

**Trust Board (performance and monitoring)
Tuesday 30 September 2025 at 09:30
Rooms 3 and 4
Laura Mitchell Health Centre Halifax
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 <i>(received in advance in writing by e:mail to membership@swyt.nhs.uk)</i>	Chair	Verbal item	5	To receive
4.	9.38	Minutes from previous Trust Board meeting held 29 July 2025	Chair	Paper	2	To approve
5.	9.40	Matters arising from previous Trust Board meeting held 29 July 2025 and board action log	Chair	Paper	5	To approve
6.	9.45	Service User / Staff Member / Carer Story	Chief Operating Officer	Verbal item	15	To receive
7.	10.00	Chair's remarks	Chair	Verbal item	3	To receive
8.	10.03	Chief Executive's report	Chief Executive	Paper	7	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	10.10	Assurance from Trust Board Committees and Members Council - Commissioning Committee 5 August 2025 - Members Council 19 August 2025 - People and Remuneration Committee 2 September 2025 - Mental Health Act Committee 27 August 2025 - Quality and Safety Committee 9 September 2025 - Finance, Investment & Performance Committee 15 September 2025	Chairs of committees/Members' Council	Paper	10	To receive
10.	10.20	Performance				
	10.20	10.1 Integrated performance report Month 5 2025/26	Executive Directors	Paper	30	To receive
	10.50	10.2 Care group performance report	Chief Operating Officer	Paper	10	To receive
	11.00	10.3 Care Quality Commission Action Plans	Chief Nurse & Director of Quality and Professions	Paper	5	To receive
	11.05	Break			10	
11.	11.15	Risk and Assurance				
	11.15	11.1 Patient Safety Oversight report	Chief Nurse & Director of Quality and Professions	Paper	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.20	11.2 Medical appraisal / revalidation annual report	Chief Medical Officer	Paper	5	To approve
	11.25	11.3 Guardian of safe working hours annual report	Chief Medical Officer	Paper	5	To receive
	11.30	11.4 Green plan	Director of Strategy and Change	Paper	5	To approve
	11.35	11.5 Cheswold Park Hospital update	Chief Operating Officer	Paper	5	To receive
	11.40	11.6 Annual Planning update	Director of Strategy and Change	Paper	10	To receive
	11.50	11.7 NHS Oversight Framework	Director of Finance, Estates and Resources	Paper	10	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	10	To receive
	12.10	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	10	To receive
	12.20	12.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	Paper	5	To receive
13.	12.25	Governance matters				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.25	13.1 Trust Seal	Company Secretary	Paper	5	To receive
14.	12.30	Strategies and Policies				
	12.30	14.1 Estates Strategy update	Director of Finance, Estates and Resources	Paper	10	To receive
15.	12.40	Trust Board work programme for 2024/25	Chair	Paper	2	To receive
16.	12.42	Date of next meeting	Chair	Verbal item	1	To note
		The next Trust Board meeting held in public will be held on Tuesday 28 October 2025 at Kendray Hospital				
17.	12.43	Any other business	Chair	Verbal item	2	To note
	12.45	Close				

**Minutes of the public Trust Board meeting held on 29 July 2025
Small Conference Room, Wellbeing and Development Centre, Fieldhead
Hospital Wakefield**

Present:	Marie Burnham (MBu) Natalie McMillan (NMc) Mike Ford (MF) Gary Ellis (GE) Margaret Kitching (MK) Erfana Mahmood (EM) Martin Neeson (MN) Mark Brooks (MBr) Dawn Lawson (DL) Adrian Snarr (AS) Prof. Subha Thiyagesh (ST) Darryl Thompson (DT)	Trust Chair Deputy Chair, Senior Independent Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Chief Executive Deputy Chief Executive and Director of Strategy, Inclusion and Change Director of Finance, Estates and Resources Chief Medical Officer Chief Nurse and Director of Quality and Professions
Apologies:	No apologies noted	
In attendance:	Izzy Worswick (IW) Christine Brereton Adele Fox (AF) Andy Lister (AL) Debbie Beynon-Fisher (DBF)	Deputy Director of Corporate Governance Interim Chief People Officer Chief Operating Officer Company Secretary Corporate Governance Officer (author)
Observers	Dr Nikhil Bhuskute (NB) John Laville (JLa) Leonie Gleadall (LG) Nick Phillips (NP)	Gatenby Sanderson insight programme candidate Public Governor – Kirklees (Lead Governor) Staff Governor – Non-clinical support Deputy Director of Estates and Facilities

TB/25/52 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) welcomed everyone to the meeting, no apologies were noted, and the meeting was deemed to be quorate and could proceed.

MBu welcomed 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.

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

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

TB/25/53 Declarations of interest (agenda item 2)

Declarations of interest were noted from Marie Burnham (MBu), Nat McMillan (NMc) and Martin Neeson (MN).

It was RESOLVED to NOTE the declarations of interest.

TB/25/54 Questions from the public (agenda item 3)

No questions were received from the public.

TB/25/55 Minutes from previous Trust Board meeting held 1 July 2025 (agenda item 4)

Darryl Thompson (DT) stated on page eight, Dr Abida Abbas was noted as Consultant Psychiatrist/Clinical Lead. It should be noted she is also Chief Clinical Information Officer.

DT also noted that Patient Safety Oversight Quarterly Report was the annual report.

The minutes of the meeting held on 1 July 2025 were accepted as an accurate record subject to the amendments noted above.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 1 July 2025 as a true and accurate record.

TB/25/54 Matters arising from previous Trust Board meeting held 1 July 2025 and Board action log (agenda item 5)

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

TB/25/55 Service User/Staff Member/Carer story (agenda item 6)

Adele Fox (AF) introduced a service user who was being supported by the Individual Placement Support (IPS) service to return to work and Leoni Gleadall (LG) who works in the IPS service, Specialist Core Team West, Wakefield, and is also a Trust Governor.

The service user attended Trust Board to share their experience regarding the work retention support received from the IPS service whilst under the care of the Wakefield Core Team West. The service user advised that following a close family bereavement they had suffered mental health issues and come under the care of the Trust's mental health services. At that time, the service user felt very alone with an uncertain future and did not know where to turn for help. They had an established career which their mental health had impacted. They had received a telephone call from LG offering support and guidance to help them work through their problems and support them back into work. LG worked with them to formulate a plan for the future which provided them with significant reassurance that everything was going to be okay. LG provided support dealing with their employer and the service user stated that following an interview for a post the previous week, they were now hopeful for a positive future. They stated that the service is very valuable in helping people to work through their problems and thanked LG for her support.

LG thanked the service user for being open to trusting the service and the suggestions made during a traumatic time in their life.

Subha Thiyagesh (ST) thanked the service user for sharing their story and asked whether they had any learning from their experience that could be used to help other people in the future. The service user reported that there were barriers relating to information from their employer being shared with LG. They had made it clear that LG was acting on their behalf and in their best interests and were happy for information to be shared. At the time, this caused extra anxiety due to delays in a process that could have been much quicker. They reported that the support from LG and the IPS was “faultless”.

Dawn Lawson (DL) again thanked the service user for their bravery in sharing their story and stated that people and services must work together to support recovery. DL asked how the Trust can improve on the support offered. The service user stated that it is important for people to accept the offer of support and trust in the process. LG was clear on the reasons for particular actions as well as informing them of their rights when communicating with their employer.

Mike Ford (MF) asked LG how she was informed about the service user and if they had not answered the call, what would have happened next? LG advised that the psychiatrist contacted her to state that this was someone who needed the support of the team and asked her to contact them as soon as possible. Once the service has been made aware of someone who requires support, they will attempt to contact them by telephone, letter and email and if no response is received, they will go to their address in person.

Mark Brooks (MBr) thanked both LG and the service user for attending the Board meeting and sharing their story. MBr noted that this was an excellent example of how the Trust supports people to live well in the community and acknowledged the level of trust between the service user and LG, stating that it is very important that there is a level of trust between health professionals and service users. MBr also asked the Board to consider what can be done to support LG to help people like the service user as well as help the service to thrive. MBr, as Chief Executive offered to provide further support to the service user if required.

Erfana Mahmood (EM) joined the meeting.

It was RESOLVED to NOTE the Service User Story and the comments made.

TB/25/56 Chair’s remarks (agenda item 7)

MBu noted that the private Board meeting would include:

- Private risks
- Complex incident update
- Cheswold Park update
- Value for money and financial forecast
- Report on Trust strategies and priorities

It was RESOLVED to NOTE the Chair’s remarks.

TB/25/57 Chief Executive’s report (agenda item 8)

Chief Executive’s report

MBr requested the report be taken as read and highlighted the following updates:

- The Ten-Year Health Plan has been published and a link was included with the agenda in order for Trust Board to review and consider.
- A new NHS Oversight Framework (NOF) has been published which sets out how NHS England will assess providers in this current year. The Trust has had an Oversight Framework for a number of years with a limited level of focus and scrutiny recently. There are five segments, with segment one being the best a Trust can achieve. There will be a notable focus on financial balance as well as other performance metrics and

any provider not in surplus or achieving a break-even position will have its segmentation limited to no higher than three. The Trust has received the initial classification which is expected to be published mid-August 2025, and this will be shared in the private Board meeting.

- South and West Yorkshire Integrated Care Boards (ICB) continue to develop their plans for the future as strategic commissioners. Formal consultation on the new structures has not commenced as confirmation is required of redundancy processes and funding arrangements. Discussions have commenced regarding the development of provider alliances in West Yorkshire and what responsibilities can potentially be delegated from ICBs. A similar approach is being initiated in Barnsley.
- NHS England (NHSE) published the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports. The report states that there has been a continued increase in the number of ethnic minority staff and very senior managers from an ethnic minority background. However, white staff were noted to be significantly more likely to be appointed from shortlisting and cases of bullying and harassment from patients to staff from ethnic minority backgrounds remains high.
- Following the recent periods of hot weather, MBr acknowledged that this can be challenging for both services users and colleagues and the Trust was ensuring measures are in place to support wellbeing. MBr thanked colleagues for their continuing commitment during the period of hot weather in keeping people safe.
- Current inpatient occupancy levels are in excess of 100%. MBr advised Adele Fox (AF) was managing daily calls from acute colleagues regarding people presenting at emergency departments requiring mental health support or a mental health bed. MBr thanked colleagues for their support in managing the increased demand.
- MBr reported that it was the last day of industrial action by resident doctors. This has been well managed within services with little disruption. It was noted that 50-60% of resident doctors had taken action. MBr added that a potential ballot for industrial action by nurses had been announced, therefore there may be further challenges for the Trust going forward.
- Dr Penny Dash's Independent Review of Patient Safety across the health and care landscape has been published and will be presented to the Quality and Safety Committee for review.
- The Mental Health Act is moving to the report stage with the passing of the Act likely to occur during the autumn.
- The Trust's financial position remains in deficit. Operational pressures on inpatient wards continue, which has made the reduction of temporary staffing more challenging.
- MBr stated that the key focus of the Trust Board meeting was on risk. The Board Assurance Framework (BAF) has been updated to reflect alignment with our refreshed Trust strategy. The Organisational Risk Register (ORR) recognises the scale of financial challenge facing the Trust and new risks associated with the changing NHS landscape including the announced reductions in staffing and roles for NHS England and Integrated Care Boards.
- MBr stated that there were a number of positive examples of work that have taken place and achievements of the Trust, including the service user story presented that day.
- MBr also thanked Erfana Mahmood (EM) for her support as a Non-Executive Director over the previous seven years and stated that Erfana had offered challenge and insight and ensured that actions were seen through in a manner that was fully aligned with Trust values. EM thanked the Board for their kind comments.

Regarding the number of people declaring a disability through the Electronic Staff Record (ESR) system and those identifying as disabled through the anonymous NHS staff survey, Mike Ford (MF) stated that this was a challenge for the Equality, Inclusion and Involvement Committee (EIIIC) and is a national issue. Christine Brereton (CB) confirmed that this is a local

and national issue and advised that the People Directorate are aware and are taking action on self-declaration in order to encourage people to report their disability.

MBu requested clarification regarding Patient Knows Best (PKB) and MBr advised this was a secure personal health record system, which went live in the integrated neighbourhood teams SystmOne unit in early July 2025. MBr stated that as the Trust moves towards the Ten-Year Plan, the PKB system will enable patients to have more access to their own records.

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

TB/25/58 Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 9)

Equality, Inclusion and Involvement Committee 25 June 2025

Dawn Lawson (DL) provided an update following the Equality, Inclusion and Involvement Committee on 25 June 2025:

- Work continues on the deployment plan for the Equality, Diversity and Inclusion (EDI) Strategy. The first objective was discussed in terms of implications for the Committee and sub-Committee. MBu stated deployment of the strategy is a work in progress and further progress is expected within the next couple of months.

Quality and Safety Committee 8 July 2025

Margaret Kitching (MK) provided an update following the Quality and Safety Committee on 8 July 2025:

- The Committee received the Internal Audit Report on the oversight of medical devices and noted that the finding of the auditors was 'moderate assurance'. The Committee requested an updated report on the performance of medical devices servicing, triangulated with the findings and actions of this audit. MK noted that any high-risk medical devices will be closely monitored.
- Committee members suggested that the Executive Management Team review the wider risk of the Older People's Transformation programme as this is now in the post-consultation phase.
- The Committee reviewed the Trust's National Institute for Health and Care Excellence (NICE) Annual Report, the Drug and Therapeutic Committee Annual Report and the Infection Prevention and Control Board Assurance Framework (IPC BAF) which only had one identified issue, relating to FFP3 Mask fit testing. MK stated that it was challenging for the Trust to achieve green standard as a Mental Health Trust.

The minutes of the previous Quality and Safety Committee meeting of 10 June 2025 were noted.

Audit Committee 14 July 2025

MF provided an update following the Audit Committee on 14 July 2025:

- Two reports with moderate assurance were presented to Audit Committee:
 - Medical Devices
 - Governance of the Care Quality Commission (CQC) action plan

The Quality and Safety Committee continue to monitor medical devices and will provide Audit Committee with further updates.

Triangulation between the Board Assurance Framework (BAF), Organisational Risk Register (ORR) and the Integrated Performance Report (IPR) has taken place, and it was noted that

there is currently no IPR metric related to medical devices. The Committee requested that this be considered with a discussion at the Executive Management Team meeting.

Action – Executive Management Team

- As part of the regular update on Committee-related risks there was a proposal for the risk on management capacity to be merged with the risk of the Trust not achieving its strategic objectives. Committee members expressed a preference to maintain a separate risk regarding capacity. MBr confirmed that the Executive Management Team meeting had agreed that the risks should remain separate.
- General assurance was received following the review of the Trust's annual Data Security Toolkit submission and the PLACE (Patient-Led Assessments of the Care Environment) inspection.
- MF reported that the Trust remains “non-compliant” with the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and will remain non-compliant until national activity and work by the Yorkshire Ambulance Service are delivered. To date there have been no implications from non-compliance. MBr added that a paper was presented to Trust Board previously outlining what could be achieved as the requirements for a Mental Health provider differ from Acute Trusts. However, Trust Board must be assured that there are appropriate EPRR policies and business continuity measures and policies in place in order for the Trust to respond appropriately.

EM stated that in relation the Care Quality Commission (CQC) actions regarding medical devices, it would be helpful to review what measures were successfully embedded previously and MK agreed to pick this up through the Quality and Safety Committee.

Action – Darryl Thompson

The minutes of the Audit Committee meeting held on 25 June 2025 were noted.

People and Remuneration Committee 15 July 2025

NMc provided a verbal update on key points from the last People and Remuneration meeting held on 15 July 2025:

- Performance overall remains positive across People metrics. There remain some limited areas of concern, however appraisal and mandatory training positions were noted to be positive.
- A lengthy discussion took place regarding recruitment and converting bank staff to substantive posts. A further update will be presented to the next Committee meeting to provide assurance regarding the process and timescale of the work.
- A deep dive into the medical workforce is planned for September 2025.
- Non-executive directors agreed to ensure that work is not duplicated across Trust Committees with a clear “ask” for each committee.

Finance, Investment and Performance Committee 21 July 2025

Gary Ellis (GE) provided an update following the Finance, Investment and Performance Committee meeting held on 21 July 2025.

- Month 3 financial position is a £2m deficit, £91k worse than plan. Further work is required in order to return to a surplus position.
- The main financial pressures continue to be pay and bank payments in Older People's Services (Barnsley and Wakefield) and Children and Young People's Mental Health services.

- The value for money programme target is £28.2m and is currently showing a shortfall of £1.2m, driven by the use of temporary staffing. Other areas continue to be positive, in particular savings in corporate services. Bank usage remains an area of focus in order to achieve the full year target.
- The forecast for a breakeven position remains. However, the risk has reduced by £800k.
- Following the introduction of the new National Oversight Framework, it is important to remain on or ahead of plan in order to avoid increased scrutiny. The current position is slightly behind plan; therefore, further work is required to improve the position.
- In relation to capital, work continues on the Older People's Transformation Programme to ensure delivery of value for money. Work is not expected to be completed by March 2026 therefore the plan will be adjusted to bring forward items from 2026/27 capital priorities to manage this slippage. As part of the revised planning framework issued by NHS England, we will be able to plan for capital over multiple financial years which will help us to manage in year variations as detailed above.
- GE advised the system improvement target for the West Yorkshire Integrated Care Board does not affect the Trust plan. A breakeven position will be accepted.

MBR emphasised the significance of recognising the progress achieved in reducing the Trust's cost base, highlighting reductions made compared to the previous year.

In relation to capital spend, Adrian Snarr (AS) confirmed that the Trust will move towards a three-year capital plan with some capital spend brought forward from 2026. AS reported that the Trust is currently confident that the capital allocation will remain at a similar level going forward.

ST provided a live update in relation to the current industrial action and confirmed that thirty three out of fifty-seven resident doctors were on strike but there were no issues relating to patient safety where additional mitigation was required.

It was RESOLVED to NOTE the assurance and minutes from Trust Board Committees and Member's council.

TB/25/59 Risk and Assurance (agenda item 10)

TB/25/59a Board Assurance Framework (agenda item 10.1)

Izzy Worswick (IW) provided context regarding the development of the Board Assurance Framework (BAF) and the Organisational Risk Register (ORR). She advised that, as part of the strategy refresh, the Corporate Governance Team has been careful to take the opportunity to explicitly align our organisational governance process to provide assurance about our statutory and strategic objectives. This included a review of a number of documents to consider how corporate governance tools can be used as enablers to delivery of the strategy.

The Board Assurance Framework is the first version aligned to the new Trust Strategy for quarter one. There are sixteen strategic aims agreed by Trust Board in March 2025. The Board Assurance Framework was presented to the Executive Management Committee on 10 July 2025 to consider risk scores and the Executive Management Team requested that each risk be aligned to one Director to ensure strong accountability of the Board Assurance Framework and organisational risks.

Trust Board were asked to receive the report, provide any feedback and approve the updated Board Assurance Framework.

MBu noted that the Board Assurance Framework was sophisticated and very well articulated and thanked IW and the team for their hard work.

MBr advised that it was important to review risks and use the Board Assurance Framework as a guide on areas which require increased focus. The Executive Management Team highlighted areas which require further work including work around discrimination, the increase in demand on services, changes to the national system, the Trust's financial position and the Trust's capacity to adjust to a new environment. These were the main areas that require Board assurance and intervention.

Martin Neeson (MN) stated that the report was comprehensive and clear and questioned the Board's authority to effect change regarding demand and capacity. MBr noted the Trust's strengths in control and assurance, however highlighted the need for greater focus on actions that lower risk scores.

DL stated that in terms of the strategy, the intention was to be deliberate in our actions, aligned with risk management, enabling the Trust to make an informed decision on where to take action.

MF observed that the report mentioned reducing risks to within appetite but did not explain how the Trust would take actions to achieve this. MBr advised risk appetite was not classified for strategic risks but was for the organisational risk register. MF also noted that where a risk appetite is open/high and the likelihood is classed as "unlikely" these tend to be risks related to wellbeing, issues with patients and incidents with staff. MF felt that the risk of "unlikely" was appropriate as the actions capture recruitment and retention of the workforce. MBr added that the main area of concern is around maintaining the position given the current challenges within the operating environment and the wider system.

Nat McMillan (NMc) thanked IW for the work undertaken and noted the focus on governance as an enabler, highlighting the importance of ensuring the Board continues to seek and evaluate opportunities. NMc stated that the Trust's ambition will help support informed decision-making and the Board Assurance Framework will serve as a key tool to advance transformation and provide robust support for Board decisions.

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

TB/25/59 Performance (agenda item 10)

TB/25/59b Corporate / Organisational Risk Register (agenda item 10.2)

IW presented the Organisational Risk Register and advised that following the last presentation of the risk register at Trust Board in April 2025, a full review of risks, controls and actions took place with Executive Directors in May and June 2025. A detailed review of the Organisational Risk Register took place at the Executive Management Team meeting on 10 July 2025. Following this review, two emergent risks were identified which have not been added to the Organisational Risk Register at this stage:

- The national direction and focus on urgent and emergency care could have an inadvertent impact on patient safety in the Trust and staff morale.
- The Trust's requirement to compare its nursing job profiles with the outcome of NHS Employers review of national nursing job profiles (bands 4-6) could result in finance, recruitment, and retention challenges, and a reduction in staff morale.

A new risk related to the structural changes of the NHS was also identified following the Executive Management Team discussion:

- Risk that, as structural changes, and changes to the role of NHSE and ICBs take place, there is less focus on mental health, learning disabilities and autism leading to contracting funding impacting on the Trust's ability to deliver high quality care.

IW advised that the report also included a risk heat map as well as number of suggested changes to wording and risk level target scores and requested that Trust Board discuss and approve the proposed changes and approve the proposed new risk.

MF stated that in relation to the new risk regarding structural changes in the NHS, the Executive Management Team have considered the likelihood of this risk “unlikely” however MF felt that it was more “likely” as there is increased focus on Acute and Emergency services compared to Mental Health Services. MBr stated that the likelihood reflects the current position and will continue to be monitored. MBr added that the reduced focus has not resulted in reduced funding at this time.

Risk 1729 - Staff wellbeing may deteriorate which could exacerbate staffing challenges leading to a delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations. MF stated he agreed with the decision made by the Executive Management Team that the risk should remain on the Organisational Risk Register.

MN raised a question about qualified assurance and actions taken to mitigate risks. In relation to demand for services and delayed discharge, MN queried what work has taken place in preparation for any potential winter pressures. Following a recent quality walk around, it was noted that inpatient services are already experiencing additional pressures therefore winter pressures is an upcoming issue that requires further consideration. AF confirmed that work is already taking place across each Place as part of a Place System Response. The Trust is working with the Acute Hospitals on their winter plan submission which is required in four weeks. MBr acknowledged that inpatient services are busier now than the same time last year and bed occupancy has remained consistently high over the last three months. AF added that a review of data is underway and an increase in length of stay has been noted in some inpatient areas. An increase in the demand for mental health inpatient and older people's service beds has been identified as well as an increase in the number of presentations at the Emergency Department. AF confirmed that the Trust is involved in the National Mental Health and Acute Emergency Department Interface Improvement Programme along with two acute hospitals and agreed to pick up a conversation with MN outside the meeting.

MBr confirmed that a review will be undertaken of people presenting to an Emergency Department who require mental health intervention to identify any trends and consider reasons for the increase in order to understand what changes are required. It was noted that the proportion of people requiring a bed admission in Barnsley is higher than Kirklees.

ST advised that discussions are also taking place in the Medical Staff Committee and Transforming Clinical Pathways meetings regarding the increase in referrals. It is reported that there has been a 45-60% increase over the last four to five years in the number of older people's service referrals for people already known to the Trust as well as an increase in new referrals. There has been an increase in referrals to Barnsley memory services, with Kirklees, Calderdale and Wakefield also reporting a similar increase. Work is underway to understand the detail and reasons for the increase. Margaret Kitching (MK) suggested that a review of the increase in length of stay may help to provide comparable information.

Darryl Thompson (DT) stated that clinical effectiveness is important when wards are under increased pressure and a piece of work is underway with colleagues visiting wards to understand how to maximise the opportunity for therapeutic activities, maximise positive experience and minimise enhanced observations when there is an opportunity to do so.

In terms of the heat map, DL noted that the number of risks related to quality far outweigh the number of other risks and provides a sense of where the focus should be. MBu added that the Trust must always ensure that services remain safe and the heat map identifies the difference between quality and safety and where the Trust can maximise quality and remain

safe within the assigned cost envelope. IW stated that it was a complex process to develop the heat map and thanked Andy Lister (AL) for his hard work.

Following review, Trust Board approved the following changes to the Organisational Risk Register:

- New Risk - *Risk that, as structural changes, and changes to the role of NHSE and ICBs take place, there is less focus on mental health, learning disabilities and autism leading to contracting funding impacting on the Trust's ability to deliver high quality care.* Risk wording and risk score for the new NHSE/ICB risk approved.
- Risk 1530 – *There is a risk that capacity in services to meet existing waiting lists and current levels of demand and acuity is placing pressure on access to and delivery of services.* Increase in risk level target score approved.
- Risk 1432 – *Risk of lack of succession planning and talent management may lead to gaps in key roles and fail to promote diversity.* Increase in risk level target score approved.
- Risk 1650 – *Inpatient areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury.* Retention of the risk on the Organisational Risk Register approved.
- Risk 1729 – *Staff wellbeing may deteriorate which could exacerbate staffing challenges leading to a delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.* Retention of the risk on the Organisational Risk Register approved.
- Risk 1157 – *Risk that the Trust does not have a diverse and representative workforce at all levels which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population served and fails to achieve national requirements linked to Equality Delivery System2 (EDS2), Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).* Retention of the risk on the Organisational Risk Register approved.
- Risk 1151 – *Risk of being unable to recruit and retain clinical staff due to national shortages and growth in mental health investment/ commissioning which could impact on the safety and quality of current services and future development.* Merger with risk 1614 approved.
- 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.* Merger with risk 1151 approved.
- Risk 1839 – ~~*Maintaining people who are clinically ready for discharge in an inpatient bed impacts on bed capacity.*~~ *Lack of provision across the system prevents transferring people that are clinically ready for discharge therefore impacts on bed capacity.* New 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.*~~ *Risk that place based or collaborative commissioning arrangements, or lack of engagement with external stakeholders change clinical pathways and financial flows which could adversely impact on the quality and sustainability of Trust services outlined in the Trusts strategic ambitions.* Revised wording and increase in risk score approved.
- Risk 1568 – *Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.* Stepping down of the risk to care group level risk registers approved.
- Risk 1624 – *Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we*

can offer to someone who may have a mental health need in our local community.
Stepping down of the risk to care group level risk registers approved

MBr confirmed that all risks are reviewed by individual Trust Board Committees and in-depth conversations have taken place.

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 risk wording and risk score for the new NHSE/ICB risk, APPROVE the increase in risk level target for risks, 1530 and 1432, APPROVE retaining the following risks on the ORR – 1650, 1729 and 1157, APPROVE the merger of risks 1151 with 1614, APPROVE the new wording for risk 1839, APPROVE the revised risk wording and increase in risk score of risk 812, APPROVE the stepping down of risks 1568 and 1624 to care group level risk registers.

TB/25/59c Infection Prevention and Control Board Assurance Framework (agenda item 10.3)

DT provided a summary of the Infection Prevention and Control Board Assurance Framework and advised it was reviewed by the Executive Management Team on 19 June 2025 and the Quality and Safety Committee on 8 July 2025 where it was recommended to be received by Trust Board.

The Framework is a self-assessment of compliance against national standards and DT confirmed that improvement and advances have been made towards compliance with criteria 6 (6.5 - All identified staff are FFP3 mask fit tested). This is not sufficient to change into a self-assessment of fully compliant. A full review of the risk factors and training needs analysis has taken place. Internal discussions are underway regarding the practicalities of achieving 100% compliance and whether a 60% coverage per area is a proportionate target. A fit testing programme has been initiated, and the Trust is actively working towards meeting the Health and Safety Executive (HSE) requirements

It was also noted that Cheswold Park Hospital transitioned onto the Trust Infection Prevention Control (IPC) policies and procedures on 12 May 2025. There are no changes to standard infection control precautions, however the introduction of the Trust's policies and procedures enables timely support from the Infection Prevention Control team to ensure the Trust is delivering outstanding physical, mental and social care in a modern health and care system.

It was RESOLVED to RECEIVE and NOTE the Infection Prevention and Control – Board Assurance Framework.

Nick Phillips joined the meeting

TB/25/59d Health and Safety Annual Report (agenda item 10.4)

Nick Phillips (NP) provided a summary of the Health and Safety Annual Report and advised that this was a report of key activities of safety services including health and safety, fire, security and emergency planning, achievements in the year 2024/25 and key aims for the current year.

- There has been a reduction in the number of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents from last year and this continues to be an area of focus in order to reduce the number of violence and aggression incidents against staff.

- Work to implement a more robust monitoring system for lone work device usage continues. There has been an increase in the number of devices being utilised, however further work is required.
- Work on the installation of the Water Mist Fire Suppression System has been completed across all ward areas except Cheswold Park Hospital at a cost of over £1m. A fire risk assessment is underway at Cheswold Park Hospital.
- Fire training – One hundred and sixty-six instructor led fire sessions (including online sessions) for essential training were delivered and it was noted that Trustwide fire training attendance was 90%.
- Security Industry Authority (SIA) training has been completed for all security staff members to ensure resilience within the team to support the Trust with CCTV and wider security measures. All security staff are now trained in the latest security industry standards.
- Work is underway to prioritise the completion of the NHSE Core Standards for Emergency Preparedness, Resilience and Response (EPRR). The current EPRR advisor will be leaving the organisation, however a plan is in place.

Trust Board were asked to note the contents of the report and approve the action plans for activity in 2025/26.

In relation to lone working devices, it was noted that there is a continued focus on usage with monthly reports presented to the Operational Management Group. In terms of compliance, NP confirmed the devices are issued following a risk assessment and the Trust has a legal requirement to ensure devices are being used and all reasonable steps have been taken to keep staff safe. AF added that use of lone working devices is included in staff contracts and work is taking place to ensure that staff who require a device have access to one and that it is being used. An update is due to be presented to the Operational Management Group in two weeks. NP confirmed that there are a number of different types of devices available including lanyards, a smart phone app and key fob. The current contract is due for renewal in the near future.

MF raised a query in relation to information contained within the report regarding the number of incidents of physical violence by patients against staff with a weapon. The report has shown an increase from eighty-seven incidents to one thousand and seventy. A reduction of physical violence by patients against staff without a weapon shows a reduction from one thousand, one hundred and six incidents down to one. NP agreed to review and confirm the figures before approval by Trust Board.

Action – Adrian Snarr

MBr stated that the Trust has a legal responsibility in terms of health and safety and there needs to be a relentless focus on safety. There was a fire incident on an inpatient ward recently, and one of the largest safety risks for the Trust relates to ligatures. MBr confirmed that a separate Annual Ligature Risk Report is presented to Trust Board in addition to the Health and Safety Annual report. MBr also stated that staff face a risk of violence and aggression when they attend work and should not suffer any injuries in the course of carrying out their duties. Risk assessments are undertaken, and support is available to staff with actions in place to reduce the number of incidents and this should remain a focus going forward.

Trust Board noted the content of the report and agreed to approve the action plans once the figures related to physical violence incidents against staff have been verified.

It was RESOLVED to NOTE the content of the report APPROVE the action plans for activity in 2025/26.

TB/25/59e Patient led assessments of the care environments (PLACE) scores (agenda item 10.5)

NP presented the Patient Led Assessments of the Care Environments return and confirmed that this was presented to Trust Board previously and is a central return with a number of set questions assessed with ward staff, service users, governors and the independent reviewer, HealthWatch. The review looks at environment, food, cleanliness and a number of other factors and it was noted that the Trust has always previously scored well. External monitoring also takes place, and the Trust is one of the highest scoring mental health organisations in the country which provides reassurance that the inpatient environment is positive.

It was noted that the Trust scores well in terms of food provision, however this is an area where suggestions for improvement have been received from service users. A piece of work was undertaken in Barnsley, working with nursing staff, to improve food choices. Feedback received so far has been positive and a significant reduction in food waste was noted. The trial moved to Newton Lodge at Fieldhead and has again received positive feedback. Further, wider, roll out across the Fieldhead site has commenced. NP thanked operational colleagues for their support and noted that two qualified chefs are now in post that have helped to drive these improvements. MBu thanked NP for his leadership and his team for their work.

AF requested that further consideration be given to the new National Communication Strategy and disabilities including deaf and hard of hearing service users.

MBr suggested that it would be worth sharing the update with the groups of people who participated in the reviews.

TB/25/59f Premises Assurance Model annual report (agenda item 10.6)

NP presented the Premises Assurance Model (PAM) Annual Report and advised that it is a central return that is mandated by NHS England and is intended to provide wide ranging assurance on a number of key performance indicators. These indicators are designed to show that the estate is being managed to a certain level and that where improvement is needed this can be recognised and actioned. The report is a data and evidence led self-assessment and was presented to the Executive Team Management on 24 July 2025. Due to changes to the timeline by NHS England, the report was not presented at the recent Audit Committee.

MF confirmed that the Audit Committee previously reviewed the data set and noted that the report has been moved to the Quality and Safety Committee agenda and the item was deferred to September 2025 which resulted in missing the deadline for Committee review. MF queried whether this was the right decision and requested a further discussion with Izzy Worswick (IW), AL and MK to consider the timing and agree the best place for the report to be reviewed.

Action – Andy Lister

Overall, NP reported that the Trust have received good scores:

- Hard FM (facilities management) - out of twenty-two domains, twenty are rated as good or outstanding, one domain (mortuaries) is not applicable, and one domain (medical devices) requires improvement.
- Soft FM has ten domains, nine of which are good or outstanding and one is not applicable.
- Patient experience has six domains, all reported as good or outstanding.
- Efficiency has five domains, all reported as good.
- Effectiveness has four domains, all reported as good or outstanding.
- Maturity is reported as outstanding.

In relation to the management of medical devices, NP confirmed that the medical devices position has improved substantially over the past year. However, in terms of this report, the Trust has not reached the pass mark giving the result of “requires improvement” for this domain.

MBu confirmed that the subject of medical devices had been noted through various Committees as well as this report and requested that Executive colleagues pick this up as a matter of urgency. MBr confirmed that medical devices are high on the Trust agenda, and the issue is related to ownership of devices and availability of resources. There has been significant improvement over the last six months however challenges remain in some areas. MBr confirmed that medical devices are receiving increased focus and stated that the Audit report noted “moderate assurance” and the Trust must continue to maintain the current level of focus. A conversation is taking place regarding Executive Director ownership of medical devices and feedback will be provided to Trust Board in due course.

MK confirmed that the Quality and Safety Committee continue to monitor the position, and a piece of work is underway to ensure that medical devices are checked and logged with an alert system in place.

AS stated, that the main challenge with medical devices is staff presenting the equipment for service. AF confirmed that a risk assessment of devices within the Barnsley physical health service has taken place in order to provide assurance that the devices will not cause any harm. It was agreed to bring a further update to the next meeting.

Action – Darryl Thompson

In relation to section eight of the report regarding the water safety system, MF raised a question about the rating being “good” given the previous discussion at Trust Board regarding historic issues at Cheswold Park Hospital. NP confirmed that the report was related to the period prior to the acquisition of Cheswold Park Hospital and that the report next year will include it. NP confirmed that a peer review was underway and is voluntary.

In relation to sustainability, Gary Ellis (GE) raised a query regarding effectiveness and noted that the report stated there were nine questions with eight rated as good and one which has moved from good to outstanding. GE queried whether a suitable sustainability approach is in place given the current limitations in terms of funding. NP confirmed that the Trust is able to provide a strong evidence base however there is further work to be done on sustainability. NP also noted that there is a strong plan to achieve net zero carbon emissions in two years.

Following submission, MBr stated it may be useful for the Audit Committee to undertake a retrospective review in order to provide Trust Board with additional assurance. NP agreed to link with MF to review the process.

Action – Mike Ford

Trust Board agreed to the submission of the Premises Assurance Model annual report.

TB/25/59g Data Security and Protection Toolkit (DSPT) (agenda item 10.7)

AS presented the Data Security and Protection Toolkit (DSPT) annual submission. Following the previous request for delegated authority for the Chair and Chief Executive in order to meet the end of June deadline, AS provided feedback following the submission process.

AS noted, that the submission had a level of self-assessment by the Trust which was supplemented by an internal audit review. The Trust has achieved the standard of “partially achieved” which is proportionate in terms of challenges regarding Cyber security.

Trust Board members agreed to note the final submission of the DSPT with a “partially achieved” Cyber Assessment Framework (CAF) profile on 27 June 2025.

TB/25/59h Cheswold Park Update (agenda item 10.8)

AF provided an update on Cheswold Park Hospital and advised that Cheswold Park is now included within the Integrated Performance Report (IPR).

- Work to improve water hygiene continues and shows an improving position. Clinically, the service is doing well.
- There is improved oversight of incidents.
- Staff are reporting that they feel supported and engaged.
- There is a good plan in place for admissions and discharges. Currently there are seventy-four inpatients.
- Leadership continues to be active on site with Julie Hall (Deputy Director of Cheswold Park Hospital Integration), Emma Cox, Emma Robinson and Jo Barber who are the Clinical Operational Trio. It was noted that the trio are working effectively.
- DL and AF are looking at different methods of communication with staff.
- AF and CB recently undertook a walkaround and spoke to a number of staff which was positive.
- Seclusion training is being rolled out and is expected to go live in September 2025.
- Electronic Prescribing Medicines Administration (EPMA) has been rolled out.

EM noted all the positive work that has taken place and queried whether there is a plan in place to reach the ninety inpatients position. A review is underway looking at the trajectory for admissions and discharge. The operational and corporate establishment is also being reviewed. There continue to be issues related to locum medics, however a plan was agreed at the Executive Management Team meeting to recruit to those posts substantively which will help to determine overall costs and how to reach the breakeven position. AF added that the work that has taken place to transition and discharge people should be acknowledged.

ST advised that she visited Cheswold Park recently and stated that there was fantastic engagement and morale was felt to be positive. DT stated that he was in regular contact with a member of the nursing team who attends Cheswold Park regularly.

MBr confirmed that the Trust remains ahead of the business case in terms of admissions and this will continue to have some reliance on the Ministry of Justice. AS added that there was limited information available when the business case was developed and in terms of secure services, there is increasing demand for low secure services compared to medium secure services. AS added that nationally there has been an increase in demand for secure services.

It was RESOLVED to RECEIVE and NOTE the report.

TB/25/60 Performance (agenda item 11)

TB/25/60a Integrated Performance Report (IPR) month 3 2025/26 (agenda item 11.1)

AS provided a summarised review of the Integrated Performance Report and noted the highlights:

Prone restraint

There have been twelve incidents within the reporting period with narrative providing additional information.

MBu raised a question regarding whether achievement of zero prone restraint was possible. DT confirmed that a number of wards are reporting zero prone restraints. Five of the recent incidents were where the patient put themselves in the prone position as part of a restraint.

DT added that work was ongoing to ensure staff have completed training in the updated approach to restraint and teams are building in a conversation at the start of each shift regarding whether staff are trained in the new approach. An additional metric has been added to the IPR related to prone restraint instigated by care team.

MBu stated that she required more assurance regarding the use of prone restraint and requested that this be picked up again in the Quality and Safety Committee.

DT noted that previously the Trust had an average rate of twenty-one prone restraints per month, and this had reduced further to between eight and ten with an ambition to reduce to zero with support from the training programme.

MK confirmed that the Quality and Safety Committee continue to monitor prone restraint closely however it was important to understand the difference between staff putting patients in a prone position and patients putting themselves in the prone position. Board are asked to note that figures are reducing.

Quality and Safety Committee scrutinise the figures every month and have noted a reduction in the number of incidents. MBr stated that since the Care Quality Commission (CQC) identified prone restraint as an issue, there has been a sizeable reduction in the number of incidents with a number of wards reporting and maintaining zero prone restraints. Training has been reviewed and revitalised and is currently being rolled out across all inpatient areas. The initial training takes place over four days with the update training taking place over two days. There continue to be some areas of concern, e.g. Walton ward, and the Executive Trio visited the ward in order to understand the issues in more depth and identify where further support is required. DT confirmed that service visits have taken place on wards where there has been a significant reduction, e.g. Newhaven. ST stated that during a visit to The Dales the previous week, there were conversations with nursing colleagues and managers who confirmed that there are multi-factorial issues to reducing the number of incidents and although it is frustrating that progress has not been made faster, a review of barriers is underway to consider whether they are related to culture/training etc.

Nat McMillan (NMC) stated that the People and Remuneration Committee receive updates on training and the extra provision and feel much more assured in line with the changes and trajectory of improvement.

People

AS confirmed that the Finance, Investment and Performance Committee undertook a deep dive into the People Performance metrics and it was noted that appraisals were only 0.2% off target. A strong performance from services and teams was noted.

In terms of finances, AS stated that there is a correlation between the threshold for sickness and how this is affecting compliance with mandatory training and driving the increase in temporary staffing costs. Conversations are taking place through the Value for Money group to understand what is required to further reduce temporary staffing costs.

Sickness is within threshold, the mandatory training position is positive, and staff turnover was reported to be at the lowest level compared to previous years and is actually lower than the figures presented in the IPR due to the data being a twelve-month rolling average and a team being transferred out following the end of the contract in March 2025.

Care groups

Pressure continues on inpatient services. Out of area placements for the Trust remain one of the best in the North of England. A target of five people out of area has been set and although there have been some out of area placements, these people are brought back into area quickly and safely. Pressures on inpatient services has been relentless but continues to be very well managed but not without consequence and challenge within Trust services. AF added that community teams, Intensive Home-Based Treatment Team and the Flow Team work hard to manage the position as well as pressure from Emergency Departments.

Finance

AS advised that the financial position at the end of month three is £100k off plan. The plan is a deficit at the end of month three therefore the financial challenge will increase going forward.

AS stated, that the IPR includes the indicators from the National Framework. Our Trust scores have been shared and discussed with the Finance, Investment and Performance (FIP) Committee. Trust performance will be measured against the performance of other organisations, and the performance team are validating all the information and FIP will spend some time reviewing the data. AS confirmed that there are consequences should the Trust not meet the National Framework indicators. The framework is only for one year in its current form and the Trust is not aware of what the indicators will be for next year.

MBr stated that the Equality, Diversity and Inclusion section has been reintroduced into the IPR and noted that the average length of stay for black and Asian people is longer than people who are white. MBr also noted that the proportion of inpatients who are black or asian is proportionally higher compared to white people. This is an important piece of information that needs to be used to understand the position and make improvements to services.

In terms of paediatric audiology, it was updated that a business case had been developed for commissioners however it was noted that this service is capacity constrained. The team is a small team, so any absence has a significant impact on the service.

The number of people clinically ready for discharge has reduced slightly and AF continues to join the Multi Agency Discharge Event (MADE) meetings which bring partners together to support the reduction in the number of people requiring a mental health bed.

The Trust continues to report a low number of falls, less than the national average, however it was acknowledged that this comes at a financial cost due to the additional staffing required for those at risk of falls.

MK noted that the Trust completion of risk assessment for inpatients had seen a drop in performance. AF confirmed that risk assessments are completed. For community patients, there are issues with the capacity to input risk assessments onto the system. Further support is required to ensure that risk assessments are input onto the system. DT confirmed that Amy Hartley, Deputy Director of Nursing, Quality and Professions is engaged with inpatient wards as part of the work to improve clinical risk assessments. DT noted that the numbers were small compared to community services due to the number of people in inpatient services being much lower than community services, therefore small numbers will have a greater impact on performance. Matrons and lead nurses have oversight and address any issues as they arise. AF stated that hotspots have been identified where colleagues have issues inputting information onto the system as well as areas with high inpatient turnover. ST confirmed that an audit is underway as part of the wider inpatient work to look at who has been seen, how the risk assessment has been documented and whether a Multi-Disciplinary Team (MDT) meeting has taken place. This will triangulate the information and the risk to identify areas where risk assessments are not being input onto the system within timescales.

