patient safety incident response framework (PSIRF) implemented
The Trust launched the patient safety incident response framework (PSIRF) in December 2023.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key principles:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

The culmination of the preparatory work included:

- Publishing the patient safety incident response plan – which sets out how the Trust will respond to patient safety priorities with a focus on learning and improvement.
- Publishing the patient safety incident response policy – which describes the systems and processes the Trust will use to learn and improve following a patient safety incident.

These are available on the Trust website.

The Trust continues to build on our processes as we [the Trust] learn and develop these collaboratively across our services. PSIRF is a key element of the overall national patient safety strategy. It allows organisations to design and learn from their incidents in line with their local context for patients, families and staff whilst considering local and national safety learning requirements. This is the largest scale national and organisational change in patient safety in the last twenty years and therefore there is not an expectation that these changes will happen rapidly. This change in 'thinking' requires a level of safety maturity, both in culture and expertise, building capability by providing peer support for learning and improvement with a focus on work systems to support our staff to do their best work.

An interim review of the first 15 months has commenced to enable revisions to processes and structures to be made.

Positive feedback has been received through the year from staff involved in learning responses. We are seeing a move to thinking about systems rather than individuals and we can strengthen them to improve safety. Engagement with people affected by incidents has improved, with some positive

feedback received. Teams are valuing being included in reviews and being able to be part of solutions. Communication and collaboration about patient safety is strengthened and patient safety culture is improving. Our oversight of patient safety is evolving with new structures, and we have strong networks with partners across the region.

Improving patient safety education and training

Progress continues to be made with the various levels of patient safety training:

- Patient safety training Level 1 e-learning for all staff became mandatory in November 2023. Data from the electronic staff record (for 2024/25) shows:
    - Level 1a – Patient safety essentials for all staff – 98.7%
    - Level 1b – Patient safety for senior managers and board members – 91%

Patient safety partners (PSP)

In December 2023, the Trust welcomed three patient safety partners (PSPs), in line with NHS England guidance who will contribute alongside our staff, patients, families and carers to improving and influencing patient safety across our range of services. The Trust sees their role as a true partnership, drawing on their experience and having an active role in highlighting good practice and challenging where care, treatment or our processes need changes to ensure that the patient voice is heard throughout.

Our patient safety partners have been supporting pieces of work, including:

- Supporting the development of being open - engaging and involving service users, families and carers following a patient safety incident guidance
- Supporting evaluation of the family liaison officer service with bereaved families and carers
- Attended quality walkarounds in different services
- Attending our patient safety improvement group
- Planned and contributed to the World Patient Safety Day learning network event including talking about the role
- Reviewing and providing feedback on the quarterly report and learning journey

A staged plan is being developed to work towards attendance at key Trust committees from 1 April 2025.

World Patient Safety Day

The patient safety support team promoted World Patient Safety Day on 17 September 2024 by:

- Holding a face-to-face learning network at Fieldhead. The learning network had a special focus around patient safety and falls prevention.
- Supporting staff to complete patient safety pledges.
- Supporting Creative Minds to hold activities for patients on some wards with a patient safety focus.

Implementing medical examiners

The national requirement to report inpatient deaths to medical examiner's office came into effect on 9 September 2024.

The Trust will not have its own medical examiner, instead will utilise those available from Mid Yorkshire Hospitals Teaching NHS Trust, irrespective of where the death has occurred within the Trust. The

exception being with Cheswold Park Hospital, which will be considered separately for the time being as systems and processes develop.

Information has been shared on the Trust internal intranet pages. All medical staff have been informed how and when to contact the Medical Examiner's Office.

There is still work ongoing regarding sharing the Trust's clinical records with the Medical Examiner's office.

- **Other Patient safety improvement work**

During 2024/25, we have continued to:

- Develop our family liaison officer role supporting bereaved families.
- Develop our patient safety oversight group structures.
- Deliver sessions for Care Groups on understanding notifiable safety incidents and when Duty of Candour applies.
- Implementation of the electronic prescribing system to aid medication safety.
- Establish a new structure for the patient safety improvement group to fit with wider patient safety activity.
- Provide the quality and safety committee with reports on a range of patient safety activities throughout the year.
- Share learning.
- Progress work related to our suicide prevention strategy.

What next?

- Reflecting on the Patient Safety Incident Response Framework (PSIRF) fifteen months since implementation, including our processes for engagement and involvement of those affected by patient safety incidents.
- Continue work to embed patient safety workstreams including:
    - expanding our patient safety specialists and ensuring they are trained.
    - reviewing our patient safety partners mechanisms to ensure we expand the role and consider further recruitment.
- Focus on data quality and management to enhance recording of themes, trends and analysis.
- Improving the reporting to LFPSE.
- Procurement of risk management system to ensure best value and providing the best quality information.

Suicide prevention

What we prioritised

- Review of the Trust's suicide prevention strategy, and cross reference with the 2023 national suicide prevention five-year strategy.
- Review project plans to include actions necessary to help inform the Trust's 2025-2028 suicide prevention strategy.
- Patient safety incident investigation project plan for suicide prevention completed, with the information being used to help shape the future ambitions in suicide prevention.
- Improvement work streams to inform the Trust's strategic forum.

- Enabling staff to access support for postvention (support provided after the loss of a person to suicide).
- Collaboration with partner organisations.
- Delivery of the annual suicide prevention conference for 2024.

What we did

The aims of the strategy are to reduce the loss of life to suicide and to support those affected by suicide or suicidal behaviour. We work in partnership with other NHS and social care providers, and our voluntary sector communities across the Trust geography to contribute to improving the mental and physical health of our patient population. In continuation with embedding the strategy the following have been developed and achieved during 2024/25:

Culture

- Established systems wide representation at the Suicide Prevention strategic forum.
- Continued engagement across West and South Yorkshire public health teams.
- Trust wide sharing through champions network, communications strategy and patient safety learning network on local, national, regional, and international updates and research across the field of suicide prevention.
- Ongoing review and updates of operational policies, procedures, and guidelines to help ensure suicide prevention is considered, and connections are made to the Trust strategy.
- Expanded the Trust suicide prevention information to include externally accessible suicide prevention guidance to the public via the Trust website.
- Completed, published, shared and promoted guidance for families and carers (downloadable booklet).
- Collaborated with performance and business intelligence team to ensure that principles of prevention of suicide are embedded in templates and tools for frontline completion.

Training and education

- Continued delivery of in-house half-day training for suicide alertness for everyone (SafeTALK) and opened seats for training to partner organisations and voluntary, community and social enterprise (VCSE) bodies.
- Delivered training for applied suicide intervention skills (ASIST) for suicide prevention, maintain collaborative conversations with partner organisations and VCSE partners.
- Delivered bespoke training for suicide risk in the form of collaborative assessment and management of suicidality (CAMS).
- Aligned the work of suicide prevention with the Trust aims and objectives for trauma informed principles of practice.
- Reviewed present training access and current agreements for future action planning.
- Commissioned and delivered bespoke organisational training on postvention – bereavement by suicide.

Family and carer involvement and collaborative care

- Actively promoted and shared information relating to suicide bereavement support services acting on behalf of families in making referrals for them following their loss.
- Increased the visibility and promotion of the family liaison officer role across the Trust.
- Developed family and carer information on suicide risk and added accessibility to members of the public via the Trust website.

- Improved visibility within new collaborative safety planning templates on involvement and engagement of family and significant others.
- Maintained information sharing from suicide prevention networks to the carer's champions' network.
- Engagement work through the bereavement development task and finish group for feedback from families to inform future actions after death of a loved one through suicide.
- Review of the friends and family feedback and customers services data to inform 2025-2028 suicide strategy refresh.

Regional collaboration

- Continued visibility with partner organisations across West and South Yorkshire for multi-agency suicide prevention sharing of learning and collaboration.
- Continued contributions to regional near real time suicide surveillance.
- Reviewed information sharing agreements to aid active engagement with partners for the review of suicide and/or drug and alcohol related deaths.
- Promoted, shared and actively engaged with preventative programmes for regional prevention of suicide.
- Development of a multi-partner collaborative safety plan template for complex individuals with high presenting need across multiple agencies.

Marginalised communities

- Promoted and shared information from partner organisations on improving awareness of mental ill health and suicide across South Asian communities.
- Invited keynote speaker to share knowledge on what works for information sharing on mental ill health and suicide prevention in South Asian communities and promoted the slides.
- Improved data capture and included data analysis on sexuality, ethnicity and marginalised communities within Datix for reporting into apparent suicides.
- Safeguarding team participation in reviews of individuals where suicide is apparent in domestic abuse/domestic violence.

Support for staff

- Recruited staff to support the launch of the suicide specific pathway for postvention.
- Ensured the well-being of the workforce is promoted and visible within the aims of the organisation for preventing loss of life to suicide.
- Reviewed the Trust's position on responding to NHS staff suicides.
- Moved existing work for prevention of staff suicide into the Trust wide well-being of the workforce to embed, prevention, intervention and postvention principles into the core of workforce support.
- Ensure access to and awareness of e-learning and face to face training for suicide prevention across the whole workforce.

Progress has continued to be made across the following areas:

- Improvement work streams on clinical risk assessment and quality monitoring for formulation informed risk management (FIRM) assessments.
- Improvement workstreams for care planning and care programme approach transformation, ensuring changes remain connected to safety from suicide.
- Ensuring other relevant forums, such as the clinical environmental safety group, are used as a means to escalate actions required to mitigate loss of life to suicide.

- Transitioned into active use and practice of the Patient Safety Incident Response framework (PSIRF).
- Updated and promoted SBARs (situation, background, assessment, response) to ensure organisational wide alerts and learnings are visible in preventing loss of life to suicide.

Suicide prevention conference

In early March 2025 our second suicide prevention conference was delivered, themed 'suicide prevention, delivering against national priorities'. We were joined by staff and colleagues from across the Trust and partner organisations, to share knowledge and good practice in suicide prevention.

We had guest speakers, the topics of which covered:

- A review of the West Yorkshire suicide prevention objectives and the way forward in ensuring momentum remains and where key priorities in suicide prevention interconnect with whole health population workstreams.
- Real time suicide surveillance, understanding locations of concerns and reducing the risk of suicide.
- Suicide prevention, a reflection on what works and recommendations for best practice principles.
- What can we learn from incident investigations processes, the impact on families and the workforce.
- Feedback from families, the important role of the family liaison officer, the barriers and challenges.
- The suicide prevention strategy refresh, reflecting on the last three years' aims and ambitions and the future, support from the R;pple charity in exploring the challenges in online harms, and delivering against the key priority areas.

Our key note speaker was Mike Palmer from three Dad's walking, his reflections on the loss of his 17 year old daughter to suicide in the period of the COVID-19 pandemic helped to highlight the priority in preventing the loss of life in our young people; the lived experience of those left behind after someone they know has taken their own life, and the importance of exploring the impact of isolation, disconnect, adversity and connections in each person we support.

Our information marketplace was supported by the representation of crucial partners in the prevention of suicide, and had displays from Papyrus Leeds UK, Andy's Man Club, Leeds based regional support from GAMcare, our Creative Minds and Recovery College leaders for deprivation and poverty network and service user community accessible support. We had support from Samaritans Wakefield, both in sharing information and pastoral offers throughout the day and representation from Amparo colleagues who deliver postvention suicide bereavement support in South Yorkshire.

Learning and insights from the conference will be used to inform the Trust's plans to reduce the loss of life by suicide.

What next?

- Launch the 2025-2028 suicide prevention strategy.
- Review the present action plans to ensure key priorities are captured and supported by actions and where necessary task and finish groups.
- Launch suicide prevention learning sets throughout 2025/2026 accessible to all.
- Support the development of best practice principles in risk assessment that ensure suicide prevention is collaboratively delivered.

- Establish a Trust cohort of experts who have experienced surviving a suicide attempt and those who live with suicidal thoughts.
- Establish a Trust wide bereavement link worker network to support access to postvention support.

Reducing restrictive physical interventions

What we prioritised

- To continue to reduce the use of prone restraint (a type of restraint which involves holding a person chest down, whether the service user has placed themselves in this position or not, and whether the person is face down or has their face on the side) across inpatient services.

- To reduce the incidences of seclusion (seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient 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- Mental Health Act (MHA) Code of Practice) across inpatient services.

What we did

The reducing restrictive physical intervention (RRPI) annual report 2024/25 reported that:

- The number of prone restraint incidents decreased by 69 from 255 in 2022/23 to 186 in 2023/24, a decrease of 27%.
- The number of prone restraints from 1st April 2024 - 31st March 2025 was 145, a reduction of 41 which equates to a 22% decrease.
- Therefore, over the past two years the Trust has seen a 43% decrease in the use of prone restraint. The introduction of the new techniques and more importantly the ethos of preventive strategies gives promise to a continuing downward trajectory.
- To support the changes to training techniques and ethos, the RRPI team have delivered training at ward level, with the new techniques also included in the RRPI inpatient new starter course from April 2025.
- Training compliance now stands at 86%, a significant improvement from 64% last year. The improvement to RRPI resources has provided the opportunity for courses to run concurrently, thus ensuring the new techniques are embedded robustly.
- Incidents of seclusion decreased by 206 from 725 in 2022/23 to 519 in the year 2023/24, a reduction of 27%.
- The number of seclusion room use from 1st April 2024 – 31st March 2025 equals 608 (this now includes Cheswold Park Hospital data)
- 105 of the seclusion episodes were based on Walton PICU ward over the past 12 months. Ward acuity has been high with several incidents requiring police assistance

As in the previous statement for 2024, reducing the use of prone restraint was highlighted as a key MUST DO action following the two CQC inspections of our acute and psychiatric intensive care units (PICU) services and forensic and secure services in May 2023. In low and medium secure wards, benchmarking data shows that the use of prone restraint is lower than the national average.

To continue delivering a reduction in prone restraint use across the Trust a number of actions were taken:

1. Pharmacy colleagues continue to work on alternate injection sites to the gluteal, given that prone restraint is on occasion utilised to administer injections.
2. Throughout the year, multiple training dates for the alternate seclusion exits have been arranged for staff working in psychiatric intensive care units (PICU) and forensic services to attend at Fieldhead hospital. The pilot for this training was rolled out to staff working on Stanley Ward. This learning has now formed part of an e-learning package developed by the Associate Director of Nursing Quality Profession in conjunction with the RRPI team.
3. In-reach work, by the RRPI team, to the wards has been undertaken in order to roll out the above training.
4. Restraint oversight group processes have been strengthened to allow for more in-depth analysis of prone restraint incidents.
    - To reduce the use of seclusion, the following has been implemented:
        - RRPI specialist advisers continue to engage with senior ward staff about the use of seclusion; this is achieved by analysis of incidents recorded in Datix which relate to seclusion, offering advice as to alternative interventions and monitoring of long-term/multiple seclusion events for service users. The latter is achieved via a process stipulated within the Trust seclusion and long-term segregation policy, whereby all seclusions lasting longer than 72-hours or where the service user has three episodes of seclusion a week are referred for advice to RRPI specialist advisors.
        - Members of the RRPI team are also conducting trauma-informed work pertaining to the use of seclusion.

Highlights and key activities completed to date

- The RRPI team continues to roll out training in the use of alternate seclusion exits using the safety pods; this has been extended to more inpatient services and the team have based themselves within the units to aid rotation of staff to attend the bespoke training.
- The RRPI team's mechanical restraint training package received BILD-ACT (Bild Association of certified training) accreditation in September 2024 and was assessed as being of a high standard in its emphasis on person-centred care. In clinical practice, mechanical restraint usually takes the form of the use of handcuffs when escorting service users from either a low or medium secure ward into the community or when transferring a service user to other another vicinity e.g. court appearance, often as a direct requirement from the Ministry of Justice.
- RRPI training compliance now stands at 86% due to the increased resources of the team which has allowed for additional courses to be provided. The Trust target is 80%.
- Both PICU wards within the Trust have been implementing quality improvement initiatives to reduce used of restraint and seclusion. This has involved the creation of sensory rooms, increasing activities including benefits of music and access to outdoor spaces, introduction of safety huddles and debriefs with service users and staff.

What next?

- The Trust has a clear ambition to reduce restrictive practice of all types. As a key aspect of this, Trust Board have been explicit that the expectation is for there to be zero occurrences of prone restraint being used in our wards.
- Specialist advisors continue to proactively engage with ward managers/clinical leaders to discuss incidents related to the restraint oversight group.

- To look at flexible ways to work with teams to facilitate the bespoke seclusion exit training, a key factor in reducing prone restraint.
- The Trust's seclusion and long-term segregation policy is due for review this year; the RRPI team are working with the Trust's trauma informed group to ensure trauma informed principles are embedded within the policy.
- From 1 April 2025, the alternate seclusion exits utilising the safety pods will be incorporated into RRPI teamwork training to allow for greater numbers of staff to be trained across the Trust and to facilitate a cultural shift regarding seclusion techniques.
- Increased in-reach work has been offered to the wards to allow for events such as technical debrief, reducing restrictive practice quality improvement work and for RRPI staff to act as a resource for ward colleagues.
- E-learning package developed for alternative injection sites.

Ligature Audits

What We Prioritised

The primary focus has been on streamlining the procedures for conducting community and inpatient ligature audits. This initiative includes the enhancement of audit tools and the optimisation of audit visits to improve overall efficiency.

What we did

- **Inpatient audits**

The Quality Governance Team (QGT) undertook a comprehensive review of the new CQC ligature audit tool designated for inpatient facilities. This tool was integrated with the existing Trust audit tool to create a unified version that encompasses all necessary information, along with supplementary data beneficial for the wards. This consolidated approach ensures a consistent methodology across the Trust and facilitates staff familiarity with the audit tool when operating across various wards. Furthermore, the revised audit tool has decreased the duration required for completing audits. Management and governance leads are now able to conduct audits for Section 136 suites (places of safety under the Mental Health Act) and seclusions as they become available, effectively mitigating delays associated with awaiting sign-off.

Over the course of the financial year, an additional fifteen audits were undertaken at Cheswold Park Hospital. Presently, there are seven audits pending completion for the 2024/2025 financial year. Six of these relate to Cheswold Park Hospital, which have had an audit completed in the previous 12 months by Cheswold Park, however they are awaiting a Trust audit to be completed. One audit remains incomplete in Wakefield due to the high acuity of the ward, seclusion continues to be utilised. Due to the purpose of seclusion, this is an area with low risk for ligation as service users are continuously monitored. This particular ward has been provisionally scheduled for its 2025/2026 audit, allowing for ample time for completion.

- **Community audits**

A thorough review and update of the community ligature audit tool was conducted to encourage building managers and team managers to collaboratively complete the new audits at their convenience. Prior to the commencement of these audits, training sessions were facilitated by the health and safety and quality governance teams, with ongoing support available for all visits as required. At this time, all audits are current, and none are overdue.

What next?

- **Inpatient**

The approach moving forward entails booking inpatient audits by geographical area when this is feasible. This method, which was piloted during the recent audits, enables an increased number of audits to be completed in a single day. Should one ward be unavailable, an alternative ward can be audited without necessitating rescheduling, thereby ensuring that all audits are conducted within the prescribed 12-month timeframe.

- **Community**

We shall continue to provide support and training to individuals who require assistance. It is also essential to confirm a standardised governance sign-off process that aligns with the inpatient audits, ensuring that all community audits are completed within the designated two-year timeframe.

Clinical effectiveness

Clinical effectiveness is informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit. It includes monitoring and improving the outcomes of service users.

Quality initiatives in 2024/25

The quality initiatives prioritised for action in 2024/25 include:

- Outcome measures
- Improving access to child and adolescent mental health services
- Care closer to home
- Falls improvement work
- Making data count
- Improvement of mental health screening for children with epilepsy

Outcome measures

What we prioritised

Implementation of Patient and Clinician Reported Outcome Measures (PROMs and CROMs).

What we did

The Trust continues to work to implement the use of outcome measures into routine clinical practice to facilitate a deeper understanding of the impact of the individual's condition on their health and social functioning, and the effectiveness of the care and interventions being provided. Capturing outcomes helps to evidence the effectiveness of the interventions that the Trust provides, ensures the opportunity to learn from areas of higher or lower performance, and the opportunity to continually improve the service offered and the outcomes achieved.

In June 2021, we replaced the mental health clustering tool being used in community mental health services, with a solution which promotes use of the Health of the Nation Outcome Scales (HoNOS) as a clinician reported outcome measure (CROM) and from which the cluster could be derived by an algorithm. Although we are no longer required to report cluster information to NHS England, we continue to use this tool. The outputs are beginning to be used to gain a better understanding of caseload profile and acuity.

Working with our portal/integration partner ReStart Consulting we have developed a digital solution to collect and report patient reported outcome measures (PROMs) using a laptop, smartphone or other handheld device. IMX digital outcomes aims to remove some of the traditional barriers to collecting PROMs where paper questionnaires often get filed and forgotten, or where the data requires re-inputting into the electronic clinical record which is time consuming and poses risks in transcribing errors. Starting in October 2023, IMX digital outcomes was rolled out to all our CAMHS and community mental health teams, supported by training delivered at individual team meetings and at tailored CPD sessions. In January and March 2024, using a 'bulk send' approach, all service users in core and enhanced community mental health teams were invited to complete an outcome. As a result, we were able to achieve the 2023/24 CQUIN related to outcomes (CQUIN 15a - 50% of adults and older adults accessing community mental health services to have a paired outcome of which 10% should be a patient reported outcome measure).

ReStart continue to develop the IMX digital outcomes tool based on clinical feedback. We have now added in-context launch from SystmOne and three new outcome measures have been included in the suite of PROMs available.

In line with the move away from CPA towards personalised care and support, links to IMX Digital Outcomes have been included in the new 'my health and wellbeing plan'.

What next?

- Ongoing training to embed the use of outcome measures into routine clinical practice. New 'personalised care and support' care plan training has been developed which includes and how to use IMX digital outcomes in conversations with service users. This will help embed use of clinical outcome measures into routine clinical practice.
- We have developed a process whereby we can notify practitioners when one of their service users has completed an outcome measure. This includes an alert for any item scores that might suggest the service user is at increased risk. This is being rolled out on a team-by-team basis.
- IMX digital outcomes provides visual information about the individual service users wellbeing and progress. Performance and business intelligence teams will work with clinical leads to develop a team and service level PROM dashboard.
- Work is underway to explore using the outputs from the HoNOS outcomes tool as part of a caseload management tool.

Improving access to child and adolescent mental health services (CAMHS)

What we prioritised

- To improve waiting times from referral to treatment.

- To ensure that children and young people have early access to the right support, at the right time and in the right place.

What we did

We focused on improving waiting times from referral to treatment. Our aim was to ensure that children and young people experiencing emotional and mental health wellbeing difficulties have early access to the right support, at the right time and in the right place.

Improving waiting times from referral to treatment in CAMHS remains a Trust, commissioner and national priority. Previous Care Quality Commission (CQC) inspections have identified that waits were a concern, particularly given the potential risk that children and young people (CYP) may experience a worsening of their mental health while waiting.

Significant progress has been made in reducing waiting times for treatment over recent years across CAMHS. Referral levels remain high, with more children presenting in crisis and with complex needs. There has also been an increase in referrals for children with eating disorders and in particular Avoidant Restrictive Food Intake Disorder (ARFID). Eating disorder referrals in Barnsley CAMHS have fluctuated and there is not currently an ARFID pathway. Calderdale and Kirklees eating disorder team have also initiated an enhanced eating disorder offer to support admission prevention and reduce delayed discharges within Calderdale. This has been supported by Calderdale commissioners.

Appointments have continued by telephone and video-link (digital solutions) with face-to-face support being the most typical offer based on service user choice and clinical need. The increased demand for face-to-face appointments is due to the clinical needs and complexity of the young people, however, we do offer a blended approach dependent on need, choice and risk.

Care packages have been enhanced and are more wide-ranging and more detailed to meet the needs of children, including those who have experienced a delay in admission to an inpatient hospital bed. This includes intensive home-based treatment. Barnsley CAMHS have tried to improve knowledge in children and young people (CYP) who present with complex co-occurring needs which include Learning Disability and Autism Spectrum Disorders given the rise in this cohort of young people presenting to the services and the need to develop staff to offer adapted interventions for children with neurodiversity.

Information on current numbers waiting in CAMHS pathways in each area is monitored by the operational management group, executive management team, the finance, investment and performance committee, and by our Trust Board.

In order to address the increasing waits, the following work has been undertaken during 2024/25:

Service evaluation – ‘changing the way we work’

- We continue to provide a flexible offer.
- Digital technology (telephone and video) was highlighted as positive for most children and families. However, the risk of ‘digital exclusion’ with the potential disproportionate impact on the most vulnerable has been highlighted.
- Face to face appointments have increased as the initial satisfaction with digital appointments accepted during the pandemic has reduced.

- More appointments are face to face due to families and service user requests and the clinical need of young people.
- In Calderdale and Kirklees all first appointments are face to face to observe the young person and pick up any non-verbal clues. Following this, a discussion with the service user about how they would like further appointments is undertaken. In Wakefield CAMHS all appointments are offered face to face or a part of a hybrid model of face to face or video consultation dependent on patient choice. Barnsley offers a hybrid or consultation model dependent on need and risk.
- Family therapy has proved successful via video link in some teams whilst only being offered face to face in others.
- The virtual approach to groups offered by Barnsley CAMHS has been valued by children and families.
- Barnsley CAMHS have successfully embedded a single point of contact called Branching Minds, which has incorporated voluntary agency, early help workers and crisis workers in the day-to-day delivery operational. A review of the Branching Minds offer is currently taking place due to the increased demand for the service and the sense of reduced capacity to meet this.
- Barnsley CAMHS have recognised the health inequality for learning disability provision within Barnsley and the increased demand for working within a neurodiversity adapted framework. Investing in staff training ensures staff are skilled to meet need and have positive therapeutic impact
- Wakefield CAMHS have invested in Anna Freud training (national autism training provider), and this is being rolled out to all staff members as a full service approach.
- Barnsley CAMHS completed capacity and demand review of the whole service to increase timely access to assessments to ensure children get access to the right support/service at the right time.
- Wakefield CAMHS have sustainably low waits at the front door with timely access and assessment. There is a robust waiting well offer in place to support whilst waiting.
- Wakefield CAMHS are developing a Wakefield wide single point of access incorporating health, social care, educational psychology, 0-19 teams and VCSE partners. The aim is to provide an access offer that removes duplication and signposting.
- There is a new pilot in Wakefield CAMHS that will focus on a crisis bed approach to increase access for young people to reduce the time spent waiting for a bed and time spent in hospital. Moving forward this will also include young people from Calderdale and Kirklees.
- We have developed a new pediatric mental health team based at Pinderfields General Hospital, with the aim of reducing inappropriate pediatric admissions for mental health issues and reduce length of admissions and utilise pathways out of hospital.
- Operationally Calderdale and Kirklees have mobilised a 0-18 CYP primary care network (PCN) service incorporating all PCN within the Kirklees Borough. This has received good feedback since implementation. This service is supported by commissioners and the service are currently looking at incorporating it as an integrated part of the early intervention offer.

Waiting list initiatives

- Capacity has been temporarily increased through additional investment.
- Most initiatives which were implemented during the Covid pandemic have been maintained, with ongoing review of care pathways to ensure they are efficient and effective. This includes a ‘while you wait’ offer within the Wakefield CAMHS service for people waiting for appointments within the core intervention team. This can include parent/carer session, safety nets or a wellbeing warrior.
- Wakefield CAMHS now has a community mental health support team (MHST) which will support children with mild/moderate mental health needs and is currently in the recruitment phase.
- Wakefield CAMHS are reviewing the whole service group offer to make it more relevant and accessible.

- Barnsley and Wakefield CAMHS offer ‘support whilst waiting’ which is a system and service approach to accessing support whilst waiting for treatment and recognises the importance of other support which can make a positive impact on mental health. We have a robust offer of waiting list monitoring to ensure that we are identifying risk, and acting in a timely manner, providing support to families and young people whilst waiting.
- In Calderdale and Kirklees teams have reviewed and designed waiting well initiatives relevant to their area and specialty. Whilst this does not reduce the waiting times overall, it supports children & Families during this period. There is also access to CAMHS crisis teams and ‘NightOwl’ lines in case of escalation in presentation.
- Barnsley CAMHS reviewed the pathway for attention hyperactivity deficit disorder (ADHD), which has sustained use of flexible approaches such as technology and funding for non-medical prescribing posts.
- The Kirklees mental health support team (MHST) has covered 57% of schools in Kirklees. Positive feedback has been received from schools, children and young people and families, commissioners and Kirklees scrutiny panel. Kirklees MHST has been expanded to include 100% of schools and colleges within the borough following the decommissioning of services through Northorpe Hall.

Neurodevelopmental assessment pathways in Calderdale and Kirklees

- Investment has been made into neurodevelopmental assessment pathways in both Calderdale and Kirklees over recent years.
- In Calderdale:
    - The enhanced service offers a large number of assessments.
    - Work is ongoing on the right to choose agenda for neurodevelopmental assessments.
    - Work continues across West Yorkshire to look at streamlining the process.
    - Maintaining the commissioned 21 assessments continues to be a challenge, however work with commissioners and new service developments has resulted in this target being exceeded during January and February 2025.
    - In agreement with Calderdale commissioners, the Trust is developing a proposal for increasing the number of completed assessments per month/per year. This outlines three different options and the funding requirements to meet.
    - Calderdale and Kirklees CAMHS eating disorders have also initiated an enhanced eating disorder offer to support admission avoidance and reduce delayed discharges within Calderdale. This has been supported by Calderdale commissioners.

- In Kirklees:
    - The neurodevelopmental assessment service has relocated and this has been positive for staff and families.
    - The Kirklees service has been commissioned to deliver 43 assessments per month. Positive recruitment has happened with only two vacancies remaining and this supports the delivery of timely assessments.
    - Due to the success of the new screening process we have received positive feedback from referrers and are now offering consultation slots within two to four weeks.
    - Challenges, including staffing, have reduced the number of completed assessments provided by the service across 2024/25. Positive recruitment has now occurred and will support the ability to achieve commissioned targets.
    - Operationally Calderdale and Kirklees have mobilised a 0-18 CYP PCN service incorporating all PCN within the Kirklees boroughs.

Secure CAMHS (Wetherby young offenders institute (YOI) and Adel Beck secure children's home (SCH)

Secure CAMHS have also been looking at ways to improve access to services for those children in secure care with examples being:

- Wetherby YOI have sustained the 'RAG' (red/amber/green) rating for any young people on a waiting list. This triggers a duty visit for the young person while they are waiting for an assessment, ensuring support is available. Due to improved recruitment and retention, there are currently no waiting lists.
- Wetherby YOI have sustained face to face three monthly reviews for young people who are not on a caseload, or sooner if required.
- Wetherby YOI have developed keeping in touch letters for young people when staff members are off for extended periods of leave.
- Wetherby YOI has continued to develop laptop content for young people and an 'app' to enable a request for an appointment with CAMHS directly.
- Wetherby YOI has introduced a senior social worker who leads on transitions with children and young people.
- Wetherby YOI and Adel Beck SCH have both sustained well-staffed teams from a range of professional backgrounds which enables a range of therapies/interventions to be offered.
- Wetherby YOI and Adel Beck SCH have launched the 'QB test' (a computer-based test to measures symptoms of ADHD) which enables a more robust diagnostic pathway.
- Adel Beck has sustained the dedicated mental health practitioner on each unit.
- Adel Beck has recruited a full-time advanced occupational therapist.
- Adel Beck continues to work with our pets as therapy volunteer to facilitate visits from the therapy dog into Adel Beck, which is loved by the children.

What next?

- The new contract for secure care has been awarded to the Trust which means that a new secure children's home (Aldine House) will join Wetherby YOI and Adel Beck SCH. In addition, the new contract includes 'psychosocial substance use' which will be provided on a subcontracted basis by 'Change, Grow, Live' (a voluntary sector provider).
- Developing a mental health strategy for the new contract awarded.
    - Optimising the level of recurrent investment in strengthening CAMHS capacity and addressing gaps in levels of investment to meet demand (within Integrate Care System (ICS) level arrangements).
    - Agreement and implementation of business cases regarding neurodevelopmental pathways.
    - Further business cases to address the challenges in meeting the needs of children in crisis and those with eating disorders.
    - Referrals into learning disability teams are increasing and funding has remained the same for several years. Business cases to be developed for further funding and development of the Calderdale and Kirklees CAMHS learning disability services.
    - A new service to have mental health practitioners in GPs surgeries in Kirklees is being developed. This is aimed at providing support in a way that will reduce the need for referrals into specialist CAMHS and into the emergency department.
    - Development of the crisis line to cover from 8am to 8pm seven days a week, to provide additional community support and prevent the need for young people to go to the emergency department.
    - Work with commissioners to ensure that the service has the capacity needed to meet demand.
    - Reviewing service functionality and considering any transformational work that can ensure services are sustainable, supportive to staff and responsive to service users.

- Wakefield CAMHS – additional ICB investment in 2025/26 to expand the ARFID offer to include additional clinical specialism and medical cover. Investment in the single point of access team focused on developing the new front door in collaboration with voluntary, community and social enterprise (VCSE) partners.
- Wakefield CAMHS – reduce waiting times for specialised therapies to under 18 weeks in line with OFSTED and SEND Inspection recommendations.
- To work with commissioners in Barnsley in looking at a strategic system review of CYP services for emotional children's mental health, incorporating a review of current services and budgets and looking at how to prioritise spending in the current financial climate given that the consistent message is there is no new investment for CYP in Barnsley.
- Barnsley has procured Night Owls which will be incorporated into NHS 111 press option 2 for mental health support out of hours, between the hours of 8am-8pm.

Care closer to home

What we prioritised:

- To focus on sustaining reductions in the number of people placed inappropriately in beds out of area.
- Ensuring that access to a bed at the point of need is always available.
- Ensuring patient safety at all points in the care journey
- Improve flow through services.

What we did

As a Trust we use out of area beds for several reasons, including:

- When a patient requires a single sex psychiatric intensive care unit (PICU) bed, which the Trust cannot facilitate.
- When local demand exceeds available beds in the Trust, in spite of all efforts to make best use of Trust beds.
- When wards are closed to admissions due to unforeseen circumstances such as an infectious outbreak and we have exhausted all other available beds in Trust.
- When we know the quality of care will be better met within an out of area bed, which may be due to staffing or specific needs of a service user.

From June 2023 the care closer to home (CCTH) approach became part of the Trust's priority programme work, linking in with the mental health improvement, workforce planning and inpatient improvement work. Following a review of the priority programmes in November 2024, care closer to home became part of the inpatient improvement programme due to the number of synergies across the work streams.

The purpose of the care closer to home priority programme is to ensure that opportunities for the provision of secondary care mental health services (inpatient) are maximised as part of a whole systems approach. This includes ensuring that out of area placements are only made when opportunities for local inpatient care provision is not possible and/or appropriate, to effectively meet the needs of the individual service user.

The work has been carried out with the golden threads of the organisation carefully woven throughout. This includes (but is not limited to) having a clear focus on adopting a trauma informed approach.

Measures and quality monitoring

The measures in place are as outlined below. This forms part of the weekly quality monitoring at Board and operational level.

Care closer to home / reducing out of area placements

Significant work has been undertaken to understand and manage bed pressures and implement the 10 high impact actions for mental health discharges, as evidenced by the reduction in out of area bed usage.

The programme was established to focus on areas with the biggest impact on reducing demand pressures and enabling a strategic longer-term approach to implementing a lower admission model. The work has focused on providing all care as close to home as possible. Moving forward, the Trust will continue to enhance discharge processes and care coordination by:

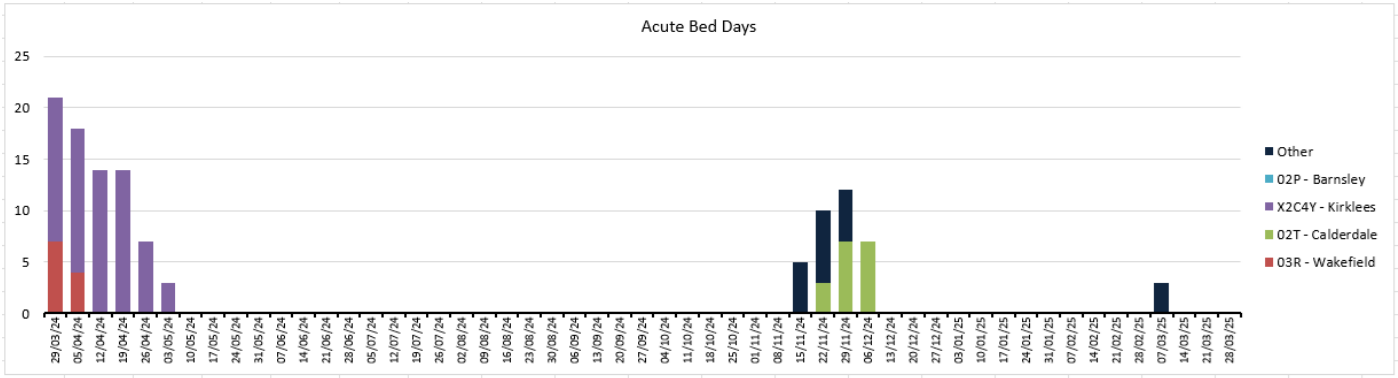
- Continuously developing and learning to improve patient flow and discharge with well-defined operating processes and systems, increasing bed turnover, allowing more patients to be treated locally, and reducing the average length of stay.
- Ensuring effective gatekeeping at the point of admission and purposeful admissions with prompt access to inpatient provision to meet a person's needs close to home.
- Implementing criteria-led discharge, efficient and timely discharges, and ensuring the discharge is planned and progressed using whole system oversight to maximise bed use.
- Utilising digital tools to identify ongoing pressures, manage flow, streamline discharge processes, and improve communication and coordination.
- Integrating mental health acute pathways into system-wide plans through collaboration with system partners to ensure comprehensive care coordination and reduce readmissions.
- Ensuring that practice, thresholds, management of risk, and caseloads are appropriate across community teams and that there is consistent community support.
- Conducting community and inpatient establishment reviews to identify areas for improvement and increase capacity and skill mix.
- Identifying and addressing training needs to support implementation and enhance staff skills to support community care and prevent readmissions.
- Utilising national service development funding to ensure equitable and safe staffing, improving patient recovery rates and local bed availability.

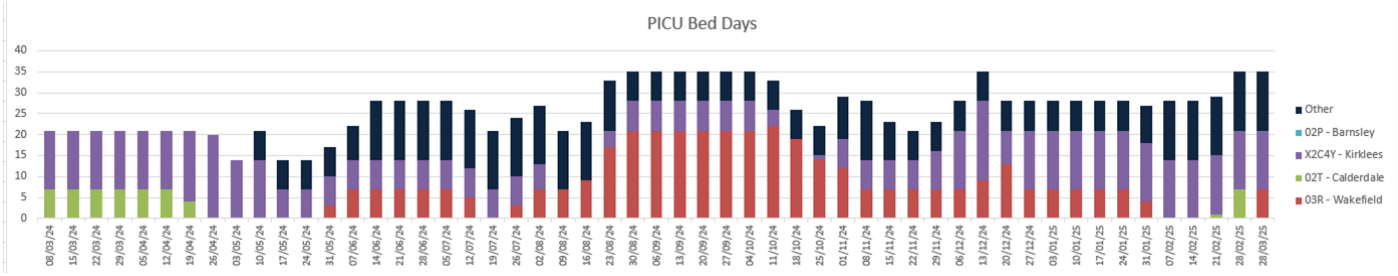
This work and the efforts of teams within the Care Group have maintained OOA placements at a low level. PICU usage is largely to manage gender-specific PICU needs not commissioned within the Trust. Our 2025/26 plan is to sustain the reduction achieved. For 2025/26, we have projected 4-5 active inappropriate adult PICU out of area placements at the end of each reporting period (i.e. 5 at the end of each month). Out of area (OOA) usage has been managed to its lowest level since 2019, with a lowest of two OOA placements and a high of six since the start of the programme. Acute out of area has all but been eliminated. This is demonstrated in the graphs below.

There is strong governance both in respect of the authorisation of the use of an OOA placement and the return of people to Trust beds. The impact of this has not shown to increase pressure within the community services, however, has instead seen some use of over occupancy and admissions out of pathway (for example a working age adult to an older person's ward). All instances of over occupancy and out of pathway admissions are reviewed for impact on the service users and the staff. This also includes if people

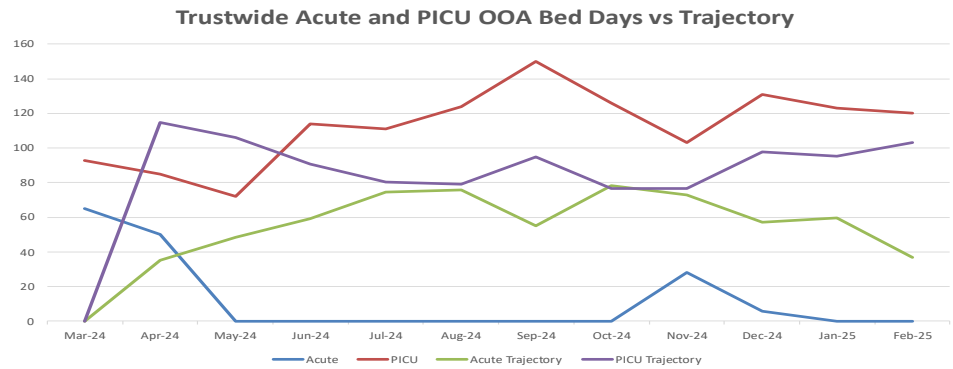
remain in the community whilst waiting for a bed. This is overseen by the improvement steering group and the Trust's mental health oversight group.

The graphs below show the out of area bed days for acute patients and patients requiring psychiatric intensive care (PICU), for the 12 months to end of March 2025. Acute bed days have remained low throughout the year, while PICU bed days have remained fairly consistent for the reasons outlined above.



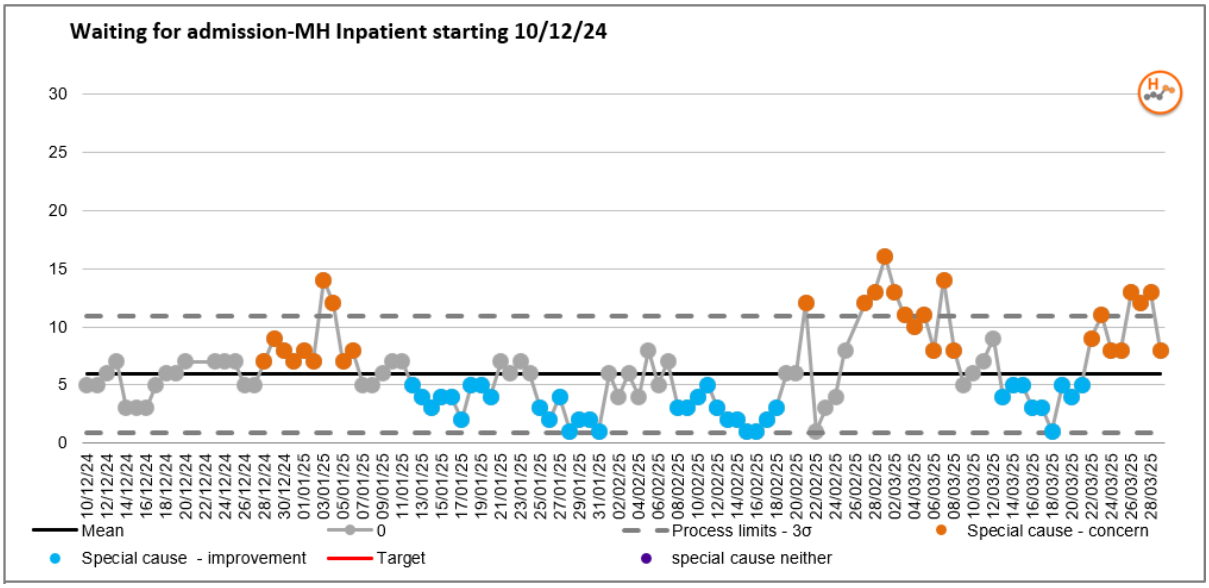


Acute & PICU Trajectory: March 2024 – February 2025



The graph below shows the number of people waiting for admissions. This data started to be recorded in November 2024 and as such the statistical processing chart (SPC) only holds data from this time. This data is reported on a daily basis as part of the operation pressures escalation levels (OPEL) framework. Many factors can affect the number of people waiting for admission and it is important that this is reviewed on a

daily basis to enable the Trust to work closely with the wider system to resolve any issues impacting on this.



Risks and Incidents

Datix incidents related to CCTH are reviewed within the CCTH steering group and within the patient safety oversight group. Risks are monitored through the patient flow meeting on a daily basis with general managers and service managers from inpatient and community services.

A weekly report is submitted to the operational management group and executive management team to ensure oversight.

What next?

- To sustain the reduction in the use of OOA beds. The target remains at zero. However, as the Trust does not have gender specific psychiatric intensive care unit (PICU) provision achieving an OOA bed use of zero will be a challenge, given the need at times for person-centred gender specific care.
- We will continue to work towards creating a sustainable pathway for the service user's journey through our services, enabling good patient flow with managed system delays and supporting people in the community.

The four main workstreams are being reviewed for 2025/26, at the time of writing they are:

- Optimising care in the community
- Point of admission
- Appropriate inpatient pathway
- Patient flow.

With the above workstreams aligning with the Trust-wide priorities of:

- Reducing the use of OOA beds
- Care closer to home

- The application and utilisation of continuity of care principles.

We will:

- Work together with all our partners in reviewing the valuable feedback given at the engagement workshops, and look to address the valuable conversations, topics and themes that emerge. Any outputs will be addressed in small task and finish groups (where required) and further specific topic workshops which may be per team or location.
- Continue to work towards creating consistency and uniformity of all processes and systems and achieve a full understanding of the roles and responsibilities required to ensure timely admittance and discharge.
- Provide a space through SharePoint where all relevant documents and links to partners' information for referrals can be easily found and shared. This will act as the main communication hub. Communication and a mechanism that would provide real time updates was identified as being a key component that needed to be addressed. Training for the patient flow dashboard and informal drop-in sessions will also be shared in this portal.
- Launch weekly engagement clinics to ensure staff have a voice within the programme.
- Continue to effectively use data and information to inform decision making and drive service improvement, ensuring that staff have access to dashboard training and knowledge of where to obtain the relevant information that will support their working group initiatives.

Falls improvement work

What we prioritised

- To continue with our ambitions to prioritise patient safety and reduce falls.
- To support patients, carers and staff to understand what creates a falls risk, and reduce falls related injuries, and the impact these can have on health, wellbeing, and independence.

What we did

Between 1 April 2024 – 31 March 2025 the Trust-wide falls coordinator for inpatient wards and units has continued to be proactive in measures to reduce falls, and to provide oversight and assurance to falls related safety events.

The falls standard operating procedure and governance pathway maintains a clear approach for the review of falls and supports learning. For example, on review of a yellow safety event, it highlighted the need for a patients' mobility aid to be checked on admission, with subsequent visual recordings made to show staff how to do this safely.

A monthly staff learning report provides recommendations for actions to take to help reduce falls, along with a bi-monthly "focus on falls" quick read and training packages are in place to further support learning and development.

Initiatives that have been developed over the last 12-month period include:

Falls

- Training needs analysis – to support understanding of staff access to falls related training. Bespoke sessions have been held to encourage learning that directly reflects the patient group on each ward.
- Patient education – two physiotherapy students from Sheffield Hallam University spent eight weeks on a ward with patients and staff. They reviewed all falls related events and themes. The students then took the main themes and developed patient educational materials and activities that supported the understanding of falls risks and how patients could take steps themselves to reduce their risk of falling.
- Post falls protocol – this continues to have a good level of completion and response. An audio recording was commissioned through the Trust communications team to support staff and students understanding of how to complete this effectively.
- Safety huddles – are being encouraged on wards where there are higher falls rates. One ward showed a 24% reduction in falls and 40% reduction in aggression and violence in the 12-month period following implementation of safety huddles.
- eFalls – this is an electronic system that captures multifactorial falls risk data and highlights early awareness of the risk of falls within a 12-month period. We are working with research and development, Leeds University and Southampton NHS Trust to further develop eFalls research that can be used in secondary care with a specific focus on mental health and learning disability services.
- Cheswold Park Hospital – we have provided staff education around falls risk, and screening tool completion. We are also implementing the post falls protocol documentation and supporting staff with assessment and care planning.

Current falls related data

The current rate of falls in the Trust is approximately 3.04 per 1,000 bed days. We continue to be below the National average for inpatient falls of 6.3 per 1000 bed days. https://www.vivid.care/insights/advice-tips/inpatient-falls-report/

Between 1 April 2024 – 28 February 2025 there was a lower rate of falls, with 89% (534) of all falls being graded as green indicating low/no harm. 2% (11) of all falls were graded as amber indicating a higher intervention or injury.

When comparing data from the previous year 1 April 2023 to 31 March 2024, a sustained reduction in falls where injury has occurred has been noted. Overall, there was a small increase in reported falls Trust-wide. This may be due to increased awareness and reporting of falls related incidents.

Out of the 603 Trust-wide reported falls, 86 (14%) of falls did not occur on an inpatient ward or unit but may still be linked with the ward if a patient falls on leave.

What next?

During 2025/26 a Trust-wide falls annual quality improvement plan will be developed which will focus on learning from 2024/25 and look at further improvements for the coming year.

Making data count

What we prioritised

The collaborative approach of making data count. Maximising opportunities to present data in a format that is co-produced with the end user(s) and promotes effective data driven decision making opportunities.

What we did

Colleagues in intelligence change (integrated change team), performance & business intelligence, research & design, equality inclusion & involvement and across operational services have worked collaboratively to identify key data required in specific areas of work to identify and implement tailored data visualisation methods.

Some key successes in this work during 2024/25 include:

- Specialist data dashboard rolled out across forensic inpatient services.
- Trialing the transfer of e-Rostering outputs onto statistical processing charts (SPC) which are now being used to form part of the weekly grip and control meetings.
- Using data to evidence service and project evaluation and continuous quality improvement. In addition to aiding local service delivery, this work has also received national recognition in the form of an article published in the British Medical Journal (BMJ) celebrating the work of the creative practitioners on our inpatient wards (Murino, Peel et al. BMJ, 2025), and a poster presentation selected for display at the division of counselling psychology annual conference by Dr E. Verdi from the Trust's Paths service (a new maternal mental health service).

What next?

Building on the successes to date, an important part of our commitment to the strategy refresh was to identity how we will measure our progress. A key aspect of this is understanding what will be different if we are getting it right. This will inherently include consideration of some of the Trust performance and risk information, but it also requires continued commitment to the consideration of improvement information and measures. This involves the triangulation of data from a wide range of sources and recognises the equal importance of data (numbers) and data (voice). We will ensure we understand how things are changing over time so we can be clear if we are improving as a result of what we are doing. It is the only way that we can provide assurance about the impact of our work, and we will continue to work collaboratively to report data that achieves this.

Improvement of mental health screening for children with epilepsy

What we prioritised

We know that there is a higher prevalence of mental health difficulties, learning disabilities, neurodevelopmental comorbidities (for example, attention deficit hyperactivity disorder and autism spectrum disorder), and a higher risk of suicide in people with epilepsy compared with the general population. We prioritised:

- Providing coordinated care for people with epilepsy.

- Being aware that children and young people with a complex childhood epilepsy syndrome can have developmental difficulties and cognitive impairment and may need additional support from a multidisciplinary team.
- Ensuring effective communication and liaison between healthcare professionals across the relevant services involved in the care of people with epilepsy and a mental health condition to agree and plan care across services.

What we did

As part of the South Yorkshire ICB Children and Young People (SY ICB CYP) network we meet regularly to improve care regionally for children with epilepsy, this feeds into the national improvements that need to be made.

We are in the process of undertaking a redevelopment of care plans to support children with epilepsy. This includes epilepsy nurses from across the region who are able to help develop a uniformed approach to care planning, approval of plans and implementation of plans.

We are also implementing the use of a mental health screening tool in order to identify children who may need support from other services such as school counselling, Branching Minds or CAMHS. In order to implement this we have extended our clinic slots for patients from 20 mins to 40 mins with the epilepsy nurse specialist and the associate specialist doctor for epilepsy to enable time for a more thorough assessment.

What next?

- Agree the care plan regionally and implement this via SystmOne.
- Review the impact of the new care plan six months after implementation to understand if it is effective in meeting the needs of the young people and identify if any changes are needed.
- From 1 May 2025 the mental health screening tool will be implemented in epilepsy clinics.

Patient experience

Patient experience is regarded as one of the key indicators of quality in healthcare provision and is closely intertwined with the two other key aspects: clinical effectiveness and patient safety.

Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. We also know that positive staff experience is fundamental for ensuring good patient experience.

Putting service users and carers first is a priority for the Trust. Our mission is to help people reach their potential and live well in their community. The Trust supports this by understanding our service users, their families, and carers experience of our services. Understanding where services have exceeded in providing a good experience and where improvements are required.

Quality initiatives in 2024/25

The quality initiatives prioritised for action in 2024/25 include:

- Triangle of Care
- Friends and family test

- Complaint closure and resolution times

Triangle of Care
What we prioritised • Completion and achievement of star one for the first year of Triangle of Care. • Work towards achieving star two Triangle of Care and continue to improve the journey and the experience for carers across the Trust. • Triangle of Care is a national initiative provided by the Carers' Trust, who describe the approach as a therapeutic alliance between carers, service users and health professionals, aiming to promote safety and recovery and to sustain mental wellbeing by including and supporting carers.
What we did The Triangle of Care creates collaboration and partnership with carers in the service users' and carers' journey through our services. As part of our commitment to keeping carers and families of people who use our services informed and supported, we are introducing the Triangle of Care model in all services across our Trust. The Triangle of Care means including carers at all levels of care, giving them equity in the service user journey. Using the Triangle of Care will help promote safety, support recovery and improve wellbeing. In July 2023 the Trust was successful in our application to become a member of the Triangle of Care. The membership is a three-stage recognition process for services who commit to self-assessing their existing services and action planning to ensure the Triangle of Care standards are achieved. The membership scheme recognises long-term commitment from mental health providers who are working towards measurable cultural change in this area. In July 2024 a submission report along with completed self-evaluations was submitted to the Carers Trust. Following which a peer review was represented by the Trusts carers project manager, associate director of nursing, alongside a number of key service leads, and community partner representatives and carers. It was heard by the head of carer & relative experience for Lincolnshire Partnership NHS Foundation Trust, a Carer expert by experience and the director of network at Carers Trust. The panel particularly valued hearing the excellent and honest carer testimonies which showed carers were comfortable in giving constructive and open feedback to the Trust, and hearing about specific carer innovations, such as the carers retreat. We achieved star one and with the following recommendations and actions we are now working towards star two: • It would be helpful to ensure clarity and consistency on the respective roles and responsibilities of the carer champion/lead/family worker titles and to ensure that terminology is applied consistently across the Trust. • At the next annual report update it would be helpful to understand the full range of family therapy options available, recognising that psychoeducation is distinct from family therapy and that there will likely be waiting times for systematic family therapy. • The panel would like confirmation of the process for referring carers for carers assessments, above and beyond the needs assessment referenced as undertaking of a statutory carers assessment is a right under the Care Act 2014.

- Building on the good practice of recognising carers who participate and contribute to the carer awareness training. There may also be further opportunities to recognise and celebrate other types of carer contributions and engagement across the Trust, in recognition that many carers will not have the capacity to engage with this more intensive type of involvement activity.

A significant amount of work has already been undertaken to improve the inclusion and experience of carers and families. This includes:

- Production of carer and staff carer leaflets
- Recruitment of 70 carers' champions across the Trust and delivery of workshops
- Co-developed staff carers awareness training
- Introduction and promotion of the use of carers' passports
- Dedicated intranet area for staff carers
- Having a dedicated carers project manager

The Trust is now well on track to support improvement in identified areas with a 550% increase in a carer being provided with a carer's passport and staff carers awareness training being accelerated with new e-learning training in development to support this.

What next?

- Self-evaluation of our community teams is in progress with approximately 40% returns to date.
- Star one annual report due 25 June 2025 (to fulfil 2025/26 year reporting).
- Evidence for Star two award (including self-evaluations and update report for Star one activity) by 25th June 2026 with a view to holding panel assessment mid-July 2026 (this will fulfil 2026/27 activity and reporting).
- Work will continue to achieve the action plans which have been developed for inpatient and community crisis teams.
- Data gathering and review of the impact of the work will also be a priority for 2024/25.
- Following achievement of star two award we will work towards star three for non-mental health services.

Capturing patient experience

What we prioritised

To achieve a Trust-wide target for satisfaction rates gathered through the friends and family test and tailored targets for some specific services.

What we did

Evidence demonstrates that service users who have a better experience of care have better health outcomes. There is also a link between experience and cost of care. A poor experience leads to higher costs as service users may have poorer outcomes, require longer stays or be admitted for further treatment. We have been working to improve the measurement of patient experience in our services.

In 2024/25 we focused on:

- **Reviewing the patient experience improvement framework**
  NHS England have launched a refreshed Experience of Care Improvement Framework in February 2025. The framework will form part of our priorities for 2025/26.

- **Further expanding text messaging across community health services**
  Text messaging went live in the community services in January 2025. Since going live there has been a 60% increase in the number of responses received through the text message link, and a 67% increase in the number of responses received for community health services. This will enable a more rounded view of experience and enable equality and protected characteristic data to be identified.

- **Working with other support services to triangulate insight to inform quality improvement**
  Patient experience and equality and involvement colleagues are working together to reestablish the equality forums as experience, equality, and involvement groups. This will form part of our priorities for 2025/26.

- **Development of service line patient experience surveys**
  Learning disability, ADHD and autism spectrum disorder (ASD) patient experience surveys will be launched in April 2025. Community mental health services and CAMHS patient experience survey are under development.

  Data for our current patient experience surveys from mental health inpatients in Forensic inpatients, community services, and carers survey are providing services with a wide range of feedback to review and assess and provide assurance around service users experience regarding feeling safe, listened to, involved, being treated with dignity and respect and knowing how to raise concerns about their care and treatment, and carers feeling engaged. This supports quality improvement work within services.

- **Volunteers**
  The first cohort of volunteers within the patient experience team, received training in January and are now being placed within services to support the collection of feedback across services. Dates are being organised for training for cohort two in May 2025.

- **Develop accessible age-appropriate Friends and Family Test cards**
  Friends and family test cards have been co-designed with a group of young people through the Trust's Connectors programme. The Trust collaborated with 21 young people to resign the cards to make them more attractive and appealing, to encourage and increase feedback from young people using our services. The impact of this will be reviewed in the coming year.

- **Work with Care Groups to collate actions taken as a result of feedback**
  Care Groups receive regular reminders through the headlines and meetings to display, where possible, 'you said, we did' posters in services demonstrating actions taken from feedback and email copies of posters to the friends and family test inbox.

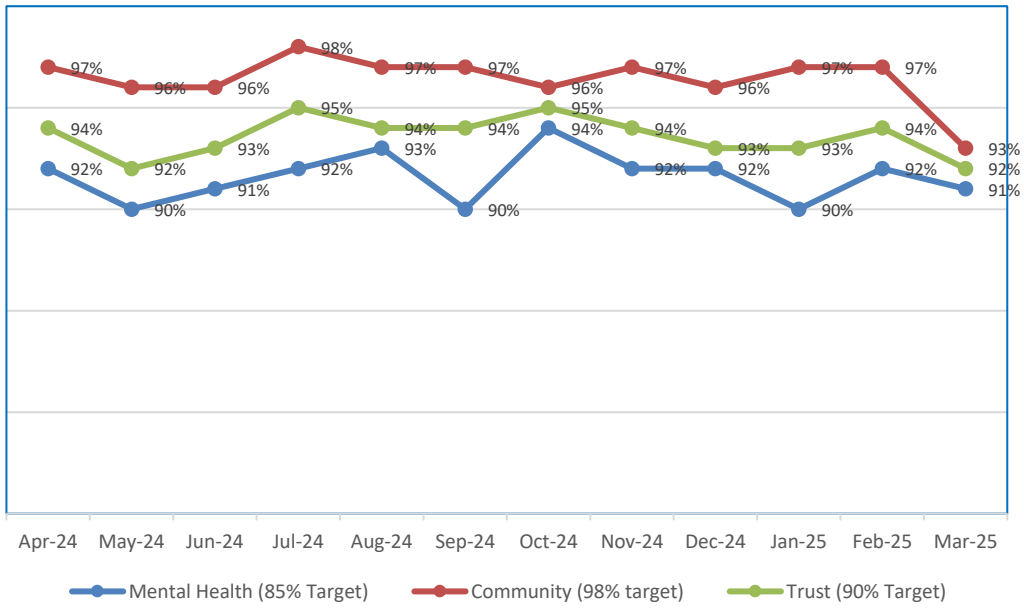
Friends & family test

The NHS friends and family test (FFT) is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This feedback is used to improve services. The FFT question asks overall how the person's experience of Trust services was and offers a range of responses from 'very good' to 'very poor,' including a 'don't know' option. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor service user experience.

The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of people who use their services. The results are available more quickly than traditional survey methods, enabling the Trust to take swift action when required. The FFT results are also a useful source of information which can help to inform choice for service users and the public. The results are available on the NHS England website and the NHS Choices website.

The FFT was implemented in the Trust in 2015. The Trust is on a progressive journey of continually refining and improving systems and processes for the collection of service user feedback and uses this to improve quality. In 2024/25 the Trust received 8801 FFT responses, an average of 733 per month compared to 8883 FFT feedback received in 2023/24. The Trust regularly reviews collection methods across services to ensure they are suitable and accessible, identified gaps where services are not receiving feedback and works with them to increase their feedback rates.

The chart below shows the number of respondents that rated the service as either 'very good' or 'good.' Community physical health services generally achieve a higher satisfaction rate than mental health. Due to this community physical health services have a higher satisfaction rate target of 98% (Trust agreed target).

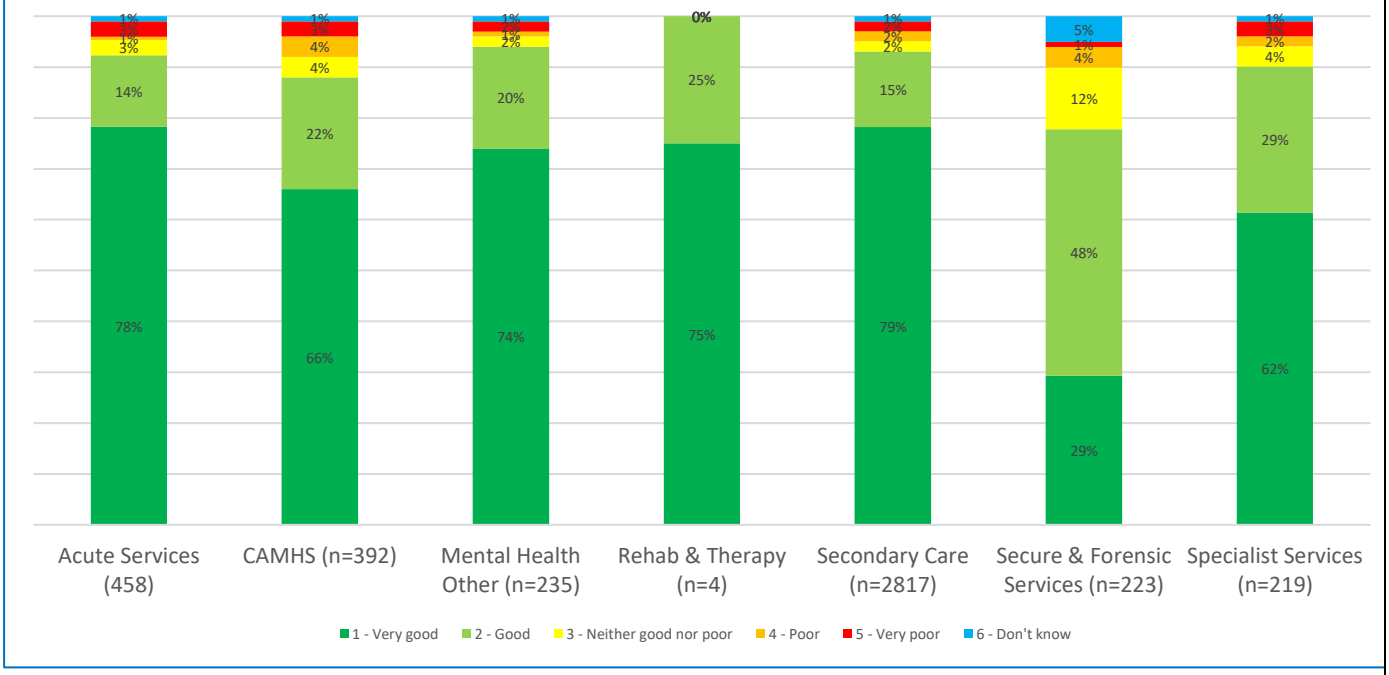


Friends & Family Test	Target	Reporting Period	Q1	Q2	Q3	Q4
CAMHS	75%	Quarterly	86%	94%	90%	80%
Learning Disability Service	85%	Quarterly	89%	92%	96%	97%
Forensics	60%	Annually	76% (April - December)			

Top three themes from Friends and Family Test feedback:

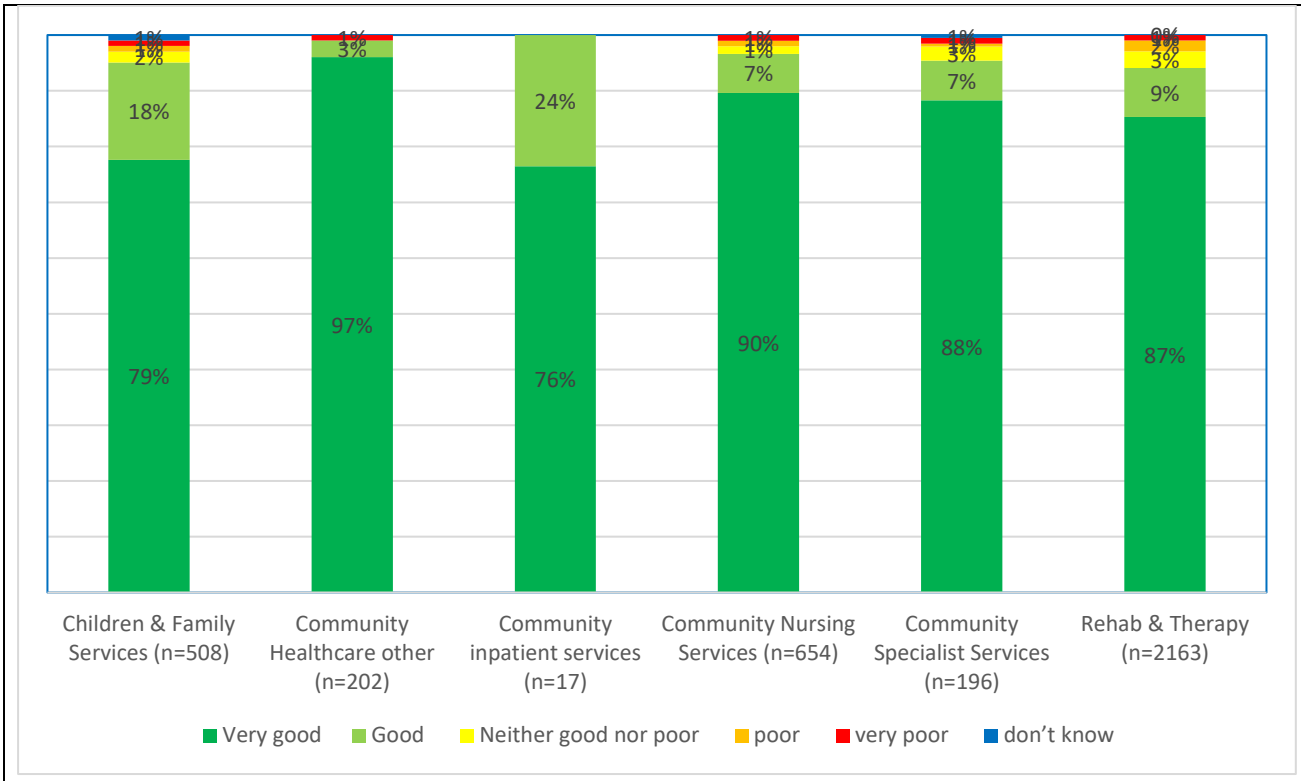
	Positive Themes	Negative Themes
Community	1. Staff, 2. Communication 3. Access and Waiting Times	1. Staff 2. Clinical Treatment 3. Access and Waiting Times
Mental Health	1. Staff 2. Communication 3. Patient Care	1. Staff 2. Communication 3. Admission and Discharge
Trust-wide	1. Staff 2. Communication 3. Patient Care	1. Staff 2. Communication 3. Access and Waiting Times

Mental Health Service Friends and Family Test Results 2024/25



92% of respondents rated the service they received as either ‘very good’ or ‘good’. 4% rated the service as ‘very poor’ or ‘poor’. The percentages for those who would rate the service as ‘very good’ or ‘good’ were 7% above the 85% target. This is an increase on the previous year when 90% of respondents rated the services they received as either ‘very good’ or ‘good’.

Community service Friends and Family Test results 2024/25



97% of respondents rated the service they received as either 'very good' or 'good. 2% rated the service as 'very poor' or 'poor'. The percentages for those who would rate the service as 'very good' or 'good' fell below the 98% target by 2%. However, this is an increase of 3% on the previous year where 93% of respondents rated the service they received as either 'very good' or 'good'.

What next?

- Implement 'Experience of Care Improvement Framework'.
- Establish experience, equality, and involvement groups across the Trust.
- Support the Patient and Carer Race Equality Framework (PCREF).
- Investigate the reduction of responses across the past three years and establish initiatives to increase feedback.

Complaint closure and resolution times

What we prioritised

- To improve our delivery timely and robust responses to feedback, both informal concerns and formal complaints.
- To improve the flow of complaints through the process and improve the experience for the complainant.

What we did

The Trust values the importance of providing anyone who uses our services or their loved ones with the opportunity to seek advice and provide feedback about the services we provide. Efficient and effective handling of complaints can be viewed as a measure of organisational strength and demonstrates the Trust's commitment to continuously listening, reviewing and improving the quality and safety of the care we deliver.

The customer services team provides an accessible and simplified gateway acting as a single point of access to hear and act on concerns, comments, compliments and complaints driven by the rights of patients as set out within the NHS constitution.

The Trust recognises that the complaint process is sometimes the best pathway for patients and families to receive an appropriate resolution to a problem. The team continues to promote a welcoming and positive culture for everyone contacting the customer services team, and is easily accessible to all users of our services via our dedicated freephone number, office number and secure email address. People can also provide feedback to the team online through the Trust's website by completing the online form. They can also contact the team in writing either by letter or completing a customer services leaflet found in service areas or local advocacy services.

The customer services team is committed to ensuring that all individuals who contact our team can communicate with us effectively and without barriers. To achieve this, we have been actively identifying and implementing measures to accommodate different communication needs, including:

- Understanding customer (anyone in contact with our team) preferences, proactively asking individuals about their preferred communication methods and any aids they require when interacting with us, including their preferred name they wish us to use throughout their contact with us.
- Utilising interpreting and translation services for spoken languages and British sign language interpreters.
- Using accessible formats, offering information in various formats, including large print, different coloured fonts and backgrounds for better readability, easy-read formats and bullet points for clarity.
- Using audio versions of forms for those who prefer listening over reading.
- Implementing on-going training. The team members are trained to recognise and respond to diverse communication needs, ensuring inclusivity and accessibility remains a priority.

The Trust acknowledges the importance of monitoring trends and patterns in concerns and complaints and facilitates early detection of any systemic problems. Learning from complaints and feedback helps the Trust to continually improve a person's experience and the services we provide.

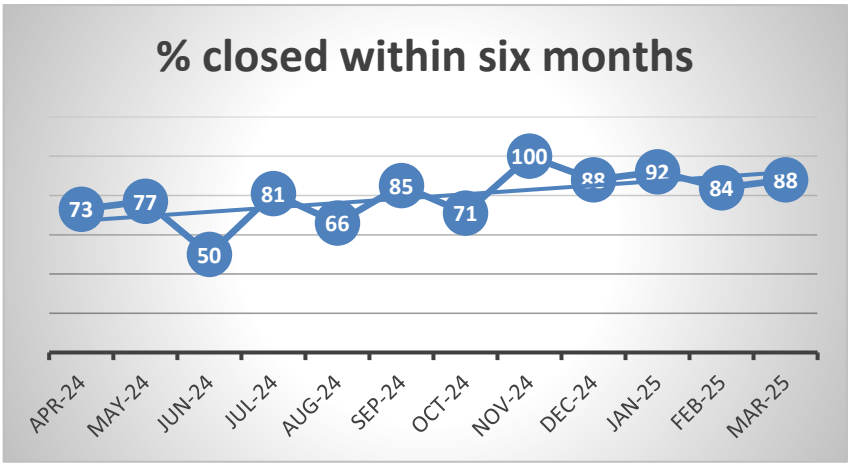
Data for Q1 to Q3 2024/25

Between April 2024 and March 2025, 168 formal complaints have been closed. Of these, 82% (n=138) were closed within six months of receipt of the complaint and this performance continues to increase month on month.

The flow of complaints through the process is under constant review. The number of complaints responded to within the six-month statutory target has improved over the last 12 months with the majority of complaints meeting this target. This will remain a focus for 2025/26. The following actions are in place to support with a timely response:

- Band 3 administrators able to complete required tasks and free up time for customer services officers to write responses.
- Close working with Care Groups to quickly identify a lead investigator for a complaint.
- Supporting thorough completion of the investigation toolkit to enable easy completion of a complaint response.
- Changes to the sign-off process to enable a complaint response to be signed off by the required senior managers and directors in a timely way.

Response times for six-month target



Reopened complaints

Between April 2024 and March 2025, 29 complaints were reopened following a complaint response letter being sent. This is 17% of all complaints which were closed and completed during this time period. This figure has increased from 2023/24 and may reflect an increase in the complexity of complaint investigations and responses alongside a corresponding increase in complainant's expectations.

The Trust has received contact from the Parliamentary and Health Service Ombudsman (PHSO) regarding 29 complaints which have been escalated to them between April 2024 and March 2025. Three of these are from one complainant and two are from another complainant.

Informal concerns/service issues

Between April 2024 and March 2025, 492 informal concerns and service issues were managed and closed through joint working between the customer services team and Care Groups.