MBr confirmed that following a number of improvements, the risk in relation to risk assessments had been removed from the organisational risk register however should the risk increase, it will be added back onto the risk register. ST also confirmed that Dawn Lawson (DL) and Paul Foster, Assistant Director of IT services and systems development, were also undertaking a review of digital solutions, looking at who has access to VPN (Virtual Private Network) to consider possible solutions. Erfana Mahmood (EM) acknowledged the pressure on staff to complete tasks within a limited amount of time. MK added that a digital solution will help to relieve the pressure on staff to upload information onto the system. Record keeping is an area of focus for the Care Quality Commission (CQC) and therefore improved record keeping is important not only in patient care but also in terms of managing risk. It was agreed

that the Quality and Safety Committee would pick this up and provide a report detailing risk assessment record keeping in both community services and inpatient wards in order to provide assurance to Trust Board.

Action – Darryl Thompson

MBr noted that the reduction in risk assessments related to one month and one ward in particular and therefore was not felt to be a trend. It was agreed for the Quality and Safety Committee to undertake a review of the data outside the meeting to clarify the information within the Integrated Performance Report and the issues.

Action – Darryl Thompson

MBr confirmed that it had been agreed to review the NHS oversight framework and revisit key metrics that require an increased focus and take the findings back to the Finance, Investment and Performance Committee.

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

TB/25/60b Care Group Performance Report (agenda item 11.2)

AF provided a summary of the Care Group Performance Report for the forensic care group:

- There have been improvements in terms of sickness, mandatory training including information governance and Reducing Restrictive Practice Interventions (RRPI).
- Newhaven is a hotspot area that requires further improvement work and AF confirmed this was underway.
- RRPI training meets the standard across the Care Group. However, there continue to be areas of improvement required.
- Cheswold Park Hospital are now undertaking the Trust RRPI training. The RRPI team are also reviewing the previous Cheswold Park training to consider any areas of good practice which could transition into the Trust training programme.
- Cardiopulmonary Resuscitation (CPR) shows a trajectory for compliance however there is some underperformance in Newhaven.
- Turnover remains stable and there continue to be no registered nursing vacancies.
- There are forty-eight Health Care Support Worker (HCSW) vacancies and following the recent bank recruitment, eighteen people are moving over from bank onto a substantive contract in forensic services within the next few weeks. AF also noted that there are sixty-eight bank staff moving over to substantive roles in mental health services.
- Work has taken place regarding what clinically ready for discharge means for forensic services. There are some people who are clinically ready for discharge. However, this is significantly less than mental health services.
- There have been two recent fall incidents in forensic services, one resulted in moderate harm, and one resulted in a significant injury. AF confirmed that falls incidents are usually related to a deterioration in physical health.
- It was noted that information related to the Cheswold Park Hospital workforce has now been included in the report.

AS stated, that the forensic care group are the first care group to reach the target of zero agency staff and thanked the service for their hard work in reaching this position.

GE noted that sickness levels at Cheswold Park Hospital and South Yorkshire are consistently lower than other areas of the Trust.

AF confirmed that forensic services have had four RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents recently, relating to violence and

aggression with staff experiencing “burnout”, staff off work due to injuries following incidents of violence and aggression as well as some longer-term sickness due to physical health conditions.

DT noted that forensic services perform well in terms of medical device oversight.

Christine Brereton (CB) confirmed that the People and Remuneration Committee are undertaking a benchmarking exercise to compare forensic services with other forensic units to consider whether the Trust is an outlier in terms of sickness. MBr stated that benchmarking should be against another organisation of a similar scale.

It was RESOLVED to RECEIVE and NOTE the care group report for forensic services.

TB/25/61 Integrated Care Systems and Partnerships (agenda item 12)

TB/25/61a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 12.1)

MBr provided an update following a recent South Yorkshire Integrated Care Board (ICB) meeting and advised that the main topic of conversation was the restructuring of the Integrated Care Boards and the requirement to postpone the consultation regarding future structures due to lack of clarity around funding of redundancies. It was noted that South Yorkshire had a challenging start to the financial year and is adverse to plan. It was noted that deficit support for quarter two would not be forthcoming. Other areas of focus were the Ten-Year Plan and the Urgent and Emergency Care Plan.

DL reported that the formal Barnsley Committee and Delivery Group had not met since the last Trust Board meeting. A task and finish group has been established to consider how to move forward in terms of the Ten-Year Plan as well as the opportunity to be a pilot site for neighbourhood care.

It was RESOLVED to NOTE the South Yorkshire Integrated Care System and Barnsley Place updates.

TB/25/61b 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 confirmed that the West Yorkshire Integrated Care Board met to discuss the restructuring of the Integrated Care Board, the Ten-Year Plan and year-end report. MBr advised that West Yorkshire have also had a challenging start to the financial year.

The Mental Health Learning Disability and Autism (MHLDA) Collaborative has undertaken a focus on the eating disorder pathway, and it was confirmed that work is taking place regarding investment in mental health support teams for schools.

MBr advised that a key meeting was taking place that week with Bradford District Care NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust regarding where to focus efforts of the collaborative going forward.

MBr confirmed that he had attended recent Place development sessions which had a focus on neighbourhood care, the development of Provider Alliances, the model blueprint for Integrated Care Boards and population health management. It was noted that both South and West Yorkshire Chairs and Chief Executives noted the potential psychological harm to people regarding the restructuring of the ICBs and not providing a date for when the consultation will take place.

It was RESOLVED to NOTE the update on the development of Integrated Care Systems and Collaborations and NOTE the minutes of relevant partnership boards/committees.

TB/25/61c Provider Collaboratives and Alliances (agenda item 12.3)

AS provided an update on the West Yorkshire and South Yorkshire and Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider, and an update on the national Phase Two Provider Collaboratives

- In relation to clinically ready for discharge, the report noted the differences between how providers report clinically ready for discharge. AS noted, that the Trust have reported a low number of delayed discharges compared to other organisations.
- The West Yorkshire Provider Collaborative Clinical Lead has undertaken a review of Psychiatric Intensive Care Unit (PICU) referrals due to an increase in referrals in Quarter four. The report identified a significant variance in the number of accepted referrals into secure services. Acceptance rates in Leeds and Bradford were noted to be higher than SWYPFT (South West Yorkshire NHS Foundation Trust). The Provider Collaborative has planned meetings with Integrated Care Board colleagues and Leeds and York Partnership NHS Foundation Trust (LYPFT) to develop an action plan.
- The financial position last month reported an overspend and AS confirmed that this month the position has moved back to breakeven due to a number of people being discharged.
- AS added that the Trust also have a risk share across West Yorkshire in terms of eating disorder services and inpatient CAMHS. Historically both services have been under financial pressure, however this year they are now reporting positive financial variances. Patient flow is being well managed through Red Kite View (young person's mental health unit), by reducing out of area beds and reducing extraordinary packages of care which is financially beneficial for the West Yorkshire Provider Collaborative as a whole.
- South Yorkshire Adult Secure Provider Collaborative continues to report a deficit driven primarily by a £1.4m pressure relating to patients awaiting NHS retained services (High Secure).
- A review of patients who are clinically ready for discharge has been undertaken to understand consistency across all providers. Clinically ready for discharge within Forensic services includes patients who are waiting to return to prison or waiting for a community package of care. AS confirmed, there is a community forensic service in Sheffield, however it has not been possible to expand the community forensic service offer further across South Yorkshire due to financial constraints. AS added that it is felt that there may be some under-reporting of patients clinically ready for discharge as there are differing clinical opinions of the definition.
- NHS North England Region submitted a proposition to extend provider contracts until the end of 2027 to provide some stability through the current financial uncertainty. The proposal was accepted by the Integrated Care Board and mechanisms will be put in place for contract extensions.

It was RESOLVED to NOTE the update on the development of Integrated Care Systems and collaborations and NOTE the minutes of relevant partnership boards/committees.

TB/25/62 Governance (agenda item 13)

TB/25/62a Assessment against NHS Constitution (agenda item 13.1)

Izzy Worswick (IW) advised that the Corporate Governance Team undertake an annual self-assessment review against all rights and pledges of the NHS Constitution. The self-assessment was updated to reflect the current position and provides assurance to Trust Board that the Trust is meeting the rights and pledges of the NHS Constitution.

IW added that the NHS constitution is currently under national review, and an updated version is expected following the release of the Ten-Year Plan, however the timescale for this is not currently known. IW confirmed that MBr is involved in national forums regarding upcoming changes in terms of Foundation Trust status and what to expect going forward.

It was RESOLVED to RECEIVE and APPROVE the Assessment against NHS Constitution.

TB/25/62b Teaching Trust Status (agenda item 13.2)

Following the approval of the Trust's application for Teaching Trust Status by the University of Leeds, Subha Thiyagesh (ST) confirmed that the Trust is working through a number of governance implications.

The Trust is progressing with the appointment of an Appointed Associate Non-Executive (NED) from the University of Leeds, and a bespoke job description has been developed with a focus on education, research and development. A joint partnership Board between SWYPFT and Leeds University will also be developed. A recommendation for appointment of an appointed Associate NED was made to the Nominations Committee on 16 July 2025 and will be considered by the Members' Council on 19 August 2025.

In relation to the proposed name change to South West Yorkshire Partnership Teaching NHS Foundation Trust, positive feedback has been received. Questions have been raised regarding the impact of the name change in terms of finance and estates. ST confirmed the proposed name change follows the strict NHS naming standards.

Moving forward, a joint partnership governance arrangement will be developed with membership from both the University of Leeds and the Trust. ST advised a partnership Board will be established between the University and the Trust with agreed Terms of Reference. A key role of the group initially will be establishing partnership agreements and formal human resource agreements.

MBu confirmed that the new Associate Non-Executive Director will not Chair a Trust Committee meeting, will not attend Private Trust Board meetings and will not have any voting rights. Their role will be to work with Executive Team between the University of Leeds and the Trust and chair the Joint Partnership Committee.

It was RESOLVED to NOTE the update on progress, NOTE the update on appointment to the Associate Non-Executive role and APPROVE the recommendation to Members' Council the Trust name change from South West Yorkshire Partnership NHS Foundation Trust to South West Yorkshire Partnership Teaching NHS Foundation Trust.

TB/25/62c Trust Board Committees Membership and Attendance (agenda item 13.3)

Andy Lister (AL) confirmed that a review of the changes to the Non-Executive Directors has taken place and presented the paper detailing the proposed new Committee membership.

Rokaiya Khan is scheduled to join the Trust on 4 August, succeeding Erfana Mahmood, who will leave her position as Non-Executive Director on 2 August 2025. Rokaiya will be the new Chair of the Mental Health Act Committee and Charitable Funds Committee and will be a member of Finance, Investment and Performance Committee and Equality, Involvement and Inclusion Committee.

Martin Neeson, Non-Executive Director, started with the Trust on 9 June 2025. Martin is a member of Audit Committee, People and Remuneration Committee and the new Chair of the Commissioning Committee.

MBr confirmed that there are regular reviews of the Executive Directors and Non-Executive Director membership of Committees.

It was RESOLVED to APPROVE the changes in Chair/membership to Trust Board Committees.

TB/25/63 Strategies and Policies (agenda item 14)

TB/25/63a NHS Ten Year plan (agenda item 14.1)

MBr presented the NHS Ten Year Plan as an executive summary for Trust Board awareness. The next Strategy Trust Board meeting will review the plan in more detail to focus on the Trust response.

The plan is intended to set out a route map of how the three shifts of a) moving more care from hospital to the community, b) analogue to digital and c) sickness to prevention can be used to fundamentally change the way care is delivered over the next decade. There are nine chapters which were reviewed by the Executive Management Team, facilitated by Sue Barton, Deputy Director of Strategy, Inclusion and Change. MBr stated that there is expected to be an increase in pace in relation to the development of neighbourhood care as well as increased focus on operating model chapters two and five.

In relation to the running of the Mental Health Emergency Department, MBr explained that a delivery plan along with operational planning guidance is expected to be developed early autumn 2025.

It was RESOLVED to NOTE the publication of the Ten-Year Plan for England and initial summary points provided.

TB/25/64 Trust Board work programme for 2025/26 (agenda item 15)

AL confirmed that the Trust Board Work Programme for 2025/26 has been updated to reflect the current position.

It was RESOLVED to NOTE the work programme.

TB/25/65 Any other business (agenda item 16)

No further business.

TB/25/66 Date of next meeting (agenda item 17)

The next Trust Board meeting in public will be held on Tuesday 30 September 2025 at Laura Mitchell Health Centre, Halifax.

Signature:

Date:

TRUST BOARD 29 July 2025 – ACTION POINTS

 = completed actions

Actions from 29 July 2025

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/25/58 (1)</u>	Executive Management Team to discuss addition of an IPR metric related to medical devices.	Executive Management Team	October 2025	September update – DT - Medical devices have been discussed in detail in EMT. A transition plan is in place to move the oversight of this from nursing, quality and professions to the estates directorate, and performance metrics by Care Group are reviewed. The transfer will include a review of the metrics for oversight and improvement, and the identification of a medical devices safety officer in the Trust.
<u>TB/25/58 (2)</u>	DT to request the Quality and Safety Committee review previous medical devices measures that were successfully embedded following a previous CQC inspection	Darryl Thompson	September 2025	Learning from previous improvement work is being incorporated in the planning as described in action TB/25/58 (1). This will be reported into the Quality and Safety Committee bi-monthly as per the workplan, with the next submission being October 2025.

<u>TB/25/59d</u>	AS to work with Nick Phillips to review the figures related to incidents of physical violence detailed within the Health and Safety Annual Report and confirm accuracy	Adrian Snarr	September 2025	The data has been checked, and the below changes have been made: The number for 'Physical Violence by Patients Against Staff with a Weapon' for 2024/25 is 70. Not 1,070 as listed. This is down from 87 in 2023/24. The number of 'Physical Violence by Patients Against Staff without a Weapon' for 204/25 is 1,070. Not 1 as listed. This is down from 1,106 in 2023/24.
<u>TB/25/59f (1)</u>	AL, IW and MF to have a discussion regarding the Premises Assurance Model Annual Report and consider the timing and the best place for the report to be reviewed.	Andy Lister	September 2025	PAM report removed from QSC agenda following discussion with Audit Committee Chair, Director of Finance Estates and Resources, Director of Nursing Quality and Professions and Chair of Quality and Safety Committee.
<u>TB/25/59f (2)</u>	AS stated a challenge with medical devices is staff presenting the equipment for service. AF confirmed that a risk assessment of devices within the Barnsley physical health service has taken place in order to provide reassurance that the devices will not cause any harm. It was agreed to bring a further update to the next meeting.	Darryl Thompson	September 2025	An update on medical devices has been received by EMT, including performance at Care Group level. The Barnsley Physical Health and Well-being Care Group has engaged in a process for when staff are allocated equipment they receive an instruction on professional roles and responsibilities, list of equipment with costings, servicing date and contact detail for faults.
<u>TB/25/59f (3)</u>	Audit Committee to undertake a retrospective review of the Premises Assurance Model Annual Report after submission to provide Trust Board with additional assurance	Mike Ford	September 2025	The Chair of the Audit Committee undertook a retrospective review of the PAM report following the Board meeting and agreed with its content.
<u>TB/25/ 60a (1)</u>	Quality and Safety Committee to provide a report detailing risk assessment record keeping in both community services and inpatient wards in order to provide assurance to Trust Board.	Darryl Thompson	October 2025	This is an agenda item in October QSC, to be added to the workplan in line with the Trust-wide clinical record keeping improvement and audit workstream.

<u>TB/25/ 60a (2)</u>	Quality and Safety Committee to undertake a review of risk assessment data within the Integrated Performance Report	Darryl Thompson	October 2025	This is an agenda item in October QSC, to be added to the workplan in line with the Trust-wide clinical record keeping improvement and audit workstream.

Actions from 1 July 2025 (June meeting)

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/25/42 (1)</u>	ST to consider how clinicians support administration of Mental Health Act (MHA) to support the MHA team.	Subha Thiyagesh	September 2025	There is a quality improvement initiative in place which has commenced to reduce the administrative impact on clinical and mental health act team administrative staff through use of automated technical placeholders on S1 and modified escalation process. This is being further reviewed in digital strategy group.
<u>TB/25/42 (2)</u>	MBu stated that a more detailed review around performance and financial planning is required as part of the Finance, Investment and Performance Committee. Dawn Lawson (DL) agreed to have a discussion with MBr and Adrian Snarr (AS) regarding the long-term plan for the committee.	Dawn Lawson	September 2025	As part of the operational planning process, progress updates will be provided to FIP, and an update report was provided to September 2025 FIP meeting.

<u>TB/25/43a (1)</u>	Digital innovation update to Board in the context of improving efficiency of recording risk assessments and updating patient records in the community	Subha Thiyagesh	September 2025	Regarding updating patient records in the community, the Trust makes available remote mobile network connectivity (4G/5G) options considered on a case-by-case basis, details available on the Intranet and are managed by the relevant service budget holder. However, blackspots remain where coverage is problematic or limited at best. Where such instances are reported to IT, the IT team can liaise with mobile network providers to ascertain plans to address such limitations. Re risk assessment completion, work is ongoing to evaluate options within SystmOne and associated processes to address compliance rates, through OneNavigation, system prompts and assessment of other available functionalities.
<u>TB/25/43a (2)</u>	AS to ensure summary section of the IPR presents a more balanced position on performance as the current presentation focusses on areas of concern and could be misconstrued.	Adrian Snarr	October 2025	The IPR has been reviewed by EMT on 25 September and there is ongoing work to consider the summary section of the IPR.
<u>TB/25/44</u>	MBu asked to have a meeting with DT, ST, and AF to better understand the safer staffing report.	Exec Trio	September 2025	Meeting arranged for 8 October.

Actions from 29 April 2025

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/25/43</u>	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	October 2025	

Actions from 25 March 2025

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>

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	September 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. Update 29 July 2025. A proposed trajectory is on the agenda for the September Quality and Safety Committee, once agreed in the executive management team. Update 25 September 2025. Updated paper presented to Trust Board, further to review in the executive management team and Quality and Safety Committee.

Actions from 26 November 2024

<u>Min reference</u>	<u>Action</u>	<u>Lead</u>	<u>Timescale</u>	<u>Progress</u>
<u>TB/24/120b</u>	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)	

**Trust Board
30 September 2025
Agenda item 8**

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 last Trust Board meeting NHS England (NHSE) has published its plans for considering provider capability which alongside segmentation, will be a key compoment of how trusts are overseen. This assessment will help inform NHSE’s response to the NHS Oversight Framework (NOF) segmentation and in the future is likely to be a consideration for trusts pursuing new Foundation Trust status.		

The aim is to ensure that NHSE has a holistic view of providers including capturing wider information relevant to grip and governance as well as being a development tool. A separate paper is including within the Board agenda on this subject. The timescales for submission are relatively tight (22 October) so a process will be agreed to ensure there is full Board engagement with the development and submission.

It is intended that the capability rating will be published alongside the quarter 2 2025/26 NOF segmentation during quarter 3.

NHSE has also published its draft planning framework. This will be a multi-year planning approach (five years) with an expectation that guidance will be published in early October with approval by Trust Boards in December. This will be a very different approach to that which has been adopted since the pandemic and the Finance, Investment and Performance Committee will have a key oversight role on behalf of the Trust Board. The Executive Management Team (EMT) have spent a time out meeting considering and developing our approach to the planning process. We await with interest any specific planning guidance relating to the mental health, learning disability & autism and community sectors. Fiscally, the position is highly likely to remain very constrained.

Following on from the publication of the Model ICB Blueprint several months ago a Model Region Blueprint has also now been published. This regional role will be fulfilled by the bringing together of NHSE and Department of Health & Social Care. The Blueprint covers the purpose of regions, their core functions, enablers & capabilities, and managing the transition from the current structures in place. It is clearly articulated that the purpose of regions is to provide strategic leadership and oversight of the regional health system and to ensure that organisations are 'high performing, sustainable and delivering reform in line with the requirements of the 10 Year Health Plan'. Core functions will cover regional strategic leadership, performance management and improvement & intervention. A link to this blueprint is provided for Board members. ([https://www.teamengine.com/korridoren/Rum14799.nsf/DownloadFile?OpenAgent&file=0701C19633AA1C73C1258D11002F170A/\\$File/Model%20Region%20Blueprint%20v.01.pdf](https://www.teamengine.com/korridoren/Rum14799.nsf/DownloadFile?OpenAgent&file=0701C19633AA1C73C1258D11002F170A/$File/Model%20Region%20Blueprint%20v.01.pdf)) This document provides an indication of what will become a stronger role for the region and our Trust will need to adapt to these changing arrangements.

NHSE has recently published its segmentation of providers based on the first quarter's operating and financial performance. Given the adverse variance (£90k) to financial plan, the financial override applies and as such the Trust has been placed in segment 3. This actually masks what is typically a strong performance and had it not been for the financial override our segmentation would undoubtedly have been higher. There is reasonable confidence the financial override will not apply during quarter 2 and this segmentation acts as a key reminder to the Trust that along with safety, delivery of financial performance is key and non-delivery has real consequences. The publication of the segmentation scores in the form of league tables has resulted in much national, local, and media interest.

The latest annual Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) report has recently been published. Positively the report shows that since 2018 the median age of death for people with a learning disability has risen by almost a year, and the proportion of

avoidable deaths has reduced from 43% in 2022 to 38.8% in 2023. However, the fact remains that adults with a learning disability are still dying on average about 20 years younger than the general population and in many instances they are dying from conditions which could have been treated or prevented, such as cancer, constipation, respiratory, and circulatory disease. Both internally in our Trust and in our systems we need to ensure that focus is maintained and strengthened on improving the lives of people with a learning disability and autistic people. The LeDeR report will be overseen by our Quality & safety Committee and presented at a future Trust Board meeting.

Along with many other organisations the Trust marked national suicide prevention week and World Suicide Prevention Day in September. Staying safe from suicide guidance was introduced earlier this year and a new national e-learning package has recently been launched to complement this guidance.

As Autumn nears we are commencing our annual flu vaccination programme. Earlier in the year we carried out a review of what worked well last year and how we can improve uptake this year. In 2024/25 we achieved a vaccination rate of over 53% which was in the upper quartile nationally (the national rate was just under 38%). NHSE senior leaders have written to all trusts asking each Trust to increase its vaccination rate by at least 5%. The very real impact of flu is highlighted in this letter with 7,757 deaths from flu recorded last year and over 340,000 occupied bed days.

We held a successful Annual Members' Meeting on 17 September which recognised the achievements of the Trust in 2024/25 and provided some excellent examples of the great work and positive impact of many of our teams. We also used the meeting to formally launch our teaching trust status. We very much look forward to working closely in partnership with the University of Leeds to realise the benefits of being one of only a small number of mental health and community providers in the country to have this accreditation. Our Trust name is now South West Yorkshire Partnership Teaching NHS Foundation Trust and a phased approach is being taken to updating our signage and documentation.

The staff consultation process for West and South Yorkshire integrated care boards remains on hold until there is clarification regarding timing and funding for redundancies.

The chief nursing officer and chief finance officer for NHS England have written to all trusts regarding a graduation guarantee for newly qualified nurses and midwives. A number of asks have been made of trusts including proactive recruitment support in the form of recognising the level of vacancies that currently exist across all bands, NHS providers are encouraged to recruit newly qualified nurses before vacancies formally arise. This will mean graduates transitioning seamlessly from training into employment, reducing uncertainty and ensuring continuous patient care capacity.

NHS providers have also been encouraged to adopt a time-limited approach to utilise existing vacant healthcare support worker roles to create time limited registered nursing posts. Regional teams will work with providers directly to explore if this approach works locally. This should include reverting posts back to support worker roles as vacancies arise and ensuring good preceptorship support is provided. The implications and implementation of this approach will be overseen by the People and Remuneration Committee (PRC).

It is worth noting that the number of students taking up nursing degrees in England has risen for the first time since 2021 driven by more than 11,500 students aged under 25 accepting a place on a nursing degree.

The chief executive of NHSE along with its chief medical officer have written to all trusts launching a ten point plan to improve resident doctors' working lives. Trust Boards have been asked to take clear ownership of local improvements, develop action plans informed by feedback and national survey results, and report progress publicly.

To demonstrate progress, from Autumn 2025 NHSE will begin publishing trust-level data on the following indicators as part of the NHS Oversight Framework:

- Access to basic facilities (lockers, rest areas, hot meals, on-call parking spaces)
- Work schedule and rota notice compliance
- Self/preferential e-rostering
- Payroll errors
- Board-level reporting and assurance

Our own chief medical officer Dr Subha Thiyagesh and our chief people officer Christine Brereton are working with colleagues to identify the actions the Trust needs to take and how this will report into the Trust Board.

Further correspondence has also been received regarding actions to tackle sexual misconduct in the NHS. This is an issue we take very seriously and Trust Board members will be aware of the actions the Trust has already taken. This letter is being reviewed along with the actions we have already taken to identify if any further actions are required. This will be reported into the People & Remuneration Committee.

Forty three national pilots have been named for the development of neighbourhood care models. Within West Yorkshire the application from Wakefield has been successful along with those from both Leeds and Bradford. In South Yorkshire the bids from Doncaster and Rotherham were successful. Arrangements are being put in place to ensure the learnings from these pilots can be shared with other places. Work to develop neighbourhood care is occurring across all the places in which we work and further information is provided in the West and South Yorkshire place reports within the Trust Board agenda.

Work is taking place nationally regarding the delivery of the 10-year Plan for Health. Six workstreams and immediate priorities were identified and are due to report back in September. Their recommendations are likely to form part of the planning guidance expected in October. These workstreams cover:

- Neighbourhood health
- NHS app and single patient record
- Oversight, model Foundation Trust and model Integrated Health Organisation
- Financial foundations and medium term financial planning
- Quality
- Workforce

I am pleased to report that the industrial action by resident doctors in July was well planned for and as such disruption was minimised. As previously reported other bodies are holding ballots, so we need to prepare for the possibility of further industrial action in the coming weeks and months.

The financial position of the Trust is £0.7 favourable to plan at the end of July with a deficit of £1.7m recorded to date. Our overall position has therefore stabilised since the end of the first quarter with a small improvement in the cumulative deficit since that time. The Value for Money Group continues to meet weekly to understand progress and highlight where further intervention is required. Operational pressures continue on inpatient wards with occupancy regularly exceeding 100% and thereby hindering the realisation of the scale of temporary staffing cost savings being achieved. Particular focus is being applied to our admission and discharge processes and the support we require from other organisations and providers to enable discharges to take place safely and in a timely manner.

Nationally the NHS financial position is broadly in line with its plan at the end of month 5 and progress is being made against key national objectives including waiting times for electives, cancer and for emergency care. It is recognised with Winter approaching there is still much to do. NHS England regions will be carrying out mid year reviews with integrated care board and providers in the coming weeks

This month's Trust Board meeting includes a focus on performance. Whilst there are some exceptions the majority of our performance metrics continue to be positive including favourable workforce metrics such as compliance with statutory and mandatory training. There has been a slight dip in completion of appraisals and focus is being applied to those services and teams that need to improve.

There have been tensions in many of our communities recently. Supportive messages have been sent to colleagues. At SWYPFT we are proud of and recognise the value that our diverse workforce brings to our organisation and how it benefits the care we provide. We are fully committed to being an inclusive organisation and our stance is resolutely clear that there is no place for discrimination in our Trust. We will continue to strive to ensure both colleagues and people in our care are fully supported in a safe environment.

There has been a significant change nationally for the mental health, learning disability and autism sector with the resignation of Claire Murdoch from her national role with NHSE. Claire has been a huge advocate for our sector over the past nine years and played a key role supporting our acquisition of Cheswold Park Hospital.

Within South Yorkshire Gavin Boyle has announced that he is retiring from his role as chief executive of the South Yorkshire Integrated Care Board (ICB). Gavin has also supported our Trust and led the ICB with great integrity. Transitional arrangements are expected to be announced shortly.

Within West Yorkshire Brendan Brown, the chief executive of Calderdale & Huddersfield NHS Foundation Trust (CHFT) is taking up the same position for up to 12 months at Leeds Teaching Hospital Trust. Rob Aitchison, the current

	deputy chief executive at CHFT will be acting as chief executive there during this interim period. I would like to formally welcome Rokaiya Khan to our Trust Board and look forward to her contribution and working with her as our new non-executive director. In line with previous reports I am providing a sample of positive achievements by our colleagues who continue to provide outstanding care in what can often be challenging circumstances. • To support the healthcare of people who are homeless, our Barnsley physical health services have worked collaboratively with colleagues from Waythrough and Barnsley Metropolitan Borough Council's Housing & Welfare, Town Centre Warden and Adult Safeguarding Team's to establish a wound care drop in clinic. • Martin Barlow our apprentice joiner has won the regional apprentice of the year for joiner. Martin is a great asset to the Trust and thoroughly deserves this recognition. • Our South Kirklees Early Intervention in Psychosis (EIP) team has successfully initiated clozapine treatment in a community setting for the first time — a significant advancement in delivering personalised and accessible care for individuals with treatment-resistant psychosis. By initiating treatment in the patient's own environment, the team avoided hospital admission, promoted autonomy, and reduced potential trauma, embodying our commitment to compassionate, trauma-informed care • We were recognised as an early adopter Trust, offering a blueprint for the NHS 10 year plan for our work to deliver a neighbourhood care model on SystmOne. • We were successful in being accredited for the second time by the Royal College of Psychiatrists' Safety Incident Response Accreditation Network. • Barnsley musculoskeletal (MSK) community service successfully held their first community appointment day on Thursday 4 September, offering patients on the MSK waiting list faster access to personalised and holistic care. • Our first T Level student, Sam Wastenev, secured a substantive role within the organisation. • I would finally like to reiterate my thanks to everyone who supported colleagues on the Trust Board, the enhanced intervention in psychosis (EIP) team, older people's service (OPS), and Calderdale enhanced team who raised over £5,000 for EyUp! charity by completing the Yorkshire Three Peaks.
Recommendation:	Trust Board members are asked to: • NOTE the Chief Executive's report.

A large decorative graphic in the center of the slide, featuring concentric rings of blue brushstrokes that form a circular pattern around the central text.

The Brief

28 August 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

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**



Our commitment to developing future talent saw us celebrate an important milestone, with our first T Level student securing a substantive role within the organisation. Our Barnsley community services and learning and development teams are celebrating this major success, as they welcome business and management T Level student Sam Wasteney to the Trust. More information on our [website](#).

Our priorities for 2025-2026

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



**South West
Yorkshire Partnership**
NHS Foundation Trust

Our improvement priorities

BEST WE CAN BE

Best Quality



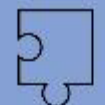
Improve our clinical pathways so they are more effective and efficient and provide the best possible patient experience

Best value



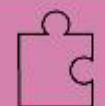
Make the most of our resources, increasing efficiency and living within our means

**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 quality – Our transformation clinical pathways OMG is progressing a range of initiatives to support improvements and productivity, with all services in scope of the programme. Initiatives include:

- Supporting staff to maximise the time they have to care by reducing clinical burden and using IT.
- Effective caseload management across pathways and tools that can support staff.
- Ensuring we have effective pathways into and through services.
- Activity to reducing admissions, improve inpatient pathways and ensure timely stays.

Best partner – The 10 year NHS plan promotes the further development of integrated neighbourhood working. We are actively working with partners in each of our areas to develop effective ways of working that will make this a reality.

Best partner



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.

'**Menopause** festival, managing your menopause' is taking place on 25 September from 4pm until 7pm. It is a free event taking place at the BHF Priory Centre, [view the leaflet for more information](#).

Our creative health partnership project with **Hospital Rooms** continued with free creative workshops held throughout August at the Hepworth Wakefield and Yorkshire Sculpture Park.



A new **wound care drop-in clinic** has opened in Barnsley to provide vital health



services to people experiencing homelessness and rough sleeping. The initiative is a collaboration between our services including neighbourhood nursing, health inclusion service, community matrons, and the tissue viability service alongside Barnsley Recovery Steps (formerly Humankind), and Barnsley Council's housing and welfare, town centre warden, and adult safeguarding teams. You can read more on the [Trust website](#).

The Trust has engaged with the final two stages of the **Culture of Care** programme focused on ward manager and staff care development. Five ward managers have signed up to start training in December 2025 with the Foundation of Nursing Studies (FoNS). The focus is on equipping ward managers with the skills and knowledge needed to cultivate a supportive, positive, and safe work environment for their staff, leading to higher quality of care for patients. Find out more on [the intranet](#).

Join the annual 'Light up for hope' event in Halifax on World **Suicide Prevention** Day to create a display of lanterns - one for each person who died by suicide in West Yorkshire in 2024. A remembrance video will be shown at the event. If you'd like to recognise a loved one, please send your photos, videos and/or messages to [Georgia](#) by 9 September

A **West Yorkshire initiative** that prioritises people's wellbeing in employee investigations has been shortlisted for the 2025 Healthcare People Management Association (HPMA) Awards. More information on this service is available on the [West Yorkshire ICB website](#).

Best quality

Our performance in July



- **56.3%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **99.7%** within 6 weeks.
- **83.3%** of MH service users followed up within 72 hours of discharge from inpatient care
- **81.1%** inpatient risk assessment completed within 24 hours before or after admission
- **89.1%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **78.1%** of people died in a place of their choosing
- **73%** in CAMHS services waiting less than 18 weeks for treatment

Congratulations to our **older people's mental health team in Barnsley**, who have been accredited for the second time by the Royal College of Psychiatrists' ACOMHS (accreditation for community mental health services) to July 2028.

Our **customer services** team dealt with **48** new formal complaints in July and closed **19** formal complaints. **56** informal concerns were received and closed. They also received **37** compliments about our Trust. The team also received and closed **130** enquiries.

97% of respondents in the friends and family test rated our physical health services either good or very good; and **91%** in our mental health services.

Learning disability services' Wakefield and Kirklees community teams have completed a Keeping My Chest Healthy pilot of the Bradford clinical pathway, which has been really successful. This pathway enables clinicians to identify and treat respiratory needs earlier on. This is now being embedded in Wakefield and Kirklees and work will now commence to embed this in Calderdale and Barnsley.



ACOMHS
ACCREDITATION FOR
COMMUNITY MENTAL
HEALTH SERVICES

ACCREDITED
UNTIL

July 2028

Best quality

Our performance in July



- **196** inappropriate out of area bed days
- **0** children / young people under 18 in adult inpatient wards
- **3.9%** of service users clinically ready to discharge (35 people)
- **70%** with care plan that includes service user input/views
- **93.5%** of our service users have their ethnicity equality data recorded, **50.2%** their disability status, **53.9%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had **13** information governance breaches

Save the date for our 2025 annual members' meeting – Wednesday 17 September, 10am – 2pm, in the wellbeing and learning centre, Fieldhead. Hear about our achievements in the last year, our Teaching Trust status and see our work and partnerships at our marketplace. We'll also present our annual accounts for 2024/25.

To book your place, visit
<https://www.eventbrite.com/e/annual-members-meeting-tickets-1540402668849?aff=oddtcreator>

Annual members' meeting 2025

NHS
South West
Yorkshire Partnership
NHS Foundation Trust



Prescribing, administering and supplying **medicines** requires careful consideration to provide the best possible care for our patients. Make sure you request medication in a timely way to help our pharmacy colleagues. Find more information on our pharmacy team on the [intranet](#).

Our **clinical strategy** sets out what we want to achieve across our clinical services and how we will achieve it. Our strategy is our road map for our journey to being outstanding across all our clinical services. Take a look at our [intranet](#) for more information on our strategy and what it means for you.

Our **new roles governance group** can give a view or advice on integrating new roles into the organisation. Any member of staff can seek new roles advice by contacting newrolesgovernance@swyt.nhs.uk

Best quality Patient Safety learning



The Trust Patient Safety Oversight Group meets weekly to discuss significant events. Themes from recent weeks are identified and shared below:

We have identified an emerging theme where service users are increasing the use of cables to self strangulate. A task and finish group has been developed to look at the data and improvement work required around environments to help support risk reduction and safely manage the ward environments.

Ligature policy – Guidance is in draft form around self strangulation and what staff can do to ensure the service user remains safe and what signs and symptoms staff can be vigilant for post self strangulation. This will be embedded within the ligature policy and an update will be shared next month.

Admissions from acute trusts

Incidents continue to be reported around the potential safety of some discharges from acute trusts back to mental health inpatient wards, where a service user has physical health needs. Improvement work is ongoing around processes to ensure effective communication is had with all parties prior to discharge and that the discharge can be managed safely.

Sepsis Awareness Day falls on 13 September this year. We will be raising awareness throughout the week commencing 8 September. Details will be included in our comms channels in the run up to the week.

Sepsis arises when the body's response to an infection injures its own tissues and organs. It may lead to shock, multi-organ failure, and death – especially if not recognized early and treated promptly.

With **all of us** in mind.

Best quality Clinical services and value for money



These are incredibly busy times, for all colleagues across both community and inpatient services. There is a very clear focus nationally on the requirement for all providers to provide safe care, within our means, therefore within the budget we have. As a result, you'll recognise a greater focus on our finances than was the case during the COVID years, and this will be felt by all teams

All clinical **vacancies** are reviewed by the care group and our Trustwide vacancy panel, to ensure there is no detrimental impact on patient safety from unfilled roles

Reducing our use of temporary staffing means that:

- We actively recruit into clinical vacancies, reducing the need for temporary staff. We know that this is the right thing to do for those in our care and for our teams
- The use of (and therefore cost of) agency staff is significantly reduced – thank-you for all your contributions to this
- The use of bank staff remains high. We are in the top 25% users of bank staff nationally

We have heard from some of you that having agency staff in your teams can be difficult, with regards to consistency of care. We have concentrated on reducing this and increasing the substantive workforce. To date we have recruited 78 health care assistants that were working on our bank to substantive roles. Many have started or will be starting in or around September.

We also know that demand is increasing in physical health services and while you continue to respond it is getting harder.

Our executive trio:



Adele Fox



Professor
Subha Thiyagesh



Darryl
Thompson



With **all of us** in mind.

Best quality Clinical services and value for money



The Trust's progress around providing **care closer to home** for mental health inpatients enables us to be confident in:

- The quality of care being provided, which is near families and carers for greater support
- Culture of care programme of work
- The person's progress to discharge
- Reduce the significant cost of out of area (approximately £795 per night)
- When clinically required, we continue to place people out of area when no other options are available

We hear great examples of inpatient and community colleagues working closely together to support patient flow. It would be good to hear about any other innovative work.

The safety of those in our care, and of those providing care, remains our priority.

There are times when we will be unable to support some additional activities, and so patient experience risks being negatively impacted.

Colleagues across the Trust are achieving great things each and every day, in each and every interaction. We're hearing really person-centred examples of how this is being approached to minimise the impact on our service users and carers.

Our executive trio will continue to come out to visit colleagues (both in the daytime and at night), to help us understand the pressures you are facing.

Overall, thank you to each and every one of you for continuing to live our values and change people's lives for the better.

Please continue to look after yourselves and each other, and please continue to escalate when you have patient safety concerns.



With **all of us** in mind.

Best value

Our finances in July



Performance Indicator	Year to Date	Forecast 2025/26
Surplus / (Deficit)	(£2m)	£0m
Agency Spend	£1.5m	£3.2m
Bank Spend	£8.2m	£22.5m
Corporate Spend	£22m	£67.8m
Financial sustainability and efficiencies	£5.8m	£28.2m
Cash	£61.6m	£56m
Capital Spend	£0.6m	£19.3m
Better Payment Practice Code	97%	

The financial performance for July is a deficit of £18k, which is 0.5m better than plan. This means that the year-to-date deficit has remained at £2m. The focus remains on the identification and delivery of further schemes to support medium term financial sustainability.

Agency spend in July is £361k. Spend is similar to June.

Bank expenditure has continued to increase each month with July spend similar to the March/April run rate.

In July corporate expenditure is £0.2m less than planned.

Cash continues to be monitored to ensure effective management of the Trust working capital position. In July this remained better than planned.

Spend on capital and leases is less than planned for the year to date. Work continues on the older people's scheme.

In July 97% of all invoice have been paid within 30 days of receipt.

Best value

Our value for money drive



The Government has set out its intention to make changes to the NHS. NHS providers like us are expected to deliver our services within allocated budgets while becoming more cost effective and more productive. The **NHS 10 year plan for health** has a strong message that providers like us must 'live within our means' so it is critically important that we continue to focus on delivering a breakeven financial position.

We continue to be focused on how we direct our limited resources into the places where we can have most impact on saving money and improving efficiency. This includes targeted action being taken across the Trust on our non-pay and our pay budgets. Below are some examples of ways you can help and get more involved.

Help the Trust save money with correct postage - As part of our ongoing efforts to improve value for money we are asking all staff to double check postal addresses before sending post. Incorrect or incomplete addresses and sending items externally when they could go via internal mail, can lead to unnecessary costs for the Trust. To help reduce these expenses:

- Please check the address before posting
- Make sure addresses are written clearly with the full correct address including postcode
- Where appropriate, email the document to ensure swift and appropriate mailing
- Use the right size envelope for posting externally
- Use internal mail for items going to another team, service, or building within the Trust

One of our value for money key lines of enquiry is about how we build a Trustwide **culture** based on improved productivity and efficiency. As part of this we are setting up a task force of colleagues who can help us to build a strong value for money ethos and culture. If you would like to get involved email comms@swyt.nhs.uk for more information.

All budget holders should check any **subscriptions , memberships and licences** and their cost codes to help us save money. This will help us to avoid duplication.

Please continue to share your ideas and suggestions for improving value for money and productivity through our [dedicated intranet page](#).

Managing risk



- 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

On Sunday 7 September 2025 there will be a **national UK emergency alert test**. Mobile phones in the UK will be sent a test emergency alert at around 3pm as part of plans to strengthen the country's preparedness. During the test, mobile phones will vibrate and make a loud siren sound for roughly ten seconds, even if they are set to silent. Anyone who has a secret phone that they may hide from an abusive partner must be informed to take action to prevent the phone from activating. More information is available [here](#).

Safety alerts are delivered across the Trust as [Bluelight Alerts](#). Please make sure that when one lands in your inbox you read it and make sure your colleagues are aware too.



With **all of us** in mind.

Best place to work and learn

Our performance in July

- **5.3%** sickness rate for the month.
- The rolling 12 months sickness rate is **5%**
- **90%** of staff have a completed annual appraisal
- We have **4,959** contracted staff in post, including Cheswold Park. We had **18** starters and **42** leavers.



The **caring garden** at Fieldhead has been shortlisted for an NHS Forest award in the 'greenspace for wellbeing' category. This recognition highlights the garden's role in providing a calming and restorative environment for our service users and staff, emphasising the therapeutic benefits of nature. The garden features a red brick path, wooden planters, and wildlife mural, making it a place for our service users, staff, families and carers to come together, connect, and show care for one another.

The **trauma informed community of practice and quality improvement network** are coming together on Tuesday 16 September, 11.30am to 1pm. The all age forensic community services will be sharing what they have learnt about taking a systematic approach to quality improvement as they have worked to embed trauma informed care principles across their services. Colleagues can join the [session online](#) and learn from the service's experiences.

Read the latest [green team newsletter](#) for updates on our Trust's social responsibility and sustainability commitment.

Join the upcoming [menopause awareness sessions](#) on 26 August for colleagues and managers. Contact [Jane Oldroyd](#) to book.

Staff health and wellbeing support from occupational health - Accessing support can help to improve your wellbeing at work. Our occupational health team offer a range of [sessions](#) for staff including support following critical incidents, reflective sessions, welfare checks, and counselling and therapy sessions.

Members of our Board prepared for their [#YorkshireThreePeaks Challenge](#) on 30 August by taking part in a 14 mile route from Hathersage, including Stanage Edge and Derwent Edge. They are raising funds for EyUp!



Our **Fieldhead and Kendray canteens** have a number of special themed menus coming up to celebrate awareness days, weeks and months.

Take home messages

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

Join the Calderdale light up for hope suicide prevention awareness event.

Attend our Annual Members' Meeting in September.

Read our clinical strategy and discover how it can impact on your role.

Help us to reduce our costs and improve our productivity.

Attend our trauma informed community of practice.

Support colleagues, carers and service users with the UK emergency phone alert.

Your health and wellbeing is important to us. Access support if you need it.

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

Trust Board 30 September 2025
Agenda item 9 – Assurance from Trust Board Committees

Commissioning Committee

Date	5 August 2025
Presented by	Martin Neeson, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Assure:</u> • The WY Adult Secure Provider Collaborative Board received assurance on the delegated quality oversight, on patient safety and safeguarding. • The WY financial position has reported an improvement YTD from previous, moving from deficit to surplus. • All WY contracts are signed. • SYB Adult Secure Provider Collaborative assurance that all appropriate actions are being taken to ensure that patients are receiving the right care in the right place at the right time and that good clinical oversight is in place • SYB Adult Secure Provider Collaborative assurance of the oversight of SYB patient care but cannot be fully assured that all SYB patients are receiving quality of care in the least restrictive way all the time. For full assurance progress is needed on delayed transfers and discharges. • SYB Adult Secure Provider Collaborative assurance of the effective quality oversight and assurance but is not fully assured that there are high quality clinical services being provided across the SYB Provider collaborative. For full assurance, all providers would be required to be within the routine monitoring processes and not subjected to any regulatory sanctions or inadequate ratings. • SYB Adult Secure Provider Collaborative assurance that there is effective oversight of the use of restrictive practices and is reassured that there is effective oversight through Case Management oversight visits. • SYB Adult Secure Provider Collaborative assurance of the financial oversight but cannot give assurance that the Lead Provider financial envelope is being used to fund the least restrictive offers of care. • The SYB collaborative have taken steps to ensure the separation of duties between the Commissioning of Services and those of the SWYPFT provider. <u>Advise:</u> • A clinical peer review process has been drafted in WY and is out for consultation. This is seeking to review service users that are stuck in services due to clinical complexity and where lengths of stay are greater than their expected discharge date with a view to ‘unsticking’ where possible. • WY women’s pathway process review within secure care with ICB, reviewing all women is undertaken quarterly. • CPH Leadership team and the Specialised Commissioning Hub continue to demonstrate positive collaborative working as we move into Phase 2 of the reopening plan. • WY FCCT is a loss-making service for the Provider and at break-even for the Commissioning Service. This requires a collaborative mechanism to resolve. • NHSE has sought a contract extension to April 2027.

Alert:

- Referrals in West Yorkshire during the past twelve months continue to be above previous levels resulting in both high numbers waiting and high occupancy within the male pathway.
- The analysis of the data which highlighted a significantly higher referral rate from PICU Leeds compared to SWYPFT prompted a deep dive to understand the differences. Whilst this review has not yet concluded, a proposal has been drafted seeking to pilot a collaborative process that seeks to support service users where there is a potential escalation to secure care by identifying alternative pathways and clinical support. This will be further updated during the month ahead.
- The upward trend in referrals from PICU and Secured Setting has led a jump in those awaiting admission from a 12-month average of 10 in number to a June 2025 number of 20 awaiting admission for low and medium secure places. The 4-month average of those awaiting admissions has correspondingly shifted upwards from 6 to 10.
- Whilst this is causing pressure on the flow from medium to low secure to free up capacity, there were 13 admissions to low-secure and medium-secure during May and June (one of which was to female low-secure). There were no Out of Area requests, consistent with the objective of ensuring wherever possible that the needs of the West Yorkshire population are met within West Yorkshire.
- The number of delayed discharges and the length of discharge delays continue on an upwards trend in West Yorkshire. There has been an increased focus in West Yorkshire during the period with a new draft Guidance being currently out for consultation. Its purpose is to focus upon the actions and support to services to enable discharging in a timely manner. Anticipated sign-off of September 2025.
- WY Adult Secure Provider Collaborative have shared concern about recent events at Newhaven and have moved them from routine to enhanced monitoring.
- SYB are reporting a downward trend on delayed discharges when measured across a twelve-month period.
- Both WY and SY Adult Secure Provider Collaboratives are committed to a breakeven position in 2025/26 where both continue to take actions based as evidenced in the latest forecasts. WY current plan shows an improvement since the last report, with a reduced reported deficit of (£10k), (£377k) previously. SYB adult secure are forecasting a deficit of (£129k), (£476k) previously.
- A Cheswold Park repatriation has eased the financial pressure by £320k in the reported period. This was achieved through some excellent collaboration between the Provider Collaborative and the Cheswold Park team, with the reported service user experience being highly satisfactory.
- Within SYB, one of the contracts continue to await being finalised, adversely affecting the forecast position. This is receiving additional attention to resolve, albeit requiring intervention at the most senior of levels.
- SYB advise that one of the service providers is no longer under operational safeguarding monitoring however do continue to be subject to an Enhanced quality monitoring level. This service provider remains closed for new admissions leading to concerns emerging about how best to secure a satisfactory outcome for all parties.
- 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. it is unlikely that additional funding will be secured, however the hub continues to flag. Long standing challenges with delayed cases

	awaiting transfer to high secure have eased with cases admitted to Rampton.
Approved Minutes of previous meeting for receiving	17 June 2025 – to be presented in the private session of Trust Board.

Members' Council

Date	19 August 2025
Presented by	Marie Burnham, Trust Chair (Chair of meeting)
Key items to raise at Trust Board	<u>Key points</u> • Members' Council received the Chair's report and feedback from Trust Board • Members' Council received the Chief Executive's comments on the operating context • Members' Council received an update in relation to Teaching Trust status • Members' Council received an update to the Care Quality Commission action plan • Members' Council received an update around the Discharge Audit • Members' Council approved the appointment of an Associate Non-Executive Director from the University of Leeds • Members' Council received information on new appointments to Members' Council groups • Members' Council received assurance from Members' Council groups and the Nominations Committee • Members' Council received governor feedback • Members' Council received the Integrated Performance Report (IPR) • Members' Council received a presentation on the 10 Year Plan • Members' Council received an update in relation finance for 2025/26
Approved Minutes of previous meeting for receiving	15 May 2025

People and Remuneration Committee

Date	2 September 2025
Presented by	Nat McMillan, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert:</u> • The committee continues to be made aware of the national profiling around nursing roles and the potential for there to be increases in bandings with financial implications. The committee will continue to monitor this risk and advise the board accordingly. • Risk 1614 has had the wording changed and relates to a risk of clinical shortages. The committee was supportive of the change in principle but sought more clarity on the wording of the risk. This risk is aligned with the QSC too and the Chair is aware of discussion in both. • Risk 1432: the committee approved the increase in the risk target score of 4 to 6. • The committee continues its focus on hotspot areas of Forensics and Estates in terms of sickness absence. The former in particular in continuing to review the levels of violence and aggression being experienced by our staff whilst recognising the complexity and acuity in this specific service.

	- The committee noted the improving position with the reduction in agency use and spend but continues to seek assurance around the use of bank staff and the use of agency for medical staff. <u>Advise:</u> - The committee had the privilege of hearing from one of our recent recruits through the T-Level placement scheme and were left feeling inspired both by the individual and the support provided by the team. Of particular note was the consistent reference to the values of the organisation and the teams being lived. - The People and Remuneration Committee continues to develop with all members confirming they feel more assured with the recent changes and developments across the directorate and accountability in key areas such as the People Strategy and quality of reporting. <u>Assure:</u> - The committee would wish the board to have assurance on the overall performance across the workforce metrics which remain positive such as turnover below target at 9.7%, net staffing movement is -59.7wte since April and in line with the 2% reduction in staffing costs planned, sickness absence is 0.1% above the target of 5% and mandatory training continues to be compliant with our target. Appraisal rates has slipped slightly to 0.3% below the target. - The committee is providing the Board with assurance that there is ongoing work through here to continue to analyse and deep dive into the data related to the productivity of our medical workforce and compliance. The first report was presented at this committee, and further assurance is now sought on compliance with opting out of the WTR and value for money. - The committee received the draft action plans for the WRES and WDES and encouraged a review of the targets which appeared ambitious and a need to have realistic targets and clear priorities. We are assured that this is being developed and is in collaboration with staff networks and our partnership forum. - The committee received an update on a successful recruitment campaign for Healthcare Clinical Support Workers (HCSW) with 102 recruited either via our values-based recruitment or conversion from existing bank staff. - The committee received the Annual Mandatory Training Report. CPR and RRPI training are the only two training modules which are below target at 85.3% and 86.5% respectively. The committee and board continue to focus on both these areas and the requirement to achieve the 90% compliance target. - The committee approved updated Terms of Reference
Approved Minutes of previous meeting for receiving	15 July 2025

Mental Health Act Committee

Date	27 August 2025
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert</u> - The Trust inequality data reflects national trends, but at lower levels. The developing annual MHA inequalities report is supporting a better understanding of activity. - The risks arising from the MHA Bill on the MHA Team are being considered.

	- Sustained pressure on 136 suites due to patients waiting for ward beds poses a risk to patient flow and timely access. AMHP's have adapted practice, but further mitigation may be required. <u>Advise</u> - The MHA Bill has now reached Report Stage and may soon be progressing to Royal Assent. - Statistical information of people with mental health issues attending A&E requiring review by psychiatric liaison teams has begun. - Positive feedback received from partnership working across the wider health and social care system - A recruitment process for Independent Associate Hospital Managers is planned for later this year. <u>Assure</u> - Seclusion recording issues identified by CQC are being responded to through a working group, with timing of reviews being clarified. - The presentation received from the Newhaven QI programme which is a Care and Treatment Review process to enhance service users experience demonstrated how service users are being held front and centre with co-production and responses to service user identified concerns. - The Monitoring and Performance report support benchmarking and trend predictions.
Approved Minutes of previous meeting for receiving	28 May 2025

Quality and Safety Committee

Date	9 September 2025
Presented by	Margaret Kitching, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert</u> - Committee received the Care Plans and Risk Assessment Improvement update and noted the continuing need for improvement. Action also identified to review the reporting to highlight the improvement work. - Committee received the Premises Assurance Model Annual Report, with a particular focus on medical devices oversight. Action was identified to identify a timeframe of expected improvement in medical devices servicing. <u>Advise</u> - Committee received a very impressive and young person focused presentation from the mental health leadership team of the Wetherby Young Offender Institution, and Adel Beck (Leeds) and Aldine House (Sheffield) secure children's homes. - Committee reviewed CQC actions and discussed in particular the potential to further review the prone restraint progress against the original action, alongside the Trust's broader ambition for zero use of prone where staff have purposefully placed the person in the prone position. <u>Assure</u> - Committee received the Patient Safety Oversight Report for Quarter 1 and recommended its submission to Trust Board. - Committee received the Safeguarding Annual Report - Committee received the Medical Appraisal and Revalidation Annual Board Report & Annual Organisational Audit (Statement of Compliance)

	• Committee received the Non-medical Education and Training Annual Report • Committee received the Quality Assurance System annual report • Committee received the Quality Strategy update
Approved Minutes of previous meeting for receiving	8 July 2025

Finance, Investment and Performance Committee

Date	23 September 2025
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>Alert:</u> • Under the criteria of the National Operating Framework (NOF) the Trust's segmentation score for Quarter 1 is 3. Overall, the Trust's score had improved from the end of the 2024/25 financial year (FY). However, the financial override was applied due to the Trust's adverse financial performance to plan of £91k. • The Trust's position in the league table for non-acute hospitals is 26 out of a total of 61 providers. • If the financial override had not been applied the position would have been 3 out of 61. • At month 5 the Trust's financial position has continued to improve and we had an in month surplus of £367k with a year-to-date deficit of £1.7m. We are now £1.2m better than plan and the expectation/aim is for us to be in segment 1 or 2 at the end of Quarter 2. We expect the latest segmentation details to be released in November. • Temporary Staffing (Bank) spend remains a challenge and continues to be monitored weekly via the Trust's Temporary Staffing Group. • Risks remain around workforce assumptions, out of area operational pressures and the financial volatility of Provider Collaboratives. • However, while there is still work to do to realise our value for money target we expect to break even by the end of the financial year as more savings are delivered. • Both West Yorkshire and South Yorkshire ICS' had further deterioration in their respective financial positions as at Month 4. This adds to the significant risk of receipt of deficit support funding for the system. • Further delays to the capital works on the Older People Services are envisaged and mitigating actions in respect of full utilisation of our capital allocation are being explored. <u>Advise:</u> • This FY we are reliant on more non-recurrent schemes to balance the financial position. Work continues to develop recurrent schemes to assist the Trust's medium term financial sustainability. • In respect of the NOF work is taking place to establish a system that locally monitors Trust performance against each of the currently 12 applicable metrics. This will enable us to have a forecast score based on timely data and the metrics will be incorporated into the IPR. • The annual planning process has commenced for both Finance and our annual operating plan for 2026/27. • The committee received assurance around the process for producing a baseline financial position for 2026/27 which will be a roll forward of the recurrent 2025/26 forecast. • The new planning guidance is much more succinct and includes a significant change where the assumption that everything is recurrent from the perspective of determining the trust underlying financial

	position, with the need for justification for anything badged as non-recurrent. • The Trust needs to consider the implications of this given our vacancy provision has previously been badged as non-recurrent (currently £21m) • The committee received an update on the planned timetable and process for production of the Operating Plan for 2026/27 and were assured in respect of the approach to its development and timescales for delivery. • Timetable for Board sign off for both the financial and operating plan is December 2025. <u>Assure:</u> • The committee reviewed and discussed the risks relevant to the committee. • Risk 2045 (that structural changes and changes to the role of NHSE and ICB's there may be a less focus on mental health, learning disabilities and autism leading to contract funding impacting on our ability to deliver high quality care) risk score was increased from 3 and 2 to 4 (major) and 4 (likely). An increase from 6 to 16. • All other risks remained the same. • The committee agenda included a deep dive for Quality Performance – Falls and Bone Health Annual Report 2024/25 and Forensics. Both reports demonstrated grip and control and plans to further improve performance. • Cash remains ahead of forecast, and we continue to perform well against the Better Payment Practice Code.
Approved Minutes of previous meetings for receiving	21 July 2025

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

Minutes of the Members' Council meeting
7 May 2025, 10.10 – 12.45

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

Present:	Marie Burnham (MBu) Claire Den Burger-Green (CDBG) Daz Dooler (DD) Amaina Elzoubir (AE) John Laville (JLa) John Lycett (JLy) Valentina McParland Bob Morse (BM) Reini Schühle (RS) Phil Shire (PS) Keith Stuart-Clarke (KSC) Nesar Rafiq (NR) Sarah Leason – Hurley (SLH) Ian Grace (IG) Elaine Lane (EL) Warren Gillibrand (WG)	Chair Public – Kirklees Public – Wakefield/ Deputy governor lead Public – Wakefield Public – Kirklees (Lead Governor) Public – Barnsley Public – Kirklees Public – Kirklees Public – Wakefield Public – Calderdale Public – Barnsley Public – Wakefield Staff – Social workers Staff – Medicine and Pharmacy Staff – Allied Health Professionals Appointed – University of Huddersfield
In attendance:	Anne Magee (AM) Christine Brereton (CB) Gary Ellis (GE) Margaret Kitching (MK) Adrian Snarr (AS) Darryl Thompson (DT) Professor Subha Thiyagesh (ST) Izzy Worswick (IW) Andy Lister (AL) Gemma Lockwood (GL) Debbie Beynon-Fisher (DBF)	Staff – Staff side Interim Chief People Officer Non-executive director Non-executive director Executive Director of Finance, Estates and Resources Chief Nurse and Director of Quality and Professions Chief Medical Officer Assistant director of corporate governance Head of Corporate Governance / Company Secretary Corporate Governance Manager (author) Corporate Governance Officer
Members' Council Apologies:	Cllr Geraldine Carter (GC) Andrea McCourt (AMc) Rosie King (RK) Stephen Baines (SB) Helen Dale (HD) Daniel Goff (DG) Leonie Gleadall (LG) Jacob Agoro (JA) Melanie Mott (MM) Susan Spencer Sara Javid (SR) Mike Ford (MF) Erfana Mahmood (EM)	Appointed – Calderdale Council Appointed – Calderdale and Huddersfield NHS Foundation Trust Public – Wakefield Public – Calderdale Staff – Nursing support Public – Barnsley Staff – Non-clinical support Staff – Nursing Staff – Psychological Therapies Appointed - Barnsley Hospital NHS Foundation Trust Public – Kirklees Non-executive director Non-executive director

Natalie McMillan (NMc)
Fatima Shahzad
Emma Hall (EH)

Non-executive director / Deputy Chair
Public – Rest of Yorkshire and Humber
Appointed – Mid Yorkshire Hospitals NHS
Trust

Apologies:

Mark Brooks (MBr)
Adele Fox (AF)
Dawn Lawson (DL)

Chief Executive
Chief Operating Officer
Executive director of strategy, inclusion and
change

MC/25/19 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 shared that David Webster's term as a Non-Executive Director had ended. She advised two new Non-Executive Directors had been recruited and a detailed paper would be presented later in the meeting.

MBu also advised that Jon Head had resigned from his post as Chief People Officer, and Christine Brereton (CB) had taken on the role of Interim Chief People Officer and Christine was welcomed to the meeting.

MBu advised John Laville (JLa), Lead Governor, had been re-elected as Governor for Kirklees and would remain in post as Lead Governor. It was advised Keith Stuart-Clarke (KSC) had also been re-elected for Barnsley, Farida Ali elected as Public Governor for Kirklees and Amaina Elzoubir (AE) elected as Public Governor for Wakefield.

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

MC/25/20 Declarations of interest (agenda item 2)

Andy Lister (AL) explained the declarations of interest process and advised that each year, declarations of interest are received from Governors on the Members' Council. These are no longer available publicly but are available by request through Izzy Worswick (IW). AL advised that the Corporate Governance team will follow up on any outstanding declarations of interest with governors in line with the required timescales.

It was RESOLVED to RECEIVE the individual declarations from governors.

MC/25/21 Minutes of the previous Members' Council meeting held on 14 February 2025 (agenda item 3)

The minutes of the meeting held on 14 February 2025 were accepted as a true and accurate record.

It was RESOLVED to APPROVE the minutes of the Members' Council meeting on 14 February 2025 as a true and accurate record.

MC/25/22 Matters arising from the previous meeting held on 14 February 2025 (agenda item 4)

MC/25/15 To obtain more detailed financial information around the required £22m savings for the next Member's Council meeting. Adrian Snarr (AS) confirmed that a paper would be presented to the meeting to provide an update on the Trust's current financial position.

MC/25/14 - Adele Fox (AF) to review the discharge process for service users back into the community. It was advised that AF has overseen the discharge audit and would present a paper to the Quality and Safety Committee before bringing a further update back to Members' Council. JLa asked why the date for completion of this action was August and whether this could be brought forward. MBu confirmed that the paper has been completed within the timescale and would be presented to Quality and Safety Committee first, as part of the assurance process. AL added that the paper was scheduled to be presented to the Quality and Safety Committee on 13 May 2025 and could be circulated to Members' Council via email in May 2025. Once circulated, governors would have the opportunity to provide feedback via the Corporate Governance team. Darryl Thompson agreed to speak with AF regarding the audit process and discuss it further with the Quality and Safety Committee.

Action – Darryl Thompson

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

MC/25/23 Chair's report and feedback from Trust Board (agenda item 5)

MBu explained that the report provided a summary of the Chair and Non-Executive Director focus and activity since the last meeting in February.

MBu highlighted that the news that NHS England will be abolished, and of structural changes to the NHS which will affect a lot of colleagues.

MBu advised that the latest Shadow Board programme had concluded and been really successful with plans to continue the programme in the future.

MBu reported that the long service awards and Excellence awards had taken place. She explained this was a fantastic event which recognised the achievements of staff. Claire Den Burger-Green (CDBG) advised that it had been noted in the Governor pre-meeting that none of the Governors (with the exception of the Lead Governor) had been invited to the Excellence awards this year, when they had in previous years, and Governors had not been aware that the event was happening. MBu advised that she was unaware that the Governors had not been invited. It was agreed that IW would speak to the comms team to find out why.

Action – Izzy Worswick

JLa advised that previously, if Governors had been involved in the judging process, they would be invited but on this occasion no Governors had been invited. Elaine Lane (EL) advised that she had expressed an interest in attending the awards.

MBu explained that the awards were different this year due to the financial constraints including having the event sponsored, and the Board providing funding for drinks.

MBu highlighted the activity of the Non-Executive Directors and the breadth of work they undertake. MBu reminded the group that Governors have the opportunity to observe committees and meetings.

MBu passed on thanks to staff and service users who have attended Board meetings to share stories which is an important part of the agenda.

Nesar Rafiq (NR) queried if there could be a section in the Chair's report which takes responsibility for key issues for example waiting lists and explain what is being done to address these. MBu explained that, in her role as Chair, her job is to ensure oversight of the Trust Board and that Non-Executive Directors deliver their objectives. MBu added that the Chief Executive's report would cover items such

as waiting lists, which are a national problem, and the Integrated Performance Report would cover other operational matters.

NR added that it would be good to explain to the public that waiting lists are a national problem and not specific to the Trust, who are doing everything possible to improve.

Bob Morse (BM) reported on page 28, the report refers to four key issues which are highlighted but not actually highlighted. Izzy Worswick (IW) advised there was an issue with numbering within the report which would be rectified next time.

It was RESOLVED to RECEIVE the Chairs' report.

MC/25/24 Chief Executive's comments on the operating context (agenda item 6)

Adrian Snarr (AS) presented the report on behalf of Mark Brooks. He explained that NHS finances are a key topic at the moment nationally, locally and within the Trust. AS explained that there are significant financial constraints across the entire NHS and the Trust needs to demonstrate it is living within its means.

AS highlighted some points from the report including:

- The Government announced that NHS England will be abolished and absorbed into the Department of Health. The changes outlined to NHSE and DHSC are accompanied by a requirement to generate savings of 50% of the current costs.
- A process to clarify the roles of Integrated Care Boards (ICB) has been announced, with ICBs asked to make cost savings of 50%.
- Provider Trusts will be asked to reduce growth in corporate services by 50% which is causing some anxieties with staff. MBu clarified that cost growth over the last five years needs to be halved. AS confirmed that for the Trust this equates to approximately 30-35 whole time equivalents across support services.
- The Trust has a good track record and hit a break even position for the 2024/25 period, as well as meeting all other targets including capital.
- All NHS organisations have received the report around the Valdo Calocane homicides in Nottingham, and all Trusts have been asked to consider the report. With South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) being a mental health Trust, this is particularly relevant. The executive team had the opportunity to meet with the Chief Nurse of Nottinghamshire around lessons learned and what the Trust can learn from this.
- The staff survey results were very similar to last year which is positive. SWYPFT is a high performing Trust in terms of staff feedback, however it is recognised that there are some areas that need focus and that there is always room for improvement.
- There is a continued and increased focus on clinically ready for discharge with a number of patients delayed in the system due to not having appropriate housing or care packages in place to be able to be discharged. There is an increase in delays in some areas and service locations with ongoing work to better understand delays, whether the Trust are in control of this, or if there is work needed with partners.

Phil Shire (PS) asked what the impact will be on the Trust of losing 30-35 roles in corporate services. AS responded that the detail is being worked through at the moment with all executives having been engaged in a piece of work with a company called Meridian who have reviewed the corporate structure of the organisation to identify areas of efficiency and focus.

PS queried why there has been such growth over the last five years that now needs to be reduced. AS explained that there was significant growth as a result of COVID which did not reduce as the impact of COVID reduced.

Anne Magee (AM) added that communications from the Trust have been good, and that everyone was being kept informed as to what is happening but that there was anxiety amongst staff, especially with the message that work will be pushed down from the ICBs into Trusts, and what this will look like. AM stated that staff are anxious about numbers being cut but work being increased.

Margaret Kitching (MK) reiterated how important it is to protect front line staff with the growing complexities of service users the Trust is working with, but also to consider the corporate staff who keep admin work away from front line staff in order to be able to concentrate on clinical work.

John Laville (JLa) highlighted that good staff survey results must mean that staff trust the management of SWYPFT which is paramount, especially in difficult times.

AS reported that there is currently a Value for Money programme running within the Trust with eight key areas of focus.

AS explained that the government have set financial targets including reducing agency usage by 30%, bank usage by 10% and achieving a break even plan.

Daz Dooler (DD) asked if taking on Cheswold Park Hospital had affected meeting costing efficiency targets and AS responded that it hadn't. At the moment the Trust continues to receive support from NHSE for Cheswold Park Hospital.

Darryl Thompson (DT) gave a brief update on Cheswold Park Hospital reporting that staff are working hard to ensure that Cheswold Park is running safely with a high level of quality. NHSE do have oversight of services and the Care Quality Commission (CQC) visit regularly to speak with service users and staff as well as undertake Mental Health Act visits.

DT reported that service users are completing their care pathways and inpatient numbers are up to 71. Feedback from the CQC is that SWYPFT is an open and responsive organisation and they have no concerns about care or services. DT confirmed that NHSE have invited the Trust to submit a case to step down their oversight.

Gary Ellis (GE) reiterated that the Trust achieved efficiencies £20.6m last year with the challenge being that savings need to be recurrent.

PS advised that the Members Council Quality Group held their last meeting at Cheswold Park and agreed that there would be another visit in a year's time. The group were impressed with the work taking place, recognising a lot of work to support integration and improvement is required. PS reported that staff seemed excited to be part of SWYPFT and that he wanted to reflect how impressed the Quality Group had been with the services they at seen at Cheswold Park.

It was RESOLVED to RECEIVE the Chief Executive's comments on the operating context.

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

MC/25/25a Appointment of Non-Executive Directors (agenda item 7.1)

The appointment of Non-Executive Directors' paper was taken as read and outlined the recruitment process. Christine Brereton (CB) confirmed that following a successful recruitment process, the recommendation from the Nominations Committee was for Members' Council to approve the appointment of two Non-Executive Directors, Martin Neeson and Rokaiya Khan.

Members' Council approved both appointments and MBu confirmed that Martin Neeson will take up the post in June 2025 and Rokaiya will replace Erfana Mahmood, taking up the post at the end of Erfana's term in August 2025.

In relation to both appointments, AL advised that the fit and proper person process had begun.

It was RESOLVED to APPROVE the Appointment of Non-Executive Directors.

MC/25/25b Appointment of Deputy Lead Governor (agenda item 7.2)

MBu introduced the item and handed over to Andy Lister (AL) to present. Daz Dooler (DD) was asked to leave the meeting for the item.

AL explained that two nominations were received for the role of Deputy Lead Governor which were discussed in Nominations Committee with the Committee agreeing to recommend Daz Dooler for the role to be ratified at Members' Council. Members' Council approved the appointment of Daz Dooler.

It was RESOLVED to APPROVE the Appointment of Deputy Lead Governor.

MC/25/25c Audit Committee Terms of Reference (annual item) (agenda item 7.3)

AL advised that as part of Good Governance for Provider Trusts it was stipulated that Members' Council should receive the Terms of Reference for Audit Committee.

AL highlighted the Terms of Reference have been updated to reflect the following:

- Receipt of a bi-annual update on the Trusts compliance with the accessible information standard (AIS)
- Review of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
- Receipt of the Freedom to Speak Up Strategy and action plan and review in detail of relevant performance indicators.
- Monitoring of clinical audit via the Quality and Safety Committee
- In line with the Trust Treasury Management Strategy and Policy receives regular updates to on treasury management and interest receivable to provide assurance of appropriate management.

It was RESOLVED to RECEIVE the Audit Committee Terms of Reference.

MC/25/26 Focus on item: Quality Assurance System (agenda item 8)

DT introduced Lauren Melling and Liam Redican to the meeting to present the focus on item relating the Trustwide Quality Assurance System (QAS).

Lauren Melling (LM) introduced herself as the Team Manager for the Quality Governance Team who oversees the Quality Assurance System which is a framework that triangulates data, information and feedback to provide an oversight of quality and culture across Trust Services.

LM presented a series of slides outlining the system and the processes behind it. A dashboard is currently in production which will present data in real time to help identify any areas of concern and provide assurance that teams are performing well. LM explained that Quality Walkarounds are part of the system which are a proven intervention that focus on open and transparent communication and allow service users and staff to provide feedback and highlight any areas of concern.

LM went on to explain the principles of QAS and collaborative working to ensure teams feel supported and enable early identification of any areas of concern. LM explained the three QAS levels and how these are implemented.

LM took the group through the milestones to be celebrated in the development of the QAS and thanked Governors and Non-Executive Directors who have been involved so far in helping to achieve these. LM highlighted the positive feedback that has been received which included 100% of respondents feeling the walkarounds were beneficial.

LM highlighted the next steps for the Quality Assurance System including launching the toolkit across the Trust which will be finalised and published in March 2026.

MBu congratulated the team for the implementation of an internal assurance system of quality and asked if there were any areas that might be hard to pick up on from the QAS. Liam Redican (LR) answered that one challenge would be how the system is used to identify any closed cultures, where soft intelligence and real time feedback will be used to gain additional insight.

MK explained that the key to the dashboard is the real time information, for example if Freedom To Speak Up issues are raised they can be addressed straight away with focussed assurance visits to those areas.

John Lycett (JLy) expressed thanks for the presentation and highlighted that the quality walkarounds he attended have been professional and well received with the system being a positive addition to the Trust.

Claire Den Burger Green (CDBG) reiterated that this system should negate any surprises when the CQC carry out their inspections. CDBG added that it would be helpful to have figures to go with the statistics as 100% of respondents could be just one person. The team agreed to add in figures going forwards and DT confirmed that these will be added in future reports.

DT highlighted that the culture aspect is key and will help make sure the system is embedded in the Trust and ensure staff feel comfortable to speak up and communicate with managers and colleagues.

Subha Thiyagesh (ST) advised that she attended one of the first evening walkarounds at Cheswold Park Hospital, which was a great experience and reiterated how important it is to be able to observe culture first hand. ST reiterated that the walkarounds are well organised and collect a great amount of useful data.

JLa gave thanks for the presentation which put the quality walkarounds into context. JLa confirmed that he had been on a couple of walkarounds and highlighted that in his visits there had been no contact with carers and that it was important to seek carer feedback. JLa added that specific people could be selected to speak to people carrying out the walkarounds. However, JLa stated that the walkarounds did feel “closer to the action” than quality monitoring visits.

MK advised that one of the changes with the new system was access to staff and patients and added that it was important to meet with “experts by experience”.

MK added that carers have been involved in visits. Whether carers are involved can be affected by the timings of the walkaround and availability of carers. LR added that evening walkarounds were introduced to have access to a wider range of people.

AM asked how often feedback is fed back to the relevant teams and LR advised that there is a written report after each walkaround which is fed back to the team during a meeting.

CDBG asked if there are different avenues for people to speak up with any concerns within the Trust. DT responded that the Freedom To Speak Up Guardian is a small part of the approach, with people able to speak up with managers, colleagues or anyone in the organisation. The Guardian role is an additional option. DT reiterated that there are also anonymous routes for people to speak up.

CDBG advised that the CQC offer remote conversations alongside physical visits and asked if this would be offered to staff, carers, service users etc as part of the Trust approach? MK confirmed that remote conversations are ongoing for staff and service users who do not attend sites.

MK reported that 34 quality walkarounds were carried out last year out of more than 230 services. MK added that every service area will have a routine walkaround, some without Executives or Governors but will have a peer review, to enable a service visit sooner and to collect data, which will mean every service will receive an annual visit. Any visit that highlights concerns or the need for a more intensive visit will then receive one.

It was RESOLVED to RECEIVE the Quality Assurance System.

MC/25/27 Members' Council Business Items continued (including annual items) (agenda item 9)

MC/25/27a Quality monitoring visits annual report 23-24 (annual item) (agenda item 9.1)

DT asked for the report to be taken as read and advised that the report is being presented to Members' Council later than expected from the workplan. Future reports will be the Annual Report of the Quality Assurance System.

It was RESOLVED to RECEIVE the Quality monitoring visits annual report 23-24 (annual item).

MC/25/27b Care Quality Commission (CQC) action plan (agenda item 9.2)

DT provided an update. He explained that most organisations have an open action plan in terms of the CQC, in response to inspections

DT highlighted a particular action from the CQC visit was the reduction in prone restraint and the Trust has reduced prone restraint by 43% over the past two years with an ambition to reduce to zero.

DT stated that the action plan was live document which is being continually updated and is regularly presented through Committee and Board.

It was RESOLVED to RECEIVE the Care Quality Commission (CQC) action plan.

MC/25/27c Quality Account Update (annual item) (agenda item 9.3)

DT explained that this was part of the required submissions and has been reviewed in Quality and Safety Committee and Members' Council Quality Group. The final draft will be presented to Committee again next week and devolved authority has been granted for the Chair and Chief Executive to sign off the report for publication by the end of June.

It was RESOLVED to RECEIVE the Quality Account Update.

MC/25/27d Appointment to Members' Council groups (to be taken as read and submit questions in advance) (agenda item 9.4)

AL explained that there is currently one vacancy in Members' Co-ordination Group for a Wakefield public Governor and comms would be sent out accordingly.

AL confirmed that Nominations Committee and Members' Council Quality Group have stipulations that the Deputy Lead Governor will attend which is now Daz Dooler following his election.

It was RESOLVED to RECEIVE the Appointment to Members' Council groups.

MC/25/27e Members' Council groups and Nominations Committee annual reports (annual item) (agenda item 9.5)

MBu asked for the paper to be taken as read and AL explained that updates from all meetings were included in the paper.

AL confirmed that each group had reviewed their Terms of Reference, Annual Report and workplan which has been submitted to Members' Council for approval as part of the governance process.

It was RESOLVED to RECEIVE and APPROVE the Members' Council groups and Nominations Committee annual reports, terms of reference and workplan.

MC/25/27f Members' Council elections – outcome (agenda item 9.6)

AL reported that the Members' Council Elections process occurred between 8 April 2025 and 30 April 2025. There were two positions in Kirklees, one in Wakefield, one in Calderdale, and one in Barnsley. Keith Stuart-Clarke (KSC) was re-elected in Barnsley. Amaina Elzoubir (AE) was elected as the new Governor for Wakefield. In Kirklees, there were four nominations for two seats; JLa was re-elected along with Farida Ali. One vacancy remains in Calderdale, so a mid-year elections will be considered later this year.

AL confirmed that Melanie Mott has resigned as Governor for Psychological Therapies and will step down effective from 27 May 2025. The Trust's constitution provides several options to address this vacancy, which will be reviewed with the Chair and Lead Governor.

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

MC/25/27g Governor feedback (agenda item 9.7)

JLa explained that he had a conversation with a member of staff who mentioned that her service was under particular pressure with long waiting lists and had some vacancies for nurses which were taking a long time to fill due to process of advertising internally first and the extra scrutiny on recruitment. The staff member understood the processes but in the meantime reported pressures in the service were increasing.

DT explained that he sits on the Vacancy Review Panel and provided assurance that where there are roles in areas where there are high waiting lists and clinical pressure, and there is confidence that there are not the appropriate skills internally, these roles are supported for external recruitment.

JLa advised he had received a Healthwatch report for Calderdale and Kirklees and asked how the Trust use such reports. DT explained that Healthwatch reports form part of the insight reports which are collated by the Involvement Team and feed into the "you said, we did" approach within care groups.

JLa highlighted that he and CDBG were both members of the Kirklees Mental Health Carers Forum Group and discussed some of the feedback from the group in the pre-meet. He advised that he understood people don't tend to feed back when everything is going well but do when there are issues. He advised there are individuals who have come to the end of their clinical pathway in the Trust and discharged to primary care who may then feel unsupported.

AM confirmed that there is ongoing work into establishing the responsibilities of teams, the services they provide and how services cross over. There can be issues when a person has exhausted all services within the Trust.

CDBG gave an example of a service user who had been discharged from mental health services but could not get the appropriate medication from their GP who advised they needed the prescription from a psychiatrist.

Elaine Lane (EL) added that pathways and journeys could be better communicated to service users, with better terminology, in order to manage expectations in terms of what services and treatments are available and a timeline for their "journey".

Sarah Leason-Hurley (SLH) stated that no service user should feel unsupported. SLH confirmed that re-referrals from GPs were having a big impact on services for needs such as a prescription. This also causes delays for secondary care for people who really need it. SLH advised that services are looking into ways around this.

DD stated more understanding of what is available in the community is needed.

JLa raised that he felt that carers were not being involved sufficiently. JLa highlighted that communications could be improved by service users seeing the same person within a service every time. Chris explained that shift patterns for staff explained why services users sometimes saw different people and if this was the case it was communicated.

JLa fed back from a recent quality walkaround in North Kirklees Community Services, admin burden had been raised.

JLa reported that Warren Gillibrand (WG) asked if the current financial constraints will lead to a reduction in services and WG confirmed that his questions have been answered and he felt assured.

Valentina McParland (VM) asked if the Trust had single sex wards, if staff have single sex changing rooms, and if service users could request same sex care. MBu confirmed that single sex facilities and changing rooms are available.

It was RESOLVED to RECEIVE the Governor Feedback.

MC/25/27h Integrated Performance Report (to be taken as read and questions to be submitted in advance) (agenda item 9.8)

MK asked that the IPR be taken as read and highlighted the following:

- There are some areas of concern within improving care including risk assessments within 24 hours of admission, which is improving. There has been a negative impact on the implementation of a new care plan but patients who do not have a care plan are followed up individually.
- Clinically ready for discharge is an issue which is being picked up, with system discussions.
- In terms of Great Place to Work, there has been an increase in turnover, mainly due to a lot of fixed term contracts coming to an end.
- There has been a dip in mandatory training compliance with some targeted work to drive this up.
- The Trust is performing well on all quality indicators.
- Out of areas beds are up to five with an ambition to reduce to zero.
- In reference to safer staff there is a large amount of work going into establishments reviews.
- Incident reporting remains within the expected range.
- In the national metrics, there has been significant improvements in paediatric audiology waits due to recruitment into the service.
- Sickness absence rates have improved which have improved the year to date average.

It was RESOLVED to RECEIVE the Integrated Performance Report.

MC/25/27i Governor Capacity (agenda item 9.9)

John Laville (JLa) explained that the work of the governors has increased over the years and presented a slide show highlighting this. In May 2020 there was a total of 13 opportunities to attend meetings which has increased to 95 in 2025.

JLa added that as well as an increase in the number of opportunities, the involvement and influence of governors has increased with governors having more of a voice. However, there are now more opportunities than governors can cover, with more on the way. JLa reiterated that Governors are

volunteers with their own lives and community commitments which leaves the question around what is reasonable and fair.

JLa presented a slide outlining the core requirements of a governor, highly recommended activities, recommended activities and what some governors feel is reasonable. JLa advised that the table will be sent to Governors to populate and reiterated that this is not set in stone and will help ensure that activities are shared out fairly bearing in mind what capacity individual governors have. EL added that the governors are diverse and will bring different strengths to different things

It was RESOLVED to RECEIVE the Governor Capacity.

MC/25/28 Closing remarks and annual work programme (agenda item 10)

It was RESOLVED to RECEIVE the annual work programme.

MC/25/29 Any Other Business (agenda item 11)

None.

MC/25/30 Teaching Trust Status (agenda item 12)

Subha Thiyagesh (ST) explained that In February 2023 the Trust's ambition to be recognised as a Teaching Trust was shared with Members' Council, to reflect the significant teaching, training and research work that the Trust does. Members' Council supported the continued work to progress to Teaching Trust status.

ST outlined the advantages of being a Teaching Trust, including attracting a high calibre workforce and students as well as strengthening applications for research and development funding.

ST explained that the Trust engaged with the University of Leeds in a four stage process. ST confirmed that the Trust has received confirmation from the University of Leeds that they have approved the application to be a recognised Teaching Trust, the first Mental Health Trust in the region to receive this status. This was confidential until joint comms could be agreed with University of Leeds.

ST outlined the next steps in the process which includes considering a name change for the Trust to incorporate 'Teaching', whilst adhering to NHS England guidance. The proposed new name is South West Yorkshire Partnership Teaching NHS Foundation Trust which will be subject to engagement and agreement with NHSE.

The University will nominate a member of staff to be an Associate Non-Executive Director for the Trust. This process will be overseen by Nominations Committee, with recommendation to Members' Council for approval.

ST invited feedback from the Members' Council.

MBu reiterated how much of an achievement it is to have obtained Teaching Trust status.

Bob Morse (BM) mentioned that achieving Teaching Trust status feels like the Trust is entering a new period of growth which will enhance the Trust and the workforce it attracts.

Anne Magee commented that once the news is sharable it will be well received by staff as good news.

It was RESOLVED to RECEIVE the Teaching Trust Status.

MC/25/31 Future meetings of the Members' Council (agenda item 13)

- Wednesday 13 August 2025 (hybrid – venue to be confirmed)

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

Close of public meeting

**Minutes of Mental Health Act Committee Meeting
Wednesday 4th June 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:	Gemma Williamson (GW)	Mental Health Act/MCA Manager (CPH, C&K)
In Attendance:	Julie Carr (JC) Nancy Cartwright Yvonne French (YF) Chris Lennox (CL) Carly Thimm (CT) Sarah Burns (SB)	Clinical Legislation Manager Chair of Independent Associate Hospital Managers Associate Director of Legal Services Director of Services, Adults and Older People Mental Health Mental Health Act/MCA Senior Manager (Trust Wide) PA to Chief Medical Officer/Minute Taker
Presenting	Nigel Beail (NB) Gareth John (GJ) Abbey Downs (AD) Mary McSharry (MMc) Jo Marsden (JM)	Consultant Clinical Psychologist Horizon Consultant Psychiatrist Psychologist Horizon Advanced Nurse Practitioner Lead Matron Associate Practice Governance Coach

MHAC/25/16 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/25/17 Declarations of Interest (Agenda item 2)

The Committee noted that there were no new declarations of interest.

MHAC/25/18 Act in Practice – Horizon QI Project Advance Choice Documents Applied in Learning Disability Services (Agenda item 3)

The presentation by JC, NB and GJ provided an update on the Horizon QI Project.

The independent review of the Mental Health Act put forward that the Advanced Choice Documents (ACDs) should be part of the Act and was accepted by the Government.

An ACD is focused on the care and treatment of a patient's mental disorder. A qualifying patient is defined as a person who has capacity or competence to make the statement and decisions in regard to their care and treatment, who has been or may be detained under the MHA.

The project looked at whether a patient who had a learning disability would be able to complete or could be party to developing an ACD and have greater involvement with their treatment.

A key driver of the MHA Bill is to reduce inequalities, though many people who have Intellectual Disability detained to Assessment and Treatment Units (ATU) do not have the capacity or competence to complete an ACD.

The project aims were to look at:

- The feasibility of using advanced choice documents with patients who have intellectual disabilities who have been detained under the Mental Health Act and admitted to an assessment and treatment unit.
- To determine if ACDs can be used with patients admitted to an NHS Assessment and Treatment Unit (ATU) for People who have Intellectual Disabilities.
- At what point prior to detention could the information be collected

NB stated that another provision within the Act will be that the ICB will be responsible for holding a register of people with learning disabilities at risk of admission to hospital.