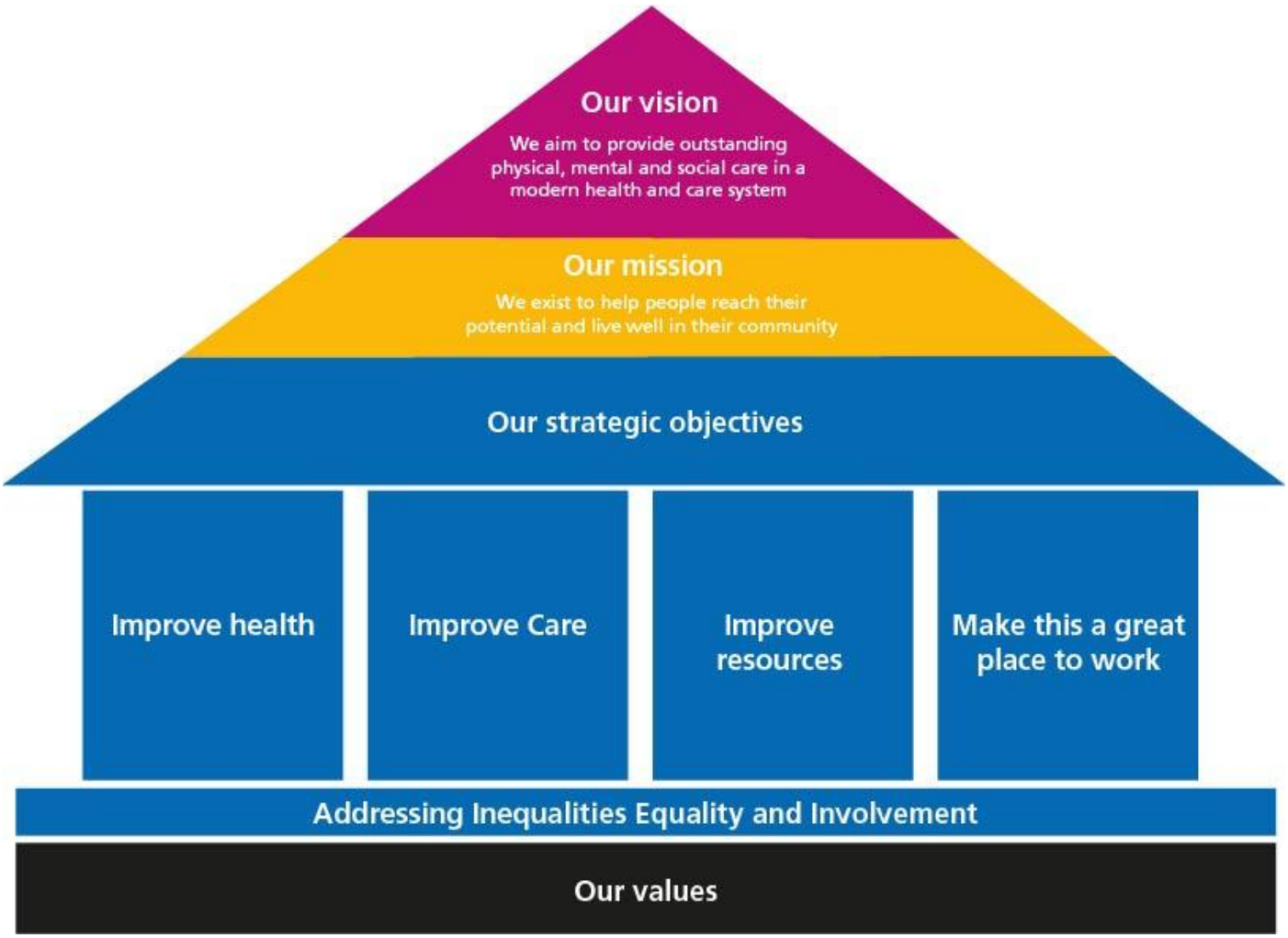
What next?

- Running a programme of engagement events across the Trust to ensure that the process for complaints management is understood.
- Implementation of an electronic survey for people who have raised a complaint, and with partner organisations, to give us a better understanding of their experience of the process and the extent

to which the resolution met their needs. This insight will inform further continuous improvement of the complaints process.

- Work to continue to improve meeting the six-month timeframe for responding to formal complaints.
- Continue to identify themes from complaints and making improvements following feedback. The customer services team work closely with lead investigators to ensure that any learning from feedback is identified.
- The customer services policy will be updated following feedback from the 360-assurance audit.
- Delivery of a Trust wide complaints training programme.
- Continue to monitor outcomes by tracking the number of complaints reopened and those referred to the ombudsman. Work with the Datix team to streamline the recording of complaints and concerns within the Datix system.
- Work with performance and business intelligence colleagues to develop a complaints dashboard which allows for easy monitoring and reporting on complaints and the complaint process. This work will continue into 2025/26.
- Continued focus on development of the team – for example, complaints handling training, letter writing skills, wellbeing /reflective sessions.

Other examples of quality improvement and innovation



Over the last year, we have seen a continued commitment to delivering high quality care, with teams going out of their way to support service users, families and each other. In this section, we highlight some additional examples of improvement and innovation that demonstrate how staff have worked to deliver our vision and mission during 2024/25.

Domestic abuse

Embedding learning from several domestic homicide reviews (DHRs) and domestic abuse related death reviews (DARDR) was prioritised during 2024/25.

The Trust is committed to supporting and protecting the safety of all those who come into contact with our services, and we are committed to recognising and responding to domestic abuse.

The learning from domestic homicide reviews supported the implementation of the roll out of routine enquiry, across the Trust, in 2023. This is where all service users are routinely asked if they are experiencing domestic abuse, this action was audited in March 2025, to consider the effectiveness of this action. To further support the clinical staff with cases of domestic abuse, one of the safeguarding advisors within the team has initiated the training of the master class for domestic abuse stalking harassment and honour-based violence (DASHH) training. This training commenced in April 2024.

The aims of the course are:

- To understand the dynamics of domestic abuse, stalking and so-called honour-based abuse
- To understand the human and financial cost of domestic abuse, stalking and honour-based abuse
- To be able to identify high-risk of domestic abuse, stalking and honour-based abuse
- To be confident in making defensible decisions based on the evidence from extensive research of cases including domestic homicides, near misses and 'lower level' incidents

There have been four training sessions with seventy staff having received the full days master class training. This training has been positively received with feedback such as 'really informative', 'highlighted my awareness of domestic abuse stalking and honour-based violence', also 'share knowledge with the team and support staff with completing multi-agency risk assessment conference referrals'.

The Team will continue to work with partners to ensure we continue to develop this work, with a view to ensuring the safety of all our service users and staff. The findings from the audit will support the workplan going forward and the evaluation of the impact of the DASHH training to further highlight the importance of understanding domestic abuse and how to report concerns.

Children's therapy (occupational therapy and physiotherapy) referral form

There was a need to reduce the number of referrals to the service that should have instead been received by universal services.

To do this the team significantly increased the information available on our website in order to help universal services support children and young people (CYP) before referring for targeted and specialist intervention from children's therapy. This included creating motor development programmes (with associated resources) for pre-school and school age CYP. These can be used by parents/carers, schools and nurseries to help CYPs fine and gross motor development.

Referral forms were redesigned to signpost people to online resources and other support available. With this in place the referral criteria was able to be tightened.

The new referral form was taken for consultation with primary referrers. The form was modified according to feedback.

As a result there has been a reduction in unnecessary referrals to children's therapy, which in turn is having a positive effect on waiting times and will help to ensure that CYP are seen in a timely fashion and by the team best placed to meet their needs.

West Yorkshire Paths

A new maternal mental health service was launched in July 2024. This was commissioned across the five places within the West Yorkshire ICB and is hosted by the Trust.

This service identifies, assesses and offers interventions for moderate to severe/complex mental health difficulties which are associated with loss and trauma occurring in the maternity/perinatal/neonatal context. The service provides consultation and advice, training into the maternity systems and provides targeted care and support to those whose needs would not be well met by other services on the perinatal pathway.

Using the six-step model for improvement the following was part of the project:

Identify:

- Early data and measurements identified.
- Ensuring data could be input and abstracted from SystmOne.
- Three monthly data requests were scheduled with performance and business intelligence team.
- Work with the Paths team to ensure core demographic data was recorded on the SystmOne referral.

Understand:

- To provide understanding of referral and did not attend activity in the first three months of service delivery.
- To identify areas of interest, such as low referral activity/uptake and understand contributing demographic and/or potential socioeconomic factors linked to CORE20Plus% and the patient and carer race equality framework.
- To use the data to understand service activity and drive improvement.

Plan and generate ideas:

- Referral and non-attendance data mapped to help visualise potential gaps in access and uptake.
- Locality data helped to identify potential gaps in knowledge of the service.
- The data also showed some areas where data quality could be improved and other areas of interest, such as ethnicity of people referred.
- The data led to some local improvements and consensus in coding of referrers on SystmOne.

Next steps:

- Links with equality and involvement colleagues to understand local communities.
- Look to develop additional professional relationships to ensure knowledge of the services and referral opportunities are maximised.
- Gather insights from experts by experience in relation to loss and trauma in diverse communities.
- Intelligence gathered from these conversations will lead to the development of the first plan-do-study-act (PDSA) cycle.

Food and drink provision quality assurance

Catering is provided to service users, staff and visitors in the ward areas and dining rooms across our Trust. In order to evaluate the service, develop and improve the standards and variation of our food offering, we devised and introduced feedback forms into the wards and dining rooms.

The feedback forms allowed meals to be rated and for the person completing the form to state whether they would choose to have that particular meal again. The option to provide comments was also available to be able to specify which meals service users, staff and visitors would like to see featured on future menus. These comments were reviewed and discussed within the catering department to adapt meal options where possible.

Some examples of comments received were:

- Healthier choices of supper snacks i.e. oat/fruit cake or biscuits/small cereal bars/seasonal fruit.
- Improvement in finger food i.e. crumpets/pizza/veg sticks.
- Can we have some different items i.e. cottage cheese.
- Some options are boring over time.
- Poor fruit and veg variety.
- Seasonal menu was better.

- More cultural options.

Improvements made as a result of these comments include:

- Creating a ‘mix & match’ range of out of hours food items to reflect diverse needs i.e. healthier eating and finger foods, oat fruit biscuits, cereal bars.
- Creating a trial of eight weeks Wednesday summer seasonal menu i.e. seasonal fruit, cottage cheese and pizza.
- Additional cultural options i.e. halal, Caribbean menu.
- Fruit (apples, oranges, bananas) and vegetables (salad, broccoli, peas, carrots, swede) are available daily.
- Celebration events i.e. South Asian Heritage month, Black History month, Diwali, Eid, Christmas.

Our food offering aims to support a mix and match approach for individual choice selection, offer diverse nutrition requirements and reduce food waste. Seasonal options provide opportunities to try new items and gain further feedback on these. We have also displayed ‘You said we did’ posters around the Trust to highlight that we are listening to and acting on the feedback received and will continue to do so.

Improvements to red emergency bags

Following an initial audit carried out by the resuscitation team, of the red emergency bags across the Trust, changes were made to make it easier for staff to maintain them and simplify the checking process.

The bags are now tagged shut with an earliest expiry date marked on a check sheet kept on the ward. This ensures staff no longer need to go through individual items weekly, which can be very time consuming.

The re-audit showed vast improvement with 100% of the equipment being in date and all but one of the bags sealed (one had recently been used at the time of the audit and staff were in the process of re-stocking it).

The improvement work also included the resuscitation team having spare equipment at all inpatient sites available to access 24 hours a day. All ordering of red bag equipment is now completed centrally through the resuscitation team, which has contributed to a large reduction in waste, as wards are no longer required to order full boxes of equipment for minimal items.

The checking procedure is also mentioned to staff within basic life support level 2 and immediate life support training.

The changes implemented have contributed to improving patient safety, as there have not been any reported incidents of missing emergency equipment since the improvements were made.

Development of adult epilepsy service mental health monitoring procedure

The mental health monitoring for service users with epilepsy procedure was implemented in September 2024. This guidance is to enable adult epilepsy nurses to identify deterioration in mood in relation to a diagnosis of epilepsy and medication side effects, assisting in the holistic management of service users with epilepsy.

The guidance gives details around educating service users about possible mood changes in relation to their diagnosis and the impact that the anti-epileptic drug can have on mood, on introduction to the service, and

provides an overview of the Patient Health Questionnaire (PHQ9) and General Anxiety Disorder (GAD7) baseline mood assessments to be documented in the clinical record.

Included within the procedure is information relating to various medication and triggers for concern, assessing for anxiety and depression (formally and informally), voluntary organisations who may be able to provide support to service users, and resources for staff.

Development of pregnant service user guidance

This guidance was implemented in June 2024 to provide practical guidance and support for services when a pregnant service user is under their care. It aims to make the approach to pregnant service users consistent across the Trust and emphasise the importance of a robust and safe multi-agency/multi professional plan.

Cases concerning interventions with pregnant service users suffering from mental disorder, illness or impairment are complex. Effective care can best be delivered when there is good communication, information sharing and joint working between professionals.

The guidance provides information on areas such as planning, midwifery appointments, local hospital/birthing centres, risk assessment, safeguarding, the voice of the child, prescribing in pregnancy, restraint, capacity, education, complications, and support for staff.

There is also an easy read flow chart included in the appendices, to supplement the guidance, which provides a clear, easy to follow guide for practitioners.

Adult Community Speech and Language Therapy (Barnsley)

Telephone-based access to health services for people who stammer can be a barrier. A survey conducted in 2023 by Stamma, a charity representing people who stammer, reported that:

- 41% of people who stammer reported they find it 'very difficult' using the phone to book an appointment. This compares with 23% of people who don't stammer
- 54% of people who stammer experienced mental distress around using the phone to make appointments

The service recognised that local people who stammer needed to request a referral typically by a GP appointment and that this would usually involve them making a phone call, so the service liaised with commissioners to allow stammerers to refer themselves direct to the adult community speech and language therapy service using email or post. With permission gained, the website and referral form were altered so that people who stammer could refer themselves.

Feedback is being sought from service users to support continual improvement of this initiative.

Children’s Speech and Language Therapy (Barnsley)

Echolalia is when a child repeats words or phrases that they have heard from other people, videos, stories, or songs. There are two types of echolalia: ‘immediate echolalia’ and ‘delayed echolalia. Children can use delayed echolalia for communication. The words the child says might not match what they really mean. This can be confusing. For example, a child might say “remember to do good sitting” to ask for a snack because they hear this every day before snack time. Echolalia is a stepping-stone to other flexible language, so it’s important not to ignore or try to ‘stop’ it. It’s important that when children use delayed echolalia, those people around them recognise it as how the child communicates.

The team developed training to help parents, carers and education settings to be “echolalia detectives”. The aim was to help them work out the intended message and then how to respond to encourage other flexible language. The training was on the booking platform and service users, parents and carers were directed to the training where it was relevant to them.

Feedback was received and any changes needed were incorporated. The feedback was 100% positive Moving forwards this training will be incorporated into our rolling training programme and knowledge and support will be shared.

Bereavement Group

In the drop-in support group, established by the Pastoral Care Department, we prioritise bereavement. We define bereavement as: loss of another person, or animal (pet), through death. We also prioritise anticipatory or preparatory grief, whereby the group attendee is anticipating or preparing for the loss of a person or an animal (pet).

We set regular monthly group meetings for patients in the hospital, Trust staff members and anyone outside the hospital who is grieving or preparing to grieve the loss of a person or animal (pet).

The group is advertised using flyers, posters and the Trust intranet.

The group is facilitated by three staff members who are all part of the Pastoral care team, one of whom is an experienced bereavement counsellor. The group is run on a drop-in basis, so some attendees can be present on a non-regular monthly basis if that best suits their style of grieving. While not specifically a therapy group, the facilitators try to maintain an ethos of empathy, positive regard, acceptance and compassion during the sessions. The group takes place in a cabin called The Pad in the grounds of Fieldhead hospital.

Time to Talk day

On 6 February 2025 we held a time to talk day, in partnership with the Co-op.

This day, hosted by Pastoral and Spiritual Care (and Mindy the Canine Befriender) included a drop-in session at The Pad, with tea and biscuits provided by Co-op, for staff, service users and carers. It was a very successful day with around 28 people attending. The feedback we received was very positive with the attendees enjoying the idea of a Time to Talk Day, and praising The Pad as being a safe environment to discuss mental wellbeing.

Annex 1: Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
Care Groups	Formally business delivery units (BDU). We have five Care Groups: Barnsley integrated services, adults and older people's mental health, CAMHS and children, forensic, learning disabilities and adult ASD and ADHD.
CORE20Plus5	An NHS England approach to support the reduction in health inequalities.
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CQC	**Care Quality Commission:** The Care Quality Commission is the health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation:** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in high quality care for all (the NHS next stage review report) of an NHS where quality is the organising principle.
DATIX	**Datixweb** is the web-based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
DoH/DHSC	**Department of Health and Social Care** – government department which supports ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer
EMT	Our **Executive Management Team** (EMT) put into action the strategic direction and priorities set by the Trust Board. They are responsible for the day-to-day running of the Trust, making sure that resources are in the right place to provide high quality care and achieve our mission and objectives. They are held to account by our Trust Board.
EPMA	**Electronic prescribing and medicines administration:** digital solution for prescribing and medicines administration.
ESR	**Electronic Staff Record:** a workforce solution for the NHS, supports the delivery of national workforce policy and strategy.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS.
IBC	**Integrated Care Board:** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing NHS budget and arranging provision of health services in the ICS area.
ICS	**Integrated Care System:** Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
IG	**Information governance:** the legal framework governing the use of personal confidential data. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act and the Human Rights Act.

KPI/Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organisation or of a particular activity in which it engages.
LeDeR	People with a learning disability and autistic people research.
LGBT+	Lesbian, gay, bisexual, transgender, queer and any other sexual orientation or gender identity
MDT	Multidisciplinary team
MHA	**Mental Health Act:** the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
NCISH	The **national confidential inquiry into suicide and safety in mental health** (NCISH) is an internationally unique project. The study has collected in-depth information on all suicides in the UK since 1996. Their recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK. Their evidence is cited in national policies and clinical guidance and regulation in all UK countries.
NHSE	**NHS England:** leads the NHS in England. Includes NHS Improvement and working together as one organisation.
NICE	**National Institute for Health and Care Excellence:** a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money
NIHR	**National Institute for Health Research**
PCREF	**Patient and carer race equality framework:** a mandatory framework to reduce racial inequalities in mental health services.
PS&C	**Personalised care and support**
SafeCare	A daily staffing software tool that matches staffing levels to patient acuity, providing control and assurance from bedside to board. The tool allows trusts to compare staff numbers and skill mix alongside actual patient demand in real time, allowing us to make informed decisions and create acuity driven staffing.
PSIRF	**Patient Safety Incident Response Framework:** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Safety Huddles	A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.
Schwartz round	A Schwartz round provides a structures forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional challenges and social aspects of working in healthcare.
SystmOne	The electronic service user record system that is used in within our Trust.
TIC	Trauma informed care
TIPD	Trauma informed personality disorder

VCSE	Voluntary, community and social enterprise

Annex 2: Statements from our stakeholders

Response of Barnsley Council's Overview & Scrutiny Committee 2024/25

The Committee would like to thank the South-West Yorkshire Partnership NHS Foundation Trust (SWYPFT) for the services they have provided to the residents of Barnsley during 2024/25, and for the opportunity to contribute to the Quality Account for this year.

The report is a detailed account of the activity undertaken to deliver on the priorities identified, including the improvement of clinical pathways and the patient experience; reducing inequalities; and supporting employees. Given that there are identified next steps for each of the priorities, the report also demonstrates that the Trust continually looks for ways in which to improve further.

The Committee would like to congratulate Barnsley's pulmonary rehabilitation service after it was recognised nationally for good practice in supporting people with long-term lung conditions, and is pleased that the work done around Speech and Language Therapy for children in Barnsley has received 100% positive feedback. We also welcome the work done locally to develop the urgent community response offer and electronic prescribing.

Linking into the work of the committee during 2024/25, we are encouraged to see the improvements made to supporting and listening to carers and the enhancements to services for those with a Learning Disability and Autism Spectrum Disorders (ASD). However, it is not clear from the report whether Barnsley CAMHS were successful in making improvements relating to children and young people with complex co-occurring needs, which include Learning Disability and ASD, and the need to develop staff to offer adapted interventions for children with neurodiversity. Nor is it clear whether there are appropriate and effective levels of support for children and young people presenting with an eating disorder in Barnsley. We will be keeping a watching brief on the work being done to review the Children and Young People's Mental Health System in Barnsley to see how this can improve outcomes over the coming years.

The report demonstrates the Trusts commitment to engagement with staff, patient groups, and the community as part of the development of strategies and services; and that the Trust is performing well against national indicators and benchmarks. The Committee is not aware of any omissions from the report based on the formal requirements.

We would like to thank SWYPFT for engaging in the work of the committee for 2024/25 and we look forward to working with the Trust again in the new municipal year.

CALDERDALE CARES
PARTNERSHIP

NHS West Yorkshire
Integrated Care Board

Darryl Thompson
Chief Nurse/Director of Quality and Professions
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

6 June 2025

Dear Darryl

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) 2024/25 Quality Account

Thank you for providing the opportunity for us to comment on the South West Yorkshire Partnership NHS Foundation Trust Quality Account 2024/25. This statement represents the views of Calderdale Cares Partnership, Kirklees Health and Care Partnership and Wakefield District Health and Care Partnership, on behalf of the NHS West Yorkshire Integrated Care Board.

To the best of our knowledge, the Quality Account presents a fair, balanced, and transparent overview of service delivery, improvement priorities and key achievements over the reporting period

We would like to acknowledge and commend the Trust for its achievements during 2024/25, particularly given the sustained operational pressures and increasing complexities and demand across services. Key highlights include:

- Completion of Electronic Prescribing Medicines Administration (EPMA) rollout across all inpatient wards, and recognition of multiple benefits including safer prescribing and reduction in medication incidents.
- Significant increase in uptake of health checks for people with Serious Mental Illness in Calderdale from 14% to 71%.
- Opening of the Horizon Centre in 2024, providing a safe, therapeutic environment for people experience mental health crises. This aligns with our commitment to modern, patient-centred facilities that promote recovery.
- Impressive Friends and Family Test outcomes in November 2024, with high satisfaction rates across all service areas.
- Continued implementation of PSIRF and transition to LFPSE, with a clear focus on learning and improvement planning.
- Exceeding NIHR research recruitment targets and engaging 633 participants in clinical research.
- Development of the Quality Assurance System (QAS) and Quality Risk Profile (QRP), supporting early identification and mitigation of risk across services.

- The Trust's smoke-free action plan and system-wide strategy to address tobacco dependency represent an important step toward reducing health inequalities and improving long-term health outcomes. We support this preventative focus and its alignment with wider public health goals.

The Integrated Care Board acknowledges that the refreshed Trust Strategy continues to shape the organisation's direction, with the three quality priorities for 2024/25 aligned to this strategic vision.

Looking ahead, we welcome the Trust's focus on continuous improvement and reflection through its quality priorities for 2025/26. These priorities align well with system-wide ambitions for safety, inclusion, and workforce wellbeing.

The following section provides our reflections on how these priority areas are being progressed and where further opportunities for development may lie.

We appreciate hearing of plans for patient experience surveys of Learning disability, ADHD and autism spectrum disorder (ASD) and look forward to receiving updates on those. We recognise the significant local, regional and national challenges in provision of neurodiverse pathways due to increased demand. It would have been valuable to include an update on the local situation, including the contribution to system responses SWYPT have made, particularly on the adult pathway and the ongoing issues with associated work for children.

We acknowledge the Trust's work to reduce long waits, strengthen VCSE partnerships, and expand mental health support, including social prescribing and the development of the 0–18 mental health offer in Kirklees.

We are pleased to see an identified focus of Integrated Neighbourhood development for community adult services including with VCSE and LA partners. These initiatives demonstrate responsiveness to local needs.

We also support ongoing efforts to improve clinical record keeping and embed coproduction in care planning, which aligns with the Trust's strategic commitment to delivering personalised, safe, and responsive care, and will improve patient experience. We look forward to updates on the Activity in the Community improvement programme and the continued application of learning from patient safety events under LFPSE.

Quality Priority 1: Safe and responsive care

We support the Trust's ongoing efforts to improve responsiveness and safety. The implementation of EPMA, coupled with structured reporting under LfPSE, illustrates commitment to a learning culture.

Efforts to reduce length of stay and improve patient flow are acknowledged, and we support further development in this area. We are also encouraged by the continued focus on improving care planning and co-production in clinical risk assessments. We would welcome future updates on the potential for extending EPMA functionality into community services, building on the successful roll-out across inpatient settings.

We encourage further development in the reporting and analysis of restrictive practices across all inpatient services, including CAMHS and learning disability wards, to ensure consistent safety oversight and improvement opportunities across settings.

Quality Priority 2: Equality, Inclusion and Equity

We welcome the refreshed EDI strategy and the Trust's strong engagement with patients, carers and communities. The development of inclusive services, Greenlight Champions, work with VCSE partners, and feedback mechanisms for learning disability services show tangible commitment. We also support the "waiting Fairly" initiative and look forward to learning about outcomes from the STOMP and Activity in the Community programmes.

Quality Priority 3: Health, Wellbeing and Experience of Staff

It is positive to see continued development of a culture that supports staff wellbeing, professional development, and safe care. We acknowledge the challenges in care delivery, and the increase in acuity and complexity of people who access your services. The Trust's collaboration with NHS England on safety and improvement, as well as coaching and leadership work, contributes to a strong foundation for supporting staff through complex service demands.

We recognise the positive focus on safer staffing and professional development. Future reporting could be further strengthened by illustrating how this work aligns with long-term workforce planning and service demand projections, particularly in community mental health teams.

While the Quality Account offers a comprehensive narrative overview of the Trust's activities and achievements, its impact could be further strengthened through the inclusion of more trend-based data and visual representation of outcomes, particularly in areas such as patient safety, freedom to speak up, workforce development, and patient experience. This would support transparency and enable clearer assessment of progress over time.

Additionally, while the quality priorities for 2025/26 are well-aligned to the Trust's strategic objectives, the inclusion of defined outcome measures for each priority would enhance the ability to monitor and evaluate their effectiveness. We are pleased to note the strong coverage of inpatient and corporate initiatives. However, there is comparatively less detail on developments within community mental health services. Future accounts could be further enriched by showcasing improvement work and quality outcomes across the breadth of community provision. The NHS West Yorkshire Integrated Care Board appreciates the Trust's ongoing collaboration and contribution to the wider health and care system. We look forward to continuing our joint work to ensure high-quality, compassionate care for the communities we serve.

Yours sincerely



Ian Bennett
Director of Nursing and Quality
Calderdale Cares Partnership
Kirklees Health and Care Partnership
Wakefield District Health and Care Partnership
NHS West Yorkshire Integrated Care Board

Statement from Wakefield MDC Adults Services, Health and Communities Overview and Scrutiny Committee – South West Yorkshire Partnership fondation Trust

The public, patients, and others with an interest in their local provider will use a Quality Account to understand:

- Where an organisation is doing well and where improvements in service quality are required:
- What an organisation's priorities for improvement for the coming year are; and
- How an organisation has involved service users, staff, and others with an interest in the organisation to help evaluate the quality of their services and determine their priorities for improvement.

In reviewing the Trust's Quality Account the Committee considered the following:

- Does the Trust's priorities match those of the public;
- Whether the Trust has omitted any major issues;
- Has the Trust demonstrated they have involved patients and the public in the production of the Quality Account; and
- Any comment on issues the Committee is involved in locally.

The committee has acknowledged that the priorities for improvement have been reviewed through a wide range of groups and individuals and that the Trust has taken into account issues highlighted in feedback from patients and staff and believe that the Trust's priorities identified in the Quality Account broadly match those of the public.

The Committee welcomes the Trust's overall approach to quality improvement which occurs as near to service users as possible. The development of skills for improvement, robust quality assurance and strong clinical governance will underpin the approach to setting quality as the organising principle for the Trust's services.

Overall, the Committee believes that the Quality Account presents a balanced and representative picture of the quality of services provided by the Trust.

During the year, the Committee was involved in the West Yorkshire Joint Health Overview and Scrutiny Committee (WYJHOSC), which considered the review of Older People's Mental Health Inpatient Services. Members were assured that the Trust had utilised Quality Impact Assessments (QIA) to ensure that any changes initiated as part of the review were fully assessed for their impact on quality and safety.

The Committee is grateful for the opportunity to comment on the Quality Account and looks forward to working with the Trust in reviewing performance against the quality indicators over the coming year.

Caring for our communities

Locala Health & Wellbeing

Eddercliffe Health Centre

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LIVERSEDGE

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10 June 2025

Dear Darryl,

Thank you for the invitation, and opportunity to comment on South West Yorkshire Partnership NHS Foundation Trusts 2024/25 Quality Account. We praise South West Yorkshire Partnership NHS Foundation Trust for their continued commitment to provide the best quality care aligned to their four strategic objectives, that align to our own, to support the system to offer equitable, safe, responsive and effective care.

We welcome further collaboration and co-production as part of the West Yorkshire Health and Care Partnership, and through the workstreams aligned to West Yorkshire Community Collaborative, to harmonize our service offerings, to support a streamlined approach to care, reduce health inequalities and to deliver integrated and seamless care across our system. We are particularly encouraged by the opportunities arising through co-production to develop system solutions to support access to adult Speech and language therapy. We look forward to continuing to work alongside South West Yorkshire Partnership NHS Foundation Trust to improve services across the system.

Yours Sincerely

Caroline

Caroline North

Director of Quality and Professionals

Locala Health and Wellbeing

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.6

Private/Public paper:	**Public**		
Title:	**Cheswold Park update**		
Lead Director:	**Adele Fox – Chief Operating Officer**		
Mission/values:	The development of joined-up care through partnership working and provider collaboratives 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 Trust Board, specifically on the risks identified pre-transfer to the Trust and progress to address these.		
Strategic aims:	Live Our Values	✓	The Integration of Cheswold Park hospital supports the delivery of our Trust values and all strategic aims.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.5 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience. 2.10 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. 3.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner	This paper highlights the opportunity available to the Trust to support continued provision of care at a local level. Central to the plans of both the Integrated Care Board and local partnerships, is ensuring the provision of high-quality local care and sustainable services. The South Yorkshire Integrated Care Board have been supportive of the approach being taken.		

With all of us in mind.

organisation objectives at national regional or local level.	
Any background papers / previously considered by:	Regular updates in relation to Cheswold Park have been provided to Trust Board since April 2024. The most recent update in relation to Cheswold Park was provided to the Trust Board on 29th April 2025.
Executive summary:	The Trust completed the asset purchase of Cheswold Park Hospital (CPH) on 1 October 2024. Implementation of transition and integration plans for CPH continue to be overseen by a programme group, chaired by the Programme Director/Senior Responsible Officer (SRO). This reports weekly into the Trust's Executive Management Team (EMT), and in turn EMT provides onward reporting to Trust Board. Reporting to the Programme Group are a number of accountable workstreams (with responsible and accountable leads). This report illustrates the intensive work taking place to integrate services and demonstrates positive progress within the first nine months of acquisition. The report also explains the governance and assurance process that are in place to effectively manage this integration. It is recognised that there is still extensive work to complete. Finance reporting is now included in this report. **Risk Appetite** This is currently outside the Trust's risk appetite for clinical safety, quality, compliance, and finance. The safeguards committed to regarding finance provide shelter from that risk for the next three years and similarly the approach being taken by the CQC reduces the risk of the overall Trust rating changing as a result of this transaction for the next two years. It should also be emphasised this approach will reduce risk to service users and staff currently at Cheswold park and maintain local service delivery. This transaction does align with the Trust's risk appetite regarding business and strategic risks.
Recommendation:	**Trust Board members are asked to:** **NOTE** this update report.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.6
Cheswold Park Update

1. Introduction and Purpose

The purpose of this paper is to provide an update to Trust Board on the programme of work to integrate services at Cheswold Park Hospital into the Trust following the transfer of Cheswold Park Hospital (CPH) to the Trust on 1st October 2024.

2. Background

The Trust completed the asset purchase of Cheswold Park Hospital on 1st October 2024.

Implementation of transition and integration plans for CPH continues to be overseen by a Programme governance structure. A Programme Group meets weekly and is chaired by the Programme Director/Senior Responsible Officer (SRO) and attended by senior representatives from clinical and operational services (including multi-disciplinary representation) estates, workforce, quality and safety, governance, information management and technology (IM&T), procurement, communications, and legal services.

The Programme Group reports weekly into the Trust's Executive Management Team (EMT), and in turn EMT provides onward reporting to Board.

Reporting to the Programme Group are a number of accountable workstreams (with responsible and accountable Leads). These are:

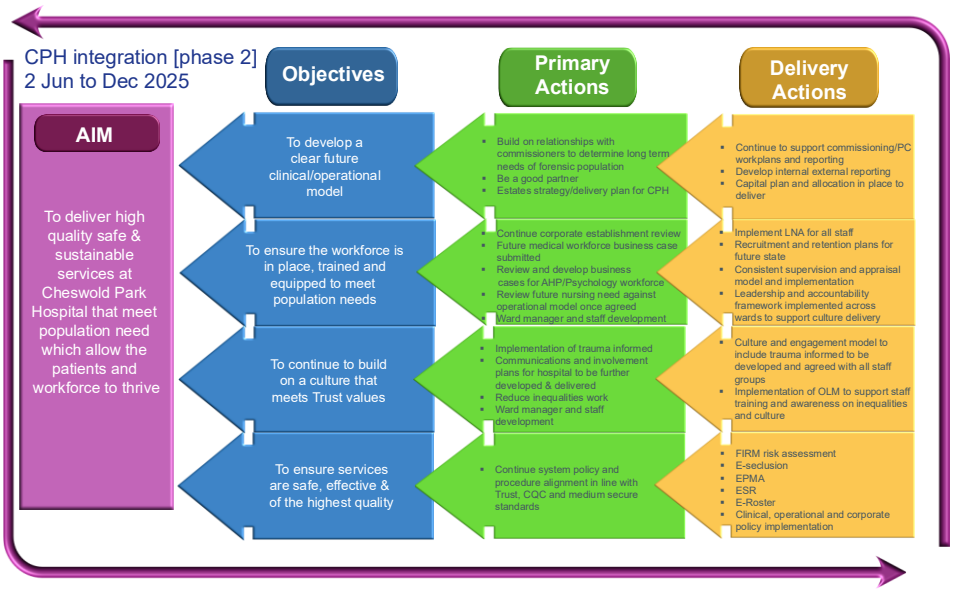
- People development.
- Clinical and Operational.
- Quality and safety.
- Finance, contracting and procurement.
- IM&T and reporting.
- Estates and facilities.
- Communication and involvement.
- Legal and governance.

Workstreams have key objectives and timelines for these, as set out in a programme integration plan.

The Trust has a full-time Deputy Director of Integration in place (for 15 months) to support existing operational and quality improvement teams across the site.

The high-level integration plans up to 30th April 2025 commenced or were implemented as originally planned.

The Programme Group met in May 2025, and developed a high-level priorities plan for phase two of the integration to run from June to December 2025. This is depicted below and includes four main objectives and actions required to deliver. Leads are now developing task lists for each objective/action supported by the integrated change team.



3. Update on progress following transfer

Progress against the Trust's integration plan for CPH is outlined below.

Workstream	Progress
Clinical and operational	• Operational governance arrangements established for CPH in line with forensic care group. • Work to understand the clinical model and allied health professional provision continues. Outline clinical model and business case developed. • Weekly catch ups regarding the medical workforce are in place. Senior Clinical lead recruited and in post. • Work to ensure medical staff are briefed on clinical guidelines has taken place. • CPH Patient Engagement Council attended by members of the Trust to answer patient questions following the transfer. • Admissions continue to progress. • A patient overview spreadsheet is discussed and updated weekly and recognised as an example of good collaborative working by NHSE. • Each admission is reviewed in relation to staff training needs. • Increased supervision of ward management is in place to support them in leading the admission process. • Clear expectations have been set regarding a quality of admission process including a pre-admission checklist and task list. • Clear and collaborative involvement of both nursing staff and patients. • To date positive feedback has been received from patients and staff on the pre and admission process.
People development	• Full time leadership presence on site. • Brew and Biscuits (3rd session) held in May 2025. Further session planned for 24th June 2025.

	• Ongoing staff engagement sessions and weekly communications to all staff on site. • Strong on-site presence of the Trust's Freedom to Speak Up Guardian, in order that staff know how to raise concerns, which has facilitated a number of referrals (15 enquiries have been received to date). • The Chief Operating Officer and Chief People Officer have been on site and spent time on wards with staff. • Engagement with Staff Side ongoing via the People Directorate. • Vacancy control process established, and resourcing panel also established. • Work has progressed to review the corporate establishment at CPH. Phase 1 completed on 28th March 2025 and was implemented as of 1st April 2025, phase 2 has now commenced, with consultation ending on the 4th July 2025. • Ways of working task and finish group to review roles and align to wider Trust has commenced. • Ward manager development continues.

Quality and safety	• E-seclusion task and finish group has commenced work on planning system implementation.
	• Policy integration continues supported by training across services.
	• The Integrated Quality Improvement Group (NHS England) meeting took place on 21 May 2025 and it was agreed to step the hospital down from enhanced to standard monitoring.
	• The Trust-wide Quality Improvement Team have commenced a piece of work on medication management, capturing the voice of registered nurses and the medical workforce. Medication safety crosses introduced in June 2025 with the aim to:
	  • Raise awareness within the team and others regarding, for example, how many medication errors occur in each clinical area.
	  • Improve patient safety.
	  • Promote good practice (i.e. look at how many days have gone by without a medication error occurring).
	  Provide real time incidence data.
	• Trust approved "red bags" and defibrillators are now in place across all wards at CPH.
	• There was a CQC Mental Health Act visit to Aire and Esk, no red flags were raised, and the Trust will respond to any actions once the reports are received.
	• In line with legislation as of the 1 June 2025 only rechargeable vapes and pods are available to buy from the Cheswold Park shop. Access to vapes is based on individual patient risk assessment.
	• Ward managers across the hospital have completed two days of mental health first aid training.