Data was collated over a two and a half-year period identifying a programme cohort of 18 people who had been detained under the Mental Health Act. These comprised of:

- 15 male, 3 Female
- Age 18 - 45 years
- 15 White British, 3 Asian
- Previous residence: Family Home 8, Residential 9, PICU = 1

Within the data collated, the project looked what the key indicators that admission was a risk, for example, referral to an intensive support team within the community, placed on the Dynamic Support register and having a Care and Treatment Review, which should be carried out prior to admission. Also looked at a patient's communication skills which were assessed by a Speech and Language Therapist or identified from existing reports with the aim of determining whether patients were able to answer the 10 areas of information listed in the White Paper for inclusion in an ACD.

The programme found that:

- 12 Referred to Intensive support teams (IST)
- 8 Care and Treatment Review (CTR)
- 4 Dynamic Support Register (DSR)

The length of time between trigger point and admission ranged from less than one month up to one year, with the majority being admitted as an emergency. In such circumstances there would have been no time to complete an ACD. No single trigger point for the completion of an ACD was identified.

The findings identified from the project outlined:

- Only two services users were assessed as having the communication skills to be able to engage in interviews about their advanced choices. Both were admitted in an emergency with no trigger for a professional to initiate completing an ACD.
- Eight were assessed as being able to answer some of the questions. Two were still on the ward and agreed to be interviewed though they were only able to answer 2 out of 10 questions, which related to whom to contact about their detention and what they did not want regarding their treatment, which was mainly around injections.
- The remaining eight service users did not have the verbal ability to engage in an interview.

In summary:

- The majority of patients were unable to complete the ACD.
- No obvious trigger point to completing an ACD was identified, raising the need to consider multiple points as to when the document could be completed.
- Identified some predictions about how ACD could be used with people who have intellectual disabilities, for example, the ACD could be completed in a best interest style approach in collaboration with family member/carer.

The areas of learning and challenges from the project

- Opportunity for all clinical disciplines on Horizon to work together and the involvement from the ward staff.
- Completed an in-depth look at a cohort of patients and will now include a further new admission
- Started to identify some predictions about how and when the ACD could be used with people who have intellectual disabilities, looking at alternative ways to be completed which are not outlined in the Bill.
- Constraints and conflicts of time to complete the tasks.
- Admissions and discharges continue.
- The main challenge is how to gather data when many patients are non-verbal or have limited verbal ability.
- Legal ambiguity around the legislation

The next steps of the project will be to look at:

- Trial of a best interest style approach to identifying patient's wishes and preferences by completing the ACD with family/carers where appropriate.
- Develop an easy-read document with the Speech and Language Therapy department.
- Proposing to work with an IST to look at the feasibility of ACDs being completed as part of episodes of care.
- Disseminate to Mental Health Act Committee and the West Yorkshire ICB
- Publication of the findings.

JC stated that the Bill is proposing that the ICBs will hold responsibility for ACDs and that they are to be completed for all patients who may come into a hospital and must be completed for all those who are admitted.

EM expressed that the development of the document would be dictated by statutory and regulatory compliance and questioned whether the Equality and Inclusion aspect had been considered and how digestible was the document in relation to patients with learning difficulties. NB confirmed that work is taking place to develop an easy read version of the document. This had not been piloted at this stage though hope to implement for new admissions going forward.

JC confirmed that the project's starting point was to focus on the Equality and Inclusion aspect, identifying the ethnicity and other protected characteristics of the patient groups. It was noted that this was a small cohort and was considering how ACDs could be applied outside of what will be the statutory requirements to support inclusivity.

The Committee thanked the Horizon team for their continuous work on the project, it was a positive example of how the trust will be practicing more consciously in line with the exceptions of the new Mental Health Act Bill, with the real promotion of choice and voice.

ST noted that the team had reviewed all the case notes in regard to admissions and questioned what particular areas had been the main focus. NB explained that a proforma had been developed which focused on several areas, this included where patients were living at the time of admission to the unit, why they were there, what section they were admitted on, were they on the dynamic support register, had they had a CTR, were they involved with IST and also the timeframes relating to admission. It was also noted that some patients did not have a next of kin who could be consulted to complete the document in a best interest style approach.

ST acknowledge that this approach may prove beneficial to support implementation across the trust, not just on Horizon ward. In terms of moving forward, NB explained that the hope was to pilot with one of the intensive support teams though due to staffing issues this has been postponed until a lead nurse has been put in place. In the meantime, work will continue with carers on the best interest feasibility.

JC explained that one of the proposals of the Bill is that ACDs will be completed with support from an Independent Mental Health Advocate (IMHA). It is currently unclear how this approach will be implemented with people with learning disabilities, or other cognitive impairments.

It was RESOLVED to RECEIVE the presentation from the Update on the Horizon QI project Advance Choice Documents applied in Learning Disability Services.

MHAC/25/19 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 4th March 2025.

It was RESOLVED to APPROVE the minutes from previous Mental Health Act Committee meeting held on 4th March 2025.

MHAC/25/20 Matters arising from previous Mental Health Act Committee meeting held on 4th March 2025. (Agenda item 5)

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

EM stated that the actions have been answered within the body of the papers and advocated that the actions are noted as completed though if any items have not been addressed or any further issues arose this would be covered within the separate agenda items.

- MHAC/25/25/10a – Item will be addressed within the Performance report, agenda item 9.1. It was agreed to mark as completed and the action closed.
- MHAC/24/52a - Item will be addressed within the Performance report, agenda item 10.3. It was agreed to mark as completed and the action closed.
- MHAC/24/35a - Item will be addressed within the Performance report, agenda item 9.1 and the Annual Advocacy Report, agenda item 10.2. YF confirmed that over the last 12 months, there have been five under 18 years admitted into the trust. From a Mental Health Act point of view, checks were carried out at the time as to whether the service user has been made aware of their advocacy rights. An area highlighted was that some of the IMHA services were not providing specialist children's advocacy. Work has been carried out with CT and the advocates, who are commissioned by the local authority, to ensure that the trust has children's advocacy provision across all areas.

CT has monitored the time that those under the age of 18 were within the trust and ensured that the child or young person had been informed of their rights, and if any issues with children's advocacy arose CT supported clinical colleagues to access IMHA services. Any themes will be reported though the performance and monitoring report and incorporated into the annual advocacy report. YF explained that reporting had taken place for any activity with those under 18 years of age, though no themes had been identified over the past year, possibly due to the service users only being admitted to the trust for a maximum of 2 days. This is an ongoing piece of work.

It was agreed to mark as completed and the action closed.

MHAC/25/21 Care Quality Commission Visits (Agenda item 6)
MHAC/25/21a Visits and Summary Actions Quarter 4 including Care Group Assurance Report (Agenda item 6.1)

Over Quarter 4, visits have taken place on Crofton ward and two individual visits to wards at Cheswold Park. All reports were due to be submitted in Quarter 1.

Six issues were identified which are repeat actions that related to out of date care plans and risk assessments. The CQC inspector confirmed that they triangulate records, where this is a change contained within the body of the clinical record they check to see if this is reflected in the care plans or and risk assessment. Where there are changes in risk they look to see if there has been a review of the risk formulation. Where care plans do not have the patient voice section completed though records

clearly identify involvement of the service user and collaborative practice this has been accepted as evidence of collaborative care planning. CQC are aware that a new process is currently being embedded for care plans supported by training. Overall, the CQC are finding good practice.

There were 45 actions opened over Quarter 4, of which 37 have been closed, with 8 open going into Quarter 1. Governance processes are in place providing assurances that the care groups are reviewing the progress of actions and the sign off processes.

MHAC/25/21b Cheswold Park Summary of CQC visits and Actions (Agenda item 6.2)

Two thematic visits have taken place. These focused visits have covered a service user based visit and a seclusion and segregation review, raising 19 actions over the last quarter. Only 2 remain outstanding at the close of Quarter 4.

JC confirmed that the protocol for the head banging was approved in May 2025 and is available on the trust intranet, leaving only 1 outstanding action for Cheswold Park from the focused visits.

GE queried the target date for the full implementation of SystmOne for Cheswold Park. CT confirmed that the switch over date was the 1st April 2025 though in relation to policies and how the systems is used this is currently ongoing.

DT gave assurance that over 97% of staff at Cheswold Park had been trained in SystmOne prior to the switch over and on 1st April 2025 all patients had in place a care plan and clinical risk assessment on SystmOne.

EM queries what was the grading severity process for each action and how this would escalate a concern. YF confirmed that there is no formal grading set by the CQC from a risk point of view, in regard to the internal grading by the trust a RAG rating approach has been used. All actions identified by the CQC are aligned to the Mental Health Code Of Practice which has statutory status, and identifies those actions that are a must do, a should do and a may do which includes those that are quality and improvement and desirable. For example, the 132 rights actions are a must do as these are a legal requirement, and seclusion actions are a should do as these are a recommendation.

YF explained that externally from the CQC, areas that they consider are a risk to service users, or breach of standards, they will issue regulatory notices. For example, if the CQC carried out a review of a seclusion area and this was deemed not fit for purpose, the CQC could use their regulatory authority and close the area, as this has been identified as a potential regulatory breach and may lead to risk and harm to the service user. These would be promptly escalated to Board and the executive directors.

EM noted that the report stated the CQC had identified that reading of rights was not fully compliant though the trust reports stipulate compliance with this requirement. JC explained that the trust report outlines set points where patient's rights are required, at admission, transfers and change to sections, and at time periods of 3 months, and for s.2 at 13 days. The CQC examine in detail a number of service user's clinical

records and triangulate; some patients may have a personalised care plan that stipulates they are to have their rights read every month, the MHA office do not have this information so this activity cannot be included in the compliance report though is what the CQC are reporting on.

DT informed the committee that Cheswold Park had been stepped down to routine monitoring by NHS England. Key evidence submitted included a positive statement of assurance from the CQC and the local CQC inspector, showing the trusts progress, openness and responsiveness to the CQC and the impact of having an internal Quality Improvement Group.

MHAC/25/21c Forensic and Specialist Serviced Care Group Action Progress (excludes Cheswold Park) (Agenda item 6.3)

MMc and JM provided an update on the Mental Health Act activity across the wards.

Over the last year there was a large number of actions for the Forensic and Specialist Services Care Group. However, they currently only have one outstanding action.

The outstanding action relates to Priestley ward and the improvement of IT access for service users focusing on the IT suites, increasing the capacity and obtaining new computer equipment. These have received a positive impact.

In relation to Priestley ward specifically, it was never the intention to have IT access actually on the ward itself though to purchase new computer equipment. Identification and application to an appropriate funding stream has been a challenge and is ongoing.

This has generated a new action relating to IT access, and a pilot project will be initiated on Prestley ward for service users to have internet access directly on the ward

MMc explained that this had moved away from the original intension, though as a care group the intention is to close the action in its original form and continue with the ongoing digital strand of workstreams that are already involved with.

The aim is to also implement the pilot project on Sandal Ward, to mirror the project on both low and medium secure wards, with the intention to apply to all the wards once the findings of the project have been gathered.

Tests have been carried out on the computer and are currently waiting for IT hardware to assist with the prevention of access to inappropriate content in order to complete the final installation.

EM acknowledge the diligent work carried out by the team to ensure that the actions were completed.

MMc raised that one of the significant areas that impacted progression of the actions was the facilities environmental works, taking a protracted route regarding funding, materials and resources, concerns around Infection prevention and control and safety.

EM recommend that the care group raise any areas or alerts of concerns to the Mental Health Act and Mental Capacity Act code of practice oversight group which reports into the committee and then in turn is highlighted through the trust board.

YF outlined that the CQC have a standing agenda item around communicating with service users and carers in relation to reports and questioned whether this has been developed further over the last 12 months. MMc confirmed that the initial interface with service users have with the CQC inspection is the day of the visit with the full opportunity to talk to the CQC reviewer. Initial themes are shared following feedback from the inspector and in detail when the report is received. The CQC have increased the activity of communicating with carers as part of the Mental Health Act inspection process. The carer related events hosted by the Care Group are less popular than the local ward-based activities. They remain a valued opportunity to hear feedback for carers. Surveys had been conducted with carers though had received a low response rate. The activity from service users interface groups continues to be well received. A further route for engagement is through the carers champion who actively contacts carers seeking views to determine the level of communication they would like to receive.

DT expressed the level of progress the care group had achieved and the robustness around the governance for the actions going forward.

It was RESOLVED to RECEIVE the Visits and Summary Actions Quarter 4 including Care Group Actions Assurance Report.

MHAC/25/22 Feedback from Local Partners (Agenda item 7)
MHAC/25/22a Partner Engagement Report (Agenda item 7.1)

CT stated that engagement with services and the Mental Health Act continues to work well.

Following the report an escalation process has been implemented with all the Approved Mental Health Professional leads (AMHP) across the trust and now includes Doncaster.

CT confirmed that 94 nurses are booked to attend social circumstances tribunal training in June and in July, 72 people are due to attend the section 117 discharge planning training. For those who are unable to attend, details will be shared on the intranet.

GE remarked on the media highlighting the issues around mental health patients in distress attending acute accident and emergency departments and was aware that the trust has good relationship with local acute hospitals. GE questioned whether there was any positive data of how proactive these working relationship were. CL explained that there was no actual data though had been engaged in development and improvement plans managed by the acute trust, and the new NHS confederation supported programme that is focusing on service user waits in an accident and emergency department which are recognised as not being an appropriate environment for people with mental health challenges. Investment has taken place around alternatives to accident and emergency departments in Kirklees and Calderdale. CL

suggested that this may be an area the NHS confederation could consider investigating from a base line as part of their project.

ST commented it should be taken into consideration that a number of patients attending accident and emergency departments need to be there due to physical health issues and recommended looking at data in regard to the mental health act detention work.

ACTION: Subha Thiyagesh/Yvonne French

MK stated that the trust is responsive in terms of psychiatric liaison action into acute trusts when a referral is received. MK advised that there needs to be caution applied to ensure that that parity of equities is not ignored in reference to those patients with mental illness who also have serious physical health needs.

DT added that there was a real risk of diagnostic overshadowing and stated that the psychiatric liaison teams have good working relationships with the acute trusts, which offers some assurance that needs are not overlooked.

CL commented that there have been more occasions over the last two quarter where a patient has been detained under section 136 and have been taken to an accident and emergency department, and that this data could potentially be requested from the acute trusts to input into the project work.

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

MHAC/25/22c Independent Hospital Managers Feedback (Agenda item 7.2)

NC confirmed that engagement continues to work well with the Mental Health Act office.

The independent hospital managers are dealing with a large number of hearings with an increase from Cheswold Park.

From the 1st June 2025 Cheswold Park Hospital Managers were integrated to the trust Forum to establish a single body of Hospital Managers. There remain a few individual concerns though these will be raised and responded to through the personal reviews.

A recruitment programme will be put in place following a review after the next committee meeting.

It was RESOLVED to RECEIVE the Independent Hospital Managers Feedback.

MHAC/25/23	Risk Registers (Agenda item 8)
MHAC/25/23a	Consideration of the items from the Organisational Risk Register (Agenda item 8.1)
MHAC/25/23b	MHA Committee Risk Register (Agenda item 8.2)

EM explained that whilst the Organisational Risk Register (ORR) does not identify the Mental Health Act Committee as the lead for any identified organisational risk, the Mental Health Act Committee considers the ORR as a whole to identify whether there are any risks that may have an impact for the Mental Health Act or Mental Capacity Act.

EM identified a correction to the report to be noted by the committee. JC confirmed that this was due to considering introducing for discussion existing risk 1530 which relates to capacity of services, existing waiting and access to services due to triangulation with findings from the CQC briefing and also in relation to risk 1319 for children accessing beds that is already stated on the report. Following discussions with ST and YF it was agreed to remove this from the report as it was considered that this had been sufficiently covered. The action had inadvertently not been removed from the report.

JC stated that there was no change in terms of levels of grading or any additional information received.

There have been occasional delays accessing to the AMHP service arising from notified limitations on specific services. This has not resulted in any patient being disadvantaged by service availability.

The trust's new strategic objective colours have been added to the report, though the content had not been changed.

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/25/24	Statistical information use of the MHA 1983 and MCA 2005 (Agenda item 9)
MHAC/25/24a	Performance Report – Monitoring Information, Quarter 4, January to March 2025 (Agenda item 9.1)

CL confirmed that the area raised previously by GE in relation to the proportion of patients detained on admission in Barnsley, is steadily increasing and continues to be a trend, though there are some variations in locality. With the relatively small number of beds in Barnsley and the presence of a PICU there would be a higher portion of patients formally detained and the occupancy levels in Barnsley over the last quarter may be a contributing factor. CL advised that any trends and understanding of any insights will be addressed through the Care Closer to Home and the In-Patient Improvement programmes.

Of patients who are assessed in the 136 suite, 51% do not require admission to hospital and of the 49% who are admitted to hospital a high number are as informal admissions.

CL expressed concerns as to whether we are utilising all opportunities both at the point when the police contact the Trust to discuss bringing someone into the suite on a section 136 and also the crisis points within the community. Systems work is taking place in Barnsley with investment from the ICB. Mental Health Matters or Touchstone is to provide a crisis service though experiencing some challenges with connectivity. CL felt that need to explore further whether there are alternatives to the use of the suites.

One death of a 67-year-old male from natural causes, pneumonia, which is being reviewed for any contributory factors, such as how his physical health was being managed.

Positive performance with Section 17 escorted leave both in forensics, where there is a higher portion of planned leave and in acute services.

One under 18-year-old admitted for 2 days this quarter. There were seven under 18s admitted in the previous. CL described that with every occurrence this has an impact on the system and is working with DT on an after-action review on a young person's journey which outlines the various challenges and how best to support to get them on the right pathway. We continually need to assert this to NHS England and commissioners around how young people can get to the right place at the right time when they do require an admission.

MK questioned whether the 2.5% increase in the use of the act outlined in the report was a positive or a negative. CL perceived this as a positive, as this was a reflection as to those who do not need to come into hospital are not being detained. This was in line with national proportions though was aware that some trust only admits detained patients.

MK remarked that the risk in relation to the pressure of capacity for beds had been raised at the Quality and Safety committee whether this should be included on the risk register. CL confirmed the access to beds was already on the ORR with an amber rating and continues to be an ongoing challenge.

GE questioned that the charts detailed on the report that related to patients being detained under section 5(2) was over 72 hours. JC explained that the two charts referred to an incident where the review by the consultant exceeded 72 hours which is now being investigated. Approximately 32% of patients admitted informally are being made subject to Section 5(2) within 24 hours of admission.

GE questioned the numbers relating to the open Community Treatment Order (CTO) outlined in the report. JC confirmed that this is how the figures are extracted from SystemOne though ensure that the number of open CTO's are correct by analysing the registers manually.

ST confirmed that at the next Quality and Safety Committee there will be a discussion around patient flow and the increase of section 136.

ST questioned the figures in relation to admissions under the Mental Health Act, the figure for Barnsley was quite high at 61% and Kirklees quite low at 40%. CL confirmed that this is due to a PICU in Barnsley and no PICU in Kirklees and there has always been local variations. CL said that Kirklees IHBT have a lower threshold for admissions, though have a large number of beds in Kirklees and know to access via the gate keeping process which is a focus for the Care Closer to Home improvement.

It was RESOLVED to RECEIVE the Performance report – monitoring information January to March 2025.

**MHCA/25/24c Cheswold Park Care Group Performance Report
(Agenda item 9.2)**

CT highlighted that the current number of patients detained at Cheswold Park was 72.

No further comments were raised by the committee.

**MHAC/25/25 Audit and Compliance (Agenda item 10)
MHAC/25/25a Section 132 (patients right's) – MHA Office Deep Dive
(Agenda item 10.1)**

CT confirmed that the deep drive in relation to section 132 was currently at 98% compliance for in-patients and informal patients, with a 100% compliance for rights under section 132A for the CTO patients.

Work is being undertaken on Systmone with the design team regarding reasons as to why patients do not understand their rights, which will enable staff to add more details into the free text box to provide a more visible account to assist staff and also provide explanation to the CQC.

Over the next 12 months implementation of the community white board for the recording of rights will take place.

EM highlighted action 1 detailed on the report rated as red: To work with SystmOne and clinical leads to track and improve the giving and recording of patient's rights without requirement for the MHA office prompt system.

It was initially agreed for the Mental Health Act office to support with compliance though this entails a large amount of administration work and EM remarked that this is an area which should be embedded back into clinical care groups to manage and proposed to take this area to trust board as part of a AAA report.

CT explained that discussions had taken place with the Systmone design team around the possibility of sending electronic alerts via the system, though due to the complexities of the section 132 rights and other areas, SystmOne would not be able to facilitate this.

ST confirmed that this is area will be investigated as part of the digital innovations, looking at other systems that could possibly be considered to assist.

MHAC/25/25b Annual Advocacy Service Report (Agenda item 10.2)

CT highlighted advocacy compliance is at 95%. Received 1635 contacts and referrals through advocacy within the last year.

The advocacy engagement groups continue to work well and agreed the meeting will now be held bi-monthly with the Mental Health Act bill as a standing agenda item to ensure that advocacy have a voice with any changes going forward.

EM highlighted action 6 detailed on the report rated as orange: To develop Independent Mental Capacity Advocate (IMCA) reporting into the annual report. This will be implemented later in 2025.

MHAC/25/25c CTO Deep Dive (Agenda item 10.3)

EM explained that the report aimed to provide background data to scope an understanding of differences between the trust and national CTO activity trends, with trust activity being highlighted as -

- 40% of patients who were recalled on a CTO and then revoked are for patients experiencing multiple readmissions.
- 91% of patients recalled were later revoked from the order for a period of inpatient admission.
- 66% of those revoked were from a White ethnic group
- 57% of patients subject to a CTO identified as being White.
- The most common age group for current CTOs is 45-54 years of age, which is higher than the national average of 35-49 years of age.

EM commented from a national understanding of ethnicity, Black and Caribbean men would be an outlier figure in terms of applications of CTOs, though in our trust data, it would appear to be Indian and Pakistani people with the Indian cohort being higher.

CT remarked that CTOs are being appropriately used and managed within the community, with no areas of concern from the report.

MHAC/25/25d Annual MoJ Restricted Patients Report (Agenda item 10.04)

JC outlined that the report was limited due to this being only the second report published by the Ministry of Justice (MoJ). The report was published at the end of April 2025 and covers the previous calendar year.

With an understanding of the report format, we will now be in a position going forward to work with Performance Management and Business Intelligence (PMBI) team, which will enable the team to set parameters within the system and extract a greater range of comparative information.

The trust activity is generally comparable with nationally reported activity rates. There is a deviation with the rates of prison transfers reported nationally at 63% and at 50% of Trust restricted patient activity.

Nationally there were a small number of absolute discharges made, predominantly by the Tribunal Service. Within 2024 there were no such discharges made for restricted patients under the care of the Trust.

Conditionally discharged patients recalled to the Trust may be admitted to either a forensic or mental health ward. JC suggested that future annual report may help to develop a better understanding of where patients are being admitted to and the impact on services.

Patients from Cheswold Park had not been included due to the lack of data though this will be introduced into next year's report as we will have 12 months of activity.

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

MHAC/25/26 Legal Briefings (Agenda Item 11)
MHAC/25/26a MHA Bill Update (Agenda Item 11.1)

The Mental Health Act Bill is progressing. Since moving into the House of Commons the first and second readings have completed and will be entering committee stage on 9th June. There is currently a call out for submissions of evidence.

JC explained a point of contention is the introduction of the extension of powers under section 135 and section 136 to hospital staff though unclear of the details as would still require the police for the power of entry.

Amendments from the Lords include the extension of the power of application under the Mental Health Act to the police for section 2, section 3 and section 5(4).

ST recently presented at trust board the potential changes in relation to the draft Mental Health Act Bill, outlining what is happening, the pressures to services with significant impact to clinical services and the Mental Health Act office and the awareness of statutory timeframes.

MHAC/25/26b CQC Monitoring the MHA Annual Report (Agenda Item 11.2)

JC explained that the report is informed by Mental Health Act inspections to wards across the country. The report is retrospective identifying themes arising from activity over 2023/24 though informs the focus of inspections occurring over 2025/26.

Six key themes were identified and with details outlined in the report:

- CQC and the Mental Health Bill
- Systems
- Workforce
- Inequalities
- Children and Young People
- Environment

MHAC/25/26c

CQC State of Care Annual Report (Agenda 11.3)

JC stated that the report is retrospective addressing a review of health and social care provisions in 2023/24. The report acknowledges that staff are carrying out a difficult job within difficult times identifying system wide concerns involving safety, quality, workforce and inequalities.

Data shows there is an increase of people who are accessing services and a lack of understanding of how to navigate health care systems putting further pressure on accident and emergency departments.

Mental health provisions were found to be impacted by high bed occupancy rates, which is a known indicator of pressure on other areas of the health and social care system. Concern is noted that continued pressure may lead to a lowering of standards or care.

EM highlighted to the committee the details stated on the report for the challenges affecting access and quality in health and social care: "People from the most deprived areas are 3 times more likely to have a hospital admission to access treatment that could have been avoided if timely access to effective care in the community had been available to them".

EM requested DT, ST and MK consider the statement as part of the Quality and Safety committee.

ACTION: Darryl Thompson/Subha Thiyagesh/Margaret Kitching

It was RESOLVED to RECEIVE the legal briefings

MHAC/25/27

**MHA/MCA Code of Practice Oversight Group
(Agenda item 12)**

MHAC/25/27a

AAA Report (Agenda item 12.1)

JC confirmed that this was for information and was taken as read.

No further comments from the committee.

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

MHAC/25/28 Key Messages to Trust Board and other Committees (Agenda item 13)

Messages for Trust Board agreed as:

Alerts from the AAA report:

- Compliance – patient rights (Pressures on the Mental Health Act Office)
- Independent Hospital Managers integration Cheswold Park

Advise from the AAA report:

- CTO Deep Drive Findings
- Mental Health Act Bill
- Ministry of Justice report
- Challenges of access to primary care and talking therapies

Approval from the AAA report:

Assurance from the AAA report:

- CQC and Mental Health Act Visits
- CTOs
- Advocacy

MHAC/25/29 Work Programme (Agenda item 14)

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 Wednesday 27th August 2025 at 14:00 to 16:30 via Microsoft Teams

EM closed the meeting.

**Minutes of Quality & Safety Committee
Tuesday 8 July 2025
9-11.30
Hybrid**

Present:	Margaret Kitching (MK) Nat McMillan (NM) Mike Ford (MF) Darryl Thompson (DT) Adele Fox (AF) Dr Subha Thiyagesh (SThi)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Operating Officer Chief Medical Officer
Apologies:	Julie Hall (JH) Yvonne French (YF)	Deputy Director of Corporate Governance Associate Director of Legal Services
In attendance:	Amanda Dixon (AD) Amy Hartley (AH) Kate Dewhirst (KD)	PA to Chief Operating Officer Deputy Director of Nursing, Quality & Professions Chief Pharmacist (for item 16)
Observing	Martin Neeson	Non- Executive Director

QSC/25/73 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/25/74 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/25/75 Minutes from previous Quality and Safety Committee meeting held 10 June 2025 (agenda item 3)

The minutes of the 10 June 2025 meeting were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 10 June 2025 as a true and accurate record.

QSC/25/76 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/25/49 Minutes from the previous Quality & Safety Committee meeting held on the 13th May.

The local relationship manager from the Care Quality Commission (CQC) attended the Quality Improvement Group meeting at Cheswold Park Hospital (CPH). It was suggested that the CQC could undertake some focused time within CPH, which would be over and above the Mental Health Act Inspections, to assist with learning and provide assurance without triggering a rating. MK added that at the meeting, she presented a challenge to both the CQC and the Commissioning Hub (CH), asking if they could provide their perception of CPH as external organizations. The response was positive from both agencies.

The group discussed whether there were any implications for the Trust from the previous rating of inadequate for Riverside Health (formerly CPH) in terms of admissions. Darryl Thompson (DT) informed that on the CQC website, the inadequate rating is still aligned to the previous provider, Riverside Healthcare. However, since the Trust has taken over this service (CPH), it is documented as being 'unrated.' Any restrictions to admission were against Riverside Healthcare, so there have been no restrictions to admissions for the Trust from the CQC since we became the provider.

It was agreed that this action can be closed, given that there is an action already in place as part of an 'alert, advise, assure'.

QSC/25/53 Executive Perspective on Quality (CMO/CNO)

DT will be taking the suggestion of the development or adaptation of a strategic risk around agency and bank staffing changes to the executive management board (EMT).

QSC/25/57 Care Group Quality & Safety Report

The new iteration of the combined above report and the Chief Nursing Officer and Chief Medical Officer (CNO/CMO) will be presented to the Committee today. Closed.

QSC/25/68 Work Programme

The meeting to review the above has now been organised. Closed.

QSC/25/46 Private Risks for Committee.

DT has discussed with Andy Lister, Head of Corporate Governance, in relation to moving a private risk into the public domain and it was agreed to have a discussion at EMT on this and how to treat the wider risk and implications.

QSC/25/11 Patient Experience Update

The updated to the report is on the agenda today.
Closed.

QSC/24/210 IPC BAF

The updates have been added to the report for the meeting today and this item can be closed.

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/25/77 Review of Committee related risks – update following Board discussion (agenda item 5)

The report was taken as read.

The Committee were happy to recommend the suggested changes for Trust Board.

It was RESOLVED to RECEIVE the update.

QSC/25/78 Staff / Team Story (agenda item 6)

No attendees for this month.

QSC/25/79 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 7)

The paper had been circulated to all members and was taken as read. DT advised that this item was a new report which merged both the above and the Care Group Quality Report to enable the Committee to be more streamlined, and DT welcomed comments on both the structure and content.

The overall consensus of the Committee was that they were happy with the structure and the merger of the documents. It was acknowledged that the content may become more complicated as the environment of the organisation continues to change over the coming months. There was an emphasis on the report remaining clinically led and operationally delivered.

SThi shared that in terms of temporary staffing, some prospective Consultant candidates from nearby organisations are asking how the Trust is managing to focus on quality and the temporary staffing situation, and how clinical leadership is being maintained. The Trust is managing this well, which is positive for potential candidates as the Trust has maintained its focus on quality and safety in these challenging times.

DT advised that later on the agenda there is reference to the re-published national quality board position and the expectations therein.

This item will be renamed on the work plan as the Executive Trio Update going forward, and the work plan will be amended accordingly. It will remain at item 7 on the agenda.

Action: SLH

In terms of breaches, acuity, and patient flow, AF advised that not all the breaches noted relate to the Trust, and therefore there is work underway to ascertain which, if any, breaches relate to the Trust. MK noted that a breach strategy for the Trust's own beds would be beneficial, and AF advised that there is a new pilot taking place in Barnsley where this is happening.

There is an escalation process from the acute trust which takes place every day, and our Trust will now be added to this list to determine the Trust's breaches. This is a very positive step. DT added that the new Chief Nurse for Calderdale and Kirklees Places is also advocating for this kind of process going forward.

It was RESOLVED to RECEIVE the merged reports of the Care Group and Quality Report and the CNO and CMO update.

QSC/25/80 Quality Assurance System Update (agenda item 8)

This report was taken as read.

- DT noted the comprehensive report which now contained a full list of services and teams within the Trust. This will continue to be developed.

AF raised a query relating to the Intensive Home-Based Treatment Team (IHBTT), where the report shows no issues; however, AF is aware of some concerns within the service. DT confirmed that discussions have taken place with the Associate Director responsible for the service, and prior to any quality walkarounds, there will be engagement with the leadership team to understand any concerns to date (if any), so conversations can be targeted. MK added that peer review visits could help with these kinds of issues.

Mike Ford (MF) added a couple of observations relating to Trust themes and was very pleased to see these added to the report. He noted that the full list of services and wards was a great addition, although he acknowledged the vast list and the places which are yet to receive a visit. DT advised that all the services and wards have operational oversight and that visits will take place as soon as feasible. Executive Directors and non-executive directors (NEDs) do visit services and wards regularly. MF had a question relating to the follow-up visits, noting that it would not necessarily be the same people who undertook the initial visit, which can leave unanswered questions from the first visits. DT advised that the Quality Governance Team has oversight of how the actions are progressed and that the quality and operational leads have the responsibility for implementing these. MF would like a discussion with the team to ensure that the actions have been followed through. DT will speak with the team on this.

Action: DT

NM echoed MF's points and noted that this will be mentioned in Members' Council meetings from the Governors. MK added that the peer review process could really help with the closure issue. It was noted that a lot of the information is contained within the Integrated Performance Report (IPR) and that further triangulation could help with this.

The Committee RECEIVED and NOTED the update.

QSC/25/81 Patient Experience Update (agenda item 9)

This report was taken as read.

MF raised a query on page five of the report where it noted, "the Trust has agreed an internal key performance indicator for measuring performance. Currently, this is not measured, having ceased during the COVID-19 pandemic when services were working differently and a backlog in complaints was seen.

MF queried whether implications of this have been seen. DT advised that during this period, response times were given a 40-day turnaround, which was agreed in EMT. This was not a national requirement at the time. MF was concerned that with the removal of this data, the Trust could have drifted slightly in terms of data collection. MK added that the Trust has always been very good at meeting the targets set for complaint responses and did not have any concerns with the Trust's current performance. The group acknowledged that there is always room for improvement and learning.

NM raised a point on page two of the report in relation to forensics, where it notes an increase in satisfaction around the involvement of carers and families and also the Triangle of Care, which she thought was very positive. She asked that this be tracked into the next quarter to see whether there is a sustained improvement. DT will feed this back to the team.

Action: DT

It was RESOLVED to RECEIVE the Patient Experience Update

QSC/25/82 Care Group Quality and Safety Report (agenda item 10)

This item was taken at item seven, there will now be a new combined report for Committee.

QSC/25/83 NICE Annual Report (agenda item 11)

This report was taken as read.

MF queried whether this report received any kind of external assurance or audit. MK noted that Commissioners seek assurance from the Trust to ensure that we are adhering to NICE guidance and evidence-based best practices. MF would like the external assurance aspect to be checked.

Action DT

The Committee RECEIVED and NOTED the NICE Annual Report

QCS/25/84 Reducing Restrictive Practice (RRP) Annual Report (agenda item 12)

This report was taken as read.

AH advised that since this report was written, the alternative seclusion exit training had now gone live for staff, and focus sessions continue.

MF had some confusion with a graph on page nine of the report in relation to restraint data and analysis and the adjustment of process limits. MF assumed that this was a step change that took place in the Statistical Process Control (SPC) chart at the start of 2024/25; however, he didn't note a step change in the SPC chart when the Trust acquired CPH. AH was unsure as to why there was not a step change to reflect CPH. Anecdotally, some of the incidents from CPH have had very good de-escalation skills, which come through in the Datix reports, therefore not showing an increase in overall restraints despite taking on the extra significant bed base. MF suggested that as the SPC chart reflects anticipated incidents, this could make it appear that performance is underplayed as CPH is not included.

AH will take this query back to the team.

Action: AH

The Committee RECEIVED and NOTED the RRP Annual Report.

QCS/25/85 Internal Audit Reports (as appropriate) (agenda item 13)

DT noted the following two audits for Committee to reflect on. Both documents received moderate assurance and both have action plans and timescales.

Medical Devices

AF raised some concerns in relation to medical devices and expressed that the only real solution to the problems would be to have a clear digital solution. The current processes are far too time-consuming, which reflects on staffing pressures for both the teams undertaking the audit and the staff on the wards. Progress has been made; however, a better solution is needed. MF asked AF whether her previous employer had a digital system for medical

devices. She confirmed it didn't, but the system was deemed better. It was noted that Mid Yorkshire has a digital system, and Nick Phillips, Head of Estates, has been asked to look into this for our Trust. There will be cost implications; however, there could be the possibility of applying for grants. MK echoed her concerns and the potential risks to patients of using uncalibrated devices and would like a planned approach. DT confirmed that an update on medical devices was brought through the Committee a short while ago, which provided assurance around the focus of this, and it was aligned to a Director of Service to help maximise engagement and the existing contracts held. The integrated change team is now looking at this to consider how it can be improved further through a quality improvement approach, together with data cleansing.

DT also wanted to acknowledge the services where this system has worked well and they are compliant.

Governance CQC Action Plan

MF queried whether there was anything within this report that would have implications on the accuracy of the report that has been sent to the Trust Board previously. It was confirmed that it would not.

The RECEIVED and NOTED the Internal Audit Reports.

QCS/25/86 Pressure Ulcer Annual Report (agenda item 14)

Alison Thomas (AT), Assistant Director of Nursing, Quality & Professions, joined the meeting today to present the annual report and to answer any questions from the Committee members. The report was taken as read.

SThi raised some questions regarding education and training and whether this would reach the mental health Care Group inpatient teams. AT confirmed that this is the case. SThi also queried whether there had been any in-reach to teams, as she had noticed that The Poplars seemed to have higher incidents of pressure ulcers compared to other bed-based wards. AT confirmed that work has taken place at The Poplars with pressure-relieving devices, enabling staff to spot any signs early and put action plans in place, which has helped improve the situation. It is to be noted, however, that the Poplars does have some complex patients, and compliance can be difficult at times. Further training with the advanced clinical practitioners (ACPs) will be underway soon and can be filtered through to the wards to assist further.

SThi asked whether Ward 19 had experienced any pressure ulcers, as they were not present on the table within the report. AT will check whether there were no pressure ulcers to report or if this was an omission.

MK asked whether the Barnsley Tissue Viability service covered The Poplars. AH confirmed that they do not. MK had concerns that as a Trust, we cover a vast area; however, the services are not providing cover for the whole of our footprint, but acknowledges all the hard work that is taking place. Also, based on the incident reports that have been seen, it could suggest that there is no suboptimal care for inpatient patients as there is no evidence. AH confirmed that work is underway, care plans are being considered, and the work and training with the ACPs could help with this.

AF asked whether any of the pressure ulcer cases had progressed to sepsis. AT advised that none of the cases reported last year developed into sepsis; however, there is a lady who developed a pressure ulcer this year and unfortunately died in acute care, and this is being looked into. AT confirmed that the Trust does have sepsis training in place.

DT advised the Committee that there is a proposal to move away from Datix for the reporting of pressure ulcers and to use SystmOne instead. This will be discussed in EMT before any decisions are made.

The Committee RECEIVED and NOTED the Pressure Ulcer Annual Report.

QCS/25/87 NMET Annual Report (agenda item 15)

This item was deferred to the September meeting.

QCS/25/88 Drug & Therapeutics Annual Report (agenda item 16)

Kate Dewhirst (KD) attended the Committee to present the annual report. The report was taken as read.

Key highlights from the report include:

- Work on STOMP, stopping over-medication of people with learning disabilities and autism.
- Electronic prescribing.
- Significant reductions in the prescribing of propranolol and clonazepam.
- Digital prescribing.
- Primary care mental health.

DT acknowledged the comprehensive annual report, noting the links to NICE guidance and the great support received from a large number of non-medical prescribers and the number of teams they are working with.

MF echoed the above and noted the great level of compliance. However, he noticed an issue on page nine of the report regarding the pharmacy and medicines optimisation strategy and an incomplete action for “develop reporting to support cost-effective prescribing” and asked whether there were any potential solutions to this issue. KD explained that there are two contracts with third-party pharmacy providers. CPH has a current contract with an independent pharmacy. Barnsley services used Lloyds Pharmacy, which left the market this year, and this transferred over to Rolands Pharmacy. The information required to complete the actions has been acquired, and the outstanding action will be updated thereafter. KD added that all pharmacy contracts will be considered this year in relation to productivity and financial savings.

NM asked about stopping the overprescribing of medication and how this would happen initially and what the impact would be. KD advised that there are multiple factors to consider and that the term overprescribing isn't very clear. Factors could include:

- People being prescribed medicines that they no longer need.
- Prescribing medications instead of considering social prescribing.
- Changes in medication/additions.
- Over-ordering of repeat prescriptions.

The Committee was pleased to hear the focus on patients and service users throughout this report.

The Committee RECEIVED and NOTED the D&T Annual Report.

QCS/25/89 Sexual Safety Report (agenda item 17)

This report was taken as read.

NM acknowledged that the report sets out the governance, processes, and what is happening and queried whether there will be a report that sets out the themes. AH confirmed that there will be an annual sexual safety report coming in September and that staff reporting is a new process that will be added. The level two training for this will commence on 1st August 2025.

MF asked whether there was a direct link with the freedom to speak up process, which AH confirmed there was, and that the guardians and staff side colleagues will also be completing the training.

MK was pleased to see the strengthening of the governance within the report but would like to see a quarterly update on incidents to build confidence in the new processes. DT added that a report also goes through to the People and Remuneration Committee (PRC). NM agreed that quarterly updates would be beneficial to both Committees for alignment. This will be added to the workplan.

Action: SLH.

The Committee RECEIVED and NOTED the Sexual Safety Report and recommended for it to be received by Trust Board.

QCS/25/90 IPC BAF (agenda item 18)

AT presented the IPC BAF report and to answer any questions from the Committee members. The report was taken as read.

AT confirmed that this report is brought to the Committee every six months and is being updated constantly. The report now includes CPH; however, they have a separate action plan given the work that is needed.

AT noted that there is partial compliance on section 6.5, which is around the FFP3 mask fit testing required for staff in some of our areas. The IPC team has a system in place and is accredited to provide the training; however, it was noted that it is quite laborious and can take around one hour to complete for each person. The sessions are provided once a week and can cause issues, with an 18% fail rate. This can be caused by factors such as having a beard, or face shape. Areas have been prioritized from an exposure point of view.

MK queried whether the testing was required for all frontline staff or just for staff who provide Electroconvulsive Therapy (ECT). AT confirmed that it is required for any member of staff who could potentially come into contact with a respiratory infection, which now includes chickenpox.

MK asked whether we have been benchmarked against other organizations. AT noted that she is aware that all organizations are struggling with this issue and it has been raised at an ICB and national level.

SThi queried whether a mandatory training passport could be used for training and compliance, so if staff have been tested in another provider, they will still be compliant. AT confirmed that they can be used; however, she advised that according to Health and Safety Executive (HSE) guidance, FIT testing has to be done every two years.

MK would like to see a measure of what people are believed to be in the risky services (e.g., ECT) against the expectations of all staff being FIT tested.

AT confirmed that 773 staff require training and a further 500 have come to the end of their two years.

The Committee was happy to recommend this report to be received by the Trust Board.

The Committee RECEIVED and NOTED the IPC BAF and recommended for Trust Board

QSC/25/91 Premises Assurance Model Annual Report (agenda item 19)

It was agreed that this report would now be transferred across to the Audit Committee.

The workplan will be updated.

Action: SLH

QSC/25/92 Acuity in SWTPFT Delivered Services (agenda item 20)

The report was taken as read. It has already been presented to Trust Board and is presented to Committee for more detailed discussion if required. The Committee added that they found the report to be helpful.

MK noted that there was some confusion among some members of the Trust Board about the different types of acuity that can affect people with physical diseases, mental health diseases, or a combination of both, and this paper really assisted with understanding. MK wondered, however, with acuity being significant in relation to fill rates, risks, incidents, and staffing models, and the national position to be driving down agency and bank staff usage, there is a concern that this will have an impact on safety and quality in Trust services.

AF advised that in the temporary staffing meeting which took place yesterday, there was further assurance provided around the fluctuations. Over the last two weeks, in working-aged adults and older adults, agency and bank usage has come down because of the separation of safety and quality. By reducing agency usage (by recruiting substantive staff), the quality will improve, ensuring this will not impact safety.

MK suggested that this would sit within the new version of the Trio report and also with the SPC chart, ensuring that clinical safety, clinical effectiveness, and patient experience are the golden threads.

QSC/25/93 Clinical Audit and Service Effectiveness (CASE) Annual Report (agenda item 21)

This report was taken as read.

T informed the group of the commitment to the clinical audit both nationally and regionally. MF queried whether this was the right report to use to provide the link to the Audit Committee to ensure they have oversight of the clinical audit or whether the Quality & Safety Committee Annual Report would cover this aspect.

DT and MF will discuss this outside of the meeting.

Action: DT

MK queried whether the Quality & Safety Committee directed any of the clinical audits for the annual plan. DT confirmed that this would sit within EMT.

MK also noted that the Committee is the oversight for quality and safety for the organisation. Therefore, when the planning of the clinical audits is taking place, would the Committee not provide thoughts or advice on these? An example of this is to ensure that there is assurance from past incidents that learning has taken place. MK suggested that a look-back audit could be a solution and asked whether there is a process already in place. DT advised that, as an example, there has been a thematic review of choking incidents, which brought in an external view of the five incidents that had taken place to ensure that they had been investigated

appropriately and that actions were embedded. The patient safety improvement group also has strategic oversight of incidents and therefore a look-back of 10 years of incidents that stand out will be discussed through this group, e.g., inpatient deaths, homicides.

DT noted that at the end of the agenda, there is an item which refers to any risks that the Committee would need to discuss further and whether the addition of a further standing agenda item would be useful, noting anything for consideration in the annual clinical audit plan. It was agreed that the annual report was sufficient but to compare the audit plan with the risk register. MK would like the proposed clinical audit areas to be brought to the Committee to seek a view. MF advised that this sits with the auditors as the plan is being discussed and that MK could join this meeting.

The Committee RECEIVED and NOTED the CASE Annual Report.

QSC/25/94 Reports from Formal Sub-Committees (agenda item 22)

Updates were received and taken as read and it was noted that there is a quarterly sequence of the 'alert, advise, assure' (AAA) reports for the Committee.

Item 22.6 Medical Devices AAA

MF asked about an incident in the report relating to the failure of a piece of equipment and queried if there was anything to be concerned about. AT confirmed that this is in hand and meetings have taken place to discuss the details. The item had not been serviced and had a broken charger.

Item 22.7 Pressure Ulcer AAA.

MK wanted to raise her concerns that the Trust doesn't have its own tissue viability coverage in our services, particularly in our inpatient areas. DT noted that there was coverage from local community providers for all inpatient services outside of Barnsley (where our own team covers).

The Committee RECEIVED the updates.

QSC/25/95 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 23)

Alert

- Committee received the Internal Audit Report on the oversight of medical devices and noted that the finding of the auditors was 'moderate assurance'. Committee requested an update report to ensure an update is received on the performance of medical devices servicing, triangulated with the findings and actions of this audit.

Advise

- Committee members suggested that the executive management team review the wider risk of the older people's transformation, given that the Trust is now in a post-consultation phase.
- Committee members discussed the ongoing contact with the Care Quality Commission at Cheswold Park Hospital, noting the continuation of the plan for CQC inspectors to maintain a view of care via Mental Health Act CQC visits and additional visits to review any shared areas of focus.
- Committee members noted and agreed to the suggested changes in the organisational risk register risks that align with this Committee.

- Committee members received and noted the quarterly patient experience update
- Committee members received and noted an update report on sexual safety in the Trust. Agreed that going forward this would be received quarterly by Committee from the perspective of service user sexual safety, with a recommendation to the People and Remuneration Committee that this report is also submitted there quarterly from the perspective of staff sexual safety.
- Committee received the Clinical Audit and Service Effectiveness (CASE) annual report. Agreed that going forward, planning of clinical audits for the year ahead will be informed by topics identified in Quality and Safety Committee.
- Committee received the Internal Audit Report of the governance around CQC Action Plan sign off, and noted that the finding of the auditor was 'moderate assurance'

Assure

- Committee members received the Trust's National Institute for Health and Care Excellence (NICE) annual report, with a discussion of exploring the potential of seeking external assurance of our approach.
- Committee members received and noted the Drugs and Therapeutics Annual Report on behalf of Trust Board.
- Committee members received the Infection Prevention and Control Board Assurance Framework (IPC BAF) bi-annual report and recommended that it be submitted to Trust Board. Committee noted the one area of partial compliance (FFP3 mask fit testing) and suggested the development of a local denominator against which to measure progress and compliance.
- Clinical Acuity will now be a standing item on the Executive Trio Update to Committee.

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

QSC/25/96 Risk Register review (agenda item 24)

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/25/97 Work Programme (agenda item 25)

A meeting has been arranged to discuss the streamlining and review of the work programme.

QSC/25/98 Date of next meeting (agenda item 26)

9 September 2025.

Minutes of the Finance, Investment & Performance Committee
Held on 21 July 2025
(Virtual meeting, via Microsoft Teams)

	Gary Ellis (GE)	Non-Executive Director (Chair)
	Marie Burnham (MBu)	Chair of the Trust
	Adrian Snarr (AS)	Director of Finance, Estates & Resources
	Rob Adamson (RA)	Deputy Director of Finance
	Adele Fox (AF)	Chief Operating Officer
	Mel Wood (MW)	Head of performance and business intelligence
	Nick Phillips	Deputy Director of Estates & Facilities
	Jane Wilson	Note taker
Apologies:		

FIP/25/19 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Gary Ellis (GE), welcomed everyone to the meeting and the meeting deemed quorate. GE stated that the meeting would be recorded for administrative purposes, then deleted after minutes were completed.

FIP/25/20 Declarations of interest (agenda item 2)

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

FIP/25/21 Minutes from previous Committee meetings held on 23 June 2025 (agenda item 3)

GE noted that, following discussions at the last meeting, the minutes were much easier to read from the chair's perspective. He asked the committee if this reflected everyone's view, it was confirmed a fair reflection for everyone. GE stated that he had a couple of minor amendments, which he would provide to JW separately after the meeting.

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 23 June 2025 subject to a couple of minor amendments

FIP/25/22 Matters arising from previous meeting held on 23 June 2025 agenda item 4)

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

FIP/25/23 items delegated to Finance, Investment and Performance Committee from Trust Board agenda item 5)

GE confirmed that there was nothing delegated from Board.

FIP/25/24 Performance (agenda item 6)

Item 6.1 Finance, Investment and Performance (FIP) Risk Register

AS advised the document is presented with track changes, as always, to allow the committee to see what has been modified. He stated that a thorough review of the risk register has been conducted, with a focus on the control environment, as it had become evident that we were incrementally adding and duplicating controls, and some controls were changed without reviewing the original ones, leading to an extended list.

Andy Lister has reviewed all the risks with each executive director, so the committee will notice more narrative in the track changes column than usual. We have also continued to explore actions to enhance the control environment.

We have adjusted some of the risk appetites but have not altered any of the risk scores. The financial situation remains demanding, and we continue to monitor the Cheswold risk through this committee. Although it is now part of business as usual, it remains challenging due to the overall environment.

GE commented that this situation mirrors the commissioning committee, where they are operating within the risk appetite boundaries but are pushing the limits. They observed that this is the reality of the situation.

It was RESOLVED to DISCUSS the current Trust-wide corporate / organisational level risks, relevant to this Committee, NOTE the risks presented as approved by Trust Board on 29 October 2024 and SATISFY themselves that they are ASSURED that the current risk level, considering Trust risk appetite, given the current environment is appropriate.

Item 6.2 Monthly performance review

- **NHSE Performance assessment framework**

AS provided the update stating that some indicators could be problematic, and it would be beneficial to use this committee to review the details. The scores will be flagged in the IPR for the board but are not currently included as they are not yet in the public domain. AS mentioned that the indicators we have been measured against are subject to change, as it is a one-year framework.

AS highlighted that mental health and community metrics differ from acute metrics for obvious reasons. There seems to be a challenge with the concept of having a mental health trust and a community trust. When combined into a mental health and community trust, there are struggles because we have all the mental health indicators but not all the community ones. AS provided further detail around this, and an in depth discussion ensued.

- **Inpatients Deep Dive**

Adele Fox provided the key headlines:-

- Mental health inpatient services have focused on performance and sustainability to improve staff and service user experiences. Leaders have overseen improvements and provided support to train staff, enhancing care quality and reducing costs.
- Sickness rates have fluctuated above the threshold, with work-related and pregnancy-related illness as main reasons. This has led to increased use of bank staff, additional staff pressure, and a poorer experience for service users due to inconsistent staffing.
- Supervision meets compliance requirements. Improvement plans are in place for areas with fluctuating compliance. Ten wards achieved over 95% compliance in

Information Governance (IG), with ongoing efforts to improve compliance in other wards

- Reducing Restrictive Physical Interventions (RRPI) training compliance remains above 85%, thanks to ward managers booking training directly and managing rosters effectively.
- Cardiopulmonary Resuscitation training compliance is consistently above 85%. Fifteen wards have met the threshold, and those below have scheduled training sessions for the next three months.
- Fire training has been prioritised this month. Fourteen wards have met the required standards, with others showing improvement. Melton and Walton wards are under increased focus to ensure staff attend training.
- Staff head count continues to reduce month by month with a small increase in turnover. This will be closely monitored to understand the reasons and determine if any interventions are required
- Staff head count continues to reduce month by month with a small increase in turnover. This will be closely monitored to understand the reasons and determine if any interventions are required.

FIP/25/25 Finance update (agenda item 7)

RA provided the update.

Key headlines:-

7.1 West and South Yorkshire ICS financial updates

- Adverse variance to plan reduced £0.5m from that reported at month 1 (£0.8m, was £1.3m). SWYPFT forms part of this adverse position.
 - Impact of National Oversight Framework metrics and requirements to achieve deficit support funding.
 - All forecasts are maintained at their planned levels, resulting in a breakeven position after accounting for non-recurrent deficit support of £49m
 - The most likely case is £68.7m with worst case £247m. Of this total, £81.7m relates to delays in efficiency delivery.
- Efficiency delivery is challenging. Most organisations behind plan with increasingly challenging profiles.
- Agency – Trusts are under pressure, but several show improving trajectories.
- Bank challenging for most and forecast to continue.

7.2 Month 3 finance report

RA provided the update.

Key headlines

- The financial position remains demanding with a reported deficit of £600k in month 3, which is slightly better than planned. The year-to-date deficit stands at £2m, with a £91k adverse variance from the plan.

- The Trust in month variance bridge highlights the main financial pressures, being the same as previous months, with pay pressures in Older People (Barnsley & Wakefield) and Children & Young People Mental Health. Provider collaboratives, as reported separately, is primarily the South Yorkshire Adult Secure with others broadly in line with plan.
- Following a significant reduction in bank and agency in May 2025 there has been a relative increase in June 2025. This continues to be a balance of managing operational pressures and actions are picked up through the weekly temporary staffing scrutiny and management group.
- Agency expenditure remains lower than plan (remaining is predominately medical agency; there is an individual exit plan for all) however bank is maintaining at previous levels. The next largest action is the onboarding of recent recruitment (including conversion of existing bank into substantive staffing).
- The corporate cost reduction plan is ahead of schedule, but fixed-term contracts are behind.
- The forecast indicates a potential deficit of £5.5 million, with risks and opportunities being monitored closely.
- Non pay run rate continues to track at less than plan for most categories. Risk on out of area placements is included in the Trust scenario modelling. General forecast increases for the remainder of the year have been challenged, and ensuring where cost reductions have been made, that these are fully captured within the value for money programme.
- Cash has increased in month as NHS England have made a number of payments agreed during 2024 / 25.
- The Trust continues to pay suppliers promptly. Creditors older than 30 days have increased in month (now £356k was £17k) and actions have been prioritised to resolve these.

7.3 Financial Forecast

RA stated this report explores the assumptions made behind the statement that the planned breakeven financial position can be delivered, and the current level of risks (and opportunities) associated with this are being appropriately managed.

There is a formal process to be undertaken before any variance to plan can be reported. If the Trust do decide that a change is required then this would be communicated to the West Yorkshire ICB.

- The financial forecast indicates a potential deficit of £5.5 million. This projection is being closely monitored, with both risks and opportunities under review to mitigate the impact.
- Through actions of the Value for Money programme some of these mitigations have been de-risked with actual schemes defined and values confirmed. There is still a part year effect number included for productivity and loss making services.
- This will continue to be developed over the course of the year with risks, and mitigations, included as we become aware.

AS remarked that he would like to mention an additional point that was not available when RA prepared the report. Last week at a time-out meeting, we had an in-depth discussion regarding potential changes in Cheswold Park Hospital terms and conditions (agenda for change) and we are currently working through the logistics of this process. He said it is likely that we will establish a launch date of November 1st. NHS England has provided some non-recurrent funding to support us with this year's transition, although this is not part of ongoing funding. This period will be used to address the admission profile based on these developments. This topic was discussed further.

Item 7.4 Efficiency Plan Review

AS stated that we have a level of concern around temporary staffing and the committee will not be surprised to hear it does not relate to agency, but rather bank, and it is beginning to impact on our

ability to deliver fully on certain targets. The tracker shows a variance in headcount due to vacancies, and we're reviewing these issues as they relate more to pay balancing than the VFM programme itself. There's been some confusion between VFM commitments and wider organisational pressures, particularly so we will reassess this area.

AS stated that on a positive note, we're ahead of plan for corporate cost reduction, though part of this is due to holding vacancies rather than planned savings. He said communication about the source of these savings could be clearer; roughly half are recurrent, the rest are vacancy related. Fixed-term contracts lag behind because many are corporate roles, which we have counted under cost reduction instead and we are validating this approach. Year-to-date, the main risk remains temporary staffing, along with minor non-pay variances.

AS remarked that looking forward, productivity and loss-making services are identified as high delivery risks, with responsibility for productivity assigned to the adult team

AS suggested that obtaining feedback from both GE and MBu following GE's participation in a Value for Money (VFM) meeting would be advantageous for identifying any gaps and areas requiring improvement. He confirmed that the process is subject to ongoing refinement as it develops.

ACTION: Adrian Snarr

Item 7.5 West and South Yorkshire Collaboratives Financial update

RA presented the update highlighting ongoing challenges. The main financial pressure remains with South Yorkshire, while West Yorkshire is currently breaking even. The volatility of the collaborative services was noted, with potential financial impacts being closely monitored.

Key highlights:-

- The provider collaboratives are reported as an in-month deficit of £127k which increases the year to date to £183k. The forecast trajectory is that this plateaus with a forecast deficit of £257k.
- West Yorkshire Adult Secure. Whilst the financial position does remain volatile month 3 is reported as broadly in line with plan and, as the forecast are based on current activity trends, result in an overall breakeven forecast for 2025/26.
- South Yorkshire Adult Secure reported a continued deficit in month 3. This is forecast to continue with forecast deficit increasing from £52k deficit to £553k (increase of £501k). The collaborative is working on a recovery trajectory.
- Forensic CAMHS, as per previous years, continues to provide a financial surplus to the Trust over and above the small planned surplus contribution.
- The financial target for each remains breakeven with actions required to create financial headroom to support investment and development into services.
- The pressures continue to relate to activity and exceptional packages of care. Each of these areas remain volatile and can have significant financial impacts.

FIP/25/26 Investment (agenda item 8)

8.1 Capital Focussed Progress Report

AS stated that Older Peoples Services (OPS) project is crucial for next year's capital planning and that the supplier has been engaged through the P23 framework. The supplier is the sole bidder operating within this national framework, necessitating careful negotiation regarding price and delivery terms due to limited alternative supply chain options. Questions may arise regarding the use of the P23 framework; however, for projects of this value, the number of potential bidders is limited. AS advised that Nick Phillips attended a full-day workshop with the approved supplier last

week where some concerns about the timeline and financial value had been flagged and NP has been addressing these.

NP provided the committee with further detail around this.

AS stated that when the planning guidance for next year is released, we aim to develop a comprehensive three-year plan to present to the Board. This will allow us to report variances against a three-year plan rather than a one-year plan. He explained that this is a common practice in the NHS, and having a three-year plan will provide a clearer and more structured approach.

NP remarked that to make the plan more realistic, we need to adjust the timeline by advancing some projects and delaying others. The inherent risks of the current system and the nature of NHS Capital contribute to these challenges. He explained that although the capital paper was initially prepared for earlier release, he had requested an update to reflect the latest information.

MBu asked when will the OPS project start, and when it is expected to finish.
NP responded that it is expected to start in September and will take 48 weeks

AS concluded by stating that while it is not directly relevant to us, there are constraints on cash at the national level impacting the financial status of NHS partners. These restrictions could affect some organisations' ability to spend capital due to limited cash resources. As a result, there is a possibility that, later in the year, cash capital may return to the system. He also outlined the potential benefits this development could bring to the Trust.

It was RESOLVED to NOTE the Capital progress focussed update.

FIP/25/27 Any other business (agenda item 9)

9.1 Waiting List report

Adele Fox presented the update. The Waiting List Report highlighted the current status and challenges related to patient waiting times. Key points included an increase in the number of patients on the waiting list, with particular pressure on elective surgeries and outpatient appointments. Efforts are being made to address these issues through additional resources and improved scheduling. The report also noted the importance of ongoing monitoring and adjustments to ensure timely access to care for all patients.

AF noted that this was her initial opportunity to review the work. She indicated the need to understand staff activity levels and plans to discuss this with Mel Wood after her return from leave. She also mentioned that ADHD triage was discussed in Kirklees. Discussions are ongoing with Commissioners regarding the adoption of this approach, and an analysis is required to determine whether staffing levels are sufficient to meet demand. Increased referrals are affecting CAMHS services and leading to crisis service usage and we need to understand this impact. This analysis gives us a better understanding beyond the IPR report, but we need to determine actions by service line and it is crucial for informed decisions.

ACTION: Adele Fox

The ADHD triage pathway in Kirklees has shown significant impact, and discussions with Commissioners about wider adoption are ongoing. We need to analyse if our staffing increases meet current demand. The rise in referrals is affecting CAMHS services, leading to increased use of crisis services. Evaluating these impacts is essential. The analysis provides deeper insights beyond the IPR report, but we must identify actionable steps for each service line. Further detailed analysis should be conducted outside this meeting. Vic Humble's work is exemplary, and collaboration with MW and Marios Adamou, Consultant Psychiatrist, Adult ADHD

upon their return may help address these issues, understand the financial shortfall, and reduce waiting times.

AF stated that continuing this analysis is vital for informed decisions. Additional service line reviews are requested to explore solutions. A response from the Commissioners, particularly concerning the Kirklees approach, is still pending.

AF advised that we await feedback from the Commissioners regarding the Kirklees CAMHS referrals. National ADHD initiatives are progressing, with Marios playing a key role in ASD and ADHD triage in Kirklees and engaging with other Commissioners and working with him presents an opportunity to innovate these services and the triage process.

GE closed the meeting

Minutes of the Finance, Investment & Performance Committee
Held on 21 August 2025
(Virtual meeting, via Microsoft Teams)

Present:	Gary Ellis (GE)	Non-Executive Director (Chair of the Committee)
	Rob Adamson (RA)	Deputy Director of Finance
	Adele Fox (AF)	Chief Operating Officer
	Nick Phillips (NP)	Deputy Director, Estates & Facilities
Apologies:	Marie Burnham (MBu)	Chair of the Trust
	Adrian Snarr	Director of Finance, Estates & Resources
	Izzy Worswick	Assistant Director, Corporate Governance

FIP/25/28 Welcome, introduction, and apologies (agenda item 1)

Gary Ellis (GE), Committee Chair, noted that the meeting was not quorate clarifying that it was a finance agenda meeting rather than a full committee agenda. GE to check with Corporate Governance to discuss whether an addendum to the Terms of Reference was needed for such meetings.

Action – Gary Ellis

GE confirmed that the meeting would be recorded for administrative purposes, then deleted after minutes were completed.

FIP/25/29 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/25/30 West and South Yorkshire ICS Financial updates (agenda item 3)

Rob Adamson (RA) provided an update on the West Yorkshire Integrated Care Board (ICB) financial position, noting a deterioration from month two to month three, with further decline observed in month four. The worsening financial situation is affecting most Trusts, with industrial action highlighted as a significant factor, particularly impacting acute Trusts more than SWYPFT (South West Yorkshire Partnership NHS Foundation Trust).

RA noted the impact of pay awards, explaining that an estimated accrual for the incremental expenditure has been made, which will be adjusted once actuals are paid. The additional financial pressure from the pay award is around £0.5million, and will need to be managed, but could rise to £1.2 million if all staff are recruited. GE and RA discussed that the scale of the pay award pressure is less severe than the previous year, but future recruitment could increase the challenge.

GE asked about the status of further industrial action, RA confirmed that actions are currently paused pending further discussions, but no final resolution has been reached. Adele Fox (AF) confirmed that nurses are awaiting the outcome of a ballot to determine if further strike action will be mandated. RA emphasised that the pause in industrial action is temporary and, if resumed, could significantly impact the financial context.

The Finance, Investment and Performance Committee NOTED the West and South Yorkshire ICS Financial updates

FIP/25/31 Month 4 finance update (agenda item 4)

RA presented the finance report, highlighting that despite the pay award being transacted in July 2025, the financial performance for the month was positive, with only a small in-month deficit and a positive year-to-date trend. RA noted that this is the first month the organisation is performing better than plan for the year to date. The main contributor to the positive financial position is having fewer staff than planned, a trend observed over several months and expected to continue.

RA and GE discussed the operational risks and challenges associated with reduced staffing, emphasising that while this benefits finances, it raises concerns about safety and service quality. There was agreement that safety must not be compromised for financial reasons, and internal communication will focus on clarifying that financial decisions are not being made at the expense of safety. GE noted the importance of demonstrating that, even if a "gold" service cannot be provided, a safe "bronze" service remains the priority. AF explained that operational managers are leading decisions on temporary staffing and establishments but emphasised that these actions are not solely operationally driven; clinical safety remains the priority. A briefing will be prepared to clarify the organisation's commitment to safety within financial constraints.

GE requested clarification on payroll data, and RA explained that the apparent reduction in substantive staff costs for August is due to the pay award estimate being transacted for previous months, not a real decrease in staff.

GE highlighted the need to reduce bank and agency staffing while increasing substantive posts, noting risks and the importance of providing assurance to Trust Board and Non-Executive Directors. AF reported that, if recruitment plans proceed as expected, one hundred and two staff will move from bank to substantive posts by October 2025, with ongoing recruitment events planned. Visa issues mean recruitment must remain continuous, and the organisation will not pay for visas going forward. AF noted that most of the one hundred and two staff expected to move from bank to substantive roles are already working with the organisation, but there are uncertainties due to varying start dates and some recent dropouts, especially in forensics. RA added that the forecast reflects these recruitment uncertainties, with expectations that bank staffing will decrease as substantive staff increase, though some fluctuation is anticipated due to ongoing changes in staff availability. AF and RA confirmed that agency staffing, mainly medical, is being addressed with exit strategies for each post, and recent recruitment successes are expected to further reduce agency reliance. AF reported that by the end of August 2025, there should be no planned agency use for nurses, with any future agency use limited to ad hoc safer staffing needs only. RA added that governance reporting shows significant progress in reducing both agency and bank staffing, particularly in admin and clerical roles, even if headline numbers do not always reflect this immediately.

RA confirmed that the positive financial position is mainly due to pay vacancies, with extra income from smoke-free grants and the Wakefield smoke-free bus. However, out-of-area placements remain a financial pressure, exceeding planned levels, and RA noted that there was a timing issue with IT spend which was planned earlier in the year but occurred in July 2025.

RA stated that non-pay spending is showing improvement, with fewer queries on requisitions and a positive trend in organisational spending behaviour. Out-of-area overspend is being monitored but is not as significant as in previous years.

RA highlighted that value for money schemes are slightly behind plan however mitigations are in place. Continued focus on efficiencies is required, especially with anticipated challenges next year. More detail will be reported next month.

In relation to capital spend, Nick Phillips (NP) reported that orders are being placed for items with long lead times, such as doors, and mechanisms for spend are in place. The Older People's scheme at Fieldhead has commenced with progress being made and confidence in delivery mechanisms is high.

RA stated that the cash position remains positive, with ongoing sessions planned to optimise cash management, including reviewing invoice payment terms and relationships with local suppliers. The organisation continues to pay promptly, supporting local businesses and maintaining strong better payment practice code metrics.

RA stated that the Trust's cash position remains positive and above plan, with no current pressure from the Centre to reduce cash holdings. RA noted that NHS England guidance suggests systems may need to manage cash collectively if pressures arise, and there is a possibility of reducing cash in exchange for a lower Public Dividend Capital (PDC) requirement, which is being explored. RA also mentioned ongoing efforts to optimise cash management, such as reviewing payment terms and ensuring prompt payments to suppliers. RA mentioned a recent self-assessment of Board reporting, indicating the organisation is generally compliant but may need to improve coverage of underlying positions and risk in public reporting.

AF and GE discussed the complexity of NHS finances, noting that it can be confusing for both staff and the public to understand why savings are needed when cash appears healthy. GE stressed that while cash is currently sufficient, it is relative to the organisation's turnover and not as substantial as it may seem. Both agreed on the importance of transparency and clear communication about the Trust's financial situation and the rationale behind financial decisions.

The Finance, Investment and Performance Committee NOTED the Month 4 Finance update

FIP/25/32 Financial forecast update (agenda item 5)

RA presented the baseline financial forecast, which initially shows a deficit based on current workforce assumptions and operational pressures. RA explained that through technical adjustments and available options, the organisation is projected to achieve a near break-even position. RA noted that many of these adjustments are one-off and not sustainable long-term. RA confirmed that the scenario has been updated to reflect increased pressure from out-of-area placements, anticipating one more than previously forecast for the remainder of the year.

RA emphasised the need to maintain focus on value for money and efficiency schemes, noting that while the current year's position is manageable, future years will be more challenging and require ongoing action. RA added the organisation is slightly behind plan on value for money but has developed mitigations through extra income and technical adjustments and the Value for Money groups are reviewing their processes after eight months of operation and are expected to implement a step change in approach.

AF provided an update on recent Value for Money meetings, describing them as increasingly difficult, with decision trees now leading to tough choices about service provision.

AF reported that the organisation has begun giving notice on loss-making services where Commissioners will not increase funding. AF noted that these decisions are uncomfortable but necessary to ensure financial sustainability. Both RA and AF agreed that Trust Board needs to understand the correlation between financial decisions and the impact on service user and staff experience.

RA confirmed a positive financial position for the month, with performance better than plan due to pay vacancies and lower staffing levels but cautioned that these are not sustainable solutions

and operational risks remain. He outlined that technical adjustments and one-off measures are supporting the break-even forecast, but future years will require continued focus on efficiencies and value for money.

GE reiterated the importance of maintaining financial discipline given the deteriorating position in the wider West Yorkshire system, emphasising that the organisation must continue to manage its own position carefully. He noted that the meeting was for financial updates only and no formal decisions were made.

GE and RA highlighted the need for transparency with Trust Board regarding the link between financial actions and their impact on services, staff, and safety, stressing that financial management is a means to support the organisation's overall objectives.

The Finance, Investment and Performance Committee NOTED the financial forecast update.

It was RESOLVED to NOTE any other business.

FIP/25/32 Next meeting date (agenda item 10)

The Committee received the future meeting date:

- Tuesday 23rd September 2025 from 10-12.30

GE closed the meeting

**Trust Board
30 September 2025
Agenda item 10.1**

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 aim to be outstanding, Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for July 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) The IPR is reviewed monthly at the Operational Management Group (OMG) meeting.		

Executive summary:	Performance against the Trust's new strategy will be reported separately 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. NHS Oversight Framework 2025/26 – an update has been included in the national metrics section of the report. This section outlines the new performance monitoring framework for Trusts for this financial year and our Trust performance for quarter 1. Quality and Safety • The Trust had 27 violence and aggression incidents against staff on mental health wards involving race during August. 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. • The total number of reported incidents in August decreased to 1,374, 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. Although there has been a decrease, 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 August 2025 resulted in no or low harm or were not under the care of the Trust. • The number of restraint incidents reduced this month from 258 reported in July to 208. 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. • There were 9 prone restraints during the month where we have purposefully placed the person in the prone position. Five of these incidents took place on one of our psychiatric intensive care units for exiting seclusion. Alternative seclusion exit training is now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. We expect this will support a move away from prone restraint being used as a method for exiting seclusion which as the data above shows is the primary reason for prone restraint use. • There were 8 information governance personal data breaches during August which is an improvement based on last month and under the Trust threshold of 12 or less. Information disclosed in error continues to

	be the highest reported category, these were spread across various care groups. 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. • There were 43 inpatient falls reported during August 2025. We actively risk assess those service users who are at high risk of falling and implement care plans. All fall incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. There has been a review by the falls lead across older adults' wards to establish any alternatives to enhanced observations to support service users. Recommendations have been progressed. • The Trust continues to work to improve the recording and collection of protected characteristics across all services to improve our service provision and experience of it. For the ethnicity indicator, the Trust is achieving 94.2% against a target of 90%. Disability recording was at 50.2%, sexual orientation 55.7% 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. • The reducing inequalities data has demonstrated a difference in the average length of stay, which is longer for Asian and Black service users. We are drilling down into this data so that we can pinpoint key actions to understand and address this. • 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%. The Trust is meeting the planned trajectory to date for all metrics except for the metric % with care plan that includes service user input/views. The risk assessment and care planning workstream are focussing on all improvements and a trajectory to meet the 95% target by end March 2026. Performance against all metrics has seen an increase in August and all risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups. Detail can be seen in the Quality dashboard and care group section of the report. • Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment.

- All services 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. 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 and communicated to the service user and ward staff. 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 six 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 regarding safe staffing and quality impact to ensure safety is maintained. Each care group have a daily huddle to review staffing and safety.

Care Groups

- 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 August, 69.3% of those waiting had been waiting for a period of 18 weeks or less.
- 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 a deep dive being carried out and presented to Executive Management Team in October to understand this further and what improvements are required by place and what dedicated support can be offered. There is an offer in place to support children and families whilst waiting. Close work with commissioners continues across each 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 August 95.3% was achieved. This has shown a sustained improvement and been consistently achieved 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 psychiatric intensive care beds continues to be a significant challenge and we have experienced increased use of out of area beds days in the last month relating to 8 service users. 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.

	• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, we have seen an overall increase in delays during August. Challenges remain associated to patients requiring specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (PICU). At the end of August 29 people were clinically ready for discharge but remained in a bed. Further detail can be seen in the care group section of the report. • 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 is approximately 27 cases across all three areas per month. The number of referrals for ADHD received for these areas in August was 274. Calderdale does not block commission assessments, but we do assess 7-8 people from that locality via the Patient Choice framework. 23 referrals were received from Calderdale in August. • 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 currently commissioned in Wakefield and Kirklees. Barnsley and Calderdale have received updated business cases for their consideration. A deep dive has been commissioned and will be presented to Executive Management Team in October to understand by place. • Mental health acute wards have continued to manage high levels of acuity and increased levels of risk to self and others. 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. • A significant reduction in the use of agency staff on wards has been sustained. However, use of bank staff increased during the month. The temporary staffing weekly meeting scrutinises the use of additional staffing and any areas of improvement to reduce the reliance on bank staff. There have been a significant number of bank staff transition to substantive staff and commenced in September, therefore we are hoping to see a reduction in bank usage over the next few months. In addition to

this, there are planned assessment centres taking place in all areas of the Trust

People

- Year to date sickness absence has increase slightly above threshold for August 2025 at 5.1%. The in month sickness position for August increased to 5.4%. We have seen an overall rise in long term sickness as a % of total absence – these are being managed in Care Groups with support from the people directorate. The introduction of a new sickness absence dashboard has been rolled out for managers, to support them in managing absences and enabling more Trustwide information to be available.
- Appraisal compliance has dropped slightly this month and stands at 88.6%. Out of all Trust services, the Barnsley Physical Health and Wellbeing Care group are the only service area above the 90% threshold. Hotspot areas are being managed across the Trust to ensure all staff have access to a meaningful, timely appraisal.
- Our 12-month staff turnover rate in August has increased slightly from last month to 10.2%. This is still a lower level than we have seen in previous years and remains under our Trust threshold of between 12-13%.
- In August, we had 31 new starters and 77 leavers. August also saw a further 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. Dedicated focus on non-compliance continues within all care groups and the wider Trust.
- Information governance training compliance remains high.

National Indicators

The Trust continues to perform well against most national metrics. The following should be noted:

- NHS England published Trust Oversight Framework scores for quarter 1 at the end of August 2025.
- Due to the Trust submitting a deficit financial position adverse to plan for quarter 1, this resulted in the Trust overall score being 3. If the financial override had not taken effect, performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as 3 out of 61 providers of non-acute hospitals (including Mental health and learning disability, community and care trusts). The detail of the performance against each metric in the framework can be seen in the national metrics section of the report.

It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways.

	Regarding the 6 weeks to a diagnostic appointment target, 102 out of 213 children (47.9%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in August. The demand in referrals outweighs commissioned activity levels – this remains a national issue. • Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%. This relates to 4 service users out of a total of 30, 2 of these cases relate to where an appointment was offered within the time frame, but this was cancelled or missed by the family. The other 2 breaches were seen but outside the timeframe. • Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing 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. It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold (18 weeks). • 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 2026. Overall, the average length of stay for people discharged in August has remained at a similar level to last month (58.3 days). In terms of performance against the trajectory, we are meeting the trajectory for August for our West Yorkshire acute mental health and PICU wards but remain above our trajectory for Barnsley wards. • 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. For services to work within the financial envelope opportunities for working differently and effectively need to be explored and introduced. • 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. • August 2025 saw a slight dip in performance for NHS Talking Therapies reliable recovery and reliable improvement indicators with both just dropping below threshold by 1%. Review of the data suggests this is linked to seasonal factors - the service saw a reduced number of clients accessing the service and pauses in treatment during the summer period. Both quarter and year to date, the service continues to exceed the recovery indicator.

	Finance • The financial performance for August 2025 is a surplus of £367k which is £0.8m better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staffing numbers and the payment of the pay award being less than originally estimated. The year-to-date position is a deficit of £1.7m which is now £0.7m favourable to plan. • Agency spend remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate. • Trust bank expenditure has continued to increase in line with continued demand and acuity within inpatient wards. The forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group. • In August corporate services spend is £0.4m less than planned. • The value for money programme is £0.6m behind plan for the year to date which is an improved position on last month. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods. • Cash continues to be monitored to ensure effective management of the Trust working capital position. In August 2025 this remains better than planned at £60.1m. • Capital spend is behind plan for the year to date and work continues on the major older people scheme. This has impacted on the overall spend profile and as such other schemes are being brought forward to ensure that the allocation is appropriately utilised.
Recommendation:	Trust Board members are asked to: NOTE the Integrated Performance Report and COMMENT accordingly.

Integrated Performance Report Strategic Overview



August 2025

With **all of us** in mind.

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Introduction

Welcome to the Trust's Integrated Performance Report (IPR) for September 2025.

The report format for 2025/26 has been changed slightly this year to align with the Trust board's focus. 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, the report has been updated to reflect this. In particular, the national metrics section includes those contained within the NHS 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. We have added the reducing inequalities section to the report again this month, this is linked to the Trust's equality, diversity and inclusion strategy it includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will guide us to being a more 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 the Trusts Equality, diversity, and inclusion strategy.

Our Integrated Performance Report is publicly available on the internet.

Headlines

This section of the report identifies metrics where there has been a change in performance or where expected levels are not being achieved. A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

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	↓	
% people dying in a place of their choosing	↑	 
Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	↓	
% 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 been reviewed within the last year	↑	New metric from April 25

People

Metric	Change from last month	Variation/ Assurance
Registered workforce growth	↔	
Sickness absence - Month	↓	
Appraisals - rolling 12 months	↓	

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	↑	 
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
Inappropriate out of area bed days	↓	 
Talking Therapies - Reliable Recovery	↓	 
Talking Therapies - Reliable Improvement	↓	 
Talking Therapies - proportion of people completing treatment who move to recovery - Trust	↓	 
Talking Therapies - proportion of people completing treatment who move to recovery - Kirklees	↓	 

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	↑	 
% of feedback with staff values and behaviours as an issue	↓	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↔	New metric from April 25
Sickness rate (monthly)	↓	
% assessed within 14 days of referral (routine)	↓	
% assessed within 4 hours (Crisis)	↑	

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	↑	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	↑	New metric from April 25
Out of area bed days	↓	 

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	 
% of clients clinically ready for discharge	↑	 
% of feedback with staff values and behaviours as an issue	↑	 

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	 
% of feedback with staff values and behaviours as an issue	↑	
Sickness rate (Monthly)	↑	 
% Bed occupancy (incl leave)	↔	 
% 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

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
Cardiopulmonary resuscitation (CPR) training compliance	↓	
% Bed occupancy	↑	
Information Governance training compliance	↓	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% of feedback with staff values and behaviours as an issue	↓	
% of people dying in a place of their choosing	↑	 

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 (I) 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.

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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 27 violence and aggression incidents against staff on mental health wards involving race during August. 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.
 - The total number of reported incidents in August decreased to 1,374, 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. Although there has been a decrease, 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 August 2025 resulted in no or low harm or were not under the care of the Trust.
 - The number of restraint incidents reduced this month from 258 reported in July to 208. 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.
 - There were 9 prone restraints during the month where we have purposefully placed the person in the prone position. Five of these incidents took place on one of our psychiatric intensive care units for exiting seclusion. Alternative seclusion exit training is now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. We expect this will support a move away from prone restraint being used as a method for exiting seclusion which as the data above shows is the primary reason for prone restraint use.
 - There were 8 information governance personal data breaches during August which is an improvement based on last month and under the Trust threshold of 12 or less. Information disclosed in error continues to be the highest reported category, these were spread across various care groups. 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.
 - There were 43 inpatient falls reported during August 2025. We actively risk assess those service users who are at high risk of falling and implement care plans. All fall incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. There has been a review by the falls lead across older adults' wards to establish any alternatives to enhanced observations to support service users. Recommendations have been progressed.
 - The Trust continues to work to improve the recording and collection of protected characteristics across all services to improve our service provision and experience of it. For the ethnicity indicator, the Trust is achieving 94.2% against a target of 90%. Disability recording was at 50.2%, sexual orientation 55.7% 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.
 - The reducing inequalities data has demonstrated a difference in the average length of stay, which is longer for Asian and Black service users. We are drilling down into this data so that we can pinpoint key actions to understand and address this.
 - 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%. The Trust is meeting the planned trajectory to date for all metrics except for the metric % with care plan that includes service user input/views. The risk assessment and care planning workstream are focussing on all improvements and a trajectory to meet the 95% target by end March 2026. Performance against all metrics has seen an increase in August and all risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups. Detail can be seen in the Quality dashboard and care group section of the report.
- Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment.
- All services 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. 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 and communicated to the service user and ward staff. 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 six months; this is linked to the grip and control measures that have been put into place in relation to the use of

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- 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 August, 69.3% of those waiting had been waiting for a period of 18 weeks or less.
 - 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 a deep dive being carried out and presented to Executive Management Team in October to understand this further and what improvements are required by place and what dedicated support can be offered. There is an offer in place to support children and families whilst waiting. Close work with commissioners continues across each 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 August 95.3% was achieved. This has shown a sustained improvement and been consistently achieved 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 psychiatric intensive care beds continues to be a significant challenge and we have experienced increased use of out of area beds days in the last month relating to 8 service users. 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.
 - Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, we have seen an overall increase in delays during August. Challenges remain associated to patients requiring specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (PICU). At the end of August 29 people were clinically ready for discharge but remained in a bed. Further detail can be seen in the care group section of the report.
 - 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 is approximately 27 cases across all three areas per month. The number of referrals for ADHD received for these areas in August was 274. Calderdale does not block commission assessments, but we do assess 7-8 people from that locality via the Patient Choice framework. 23 referrals were received from Calderdale in August.
- 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 currently commissioned in Wakefield and Kirklees. Barnsley and Calderdale have received updated business cases for their consideration. A deep dive has been commissioned and will be presented to Executive Management Team in October to understand by place.
- Mental health acute wards have continued to manage high levels of acuity and increased levels of risk to self and others. 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.
 - A significant reduction in the use of agency staff on wards has been sustained. However, use of bank staff increased during the month. The temporary staffing weekly meeting scrutinises the use of additional staffing and any areas of improvement to reduce the reliance on bank staff. There have been a significant number of bank staff transition to substantive staff and

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- Year to date sickness absence has increase slightly above threshold for August 2025 at 5.1%. The in month sickness position for August increased to 5.4%. We have seen an overall rise in long term sickness as a % of total absence – these are being managed in Care Groups with support from the people directorate. The introduction of a new sickness absence dashboard has been rolled out for managers, to support them in managing absences and enabling more Trustwide information to be available.
- Appraisal compliance has dropped slightly this month and stands at 88.6%. Out of all Trust services, the Barnsley Physical Health and Wellbeing Care group are the only service area above the 90% threshold. Hotspot areas are being managed across the Trust to ensure all staff have access to a meaningful, timely appraisal.
- Our 12-month staff turnover rate in August has increased slightly from last month to 10.2%. This is still a lower level than we have seen in previous years and remains under our Trust threshold of between 12-13%.
- In August, we had 31 new starters and 77 leavers. August also saw a further 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. Dedicated focus on non-compliance continues within all care groups and the wider Trust.
- Information governance training compliance remains high.

National Indicators

The Trust continues to perform well against most national metrics. The following should be noted:

- NHS England published Trust Oversight Framework scores for quarter 1 at the end of August 2025.
- Due to the Trust submitting a deficit financial position adverse to plan for quarter 1, this resulted in the Trust overall score being 3. If the financial override had not taken effect, performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as 3 out of 61 providers of non-acute hospitals (including Mental health and learning disability, community and care trusts). The detail of the performance against each metric in the framework can be seen in the national metrics section of the report.
- It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Regarding the 6 weeks to a diagnostic appointment target, 102 out of 213 children (47.9%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in August. The demand in referrals outweighs commissioned activity levels – this remains a national issue.
- Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%. This relates to 4 service users out of a total of 30, 2 of these cases relate to where an appointment was offered within the time frame, but this was cancelled or missed by the family. The other 2 breaches were seen but outside the timeframe.
- Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing 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 It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold (18 weeks).
- 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 2026. Overall, the average length of stay for people discharged in August has remained at a similar level to last month (58.3 days) In terms of performance against the trajectory, we are meeting the trajectory for August for our West Yorkshire acute mental health and PICU wards but remain above our trajectory for Barnsley wards.
- 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. For services to work within the financial envelope opportunities for working differently and effectively need to be explored and introduced.
- 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.
- August 2025 saw a slight dip in performance for NHS Talking Therapies reliable recovery and reliable improvement indicators with both just dropping below threshold by 1%. Review of the data suggests this is linked to seasonal factors - the service saw a reduced number of clients accessing the service and pauses in treatment during the summer period. Both quarter and year to date, the service continues to exceed the recovery indicator.

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Finance

- The financial performance for August 2025 is a surplus of £367k which is £0.8m better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staffing numbers and the payment of the pay award being less than originally estimated. The year-to-date position is a deficit of £1.7m which is now £0.7m favourable to plan.
- Agency spend remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
- Trust bank expenditure has continued to increase in line with continued demand and acuity within inpatient wards. The forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
- In August corporate services spend is £0.4m less than planned.
- The value for money programme is £0.6m behind plan for the year to date which is an improved position on last month. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
- Cash continues to be monitored to ensure effective management of the Trust working capital position. In August 2025 this remains better than planned at £60.1m.
- Capital spend is behind plan for the year to date and work continues on the major older people scheme. This has impacted on the overall spend profile and as such other schemes are being brought forward to ensure that the allocation is appropriately utilised.