<table>
<tr><td></td><td>All patients are having physical health impact assessments due to ongoing water quality issues, supported by Infection Prevention and Control. .</td></tr>
<tr><td>Estates and facilities</td><td>Work to replace the non-certified seclusion doors is now completed.
Following the appointment of a contractor we are planning the Brook refurbishment as well as the proposed seclusion scheme approved under a centrally funded bid.</td></tr>
<tr><td>Finance, procurement and contracting

Month 2 2025/26</td><td>At the end of May 2025, Cheswold Park Hospital is currently overspending against the Trust business case assumptions by £89k. This is predominantly due to increased staffing on the wards (7wte additional in low secure). Medical cost pressures (locum and on call arrangements) have contributed £76k to the year-to-date cost pressures. However, reduced corporate staffing and Allied Health Professional Vacancies continue to underspend against the business case assumptions.

The forecast overspend for Cheswold Park is £809k, and the table below shows the overspend by area. The forecast includes a provision for a cost of living pay award.

<table><tr><th>Area</th><th>£k</th></tr><tr><td>Low Secure</td><td>1,058</td></tr><tr><td>Medical</td><td>661</td></tr><tr><td>Operational Management</td><td>194</td></tr><tr><td>Medium Secure</td><td>(166)</td></tr><tr><td>Support and Therapy</td><td>(262)</td></tr><tr><td>Corporate Services</td><td>(675)</td></tr><tr><td>Total forecast overspend</td><td>809</td></tr></table>
A business case is currently being drafted to address the medical cost pressure with a proposal to reduce to recurrent cost pressure.

Phase 1 of the Corporate Establishment review has concluded, and phase 2 is currently underway which is anticipated to result in further savings not included in the financial forecast at month 2.</td></tr>
<tr><td>IMT & Reporting</td><td>Reporting at Cheswold Park Hospital (CPH) continues to operate as per pre-transfer arrangements, with oversight from SWYPFT governance prior to reports being shared in relation to CPH externally.
Individual staff email accounts and network folders were established in the background in advance of move to SWYPFT network.
Roll out of new IT equipment completed.
SystmOne went live on the 1 April 2025, the response by staff to the new system is very positive and support continues to be in place for staff.</td></tr>
</table>

	• A recommendation was approved through the Trust electronic prescribing and medicines administration board (EPMA) Project Board that EPMA deployment activity will follow SystmOne implementation in October 2025.
Communication and involvement	• Mechanisms to share SWYPFT communications developed and in place. • Weekly communication bulletin (The Update) is being issued to all CPH staff. • The Brief issued to CPH senior leadership team and guidance provided on how to cascade to teams. • Review of CPH communications materials in progress. • SWYPFT communications team has met with local authority communications and engagement leads and attend the Doncaster place communication and engagement network. • Review of communications tools and their effectiveness has taken place with staff on site.

4. Risk management

There are a number of current risks associated with taking on delivery of services at Cheswold Park. The Trust has developed a full risk register. This is reviewed at biweekly Programme Group meetings and shared with EMT.

5. Next steps

The Trust continues to work with our colleagues at Cheswold Park to integrate services into the Trust.

Planned next steps in terms of programme implementation include:

- Work continues to progress on the delivery of the quality and safety improvement plan.
- To commence implementation of phase 2 of the integration plan.
- Continued focus on new patient admissions, in partnership with the South Yorkshire and Bassetlaw Provider Collaborative Commissioning Hub. This will support financial sustainability of the hospital and support the South Yorkshire adult secure system to provide care closer to home. Fortnightly meetings in place.
- Preparation for further system implementation e.g. EPMA.
- Policy implementation plan in progress.
- Engagement continues with staff-side colleagues.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 11.7

Private/Public paper:	**Public**		
Title:	**Nottinghamshire Healthcare Foundation Trust Homicide Investigation Update**		
Lead Director:	**Adele Fox, Chief Operating Officer**		
Mission/values:	The report demonstrates 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 this report is to provide Trust Board with a summary of the findings from the homicide review into the Nottinghamshire attack that occurred in June 2023, and an update on the Trust's response to national learning requirements and next steps.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider Trust within the Integrated Care System is governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from serious incidents, including those that occur outside of the Trust, and action is taken to remedy any findings. Understanding our current position, including areas for improvement, supports us to be an engaged member of the integrated care systems and national response to this incident. The progress described in this report and the completion of these actions contributes directly to the quality and safety objectives of the integrated care systems.		

Any background papers / previously considered by:	An earlier version of this paper was received by Trust Board in March 2025. This is an update on progress against the defined actions, and has been presented to the executive management team, and to the Quality and Safety Committee on 10 June 2025.
Executive summary:	On 5 February 2025, NHS England published a report into the care and treatment of VC. The report's findings describe critical missed opportunities for the care provider, Nottinghamshire Healthcare Foundation Trust, prior to him killing three members of the public. The report also sets out detailed findings and recommendations for all providers of mental health care. The Trust has continued to respond to the two national recommendations as required. The first relates to a self-assessment of the service offer for people who might present with similar needs to VC with regards to diagnosis of severe and enduring mental illness, potential risk and challenges with engagement. The Trust's provision of a service to this population continues to be reviewed in line with learning from this investigation, with progress being made against each aspect. The second national action relates to clinical risk assessment, and the need for this to be fully understood, managed and documented. The Trust's clinical risk assessment and care planning improvement group is overseeing developments in training in the Trust, in line with the learning from this investigation. In addition to the national recommendations, Nottinghamshire Healthcare Foundation Trust received local recommendations. These have also been reviewed in the Trust for opportunity for learning, and a summary is detailed in the report against each, including updates where required as of June 2025. The Executive Trio continue to lead the Trust's response to this learning, and will report to the executive management team, the Quality and Safety Committee and Trust Board as necessary. Of note, the Trust is also liaising directly with the Chief Nurse and others in the senior team of Nottinghamshire Healthcare NHS Foundation Trust. Nottinghamshire colleagues recently attended a meeting of the executive management team and senior leaders across the Trust to directly share their learning and response to this incident. This additional learning has been embedded into the Care Group clinical pathways workstream. The current action plan for the Trust is attached as an appendix to this report.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** this report.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Independent mental health homicide report into the treatment of VC – update on Trust workstreams

1. Introduction

On 5 February 2025, NHS England published a report into the care and treatment of VC (Independent investigation into the care and treatment provided to VC). The analysis within the report identifies critical missed opportunities within Nottinghamshire Healthcare Foundation Trust prior to him killing three members of the public.

The report sets out findings and recommendations to ensure all providers learn from this incident and work across integrated care boards to ensure that robust plans are in place to prevent similar tragedies. As part of the Trust's response, core mental health standards and practices are being reviewed, to measure current practice against the recommendations and make improvements where necessary. These are described on the following pages.

VC had several interactions with his local mental health services, including liaison and diversion, crisis intervention, and Early Intervention in Psychosis (EIP) teams. He was detained under the Mental Health Act on three occasions, under Section 2 and Section 3, and had a diagnosis of paranoid schizophrenia. Violent behaviours were also noted. He also had contact with non-healthcare agencies (for example the university and the police). This report is an update to the report that was submitted to Trust Board in March 2025.

2. Investigation findings and national recommendations

Recommendations from the report included those for Nottinghamshire Healthcare Foundation Trust, and those for a national response. The national recommendations for action by the Trust are as follows:

Area for improvement 1 – Care delivery

The investigators found that the offer of care and treatment available for VC was not always sufficient to meet his needs. This included the service having difficulty in providing VC with support when he did not wish or was unable to maintain contact with services. From conversations with others as part of this review, we believe that the experience of VC was not unique in how some people with severe and enduring mental illness are supported by mental health services.

Summary of recommendations

NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

Current Trust Position
March 2025
The Trust has completed the required Community Mental Health Service Review, ICB (Integrated Care Board) Maturity Index Self-Assessment Tool. This review focused on the service offer for the cohort of people presenting with needs similar to VC. Traditionally, this service offer would have been from Assertive Outreach Teams, a service approach underpinned by practitioners having a caseload of no more than 12 people and being in frequent contact with them. The Trust moved away from Assertive Outreach Teams around ten years ago as part of a community mental health service transformation. Therefore, services do not routinely identify this cohort in terms of numbers and service location against Assertive Outreach criteria.

However, the cohort has been identified and mapped by location across the Trust, and findings indicate that most remain within Enhanced teams (which can include a flexible assertive community team response when required, but not to the full fidelity of an Assertive Outreach team as it is not ongoing); with some in the Early Intervention in Psychosis teams (which offer an assertive approach), forensic teams, and also in the Trust's Core community mental health teams.

Other findings of the self-assessment include that the Trust's Care Programme Approach Policy provides a framework for safe and effective care of this cohort, and a crisis response is available when required. In addition, Trust policies and procedures are clear that we do not discharge people who present with needs similar to VC solely on the basis of non-attendance, and we operate on a multi-disciplinary risk assessment process to inform any decision prior to discharge. Areas requiring potential action include a need to consider smaller caseloads for this cohort and an increased frequency of face-to-face contact.

Update June 2025
The Trust has contributed feedback on the draft National Community Mental Health Framework, which provides further, more detailed guidance on community mental health transformation and will include specific recommendations on engagement with people with severe and enduring mental illness. The review of clinical pathways work has commenced through the operational management group (OMG). This provides an opportunity to review the Trust's current offer in line with national learning and understanding of local population health needs.

The Trust has co-produced, with a wide range of stakeholders, an action plan in response to the Patient Carer Race Equality Framework (PCREF). This plan was agreed by our Executive Management Team in May and has been shared with NHS England and published on our website. The action plan includes work to review the process for development of policies to ensure that relevant ones are co-reviewed by experts by experience and community representatives.

Next Steps
Actions in response to the review include:

- Reviewing the structure of the teams to explore the potential to provide a dedicated function, either within a team or a specialist team in accordance with the new

guidance. **Update June 2025 –** this is being considered as part of the Trust's clinical pathways workstream, alongside a dedicated peer review with a neighbouring provider of caseload management for this cohort, to ensure external review, learning and challenge.

- Reviewing the care pathway for this cohort of people in line with new guidance. **Update June 2025 –** reviewing the care pathway for this cohort of people will be undertaken once new guidance is available
- Reviewing learning needs in line with expectations of caseload management of this cohort, including trigger mechanisms regarding early warning signs to prevent and manage risk. **Update June 2025 –** as above, in the clinical pathways workstream.
- Implementing the personalised care and support model, in line with NHS England expectations**. Update June 2025 –** this is being led by an experienced Care Group colleague, who is also aligned with national planning for this work. This is also part of community mental health transformation workstreams.
- Reviewing our policies and procedures as outlined in the Patient & Carer Race Equality Framework and agreed as part of our published action plan. **Update June 2025 –** The Trust has reviewed the governance arrangements for reviewing completed equality impact assessments and the mitigating actions for those with protected characteristics and those who are likely to be impacted by health inequalities. Each service, policy and strategy now needs to demonstrate consideration of any potential impact through the lens of PCREF and provide mitigation and assurance.
- Developing protocols for management of people who are non-concordant in line with expected guidance from NHS England and the Royal College of Psychiatrists. **Update June 2025 –** the policy for people who do not adhere with treatment has recently been reviewed, with suggested clarification to ensure the carer voice can be heard, even in the absence of consent from a non-engaged service user.

Executive Lead: Adele Fox, Chief Operating Officer
Date: The ICB have been given 6 months to collate information. **July 2025**.
NHS England » Guidance to integrated care boards on intensive and assertive community mental health care.
Update June 2025 – this is complete.

Area for improvement 2 – Risk
The investigators found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience suggests that this issue is not isolated to this case.

Summary of recommendations
NHS England should consider how providers understand the concept of risk, risk assessment and risk management systems, to ensure effective and appropriate safety measures. This includes across multiple agencies and recognises the need for multiple agencies to share information about risk in real time.

Current Trust Position
March 2025
The Trust has an established and comprehensive formulation informed risk management (FIRM) approach to clinical risk assessment, which as part of formulation will include the views of other agencies. Multi-disciplinary reviews also include other agencies who are involved in that person's care, to ensure a shared understanding of risk and clinical need. In addition, the Trust also has other established groups and networks where agencies share information. These groups include the multi-agency public protection (MAPPA) strategic and operational groups across the systems, the 'right care, right person' workstream, the Prevent forum in the Trust and the Prevent meetings across all four Places that the Trust covers and external strategic and operational domestic abuse meetings.

Next Steps
The Trust's care planning and clinical risk assessment improvement group is the vehicle for ongoing focus and improvement in risk assessment, with updates provided to the Quality and Safety Committee. This will include a specific review of the Trust's approach in line with these recommendations, including mechanisms of communication across multiple agencies and service response to fluctuating levels of risk.

Update June 2025 –

- The Trust hosts a multi-agency partnership forum that facilitates thematic as well as individual anonymised case discussion and learning across partnership organisations.
- The Trust's risk assessment policy is being reviewed to ensure alignment with national policy, guidance and best practice. The review has an expected completion date of end of July 2025.
- The current Trust risk training offer is being reviewed, with a plan to develop enhanced clinical risk training that uses a variety of methods, including videos and face to face training. The aim of this is to ensure staff have the right skills and confidence to provide collaboratively produced robust risk formulation and safety planning, particularly when working with people who present with complex and multifaceted risks.

Executive Lead: Darryl Thompson, Chief Nurse / Director of Quality and Professions
Date: October 2025

3. Local areas for improvement for Nottinghamshire Healthcare Trust

Whilst these are local recommendations for VC's provider of care, we are also reviewing these in the Trust to ensure all opportunities for learning are captured.

Area for improvement for Nottinghamshire Healthcare Trust	**Current position of South West Yorkshire Partnership Trust**
Area for improvement 4 – Serious incident policy *The investigators found that the Trust's serious incident policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is*	The Trust's patient safety incident response policy was approved by Trust Board in December 2023 and is line with the expectations of the Patient Safety Incident Response Framework (PSIRF).

opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.	**Next steps** Enhancing a focus on evidencing of learning response and themes of incidents. This will be built into the objectives of our patient safety investigators. **Update June 2025** The Trust's Patient Safety Improvement Group terms of reference have been reviewed to ensure an oversight and focus on themes and trends, with reporting to the executive management team and the Quality and Safety Committee. Executive Lead: Darryl Thompson, Chief Nurse / Director of Quality and Professions By when: June 2025
Area for improvement 5 – Family engagement *The investigators found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.*	The Trust has engaged in the Triangle of Care self-assessment, and a key driver behind this was helping to ensure that a person's family are engaged and are part of the care team whenever possible. The Trust has been awarded its first star as part of this accreditation. One aspect of the implementation of this, including in policy development, is an affirmation that we can always listen to a family, even if consent to share confidential information about the patient has not been agreed. **Next steps:** To continue to implement Triangle of Care standards, ensuring that family and friends are involved in care planning and clinical risk assessment whenever possible, including within the Care Programme Approach structure. **Update June 2025** The Trust successfully completed Triangle of Care stage one accreditation in July 2024 and has now commenced stage two accreditation. Stage two is a two-year programme of self-assessment across all community mental health and specialist services. This is due for completion in July 2026. Self-assessments are underway with approximately 40% of services in scope having returned their self-assessment. In addition to this, feedback from the Carers Trust assessment for stage one accreditation has been actioned and a data dashboard is being developed to enable robust oversight.

	Executive Lead: Darryl Thompson, Chief Nurse / Director of Quality and Professions By when: July 2026
Area for improvement 6 – Clinical information sharing *The investigators found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.*	The Trust has established data sharing agreements in place across its footprint, to ensure clinical information can either be shared on a basis of risk or through another framework. This is overseen by the Improving Clinical Information Group, which reports to Quality and Safety Committee. **Update June 2025** An engagement meeting with multi-agency colleagues is being planned around the Right Care Right Person agenda, with a focus on learning from the issue of a recent Regulation 28 / Prevention of Future Death Report to a partner in the system. Expected product of this work will be ensuring that robust and clear information sharing arrangements are in place across agencies. Executive Lead: Darryl Thompson, Chief Nurse and Director of Quality and Professions / Caldicott Guardian By when: October 2026
Area for improvement 7 – Across organisational working *The investigators found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.*	There are established multi-agency relationships across the Trust's footprint. An example of this is the multi-agency right care right person group. **Next steps** To assure partnerships are robust, in particularly, communication and clinical decision making between teams and the wider. **Update June 2025** Please see earlier in the report re: the multi-agency group. Executive Lead: Adele Fox, Chief Operating Officer By When: October 2025
Area for improvement 8 – Governance arrangements *In this case, the investigators identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the*	The Trust has an established patient safety oversight group that reviews all incidents rated 'amber' or 'red. This includes executive director representation. Identifying opportunities for system-wide learning is part of the review of each incident, and part of the Trust's patient safety incident response framework.

Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.	**Next steps** To ensure continuation of regular thematic analyses of the serious incidents to facilitate triangulation and opportunity for learning. Oversight of the above via regular updates to the executive management team, Quality and Safety committee and Trust Board. **Update June 2025** The Trust is undertaking a review of learning from PSIRF implementation and as part of this review the Patient Safety Improvement Group (PSIG) is relaunching in June 2025 with a core focus on Trust-wide learning and emerging themes and trends including those that have system-wide learning opportunities. Executive Lead – Darryl Thompson, Chief Nurse / Director of Quality and Professions
Area for improvement 9 – Policy development and review *The investigators found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day-to-day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.*	Policies are overseen by the executive management team, with the complete log of policies and review dates. **Next steps** To maintain a grip and oversight of policy review processes. **Update June 2025** Clinical policies are reviewed and discussed at the Clinical Policy Ratification Group before coming to the Trust-wide Clinical Governance Group for approval before being received at the executive management team. The Quality Governance Team maintain oversight of clinical policies and review timescales, any extension to review timescales are agreed at the executive management team, where review progress of all Trust policies is overseen, with action taken as necessary. During the review of incidents in the weekly patient safety oversight group, any learning about policy content or application is considered, with actions put in place as necessary. **Complete** Executive Lead – Darryl Thompson, Chief Nurse / Director of Quality and Professions
Area for improvement 10 – Peer support *In VC's case the investigators found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find*	Within the Trust's early intervention in psychosis teams, social and peer support groups are an integral part of the service offer. The teams also employ peer support workers, to further provide opportunity to

evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.	benefit from peer support as part of understanding the experience of psychosis and keeping well. **Next steps:** To review the consistency of this offer across the Trust's footprint, including in the Trust's Enhanced teams. Executive Lead – Darryl Thompson, Chief Nurse / Director of Quality and Professions By when: August 2025
Area for improvement 11 – Care planning *The investigators found limited evidence that care planning arrangements were co-produced with VC and his family. Building on area for improvement 5, once the Trust has developed its family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family.*	The Trust's new 'my health and wellbeing plan' is a mental health care plan which went live in the Trust in January 2025. The new plan aims to reflect the five key criteria for personalised care and support plans, and includes a clear expectation of co-production, and the person's voice being heard throughout the plan. **Next steps** The Trust's care planning and clinical risk assessment improvement group is overseeing this roll out, with updates provided to the Quality and Safety Committee. **Update June 2025** A further training package is under development to strengthen the current training on the move to personalised, collaboratively designed plans of care in line with the new template. This includes short videos, face to face drop-in sessions and face to face training for teams by request. This is due to go live in July 2025. Executive Lead: Darryl Thompson, Chief Nurse / Director of Quality and Professions By when: August 2025
Area for improvement 12 – Joint clinical decision making *We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental*	The Trust is committed to maintaining the safety of those in our care and those around them. This is achieved through robust multi-disciplinary discussions to ensure agreement between teams with regards to both the use of the Mental Health Act (including Community Treatment Orders) and prescribing decisions. Clinical leadership structures are in place across the Care Group to ensure that challenges or concerns can be escalated and addressed. **Next steps**

health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.	Review the Trust's current medicines management approaches and underpinning policies and procedures, to ensure that these clearly encompass therapeutic approaches to people in our care who are non-compliant with prescribed medication. By when: June 2025 **Update June 2025** Routine professionals' meetings take place as required involving inpatient, community teams and Mental Health Act team leads to discuss relevant use or not of mental health legislation. Plans are in place to review this further in the Trust working group. Plans are in place to improve visibility on NICE and British Association of Psychopharmacology guidance via the antipsychotic medication clinical guidelines. This will be added to the Drugs and Therapeutics sub-committee agenda. The Chief Pharmacist is joining Trust working group around considering these recommendations, to improve recognition of importance of medicines management and the inclusion of pharmacists in clinical teams. Exec lead: Subha Thiyagesh, Chief Medical Officer

Summary

The Executive Trio will continue to keep these local action plans under regular review, ensuring they address the issues identified in the independent review with particular attention to:

- personalised assessment of risk across community and inpatient teams
- joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
- multi-agency working and information sharing
- working closely with families
- eliminating out of area placements in line with integrated care board 3-year plans

Progress against these actions will continue to be overseen by the executive management team and reported to Quality and Safety Committee and Trust Board.

	Intensive & Assertive Community Mental Health Action Plan				
Issue	**Executive Lead**	**Action**	**Lead**	**Update**	**Due Date**
1/ Current Core/Enhanced FACT model does not meet service user needs as per NHSE guidance – dedicated function / caseload / Clinical pathways / skill mix / training / PSI / cohort not specifically identified in caseloads	Adele Fox	Review current structure and explore potential for a dedicated function or specialist team in line with national guidance	Amanda Miller	Exploratory work underway	August 2025
		Review clinical pathway	Stuart Davis ~~/~~Amy Hartley	Mapping exercise of pathway to be completed in July 2025.	August 2025
		To source psychosocial interventions training. This is a recognised and evidence-based approach, focusing on practices that help individuals cope with symptoms and improve their quality of life.	Amy Hartley	Two cohorts of 20 places each have been funded through CPD monies for the new (Sept 24) Royal College of Nursing (RCN) Psychosocial Interventions Programme with preference given to staff working in enhanced community teams across the Trust, to support the embedding of PSI approaches. Core Principles: Includes co-production, cognitive-	Completed

				behavioural therapy (CBT), family-inclusive practice (FIP), psychoeducation, and social support. The training aligns with the Nursing and Midwifery Council's (NMC) Future Nurse Standards, incorporating various therapeutic approaches like motivational interviewing, solution-focused therapies, and positive behaviour support.	
		NHSE request to cost shortfall in workforce	Amanda Miller/Roland Miller	Trust submitted to West Yorkshire and South Yorkshire ICBs in November 24. Awaiting national and regional formal response to provider funding requests.	Completed
		System 1 I&ACMHS screening tool	Stuart Davis	System 1 I&ACMHS screening tool – in place and operational.	Completed

		Engagement with regional and national network/learning events	Stuart Davis/Amy Hartley/Roland Miller	Trust representation and feedback in line with proposed national learning and changes has been robust.	Ongoing
		Establish model of caseload management	Roland Miller	Caseload management has been absorbed as part of productivity workstream	October 25
2/ Risk management – review of current policies/process/training Need to improve formulation skills in the workforce	Darryl Thompson	Risk Assessment Policy Review	Julie Poxton	Final draft being peer reviewed, to go to Clinical Policies Ratification Review Group in July 2025	31st July 2025
		Review other policies that include risk assessment/guidance to ensure consistency	Amy Hartley	Care Planning & Risk Assessment Improvement Group are leading on this. A review of all clinical policies is being undertaken to identify relevant policies and a T&F group will be established to review and recommend updates.	30th September 2025

3/ Move away from CPA to Personalised Care and Support.	Darryl Thompson	Replace CPA policy with new PC+S policy with related guidance re Key Worker / MDT roles / personalisation process	Stuart Davis/Amy Hartley	Draft Personalised Care Framework has been shared with providers and ICBs for comment. The Trust has submitted comments. Awaiting publication of National Personalised Care Framework to inform policy change.	30th August 2025
		Develop use of PROMS/PREMS within adult and OP mental health community teams.	Stuart Davis	DIALOG scale has been implemented across adult and OP mental health community teams.	Completed
		Review and update of care planning guidance, to ensure care plans reflect individual	Roland Miller	T+F completed Care Planning and Risk Assessment guidance in 2024 in	Completed

		needs are person centred and collaboratively written.		line with move to new care plan.	
		Update Care Plan on S1 to include DIALOG domains	Mike Garnham	SystmOne changes made to ensure care plan includes DIALOG domains.	Completed
4/ Ensure service users in this cohort are not discharged due to DNA		Review Discharge/Transfer of care policy and consider any further learning which may require additional review.	Roland Millar	Discharge / Transfer of Care policy was reviewed 2024 to ensure we do not discharge people in this cohort due to DNA.	Completed
		To review Local Access Policy in line with new contractual requirements to include focus on people who do not attend.	Stuart Davis		30th September 25
4/ Medicines management review - Non-adherence to with treatment policy is due for review	Subha Thiyagesh	Task and finish group to review and update medicines management policy aligned with national learning and guidance to support medication management	Amanda Miller/ Kate Dewhirst	Non-Adherence to treatment policy has recently been reviewed (March 25). A specific T+F group is being established to	30th September 2025

		particularly non-compliance in community.		ensure the March 25 policy version has been reviewed through a I&ACMHC lens.	
5/ Strengthen engagement with Carers/Families	Darryl Thompson	T+F Triangle of Care -Level One: roll out to inpatient units and community teams, complete self-assessment teams audit.	Roland Miller	Triangle of Care Level One was achieved in August 2024.	Completed
		Use existing patient / carer forums to enhance communication around care/discharge planning with families and carers	Amanda Miller	Feedback from existing forums is being collated. Existing patient/carer forums are being identified where service communication with families and carers will be a standard agenda item.	September 30th 2025
5/ Partnerships / Information/risk sharing: Differing models of integration across SWYT Need to collaborate with local authority partners in further developing service. Social care roles have changed	Adele Fox	Continue to use current provider / commissioner forums across four areas to develop a collaborative action to meet the needs of this cohort.	Amanda Miller	Representation on WY and SY calls well established. Ongoing SWYFT attendance at community of practice and national development groups.	Ongoing

since AOT's were established in previous model. Governance structures do not have a focus on this cohort.					
7/ Peer Review with RDASH	Adele Fox	MOU to be agreed	Rachael Smith	Contacted IG lead at RDASH, currently with RDASH procurement to review and arrange sign off.	31st July2025
		Scope of review to be agreed	Stuart Davis/ Roland Miller	Joint Planning meeting arranged for 30/6/25 to inc. agreement on timescale/completion date.	30th August
		Membership of review group	Amy Hartley/Chris Lennox	Key members identified and awaiting confirmation of individual names.	30th June 2025

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)**		
Lead Director:	**Mark Brooks - Chief Executive** **Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive**		
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 aims:	Live Our Values		The Trust's partnership working at system and Place supports it to be the 'Best Partner' and to achieve its ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	2.6 Financial pressures in our systems could result in less focus on mental health, learning disability and autism, community services and/or Place. 2.7 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 3.2 System pressures could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 3.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions. There is no impact of the paper on BAF risk scores.		

With all of us in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place - based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative. The last update was received by Trust Board on 29 April 2025.
Executive summary:	The Trust is an active participant in the South Yorkshire Integrated Care System and this report provides a summary of key points from the main meetings and forums which take place in that system and includes 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 members are asked to:** • **NOTE** the SY ICS and Barnsley Place updates.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 1 July 2025

Agenda item – 12.1 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 7 May 2025 Key agenda items included: • Story Telling: Roma Community- the Board heard a story facilitated by the Clifton Learning Partnership who work closely to support the Roma community in Rotherham. The historical and current challenges of persecution and discrimination were highlighted. The community is typically challenged by deprivation and exclusion and often only access healthcare when they are no longer able to cope. Communication can be a major barrier. The partnership held a healthy family fun day which built up some trust. The vital role of community organisations was highlighted as was developing awareness and understanding. • Chair's matters. • CEO Report- key updates included: o Foundations for reform of the NHS- operating costs of ICBs nationally will need to reduce by 50%. NHS trusts have been asked to reduce corporate costs growth by 50% of the 2019 spend position. o Pathways to work- the Government have committed £18m to South Yorkshire ICB, the South Yorkshire Mayoral Combined Authority and the four Local Authorities for the Trailblazer/Accelerator programme, which aims to support around 10,000 people into work or to stay in work. o Financial plan 2024/25- the ICB exceeded its overall budget by nearly 1%, with a deficit at the end of the year of £30.1m. Included in this total was a deficit against the ICB of £38.3m, with local providers generating an overall surplus of £8.2m. o Operational and Financial Plan 2025/26 and NHS Joint Forward Plan for South Yorkshire- NHS South Yorkshire

	submitted its plan for 2025/26 to deliver a balanced financial position at the year-end, inclusive of agreed deficit support, albeit with significant risk. A refresh of its Joint Forward Plan has been published, noting the imminent publication of the national 10 Year Health Plan o Mental Health Out of Area Placements investment- the three South Yorkshire NHS providers of adult mental health services have been awarded £7m of NHS England capital funding to increase capacity in mental health inpatient provision and reduce out of area placements. o UK Supreme Court Ruling regarding gender definition- further understanding of the implications on recent legal judgement is required. The ICB outlined commitment to ensuring that everyone has a right to be themselves, feel welcome and accepted. o Eligibility changes to Non-Emergency Patient Transport across South Yorkshire- from 1 April 2025 the updated national eligibility criteria for Non-Emergency Patient Transport Services were implemented across South Yorkshire. o Specialised Commissioning- NHS South Yorkshire took formal responsibility for specialised commissioning functions from NHS England on 1 April 2015. o NHS Staff Survey results for NHS South Yorkshire- the response rate and survey results were much improved and reflective of the work undertaken. • South Yorkshire Board Assurance Framework and Corporate Risk Register- risks will need to be re-evaluated following the announcement regarding restructuring and 50% cost reduction. Some risks will likely transfer to other bodies. • Involvement update. • Place Partnership Updates. Key updates for Barnsley Place included: o Work to support individuals back to work o Progress on addressing health inequalities and Core 20 + 5 o Positive performance in community re meeting 2-hour target for urgent referrals and use of virtual wards. o Continued growth in Children and Young People accessing mental health services. • Independent Mental Health Homicide Review. • South Yorkshire – Delivering our Performance Objectives including System Quality and Patient Experience update. • Cancer Alliance update. • NHS South Yorkshire Financial Delivery Report. • NHS South Yorkshire ICB Financial and Operational Plan. • Specialist Commissioning Delegation Update. Responsibility for specialist commissioning transferred from NHS England to the ICB effective from April 2025 • Corporate Assurance Report and ICB Governance Items. • Emerging SY cyber strategy- this was approved and effective engagement with providers was highlighted. • Minutes of the South Yorkshire ICB System Leaders' Executive meetings.

	• Minutes of the South Yorkshire ICB Place Committee • Meetings. • Minutes of the South Yorkshire ICB Assurance Committee meetings.
Date of next meeting	Next meeting in public is scheduled for 2 July 2025
Further information:	https://southyorkshire.icb.nhs.uk/our-information/meetings-and-papers

3. South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board

Member	Chief Executive
Items discussed	Update from meeting on 14 May 2025 Key items discussed included: • Managing Director Report- the Board received an overview of the national changes to Integrated Care Boards (ICBs) and NHS England, and noted the potential implications of the changes on Provider Collaboratives in terms of funding and engagement. • Service Development Funding (SDF) and the Mental Health Investment Standard (MHIS)- the Executive Place Director Rotherham & Deputy Chief Executive of the ICB provided the Board with an update on the plan for the Service Development Funding for 2025/26. The high-level message was that funding had been applied differently this year and there has been a 7% reduction nationally compared with 24/25. Members of the Board requested more detail on the impact assessment process, including what it covers, decisions made, and outcomes. • Mental Health Investment Standard (MHIS)- it was updated that MHIS applies to Integrated Care Boards (ICBs) and will continue to be subject to an independent review. For 2025/26, the MHIS requires ICBs to increase spending on mental health services in line with the growth of the ICB programme allocation base. • Financial Planning- an update was given on the development of a three-year plan for the South Yorkshire MHLDA Providers which is being developed by the Directors of Finance and Chief Executives. • Delivering Our Work programme- the Board was provided with an overview of progress against existing programmes and the recently agreed priorities for 2025/26 which are the Information and productivity programmes. • Out of Area Placements (OAP)- the Board were advised that a deep dive into the OAP programme had identified current challenges and highlighted opportunities to further develop services closer to home. Progress has already been made across the Trusts with further work planned in 2025/26. • Specialised Commissioning Update- the Board received the routine report from the South Yorkshire and Bassetlaw

	Specialised Commissioning Provider Collaborative Partnership Steering Group. • Board Assurance Framework- an updated BAF was presented, and the Board requested further review to include the changing funding landscape and a review of the scoring. • Terms of Reference updates.
Date of next meeting	Next meeting scheduled for 9 July 2025

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	<u>Update from meeting on 19 June 2025</u> Key items discussed included: • Place Director Update and Barnsley Place Achievements. - demand across the system not just to emergency department demand was noted. Proactive care is stemming growth. It was noted the Trust's target to increase virtual ward utilisation over 80% was achieved at 119% at end of March 2025. Urgent Community Referrals seen within 2 hours also achieved 95% against the 70% standard. • Feedback from South Yorkshire Integrated Care Partnership Board- it was updated the next meeting is due to take place on 2 July. • Healthwatch Update Report. In Barnsley, local Healthwatch is delivered through a 'hosted' arrangement, and Barnsley CVS have acted in this capacity for the last 10 years. Barnsley CVS were successful in the re-procurement exercise in November 2024, and they • remain the host and accountable body for Healthwatch Barnsley for the next four years. New priorities for 2025/26 are being developed. • ICB changes. It was updated that the model ICB document has been published. Work is ongoing to reshape ICBs, which will focus on strategic commissioning responsibilities. • Quality and Safety Report. • Annual Assurance Report. • Board Assurance Framework, Risk Register, and Issues Log. • Performance Dashboard. • Committee Minutes & Assurance Reports. • Updates and Escalations from Partners. Inpatient mental health bed pressures in Barnsley were noted, along with clinical ready for discharge delays. • Risks and Items for Escalation to NHS South Yorkshire ICB.
Date of next meeting	Next meeting scheduled for 31 July 2025
Minutes	Papers and draft minutes when available

	https://southyorkshire.icb.nhs.uk/about-us/who-we-are-and-what-we-do/place-map/barnsley/barnsley-place-committee-partnership-board-public-meetings

Barnsley Place Partnership Delivery Group

Member	Deputy Director of Strategy and Director of Strategy and Change
Items discussed	Update from meeting on 10 June 2025 The main agenda items was demand management linked to the South Yorkshire ICB efficiency programme, and the savings required on non-elective admissions. There was a discussion covering what could be done differently, or more efficiently recognising increase in demand across sectors.
Date of next meeting	Next meeting scheduled for 12 August 2025.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy and Change
Items discussed	Update from meeting on 30 April 2025 Key items discussed included: • Connecting Care Approach- it is planned that each neighbourhood will have a Connecting Care Hub with health, Local Authority and voluntary sector colleagues co-located. This work will link to the Urgency and Emergency Care Group work and broader neighbourhood work taking place. • Urgent Response integrated service offer out of hours- a pilot has been completed and discussion taking place with the Local Authority regarding future funding. An increase in referrals patients out of hours was observed. Increased capacity in Urgent Community Response prevented potential escalations in cases, ambulance call out and supported care home placements to be maintained. • Rapid Access Frailty Hub- it was reported that the pilot is progressing well with positive patient feedback. • Home visiting criteria- a set of principles regarding which patients should be eligible to receive a home visit rather than coming into clinic have been implemented. Importance of staff engagement was noted. • Alliance & BHNFT - Waiting Fair, Waiting Well • High Intensity Users- a cohort of patients have been identified as high intensity users, and support provided from care navigators and social prescribers. The intervention has demonstrated strong impact to reduce service utilisation. • Delivery Group Work Plan. • What's Your Move – Physical Activity Framework. • Mental Health Additional Roles Resource.
Date of next meeting	Next meeting scheduled for 25 June 2025

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change
Items discussed	Update from meeting on 15 May 2025 Key items discussed included: • Barnsley Place Update - March 2025. • Minutes of the NHS South Yorkshire Integrated Care Board Barnsley Place Committee and Barnsley Place Partnership Board - 28th November 2024. • Minutes of the NHS South Yorkshire Integrated Care Board Barnsley Place Committee and Barnsley Place Partnership Board - 30th January 2025. • Health and Wellbeing Strategy - Introduction to the Draft Outcomes Framework. • Focus on Active Travel - Strategy Priority. It was agreed that the Health and Wellbeing Board would support and champion behaviour change campaigns/communication for walk, cycle and wheel. • Delivery and Implementation of the Strategy (the 'Hows') - Focus on Co-production- a presented was shared on the co-created approach used in Calderdale and Wakefield to engage people with severe mental illness in art. The learning from the methodology was noted. A project which addressed the reduction in uptake in routine immunisations, vaccine equity and vaccine hesitancy was also shared and how solutions were co-created to address these issues within eastern european migrant communities in Barnsley. • Barnsley Better Care Fund Planning Template.
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143
Date of next meeting	Next meeting scheduled for 17 July 2025

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 12.2

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.**		
Lead Director:	**Mark Brooks - Chief Executive**		
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 aims:	Live Our Values		The Trust's partnership working at system and Place supports being the 'Best Partner' and the Trust to achieve our ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	2.6 Financial pressures in our systems could result in less focus on mental health, learning disability and autism, community services and/or Place. 2.7 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 3.2 System pressures could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 3.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		

With all of us in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place-based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board. The last update was received by Trust Board on 29 April 2025.
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. 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. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.