Summary	Quality & Safety	People	National Metrics	Care Groups	Ward Detail	Finance/ Contracts

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jun-25	Jul-25	Aug-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks ⁵	Best Quality	Responsive	TBC	76.0%	73.0%	69.3%	N/A
Complaints	% of feedback with staff values and behaviours as an issue ¹²	Best Quality	Caring	< 20%	8% (3/38)	17% (8/48)	9% (2/22)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	108.4	144.8	108.7	N/A
	Complaints - Number of responses provided within six months of the date a complaint received ¹⁶	Best Quality	Well led	100%	95% (18/19)	84% (16/19)	95% (20/21)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	86%	91%	89%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	95%	97%	97%	1
	Number of compliments received	Best Quality	Caring	N/A	74	37	68	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) ⁴	Best Quality	Safe	Trend monitor	6	7	3	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions ⁴	Best Quality	Safe	Trend monitor	0	2	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	8	13	8	2
	% of inpatients clinically ready for discharge [*]	Person first and in the centre	Responsive	3.5%	5.4%	3.9%	5.2%	3
	Total number of reported incidents ¹⁸ *	Best Quality	Safe	Trend monitor	1488	1671	1374	
	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	32	37	29	
	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	2	4	2	
	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	0	0	0	
	Safer staff fill rates [*]	Best Quality	Safe	90%	119.4%	119.4%	118.3%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	97.5%	96.0%	97.9%	1
	Number of pressure ulcers which developed under SWYPFT care ¹	Best Quality	Safe	Trend monitor	38	50	45	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement ²	Best Quality	Safe	0	0	1	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	1
	Number of Falls (inpatients) [*]	Best Quality	Safe	Trend monitor	49	49	43	
	Number of restraint incidents [*]	Best Quality	Safe	Trend monitor	184	258	208	
	% of staff receiving supervision within policy guidance ¹⁵	Best place to work and learn	Well led	80%	88.3%	88.9%	86.6%	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%	93.1%	78.1%	94.4%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	17	17	11	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%	69%	Due Nov 2025		
	Number of violence and aggression incidents against staff on mental health wards involving race [*]	Best place to work and learn	Safe	Trend Monitor	37	36	27	N/A
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	9	Due October 2025		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	98.9%	95.6%	92.4%	
	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%	100.0%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	93.8%	94.3%	94.2%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	52.8%	52.4%	52.0%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	56.9%	56.3%	55.7%	
	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	Jun-25	Jul-25	Aug-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%	100% Service	100% Service	100% Service	
					100% Policy	100% Policy	97.3% 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%	65.4%	75.7%	84.6%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		70.1%	70.0%	74.8%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		92.5%	94.5%	96.9%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		78.3%	81.1%	81.4%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		88.8%	89.1%	91.5%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	June and July – 10 Aug and Sept - 8	7	5	9	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	54	39	64	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	5093	6639	6756	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 Oversight Framework segmentation	All	Well led	1/2	3	Due Nov 25		
	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 21 complaints responded to during the month, 20 were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 108.7 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.
- Compliments received during the month increased by 84% compared to July, reflecting a positive trend in service user and carer feedback.
- Clinically ready for discharge (previously delayed transfers of care) - Overall Trust position for August was 5.2%, this includes data for Cheswold Park Hospital. The performance excluding Cheswold Park Hospital is 5.46%. 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.
- The number of reported incidents - An reduction in incidents has been seen in August, the total figure for the month incudes 131 incidents that are attributed to Cheswold Park Hospital; 1243 incidents were attributed to the rest of the Trust. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
- There were 2 severe harm incidents reported during the month one related to a pressure ulcer and one related to self harm. Both incidents were managed following Trust procedures.
- The overall number of restraint incidents in August was 208 though this figure now includes data for Cheswold Park Hospital. 31 of these incidents were attributed to Poplars ward, and 26 to Ward 18 at the Priestley Unit. 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.
- The number of prone restraint incidents where we had purposely put the person in the prone position was 9 for August. There were also 3 instances where the prone position was service user led. Alternative seclusion exit training is now embedded in both four day initial and two day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. This should support a move away from prone restraint being used as a method for exiting seclusion which the data above shows is the primary reason for prone restraint use in August 2025.
- 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.

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. This has been finalised and submitted as evidence and will be reviewed by the Accreditation Committee by the end of September.

Learn from Patient Safety Events (LFPSE) Data Validation

The LFPSE is a standardised framework designed to categorise and report patient safety incidents in healthcare settings. Its purpose is to facilitate better data collection, reporting, and analysis, which ultimately aims to improve patient outcomes and care quality. LFPSE data validation has taken place in line with a national request. RLDatix have recently released LFPSE Taxonomy V6. An upgrade Datixweb will be carried out once scoping has taken place.

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 2024 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.

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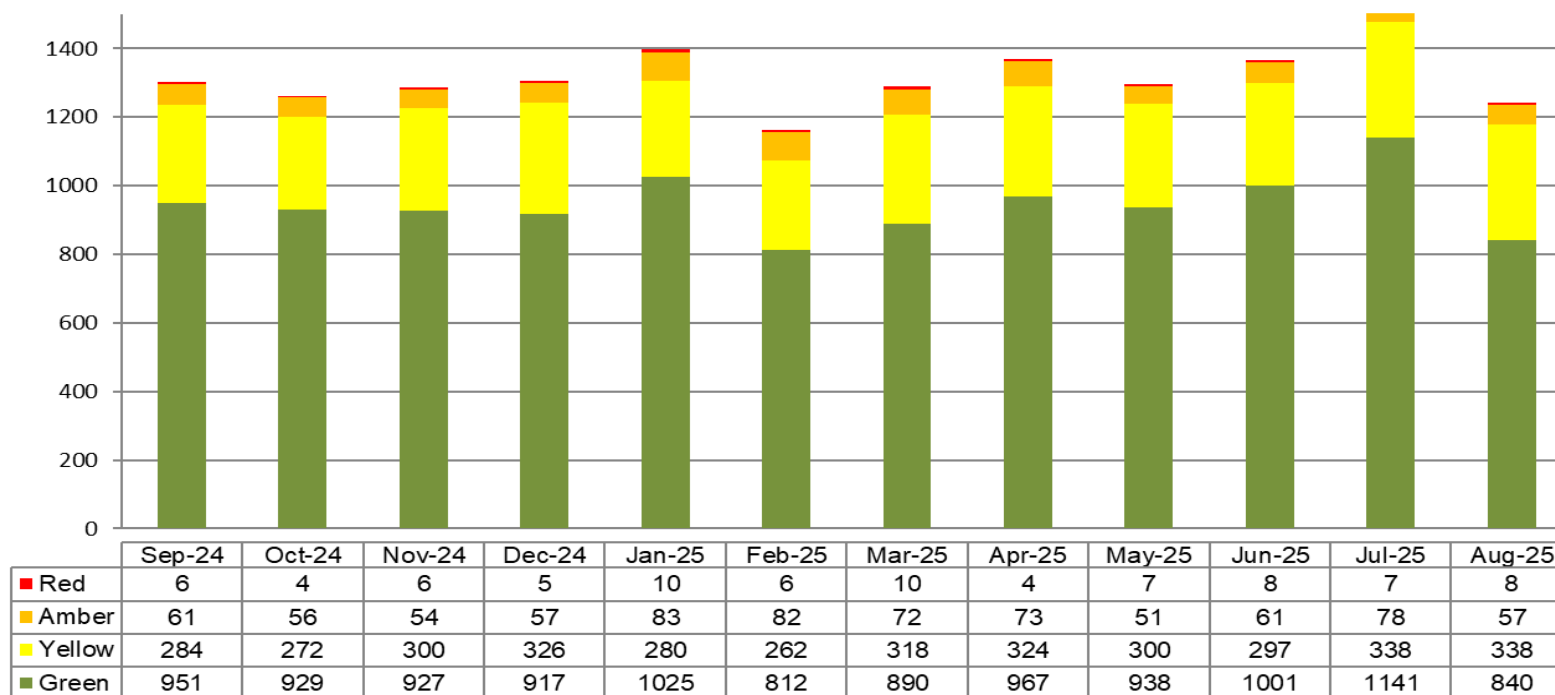
Safety First

Summary of Incidents

Although we have reported 8 red incidents in August, incidents may be subject to regrading as more information becomes available, which means this figure is subject to change.

96% of incidents reported in August 2025 resulted in no harm or low harm or were not under the care of SWYPFT.

No never events reported in August 2025



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).

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Safety First cont...

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

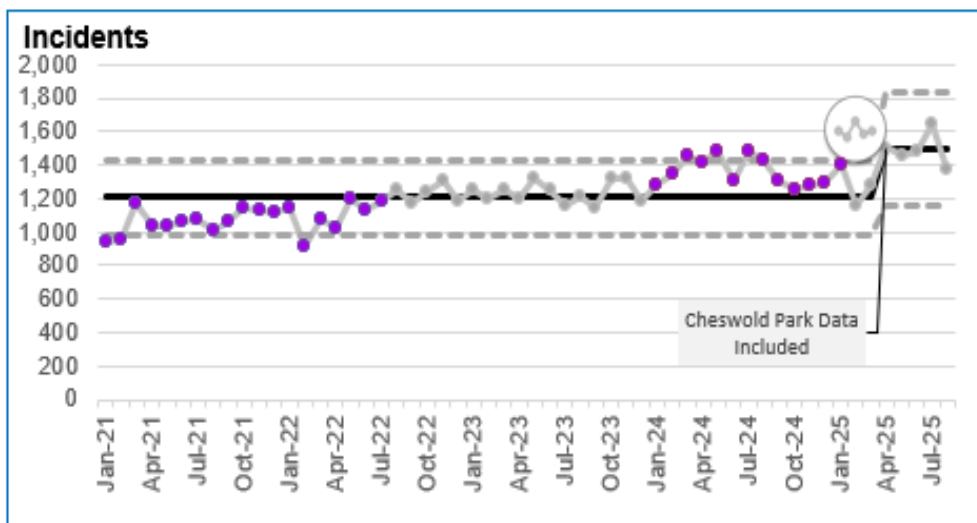
Breakdown of incidents in August 2025

29 moderate harm incidents:

The most common subcategories for incidents were pressure ulcers and self harm.

There were 2 severe harm incidents one in the Barnsley neighbourhood team and one in the Wakefield intensive home based treatment team.

Incidents



We have re-entered a period of common cause variation in August 2025 due to 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 (PSIRF) 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.



Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience. Further examples can be found on the SWYPFT intranet page.

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

Patient Safety Alerts

There were no patient safety alerts that were not completed by deadline in August 2025.

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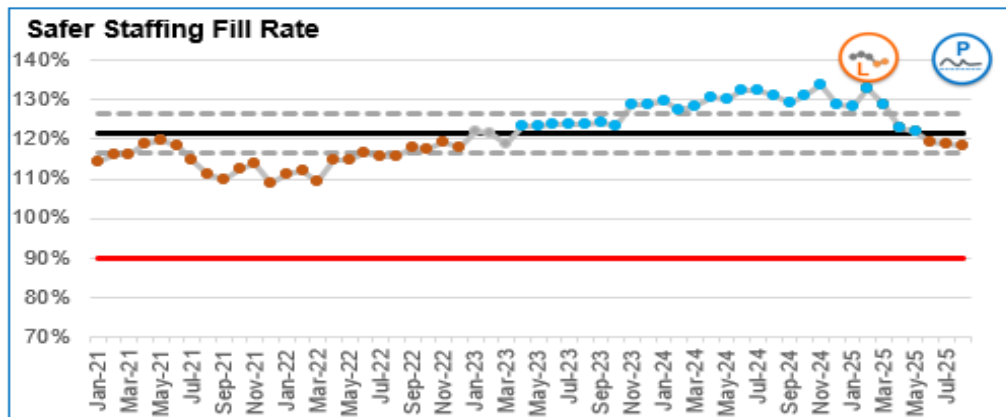
National Metrics

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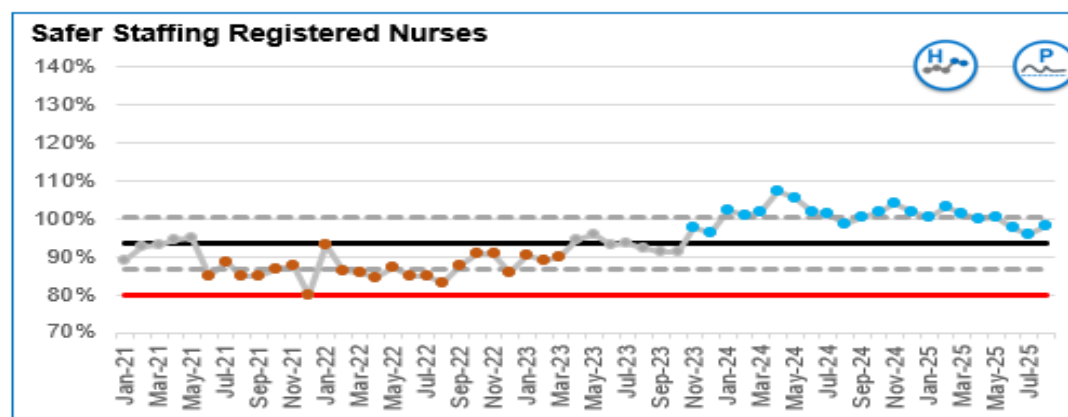
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Safer Staffing Inpatients



The chart above shows that as at August 2025, we remain in a period of special cause concerning variation (something is happening and this should be investigated) and we are expected to meet the target.



The chart above shows that in August 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 target.

- In August, excluding Cheswold Park Hospital (CPH), within the flexible staffing pool, there were a total of 53 (6,356) less shift requests, and the overall fill rate for flexible staffing decreased by 1.55% to 83.16%.
- Within overall fill rates there was an increase in the fill rates of 8.3% for Forensic and Learning Disability (LD) care group to 122.7%, Adult and Older Peoples Care Group reduced by 5.4% to 117.7%, Cheswold Park Hospital increased by 4.3% to 120.0% and Barnsley Integrated Services decreased 16.7% to 91.2% - although within Barnsley there was a low bed occupancy, annual leave and excess hours were being taken after a clinical risk assessment had been made regarding staffing requirement.
- We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny and e-rostering groups.
- The utilisation of agency workers has increased in authorised situations which is in line with our Grip and Control group.
- The overall fill rate, with CPH, was similar to the previous month and was 118.3%. The day fill rate for Registered Nurses (RNs) decreased by 1.4% to 95.0%. Four wards, an increase of one on the previous month, Ward 19 in the Adult and Older Peoples care group, Calder Ward at Cheswold Park Hospital, Stroke Rehab within Barnsley Integrated Services and Waterton Ward within the Forensic and LD care group, fell below the 90% RN day fill rate. They were supported through local escalation plans.
- The night RN fill rate decreased (3.4%) to 102.5%. Night fill rate was not achieved by Calder Ward at Cheswold Park and Neuro Rehab in Barnsley Integrated Services. This was consistent with the previous month.
- In August two wards, Stroke Rehab (83.1%) within Barnsley Integrated Services and Aire Ward within Cheswold Park Hospital (88.8%), fell below the 90% overall fill rate threshold. This was consistent with the previous month. Please note, Stroke and Neuro rehab figures have been influenced by bed occupancy and resultant decisions are described above.
- There was a decrease of 11 registered unfilled shifts and a decrease of 39 unregistered additional shifts not being filled in comparison to the previous month. This does not include shifts that have been cancelled or taken off the system by the ward.
- We continue to develop the safer staffing power BI dashboard which will include Cheswold Park Hospital. All fill rate figures include CPH.

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Safer Staffing Inpatients cont...

Registered Nurses Days

Registered day rate	Jun-25	Jul-25	Aug-25
Adults and Older People	95.6%	95.4%	94.8%
Barnsley Integrated Services	112.6%	112.3%	88.0%
Forensic and LD	96.1%	94.1%	93.3%
Cheswold Park Hospital	95.7%	99.3%	102.4%
Overall shift fill rate	96.7%	96.4%	95.0%

Registered Nurses Nights

Registered night rate	Jun-25	Jul-25	Aug-25
Adults and Older People	107.8%	109.3%	103.1%
Barnsley Integrated Services	99.3%	101.5%	101.6%
Forensic and LD	112.9%	112.9%	112.8%
Cheswold Park Hospital	88.6%	87.8%	85.2%
Overall shift fill rate	105.3%	105.9%	102.5%

Overall Registered Rate: 97.9%.

Overall Fill Rate:

Overall Fill Rate	Jun-25	Jul-25	Aug-25
Adults and Older People	124.4%	123.1%	117.7%
Barnsley Integrated Services	106.5%	107.9%	91.2%
Forensic and LD	112.4%	114.4%	122.7%
Cheswold Park Hospital	117.0%	115.7%	120.0%
Grand total	118.9%	118.7%	118.3%

Excluding Cheswold Park Hospital, Bank staff filled 71.0% (a decrease of 1.53% on the previous month) of RN requests for flexible staffing and 79.49% (a decrease of 1.81% on the previous month) of HCA requests.

Agency staff filled 2.42% (an increase of 0.91% on the previous month) of RN requests for flexible staffing and 5.77% (an increase of 0.32% on the previous month) of HCA requests.

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Information Governance (IG)

Eight personal data breaches were reported during August 2025.

Information disclosed in error continues to be the highest reported category.

Breaches during the month related to:

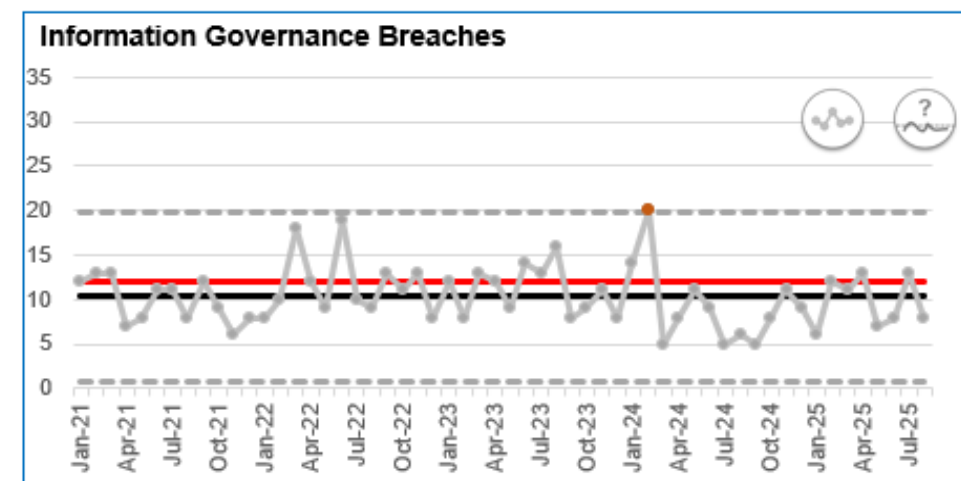
- Letter sent to wrong recipient due to being saved in the wrong patient folder.
- Letter sent to wrong address as record had not been updated.
- Two letters being placed into one envelope.
- Email sent to wrong recipient due to similar name as intended recipient.
- Information stored to wrong folder due to two individuals having the same name and subsequently shared in response to an access request.

An availability breach occurred when observation records were not uploaded to the patient record so were missing when the shift changed over.

A security breach occurred when paper information provided by a family was shared with Trust staff and lost.

A communication campaign is in progress with a key focus being personal responsibility for ensuring emails are sent to the correct, intended recipients.

This SPC chart shows that as at August 2025 we remain in a period of common cause variation. Overall there has been a decrease in the number of IG breaches.



Trustwide Falls

August 2025, Datix reported a Trustwide total of 52 slips, trips and falls. This equates to 3.7% of all Datix safety events reported in August 2025. Below is a breakdown of falls and where they occurred in the community, inpatients or staff group/visitor.

Slips, trips and falls reported in August 2025

	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	0	0	0	0
Yellow Incident	0	2	0	1	3
Green Incident	4	37	6	2	49
Total	4	39	6	3	52

Red Incident Amber Incident Yellow Incident Green Incident Total

The Trust inpatient falls rate is 2.75 per 1,000 bed days. We continue to be below the National average for inpatient falls of 6.3 per 1,000 bed days

Incident Grading

Red: No red fall incidents reported.

Amber: No amber fall incidents reported.

Yellow: A total of 3 (6%) reported events needed higher intervention, such as attending A&E, or minor treatment.

Green: A total of 49 (94%) reported safety events had low, or no harm recorded. Main themes reported linked with developing infections and/or physical health needs such as shuffling gait/tremors, agitation and responding to unseen stimuli, and general slips and trips.

Inpatient falls had a high correlation with:

- there were 21 falls (49%) for older adults, aged >65yrs; of these falls:
- there were 19 (90%) patients who had a recognised falls risk and multifactorial assessment and mobility plan in place
- with 17 falls (81%) for patients with a diagnosed cognitive change such as dementia
- there were six falls (14%) directly linked with agitation
- and seven falls (18%) linked with physical health need such as developing infection, tremor, pneumonia
- and three falls (7%) occurring on leave and not on the inpatient unit

National Institute of Clinical Excellence (NICE) quality standard reviews in August 2025, across older adult, and the stroke/neuro wards they had approximately 80 patients, 65 years and above, recognised as being at a high risk of falls, of those:

- all patients (100%) were referred to a physiotherapist for assessment
- on review, 79 patients (99%) had a good quality multifactorial risk assessment documented in the progress notes
- with 46 patients (58%) receiving education to reduce falls risk. There has been an approximate 25% increase in falls education evident in mobility plans and progress notes since April 2025

Things to celebrate

- Post Falls Protocol completion has averaged 89% this month, with a continued good response from staff. Where the Post Falls Protocol or checklist was not completed, staff had documented clear progress notes.
- Physical health checks were completed in 100% of all patients who had a fall.

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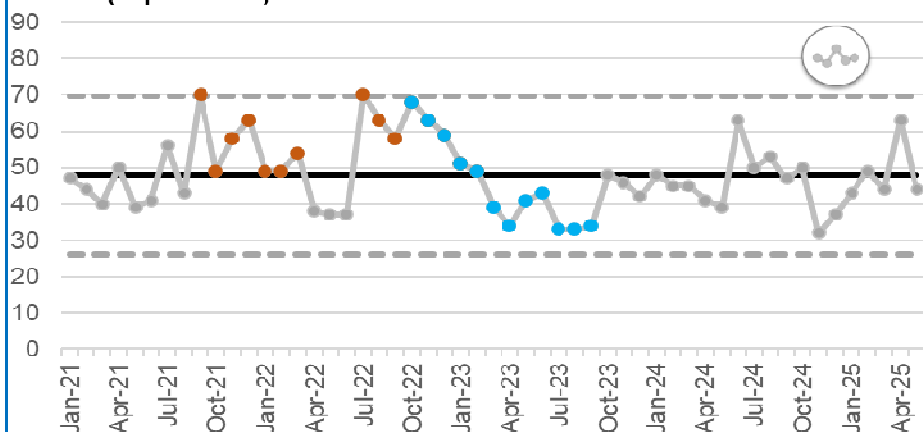
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Falls (Inpatient)

The total number of inpatient falls was 43 in August.

Falls (Inpatients)

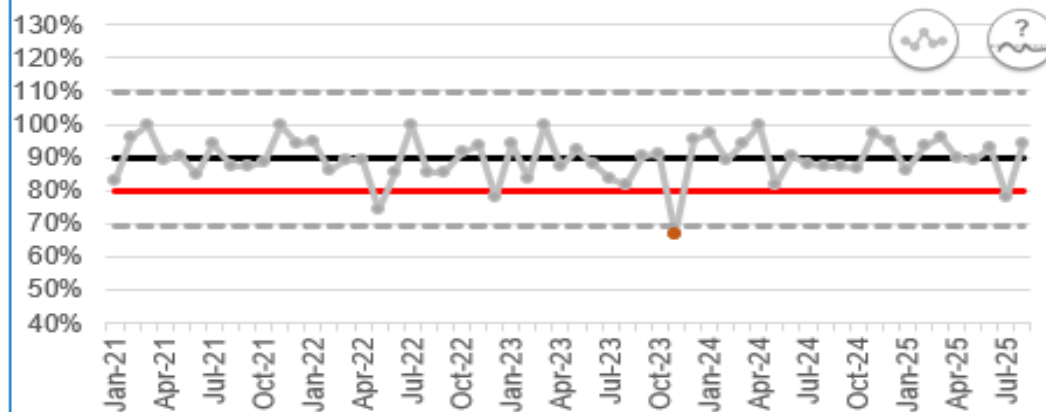


The SPC chart above shows that in August 2025 we remain in a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 94.4% in August. 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.

End of Life



The chart above shows that in August 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%.

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Patient Experience

Friends and family test results (FFT) show:

- 97% would recommend physical health services
- 89% would recommend mental health services

	Target	June	July	August
Mental health community	85%	94% (268)	95% (377)	88% (145)
Mental health inpatient	85%	92%(64)	79% (66)	83% (29)
Learning Disabilities	85%	97% (36)	97% (38)	98% (46)
ASD/ ADHD	85%	88% (43)	90% (69)	90% (29)
CAMHS	85%	77% (26)	79%(28)	81% (16)
Forensic	60%	N/A	75% (52)	75% (4)
Mental health overall	84%*	86% (480)	91% (630)	89% (273)
Barnsley Physical Health	95%	95% (371)	97% (355)	97% (319)
Trustwide	85%	90% (854)	93%(985)	93% (592)

* weighted for 2023/24

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

- All services met their performance targets in August, with the exception of Mental Health Inpatients and CAMHS. However, both services performance improved in August.
- Satisfaction levels remained the same across ADHD & ASD services, Forensic Inpatients, and Barnsley General Operations.
- Mental Health Community Services experienced a decline in satisfaction, which is currently under review by the Quality Governance Team. This trend is likely influenced by seasonal factors, as response rates typically dip during August and September due to holiday periods.
- A reduction in survey returns was noted across all services, except for Learning Disabilities, which saw an increase.
- Forensic Inpatients also reported a decrease in returns, attributed to the biannual schedule of the patient experience survey. Despite this, satisfaction levels remained consistent.

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Safeguarding

Safeguarding Adults:

In August 2025, there were 27 safeguarding adult incidents recorded on Datix. Of these, there were zero incidents graded red, 4 graded amber, 11 graded yellow and the remaining 12 were graded green. The most common subcategories of these were self-neglect and neglect, physical, domestic and emotional/psychological abuse.

In addition to the Safeguarding Adult Datix's, there were 19 sexual safety incidents recorded on Datix. Of these, there were zero Datix graded red or amber, 5 were graded yellow and 12 were graded green. The most common subcategory related to inappropriate sexual behaviour.

Safeguarding Children:

In August 2025 there were 20 Datix categorised as Safeguarding Children. The most common subcategories of these were requests for service, sexual abuse and child protection (non specific).

Complaints

- In August there were 22 new formal complaints received into the Trust. This includes Cheswold Park. This represents a significant 54% decrease compared to the previous record high of 48 complaints.
- 18 (82%) were acknowledged within the required three working days. An improvement plan is in place with the customer service administrative team to further strengthen timely acknowledgements.
- Closure of complaints: In August, 21 complaints were closed. Of these, 20 (95%) were resolved within the statutory six-month timeframe. The one case that exceeded the target involved complex circumstances, including the need for Caldicott Guardian approval (as the service user lacked capacity) and extended discussions to agree the scope of the complaint with the complainant.

Infection Prevention Control (IPC)

Outbreaks - August 2025

- There was an outbreak of Covid-19 on Willow Ward. This was managed by the ward and the infection prevention control team.

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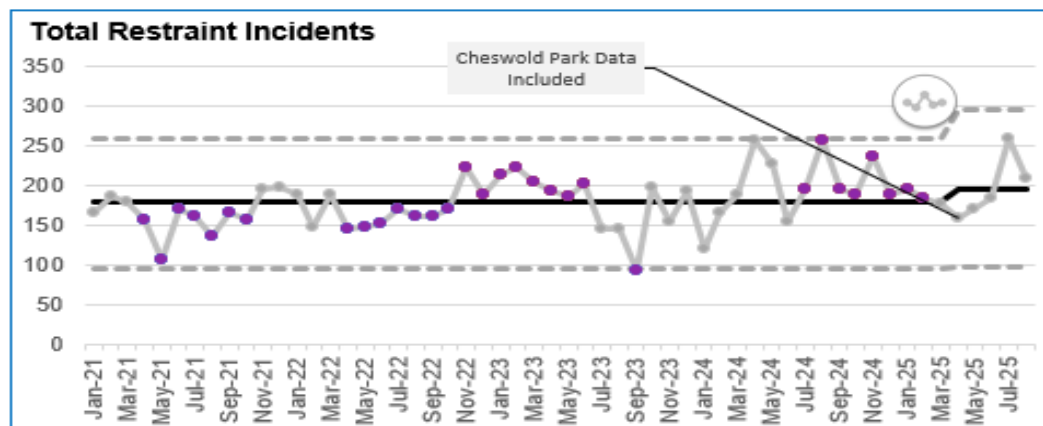
Reducing Restrictive Physical Intervention (RRPI)

This report includes Cheswold Park data from April 2025.

- There were 208 incidences of restrictive interventions in August 2025, a decrease of 50 from July 2025.
- There were nine prone restraints across the organisation in August 2025 where we have purposefully placed the person in the prone position. There were also three prone restraints that were service user led. 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 8 restraints during August has not been achieved. 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 restraint table shows the type of restraint positions used Trustwide August 2025 (in 208 restraints)

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	115	37.7%
Safety Pod	34	11.1%
Side	21	6.9%
Seated	69	22.6%
Supine - held on their back regardless of surface	23	7.5%
Prone descent then remained in chest down position	10	3.3%
Restricted escort	12	3.9%
Kneeling	9	3.0%
Prone descent then immediately rolled to other position side/back	7	2.3%
Service User placed self in prone and staff immediately let go or rol	3	1.0%
Safety Pod Technique (Immediate Exit)	1	0.3%
Safety Pod Technique (IM administration then exit)	1	0.3%
Total	305	100.0%

Please note there are more positions used than incidents due to multiple positions used during one incident.



This SPC chart shows that in August 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.

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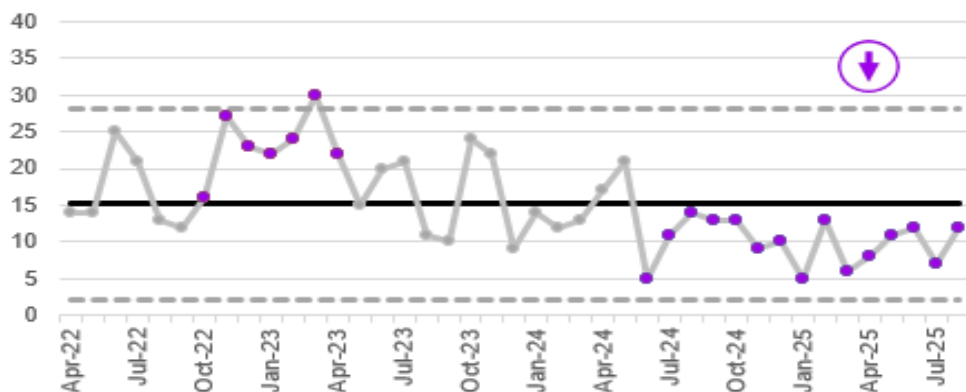
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Reducing Restrictive Physical Intervention (RRPI)

Prone Restraint (Total Number)

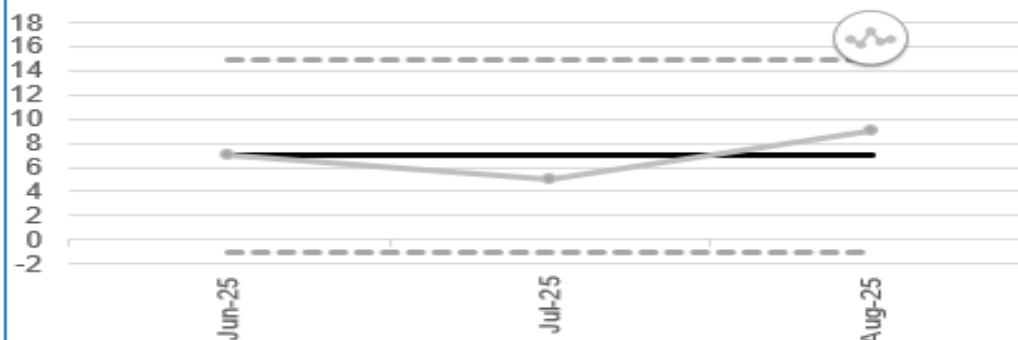


The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication.

From June 2025 we have separated out the number of prone restraints where we have purposefully placed the service user in the prone position from those that were service user led.

In August 2025 there were three instances of prone restraint that were service user led.

Prone Restraint (where we have purposefully placed the person in prone position)

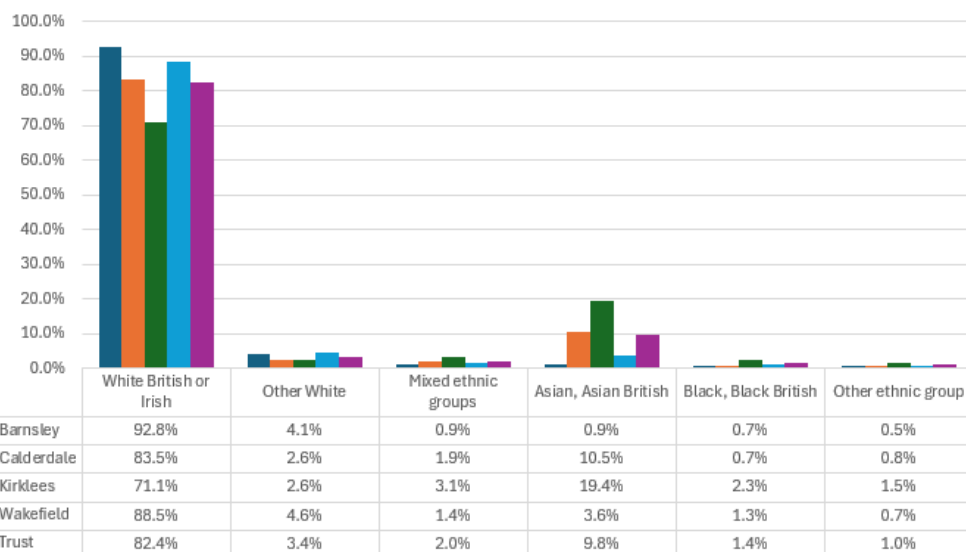


Reducing Inequalities

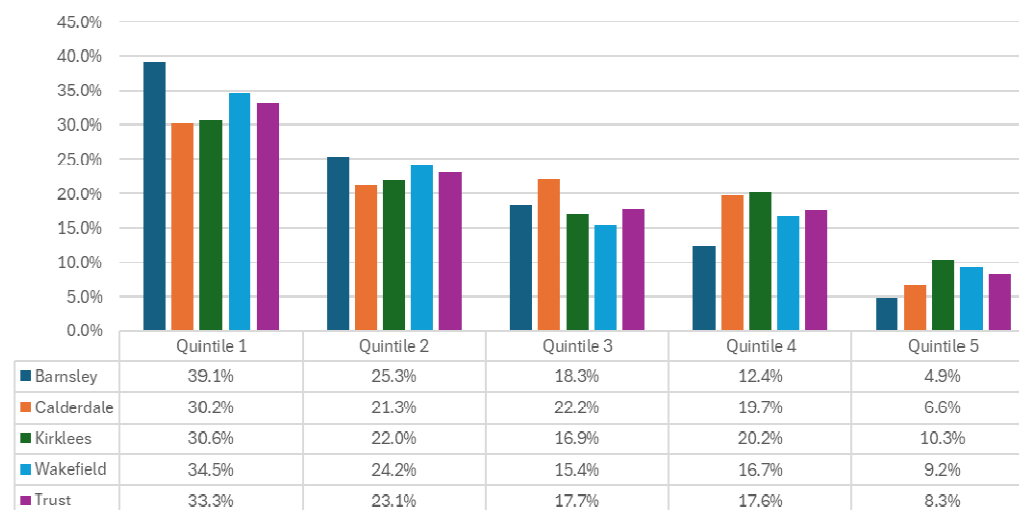
This section of the report has been added to give focus to a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. 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



Population Served by the Trust and each of its Main Localities Split by Deprivation Level



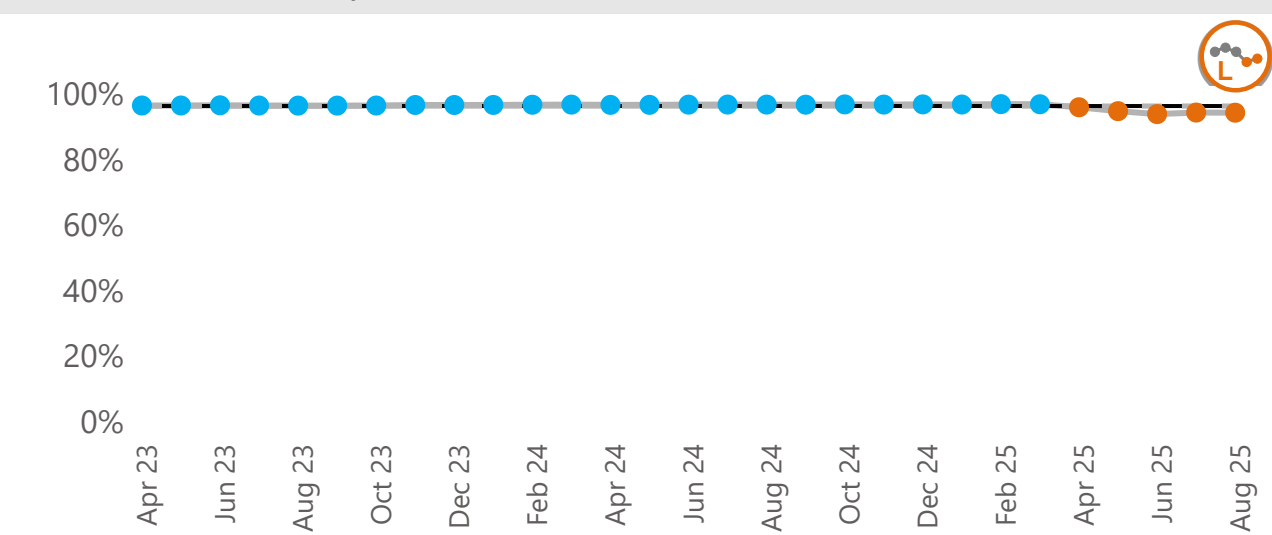
Reducing Inequalities

Data as of : 24/09/2025 17:16:26

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. A priority area of equality diversity and inclusion has been agreed at EMT to align to strategic priority programmes to Improve our Clinical Pathways, apply the Patient Carer Race Equality Framework core actions to reduce the gap in inequalities and improve access, experience and outcomes for communities faring worse across all of our mental health, learning disability and community health services with specific focus on improving systematic collection and analysis of data (both numbers and voice) according to protected characteristics and continue to promote ‘All of You’ campaign. This will provide insights that can be used to develop understanding and as the basis for our decisions leading to improved performance and positive impact for people.

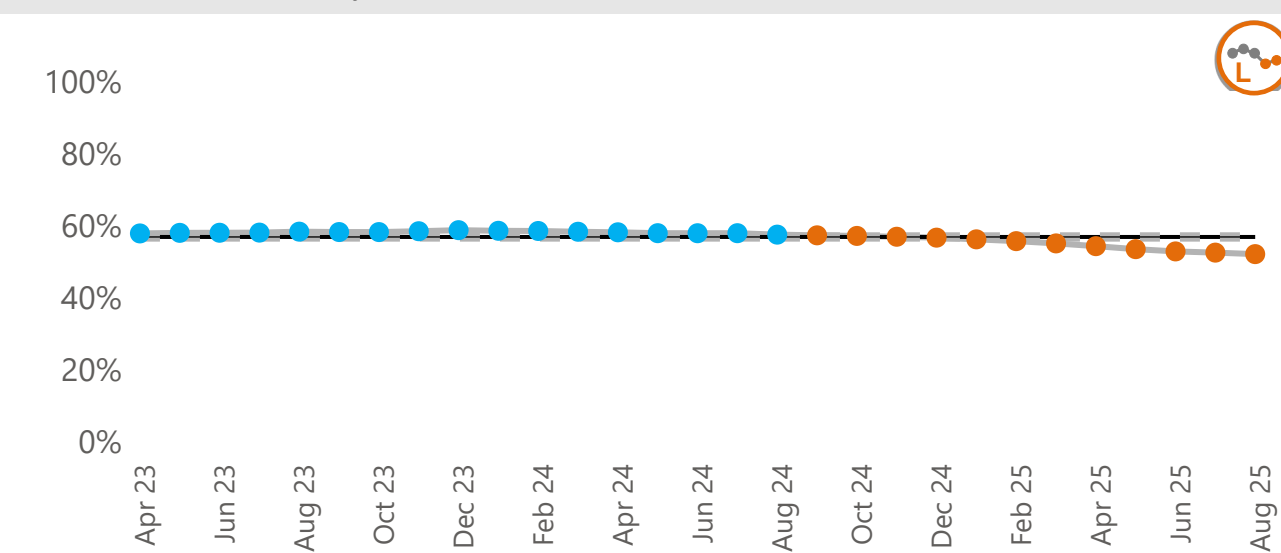
The SPC charts below show the completion rates for these measures.

M92 - Percentage of service users who have had their equality data recorded - ethnicity



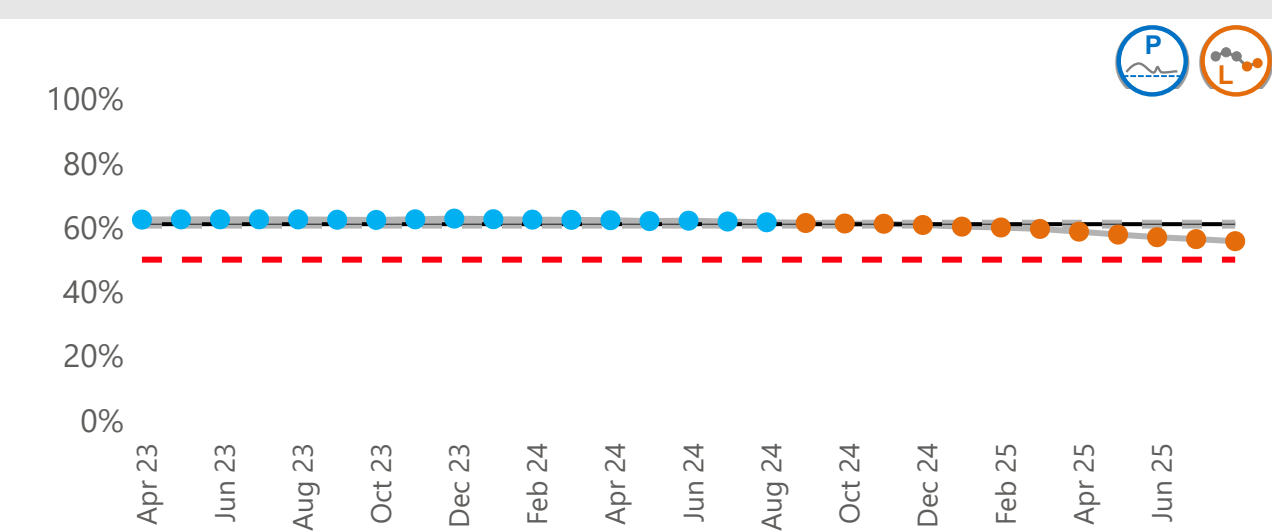
The Statistical Process Control (SPC) chart shows that in August 2025 due to the continued dip in performance we have entered a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

M93 - Percentage of service users who have had their equality data recorded - disability



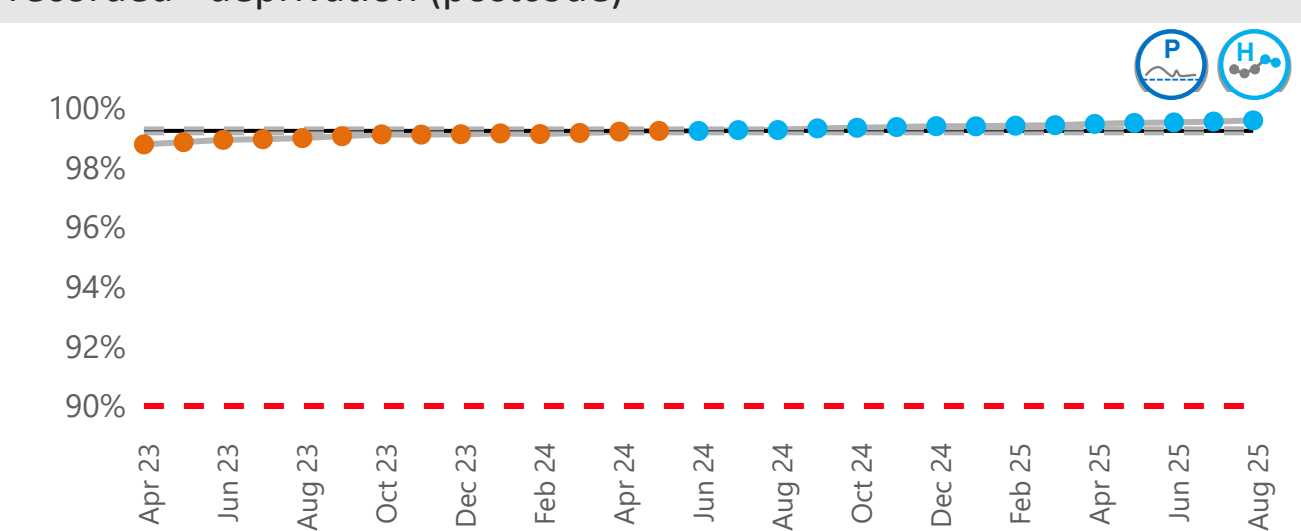
The SPC chart shows that in August 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

M94 - Percentage of service users who have had their equality data recorded - sexual orientation



The SPC chart shows that in August 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 August 2025 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance.