Recommendation:	**Trust Board members are asked to:**
	• **NOTE** the update on the development of Integrated Care Systems and collaborations:
	  o West Yorkshire Health and Care Partnership.
	  o Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.
	• **NOTE** the minutes of relevant partnership boards/committees.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 1 July 2025

Agenda item 12.2

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.

The paper summarises key developments from recent ICB and place-based partnership meetings. A key focus of system discussions is the requirement of reducing ICB costs by 50% by the third quarter of this year, the recently published ICB blueprint and the role ICBs play in the future as strategic commissioners.

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	An extraordinary meeting of the West Yorkshire Integrated Care Board was held on 29th May 2025. The main agenda item was the approval of organisational change plan for submission to NHS England on 30 May 2025.
Date of next meeting	Next meeting scheduled for 24 June 2025.
Further information:	Integrated Care Board :: West Yorkshire Health & Care Partnership

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the West Yorkshire Health & Care Partnership Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 15 July 2025.
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 Mental Health, Learning Disability and Autism Partnership Board

Member	Chief Operating Officer and Medical Director.
Items discussed	Update from meeting on 12 June 2025. Agenda items included: • Chair's update. • West Yorkshire Adult Secure Provider Collaborative. • Secondary care pathways. • Place and provider updates. • Integrated neighbourhood teams. • Mental health support teams update. • Safeguarding oversight process. • Escalation of AAA reports. • Planning and performance update.
Date of next meeting	Next meeting scheduled for 8 July 2025.

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (WDHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive
Items discussed	Update from meeting on 3 June 2025. Key agenda items included: • Wakefield Place Lead Quarterly Report- updates included: ○ Work is progressing on the development of the Wakefield Provider Alliance, a key step towards the creation of a local neighbourhood health model. It is expected that the

	Wakefield Provider Alliance will replace the Transformation and Delivery Collaborative (TDC). ○ Community engagement continues to shape the upcoming NHS 10 Year Health Plan, with more than 12,000 people sharing their views across West Yorkshire. The Plan will be published over the summer. ○ Rachel Bowes has been appointed as the new, permanent Corporate Director, Adults and Health (DASS) at Wakefield Council. • Development of the Wakefield District Plan- following extensive work with partners, the Wakefield District Plan is progressing towards publication. The plan will provide a joint vision for improving outcomes for all who live, work or study in Wakefield. The Plan is built around six key themes: Health, happy children; Living healthy lives; Thriving, safe communities; An economy that works for everyone; Tackling climate change, and Targeted and collaborative support for people with complex lives. The District Plan will be discussed at a development session of the Health and Wellbeing Board in July. The final plan is due to be presented for approval by Wakefield Council in July. • High level Risk Register. • Quality, Safety and Experience Report: Quarter 4 2024/25- the report provided an overview of the district's health and care services' performance and improvements during the final quarter of the year. • Performance Exception Report- significant improvements were noted in the number of annual physical health checks for people with a learning disability being completed. • Annual Report for Wakefield Place- it was updated that the annual report will highlight achievements against the three strategic priorities: equal health for all, building community support and managing service demand. • Report from the Chair of the Wakefield Integrated Assurance Sub-Committee. • Report from the Chair of the Wakefield Transformation and Delivery Collaborative Meeting – it was updated that the Committee had noted the recommended changes to the Delivery Collaborative to support the transition to the Provider Alliance from October, including a focus on the development and implementation of the neighbourhood health programme and a move to exception, risk-based reporting. • Wakefield Place Partnership Agreement. • Annual Report for the Wakefield Health and Care Partnership Committee. • End of Year Committee Effectiveness for the Wakefield Integrated Assurance Sub-Committee. • End of Year Committee Effectiveness for the Wakefield Transformation and Delivery Collaborative Meeting. • Escalations to the West Yorkshire ICB Board.
Date of next meeting	Next meeting scheduled for 4 September 2025
Further information	Meeting papers are available here:

	Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	Update from meeting on 17 June 2025. Key agenda items included: • Population Health Management, including digital. • Modern General Practice. • Children's Neighbourhood Multidisciplinary Teams. • Adults' Neighbourhood Multidisciplinary Teams. • Escalation from Programmes/Alliances and Delegation to Programmes/Alliance. • Items for escalation to Wakefield District Health and Care Partnership Committee and other Committees.
Date of next meeting	Next meeting scheduled for 17 July 2025.

Wakefield Mental Health Alliance

Member	Director of Integrated Change - Wakefield (Chair), with Trust representative as a member.

Items discussed	Update from meeting on 4 June 2025.
	
	Key agenda items included:
	• Mental Health Alliance performance dashboard.
	• Standing item updates:
	  ○ Mental Health Emergency Dept Strategy Group.
	  ○ Community Mental Health Transformation.
	• Community mental health panel update.
	• 2025/26 Planning.
	• Mental Health Alliance next phase.
	• Partner updates.
	• Wakefield Transformation and Delivery Collaborative.
	• Wakefield District Health and Care Partnership Committee feedback.
	• West Yorkshire MHLDA Partnership Board feedback.
	• Alliance Forward Plan.

Date of next meeting	Next meeting scheduled for 2 July 2025.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Integrated Change - Wakefield)
Items discussed	There has been no further meeting of the Wakefield Health and Wellbeing Board since the last report to Trust Board.

Date of next meeting	Next meeting scheduled for 31 July 2025
Further information	Papers and draft minutes are available at: www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board

Wakefield Together Chief Officer Group meeting

Member	Director of Integrated Change - Wakefield
Items discussed	There has been no further meeting of the Wakefield Together Chief Officer Group since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 25 June 2025

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 29 May 2025.
	Agenda items included:
	• Deep Dive: Calderdale Partnership approach to Anti-Microbial Stewardship.
	• Place Lead Report- this included the following:
	  ○ A focus on the ICB 50% cost saving requirements and potential impact on Calderdale place.
	  ○ Positive news on completion of annual health checks in 24/25 for people with severe mental illness (2024-2025 shows an uptake of 72%) and learning disabilities (the end-of-year data for 2024-2025 shows that Calderdale achieved 92% uptake for Learning Disability Annual Health Checks).
	  ○ Discussion regarding neighbourhood care which will be discussed in detail at next development session.
	  ○ Risk Report- it was agreed impact of ICB cost savings needs to be taken into account.
	  ○ Performance Report.
	• Annual Governance Review 2024/2025 and review of Terms of Reference.
	• Annual Report, Terms of Reference and Work Plan of the Calderdale Cares Partnership Quality Group.
	• Review of Workplan.
	• Finance Report.
	• Quality and Safety AAA Report.
	• Papers received for information:
	  ○ Calderdale Quality Group Minutes.
	  ○ Calderdale Primary Care Strategy Group.
	  ○ WY&H Cancer Alliance Board.

Date of next meeting	Next meeting scheduled for 4 September 2025.

Further information	Further information and meeting minutes can be found here: Calderdale Cares Partnership Board Papers - Calderdale Cares Partnership

Calderdale Cares Community Programme Board

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	Update from meeting on 12 June 2025. Agenda items included: • Integrated Neighbourhood Health- System Development Funding business cases • Future allocation of Core 20 Health Inequalities funding
Date of next meeting	Next meeting is scheduled for 10 July 2025.
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 Integrated Change - Wakefield.
Items discussed	Update from meeting on 19 June 2025. Agenda items included: • Starting Well. • Learning Disabilities- support and long term planning for people with a learning disability placed in Assessment and Treatment provision. • Calderdale Pharmaceutical Needs Assessment 2025-2028. • Confirmation of membership of the Health and Wellbeing Board for 2025-26. • Health & Wellbeing Board Annual Report 2024-25. • Health and Wellbeing Board Forward Plan and Action Log 2025-26.
Date of next meeting	Next meeting is scheduled for 18 September 2025.
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
Items discussed	Update from meeting on 14 May 2025. Key agenda items included: • People Story. • Developing Integrated Neighbourhood Teams (INT) in Kirklees- an overview of the national guidance regarding Integrated Neighbourhood Health and the 6 core components, of which Integrated Neighbourhood Teams (MDT working) is one was shared. • Future Provision of Primary Care Services for B85659 Whitehouse Centre Practice Population. • 2024/25 Financial Update and 2025/26 Financial and Operational Planning and Better Care Fund. The final 2024/25 financial position for NHS partners, the plans for partners for 2025/26 and an update on a further stretch challenge of £33m to be identified by partners was shared. • Annual Reports, Terms of Reference and Work Plans of Sub-Committees, Clinical and Care Professional Forum and Delivery Collaborative. • Committee Annual Report, Terms of Reference and Work Plan. • Kirklees Health and Care Partnership Collaboration Agreement – extension to 31 March 2026. • Accountable Officer's Report. • Kirklees Place Quality Report. • Kirklees Clinical and Care Professional Forum AAA Report. • Contracting Report. • Performance Report against Key Performance Indicators. • High Level Risk Report: Cycle 1 2025/26 (March – June 2025) and Board Assurance Framework. • Receipt of Minutes.
Date of next meeting	Next meeting scheduled for 13 August 2025.
Further information	Further information and papers are available at: Kirklees Integrated Care Board Committee - NHS Kirklees HCP

Kirklees Integrated Health and Care Partnership Forum

Member	Assistant Director of Corporate Governance
Items discussed	Update from meeting on 5 June 2025. Key agenda items included:

	• Update on the West Yorkshire Power of One Power of Many: Working Together for Equity and Fairness. An introduction to the strategy was given.
	• Update on Physical Activity Work Across our Health and Care Partnership and plans for 2025/26 -an update on work with Sport England was provided.
	  ○ As part of Sport England Uniting the Movement programme expansion, support has been provided to Kirklees Place.
	  ○ Recruitment to programme manager role is in progress to manage delivery of the Sport England development award.

Date of next meeting	Next meeting scheduled for 4 September 2025.

Kirklees Health and Wellbeing Board

Invited Observer	Assistant Director of Corporate Governance
Items discussed	There has been no further meeting of the Kirklees Health and Wellbeing Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 24 July 2025.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Delivery Collaborative

Member	General Manager Adult Community and Recovery Services Kirklees and Calderdale
Items discussed	There have been no further meetings of the Kirklees Delivery Collaborative since the last update to Trust Board. The meetings have currently been paused.
Date of next meeting	To be confirmed.

Kirklees Mental Health Alliance

Member	Chief Executive (Co-Chair), with Associate Director of Corporate Governance as a member
Items discussed	A workshop was held on 28 April 2025 which was focused on crisis pathways.
Date of next meeting	Next meeting to be confirmed.

Recommendations:

Trust Board is asked to:

- **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.**
- **Note the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
18 July 2025
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Provider Collaboratives and Alliances**		
Lead Director:	**Adrian Snarr (Director of Finance and Resources)**		
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 paper provides an update on 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, and an update on the national Phase 2 Provider Collaboratives.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.1 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. 3.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care. 3.2 System pressures could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience.		
Contribution to the objectives of the Integrated Care	The paper provides an update on the work of the Provider Collaboratives and their relationship to ICB, and Place based organisations. The paper highlights the opportunities available to the Trust to work with other providers to tackle		

System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	shared challenges through provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.
Executive summary:	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. Where the Trust is the co-ordinating provider, the paper provides insights into the areas of improvement being undertaken. These include in West Yorkshire and South Yorkshire, projects to address challenges in patient pathways and flow (out of area and clinically ready for discharge), health inequalities and work to improve our insights and sharing of patient experiences. Updates relating to environmental changes in services are also shared that impact on the access to services/patient experience and quality. Financial updates are provided for all Provider Collaboratives and the impact on the Trust through agreed risk shares.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the updates provided within the paper.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board

Agenda item 12.3

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 1 October 2020, and the CAMHS and Adult Secure Collaboratives 1 October 2021 (with transitional support from NHSE/I until 31 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 1 October 2021, and the Adult Secure Provider Collaborative on 1 May 2022.

Although the South Yorkshire Integrated Care System does not include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population and will link with Nottinghamshire Integrated Care System as required.

3. Phase 1 Provider Collaboratives - West Yorkshire

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative has progressed amongst a range of items:

- Continue the work to improve the identification and reporting of clinically ready for discharge (CRFD) cases to improve our understanding of themes and support the unblocking of pathways. This is supported with a new West Yorkshire Provider Collaborative Commissioning Hub monthly CRFD panel, where all delays are reviewed, actions and onward escalation agreed, as necessary.
- We have concluded our response to the national decommissioning of (Women's Enhanced Medium Secure Services (WEMSS) and have transferred all patients to low secure services. A financial allocation is expected from NHSE as the original WEMSS population were not considered in our original base line when the provider collaborative went live.
- We continue to progress the wider improvement work to women's pathways in line with the national secure care transformation programme with focus on a shared admission criteria, quarterly meetings reviewing all women in secure care and their pathways.
- Repatriation plans continue for patients placed out of area and outside natural clinical flow. Pressures continue to be experienced with access to male mental illness medium secure beds and high secure beds. The provider collaborative at the last reporting period had 53 cases out of area, 34 outside natural clinical flow (ONCF), and 19 in natural clinical flow in specialities not provided in West Yorkshire. From the 34 ONCF 9 could be cared for in West Yorkshire and have repatriation plans in place, however due to current new demand from prisons and psychiatric intensive care (PICU) it is unlikely many will be repatriated in the short term. The remaining ONCF have legitimate reasons for being placed outside West Yorkshire, which include safeguarding, restriction orders or are closer to family.
- The provider collaborative reported on the findings of a physical health review across all West Yorkshire services. An individual service level report has been provided with must do, and should do, recommendations for improvement.
- A new West Yorkshire wide patient experience questionnaire has been developed and will be rolled out in Q2. Plans have commenced to develop a patient AGM. At the end of June, 'the BIG event' is planned for service users, hosted at Sandal Rugby Club and open to all secure patients in Yorkshire and Humber.
- A review of PICU referrals was undertaken due to a noted increase in referrals in Q4. This demonstrated increasing trajectory in Leeds and Bradford, leading to the pressure on access to beds. 34% of all cases referred are accepted however 9% of all admitted cases are from SWYPFT services and 55% from Leeds, demonstrating variance within West Yorkshire. The collaborative will be working with ICB colleagues to further understand the variance and any improvement work.

All Provider Collaboratives are facing financial challenges driven by increases in demand balanced with the ability to maximise internal capacity. In addition, the acuity and complexity of service users is necessitating additional costs for packages of care which are over and above those previously commissioned.

The most recent meeting of the Commissioning Committee (formerly Collaborative Committee) of the Trust Board took place on 17th June 2025.

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.

After closing 2024/ 25 with a deficit position (£165k), the provider collaborative is reviewing their inpatient and community service offer. This has included a pilot which supports our acute care colleagues and the Medical Emergencies in Eating Disorders (MEED) pathway. The service review is expected to be shared in Q3 of this year.

The collaborative has no OOA admissions, which contributes to a positive forecast for this financial year. Where this position continues, the anticipated small surplus (against the OOA budget) will be held within the investment fund for the collaborative.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

Despite posting a deficit position of £2,108k at financial year end (2024/25), the Children and Young People's Provider Collaborative has realised efficiencies against plan at month 2. This is largely driven by reduced OOA spend and associated exceptional packages of care (EPCs).

The collaborative is developing several priority workstreams to maximise efficiency of in area provision and to work with system colleagues in identifying viable alternatives to hospital admission, and/ or facilitated discharge.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire and Bassetlaw (SYB) Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Oversight Group meets monthly and continues to provide oversight of the Trust's commissioning responsibilities, this reports into the Trust's Commissioning Committee and key areas of focus have been as follows.

- Ensuring the efficient use of the SYB Adult Secure bed base to reduce out of area usage and capitalise on the reopening of beds within the SYB Region.
- Clinical oversight of patients that are clinically ready for transfer or discharge. Specific focus has been on 2 patients that are awaiting high secure services with annual packages of care totalling £1.4m – this presenting a cost pressure to the SYB Adult Secure Provider Collaborative.
- Continued focus on the Women's Pathway, overseeing a plan to transfer an SYB patient from the soon to be decommissioned Women's Enhanced Medium Secure pathway to Cheswold Park Hospital.
- Hosting a Women's Provider Collaborative Transformation event inclusive of experts by experience, staff, and existing women in services.
- Consideration is being taken on the possibility of expansion of the Community Forensic Service through a staged approach with women being the first focus area in support of national and local work on the women's specification.
- Continued oversight of admissions, repatriations, and transfers to Cheswold Park Hospital, with the aim to increase to 80 patients across the site. 15 patients have now been admitted to Cheswold Park since 1 January 2025.

- The ‘Enhanced Packages of Care working group’ continues to both clinically and financially manage all Enhanced Packages of Care in place to ensure least restrictive care and reduce unnecessary spend.
- Working in collaboration with several providers following the annual quality reviews to ensure improvement areas are closely monitors and improvements embedded.
- Enacting enhanced monitoring arrangements collaborating closely with the Provider, Lead Provider and NHSE.
- Health Inequalities lead is concluding his work which is being shared back via summer workshops with all Stakeholders which will inform a final report.

The SYB Provider Collaborative has in previous financial years reported a surplus position, however the 2025/26 forecast position is reporting a potential £129k overspend, this is impacted by.

- £1.4m pressure relating to patients awaiting NHS retained services (High Secure). This has been flagged with NHSE with a request for a focussed discussion on possible mitigation support in place.
- An additional £500k pressure has been factored into the forecast expenditure for Extraordinary Packages of Care for 2025/2026 working from analysis from 2024/2025 and linked to above retained patient pressures.

5. Phase 2 Provider Collaboratives

5.1 Forensic CAMHS

The Collaborative went live on 1 April 2023.

Commissioning oversight of Yorkshire and Humber FCAMHS transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1 January 2024.

To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, developments and quality activity, a Yorkshire and Humber Provider Collaborative Oversight Meeting has been established between the three Commissioning Hubs, chaired by West Yorkshire Commissioning Hub. The minutes and content are shared with SWYFT Commissioning Committee

Regular reporting and governance structures have been established, alongside quality oversight arrangements.

5.2 Perinatal Mental Health (PMH)

The Collaborative went live on 1st October 2024, in shadow form.

Commissioning oversight of Yorkshire and Humber (inpatient) PMH PC transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1 April 2025

West Yorkshire ICB 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.

The Yorkshire and Humber PMH Provider Collaborative Board has been established. SWYPFT as a named partner, have representation at the board level, and as such will be in receipt of updated positions, partnership agreements and finance and activity reporting.

The PMH PC commissioning and quality activity will be shared at the established Yorkshire and Humber Oversight Group (detailed above).

A full business case for the provider collaborative has been shared with all partners, further work is being undertaken to progress the partnerships agreements to signature.

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
1 July 2025
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Trust compliance with NHS provider licence conditions**		
Lead Director:	**Dawn Lawson – Director of Strategy, Inclusion and Change/ Deputy Chief Executive**		
Mission/values:	Effective governance, and compliance with the conditions of the NHS provider licence support the Trust to deliver its mission and adhere to its values.		
Purpose:	The purpose of this paper is to provide an overview of the process the Trust has gone through to self- assess against the conditions of the NHS provider licence and to provide assurance of compliance.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Given the requirement for the Trust to comply with its provider licence conditions, all risks on the Board Assurance Framework are relevant to this paper.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	This self-assessment process provides evidence to assure the Board that the Trust is operating in line with its licence. It also provides assurance to partners and the system of adherence to the conditions of our licence and is published on the Trust website.		
Any background papers / previously considered by:	Self-Assessment against the NHS provider licence – Trust Board June 2024 Executive Management Team – 19 June 2025		

With **all of us** in mind.

Executive summary:	This retrospective report (1 April 2024 to 31 March 2025) is in line with the licence provider requirements for the year 2024/25 and conditions as shown below: Section 1 – Integrated care. Section 2 - Trusts working in systems. Section 3 – General conditions. Section 4 – Trust Conditions. Section 5 – NHS controlled provider conditions. Section 6 – Continuity of services. Section 7 – Costing conditions. Section 8 – Pricing conditions. Section 9 – Interpretations and definitions. NHS foundation trusts are no longer required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), or that they have the required resources available if providing commissioner requested services, and have complied with governance requirements. However, in the interests of good governance, and in support of the renewed annual governance statement, this assessment has been undertaken on behalf of Trust Board by the corporate governance team. Key updates for this year include: • Integration of new Trust strategy where applicable. • Updated narrative in sections where required. • WS2 – The triple aim – this section has been updated to reflect Trust's performance metrics being aligned to the five national themes of the NHS System Oversight Framework. • WS3 – Digital transformation – this section has been updated to align to the Trusts new digital strategy • CoS 1: Continuing provision of Commissioner Requested services (CRS) – this section has been updated following consultation with NHS England which confirmed following the establishment of provider collaboratives, adult secure services fall under CRS criteria, in addition to Barnsley physical health services. • CoS 2 - Restriction of the disposal of assets – updated as per CoS 1. The updates for 2024/25 were presented to the Executive Management Team on 19 June 2025 and recommended to Trust Board for approval. Trust Board can be assured that the Trust has a sound system of corporate and clinical governance in place to meet the requirements of its licence.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the outcome of the self-assessment against the Trust's compliance with the terms of its Licence.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 1 July 2025

NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023. The licence has now been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence.

The provider licence is split into nine sections:

Section 1 – Integrated care.
Section 2 - Trusts working in systems.
Section 3 – General conditions.
Section 4 – Trust Conditions.
Section 5 – NHS controlled provider conditions.
Section 6 – Continuity of services.
Section 7 – Costing conditions.
Section 8 – Pricing conditions.
Section 9 – Interpretations and definitions.

Section	Provision	Comments
Section 1 – Integrated Care IC1: Provision of integrated care	1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph	The Trust actively works with its partners, through formal and informal mechanisms to enable integrated care and is involved in several provider collaboratives with formalised ways of working and models of delivery. A number of services are provided through partnership working with local stakeholders. The Trust plays an active role in Integrated Care Systems in West Yorkshire and South Yorkshire and is a signatory to a Memorandum of Understanding with both. The Trust is also fully engaged in place-based
	2. The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including	

With all of us in mind.

	the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	arrangements in our respective localities. The Trust is the lead/coordinating provider for adult secure services in West Yorkshire and South Yorkshire and is lead provider for Forensic CAMHS across Yorkshire and Humber. Reducing health inequalities is part of the Trust's strategic aims under "Best quality". The Trust works with each of our partners in all four of our places to address health inequalities. Examples include our work with partners on annual physical health checks for people with a learning disability and severe mental illness and using data and insight to identify communities for focused work on waiting lists and times.
	3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition	
	4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.	
IC2: Personalised Care and Patient Choice	1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	The Trust has developed a programme to improve personalised care and support addressing the national requirements to move away from the standards of the Care Programme Approach (CPA) and align to the five key NHSE principles. The Trust ensures this work is co-produced and that everyone with an interest can have their say and share thoughts on progress. During 2024-25 the Trust has launched a new person-centred care plan along with DIALOG, which is an 11-point scale that can be used as a person reported outcome measure (prom) or person reported experience measure (prem). Historically health outcome measures have been captured in paper form. However, the Trust has implemented a solution to improve and streamline collecting and reporting health outcomes digitally. This aids in improving timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment, offering more personalised care
	2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	
	3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.	
	4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	
	5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as	

	reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	and support through service user identified needs and goals. For points 4 and 5 choice of secondary care provider is offered through primary care and is therefore not applicable to the Trust. However, where the Trust utilises external providers for the provision of services on its behalf, patients are informed of this and offered the choice to accept this service or be referred back to primary care.
	6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	
Section 2 – Trusts Working in Systems WS1: Cooperation	1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	The Trust has undertaken a significant amount of work in integrated care partnerships in each of our four local areas. We are members of key strategic and operational groups in each of our four places and in both South Yorkshire and West Yorkshire integrated care systems. The Trust has participated in the development of the transformation of community mental health services in both integrated care systems. The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes. The Trust has in place a system for the review and dissemination of guidance/information to the executive management team and senior managers.
	2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	
	3. Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i. as necessary and appropriate for the purposes of developing and delivering system plan(s). ii. ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year. iii. iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans. b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services.	

	ii. ii. as necessary and appropriate for the purposes of improving NHS services. 4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England. For the purposes of this condition, cooperation is considered synonymous to collaboration	
WS2: The Triple Aim	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim. 3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act. 4. In this condition, "the triple aim" refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	Performance metrics are aligned to the five national themes of the NHS System Oversight Framework which include: quality of care, access, and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. These metrics are used to identify potential issues and prompt further investigation of support needs. At the end of 2024/25, the Trust achieved all applicable key performance indicators in the Oversight Framework set by our regulator with the exception of the number of out of area bed placements. These metrics are monitored monthly in the Trust integrated performance report in the national metrics section and can be found at this link: Performance reports - South West Yorkshire Partnership NHS Foundation Trust. The Trust has continued to focus on out of area bed placements in 2024/25 and has maintained the significant reduction in such placements in year comparted to previous years.
WS3: Digital Transformation	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they	We rely on digital technology every day in our working lives. It is therefore essential that the systems and technologies the Trust uses are efficient, effective, and contribute to better outcomes for the people who use our services.

	pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Embracing digital innovation within the NHS is crucial for enhancing patient care and by adopting new and emerging digital technologies, we can streamline processes, enable better data management and information sharing, support increased productivity, and foster a culture of continuous improvement and adaptability. This ensures we can meet the evolving needs of the communities we care for and deliver high-quality person-centric healthcare services. The views of our staff, service users and carers from their day-to-day experiences continue to be critical in driving the Trust's digital agenda and in designing fit-for-purpose, secure and robust digital capabilities that provide equitable access. Within our approach, the Trust persistently takes stock of the national digital strategic direction, associated standards, and wider digital priorities, perpetually assuring the organisation of our constant strategic alignment, both nationally and regionally, and digital standards compliancy obligations.
	3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	
Section 3 – General Conditions G1 – Provision of Information	1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	The Trust is currently obliged to provide NHSE with any information it requires and, within reasonable parameters, to publish any information NHSE requires it to. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust. Conditions are broad, so there is a potential risk of increased burden in the future. All NHSE mandatory performance indicators are reported through the Finance, Investment and Performance Committee and to Trust Board
	2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require	
	3. The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested	

	4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	through the monthly integrated performance report (IPR).
G2: Publication of information	1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct	See G1 – as above.
	2. For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals	
G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)	1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.	NHS England published a revised fit and proper persons framework to the Kark review (2019). This came into effect in September 2023, and the Trust updated its fit and proper persons process accordingly. There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors. All Board members and, for Foundation Trusts, governors must meet the 'fit and proper' persons test as described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain
	2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.	
	3. For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations	

	2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986; iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985. 4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts must also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors. With which the Trust is fully compliant for 2024/25. The Trust considers the membership of the Trust Board to be appropriate having the balance of skills, experience, and knowledge it needs to act as an effective unitary board of a Foundation Trust. It regularly reviews the balance, completeness, and appropriateness of the Board to meet such requirements through the Nominations Committee. Where appropriate, the Trust will look to recruit and / or retain individuals with certain skills and experience to ensure that this is maintained.
G4: NHS England guidance	1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act. 2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes.
G5: Systems for compliance with licence conditions and related obligations	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Strategy, Inclusion and Change and the Corporate Governance

	c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS. 2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness	Team.
G6: Registration with the Care Quality Commission	1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS. 2. The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission. 3. A notification given by the Licensee for the purposes of paragraph 2 shall: a. be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).	The Trust is registered with the CQC and understands its duties in terms of notification and has systems and processes in place to manage these, should they occur. In 2024/25 the Trust worked with CQC to register a new location, Cheswold Park Hospital from 1 October 2025.
G7: Patient eligibility and selection criteria	1. The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them	The Trust's website sets out the service directories for each Care Group (CG) and the relevant access criteria for the services.

	readily accessible by any persons who could reasonably be regarded as likely to have an interest in them	
	2. “Eligibility and selection criteria” means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b. if the person is selected, the manner in which the services are provided to the person	
G8: Application of section 6 (Continuity of Service)	1. The Conditions in Section 6 shall apply: a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service, b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2, c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension), d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service), e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS). See CoS1.
	2. A service is designated as a Commissioner Requested Service if: a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to	

	NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4	
	3. A notice in accordance with this paragraph is a notice: a. in writing, b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.	
	4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable	
	5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.	
	6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either: a. an instruction of the sort referred to in paragraph 7, or b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.	
	7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service,	

	NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service	
	8. A service shall cease to be a Commissioner Requested Service if: a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.	
	9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.	
	10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.	
	11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a	

	determination in writing.	
	12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.	
	13. In this Condition "NHS contract" has the meaning given to that term in Section 9 of the 2006 Act	
Section 4 – Trust Conditions NHS1: Information to update the register	1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	The Trust has provided all necessary documentation to NHS England as required and will make any necessary documentation available on request. Formal articulation of this Condition, therefore, does not present any issues for the Trust.
	2. The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution; b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published	
	3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	
	4. The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person	
	5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	
	6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to	

	NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	
NHS2: Governance arrangements	1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance. • The Trust's Constitution, based on NHS England's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. • A review of the Trust's Constitution was undertaken in December 2024. This was approved by Trust Board 28 January 2025 and ratified by the Members' Council on 14 February 2025. • The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. • Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structures. This provides assurance to Trust
	2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS	
	3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition	
	4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation.	
	5. The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	

	c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.	Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April. • Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annually in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme. • The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually. Directors and Governors are expected to declare any additions or changes to their declarations as and when they arise. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. • See section G3 for fit and proper persons requirements and compliance. • All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution and are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties. • The Trust has held a Licence since 1 April 2023. • The most recent Care Quality Commission (CQC) rating overall is good (which includes a rating of good for the well-led domain). • During 2024/25, the Board continued its
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	

	f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. 7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	development programme which included amongst other items, Trust strategy development, trauma informed training, Trust Board effectiveness survey, and strategy alignment sessions. For 2024/25 the Head of Internal Audit Opinion is one of significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement.
Section 5 – NHS Controlled Providers Conditions CP1: Governance arrangements for NHS-controlled providers	1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence. 2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS. 3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.	Not applicable.

	4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).	
	5. The Licensee shall establish and effectively implement systems and/or processes: a. to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements	
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care	

	provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	
Section 6 – Continuity of Services CoS 1: Continuing provision of Commissioner Requested services	1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.	Under the Trust's 24/25 contracts with each integrated care board (ICB), Barnsley physical health services are classified as a commissioner requested/essential service. The Trust also provides secure adult services that are commissioner requested services, and the Trust is compliant with the terms of the licence.
	2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.	
	3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested	

	Service except: a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.	
	4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.	
	5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in: a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	
CoS 2: Restriction of the disposal of	1. The Licensee shall establish, maintain and keep up to	Under the Trust's 24/25 contracts with each

assets	date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	integrated care board (ICB), Barnsley physical health services are classified as a commissioner requested/essential service. The Trust also provides secure adult services that are commissioner requested services, and the Trust is compliant with the terms of the licence.
	2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	
	3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	
	4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern	
	5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this Condition.	
	6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	
	7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	
	8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i. transactions of a specified description; or ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset	

	9. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	
CoS 3: Standards of corporate governance, financial management and quality governance	1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress	The Trust has robust and comprehensive corporate and financial governance arrangements in place. Any adjustments have been approved through Trust Board during the year. Corporate and Financial governance arrangements remain subject to both internal and external audit annually. All audit plans are agreed by the Audit Committee and the outcome of all audit reports are received and reviewed at the Audit Committee. Where the outcome is of limited assurance, executive leads report back to Audit Committee on progress against action plans.
	2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	
CoS 4: Undertaking from the ultimate controller	1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by,	Not applicable to the Trust.

	the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	
	2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	
	3. The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.	
	4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others	
	5. A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act;	

	b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity	
CoS 5: Risk pool levy	1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	There is currently no risk pool levy in place.
	2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	
CoS 6: Cooperation in the event of financial or quality stress	1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	The Trust submits monthly financial returns in line with all NHS providers. The Trust has been fully engaged in regular finance meetings with both West and South Yorkshire systems throughout 2024/25 and this will continue during 2025/26. As a provider currently placed within Segment two, we continue to follow the single oversight framework requirements.
	2. When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	
CoS 7: Availability of resources	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required	The Trust has sound and robust processes and systems in place to ensure it has the resources

	Resources	necessary to deliver Commissioner Requested Services.
	2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	
	3. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate	
	4. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	
	5. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.	
	6. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	
	8. In this Condition: “distribution” includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; “Financial Year” means the period of twelve months over which the Licensee normally prepares its accounts; “Required Resources” means such: a. management resources including clinical leadership, b. appropriate and accurate information pertinent to the governance of quality c. financial resources and financial facilities, d. personnel, e. physical and other assets including rights, licences and consents relating to their use, f. subcontracts , and g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable	

	the Licensee at all times to provide the Commissioner Requested Services.	
Section 7 – Costing Conditions C1: Submission of costing information	1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	The Trust responds to guidance and requests from NHSE. The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes. The Trust has in place a system for the review and dissemination of guidance/information to the executive management time and senior managers.
	2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.	
	3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner.	
	4. Records required to be maintained by this Condition shall be kept for not less than six years	
C2: Provision of costing and costing	1. Subject to paragraph 3, and without prejudice to the	The Trust responds to requests from NHS

related information	generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	England as required. Also see C1 above.
	2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested;	
	3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	
C3: Assuring the accuracy of pricing and costing information	1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	See C1 and C2
	2. This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	
Section 8 – Pricing Conditions P1: Compliance with the NHS payment scheme	1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the	See above C1, C2 and C3.

<table>
<tr><td></td><td>NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.</td><td></td></tr>
<tr><td>Section 9 – Interpretation and Definitions
Condition D1: Interpretation and Definitions</td><td>1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right-hand column of the table.

<table><tr><td>“the 2006 Act”</td><td>the National Health Service Act 2006 c.41;</td></tr><tr><td>“the 2008 Act”</td><td>the Health and Social Care Act 2008 c.14;</td></tr><tr><td>“the 2009 Act”</td><td>the Health Act 2009 c.21;</td></tr><tr><td>“the 2012 Act”</td><td>the Health and Social Care Act 2012 c.7;</td></tr><tr><td>“the 2022 Act”</td><td>The Health and Care Act 2022;</td></tr><tr><td>“the Care Quality Commission”</td><td>the Care Quality Commission established under section 1 of the 2008 Act;</td></tr><tr><td>“Commissioner Requested Service”</td><td>a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;</td></tr><tr><td>“Commissioners”</td><td>NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;</td></tr><tr><td>“Director”</td><td>includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of:
(i) an NHS foundation trust,
(ii) an NHS Trust or
(iii) a company constituted under the Companies Act 2006;</td></tr></table></td><td>This section determines NHSE interpretation and definitions and is for the Board to note and this document in its entirety complies with the guidance and conditions.</td></tr>
</table>

	"Governor"	a Governor of an NHS foundation trust;
	"Hard to replace provider"	has the meaning given in condition G8 of the licence;
	"Integrated Care Board"	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
	"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
	NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10;
	"NHS England"	the body named as NHS England in section 1 of the 2022 Act;
	"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
	"NHS Trust"	an NHS trust established under section 25 of the 2006 Act;
	"Relevant bodies"	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
	"Trusts"	means NHS foundation trusts and NHS trusts.
	2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body	
	3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act	
	4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 13.2

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Lead Director:	**Andy Lister – Head of Corporate Governance (company secretary)**		
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 to 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 aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	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.		

With all of us in mind.

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 been used on twelve occasions since the last report to Board in March 2025.
	• Beckside Court deed of variation to terminate lease of second floor to allow lease of whole building
	• Beckside Court lease for the whole building
	• Beckside plan drawing site plan
	• Folly Hall Mills renewal lease for the following:
	  • Suites 1 – 7 in small and main mills (individual seals)
	  • Suite 10 – fourth floor main mill
	• Renewal lease which extends Calderdale Councils occupation of the Trust owned health centre. The lease is for five years with a mutual break option on the third anniversary.