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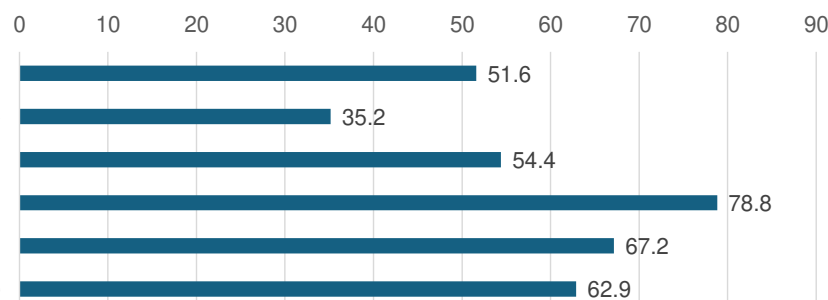
Reducing Inequalities

Please note the charts have been revised due to an error in the previous data reported. The charts 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). A review of the data relating to admissions for an inpatient stay is currently underway (anticipated completion October 2025). This work will look at:

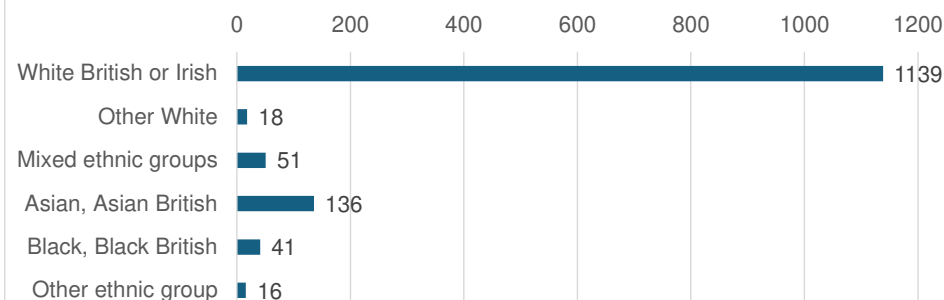
- Sex
- Age
- Ethnicity
- Deprivation
- Admission type / reason i.e. formal, informal
- Admission route
- LoS (review as a median to provide greater understanding of the distribution of the data)

The findings will be presented at the Acute Pathways & Inpatient Improvement Programme Steering Group for follow up and review of any themes identified.

Average Length of Stay by Ethnic Group

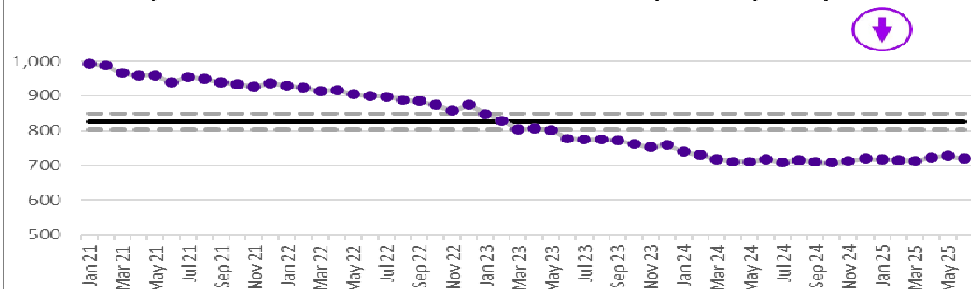


Discharges by Ethnic Group

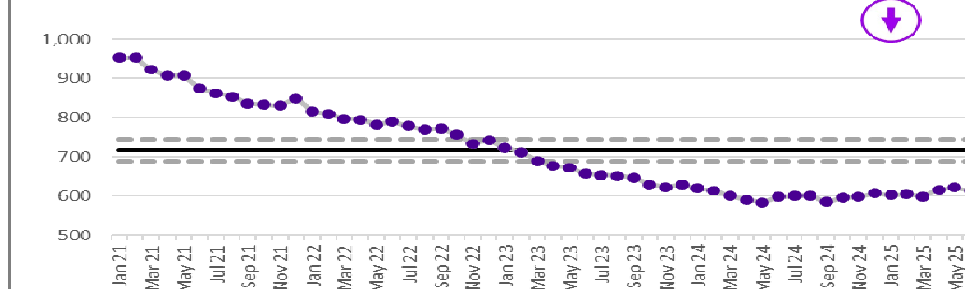


The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Quintile 1) and those with a post code in the least deprived areas (Quintile 5).

Community mental health caseload duration Quintile 1 (most deprived)



Community mental health caseload duration Quintile 5 (least deprived)



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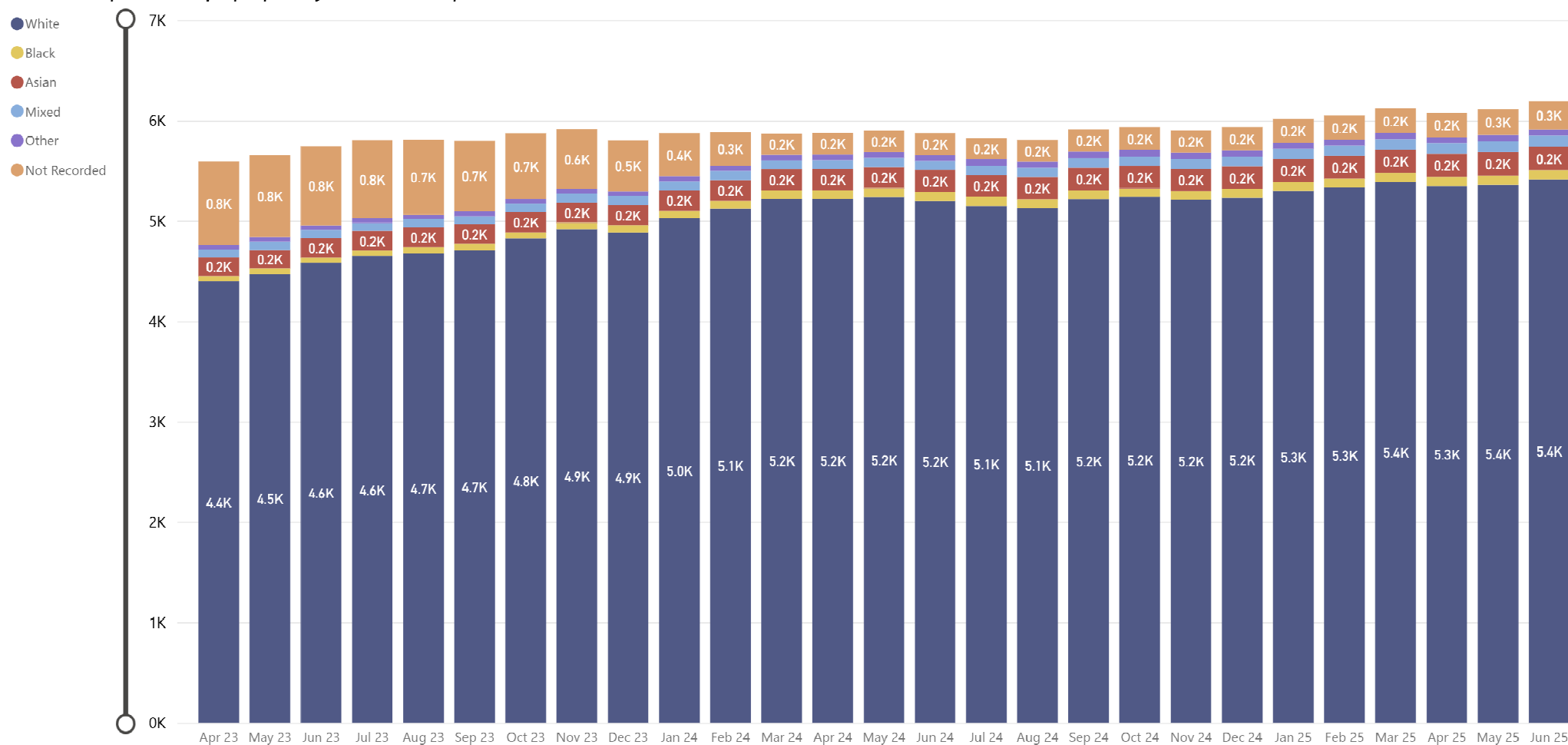
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The chart below shows the split by the ethnic group of the clients on the caseload of a community health team, shown per 100,000 population.

Caseload per 100k pop split by Ethnic Group



NB: 'White Other' is incorporated in the 'white' category in this chart.

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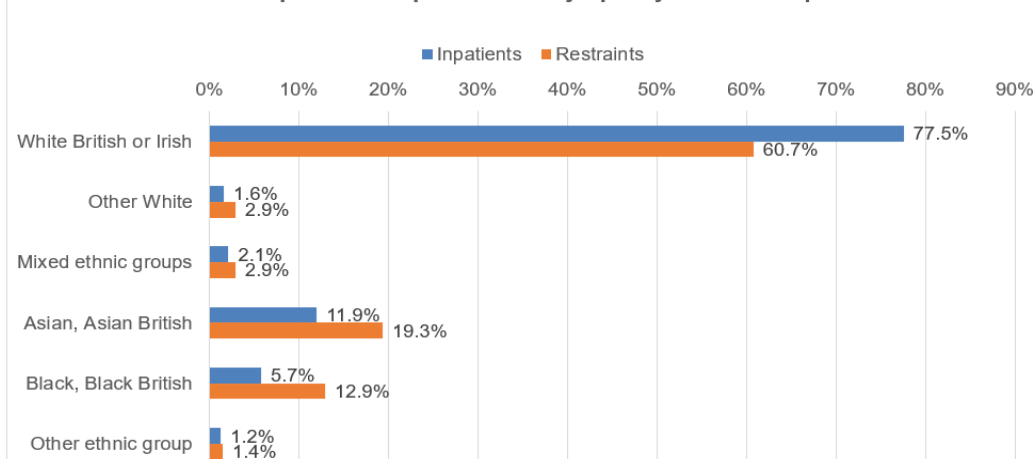
Ward Detail

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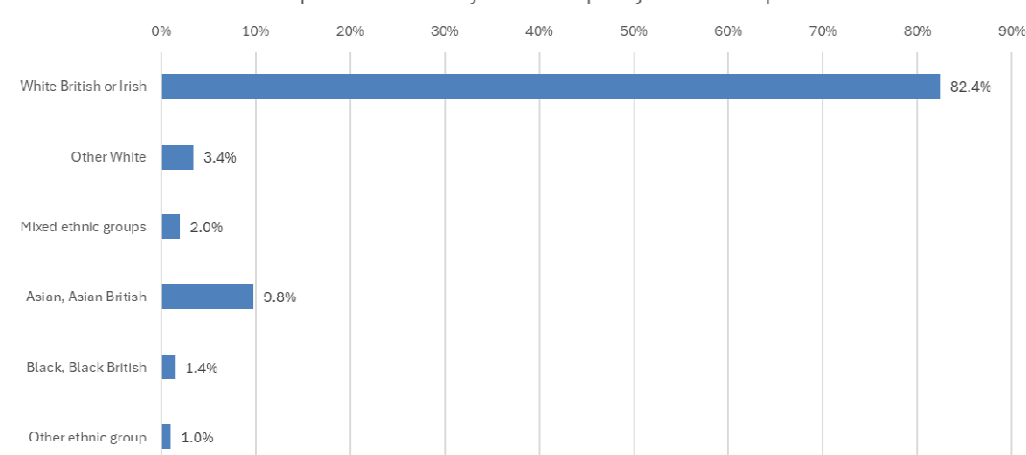
Reducing Inequalities

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.

Proportion of Inpatients in May Split by Ethnic Group



Population Served by the Trust Split by Ethnic Group



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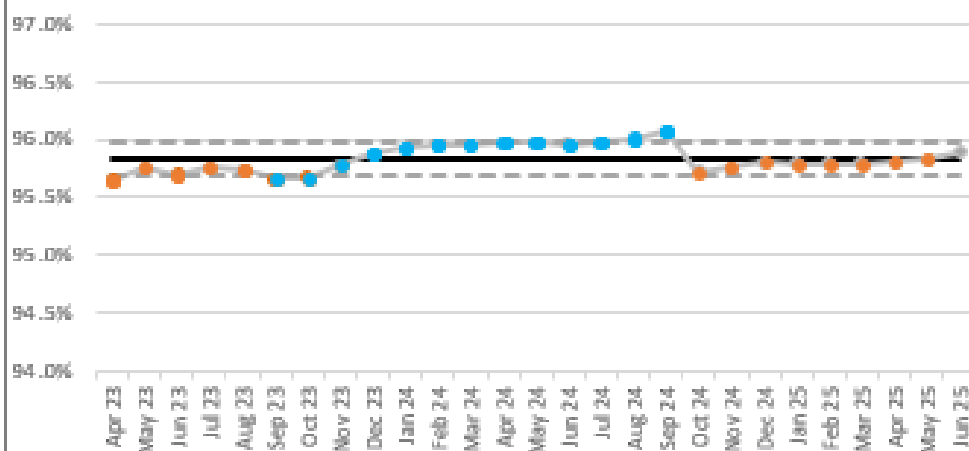
Finance/
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Reducing Inequalities

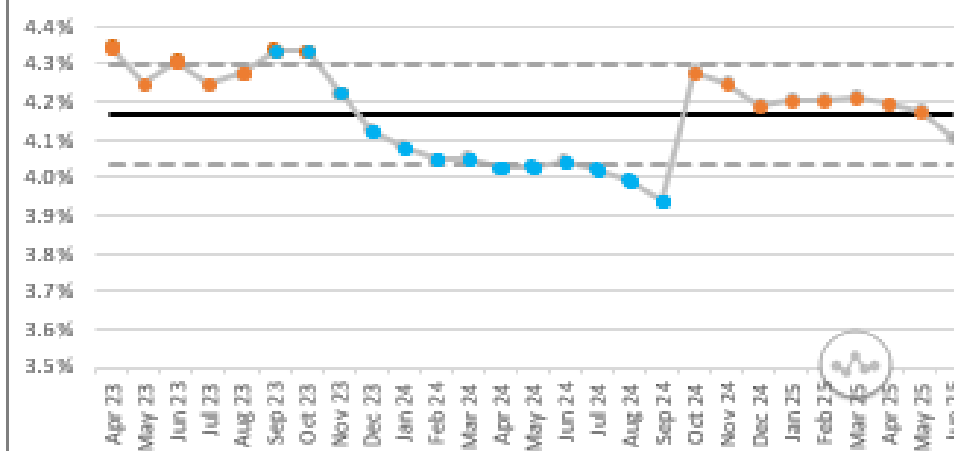
Disability Confidence and Data Transparency

Objective: Foster a culture where more colleagues feel safe and supported in disclosing their disability status.

Percentage of staff who have had their disability status recorded



Percentage of staff who have a disability status of 'unknown' recorded



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.

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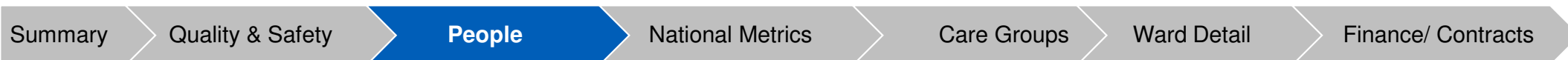
People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Establishment	Best place to work and learn	Well led	-	5514.2	5733.3	5733.3	5728.1	5724.5	5757.0
Contracted Staff In Post (Ledger)	Best place to work and learn	Well led	-	4749.9	4988.0	4971.6	4980.1	4959.0	4981.0
Vacancies	Best place to work and learn	Well led	-	764.3	745.3	761.7	748.0	765.5	776.0
Turnover external (12 months rolling) *	Best place to work and learn	Well led	>12% - <13%	8.6%	9.4%	9.2%	9.4%	9.7%	10.2%
Starters	Best place to work and learn	Well led	-	25.2	21.2	19.4	30.0	17.8	31.2
Leavers	Best place to work and learn	Well led	-	74.1	41.8	24.0	38.1	41.7	77.7
% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	85.7%	84.6%	80.8%	77.0%	72.5%	71.0%
% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	82.6%	85.2%	87.3%	82.4%	81.3%	79.5%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	90.9%	89.7%	89.5%	86.6%	84.7%	83.1%
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in post band 7 and above, excludes bank staff) *	Best place to work and learn	Well led	-	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%)	232 - All staff (17.7%) 95 - excl medics (8.6%)	232 - All staff (17.7%) 94 - excl medics (8.6%)	237 - All Staff (18.1%) 94 - excl medics (8.5%)
Proportion of staff in senior leadership roles who were women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	935 (71.4%)	936 (71.4%)	937 (71.3%)	933 (71.2%)	930 (71.1%)	71.2%
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.2%	4.7%	4.7%	4.8%	5.0%	5.1%
Sickness absence - Month	Best place to work and learn	Well led		4.6%	4.7%	4.7%	4.9%	5.3%	5.4%
Employees with long term sickness over 12 months	Best place to work and learn	Well led		2	1	1	1	0	0
Appraisals - rolling 12 months	Best place to work and learn	Well led	Feb 82.3% Mar 84.9% April 87% May 88% June 89% July onwards 90%	86.3%	88.9%	90.8%	89.9%	90.2%	88.6%
Employee Relations - Suspensions (over 90 days)	Best place to work and learn	Well led	-	2	2	6	4	2	4
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	60	66	72	74	65	62
Workforce growth (substantive staff)	Best place to work and learn	Well led	-2%	2.3%	-0.9%				
Registered substantive staff in post mental health and learning disabilities services	Best place to work and learn	Safe	Establishment - 1315	1,143	1,174	1,174	1,180	1,176	1,174
Registered substantive staff in neighbourhood teams	Best place to work and learn	Safe	Establishment - 169	166	162	160	161	160	159
% 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%	93.3%	94.0%	94.7%	95.1%	95.3%	95.7%
Mandatory Training - Reducing Restrictive Practice Interventions	Best place to work and learn	Well led		79.6%	82.1%	84.3%	83.4%	84.0%	86.4%
Mandatory Training - Cardiopulmonary Resuscitation	Best place to work and learn	Well led		79.7%	80.9%	82.7%	84.9%	85.7%	87.0%
Mandatory Training - Clinical Risk	Best place to work and learn	Well led		96.4%	96.7%	97.0%	97.6%	97.7%	97.4%
Mandatory Training - Display Screen Equipment	Best place to work and learn	Well led		98.2%	98.3%	98.5%	98.5%	98.6%	98.7%
Mandatory Training - Equality & Diversity	Best place to work and learn	Well led		95.9%	96.6%	97.3%	97.5%	97.5%	97.8%
Mandatory Training - Fire Safety	Best place to work and learn	Well led		88.9%	90.7%	91.9%	93.2%	94.3%	94.4%
Mandatory Training - Food Safety	Best place to work and learn	Well led		92.5%	94.0%	94.6%	95.1%	95.1%	92.0%
Mandatory Training - Freedom To Speak Up (FTSU)	Best place to work and learn	Well led		97.2%	97.4%	97.7%	97.8%	97.9%	98.0%
Mandatory Training - Infection Control & Hand Hygiene	Best place to work and learn	Well led		94.4%	95.6%	96.3%	96.0%	95.8%	96.1%
Mandatory Training - Information Governance (Data Security)	Best place to work and learn	Well led	>=95%	91.1%	92.4%	95.8%	97.8%	98.2%	98.3%
Mandatory Training - Moving & Handling	Best place to work and learn	Well led	>=80%	98.0%	98.3%	98.7%	98.3%	98.3%	98.4%
Mandatory Training - Nat Early Warning Score 2 (New S2)	Best place to work and learn	Well led		97.9%	98.0%	98.3%	98.2%	98.4%	98.4%
Mandatory Training - Mental Capacity Act/Dols	Best place to work and learn	Well led		91.3%	91.8%	92.2%	92.8%	93.2%	93.5%
Mandatory Training - Mental Health Act	Best place to work and learn	Well led		90.4%	91.7%	92.4%	93.7%	93.5%	93.2%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism e-learning aspect of Level 1	Best place to work and learn	Well led		94.0%	94.8%	95.3%	95.7%	95.8%	96.1%
Mandatory Training - Prevent	Best place to work and learn	Well led	>=80%	95.4%	96.4%	96.9%	97.3%	97.7%	97.7%
Mandatory Training - Safeguarding Adults	Best place to work and learn	Well led		91.1%	91.6%	91.4%	92.0%	92.0%	92.9%
Mandatory Training - Safeguarding Children	Best place to work and learn	Well led		92.4%	91.7%	91.7%	92.1%	91.6%	92.7%

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

- We continue to see and overall reduction in staff. A large proportion of this is due to ending of diversion liaison services. It has also, to lesser extent, been down to terminations of fixed term contracts as part of the Trust Value for Money programme. 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
- Ongoing recruitment of Clinical Support Workers (Health Care Support Worker) roles into our ward areas continues. This has come from both bank to substantive conversion and values based assessment centre recruitment. A number of starters have either start dates agreed or to be confirmed. A second wave of recruitment over the coming weeks has been planned to meet the remaining identified vacancies from the establishment review.

Turnover & Stability

- The increase in turnover from 9.7% to 10.2% is as a result of seeing sustained higher turnover rate within Cheswold Park (20.3%) since October 24

Our Leavers

We have seen 77.7FTE of leavers, within August 25. This is a 78% increase since July 25, which is as a result of a significant number of Fixed Term contracts ending in August. As part of our VFM, KLOE we are now seeing the impact of fixed term contracts, of which there were 23 (20.4 FTE) employees, this compared with previous months, which were considerably lower (July – 4 FTE / June – 2 FTE).

Sickness

- Overall sickness absence (year to date rolling) has risen in August to 5.1% which is now just outside overall target.
- We are seeing higher absence rates in Forensics (7.35%) and Estates (6.95%) and Mental Health (6.11%) with majority relating to higher levels of long term sickness cases which are being pro-actively managed between People Directorate Business Partners and Operational leads.
- 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 August 2025 is 88.6%. This has now slightly reduced from July (90.2%). Uptake by care group continues to be an Operational Management Group focus.
- Work to integrate the Cheswold Park Hospital appraisal rates into Trust reporting is ongoing.

Training Compliance

- Our overall mandatory training compliance remains above target at 95.7% and has risen month on month since February.
- All mandatory training at Trust level in August remains above our targets (Green).
- Information Governance training is now green at 98.2% and is the highest compliance level the Trust has ever achieved.
- Reducing Restrictive Practice Interventions Self Service and Manager self-service is open, and training planned until the end of September with availability on both 2 and 4-day

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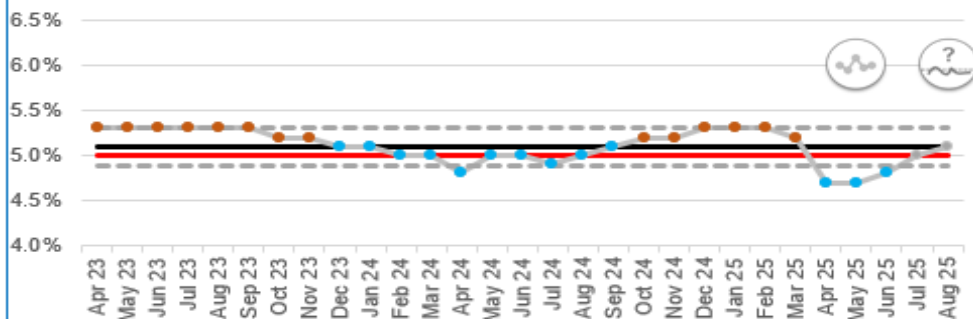
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Statistical process control charts

Trust Sickness Absence - YTD

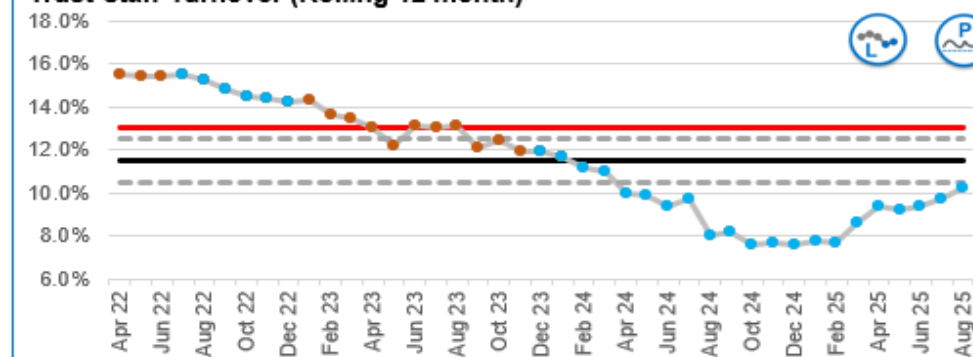


The SPC chart shows that in August 2025 we have entered a period of common cause variation (no concern) following a sustained improvement in the sickness rate.

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

From April 2025 this data includes Cheswold Park Hospital.

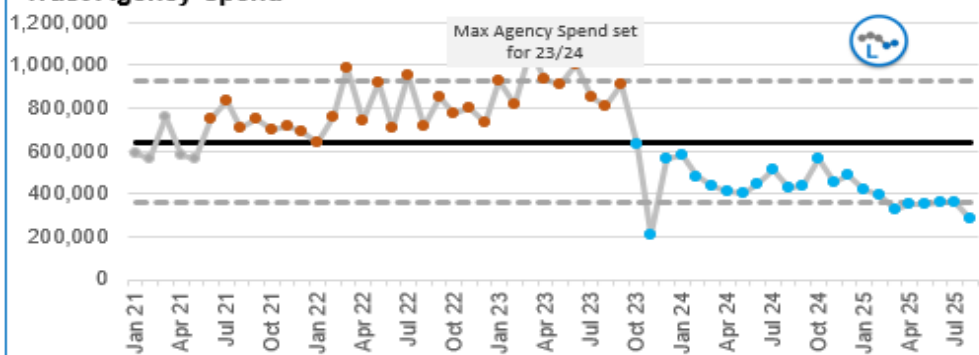
Trust Staff Turnover (Rolling 12 month)



The SPC chart shows that in August 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.

Trust Agency Spend



Agency spend in August is £281k. This remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.

The SPC chart shows that due to the sustained reduction in spend in August 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.

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NHS Oversight Framework 2025/26

On 26th June NHS England published the NHS Oversight Framework (NOF) for 2025/26. The framework outlines a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts.

It ensures public accountability for performance and is a foundation for how NHS England will work with systems and providers to support improvement.

It is a 1-year framework and will be reviewed at the end of 2025/26. A range of agreed metrics will be used to assess performance. These reflect the 2025/26 NHS priorities and operational planning guidance. Not all metrics will be used to formulate the segmentation; some metrics are contextual metrics which will be used for consideration in NHS England's oversight response. All metrics are split into domains: access to services, effectiveness and experience of care, patient safety, people and workforce, finance and productivity, improving health and reducing inequality. Assessment of the scoring metrics will determine a segmentation score.

Segmentation scores will range from 1 (high performing) to 4 (low performing). An additional segment (5) will be used if the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve, or an organisation is a challenged provider where NHS England has identified significant concerns. All organisations in deficit, or in receipt of deficit support, will be limited to an organisational delivery score of no greater than 3. Promotion of improvement and identification of support needs. Segmentation data will be reviewed at least quarterly as part of a review meeting and segments may be updated at any time based on emerging information. Data on Trust performance for quarter 1 can be seen in the table below and is also publicly available NHS.co.uk

The majority of these metrics are already included in the IPR and performance is monitored monthly, where available. Work will take place to report actual performance and associated NOF score for the Trust as soon as the data is publicly available, we are also working to have a more timely local forecast of our position.

NHS Oversight Framework			
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST (RXG)	Quarter 1		
	Performance	Score derived	Average score
Percentage of community services waiting list waiting over 52 weeks	0.00%	1.00	
% change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12 month period	0.63%	3.28	
DOMAIN SCORE - Access to Services			2.14
National CQC community mental health survey overall experience rating	As expected	2.00	
Urgent Community Response % achieving 2hr standard	97.68%	1.00	
Percentage of adult discharges with a length of stay above 60 days	22.09%	1.83	
DOMAIN SCORE - Effectiveness and Experience			1.61
NHS Staff Survey raising concerns sub-score (MHPRV)	6.92	2.00	
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours	72.24%	1.67	
DOMAIN SCORE - Patient Safety			1.83
Sickness absence rate	5.14%	2.19	
NHS Staff Survey engagement sub-score (MHPRV)	7.19	2.10	
DOMAIN SCORE - People and Workforce			2.15
Planned surplus / deficit as a proportion of turnover	0.0%		
YTD surplus / deficit	-0.1%		
Aggregated finance score		1.00	
Relative cost difference	88.55	1.40	
DOMAIN SCORE - Productivity and Value for Money			1.20
Total Score	19.47		
OVERALL AVERAGE SCORE			1.77
FINAL SEGMENTATION	3		

Due to the Trust submitting a deficit financial position, this has resulted in the Trust overall score being 3. If the financial override had not taken effect, performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as 3 out of 61 providers of non-acute hospitals (including Mental health and learning disability, community and care trusts). Performance against each of the applicable metrics can be seen above.

Drilling down into the individual metrics - areas of risk for us relate to:

* % change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12 month period. The Trust has a score of 3.28 for quarter 1 reporting a 0.63% increase over the last 12 months (June 24 - June 25), this places us as 34 out of 46 (Trusts where this metric is applicable). The metric is looking for an increase in people under 18 years old accessing the services so a higher value is better. The average value across Trusts where this metric is applicable is 4.57%. The data for this metric feeds from the Trusts Mental Health Services Data Set (MHSDS) submission which is a monthly submission of data extracted from our clinical information system, SystemOne.

Underpinning all the operational metrics is data quality. Data used for the metrics is taken from existing data flows, it is there essential that the Trust is submitting data of a high quality and this message is being re-enforced across care groups and some detailed guidance relating to the metrics is being shared with operational services to increase their knowledge and understanding of this.

A local dashboard is being developed which will allow users to drill down to patient level is being established to be able to monitor performance on this.

National Metrics

Data as of : 24/09/2025 16:50:03

South West Yorkshire
Partnership Teaching
NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0			0	0	0	0	0	0	0	0	0	0	0	0
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%			99.5%	99.2%	99.0%	98.2%	97.2%	96.7%	97.0%	97.1%	97.2%	97.8%	97.7%	97.5%
M202	RTT waiting list, of which children aged 18 years and under (WLMDs)	Best Quality	Responsive												31	53	58	50	47
M203	Number of 52+ week RTT waits, of which children aged 18 years and under (WLMDs)	Best Quality	Responsive		0										0	0	0	0	0
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680										3957	4035	4025	4151	4319
M205	RTT waiting list within 18 weeks, of which children aged 18 years and under (WLMDs)	Best Quality	Responsive												31	53	58	47	45
M206	Diagnostic test activity	Best Quality	Responsive		190										128	70	128	206	239
M209	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Best Quality	Responsive		5%										35.7%	51.3%	60.4%	53.5%	47.9%
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			97.5%	100%	97.8%	100%	100%	98.9%	100%	97.8%	97.9%	100%	98.7%	96.3%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0			138	96	131	127	106	92	128	144	148	159	196	203
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5			4	4	5	4	3	4	4	5	5	5	7	8
M208	Average Length of stay for Adult Acute Beds (rolling 3 months)	Best Quality	Responsive					59.9	61.7	64.1	59.2	61.6	62.7	65.3	58.9	58.7	56.8	58.0	58.3
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%			90.3%	97.6%	91.8%	96.7%	87.2%	94.3%	100%	88.2%	88%	97.4%	95.5%	86.7%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.4%	96.4%	96.9%	98.0%	97.8%	97.5%	97.0%	97.0%	97.6%	95.6%	96.0%	95.9%
M34	% Clients in settled accommodation	Best Value	Effective		60%			84.0%	83.3%	84.1%	84.4%	84.3%	83.1%	83.2%	83.2%	83.5%	83.0%	82.9%	75.9%
M35	% Clients in employment	Best Value	Effective		10%			12.5%	13.1%	13.3%	12.8%	12.5%	13.2%	13.2%	13.0%	13.2%	13.0%	13.3%	12.5%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	1	0	1	0	2	0	0	0	0	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	1	0	1	0	1	0	0	0	0	0

National Metrics

Data as of : 24/09/2025 16:50:03

South West Yorkshire
Partnership Teaching
NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%			100%	100%	100%	100%	85.7%	100%	100%	100%	50%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%			84.8%	88.9%	76%	59.3%	72.5%	70.2%	60.4%	75.6%	93.9%	93.3%	79.5%	86.7%
M47	Virtual ward occupancy	Best Quality	Responsive		80%			82.9%	86.7%	112%	101%	98.7%	121%	119%	101%	81.3%	90.7%	84%	90.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0			0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					97	95	117	99	91	102	93	111	109	103	87	98
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					10.3%	24.2%	17.9%	18.2%	25.3%	15.7%	19.4%	24.3%	22.0%	26.2%	23.0%	24.5%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%			99.0%	98.7%	98.6%	97.8%	98.7%	99.8%	99.6%	99.7%	99.8%	99.8%	99.7%	99.4%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%			100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%			100%	99.0%	99.1%	99.2%	99.7%	99.8%	99.8%	99.5%	99.7%	99.2%	99.7%	99.6%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%			50.7%	52.0%	52.6%	50.7%	52.6%	49.4%	50.1%	48.5%	51.9%	47.3%	53.5%	47.6%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%			70.3%	71.0%	68.4%	68.6%	68.9%	67.9%	71.6%	68.1%	68.5%	66.0%	72.1%	66.0%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%			99.5%	99.6%	98.4%	98.4%	98.0%	99.6%	99.6%	99.2%	99.6%	99.7%	99.6%	99.6%
M41	Completion of a valid NHS number	Best Value	Well Led		99%			99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100%	100.0%	100.0%
M42	Completion of ethnicity coding for all service users	Best Value	Well Led		90%			100.0%	99.5%	99.6%	99.5%	99.6%	99.6%	99.4%	99.4%	99.5%	99.0%	99.6%	99.6%
M43	Community health services two hour urgent response standard	Best Quality			70%			91.6%	90.9%	88.0%	89.2%	90.6%	90.2%	92.6%	90.3%	91.0%	91.3%	90.9%	91.9%

National Metrics

Data as of : 24/09/2025 16:50:03

South West Yorkshire
Partnership Teaching
NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%			54.1%	53.9%	54.6%	52.4%	55.1%	53.0%	53.2%	51.0%	53.5%	49.8%	56.2%	50.3%
				Place	Barnsley	50%			51.2%	51.0%	50.8%	50.9%	50.8%	49.4%	52.7%	51.3%	52.8%	48.1%	52.8%	52.6%
					Kirklees	50%			56.8%	57.0%	59.1%	53.8%	59.2%	56.3%	53.8%	50.7%	54.2%	51.6%	59.2%	48.6%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				518	679	586	509	633	524	566	615	600	653	613	476
				Place	Barnsley				253	355	317	241	311	244	270	318	312	324	272	200
					Kirklees				265	324	269	268	322	280	296	297	288	329	341	276
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				15145	15125	15096	15087	15044	14961	15248	15215	15284	15490	15560	15511
				Place	Barnsley	2000			2793	2796	2765	2750	2756	2711	2777	2862	2902	2967	3021	3026
					Calderdale	1200			1391	1400	1415	1433	1457	1480	1531	1532	1547	1559	1549	1544
					Kirklees	3600			4967	4879	4897	4875	4767	4699	4780	4749	4810	4887	4950	4917
					Wakefield	3900			4585	4620	4587	4583	4613	4632	4741	4715	4699	4779	4771	4771
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust				1305	1421	1519	1566	1642	1696	1833	1912	1982	2089	2168	2189
				Place	Barnsley	283			203	226	244	250	252	255	278	298	314	332	342	341
					Calderdale	247			242	261	264	269	279	281	302	305	312	330	339	340
					Kirklees	541			486	521	546	553	570	576	626	660	694	735	765	780
					Wakefield	406			347	375	418	440	477	508	543	558	567	588	618	624
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust				485	482	480	480	483	466	463	448	437	447	446	436
				Place	Calderdale				115	113	108	102	109	106	110	104	99	105	99	95
					Kirklees				162	162	127	125	141	142	157	153	149	155	157	167
					Wakefield				188	186	186	182	173	158	151	150	154	153	158	156

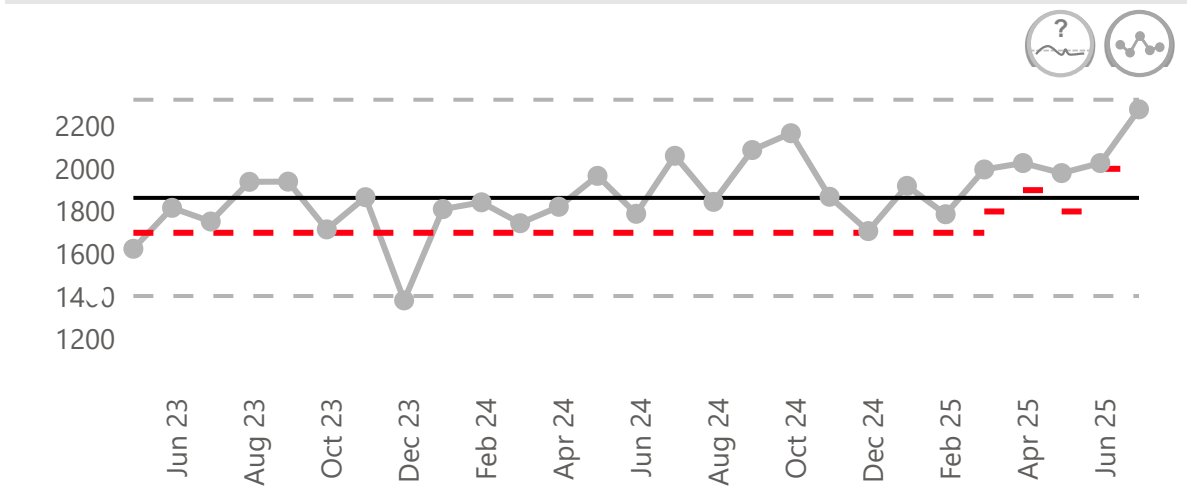
National Metrics

Data as of : 24/09/2025 16:50:03

NHS

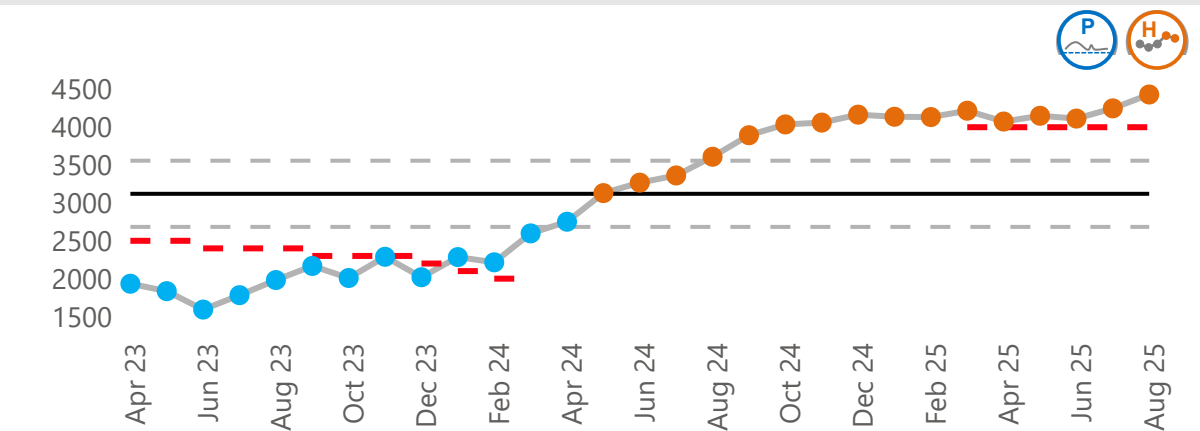
South West Yorkshire Partnership Teaching NHS Foundation Trust

M184 - New RTT pathways (clock starts)



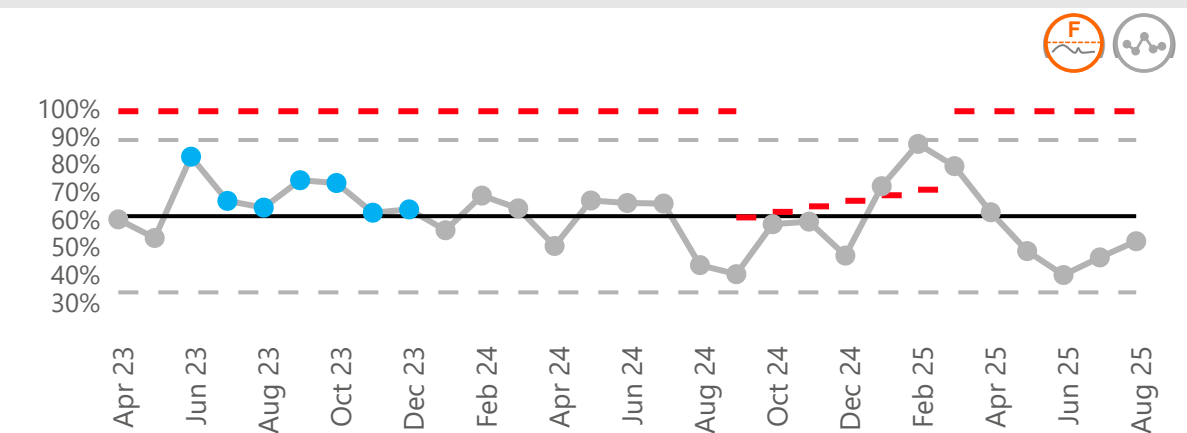
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new target is in place for 2025/26.