Recommendation:	**Trust Board members are asked to:** **NOTE** the update to the Trust Seal since the last report in March 2025.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
1 July 2025
Agenda item 14.1

Private/Public paper:	**Public**		
Title:	**Digital Strategy 2024-30 – Strategy Progress Report**		
Lead Director:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Mission/values:	Embedding a culture that embraces digital solutions within our approaches, ensures an integral way of supporting our staff and enabling our service users, carers, and wider communities to achieve their potential and live well based on value, need, risk, choice, and preference. Becoming a digitally mature organisation through innovation and continuous improvement is a priority for the Trust.		
Purpose:	The purpose of this report is to inform the Board of the progress, and developments made during the first half of 2024/25 in respect of the Trust's digital strategy delivery.		
Strategic aims:	Live Our Values	✓	The Trust's digital strategic agenda and programmes of work are aligned with Trust strategies and priorities. Digital spans all our strategic aims.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.1 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. 5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision. 6.3 Inability to build and sustain the right organisational capability, capacity, and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions. Digital is an enabler and together with digital transformation activities supports the Trust in providing robust digital technologies, solutions, services, information, and insights, which assists in delivering services, productivity, and		

	efficiency improvements, whilst bettering experiences for all and improving/maintaining quality.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust's revised digital strategy spanning 2024-30 remains fully aligned with the digital priorities and objectives of our Integrated Care Systems, Integrated Care Boards and Place-based partnerships across West and South Yorkshire, and in-step with national strategic digital direction. Continued progress is being made as presented in this report which serves to demonstrate our overall improving levels of digital maturity, providing the Trust Board with the assurances that our existing digital strategy and plans remain fit for purpose and relevant within local, regional, and national agendas.
Any background papers / previously considered by:	Digital Strategy 2024–30 approved by Board in January 2025 and the last progress update report provided in October 2024.
Executive summary:	The purpose of this report is to inform the Board of the progress being made to date in delivering against the revised 2024-30 Digital Strategy during the latter half of 2024/25. **Summary of progress** The report summarises progress against each digital domain, with notable updates and achievements highlighted recognising the end of year position for 2024/25. Most notably the work to support the extremely successful, safe, and smooth transition of the Cheswold Park Hospital site onto the Trust's digital infrastructure and clinical system, SystmOne. The dashboard on page 10 outlines the collective picture across the broad spectrum of work in support of the growing digital agenda. Where initiatives have been subject to revised delivery timescales for a variety of reasons, appropriate governance remains to be followed. **Key risks** The key risks associated with the digital agenda and programmes of work are subject to constant review in line with notable progress being made, with mitigating actions put in place, as necessary. **Financial investment** The capital funding made available to support digital developments during 2024/25 has been fully expended and opportunities to utilise additional available capital underspend in year has enabled further strategic infrastructure work to proceed and where appropriate, brought forward from 2025/26 plans. A consequence of the financial climate we are operating in and priority assigned

	to the Older People's development, means that capital for digital schemes in 2025/26 is extremely limiting. **Overall summary rating** This report demonstrates that overall considerable progress is being made against priorities, placing the Trust in an advantageous position from which to expand our digital capabilities during 2025/26 and beyond. The reported position is rated as Green overall.
Recommendation:	**Trust Board members are asked to:** **NOTE** the update and achievements made to date in respect of the digital focus areas and **COMMENT** on the contents of the paper.

South West Yorkshire Partnership NHS Foundation Trust

Digital Strategy 2024-30

6-Month Progress Report

(2024/25 End of Year Reporting Period)



Assistant Director of IT Services & Systems Development

Chief Clinical Information Officer

May 2025

With **all of us** in mind.

www.southwestyorkshire.nhs.uk

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Purpose of report

The purpose of this report is to inform the Board of the progress made during the latter half of 2024/25, detailing the end of year position with notable updates and achievements. The report also summarises how we are driving forward the Trust's digital agenda, since the last report was produced in October 2024 in respect of the Trust's preceding 2021-24 digital strategy.

Introduction

This report focuses on the progress in the last six months regarding the digital priority areas that underpin delivery against the aims and objectives of the 2024-30 digital strategy revision (approved at the January 2025 Trust Board) following transition from the preceding 2021-24 digital strategy. This update incorporates new and emerging themes, as well as ongoing programmes that are continuing to be progressed during 2025/26. All such initiatives are incorporated into the milestone delivery plan for the 2024-30 digital strategy, contained within Appendix A.

Our continuous digital journey of evolution and maturity

From a digital perspective, a lot has changed in the last three years since the preceding digital strategy was approved in 2021. Digital services, technologies and solutions are becoming ever more prevalent both in the workplace and in everyday lives, and it is expected that the reliance on digital and its continuous evolution will persist at an ever-increasing and accelerating pace.

The digital landscape is constantly expanding in scope and where we can potentially deploy digital solutions, especially in support of service improvement and enabling/assisting increases in productivity. This brings its own challenges as there is a need to focus finite resources in line with the Trust's strategic aims and objectives, balancing our organisational priority programmes with those of our integrated care systems and places, whilst also ensuring compliance with regulatory standards, and adherence with national direction and policy requirements.

We are part of an NHS which is under pressure, and which is continuing to address the impact of the pandemic, dealing with changes in demand/acuity and longer waiting lists. We also have increased financial constraints and fundamental restructuring within a challenging economic climate. This places an enduring expectation that digital will serve to provide opportunities for high quality service improvement that delivers efficiencies, whilst enhancing the overall experiences for staff, service users, carers and those accessing care. However, we also need to be mindful that digital is an enabler, but the ability and degree in which we can realise service improvement, productivity and efficiency gains, is more about how digital opportunities are considered, assessed, implemented, used and adopted. How we approach this will be equally important in ensuring equitable access to services for all and in providing appropriate channels for interactions and engagement in line with individual preferences. Our quality improvement approach will be central in safeguarding how we deliver our priorities and strategic objectives in keeping with Trust values.

Across the NHS and within the Trust, we need to get better at how we safely consider the potential and application of digital technologies, and how we look to exploit and harness digital innovation capabilities that incorporate artificial intelligence (A.I.), in a supportive/assistive manner where

human interventions remain in control, underpinned by governance and regulation. This will be key in driving forward the continued shift from paper/analogue to digital.

Our approach continues to be encouraging, supportive and enabling together with robust governance firmly embedded to ensure that digital opportunities are clinically led when appraising innovations and new solutions through forums such as the Digital Strategy and Innovation Group, whilst also ensuring due diligence and compliance with clinical/patient/technical safety.

Our Chief Clinical Information Officer plays a key role in engaging staff from across the organisation in key digital improvement and change programmes, notable developments such as the Yorkshire & Humber Care Record (shared care record), enhancements to the Patients Know Best patient engagement portal platform, our electronic clinical record system, SystmOne and the Trust-wide digital dictation solution.

Our digital priorities serve to deliver the aims and objectives set out in the 2024-25 digital strategic by: -

- **Equitable Accessibility**: Advocating improvements in equitable access to services for all by supporting a collective approach to understanding, addressing and overcoming accessibility challenges digitally or otherwise, ensuring equity for all.
- **Digitally Literacy**: Working collaboratively across our systems, at place and within the Trust to support the improvement of digital literacy and skills for all.
- **Digitally Capable Workforce**: Improve the skills, competencies and confidence, nurturing a digitally aware and capable workforce, embracing flexibility and work-life balance in keeping with Trust values.
- **Digitally informed**: Better use of data and information in decision making to improve how we deliver services and provide better care in keeping with needs.
- **Digital Ambiance**: Providing a safe, supportive and collaborative environment that openly encourages a culture of digital opportunity exploration at all levels.
- **Digital Innovation**: Excelling in exploiting new and emerging digital innovations and opportunities that bolster quality service improvements and individual experiences, in a safe, sustainable and efficient manner, underpinned by digital transformation and user centred design.
- **Digitally Safe**: Keeping our staff, service users and carers' information safe, protected, secure and legitimately accessible in line with legislation and regulatory obligations.
- **Striving to be our digital best**: Sharing and adopting learning that encourages digital best practices, reducing duplication and waste in processes to provide better care whilst improving quality and service user, carer and staff experiences.

These are central themes that span all our digital domains and digital initiatives that are supported through an integrated approach to change.

Summary of progress against the digital domains (April 2025 position)

To support the implementation of the 2024-30 digital strategy, the digital domains are mapped against the Trust's current priorities as shown in the matrix below.

DIGITAL DOMAINS	TRUST PRIORITIES FOR 2025-26			
Digital Accessibility	Best quality	Best value		Best partner
Digitally Empowered Workforce	Best quality	Best value	Best place to work & learn	
Digital Information Led	Best quality	Best value	Best place to work & learn	Best partner
Digital Information Sharing	Best quality	Best value	Best place to work & learn	Best partner
Digital Care Records	Best quality	Best value	Best place to work & learn	Best partner
Cyber Security	Best quality	Best value	Best place to work & learn	Best partner
Digital Infrastructure	Best quality	Best value	Best place to work & learn	

The accompanying Appendix A document provides detailed additional supporting information regarding the activities and milestones for each initiative by domain within the 2025/26 digital programme.

Below is a summary of the main notable achievements in this reporting period by each digital domain.

Digital Accessibility	Supports the following Trust Priorities for 2025-26			
	Best quality	Best value		Best partner

Key achievements and notable updates

Digital health app – Create & Bloom: The development of the Create & Bloom App has been completed and issues impacting the ability to make the App available resolved, enabling the App to be fully rolled out.

Digital innovation - Limbic: Limbic is an artificial intelligence (A.I.) chatbot solution that supports clinicians with assessments and triaging. The implementation of this solution within the Talking Therapy services has been completed.

Trust website enhancements: The Trust commissioned the 3rd party website developer to make the necessary changes to the Trust website, which was completed during the 2024/25 financial year, following an opportunity to leverage digital capital funding which became available in-year.

Access to digital personal health record: The Patients Know Best platform (patient engagement portal) continues to see increased uptake and usage consistently monthly and developments are progressing to enhance the solution further.

Digital inclusion:

The Trust actively participates in digital inclusion networks at both system and place levels. Whilst organisational liabilities remain a constraining factor preventing the re-purposing of the Trust's decommissioned IT equipment within our local communities, the IT services team continue to monitor and investigate the landscape to ascertain a suitable way forward that legally discharges Trust liabilities. We continue to explore opportunities with partners (NHS and Local Authority) to drive this initiative forward if we can confidently and appropriately navigate the legal liabilities obstacle.

There is also a potential opportunity to look to change the current approach for how we dispose of decommissioned IT equipment to generate a small income for the Trust, which could be utilised to invest back into the existing equipment replacement programme. This is being explored presently. An updated iteration of the paper presented to EMT in February 2023 will be presented back to EMT for consideration at the right time to inform any potential changes to the Trust position.

Digital Enabled Workforce	Supports the following Trust Priorities for 2025-26			
	Best quality	Best value	Best place to work & learn	

Key achievements and notable updates

Trust-wide digital dictation solution: The deployment of the Trust's Lexacom digital dictation solution is progressing and is planned to complete the project by October 2025.

Microsoft SharePoint 365 developments: Enhancements to Trust's SharePoint365 environment were undertaken in year, most notably for the IT and systems access change forms. The Trust also enacted a change in supplier relationships in the provisioning of SharePoint365 services, resulting in a direct arrangement with iThink365.

Automated Microsoft Teams minute taking (Proof of Concept): A time-limited proof of concept has commenced to assess the potential of assistive Artificial Intelligence (A.I.) enabled digital technologies to improve productivity and efficiencies of administering Microsoft Teams meetings by automating minute taking activities. The time-limited trials are in progress and once completed, the findings encompassing benefits, solution limitations and the wider potential opportunities for use and application will be reported.

Digital Insight	Supports the following Trust Priorities for 2025-26			
	Best quality	**Best** value	**Best** place to work & learn	**Best** partner

Key achievements and notable updates

A significant amount of work has been undertaken, progressed, and completed during 2024/25 in support of the Trust's performance and business intelligence agenda, spanning compliance with national reporting requirements, new developments including automation of processes and business as usual reporting activities. Notable achievements include: -

Business as usual (BAU) reporting: Additional reporting requirements and enhancements to support the performance management agenda and operational service delivery have been completed during 2024/25 in line with the work plan.

National reporting requirements: Numerous reporting developments have been completed to comply with national reporting requirements and timescales.

Data warehouse developments: Work has continued developing data feeds from other Trust data sources such as Tenable, Datix and eRoster (health roster).

Integrated neighbourhood teams reporting: Continued development of reporting capabilities in support of the integrated neighbourhood team's system changes on SystmOne in line with the programme and service requirements.

Process automation: Activities to automate processes within the Performance & Business Intelligence function are progressing and will continue during 2025/26.

Digital Information Sharing

Supports the following Trust Priorities for 2025-26



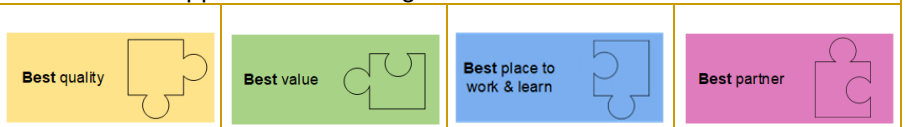
Key achievements and notable updates

Yorkshire & Humber Care Record (YHCR) consumption: Enhancements to how Trust staff access the Yorkshire & Humber Care Record available data has been made to streamline the process and improve the end user experience.

This work was completed mid-March 2025 which provides in-context launch direct from the Trust's clinical portal "PORTIA" to the YHCR portal. This streamlines access and minimises local bespoke development work. In-context launch essentially passes registered user and service user record credentials through to the YHCR, thus negating the need for the staff member to log in separately and conduct another search for the service user in question.

Digital Care Records

Supports the following Trust Priorities for 2025-26



Key achievements and notable updates

Clinical Records System (SystmOne): This is a continuous programme of development work that also ensures that both existing and potential future functionality is considered and utilised as appropriate within the Trust's services. Whilst there has been notable progress in SystmOne developments during 2024/25, a number of these areas of attention have been carried forward into 2025/26, partly due to the focus during the latter half of 2024/25 on preparing for the implementation and the successful deployment of SystmOne at the Cheswold Park Hospital site which went live on 1 April 2025 as planned.

The main additional item to note is the Integrated Neighbour Teams service, where good progress overall is continuing to be made within Barnsley for this initiative. It is planned that this major systems development work will conclude by the end of Q2 2025/26, once the last remaining services are migrated into the integrated service model.

Electronic prescriptions & medicines administration (EPMA): Planning and prioritisation activities for the deployment of EPMA/EPS are progressing with the plan/proposal approach supported by the EPMA Community Project Board and under review by the Operational Management Group (OMG).

Records scanning bureau system re-procurement: The procurement for the replacement of the life expiring electronic records management system was concluded in March 2025 as planned. Focus in 2025/26 shifts to implementation of the chosen solution.

Introduction of SystmOne at Cheswold Park Hospital: The safe introduction and smooth transitioning of SystmOne within Cheswold Park Hospital was completed to replace the life-expiring CareNotes electronic care record system. The deployment was achieved with significant success as planned on the 1 April 2025 managed by the Systems development team.

Cyber Security	Supports the following Trust Priorities for 2025-26			
	Best quality	Best value	Best place to work & learn	Best partner

Key achievements and notable updates

Cyber security programme for 2024/25: All planned activities within the cyber security programme in 2024/25 has been completed as planned, spanning:-

- Implementation of Security Information and Event Management (SIEM) and Intrusion Prevention System (IPS) to enhance the Trust's cyber controls and measures. The timeline for this was extended to incorporate the Cheswold Park Hospital site.
- Annual cyber security table top exercise completed in November 2024.
- Penetration testing undertaken by independent testers providing assurances that services being provided are being actively managed. This was conducted in November 2024.
- Cyber essentials plus reaccreditation completed in March 2025.

Digital Infrastructure	Supports the following Trust Priorities for 2025-26			
	Best quality	Best value	Best place to work & learn	

Key achievements and notable updates

Infrastructure modernisation: All planned work within the infrastructure modernisation programme in 2024/25 has been completed as scheduled.

Email platform re-accreditation: The Trust's email platform successfully completed the annual reaccreditation in September 2024 and all remediation activities (a few non-critical enhancement suggestions) have been completed within 2024/25, ensuring compliance with DCB1596, which is the NHS England Data Co-ordination Board (DCB) accreditation standard for secure email and encryption.

Desk telephony rationalisation: The IT team completed a rationalisation exercise of the Trust's desk telephony estate engaging and working with services consolidate requirements based on need and usage, resulting in the reduction from 1900 to 1200 telephone handset as estimated. This consolidation exercise enabled the Trust to make best use of resources and preparations for the

migration to the new hosted telephony platform. An ongoing review of utilisation on the platform will continue to ensure the Trust makes best use of the solution, and that best value can be gained from future contracts.

Introduction of the Trust digital network within the Cheswold Park Hospital site: The planning and activities to introduce the Trust's SWYT network, @swyt.nhs.uk email, replacement of end user computing devices and mobile telephones were successfully completed in a safe and smooth manner, minimising impact to staff based at the hospital.

Digital strategy progress - metrics

Table 1 below presents the metrics based on the 2024/25 digital priorities that have been identified to demonstrate how we are moving forward the of use digital approaches to deliver best care and support to service users, carers, staff, and the wider community. These metrics will be subject to review and revision to reflect the 2025/26 digital priorities.

MARCH 2025 POSITION		2024/25					
Digital Domain & Initiative	**Metric**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**	**Key supporting comments by exception**
DIGITAL INFRASTRUCTURE							
Cyber Security & Threat Monitoring	% of NHS England high severity CareCert threat notifications acknowledged by the Trust within 48 hours of receipt (Target 100%)	**100%**	**100%**	**100%**	**100%**	**100%**	All high severity CareCerts issued have been responded to within the requisite timeframes.
	% of NHS England high severity CareCert threat notifications issued that the Trust has completed remediation for within 14 days (Target 100%)	**100%**	**100%**	**100%**	**100%**	**100%**	All high severity CareCerts issued have been investigated and remediated as appropriate within the required 14 days.
DIGITAL INFORMATION SHARING							
Yorkshire & Humber Care Record data consumption	Number of YHCR information requests performed by staff	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	Statistics relating to the consumption of YHCR data will be provided in the next report as this solution went live mid-march 2025
DIGITALLY ENABLED WORKFORCE							
Trust-wide Digital Dictation	Number of clinicians able to use Trust-wide digital dictation solution	**n/a**	**111**	**238**	**609**		Accelerated deployment of the solution Trust-wide is progressing.
DIGITALLY ENABLING SERVICE USERS & CARERS							
Access to Digital Personal Held Care Record	Number of service users registered enabling digital access to personal health records	**9,588**	**11,522**	**12,965**	**15,481**		The number of service user registrations is increasing month on month
Mental Health Annual Physical Health Checks	Number of APHCs undertaken at point of care within the Trust	**568**	**531**	**589**	**636**	**2,324**	
Digital Inclusion	Number of service user digital preferences recorded on SystmOne	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	Further revision work is being planned regarding the uptake of recording this information on SystmOne.
Collecting and Reporting Health Outcomes	Number of service user completed digital health outcome questionnaires returned to the Trust.	**498**	**455**	**492**	**542**	**1987**	

Table 1

Table 2 below provides an insight into the IT service operations 'business as usual' quarterly volumetrics that underpin the digital programmes.

MARCH 2025 POSITION	2023/24					2024/25					Annual Totals Variation (2024/25 - 2023/24)	
IT OPERATIONS VOLUMETRICS	Q1	Q2	Q3	Q4	Annual Total	Q1	Q2	Q3	Q4	Annual Total		
Total numbers of tickets logged with Service Desk	13,468	14,151	13,374	15,462	56,455	16,630	16,808	14,074	14,450	61,962	5,507	↑
Total tickets emailed to service desk	10,530	11,089	9,745	10,891	42,255	11,743	12,246	9,418	10,044	43,451	1,196	↑
Total tickets phoned to service desk	5,736	5,983	3,629	4,571	19,919	4,887	4,562	4,656	4,406	18,511	-1,408	↓
Total phone calls to service desk	6,156	5,983	6,195	6,989	25,323	6,688	7,574	6,146	6,175	26,583	1,260	↑
Number of new registrations on NHS Wi-Fi (Patient Wi-Fi)	1,900	2,096	2,382	1,877	8,255	1,096	954	1,034	1,344	4,428	-3,827	↓
New network accounts created	472	567	478	480	1,997	501	650	418	395	1,964	-33	↓
Number of SystmOne tickets (system requests/amendments)	1,016	1,035	921	944	3,916	1,018	1,005	939	970	3,932	16	↑
Number of Smartcard related tickets	1,797	2,080	1,598	2,029	7,504	1,698	1,464	1,441	1,543	6,146	-1,358	↓
Number of staff with VPN at present	13,577	13,922	13,356	13,418		4,465	4,458	13,487	13,604			
Average number of daily VPN connections	10,511	10,812	11,197	10,555		3,597	3,809	11,534	10,979			
Number of Microsoft Teams 1:1 Calls	30,796	28,109	30,225	28,578	117,708	29,103	30,917	31,994	37,253	129,267	11,559	↑
Number of Microsoft Teams meetings participated in	54,779	49,844	52,430	50,904	207,957	50,985	56,955	56,264	65,075	229,279	21,322	↑
Number of Microsoft Teams Messages (Chat function)	437,037	400,427	453,161	479,704	1,770,329	488,562	514,427	596,881	596,057	2,195,927	425,598	↑
New/replacement Smartphones provided to end users	185	158	139	141	623	241	449	247	444	1,381	758	↑
New/replacement voice-only mobile phones provided to end users	127	134	133	117	511	107	28	28	52	215	-296	↓

Table 2

Digital Maturity Assessment (DMA) 2025 (currently in progress)

NHS England launched the 2025 digital maturity assessment (self-assessment) at the start of April with a deadline to complete the initial submissions by the 9 May 2025 deadline. The Trust completed the separate DMA submissions for Mental Health and Community Services respectively within the stipulated timeframe.

This activity was co-ordinated and managed by IM&T management who involved key subject matter specialists in support of the lines of enquiry. Validation activities following the initial submission commence from 19 May 2025, whereby any required changes can be made where appropriate by the deadline of 13 June 2025. A summary report articulating the Trust's 2025 DMA posture will be presented to EMT prior to the 13 June 2025 final submission deadline.

Digital strategy dashboard (April 2025 position)

In Figure 1 below is the dashboard summarising all the digital initiatives by domain which forms the basis of the digital work plan in 2024/25.

September 2024 Position		DIGITAL DOMAINS & INITIATIVES	2024/25 - MARCH 2025 REPORTED POSITION		
RAG Status	Progress Indicator		RAG Status	Progress Indicator	Key supporting comments by exception
DIGITAL ACCESSIBILITY					
A	→	Digital Inclusion	G	↗	The Trust continues to actively participate in digital inclusion networks at both system and place levels.
G	↗	Access to Digital Personal Held Care Record Deployment	G	↗	Phase 2 developments are progressing and service user registration and uptake remains on an upward trajectory.
G	↗	Collecting and Reporting Health Outcomes	G	↗	Development enhancements continue to be considered together with additional opportunities to develop questionnaires digitally.
G	↗	Digital Health App - Create & Bloom	C	✓	The development and deployment of the App has been completed
G	↗	Digital Innovation - Limbic (Talking Therapy Services)	C	✓	The implementation of the solution within Talking Therapy services has been completed
P	→	Website Re-development	C	✓	This was progressed due to the opportunity to leverage digital capital funding available in year.
DIGITALLY EMPOWERED WORKFORCE					
G	↗	Microsoft SharePoint365 Developments 2024/25	C	✓	Planned developments in 2024/25 have been completed together with a change in service provision.
A	↗	Trust-wide Digital Dictation Solution - Implementation	G/A	↗	The accelerated deployment of the Trust-wide solution is progressing with approaching 900 staff (as at mid-May 2025).
		Automated Microsot Teams Minute Taking (Proof of Concept)	G/A	↗	A small selection of digital options incorporating A.I. have commenced on a trial basis to assess potential for wider use.
P	→	Trust Workforce Digital Literacy	G	→	Activities will be re-initiated as part of the 2024-30 digital strategy revision and launch.
DIGITAL INSIGHT					
G	↗	Performance & Business Intelligence	C	✓	A significant amount of work has been undertaken as planned during 2024/25.
DIGITAL INFORMATION SHARING					
G	↗	Yorkshire & Humber Care Record (YHCR) Consumption	C	✓	Enhancements to how Trust staff access the YHCR available data was completed in during March 2025 and access now live.
		Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign	G	↗	Focus has now shifted to raising awareness to increase uptake and usage of available YHCR data by Trust staff.
		Yorkshire & Humber Care Record (YHCR) Provision	G	↗	The subsequent project focussing on provision of Trust data to feed into the YHCR has commenced.
A	↗	ICE Integration with SystmOne	A	↗	Technical & testing activites have been completed with Mid-Yorks with plans for rollout for in scope areas being finalised
G	↗	Information Goverance	G	↗	Activities are progressing in support of the Data Security & Protection toolkit submission by the 30 June 2025 deadline.
G	→	Consent to Share Re-engagement	G	→	A review is to be conducted of the paper that determined the Trust approach previously to reflect the current landscape.
DIGITAL CARE RECORDS					
G	↗	Clinical Records System Developments	G	↗	Continuous progress is being made which will carry forward into 2025/26.
G	↗	EPMA & EPS Community	G	↗	Planning and prioritisation activities for the deployment of EPMA/EPS are progressing with the plan/proposal approach under review as part of governance.
R	↗	Records Scanning Bureau System Replacement Procurement	C	✓	The procurement exercise was successfully completed during Q4 24.25.
		New Records Scanning Bureau System Implementation	G	↗	Planning activities for the implementation of the new system have commenced.
P		Introduction of SystmOne at the Cheswold Park Hospital site	C	✓	SystmOne was successfully deployed at Cheswold Park Hospital as planned with the system going live on 1 April 2025 as planned
CYBER SECURITY					
G	↗	Cyber Security Programme 2024/25	C	✓	All planned activities within the cyber security programme in 2024/25 have been completed as planned.
DIGITAL INFRASTRUCTURE					
G	↗	Infrastructure Modernisation Programme 2024/25	C	✓	All planned work within the infrastructure modernisation programme in 2024/25 have been completed as planned.
C	✓	Email Platform Re-Accreditation	P		Planning & scheduling activities are set to commence imminently to prepare for the annual email platform re-accreditation in 2025.
G	↗	Desk Telephony Rationalisation	C	✓	Significant progress made rationalising from 1900 deskphone handsets to approximately 1100.
G	↗	Introduction of Trust IT network within Cheswold Park Hospital	C	✓	Significant planning and installation activities were successfully completed in a safe and smooth manner minimising staff impact.
P		Desk Telephony Platform Replacement at Cheswold Park Hospital	G	↗	Planning preparations have been completed and it is planned to replacement the desk telephony platform during June 2025.
P		Decommissioning of the legacy Cheswold Park Hospital Digital Infrastructure	G	↗	Planning activities are progressing regarding the dependencies and timelines for decommissioning of the digital environment.
G	↗	Microsoft Developments	G	↗	Preparations are underway for the annual review/renewal of the Trust's Microsoft Licencing.
G	↗	Windows 11 Migration	G	↗	The migration from Windows 10 to Windows 11 has been accelerated with the Trust now at 99% of its IT estate complete.
		CAMHS Secure Estate Infrastructure	A/R	↗	Progress is dependent upon identifying capital funding in 2025/26 to support this.
		LIFT Buildings Telephony (Barnsley)	G/A	↗	Options appraisal in progress and funding sources being determined to support this.

Dashboard Key

C	Completed	G	On track	G/A	On track but management of risk needed	A	Off track but in control	A/R	Off track with urgent action being taken to address risk/issue	R	Off track major issues impacting overall viability
P	Planned for the future	↗	Improving position	→	No progress	↘	Deteriorating position	✓	Completed activities	➢	Ongoing activities

Figure 1

Financial Investment

2024/25 Digital Capital Allocation

To meet the priorities outlined in this report, a capital allocation of £1.470m was approved and made available to support digital developments in 2024/25. Additional separate capital for the digital integration of Cheswold Park Hospital was made available totalling £750k. The Trust digital capital schemes in 2024/25 also utilised additional available capital underspend from the Older Peoples development enabling strategic infrastructure opportunities to proceed. The actual digital capital expenditure against the Cheswold Park Hospital scheme underspent based on the original allocated due to tight management control ensuring best value. Table 3 below provides a summary of the capital allocation and associated expenditure as at the end of March 2025 against the digital schemes in 2024/25.

Digital Capital Plan (Approved) for 2024/25 - April 2025 - End of Financial Year Position

Digitial Capital Schemes	2024/25 (£'000s)			Scheme Owner	Comments
	Capital Allocation	Capital Expenditure	Variation		
Submitted Digital Schemes					
Electronic Prescribing & Medicines Administration (EPMA)	100	100	0	Pharmacy	Full alloction expended as planned
Scanning Bureau System Replacement	300	426	126	Health Records	Preparatory activities for procurement commenced
Learning Management System Replacement	30	0	(30)	People Directorate	Re-prioritised to other digital schemes
Live Well Wakefield Website Development	20	0	(20)	Live Well Wakefield	Re-prioritised to Scanning Bureau system replacement
Sub Total	***450***	***526***	***76***		
Core Digital Schemes					
Digital Infrastructure	440	750	310	IM&T	Full allocation expended and opportunity to utilise additional capital underspend during Q3/Q4 for strategic infrastructure completed.
Cyber Security	150	150	0	IM&T	Full allocation expended as planned
Information Sharing & Interoperability	50	0	(50)	IM&T	Re-prioritised to Scanning Bureau system replacement
Digital Workforce Innovation	150	150	0	IM&T	Full allocation expended as planned
Digital Accessibility	230	230	0	IM&T	Full allocation expended as planned
Sub Total	***1,020***	***1,280***	***260***		
Overall Trust Digital Capital Total	**1,470**	**1,806**	**336**		
Cheswold Park Hospital Integration (Digital/IT)					
Digital Infrastructure	750	565	(185)	IM&T	Actual digital capital spend for CPH has come in under original estimations due to tight management control.
Sub Total	***750***	***565***	***(185)***		
CPH Digital Capital Total	**750**	**565**	**(185)**		
Overall Digital Capital Total	**2,220**	**2,371**	**151**		

Table 3

2025/26 Digital Capital Allocation Requested

As part of the 2025/26 annual planning process, requests for digital capital bids were received totalling £1.663m. However, this was subject to internal review to ascertain what schemes could be potentially brought forward into 2024/25 to offset the Older Peoples development priority scheme for 2025/26 and recognising that capital in 2025/26 was going to be extremely limited. This resulted in a revised digital capital draft plan for 2025/26 totalling £1.422m (see Table 4 below). Due to the financial position across the system, the entire Trust's capital allocation has been allocated to the Older Peoples development scheme as the priority, therefore, no capital has been allocated for digital schemes in 2025/26. However, any underspend from the Older People's scheme that becomes available in year will be assigned to digital to prioritise accordingly. At this stage it is anticipated that this will impact the digital agenda and programmes of work during 2025/26, so has been highlighted as a risk.

Digitial Capital Schemes	2025/26 (£'000s)				Scheme Owner	Comments
	Capital Allocation Requested	Capital Allocated	Capital Expenditure	Variation		
Submitted Digital Schemes						
Electronic Prescribing & Medicines Administration (EPMA)	80	0	0	0	Pharmacy	
CAMHS Secure Estate (HMYOI)	92	0	0	0	Health Records	
Sub Total	***172***	***0***	***0***	***0***		
Core Digital Schemes						
Digital Infrastructure	600	0	0	0	IM&T	
Cyber Security	150	0	0	0	IM&T	
Digital Care Records	250	0	0			
Information Sharing & Interoperability	50	0	0	0	IM&T	
Digital Workforce Innovation	100	0	0	0	IM&T	
Digital Accessibility	100	0	0	0	IM&T	
Sub Total	***1,250***	***0***	***0***	***0***		
Overall Trust Digital Capital Total	**1,422**	**0**	**0**	**0**		

Table 4

Key risks

The provision of digitally enabled services remains vital in enabling Trust staff to deliver safe care. Whilst the progress set out in this report continues to reduce the likelihood of risk associated with digital system failure, the highlighted key risks summarised below in Table 5 require sustained focus and advancement of remedial controls and measures. It is also worth highlighting that two new risks have been added relating to the limited capital funding available to support the digital agenda in 2025/26 and NHS reforms. As such the overall risk appetite is considered low with a target score of 1-6.

Risk	Summary	Actions, controls, and measures
Cyber Security. (ORR 1080)	Risk that the Trust's Digital/IT infrastructure and corporate/clinical information systems could be the target of cyber-crime leading to theft of personal data or loss of service availability.	Continuation of persistent infrastructure modernisation spanning proactive infrastructure roadmap planning, replacement and subsequent decommissioning; business continuity and disaster recovery; network resilience and applicable/systems availability. This work incorporates stringent service management and cyber security enhancements that establish further controls, measures and safeguards that reduce the risk and likelihood associated with the threat of cyber-attacks. Implementation of Security Information and Event Management (SIEM) and Intrusion Prevention System (IPS) to enhance the Trust's current cyber controls and measures, which serves to reduce the organisation's risk (1080) score associated with cyber security. Implementation activities are now nearing completed following the inclusion of Cheswold Park Hospital into the scope. Live service operations and ongoing monitoring will allow the risk 1080 to be reviewed and the score revised in July 2025.
Capacity & capability to	Dependency on limited available resources and capacity with suitable project,	Exploration of options to expand scarce specialist resources available to the Trust, such as graduate schemes, apprenticeships, internal development opportunities and

deliver on all digital priorities.	technical and change management skills within corporate support services to delivery against all digital priorities.	engagement of 3rd party professional services supplier organisations. Careful management and prioritisation of the digital work programmes aligned with Trust priorities and associated timelines.
Capacity within Care Group services to consider digital innovation opportunities due to existing service pressures	There is a dependency on operational services staff within Care Groups to collaborate in exploring the potential and participate in the deployment and adoption opportunities to drive forward frontline digital innovations, hampered by existing operational service pressures.	Liaise and work closely with Care Group management regarding timings and scope to ascertain impact on services and further explore avenues that enable consideration of digital innovation opportunities that could present means from which to address capacity, and service efficiencies which could result in quality service improvements. Ad-hoc IM&T management team site visits are available for services to book on an ongoing basis, to discuss day-to-day challenges and explore where digital opportunities could help to alleviate and provide service improvement/improved productivity.
Ever-increasing demand and reliance upon digital technologies, solutions and services (including A.I.)	The ability to continue to meet expectations brought about by significantly heightened digital needs and aspirations to bring about productivity and efficiency gains, as well as potential cost savings. These associated dependencies will require careful balancing of resources and management of expectations.	Careful management of expectations through robust communications and engagement planning, together with horizon scanning to exploit opportunities to source and secure external funding to support digital organisational aspirations. Appropriate governance and assurance for areas of focus and key lines of enquiry to support the Value for Money programme.
Lack of clarity for sustainable working arrangements impacting ability to plan the digital infrastructure.	Dependency on understanding sustainable working needs which is impacting the ability to plan and prepare the Trust's digital infrastructure and contractual agreements, e.g. desk telephony requirements and wide area network connectivity and capacity across Trust sites.	Ensure digital infrastructure requirements are considered and accounted for as part of the enabling working effectively group activities to take a coordinated and programme approach when adapting to new sustainable models of working, to ensure seamless transition and effective continuity of services.
Increased costs due to the current economic climate	As in all walks of life, we are experiencing an increase in costs associated with digital technologies, solutions, and services.	Ensure that increased costs avoidance opportunities are explored consistently. Ensure procurement frameworks and collaborative purchasing arrangements are exploited where possible to enable best value outcomes. Exploit market opportunities to extend current contracts on existing terms where possible and in the best interests of the Trust.

		Ensure that value for money is clearly demonstrated through benefits realisation, return on investment and associated cost improvements.
Potential risks associated with the introduction of digital health innovations including apps and solutions that have built-in artificial intelligence (A.I.) capabilities	Digital health innovations that are clinical and/or service user focused are considered to be medical devices. Whilst the Trust has robust governance mechanisms in place, there is a need to ensure close alignment of the respective assessment processes and governance arrangements to minimise potential clinical risks.	The Trust has developed a governance framework for digital innovation incorporating A.I. capabilities that provides approach co-ordination considering robust procurement, IT, IG, clinical safety, and medical devices governance mechanisms in place. Trust has established an A.I. & Digital framework group incorporating key stakeholder representation to develop robust mechanisms and governance to consider digital health innovation opportunities incorporating research and development dimensions.
Extremely limited capital funding available will adversely impact the ability to progress digital priorities and programmes in 2025/26.	Whilst all measures will be taken to minimise the impact on the digital agenda and priorities in 2025/26, this position may impact the Trust's ability to ensure appropriate measures and remediations are taken, which could potentially lead to cyber vulnerabilities.	Activities to reduce the digital capital requests in 2025/26 has been planned for in recognition of the Older People's development priority have been taken. Any in-year underspend from the Older People's development scheme to be assigned for digital prioritisation. However, this is difficult to plan for and schedule works accordingly. Opportunities to leverage additional national sources of capital funding which may become available will be explored.
NHS Reforms impacts the ability of the Trust to appropriately progress its digital strategic agenda	The announced NHS reforms exert an adverse impact on the Trust's ability to progress its digital priorities where there are wider system level requirements and dependencies, due to the organisational restructuring.	Ensure the Trust remains attune to communications, plans, developments at national, regional and system levels relating to digital so that the landscape and environmental influences can be considered, understood and assessed against the Trust's digital priorities and plans.

Table 5

Organisational Summary

The Trust's digital strategy, roadmap, plans, and programmes of work remain comprehensively aligned with National direction and strategies which serves to provide the Trust with assurances that our current digital journey and plans remain fit for purpose and relevant within local and national agendas.

However, there is a constant need to consider, develop, enhance, and expand our digital landscape further, to better support and empower our staff to augment their digital skills ensuring that we make best use of available resources. We will do this by perpetually evolving our digital posture through horizon scanning across the digital technologies, solutions and services to assess potential, and by networking (nationally, regionally, system, sector and at place levels) to share insights and learning,

exploring collaborative/partnership working opportunities and for accessing external funding streams. Mutually beneficial collaboration and partnership working will be fundamental in supporting how we plot and navigate our strategic journey of digital evolution, especially in the challenging economic climate.

Given the ever-increasing pace of change, persistently emerging digital innovations, and relentless interest in exploring the potential of digital, it is critical for us to carefully formulate and plan our digital agenda through annual planning cycles accounting for the organisation's priorities and constantly review. This approach ensure that we remain dynamic and attune to the organisation's needs and wider environmental influences, whilst also maintaining realistic and achievable timescales, based on allocated/available resources and capacity. Any associated risks are managed with mitigating actions put in place where necessary.

This update is a culmination of the collective work by all involved in continuing to drive forward the Trust's incessantly broadening digital agenda in line with our strategic objectives. Individual contributions are acknowledged in the respective digital initiatives listed within the accompanying Appendix A document.

As this report hopefully demonstrates, significant progress overall continues to be made, which is a great achievement when balancing working collaboratively and sensitively with frontline services who face challenging operational pressures, and whilst having to flexibility respond to additional urgent/unplanned work. The reported position remains rated as **GREEN** overall.

EMT is asked to note this progress report and will continue to be updated twice a year in respect of progress on the digital agenda, with the next update to be provided in October/November 2025.

South West Yorkshire Partnership NHS Foundation Trust

Digital Strategy 2024-30

Appendix A for the Progress Report

(2024/25 End of Year Reporting Period)

Assistant Director of IT Services & Systems Development

Chief Clinical Information Officer

May 2025

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

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Key

	**COMPLETED**		**AMBER: Off track but in control**
	**GREEN: On track**		**AMBER\RED: Off track with urgent action being taken to address risk/issue**
	**GREEN/AMBER: On track but management of risk needed**		**RED: Off track major issues impacting overall viability**

✓	**COMPLETED**	⬆	**PROGRESSING**
➡	**NO CHANGE**	⬇	**DETERIORATING**

Organisational Risk Matrix

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

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

DIGITAL INITIATIVES COMPLETED IN 2024/25

Digital Accessibility	Best quality	Best value		Best partner

Digital Health App – Create & Bloom			Overall Summary
Overall Status: ✓	COMPLETED	Lead: V. Whyte Start Date: 01/04/2024 End Date: 31/03/2025	The development of the Create & Bloom App has been completed and issues impacting ability to make the App available resolved. This enabled the App to be fully rolled out.

Purpose	Expected Outcomes
To digitally enhance services through the application of digital health apps that improve access to services and supportive information.	• Improves the overall service user experience. • Improves access to services and supportive information. • Forms part of the wider digitisation of the NHS

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Full App development & rollout	The development of the full app was commissioned and the development work completed and fully rollout out.	Dec 2024	Dec 2024	C

Trust Website Enhancements			Overall Summary
Overall Status: ✓	COMPLETED	Lead: G. Richardson Start Date: 01/04/2024 End Date: 31/03/2025	The Trust commissioned the 3rd party website developer to make the necessary changes to the Trust website, which was completed during the 2024/25 financial year, following an opportunity to leverage digital capital funding which became available in-year.

Purpose	Expected Outcomes

Redevelop Trust public facing website to improve signposting, functionality and accessibility to stakeholders, staff, and public.	• Make accessibility improvements so the Trust continues to meet its accessibility obligations. • Ensure a continuation of the current high standards of data security and IG whilst identifying any current and future risks. • Ensure that the high standards of the NHS and Trust brands are maintained.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Trust website enhancements	Undertake enhancements to the Trust website to appropriate standards.	Mar 2025	Mar 2025	C

Digital Innovation - Limbic

Overall Status: ✓		Lead:	Talking Therapies Services
		Start Date:	01/04/2024
		End Date:	31/03/2025

Overall Summary

The implementation of the Limbic solution within the Talking Therapy services has been completed.

Purpose	Expected Outcomes
The supply-demand problem in Talking Therapy Services creates long wait times for vulnerable patients, which is known to negatively impact health outcomes. A clinical assessment is completed by a Talking Therapies therapist and involves a phone call to screen for service eligibility, assess risk, collect basic patient information and routine outcome measures. Limbic is Artificial Intelligence (AI) chatbot software as a service (SAAS) solution that supports clinicians with assessments and triaging, screening referrals for eligibility, signposting ineligible referrals onwards, collecting patient data, conducting clinical questioning, prioritising high-risk patients.	• Improves service user equity of access to psychological support by making the process more interactive and engaging, offering 24-hour multilingual access. • Reduce waiting times for treatment. • Improves the overall service user experience. • Enhancing quality of life for people. • More effective use of clinical time leveraged through more efficient processing of referrals and assessments.

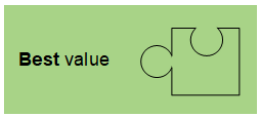
Key Milestones

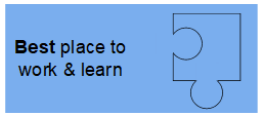
Activity	Summary	Target Date	Completion Date	Status

Solution deployment	Implementation and deployment of the Limbic solution within Talking Therapy services has been completed.			C

Digitally Empowered Workforce







Microsoft SharePoint365 Developments 2024/25

Overall Status: ✓		Lead:	SharePoint Development Group
		Start Date:	01/04/2024
		End Date:	31/03/2025

Overall Summary

Enhancements to Trust SharePoint365 sites undertaken in year, most notably for the IT and systems access change forms. Also, due to Emposo (professional services provider) exiting the UK market, the Trust enacted a change in supplier relationships in the provisioning of SharePoint365 services, resulting in a direct arrangement with iThink365 rather than engaging in-directly with iThink365 via Emposo.

Purpose

Enhancements and new developments to the Trust's Microsoft SharePoint365 environment and constituent SharePoint365 sites (Intranet, Payroll forms and processes, Business Intelligence dashboards and performance reporting, Criteria led discharge dashboard and processes, Supervision database, Membership database, Emergency planning, and IT and systems access forms.

Expected Outcomes

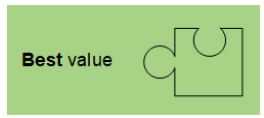
- To continue to improve access to corporate systems and information in a timely and responsive manner.
- Ensuring that the Trust corporate assets as listed above are continually developed, maintained and services/information is accessible across the workforce.
- Continues to support information asset management, integrity, and confidentiality to comply with GPDR requirements.
- Establish a robust and strategic approach for ongoing maintenance & support and continuous development (strategic roadmap) of the SharePoint environment, subject to Trust governance and approvals.

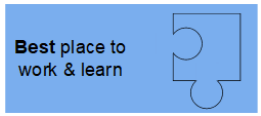
Key Milestones

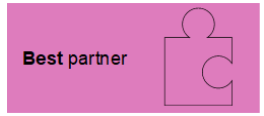
Activity	Summary	Target Date	Completion Date	Status
Development work programme for 2024/25	Ongoing developments and scoping of potential new requirements coordinated through the SharePoint Development Steering group, which determines the development work programme and priorities.	Dec 2024	Dec 2024	C
SharePoint environment review	Commissioned a review of the SharePoint environment and constituent sites, conducted by iThink365 as part of provider relationship changes	Mar 2025	Mar 2025	C

Digital Insight









Performance & Business Intelligence Work Programme 2024/25

Overall Status: ✓	COMPLETED	Lead:	M.Wood
		Start Date:	01/04/2024
		End Date:	31/03/2025

Overall Summary

A significant amount of work has been undertaken, progressed and completed during 2024/25 in support of the Trust's performance and business intelligence agenda, spanning compliance with national reporting requirements, new developments including automation of processes and business as usual reporting activities.

Purpose

The development of a business intelligence, performance management and reporting capabilities that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service line reporting through key performance indicators to aid service improvements and delivery.

Expected Outcomes

- Improve availability of information to support operational services and transformation agendas.
- Improve performance reporting.
- Improve data quality.
- Identification of additional key performance indicators and associated metrics

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Business As Usual (BAU) Reporting	Ongoing additional reporting and reporting enhancements to support the performance management agenda and operational service delivery/management.	Mar 2025	Mar 2025	C
National Reporting Requirements	Reporting developments to support: - ▪ Readiness for MHSDS (version 6) to meet national standards from April 2024. ▪ First submission made in May 2024. Continuing to add data items working towards a more comprehensive submission file. ▪ Expansion of MHSDS DQMI reporting to include additional 26 data items. Not progressed nationally.	Apr 2024 Apr 2024 Sep 2024	Apr 2024 Apr 2024 Sep 2024	C

	▪ Community Mental Health National waiting times reporting – work required in house to replicate the national reporting to allow drill down to review data. ▪ Faster data flows reporting for community services. Daily flow commenced from 27/09/24. ▪ OPEL for mental health – new daily metrics to commence from February 2025 (date revised nationally from December 24)	Sep 2024 Feb 2025	Sep 2024 Feb 2025	
Datawarehouse Developments	Data warehouse development efficiencies, continued work on feeds of data from other Trust sources such as Tendable, Datix, health roster. ▪ Datix feed – Compliments and complaints data complete. work ongoing with incident data to map this for reporting.	May 2024	May 2024	C
Integrated performance report developments & automation	Quality section of the IPR being automated ▪ Quality data from SystmOne – reporting complete – currently under validation ▪ Datix metrics - linked to Datix data feed previously completed *Completion of the project was expected by the end of the 2023/24 financial year. However, timescales have slipped/been revised due to expansion of project scope to include People data into data warehouse.*	Apr 2024 Jul 2024	Apr 2024 Jul 2024	C

Digital Information Sharing

Best quality | Best value | Best place to work & learn | Best partner

Yorkshire & Humber Care Record Consumption Project				Overall Summary
Overall Status: ✓	COMPLETED	Lead:	Systems Development	Enhancements to how Trust staff access the Yorkshire & Humber Care Record available data has been made to streamline the process and improve the end user experience. This work was completed mid-March 2025.
		Start Date:	01/04/2024	
		End Date:	31/03/2025	

Purpose	Expected Outcomes

The Trust is actively engaged in onboarding ("connecting") to the Yorkshire & Humber Care Record (YHCR) via the Trust's clinical portal solution which enables the Trust to bring together information from different clinical information systems both internally and externally into a single integrated record view. This is being achieved via the Trust's existing clinical portal solution "PORTIA" (IMX) which is the Trust's channel for consuming available YHCR datasets.	• Enhances integrated holistic patient record view. • Reduces time staff spend locating the relevant clinical information they need. • Sourcing data from Trust internal systems and externally with partners leveraged via the YHCR. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. • The richness of the YHCR will increase as more partner organisations' onboard and additional datasets defined and become available. This is a strategic priority across both West Yorkshire & South Yorkshire ICS regions and constituent places.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Completion of the onboarding to the YHCR for consumption by the Trust	During September 2024, the Trust commenced a 'soft launch' of YHCR enabling access to available data via the Trust's clinical portal PORTIA following an extensive period of technical, clinical, and operational testing.	Jun 2024	Sep 2024	**C**
Enhancements to YHCR dataset consumption	Since we commenced on this YHCR data consumption onboarding journey in 21/22, the YHCR recently developed a separate portal that provides additional datasets. Therefore, we took a conscious decision to revise how we access YHCR data by enabling an in-context launch direct from the Trust's clinical portal "PORTIA" to the YHCR portal. This streamlines access and minimises local bespoke development work. *In-context launch essentially passes registered user and service user record credentials through to the YHCR, thus negating the need for the staff member to log in separately and conduct another search for the service user in question.*	Mar 2025	Mar 2025	**C**

Records Scanning Bureau System Reprocurement				Overall Summary
Overall Status: ✓		Lead:	C. Doran J. Vickers	The procurement for the replacement of the life expiring electronic records management system was concluded in March 2025 as planned.
		Start Date:	01/04/2024	
		End Date:	31/03/2025	

Purpose	Expected Outcomes
To explore the marketplace and conduct a formal procurement exercise for a digital document scanning solution to replace the life expiring existing system. This will also incorporate the migration of existing digitised records into the new solution. Preparatory activities have commenced with some explorative discussions with a potential supplier. This work is informing the potential options available and route to market for the Trust to take this system replacement forward strategically. It remains on track for the procurement and contract award activities to be completed during 24/25.	• Improve scanning bureau workflow and processes. • Increase ability to target key areas and monitor KPI performance against data-drive insights. • Reduce reliance on off-site storage (avoidance of increased costs and to reduce associated costs) • Improve governance through having easy, electronic access to all records related to a Trust client, through seamless integration with the Trust's electronic care record system. • Supports the digitisation and paperless NHS agenda

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Evaluation of digital solutions, marketplace and procurement frameworks	Undertake a review of the digital solutions available within the marketplace and in existence across the NHS to inform the Trust's options and routes to market.	Oct 2024	Oct 2024	C
Development of a detailed specification of requirements	Prior to initiating a formal procurement process, it is necessary for the Trust to articulate its business needs in a specification of requirements document for prospective suppliers to respond to once the invitation to tender has been issued. This process will require appropriate stakeholder representation and involvement.	Nov 2024	Nov 2024	C
Procurement exercise for an electronic document management system	Undertake procurement activities via the most viable and appropriate route to market and conclude award of contract	Mar 2025	Mar 2025	C

Introduction of SystmOne at Cheswold Park Hospital				Overall Summary
Overall Status: ✓		Lead:	P. Foster	Safe introduction and smooth transitioning of SystmOne within Cheswold Park Hospital to replace the life-expiring CareNotes electronic care record system currently in use. The deployment was achieved with significant success as planned on the 1 April 2025.
		Start Date:	01/04/2024	
		End Date:	31/03/2025	

Purpose	Expected Outcomes
To manage the introduction of the Trust's Electronic Care Record, SystmOne at Cheswold Park Hospital. This is overseen by the IM&T and Information Reporting workstream as part of the Cheswold Park Hospital Trust integration programme.	• Safe and smooth transition of services into the Trust. • Reduction of potential digital related risks spanning operational, clinical, technical, cyber, service user dimensions. • Provision of a robust, resilient, and future-proofed digital environment conducted. • Reduction/removal of risks associated with end-of-life approaching IT equipment and information systems conducted in a safe and supportive manner. • Improved performance reporting governance and reporting capabilities. • Improved staff satisfaction and experiences

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
SystmOne	Implementation, configuration and deployment of SystmOne from 1 April 2025 at Cheswold Park Hospital to replace the life-expiring CareNotes system in use. 98% of all CPH staff trained in readiness for 1 April 2025 go live.	Apr 2025	Apr 2025	C

Cyber Security



Cyber Security Programme 2024/25				Overall Summary
		Lead:	C. Crocker	

Overall Status:		Start Date:	01/04/2024	All planned activities within the cyber security programme in 2024/25 have been completed as planned.
✓		End Date:	31/03/2025	

Purpose	Expected Outcomes
Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the likelihood, impact, and consider cyber security in all aspects of the digital agenda.	• Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats. • Adoption of industry standard best practices, as appropriate. • Improve the defence against cyber-attack.

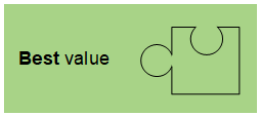
Key Milestones

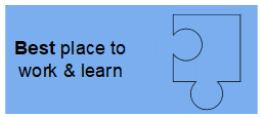
Activity	Summary	Target Date	Completion Date	Status
Implementation of SIEM/IPS	Implementation of Security Information and Event Management (SIEM) and Intrusion Prevention System (IPS) which will enhance the Trust's current cyber controls and measures to further bolster its current protection levels and reduce the organisation's risk (1080) score associated to cyber security. As of October 2024, the solution was in place in proactive mode and configuration was being finalised alongside operational support processes and handover. The original target date was deferred to March 2025 to incorporate the Cheswold Park Hospital site within the scope.	~~Dec 2024~~ Mar 2025	Mar 2025	C
Cyber security communications plan	Undertake a review of the cyber security communications plan in collaboration with the Trust's Communications team to improve awareness of cyber phishing.	Aug 2025	Aug 2024	C
Cyber security survey	An annual phishing survey to further gauge staff awareness, and understanding, to determine if vigilance is improving. The results of the survey will inform an action plan.	Nov 2024	Nov 2024	C
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled early 2024 in line with the cyber programme.	Nov 2024	Nov 2024	C
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed. This has been booked for November 2024	Feb 2025	Feb 2025	C

Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Mar 2025	Mar 2025	C
Cyber Essentials Plus reaccreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance. This has been booked for January 2025	Mar 2025	Mar 2025	C
Cloud Management Gateway	Designs have been completed to introduce Cloud Management Gateway, which will enhance the patching ability for devices that rarely connect to the Trust network.	Mar 2025	Mar 2025	C

Digital Infrastructure







Infrastructure Modernisation Programme 2024/25

Overall Status: ✓



Lead:	C. Crocker
Start Date:	01/04/2024
End Date:	31/03/2025

Overall Summary

All planned work within the infrastructure modernisation programme in 2024/25 has been completed as planned.

Purpose

Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.

Expected Outcomes

- Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray).
- A more readily scalable infrastructure that can flex to meet changing demands.
- No requirement for major short-term investment in the event of a disaster.
- Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs).
- Proven disaster recovery position with confirmed recovery points and associated timelines.

	• Enhanced cyber security position would bring about improved resilience and reduce the risk from cyber-attack, malicious or otherwise.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Digital infrastructure capital programme	Detailed programme planning, and mobilisation of planned 2024/25 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements. ▪ Corporate Wi-Fi modernisation programme replacing end of life approaching Wi-Fi controllers and access points. ▪ Partner Wi-Fi access (Govroam/Eduroam) upgrades ▪ Virtual Private Network (VPN) enhancements Local area network (LAN) and wide area network (WAN) enhancements.	Mar 2025	Mar 2025	**C**
Cisco DNA	Project scoped to upgrade from existing 2 node cluster, to 3 nodes, providing enhanced resiliency, and support introduction of Software Defined Access (SDA).	Mar 2025	Mar 2025	**C**

Email Platform Re-Accreditation 2024/25

Overall Status: ✓		Lead:	A. Siddle
		Start Date:	01/04/2024
		End Date:	31/12/2024

Overall Summary

Activities in support of the Trust's @swyt.nhs.uk email platform re-accreditation to the required national secure email and encryption standards was successfully completed as planned during 2024/25.

Purpose

To oversee the re-accreditation and compliance with NHS Digital's advanced security protocols, meaning that emails can then be sent and received containing sensitive/confidential information using the Trust's Microsoft Office365 email platform.

Background
The Trust achieved accreditation status in August 2021 which enabled the decommissioning of NHSMail (NHS.Net) email accounts that were in use across the Trust. The Trust subsequently achieved re-accreditation status in August 2022.

Expected Outcomes

- Staff can use their Trust's Microsoft Office365 email accounts to send and receive emails containing sensitive and confidential information. The sending of sensitive and confidential information via this means to external third parties requires the organisation in question to confirm that their email platform complies with the requirement of the DCB 1596 Secure Email and Transport Layer Security (TLS) encryption standard, which is NHS England's Data Co-ordination Board (DCB) secure email and encryption standard.
- Removes the need for Trust staff to use multiple email platforms for Trust business purposes. Please note that there will be a requirement for a small number of Trust staff to retain their NHSMail email accounts for specific external correspondence purposes.

Key Milestones				
Activity	**Summary**	**Target Date**	**Completion Date**	**Status**
Email platform compliancy	The Trust's Microsoft Office365 email environment complies with the NHS Digital standards. Confirmation of re-accreditation achievement provided by NHS Digital.	Sep 2024	Sep 2024	**C**
Remediation activities	A few non-critical enhancement suggestions by NHS England are currently being implemented by the Trust's IT service provider. The actions for the 2024/25 plan are currently being progressed.	Dec 2024	Dec 2024	**C**

Desk Telephony Rationalisation

Overall Status:		Lead:	C.Crocker
✓		Start Date:	01/04/2024
		End Date:	31/12/2024

Overall Summary

The IT team completed a rationalisation exercise of the Trust's desk telephony estate engaging and working with services consolidate requirements based on need and usage, resulting in the reduction from 1900 to 1200 telephone handsets as estimated. This consolidation exercise enabled the Trust to make best use of resources and preparations for the migration to the new hosted telephony platform.

Purpose

Following on from the pandemic response and recovery activities within the Trust, the IT team has undertaken an exercise to review the desk telephony estate with a view to rationalising the number of desk telephones in place that are either no longer required or not in use. It is projected that we reduce the number of desk telephones from 1900 to 1200.

Expected Outcomes

- Ensures the Trust makes best use of available resources, especially given the mixed economy of desk telephony and mobile telephony and increasing prevalence of Trust issues smartphones.
- Ensures Trust desk telephony platform and contract remains future-proofed and actively supported.

Key Milestones				
Activity	**Summary**	**Target Date**	**Completion Date**	**Status**
Communications & Engagement	During Q4 23/24, the IT team issued communications informing of plans to start contacting services regarding the rationalisation of desk telephones adopting the following lines of enquiry: - ▪ Contacting staff who have a desk telephone registered in their name that has not be used for a time to ascertain plans for future use and to determine if there is still a need for the desk telephone. ▪ Contacting staff who have a desk telephone on their network (AD) account and smartphone registered to them.	Jun 2024	Jun 2024	**C**

	Contacting staff who have a smartphone, just to query if they also have a desk telephone and if they would be willing to remove the desk telephone or hand back their smartphone (if no longer required).			
Consolidate the findings and review with senior management	Review the findings and feedback with care group and support services senior management to establish the agreed position	Jun 2024	Jun 2024	**C**
Rationalise desk telephony estate	Physically remove the designated desk telephones that have been confirmed/agreed for removal due to no longer being required.	Sep 2024	Sep 2024	**C**
Operational rationalisation	The IM&T team have developed a process for ongoing review of active connections, similar to the 90-day process for mobile telephony. Once finalised this will be agreed through the appropriate Trust operational forums and then implemented.	Dec 2024	Dec 2024	**C**
Migration to the new hosted desk telephony platform	Migration of all Trust sites and handsets to the new virgin media business hosted desk telephony platform.	Mar 2025	Mar 2025	**C**

Introduction of Trust Digital Network within Cheswold Park Hospital

Overall Status:		Lead:	P. Foster
✓		Start Date:	01/04/2024
		End Date:	31/03/2025

Overall Summary

The planning and activities to introduce the Trust's SWYT network have been completed in a safe and smooth transition minimising impact to staff based out of Cheswold Park Hospital.

Purpose

To install and introduce the Trust digital and IT network infrastructure and environment within Cheswold Park Hospital as part of the wider integration programme for Cheswold Park Hospital following take-on on 1 October 2024.

Expected Outcomes

- Safe and smooth transition of services into the Trust including adoption of the requisite and appropriate Trust policies.
- Reduction of potential digital related risks spanning operational, clinical, technical, cyber, service user dimensions.
- Provision of a robust, resilient, and future-proofed digital environment conducted.
- Reduction/removal of risks associated with end-of-life approaching IT equipment and information. systems conducted in a safe and supportive manner.
- Improved performance reporting governance and reporting capabilities.
- Improved staff satisfaction and experiences

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Wide Area Network (WAN) Connectivity and IT infrastructure	Installation and configuration of WAN connectivity enabling the Cheswold Park Hospital site to establish connection to the Trust SWYT network, incorporating cyber security controls and safeguards.	Jan 2025	Jan 2025	**C**
End User Computing	Deployment of standardised Trust issued IT devices (laptops/desktops) replacing legacy Cheswold IT equipment. This also incorporated provision of SWYT network and email accounts, software licencing, migration to the requisite Trust policies and procedures, and onsite support aiding the smooth transition.	Jan 2025	Jan 2025	**C**
Mobile Telephony	Provision of Trust issued mobile phones and smartphones to replace mobiles in use at Cheswold Park Hospital	Jan 2025	Jan 2025	**C**

NEW & CARRIED FORWARD DIGITAL INITIATIVES INTO 2025/26

Digital Accessibility	Best quality	Best value		Best partner

Digital Inclusion				Overall Summary
Overall Status:		Lead:	P. Foster	The Trust continues to actively participate in digital inclusion networks at both system and place levels. Whilst organisational liabilities remain a constraining factor preventing the re-purposing of the Trust's decommissioned IT equipment within our local communities, we continue to monitor the landscape to ascertain a suitable way forward that legally discharges Trust liabilities to enable this.
		Start Date:	01/04/2025	
		End Date:	31/03/2026	

Purpose	Expected Outcomes
Championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve. Digital inclusion remains a key area of focus within the Trust, across both ICSs and in all our places.	• Service users and carers are more informed about their care, the options available and what they can expect from accessing services digitally. • Needs, wishes, preferences, and aspirations of our service users are comprehensively considered, and they feel listened to and are actively in control of the care they receive. • Service users and carers can use digital technology available to them to access services and information in ways that are preferable.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
ICS and place-based digital inclusion networks	Active participation in ICS (WY & SY) and constituent place-based digital inclusion forums.	Ongoing		G
Exploration/monitoring of the potential repurposing of Trust decommissioned IT equipment for re-use within our local communities	*Background* A briefing paper was presented to EMT in February 2023 recommending that the Trust continues with its existing IT equipment decommissioning, disposal, and recycling processes. Whilst this does not result in IT equipment being reused, the process it is considered sustainable due to the associated recycling elements included in the WEEE guidelines.	Ongoing		G

	The overriding factor preventing the Trust from donating redundant IT equipment to a 3rd party provider is that the Trust does not release or relinquish its liability obligations associated with the IT equipment and their future use. Whilst it may represent a relatively minimal risk to the Trust, should a circumstance arise where a previously issued Trust device develops a fault which potentially leads to a fire for example, this could have a significant consequence, financial liabilities, and result in organisation reputational damage. The Trust together with WY ICS engaged specialist legal advice and there is no avenue open that would relinquish the Trust's responsibilities and liabilities, hence the recommendation. *Current position* The IT team continues to monitor the position and exploring this along with other partners (NHS and Local Authority) to take this forward if we can confidently and appropriately navigate the legal liabilities obstacle.			

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
There are several challenges as outlined above to overcome with regards to repurposing decommissioned Trust owned devices for re-use within our local communities.	3	3	**9**	• Exploring opportunities with partners and digital service providers to establish mechanisms to reduce barriers to digital inclusion through device repurposing whilst considering the legal/liability implications for this.

Access to Digital Personal Held Care Record

Overall Status:	Lead:	Systems Development
⬆	Start Date:	01/04/2025
	End Date:	31/03/2026

Overall Summary

Consistently good progress is being made regarding uptake and registration by service users prompted and promoted by Trust communications. Development work to provide the new Mental Health care plans via the Patients Know Best (PKB) platform has been consciously delayed and timelines for deployment revised due care plan document revision, to ensure consistency for end users.

Purpose	Expected Outcomes
To provide service users and carers with access to their own digital care record via a patient engagement portal (PEP) solution. They are utilising the Patients Know Best (PKB) digital platform which offers the potential to self-manage and engage more readily in the delivery of their care and an	• Improve communication between service users, carers, and care professionals. • Providing service users (and, where appropriate their carers) with online access to relevant parts of the clinical record. • Support self-management using online self-management tools. • Supports recovery through signposting to support and recovery resources.

alternative means to communicate with care professionals offering greater flexibility.	• Improve service user and carer awareness of and engagement with Trust related initiatives, events, research opportunities and Recovery College courses. • Improve the consistency and quality of service user-related data collection through direct online input by individuals themselves, saving staff considerable time.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Enhancements to the PKB platform	Developments focusing on the provision of Mental Health care plans from SystmOne and mood diaries to be made available within PKB.	~~Jun 2024~~ Jul 2025		A
Inclusion in NHS England's national Wayfinder programme	Through existing NHS App integration with PKB, this serves to further enhance the data provisioned from the Trust's electronic care record system, TPP SystmOne, providing additional appointment data and enabling appointment management functionality within PKB to further improve the patient portal experience for our service users and carers.	~~Mar 2025~~ Jul 2025		A
Stakeholder feedback	Capture feedback from stakeholders and users of the PKB platform and use the insight to inform future development plans and priorities	Q3 25/26		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Project development timelines impacted by wider initiative(s) dependencies	3	3	9	• Consideration of the inter-dependencies between various initiatives to ensure respecting project timelines and plans are aligned.

Collecting & Reporting Health Outcomes

Overall Status: 



Lead:	M.Garnham
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Development enhancements continue to be considered and development together with additional opportunities to develop additional questionnaires digitally as opposed to paper.

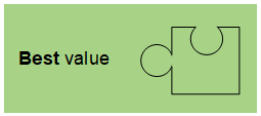
Purpose	Expected Outcomes
There is no consistent approach to outcome measure collection presently within the Trust. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the five domains set out in The NHS outcomes framework indicators. Therefore, the Trust has developed a solution to enable collecting and reporting health outcomes digitally.	• Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient. • Improved timeliness, offering real time insight into patients' wellbeing and quality of life, providing quicker decision making and ability to tailor treatment. • Automatic analysis, scoring and reporting in real time at clinical, service, and organisational level. • More personalised care and support through service user identified needs and goals. • Better understanding of clinical needs and effectiveness of services.

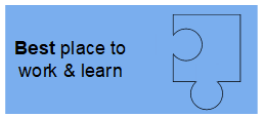
Key Milestones				
Activity	**Summary**	**Target Date**	**Completion Date**	**Status**
Enhancements & developments: Email notification to clinicians	When automatically sending an outcome ahead of an appointment the clinician will not necessarily know that an outcome has been sent or if it has been completed without going into the clinical record system and checking. Therefore, we are building an automatic email notification that will be sent to any Health Care Professionals (HCPs), the service user is allocated as well as the generic team email address to let them know if a ReQOL outcome has been completed, and if the item score related to Hope is particularly low, highlighting if an action may be required.	Dec 2024		G
Expert reference group	To aid moving towards personalised care and support, and to align use of outcome measures with care planning, an expert reference group has established to redesign mental health care plans to ensure they reflect best practice and that goals are aligned the outcome measure.	Completed & in place		C
Wider development & deployment opportunities	Continue to explore opportunities to develop additional patient reported outcome measures (PROMs) questionnaires and deploy across the Trust as applicable.	Ongoing		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Digitally Empowered Workforce







Microsoft SharePoint365 Developments 2025/26				Overall Summary
Overall Status:		Lead:	SharePoint Development Group	Identified enhancements to Trust SharePoint365 sites will be scoped in year and readied in case of any capital underspend becoming available in 2025/26.
		Start Date:	01/04/2025	
		End Date:	31/03/2026	

Purpose	Expected Outcomes
Enhancements and new developments to the Trust's Microsoft SharePoint365 environment and constituent SharePoint365 sites (Intranet, Payroll forms and processes, Business Intelligence dashboards and performance reporting, Criteria led discharge dashboard and processes, Supervision database, Membership database, Emergency planning, and IT and systems access forms.	• To continue to improve access to corporate systems and information in a timely and responsive manner. • Ensuring that the Trust corporate assets as listed above are continually developed, maintained and services/information is accessible across the workforce. • Continues to support information asset management, integrity, and confidentiality to comply with GPDR requirements. • Establish a robust and strategic approach for ongoing maintenance & support and continuous development (strategic roadmap) of the SharePoint environment, subject to Trust governance and approvals.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Development work programme for 2025/26	Ongoing developments and scoping of potential new requirements coordinated through the SharePoint Development Steering group, which determines the development work programme and priorities.	Mar 2026		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Inability to progress new SharePoint365 development opportunities due to lack of digital capital available in 2025/26	3	3	9	• Scope potential new SharePoint development opportunities in case of in-year capital funding becoming available. • Ensure scoped potential new SharePoint365 development opportunities are included in capital planning for the 2026/27 planning cycle.

Trust-wide Digital Dictation Solution deployment

Overall Status:



Lead:	R. Hutchison
Start Date:	01/07/2024
End Date:	30/09/2025

Overall Summary

The accelerated deployment of the Trust-wide digital dictation solution is progressing with approaching 900 staff (as at mid-May 2025) now set up, trained and licences issued.

Purpose	Expected Outcomes
Deployment of the Trust's preferred strategic Trust-wide digital dictation solution following conclusion of the procurement exercise, Trust approval and award of contract.	• To deployment of the chosen solution Trust-wide, offering standardisation. • Supports the paperless agenda. • Improves service effectiveness and efficiency. • Potential economies of scale

Key Milestones				
Activity	**Summary**	**Target Date**	**Completion Date**	**Status**
Deployment and adoption of Trust-wide digital dictation solution	Effective planning, deployment and adoption of the Trust-wide digital dictation solution Lexacom.	Oct 2025		**G**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Potential variation in end user experience resulting from differing versions of the Trust-wide digital dictation solution	2	3	**6**	• Close working with the solution supplier and active monitoring of version controls across the Trust end user community.

Automated Microsoft Teams Minute Taking (Proof of Concept)

Overall Status:



Lead:	IT Team
Start Date:	01/04/2025
End Date:	30/06/2026

Overall Summary

In response to capacity challenges within the Executive Management Team PAs, digital options are being considered and trialed as a time-limited proof of concept to determine if such digital assistive interventions help to address the challenges faced. Insights and feedback from the trials will help to inform future wider deployment opportunities and potential efficiencies.

Purpose

To improve capacity and operational efficiencies through digital enabled opportunities.

Expected Outcomes

- Ensures that the Trust makes best use of the available digital technologies, solutions and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.
- Supports the value for money programme.

Key Milestones				
Activity	**Summary**	**Target Date**	**Completion Date**	**Status**
Baselining of resource commitments	Reviewing and baselining of existing resource commitments (PAs time) for administering meetings, recording and transcribing minutes.	Feb 2025	Feb 2025	**C**
Exploration of options to be considered	Technical, security and governance assessment within the Trust network environment and setup for proof-of-concept options being considered. ▪ Microsoft CoPilot ▪ Trust-wide Digital Dictation solution: Fast-tracking of next planned version incorporating Ambient Voice (A.I.) capabilities ▪ Enhanced transcribing of Microsoft Teams utilising A.I. capabilities (iThink365's SmartNote solution)	Apr 2025		**G**

Conduct time-limited proof of concept with Exec. PAs	Conduct proof of concept trials of the above stated digital solutions, capturing feedback and insights	May 2025		G
Evaluate findings	Evaluate findings from the proof of concept, benefits and potential limitations of each solution, demonstrable return-on-investment (value for money), potential wider areas for application and recommendations.	Jun 2025		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Trust Workforce Digital Literacy

Overall Status: 



Lead:	P. Foster R. House
Start Date:	01/04/2024
End Date:	31/03/2025

Overall Summary

Learning & Development have completed the annual learn needs analysis (LNA) activities as part of planning for 2025/26. However, this generic activity may provide some degree of digital learning and development requirements, it is planned to undertake a more digital focus evaluation to gauge current digital skills and any areas of need both now and in the future.

Purpose

Our workforce is our greatest asset and to be truly digitally excellent, our staff need to be fully conversant, competent, capable, and confident in their use of digital solutions which promote high quality care provision. Exhibiting good digital knowledge, skills and capabilities is not about developing technical proficiency but in recognising that when coupled with an assured outlook, it is how digital solutions can be applied during effective care delivery which improves care and creates positive health outcomes. This requires a cultural shift throughout the Trust's workforce.

Expected Outcomes

- Supports in making this a great place to work, also improving staff retention.
- Enables a digital capable workforce that embraces flexible and adaptable work-life balance.
- Improve access, timeliness and availability of training and development opportunities in support of identified needs.
- Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience, and capabilities.
- Adopting and learning from digital best practices.
- Better use of Trust resources.
- Helps to nurture a continuously evolving digital culture throughout the organisation.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Evaluation of annual learning needs	Evaluation of the annual learning needs analysis co-ordinated by Learning & Development, specifically related to digital requirements to inform 25/26 priorities, plans and approach			G
Digital Literacy Staff Self-Assessment	Explore ways in which we can determine the digital skills, learning requirements and aspirations via a digital competency self-assessment			P
Develop a Digital Literacy Workforce Plan	From the insights and findings from the above activities, devise a plan focusing on key priority areas across the Trust.			P

Implement the Digital Literacy Workforce Plan				P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Staff do not honestly complete the individual self-assessment, which does not provide a true representation of digital skills and competency needs.	3	3	**9**	• Ensure robust awareness, engagement and consultation approach and communication campaigns across all stakeholder groups, forums and networks in the design and development of digital education and training opportunities. • Develop key principles for digital education and training that are built upon ethical, positive, sensitive, and appropriate attitudes and behaviours
Staff resistance to digital education, training, and development service changes and in adopting new ways of learning due to service pressures and capacity limitations.	3	4	**12**	• Establish digital champions and supportive networks with positive attitudes, seeking out appropriate and innovative digital technologies to enhance learning for self and others.
Implementation of the requisite digital literacy workforce plan is impacted by capacity and available resources	3	4	**12**	• Ensure plans are realistic and aligned with available resources/capacity which are closely aligned with identified/agreed priorities.

Digital Insight

Best quality | Best value | Best place to work & learn | Best partner

Performance & Business Intelligence Work Programme 2025/26

Overall Status:



Lead:	M.Wood
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Activities carried forward from 2024/25 are progressing and planning/formulation for the Performance & Business Intelligence function's 2025/26 work programme is underway.

Purpose

The development of a business intelligence, performance management and reporting capabilities that facilitates the

Expected Outcomes

- Improve availability of information to support operational services and transformation agendas.

provision of an information hub and dashboards to improve access to business performance information that informs service line reporting through key performance indicators to aid service improvements and delivery.	• Improve performance reporting. • Improve data quality. • Identification of additional key performance indicators and associated metrics

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Neighbourhood Teams Developments	Continued development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available. Developments continue in line with the implementation plan.	Oct 2025		G
Business As Usual (BAU) Reporting	Ongoing additional reporting and reporting enhancements to support the performance management agenda and operational service delivery/management, spanning: - ▪ Supporting the Value for Money (VfM) programme. ▪ Supporting Trust priorities. ▪ Supporting new contracts (e.g. secure CAMHS). ▪ Supporting the Trusts Quality Assurance Framework system. ▪ Data visualisation project in conjunction with Integrated change team.	Mar 2026		G
National Reporting Requirements	Reporting developments to support: - ▪ Readiness for MHSDS (version 6.1) to meet national standards – national implementation date awaited. ▪ Community Mental Health National waiting times meaningful interventions reporting – work required in house to replicate the national reporting to allow drill down to review data. ▪ Faster data flows reporting for community services. Daily flow commenced from 27/09/24. Developments ongoing. ▪ OPEL for mental health – new daily metrics commenced flowing from February 2025 with automation work ongoing. ▪ Virtual ward SitRep reporting daily – automated process ▪ EPMA national data collection	Mar 2026 Oct 2025 Mar 2026 Jun 2025 Nov 2025 TBC		G
Datawarehouse Developments	Data warehouse development efficiencies, continued work on feeds of data from other Trust sources such as Datix, eExpenses. ▪ Datix ○ Work completed for the data feed ○ Reporting work continues with the identification of reporting requirements and standardization in progress (IPR, contracts and other reporting to be defined)	Mar 2026		G

	○ Work ongoing with incident data to map this for reporting. Some delays due to capacity within the Quality team.			
Integrated performance report developments & automation	▪ Continued development of the IPR. ▪ Finalisation of people metric reporting and output automated. ▪ Quality section of the IPR being automated. ○ Quality data from SystmOne, reporting activities complete and currently undergoing validation	Mar 2026 May 2025		G
Process Automation	Piece of work to review and automate existing manual processes to improve efficiency and allow more capacity for data analysis.	Mar 2026		G
New reporting server hardware implementation	Replacement of the reporting infrastructure	Jun 2025		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Capacity limitations within the team to continue to provide the necessary capability to support this key Trust programme of work	3	3	9	• Effective prioritisation and review of the work programme in line with available resources and available capacity.

Digitally Information Sharing



Yorkshire & Humber Care Record – Consumption Project – Awareness Campaign

Overall Status:



Lead:	Systems Development
Start Date:	01/04/2025
End Date:	31/07/2025

Overall Summary

Since enhancements to how Trust staff access YHCR available data were completed in March 2025, the Systems development team have been focusing on an awareness campaign to increase uptake and usage of the YHCR across the Trust.

Purpose	Expected Outcomes
The Trust is actively engaged in onboarding ("connecting") to the Yorkshire & Humber Care Record (YHCR) via the Trust's clinical portal solution which enables the Trust to	• Enhances integrated holistic patient record view. • Reducing the time staff spend locating the relevant clinical information they need.

bring together information from different clinical information systems both internally and externally into a single integrated record view. This is being achieved via the Trust's existing clinical portal solution "PORTIA" (IMX) which is the Trust's channel for consuming available YHCR datasets.	• Sourcing data from Trust internal systems and externally with partners leveraged via the YHCR. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. • The richness of the YHCR will increase as more partner organisations onboard and additional datasets defined and become available. This is a strategic priority across both West Yorkshire & South Yorkshire ICS regions and constituent places.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
YHCR Awareness Campaign	An awareness campaign to raise uptake and usage of the YHCR across the Trust is in progress, with the Systems development team issuing communications, providing demonstrations and user guidance	Jul 2025		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Yorkshire & Humber Care Record – Provision Project

Overall Status:



Lead:	Systems Development
Start Date:	01/04/2024
End Date:	31/03/2025

Overall Summary

Since concluding the YHCR consumption project phase, the Systems development team are engaging with the YHCR team regarding the provisioning of the Trust's data (defined datasets from within SystmOne for partners connected to the YHCR to consume.

Purpose	Expected Outcomes
The Trust is actively engaged in onboarding ("connecting") to the Yorkshire & Humber Care Record (YHCR) via the Trust's clinical portal solution which enables the Trust to bring together information from different clinical information systems both internally and externally into a single integrated record view. This phase of the project focuses on provisioning of access to Trust data held within SystmOne to become available in the YHCR.	• Enhances integrated holistic patient record view. • Reduces time staff spend locating the relevant clinical information they need. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. • The richness of the YHCR will increase as more partner organisations onboard and additional datasets defined and become available. This is a strategic priority across both West Yorkshire & South Yorkshire ICS regions and constituent places

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Onboarding to the Yorkshire & Humber Care Record to provision SWYPFT data	This activity serves to provision Trust data (via defined datasets) to feed into the YHCR for partners to consume. To provision Trust data into the YHCR, we are aligned to the work in progress between the YHCR team and TPP (system supplier for SystmOne) for non-GP data SystmOne data provisioning. From a Trust perspective this is more of a governance focused activity.	Jul 2025		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

ICE Integration with SystmOne

Overall Status:



Lead:	L Maden
Start Date:	01/04/2024
End Date:	31/03/2026

Overall Summary

Technical and testing activities have been completed between the Trust and Mid-Yorkshire NHS Foundation Trust that provides systems integration enabling ICE results to be received directly into SystmOne at the Trust. The Systems development team are liaising with Trust services to initiate trial areas prior to wider deployment. Once this work has concluded, activities will focus on enabling the same integration with our other acute partners.

Purpose

To improve accessibility and arrangements for accessing ICE to request and receive order communications and results reporting information with our acute partners (Mid-Yorkshire NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust, and Barnsley Hospital NHS Foundation Trust.

Expected Outcomes

- Improved ability to access and make requests e.g., blood test via the ICE systems(s) in place with our acute partners.
- Improve timeliness of access to results information electronically.
- Ability to update the results directly into the SystmOne record.
- Improve user set up time on the ICE system as we move to a structured process covered by a Service Level Agreement (SLA)
- Enabling users to electronically add Pathology test results from within the Trust's Clinical information system (SystmOne)
- Reduce the risk of manually adding Pathology test results to the wrong record.
- Save clinicians time by not having to log-in to numerous applications.
- Improved visibility of all Pathology test results for all three Laboratories in the Trust's area including those submitted by other organisations for a complete diagnostic history

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Mid Yorkshire Hospitals NHS Trust (MYHT) ICE integration	All activities have been completed, and the Systems development team are currently engaging with Trust services to enable access initially via early adopter areas before wider deployment.	May 2025		G

Calderdale & Huddersfield NHS Foundation Trust (CHFT) ICE integration	Testing has commenced and we are waiting for CliniSys/CHFT laboratory to send a test result back into our SystmOne unit to complete the test. Once it has been completed the functionality will be rolled out to all the wards at the Dales.	Sep 2025		**A**
Barnsley Hospitals NHS Foundation Trust (BHFT) ICE integration	Once work at CHFT and/or Mid-Yorks is completed and goes live, CliniSys will be able to allocate resource to the BHNFT Laboratory configuration and SystmOne set up.	Dec 2025		**P**
Doncaster & Bassetlaw Teaching Hospitals NHS Trust ICE integration	Initial engagement has been made to commence the journey to establish ICE integration with SystmOne. This follows on from the successful deployment of SystmOne at the Cheswold Park Hospital site.	Mar 2026		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Challenges across the wider system impacting the ability to improve access to ICE for requesting/receiving order communications.	4	3	**12**	• Options explored and proposal depicting a way forward approved by the Trust. • Continue to liaise and collaborate with local acute partners and system suppliers. • Arrange appropriate training for staff to use the proposed new functionality.
Dependencies on external parties (ICE system supplier and Acute hospital partners) impacting the ability to move this forward in as timelier manner as the Trust requires	4	3	**12**	• Liaise and collaborate with local acute partners and system suppliers to explore having access to their ICE systems and to work through clinical, operational, and technical challenges for mutual benefits.

Information Governance 2025

Overall Status:



Lead:	R. Smith
Start Date:	01/07/2024
End Date:	30/06/2025

Overall Summary

Activities are progressing with evidence gathering in support of the Data Security & Protection toolkit submission by the 30 June 2025 deadline. Internal audit activities in support of this and providing organisational assurances are in progress.

Purpose

To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.

Expected Outcomes

- Mandatory IG training target achieved.
- The Data Protection & Security toolkit target of meeting all mandatory standards is maintained.
- Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Information Governance Training	Ensure that all staff complete satisfactory data security training in support of Digital Security & Protection Toolkit compliance. (95% Target threshold)	June 2025		G
Evidence gathering	Evidence gathering is in progress to support the Data Security & Protection toolkit submission together with internal audit assurance activities	June 2025		G
Information Governance Training (2026) preparation activities	Ensure that all staff complete satisfactory data security training in support of Digital Security & Protection Toolkit compliancy.	Mar 2026		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet the Data Security & Protection Toolkit standards due to low compliance with mandatory information governance training	2	3	6	• Organisational, operational, and individual communications and monitoring in place. • Classroom session(s) offer available. • Where completion is via e-learning, advice is to screen shot for evidence due to risk that ESR may not update automatically.

Consent to Share Re-Engagement

Overall Status:



Lead:	Dr. A. Abbas R. Smith
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

The main focus currently is to review the paper that outlined the Trust approach previously and update accordingly to reflect the current landscape.

Purpose

A project that focuses on reviewing the Trust's approach to gaining/confirming consent to share out from existing patients, and on implementing a process based on the agreed approach to be taken, including the management and of exclusions and withdrawals of consent, whilst embedding this within clinical practice.

The review will be based around the Trust's agreed position that consent would continue to be the lawful basis to share, providing a sensitive approach with patient centredness. It

Expected Outcomes

- All existing patients will have been asked if they consent to share out.
- All new patients will be asked if they will consent to share out.
- All patients will be aware of the right to withdraw consent at any time and how to do so.
- All responses are recorded, and system settings amended as required.

should be noted that sharing out can be turned on at short notice where another lawful basis applies, e.g. to protect vital interests, reasons of substantial public interest, etc., so there is no risk attached to patients refusing to share. This follows the expiry of the COPI notice in July 2021.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Revision of the paper previously produced outlining the Trust approach	As a starting point, a review of the paper previously drafted stating the Trust approach to be conducted and to make recommendations to be considered via appropriate Trust governance routes.	Jul 2025		G
Implement recommendations for agreed Trust approach	Implement recommendations in line with the agreed Trust approach with comprehensive staff engagement, communication and guidance to support operational adoption.	Sep 2025		P
Exploration & development of a digital solution to capture consent to share	The Systems development team are exploring functionality available within SystmOne that could potentially meet this need (please refer to Communications Annex in the Clinical Records System update below). The output from this work will then determine if there is a need to explore alternative digital options to meet the Trust's requirements, determine route to market and development of a case for Trust governance and approvals. This work will be coordinated via the Consent to Share working group.	Mar 2026		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet Trust agreement to give patients choice in sharing their sensitive data	2	3	**6**	• Working group to consider options and develop a plan for Trust governance and approval. • Regular updates to the Improving Clinical Information Group (ICIG) for oversight and monitoring.

Clinical Records System Developments 2025/26				Overall Summary
Overall Status: 		Lead:	L.Maden	A whilst there has been notable progress in SystmOne developments during 2024/25, a lot of the areas of focus have been carried forward into 2025/26. Significant systems development focus during the latter half of 2024/25 has been on preparing for the implementation and successful deployment of SystmOne at the Cheswold Park Hospital site which when live on 1 April 2025 as planned.
		Start Date:	01/04/2025	
		End Date:	31/03/2026	

Purpose	Expected Outcomes
SystmOne is the Trust's main electronic clinical record system spanning both mental health and physical health services. This programme of work ensures that the Trust continues to use SystmOne to its full potential, improving how services work both now and in the future, presenting opportunities and challenges faced by an ageing population with changing health needs, linked long-term conditions and those triggered by lifestyle choices. Supported through constantly adapting and enhancing integrated care pathways.	• SystmOne is used more consistently and effectively. • Processes and workflows that help staff and improve outcomes for our service users. • Supports the development of new integrated models of care. • Contribute to the drive towards digitisation of the NHS. • Ensures continuity of care with key clinical documentation re-designed to meet service needs and providing easier access to clinical information. • To ensure that all services are fully optimised in their usage of SystmOne

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
SystmOne Local Developments	***SystmOne eLearning training development:*** Continued development of tailored and bespoke training materials and course packages being created specifically for services, teams, and roles.	Mar 2026		G
	Task management implementation: Satisfactory progress continues to be made in the deployment of task management within Mental Health services with sustainable ongoing support being provided.	Mar 2026		G
	Integrated Neighbourhood Teams Service: Excellent progress is being made within the Barnsley Integrated Neighbourhood Teams Service developments. For the remaining services, Dietetics are due to go live in June 2025 and finally, Adult Speech & Language Therapy are to be scheduled following this. It is planned that this major programme undertaking will be completed by the end of Q2 2025/26. A lesson's learnt exercise will be conducted as part of the formal project closure activities.	Sep 2025		G
	Exploration of TPP Brigid App use in community: The Systems development team are planning to explore the potential for the use of the	Potentially from Sept 2025		P

	Brigid App with TPP for improving SystmOne access/usage for staff when out in the community.			
SystmOne Functionality Enhancements	***TPP SystmOne enhancements – Communications Annex:*** This brings together in one place the SystmOne functionality to send messages to service users via SMS or e-mail, with the addition of attaching a template or questionnaire to be completed. There is also an option of allowing the service users to reply to the message including returning the completed document, which arrives into SystmOne as a task that can then be uploaded into the client's record. Work has commenced with the SystmOne Clinical lead, looking at utilising this functionality to send Protected Characteristics and Consent to Share information direct to patients. It is planned to deploy this on a service-by-service basis throughout the year.	Mar 2026		**G**
	TPP SystmOne enhancements – Remote Appointment Booking: Mental health and Hospital services can now make appointment slots available to be booked into electronically by service users via the remote booking functionality. Further work is required to assess the potential, suitability, and applicability for our services.	Dec 2025		**P**
New SystmOne Functionality (Planned)	***Exploration of the next version of the Trust wide digital dictation solution incorporating Ambient Voice technologies (A.I.) and how this integrates with SystmOne:*** Activities to test the new version of the Lexacom solution (Ambient Voice/AI) following general release by the supplier and how this integrates with SystmOne. The outcomes from testing will define/determine the opportunities for trialing/piloting, application and usage across the Trust's SystmOne user community.	Potentially from July 2025		**P**
	Exploration of SystmOne AutoPlanner: This new SystmOne functionality aids in providing auto-scheduling capabilities. Plans and timelines are being considered as there is a dependency/requirement for integration between SystmOne and Allocate eRostering. This is to be explored by the System development team who will liaise with payroll and operational colleagues appropriately.	Potentially from July 2025		**P**
	Exploration of Autofiling (Pathology results): This new SystmOne functionality enables automatic review/filing of blood results within SystmOne, with rules set/defined locally. There is a dependency on ICE (Acute system) integration with SystmOne which is currently progress, with results from Mid-Yorks expected to be live from April 2025 and integration with our other acute care partners to follow on.	Potentially from Sept 2025		**P**

	TPP DNA levels utilising AI: TPP have developed an AI capability within SystmOne that is reporting to reduce DNA levels. The initial focus has been within primary care and TPP are planning to explore this capability within Mental Health and Community care settings – The Systems Development team has registered interest in wanting to explore this further as a potential early adopter site. (October 2025)	Potentially from Oct 2025		**P**
	System Connect: Work ongoing by TPP to integrate SystmOne with the NHS App, which will enhance capabilities for providing service users within appointment reminders via NHS App (as an alternative to text messaging), plus other capabilities. This has the potential to reduce the costs incurred by sending text messages and appointment reminders as the NHS App does not incur a cost. The Trust has expressed interest in this as a potential early adopter.	Potentially from Oct 2025		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Risk that the SystmOne training leads to inconsistencies in usage, impacting data quality	2	3	**6**	• Comprehensive assessment of training needs conducted during service deployment and introduction of new functionality has training, learning and development aspects incorporated into the approach. • Adopts a co-design, co-produced approach following best practice in the development of bespoke training programmes, materials in collaboration with services leads to aid successful uptake, improved data quality and optimal system usage. • The introduction of eLearning capabilities has improved training access equity across the Trust and virtual short courses serve to aid good practice and message reinforcement, especially where areas requiring data quality improvement are highlighted.
Risk that data quality is impacted through ineffective use of the system and application of available functionality	2	3	**6**	• As well as improved and appropriate systems training for staff, several additional initiatives are pursuing improvements in data quality, specifically relating to correctly recording outcomes on SystmOne, the waiting lists project and other targeted interventions.
Dependency on Systems Development team available resources and capacity to deliver the priorities and initiatives within the systems development work programme and roadmap	3	3	**9**	• Ensure robust planning, resource development/assignment opportunities and prioritisation activities that are aligned with the work programme.

timelines, as well as meeting operational service expectations				• Working in close partnership with operational service management colleagues to align plans and prioritise requirements within the work programme.

EPMA & EPS Community

Overall Status:		Lead:	K. Dewhirst
		Start Date:	01/04/2024
		End Date:	31/03/2026

Overall Summary

Planning and prioritisation activities for the deployment of EPMA/EPS are progressing with the plan/proposal approach supported by the EPMA Community Project Board and under review by the Operational Management Group (OMG) and the Executive Management Team (EMT).

Purpose

Electronic Prescribing and Administration of Medications (EPMA) together with the Electronic Prescription Service (EPS) are key developments which are designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. It converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. Many Trusts are taking this approach. The inclusion of EPS also further enhances this capability by enabling the electronic transfer of prescriptions between the Trust and community pharmacies that allows the streamlining of prescription services to service users and carers.

Expected Outcomes

- Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve.
- Reduce risks associated with medicines prescribing and dispensing.
- This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution.
- Improves the Trust's overall digital maturity.
- Enables service user choice and improves the service user experience.
- Prescribers can process prescriptions more efficiently.
- Dispensers can reduce paper use and improve stock control.
- Dispensers reduce the risk of dispensing errors compared to hand-written prescriptions.
- Service users can collect repeat prescriptions from a local pharmacy without visiting their GP.
- Service users can manage their nominated pharmacy and track prescriptions in the NHS App.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Deployment of EPMA and EPS into Community Services (Mental Health & Physical Health Services)	Deployment of EPMA and EPS SystmOne functionality within Community Services (Mental Health and Physical Health Community Services).	Mar 2026		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Records Scanning Bureau System Implementation				Overall Summary
Overall Status: ⬆		Lead:	C.Doran	Planning activities for the implementation of the replacement system have commenced following successful conclusion of the procurement conducted in 2024/25.
		Start Date:	01/04/2024	
		End Date:	31/03/2025	

Purpose	Expected Outcomes
To implement the chosen electronic records management system to replace the existing life expiring system. This follows the completion of the procurement exercise and subsequent contract award to the preferred supplier completed in 2024/25.	• Improve scanning bureau workflow and processes. • Increase ability to target key areas and monitor KPI performance against data-drive insights. • Reduce reliance on off-site storage (avoidance of increased costs and to reduce associated costs) • Improve governance through having easy, electronic access to all records related to a Trust client, through seamless integration with the Trust's electronic care record system. • Supports the digitisation and paperless NHS agenda

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Planning and implementation solution	Plan for the implementation of the Trust's chosen digital records management solution.	Q1 25/26		P
Implementation of the new solution	Implementation of the new solution including the migration from the existing legacy platform.	Q2 25/26		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
The current system is end of life and the support from the existing supplier is extremely poor	5	3	15	• The chosen digital replacement solution provides a strategic and supported way forward for the Trust.
Hardware Scanners require replacement during 25/26 incurring cost pressure.	5	3	15	• Exploring options to provide extended warranty during 25/26 and plan for replacement in 26/27. • Replace scanners in 25/26 if capital funding becomes available in-year

Cyber Security

Best quality | Best value | Best place to work & learn | Best partner

Cyber Security Programme 2025/26

Overall Status:



Lead:	C. Crocker
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

The programme of work for cyber security in 2025/26 is in the planning stage accounting for the agreed schedule of standards assurance controls, including communication plans and activities that serve to improve ongoing staff awareness.

Purpose

Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the likelihood, impact, and consider cyber security in all aspects of the digital agenda.

Expected Outcomes

- Continued vigilance and awareness of the threat of cyber-attack.
- Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats.
- Adoption of industry standard best practices, as appropriate.
- Improve the defence against cyber-attack.

Key Milestones

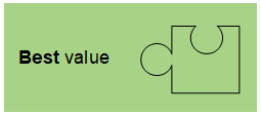
Activity	Summary	Target Date	Completion Date	Status
SIEM/IPS enhanced monitoring	SIEM/IPS enhance monitoring capabilities. ***Please note that the risks associated with cyber security remain real and that by the Trust introducing proactive additional controls, measures and safeguards, this support in providing extra levels of protection can serve to reduce the organisational risk rating from 15 to 8 for cyber security, once fully implemented and operational.***	Ongoing Jul 2025		G
Cyber security communications plan	Undertake a review of the cyber security communications plan in collaboration with the Trust's Communications team to improve awareness of cyber phishing.	Aug 2025		P
Cyber security survey	An annual phishing survey to further gauge staff awareness, and understanding, to determine if vigilance is improving. The results of the survey will inform an action plan.	Nov 2025		P

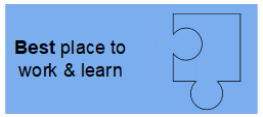
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled during 2025 in line with the cyber programme.	Nov 2025		**P**
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed. This has been provisionally booked for November 2025	Feb 2026		**P**
Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Mar 2026		**P**
Cyber Essentials Plus reaccreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance. This has been booked for January 2026	Mar 2026		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Extremely limited capital funding available during 2025/26 may significantly impact the Trust's cyber security posture	3	4	**12**	• Capital planning for 2025/26 conducted during Q3/Q4 2024/25 reduced the required capital ask in 2025/26. • However, due to priority on Older People's development, there is no planned capital funding available for the digital programme in 2025/26. Digital requirements will have first call against any capital underspend, or additional capital that may become available, in year as a contingency.

Digital Infrastructure







Infrastructure Modernisation Programme 2025/26

Overall Status:



Lead:	C. Crocker
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

The detailed planning for the infrastructure modernisation programme for 2025/26 has commenced.

Purpose	Expected Outcomes
Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.	• Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray). • A more readily scalable infrastructure that can flex to meet changing demands. • No requirement for major short-term investment in the event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position would bring about improved resilience and reduce the risk from cyber-attack, malicious or otherwise.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Digital infrastructure capital programme	Detailed programme planning, and mobilisation of planned 2025/26 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements. ▪ Corporate Wi-Fi modernisation programme replacing end of life approaching Wi-Fi controllers and access points. ▪ Partner Wi-Fi access (Govroam/Eduroam) upgrades ▪ Virtual Private Network (VPN) enhancements Local area network (LAN) and wide area network (WAN) enhancements.	Mar 2026		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Extremely limited capital funding available during 2025/26 may significantly impact the Trust's ability to progress any digital infrastructure requirements in year, which may in turn impact the overall cyber security posture	3	4	**12**	• Capital planning for 2025/26 conducted during Q3/Q4 2024/25 reduced the required capital ask in 2025/26. • However, due to priority on Older People's development, there is no planned capital funding available for the digital programme in 2025/26. Digital requirements will have first call against any capital underspend or any additional capital that may become available in year as a contingency.

Email Platform Re-Accreditation 2025/26

Lead:	A. Siddle
Start Date:	01/04/2025

Overall Summary

Planning & scheduling activities are set to commence imminently to prepare for the annual email platform re-accreditation requirement.

Overall Status:		End Date:	31/12/2025	

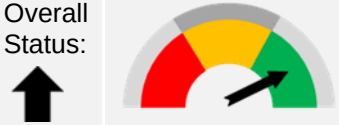
Purpose	Expected Outcomes
To oversee the re-accreditation and compliance with NHS Digital's advanced security protocols, meaning that emails can then be sent and received containing sensitive/confidential information using the Trust's Microsoft Office365 email platform. Background The Trust achieved accreditation status in August 2021 which enabled the decommissioning of NHSMail (NHS.Net) email accounts that were in use across the Trust. The Trust subsequently achieved re-accreditation status in August 2022.	• Staff can use their Trust's Microsoft Office365 email accounts to send and receive emails containing sensitive and confidential information. The sending of sensitive and confidential information via this means to external third parties requires the organisation in question to confirm that their email platform complies with the requirement of DCB 1596 Secure Email Standards and Transport Layer Security (TLS) encryption. • Removes the need for Trust staff to use multiple email platforms for Trust business purposes. Please note that there will be a requirement for a small number of Trust staff to retain their NHSMail email accounts for specific external correspondence purposes.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Email platform compliancy	The Trust's Microsoft Office365 email environment complies with the NHS Digital standards. Confirmation of re-accreditation achievement provided by NHS Digital.	Sep 2025		P
Remediation activities	A few non-critical enhancement suggestions by NHS England are currently being implemented by the Trust's IT service provider. The actions for the 2025/26 plan are currently being progressed.	Dec 2025		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Extremely limited capital funding available during 2025/26 may significantly impact the ability to effectively remediate any required actions in year. This may also impact the overall cyber security posture	3	4	**12**	• Capital planning for 2025/26 conducted during Q3/Q4 2024/25 reduced the required capital ask in 2025/26. • However, due to priority on Older People's development, there is no planned capital funding available for the digital programme in 2025/26. Digital requirements will have first call against any capital underspend, or additional capital that may become available, in year as a contingency.

Desk telephony platform replacement at Cheswold Park Hospital

Overall Status:	Lead:	C. Crocker
	Start Date:	01/01/2025
	End Date:	30/06/2025

Overall Summary

The planning and preparations for the introduction of the Trust's Virgin Medial Business desk telephony platform has been completed in readiness for the migration to take place. The migration was consciously deferred to effectively manage the degree of change for staff and avoid making the change during the implementation of SystmOne at the hospital site.

Purpose

To install the Trust wide desk telephone platform and to replace the life expiry platform currently in existence.

Expected Outcomes

- Safe and smooth transition of services into the Trust including adoption of the requisite and appropriate Trust policies.
- Reduction of potential digital related risks spanning operational, clinical, technical, cyber, service user dimensions.
- Provision of a robust, resilient, and future-proofed digital environment conducted.
- Reduction/removal of risks associated with end-of-life approaching IT equipment and information. systems conducted in a safe and supportive manner.
- Improved staff satisfaction and experiences

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Desk Telephony Platform replacement	Introduction of the Trust's desk telephony platform at Cheswold Park Hospital. The desk telephony platform build and configuration has been completed, with the scheduling of the change being agreed with operational management.	Jun 2025		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Decommissioning of the legacy Cheswold Park Hospital digital infrastructure

Overall Status:	Lead:	P. Foster
	Start Date:	01/01/2025
	End Date:	30/09/2025

Overall Summary

Planning activities are progressing regarding the dependencies and timelines for legacy clinical/corporate systems decommissioning following replacement, and the subsequent decommissioning of the legacy Cheswold IT infrastructure and services.

Purpose

Expected Outcomes

To manage the safe and controlled decommissioning of the legacy Cheswold Park Hospital digital infrastructure (IT network and systems) following the integration and transition over to the Trust network environment and systems.	• Safe and smooth transition of services into the Trust. • Reduction of potential digital related risks spanning operational, clinical, technical, cyber, service user dimensions. • Reduction/removal of risks associated with end-of-life approaching IT equipment and information. systems conducted in a safe and supportive manner. • Legacy costs reduction/negation offsetting costs for Trust digital infrastructure.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Legacy Corporate systems	Supporting the relevant Cheswold Park Hospital programme workstreams in the decommissioning of legacy systems following the transition to Trust corporate systems. This will involve procurement and information governance and the relevant asset owners.	Oct 2025		**P**
Legacy Clinical System	Decommissioning of the CareNotes electronic care record system following the successful introduction of SystmOne.	Oct 2025		**P**
Legacy Cheswold Park Hospital IT network infrastructure	Decommissioning of the legacy IT network infrastructure and telephony at Chewold Park Hospital	Jul 2025		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Residual reliance on legacy systems may impact the ability to decommission the CPH IT/digital infrastructure and services incurring additional costs.	3	3	**9**	• Working closely with all workstreams and asset owners to ensure robust and timely exit plans are in place to affect the safe and efficient decommissioning of the legacy IT/digital estate at Cheswold Park Hospital. • Cheswold Park Hospital integration programme is overseeing this work.

Microsoft Developments 2025/26

Overall Status:



Lead:	C.Crocker
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Preparatory activities have commenced in readiness for the annual review and renewal of the Trust's enterprise-wide licencing agreement with Microsoft.

Purpose

Expected Outcomes

To ensure that the Trust makes optimal use of existing and future Microsoft products available via the Trust's enterprise-wide agreement with Microsoft.	• Ensures that the Trust makes best use of the available Microsoft products and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Renewal of the Trust's Enterprise-Wide Agreement with Microsoft	Review the Trust's requirements and complete the timely renewal of the organisation's enterprise-wide agreement for the Microsoft suite of software and products. The revised agreement to take account of and be based on the NHS England nationally negotiated contract with Microsoft.	Jun 2025		G
Office365 platform enhancements	Evaluate and consider opportunities to further enhance the Trust's use of its Microsoft Office365 platform entitlement.	Ongoing		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Windows 11 Migration

Overall Status:			
		Lead:	C.Crocker
		Start Date:	01/04/2023
		End Date:	30/06/2025

Overall Summary

All new machines being deployed by the Trust are built with a Windows 11 operating system as standard and the wider rollout of the Windows 11 upgrade to existing Windows 10 machines has been accelerated, resulting in 99% of the Trust end user computing estate running Windows 11.

Purpose	Expected Outcomes
A programme of work was initiated during 2023/24 to commence the upgrade/migration of the Trust's end user computing estate (desktops and laptops) from the existing Microsoft Windows 10 to Microsoft Windows 11 operating system ahead of the October 2025 deadline for when Windows 10 goes out of support.	• Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner, making better use of available resources through centralised control of assets. • Improves end user experience and general computing performance. • Provides greater assurance and controls from which to minimise the risk of cyber threats through continuous availability to software security updates.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Upgrading of Windows 10 devices to the Windows 11 operating system	Upgrading to the Windows 11 operating system for all Trust issued devices (laptops and desktops) from Windows 10 ahead of the October 2025 deadline. The accelerated migration approach within the Trust has resulted in 99% of all Trust devices running the Windows 11 operating	Jun 2025		G

system. This places the Trust at the forefront nationally, when compared to national statistics by region as depicted below.

	W10	W11	Total	% Complete
EoE	107,540	51,640	159,180	32%
London	223,018	89,878	312,896	29%
Midlands	203,050	121,713	324,763	37%
NEY	165,714	127,915	293,629	44%
NW	176,186	79,710	255,896	31%
SE	177,334	60,950	238,284	26%
SW	147,797	42,792	190,589	22%

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

CAMHS Secure Estate Infrastructure

Overall Summary

Overall Status:



Lead:	R. Tyas
Start Date:	01/04/2025
End Date:	30/09/2025

Planning and mobilisation activities are commencing regarding the establishment of the Trust network infrastructure at Wetherby Young Offenders Institution, Adel Beck (Leeds) and Aldine House (Sheffield).

Purpose

To install and implement the SWYT network infrastructure within the CAMHS Secure estate enabling access to Trust corporate systems and Intranet, following the successful tender outcome to continue to provision and enhance Mental Health services.

Expected Outcomes

- Enhanced service provision through improved access to SWYPFT systems and infrastructure and organisational autonomy.
- Improves end user experience.
- Provides service staff with equitable access to wider Trust services and support.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Establishment of the SWYT network infrastructure across the CAMHS Secure estate stated sites.	Place order for the wide area network links to connect the sites to the Trust network, install network hardware, implement and configure the SWYT network and provision of end user computing into the environment for service staff.	Sep 2025		A/R

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Due to the extremely limited capital funding available to the Trust during 2025/26, this may significantly impact the ability to complete the activities in a timely manner during 2025/26.	3	4	**12**	• Capital requirements for this initiative (£92k) were identified as part of annual planning cycle for 2025/26, but there are no digital capital schemes in 2025/26 to enable this, due to the priority on Older People's estate developments. • The digital programme in 2025/26 and key priorities will have first call against any capital underspend, or additional capital that may become available, in year as a contingency. • This is being escalated to explore funding to enable the necessary works to proceed.
Preparatory activities to start mobilisation work were delayed due to the focus and priority assigned to Cheswold Park Hospital programme raising concerns on timeline expectations with Leeds Community Healthcare NHS Trust who are currently supporting elements of this service.	3	3	**9**	• This position was made clear during the service tendering process and due to the required capital funding necessary in 2025/26.

LIFT Building Telephony (Barnsley)

Overall Status:		Lead:	R. Tyas
		Start Date:	01/05/2025
		End Date:	30/09/2025

Overall Summary

Viable options for the Trust have been explored and a summary options paper has been produced, with recommendations for the Trust to consider and approve. This options paper is currently being discussed/reviewed with Barnsley Care Group management to endorse the proposed recommendations, prior to wider Trust governance and approval.

Purpose

To replace/upgrade the desk telephony platform used by Trust staff within the seven LIFT buildings located across Barnsley. This is a result of the ICB serving notice to the incumbent telephony solution supplier for primary care services in Barnsley as part of a national initiative to migrate to a new desk telephony platform by September 2025.

Expected Outcomes

- Enables continuity of desk telephony services for our staff based out of the LIFT buildings in Barnsley.
- Service improvement through deployment of the proposed Trust-wide telephony platform, enabling equitable service and performance.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Options appraisal	Conduct options appraisal and make recommendations for the proposed way forward in collaboration with Barnsley Care Group management prior to formal Trust governance and approval.	Jun 2025		**G**
Implement the proposed desk telephony solution following approval and securing of required monetary resources	Install, configure, and implement the replacement desk telephony solution across the seven LIFT buildings in a considered manner in collaboration with Barnsley Care Group management and impacted services.	Sep 2025		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
No capital funding has been identified/planned for this work and there are no digital capital schemes in 2025/26 to accommodate this.	3	4	**12**	• The digital programme in 2025/26 and key priorities will have first call against any capital underspend, or additional capital that may become available, in year as a contingency. • This is being escalated to explore funding to enable the necessary works to proceed given the prescribed timeframes.
All migration work needs to be completed by September 2025, which includes a full telephone renumbering exercise for all seven LIFT building sites as there will be no option to retain existing numbers.	3	3	**9**	• Preparations to place orders and mobilise the works are being readied in lieu of Trust approval.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2025-26

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	29 Apr	20 May	1 July (June)	29 July	26 Aug	30 Sep	28 Oct	2 Dec (Nov)	16 Dec	27 Jan	24 Feb	31 Mar
Standing Items												
Welcome, Introduction and Apologies	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Declarations of Interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Minutes from the previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
Action log and matters arising from previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Service User/Staff Member/Carer Story	✘		✘	✘		✘	✘	✘		✘		✘
Chair's remarks	✘		✘	✘		✘	✘	✘		✘		✘

Agenda item / issue	29 Apr	20 May	1 July (June)	29 July	26 Aug	30 Sep	28 Oct	2 Dec (Nov)	16 Dec	27 Jan	24 Feb	31 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement												✘
Complex Clinical Matters update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Patient Safety Oversight Report (formerly Incident management quarterly report (public))			✘ (annual)			✘		✘				✘
Guardian of safe working hours annual report			✘									
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (October Annual report and April 6 monthly update) **Moved to align to Audit Committee**	✘						✘					
Medical Education Annual Board report								✘				
Data Security and Protection toolkit (delegated authority required for submission for 30 June)		✘		✘								
Cyber Board training (TBC)												

Agenda item / issue	29 Apr	20 May	1 July (June)	29 July	26 Aug	30 Sep	28 Oct	2 Dec (Nov)	16 Dec	27 Jan	24 Feb	31 Mar
Annual report and accounts (including Quality Account for 2025)		✘										
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 annual report				✘								
EPRR Compliance report						✘						
IPC BAF				✘								✘
PLACE report	✘											
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report			✘							✘		
Care Group Performance report	✘		✘	✘		✘	✘	✘		✘		✘
CQC action plan updates			✘			✘		✘				✘

Agenda item / issue	29 Apr	20 May	1 July (June)	29 July	26 Aug	30 Sep	28 Oct	2 Dec (Nov)	16 Dec	27 Jan	24 Feb	31 Mar
Strategic Direction												
Board Development		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘							✘				
Strategic Objectives/Priority Programmes												✘
Trust Board Annual Work Programme												✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan												
Finance updates (private)	✘		✘	✘		✘	✘	✘		✘		✘
Governance												
Constitution (including Standing Orders) and Scheme of Delegation (if required)							✘					
Compliance with NHS provider licence conditions and code of governance			✘									
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												✘
Stakeholder map (private)											✘	✘
Strategies and Policies												
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		

Agenda item / issue	29 Apr	20 May	1 July (June)	29 July	26 Aug	30 Sep	28 Oct	2 Dec (Nov)	16 Dec	27 Jan	24 Feb	31 Mar
Standards of Conduct in Public Service Policy (conflicts of interest)	✘											
Best place to work and learn strategy				✘								
Risk management governance framework	✘											
Emergency Preparedness Resilience and Response Policy								✘				
Research and Development Strategy							✘					

Policy / strategy review dates:

- Trust Strategy *(July 2030)*
- 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 2025) (or as required)
- Equality, Diversity and Inclusion Strategy (March 2028)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(September 2026)*
- Digital Strategy *(January 2030)*
- Clinical Strategy *(TBC))*
- Estates Strategy *(July 2033)*
- Learning from Healthcare Deaths Policy *(June 2027)*
- Organisational Development Strategy *(July 2025)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2026)*
- Procurement Strategy (to be updated as a result of the Procurement Act - TBC)
- 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 April 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)*
- Best place to work and learn Strategy *(July 2025)*
- Research and Development Strategy *(October 2025)*