M45 - The number of incomplete Referral to Treatment (RTT) pathways



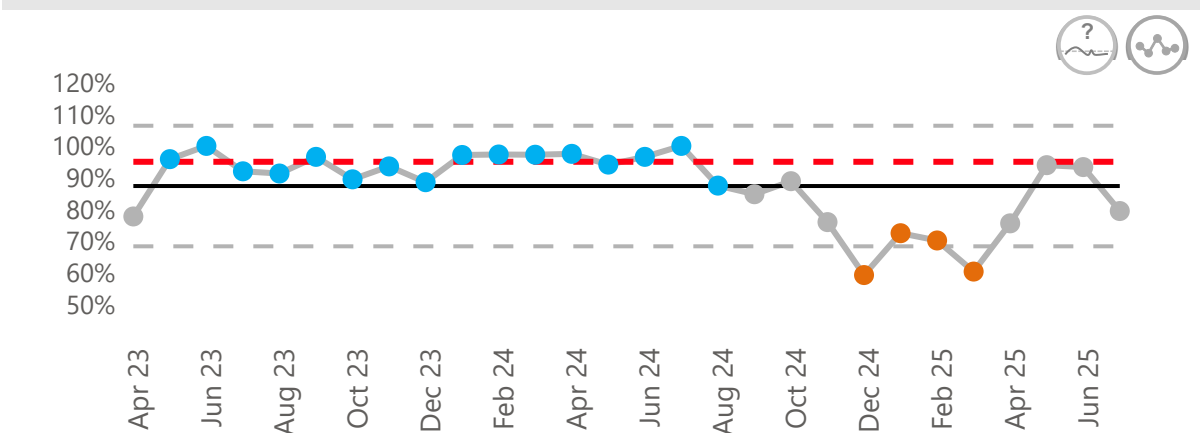
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)



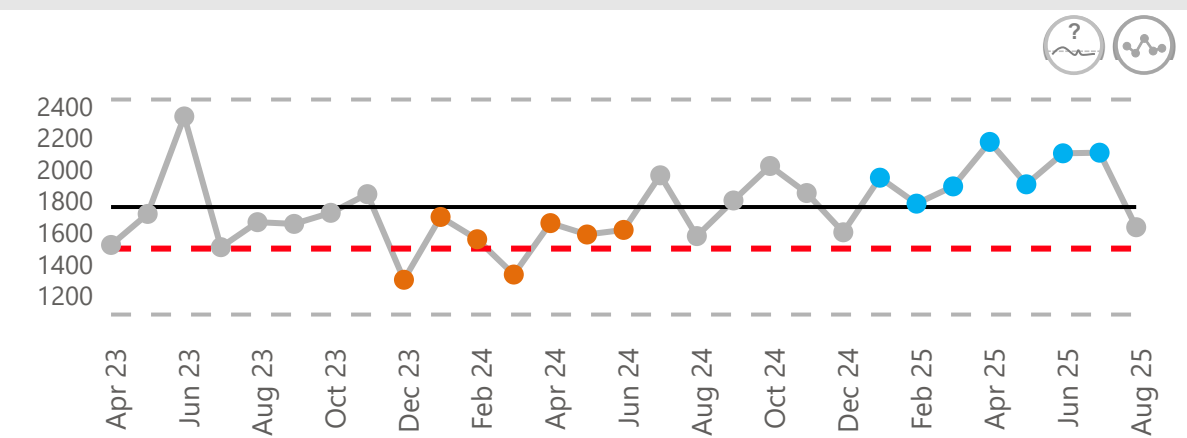
The SPC chart shows that we remain in a period of common cause variation (no concern).

M14 - Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



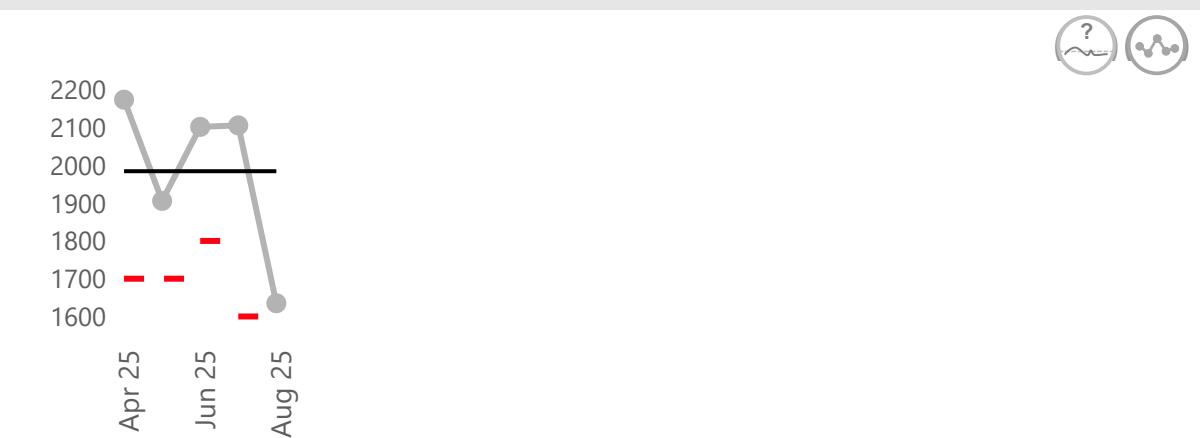
The SPC chart shows that we have re-entered a period of common cause variation (no concern) following an increase in performance in the last month which is back in line with usual performance.

M44 - The number of completed non-admitted RTT pathways in the reporting period

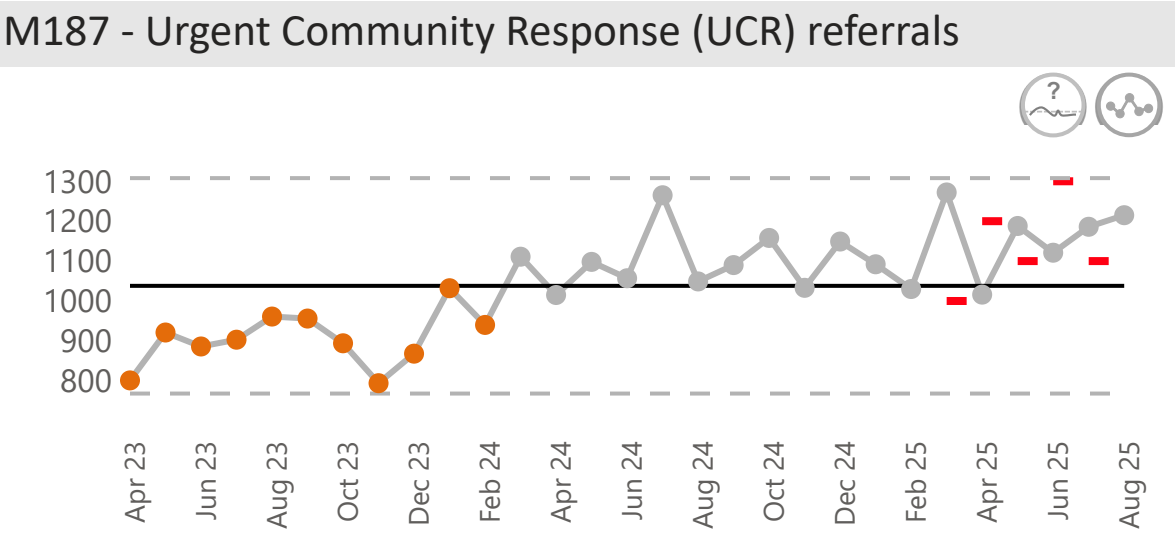


The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

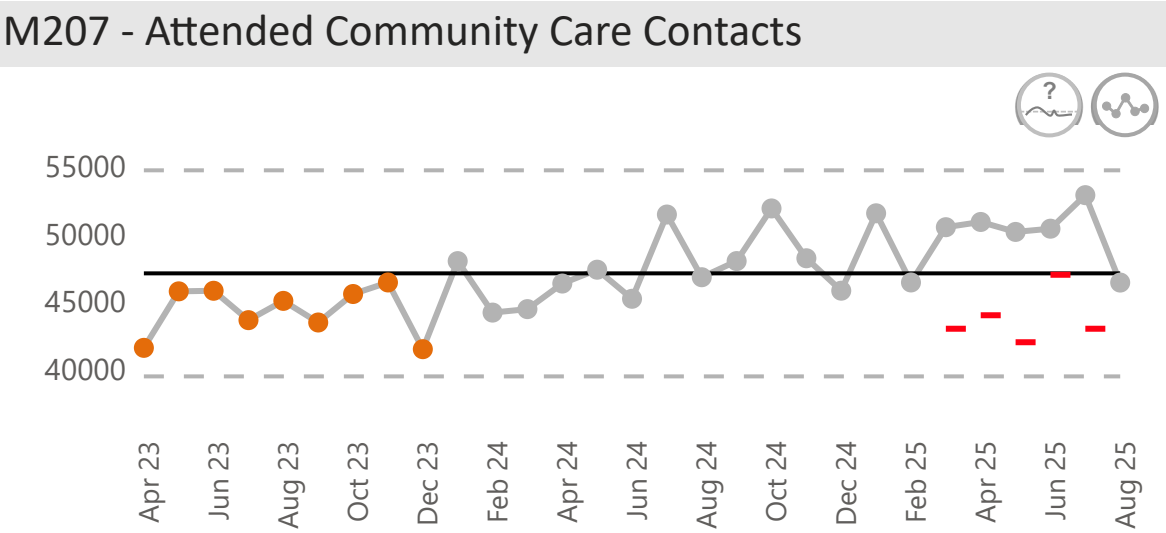
M210 - The number of completed non-admitted RTT pathways in the reporting period



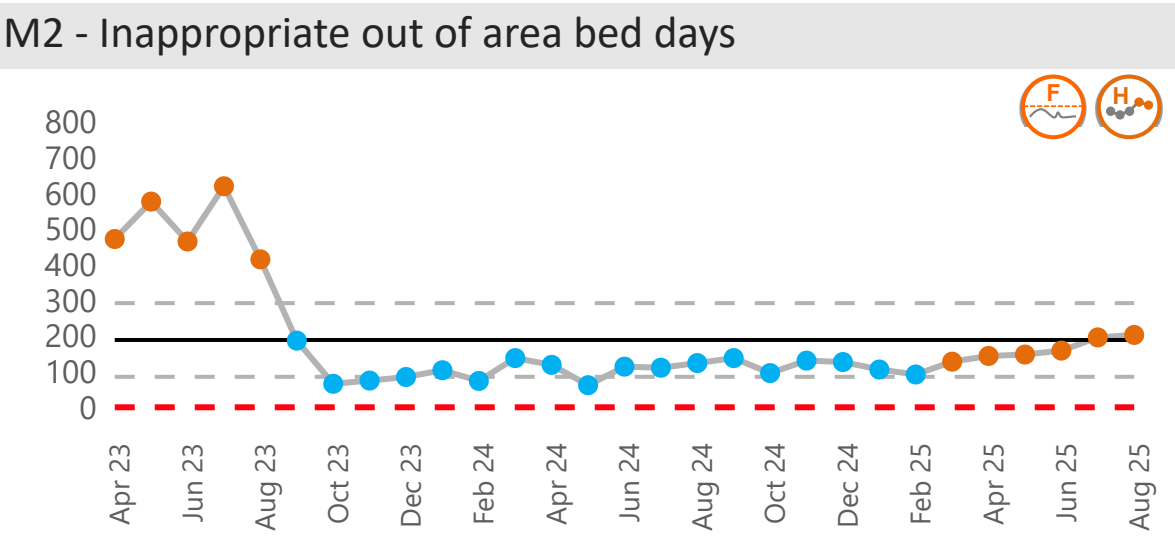
The run chart shows the continued performance above the target for this measure. As this is a new metric from April 2025 we cannot yet determine any patterns in variation.



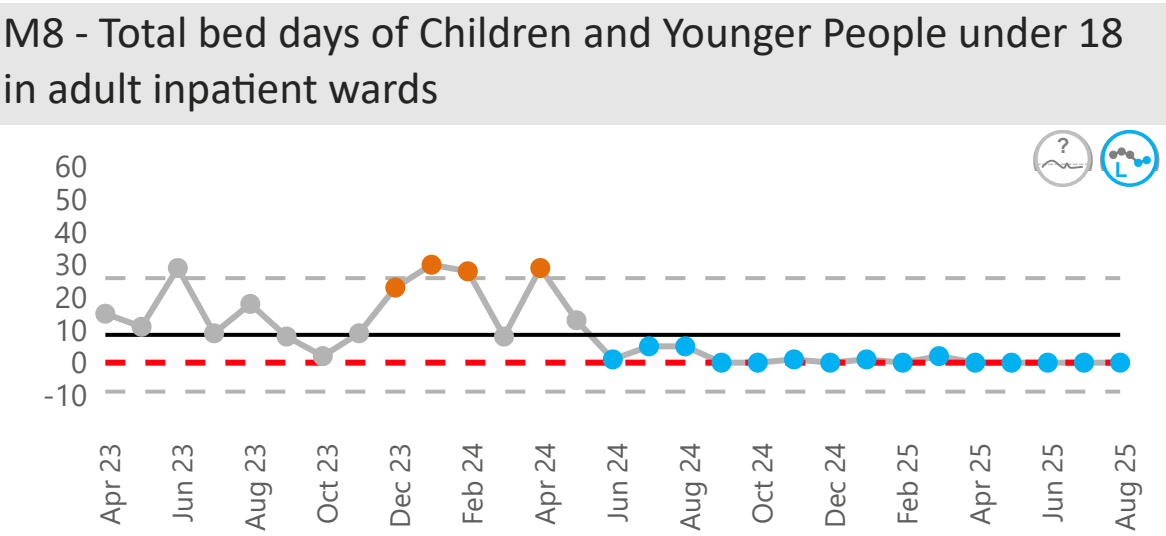
The SPC chart shows that we remain in a period of common cause variation (no concern).



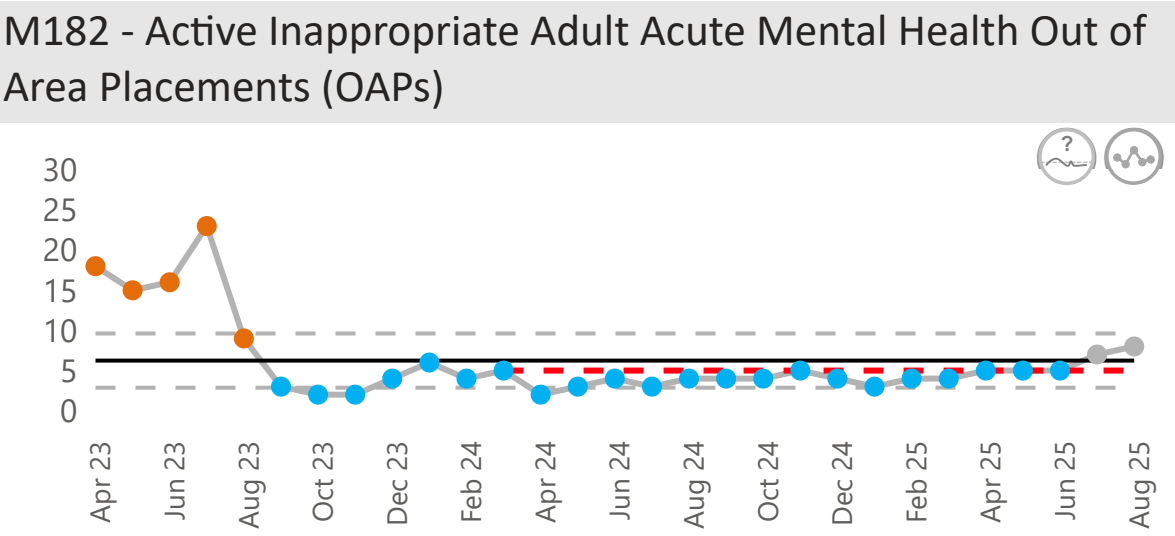
The SPC chart shows that we remain in a period of common cause variation (no concern).



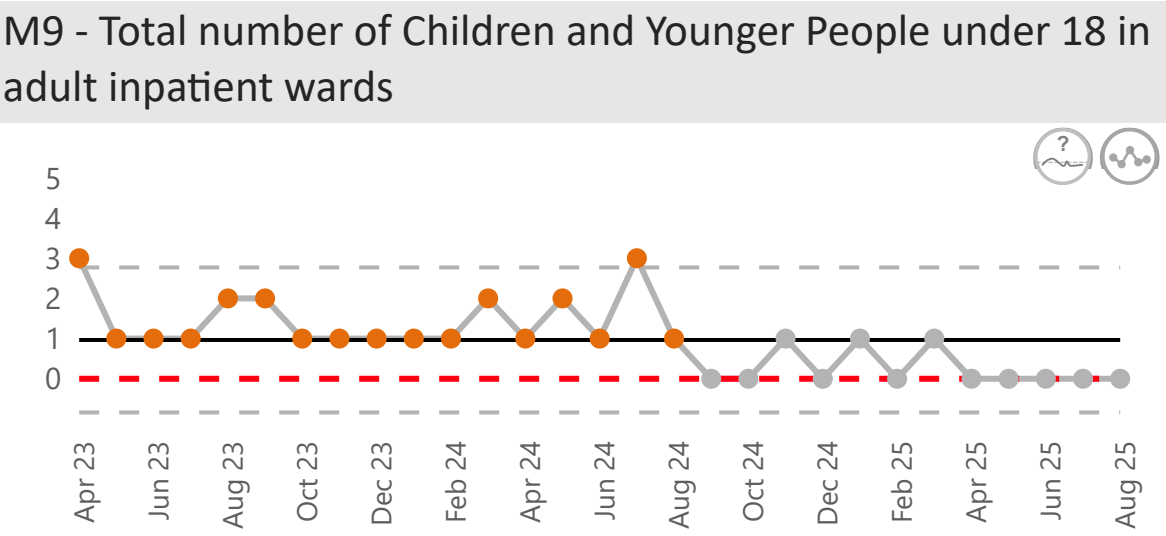
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a continued overall reduction in the performance in August. We are still not anticipated to achieve the target of zero.



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.



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.



There were no admissions aged under 18 to an adult ward in August 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.

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

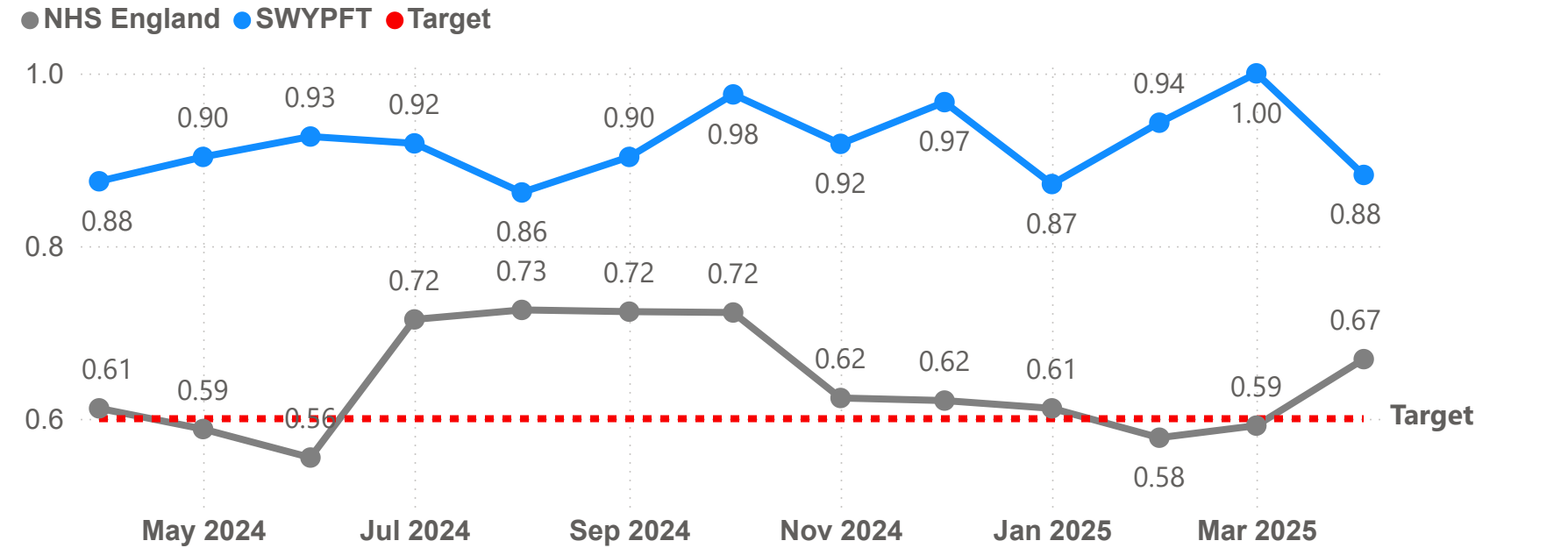
- There were no admissions of under 18 year olds to adult acute mental health beds during August.
- There was a further increase in out of area bed usage, up to 203 days used in August and 8 people remaining placed out of area at the end of the month.
- The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 86.7% in August - this relates to eight service users who was not seen, three of which relate to the ARFID (avoidant restrictive food intake disorder) pathway. The urgent access to treatment measure has achieved 100% in August.
- 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 90.7% for August.
- 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.
- Talking Therapies - Proportion of people who complete treatment who move to recovery - has decreased below threshold to 48.6% in August for Kirklees, though the Trust position remains just above the 50% threshold. The reliable recovery and reliable improvement figures for August have also dropped just below their respective targets.
- The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks in has increased in August to 52.1%, remaining below the national threshold of 99%.

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 fourth month performance against these metrics has been reported in the integrated performance report. In August none of these metrics are below expected levels.

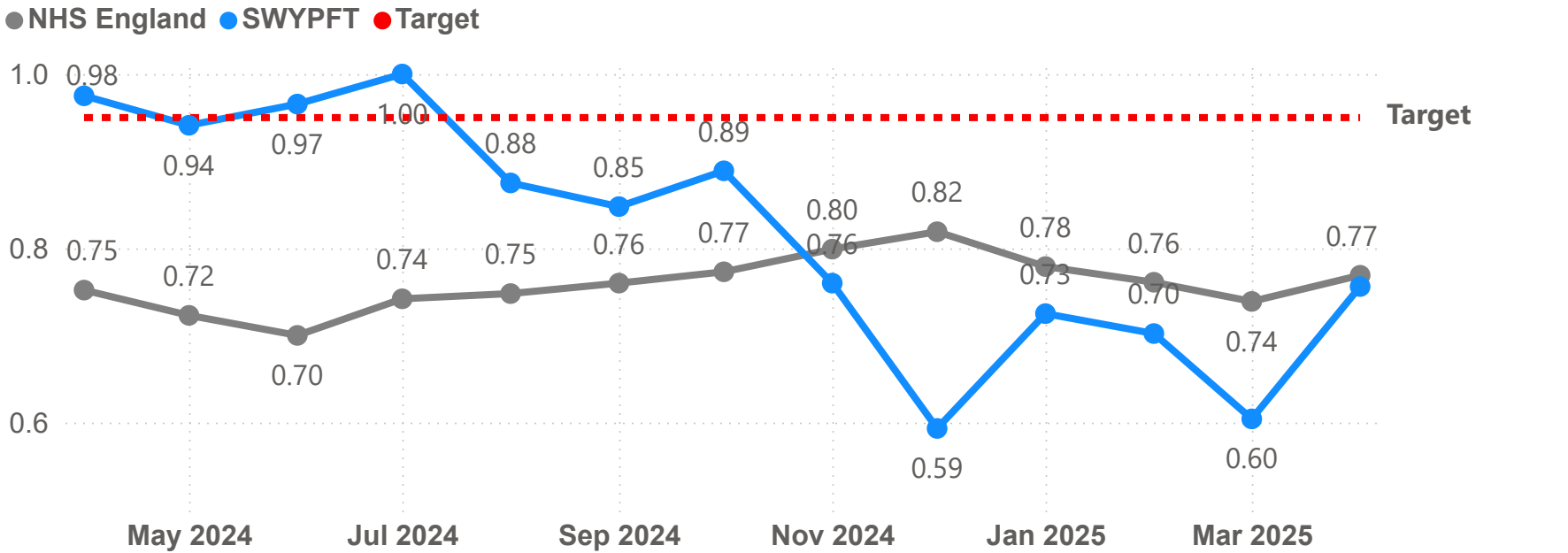
Benchmarking Headlines

This section of the report shows how the Trust benchmarks against the national England position for a number of metrics where data is readily available via NHS Futures Mental Health Core data pack. As you can see from the charts below, for all metrics except children and young people with an eating disorder % of routine cases accessing treatment within 4 weeks the Trust performs consistently above the England average. As noted above, this is due to the metric including Avoidant/Restrictive Food Intake Disorder pathway data – work continues to explore with NHS England whether these cases should be included within this metric.

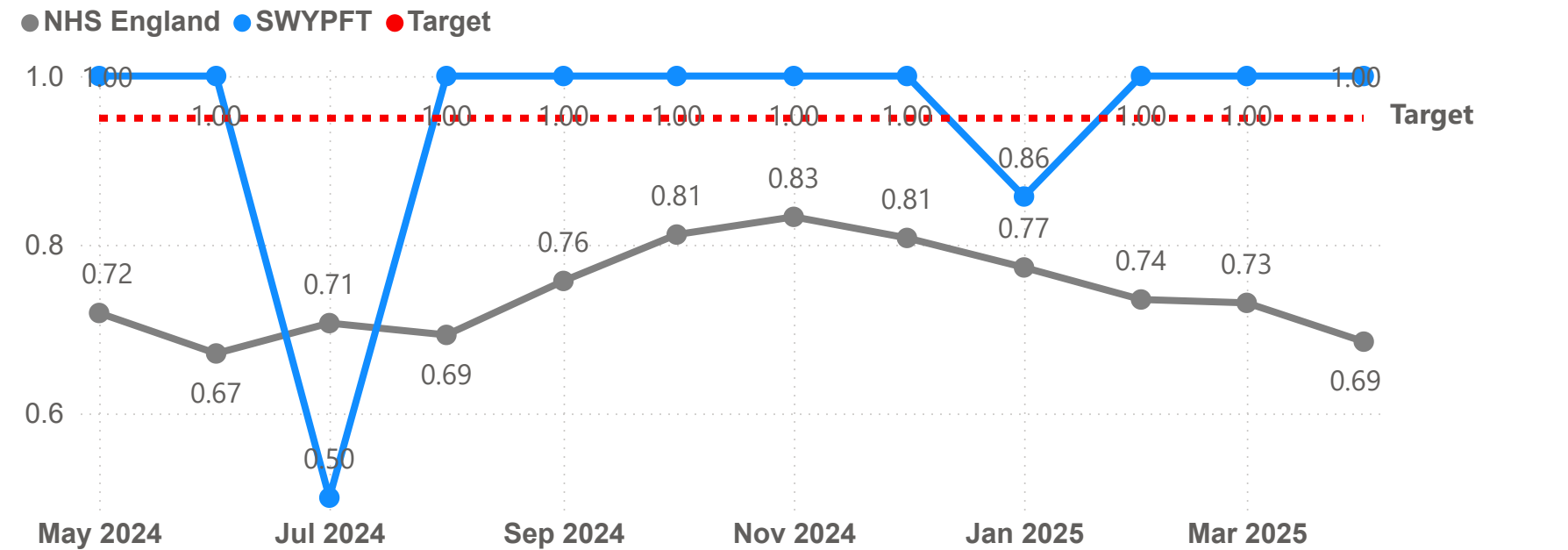
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops



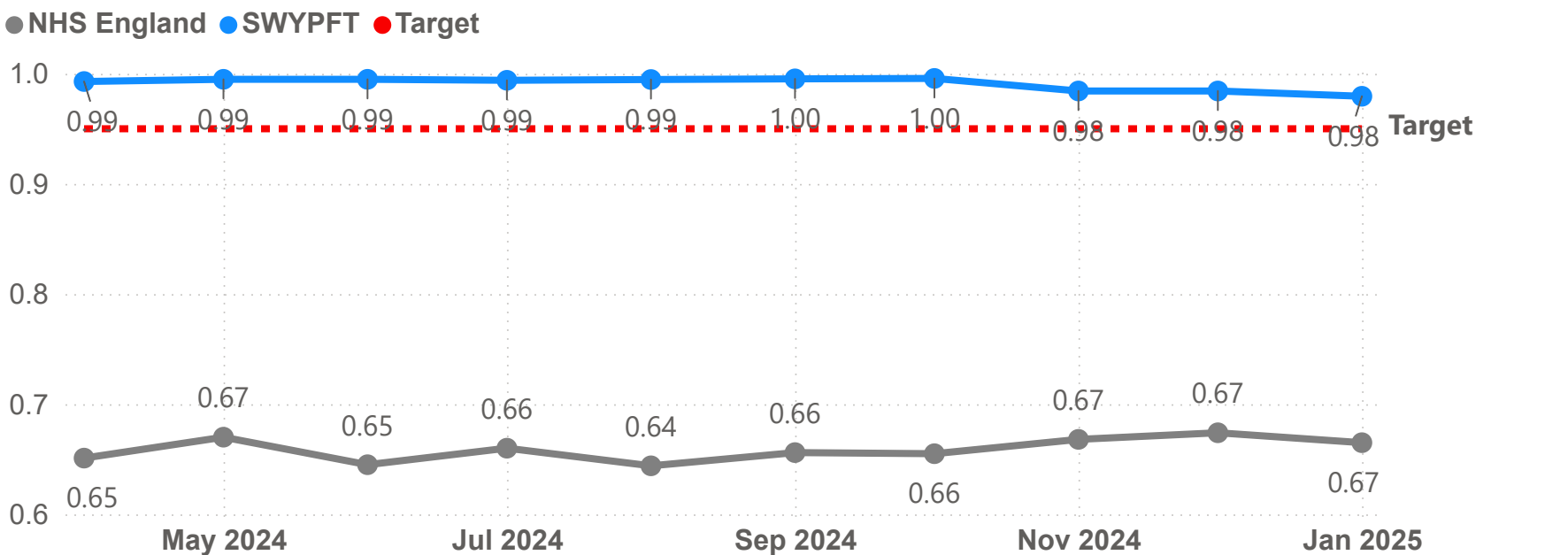
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week



Data Quality Maturity Index



Summary

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

- The reporting for employment and accommodation shows 12.8% of records have missing employment and/or accommodation status with a further 2.1% 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.

Work will be taking place over the coming weeks to prepare for planning for 2026 onwards, it is anticipated that this will include 5 year rolling plans, national guidance awaited.

Summary

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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
2.67

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

Children and Young Peoples Mental Health Services

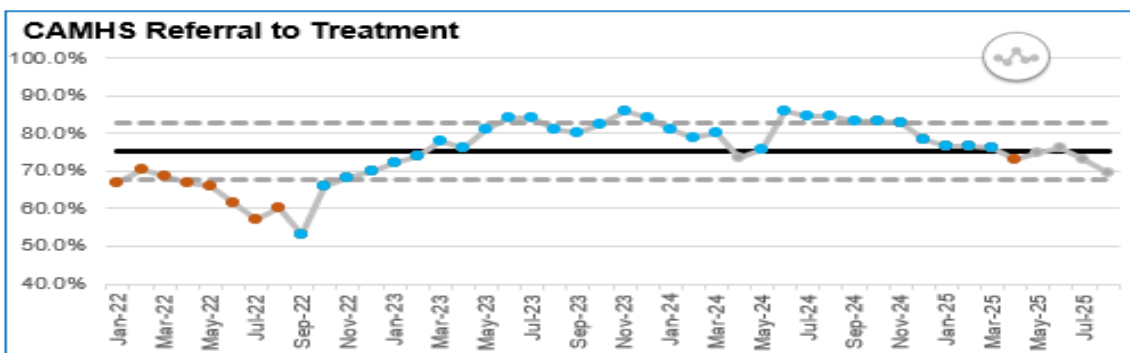
Headlines

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	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	84.0%	88.2%	88.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/5)	0% (0/5)	33% (1/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	87.1%	90.9%	89.6%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.4%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.0%	82.8%	81.7%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	93.3%	79.5%	86.7%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	100.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	98.7%	99.0%	97.8%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.5%	78.7%	80.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.6%	4.0%	4.1%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	370	356	408	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	921	959	905	
Total number of reported incidents	Best Quality	Safe	Trend monitor	46	49	29	

*From April 2024, figures now include children's physical health teams as per the change to the care group structure



In August 2025, the SPC chart indicates that we remain in a period of common cause variation (no concern), 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. Services are implementing While You Wait offers.
- Calderdale & Kirklees CAMHS Keeping Kirklees in Mind (KKiM) MHST (Mental Health Support into Schools) continues to experience significant challenges around referral numbers and recruitment and retention. These directly correlate to increased waiting numbers across all KKiM waiting lists. The Service have worked with Commissioners and now have a funded recovery plan in place, which will commence in September 2025.
- 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.
- Wakefield CAMHS staffing – ReACH Team, Primary Intervention Team (PIT) which is the single point of access (SPA) and ED Teams implementing business continuity plans due to low staffing numbers and challenges recruiting to posts although this is now an improving situation. A range of options is being considered activated led by the General Manager. The Paediatric Liaison offer is being streamlined and formalised to ensure this resource is accessible to ReACH.
- Wakefield CAMHS PIT/SPA Team is experiencing increased waits. The team is the front door to the service and handles all referrals and assessments. The KPI wait is 12 weeks for assessments and the wait now is 31 weeks. Recruitment is a real challenge. Focused work is underway around triage and developing a new assessment model.
- Secure CAMHS –The installation of SWYFT IT system access within the three settings has been approved, the timescales of the work being commenced is to be agreed. The lack of SWYFT IM&T infrastructure within the three secure settings continues to provide challenges and risks. This issue remains on the risk register due to concerns of the impact that this will have upon service delivery but has been downgraded to amber.
- Secure CAMHS –Work continues to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes
- The new care plan metrics for community are now capturing the whole community caseload including CYP&F. The care group are working with P&BI 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.

Advise

- Calderdale & Kirklees CAMHS experiencing increased referrals and reduced resources which are impacting waiting times for ADHD medication activity. Increased prevalence of ADHD has led to SWYFT receiving an increased number of referrals for medication assessment and titration from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to the number of diagnosed assessments undertaken by the Neuro Developmental assessment team in Kirklees. Calderdale commissioners considering business proposal for increasing capacity with Calderdale ADHD.
- Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for CYP requiring emergency or urgent support. In addition, the C&K CAMHS Crisis line receives in the region of 100 calls per month and also a further 25 calls per month from NHS 111. Service is working with IM&T to maximise telephony provision to streamline calls more productively.
- 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. Kirklees ND are predicting 95% establishment by end of October. Once inducted this will increase the number of assessments completed, however, demand will still outstrip capacity.
- Wakefield CAMHS – Eating Disorders team will face staffing pressures due to vacancies. Recruitment is in process. The team is using resource from across CAMHS teams to deliver the core assessment offer which adds to pressures across the service and a bank member of staff is also offering support to this process.
- Some GP practices in Barnsley are no longer accepting shared care agreements for ADHD prescriptions. This means that there is an increase in prescribing workload. Adult ADHD service will not accept CYP who do not have shared care arrangements in place, this means a delay in transition and CHYP staying on the CAMHS caseload post 18 years on and so delaying other CYP in starting medication treatment.
- Appraisal rates across the Care Group continue to improve at 89.5% in August. Targeted action plans across the care group continue for those services indicating low appraisal rates.

Assure

- Supervision continues to be above the 80% threshold in August at 86.6%
- In August overall mandatory training compliance for CYP&F in August is 94.2% above the target of 80%.
- The C&YP Management Team has realigned some of its portfolio responsibilities, and from 01.09.25 each both Calderdale and Kirklees will have a dedicated GM in each area. This will increase operational and strategic focus and provide additional support for both teams.
- Barnsley CAMHS- Our business proposal has been approved by Commissioners for the LD CAMHS pathway and wider provision which will positively impact health inequalities and service user experience. Mobilisation plans are being developed, and recruitment has commenced.

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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 and we did see an increase in use of out of area beds during July and August.

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. Community services also saw an increase in sickness during August.

Under-performance in appraisals is being addressed through line management support and oversight.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	90.2%	86.6%	 
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	76.0%	72.7%	62.6%	 
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	96.2%	88.0%	95.3%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	13% (1/8)	14% (3/22)	0% (0/6)	 
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.5%	91.9%	87.6%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	90.7%	90.1%	88.6%	 
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	94.6%	95.4%	95.3%	 
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	95.8%	95.4%	95.7%	 
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.3%	82.8%	85.5%	 
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	91.7%	92.4%	92.4%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.8%	98.4%	98.4%	 
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	83.9%	84.9%	87.3%	 
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.8%	5.5%	5.9%	 
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,207	13,182	13,176	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	129	137	107	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	94.0%	93.1%	94.9%	 
% Bed occupancy (excl leave)	Best Quality	Safe	85%	91.2%	91.2%	89.6%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	10% (2/20)	14% (1/7)	0% (0/3)	 
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	94.3%	92.2%	92.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.7%	89.9%	90.2%	 
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	6.3%	8.4%	 
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	82.1%	83.8%	85.0%	 
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (July)	158	196	203	 
Information Governance training compliance	Best place to work and learn	Well led	>=95%	99.0%	99.2%	98.8%	 
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	22	28	22	 
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	46	61	59	 
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	87.6%	89.8%	90.3%	 
Restraint incidents	Best Quality	Safe	Trend Monitor	111	160	119	 
Safer staffing (Overall)	Best Quality	Safe	90%	124.4%	123.1%	117.7%	 
Safer staffing (Registered)	Best Quality	Safe	80%	99.9%	100.2%	97.8%	 
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	6.4%	6.6%	7.6%	 
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	Best Quality	Safe	Jun 62.0, Jul 61.5, Aug 60.9	54.6	53.3	56.9	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	Best Quality	Safe	Jun 62.4, Jul 62.2, Aug 61.7	67.1	74.3	66.8	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	669	753	618	

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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 ICB's 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 August 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 remains challenging in August 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.
- 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. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and August'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.
- 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 P&BI 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.
- Care Programme Approach (CPA) review performance is above target in Calderdale and Wakefield. Barnsley and Kirklees are slightly under target this month at 94.04% and 94.69% respectively. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in August.
- The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness 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 administering 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.
- SPA is 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 August is 52.63% for Barnsley achieving the national standard of 50%. Kirklees was under target at 48.8% in August. Barnsley and Kirklees Talking Therapies were above the expected national standard of less than 10% for waits to second treatment within 90 days at 25.97% and 22.78% respectively. 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 System One. Completeness of equality data is on our data quality improvement action plan.
- There were 10 incidents of prone restraint in August all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by NQP, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.

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
- Supervision continues to be above the 80% threshold at 89.2%
- The appraisal target of 90% was met in August (90.4%)

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 - 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 number of discharges have taken place which have positively impacted those identified as clinically ready for discharge work continues with partners to encourage flow.

LD, ADHD & ASD							
Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	88.4%	85.9%	87.3%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	20% (1/5)	0% (0/4)	 
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	85.8%	93.8%	88.3%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	32.1%	40.7%	43.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.3%	86.0%	88.4%	 
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	81.8%	44.6%	56.1%	 
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.8%	97.2%	96.7%	 
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	93.1%	91.5%	95.3%	 
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	7	8	1	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.0%	85.9%	89.5%	 
Safer staffing (Overall)	Best Quality	Safe	90%	104.5%	115.4%	118.9%	 
Safer staffing (Registered)	Best Quality	Safe	80%	172.9%	170.5%	171.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.9%	4.4%	4.8%	 
Restraint incidents	Best Quality	Safe	Trend Monitor	11	5	4	
Average length of stay	Best Quality	Safe	Trend Monitor	114	333	27	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	52	41	24	

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

Alert/Action

Integrated Care Board (ICB) West Yorkshire Neurodiversity Project – Emerging Developments

- West Yorkshire Integrated Care Board (ICB) are consulting on the development of an all-age Neurodiversity (ND) hub. The hub would act as a first point of contact; offering triage, early intervention, and potential diversion from formal assessment pathways.

Adult ADHD Service

- Referral Prioritisation: Patients are not seen strictly in referral order; prioritisation is based on clinical need and multi disciplinary team decisions, including referrer requests.
- Screening & Triage - 835 individuals are awaiting ADHD triage.
- Introduced in Kirklees and Wakefield (Summer 2024) to improve referral quality.
- Early data shows reduced waiting list growth in Wakefield (from 3.7% to 1.2%).
- Barnsley and Calderdale have not yet commissioned triage but have requested updated business cases.
- Assessment Waiting List - over 6,500 people are waiting, with some waiting up to three years.
- The service is on track to meet its annual target of 430 assessments; 126 (29%) have started since April 2025.

2025/26 Capacity & Commissioning:

- Capacity remains at 430 assessments.
- Only 330 places commissioned by Barnsley, Kirklees, and Wakefield.
- Remaining capacity offered to Calderdale, with reimbursement expected via Patient Choice.

Adult Autism Pathways

- Referral Growth & Triage:
- Referrals in Barnsley, Kirklees, and Wakefield have more than doubled since 2019/20, with projected volumes exceeding 1,300 in 2025/26.
- All three areas have commissioned a triage model, where autism specialists review referral information and health records to determine clinical appropriateness.
- While feedback from some patient groups has been mixed, the model aligns with NHS England's April 2023 guidance for all-age autism pathways.
- Despite increased referrals, there has not been a corresponding rise in clinically appropriate cases, helping to keep waiting times relatively low.
- Calderdale Pathway - Waiting times have increased significantly. ICB funding originally allocated for triage was redirected to expand assessment capacity (from 30 to 55 cases/year), however, demand continues to exceed capacity by over threefold, resulting in a growing

Advise

Shared Care for ADHD Medication

The service has been delivering shared care for ADHD medication in Barnsley, Kirklees, and Wakefield for several years, and has recently expanded to include Calderdale following agreement with the ICB. National medication shortages and increased demand for ADHD assessments have placed added pressure on primary care.

Barnsley 17+ Autism Pathway

- The service have been invited to submit a business case to deliver approximately 20 autism assessments for 17-year-olds in Barnsley. This proposal mirrors a successful project delivered last year and aims to reduce waiting times for young people currently on the paediatric caseload at Barnsley Hospital NHS Foundation Trust. The business case has been developed and shared with the relevant stakeholders and outcome is awaited.
- Innovations - the service are actively reviewing and developing processes to enhance efficiency and improve outcomes for both staff and service users. Innovations include the ADHD Triage model, now commissioned in Wakefield and Kirklees, and the upcoming launch of digitised self-questionnaire tools within six months. These initiatives aim to improve patient experience, optimise clinical time, and reduce non-pay costs, offering potential financial benefits to the Trust and the wider ICB.

Assure

- All key performance targets are met
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies.
- All mandatory training meeting the threshold.

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Learning disability services:

Alert/Action

Waiting List – Quality Improvement Programme:

- Significant progress since March 2024 in reducing longest waits.
- Targeted resource deployment (e.g., Wakefield nursing staff supporting Barnsley).
- Short-term locum cover for Speech and Language Therapy, prioritising dysphagia assessments.
- 22 additional staff trained to deliver ADOS assessments, improving autism waiting list management.
- Strong clinician engagement and embedded culture of waiting list management.
- Implementation of 'Waiting Well' and 'Waiting Fairly' approaches to accelerate progress on lower-priority cases.
- Non-urgent work paused to focus on reducing waits; enhanced caseload planning and allocation.

Calderdale Physiotherapy:

- Service transitioned to the Trust on 1 April 2025.
- Contract limits caseload to 12 open cases, contributing to a growing waiting list.
- Three service users have exceeded the 18-week wait, with one waiting over 50 weeks.

Clinical Acuity

- Community Teams continue to report high levels of learning disability service users in crisis.
- Contract specifications for Calderdale, Kirklees and Wakefield are currently being updated by commissioners, these are expected back during the month for review.

Assessment and Treatment Unit (ATU) (Horizon)

- Following a recent workshop, several focused workstreams will commence in September to improve operational effectiveness and patient flow:
 - Bed Utilisation and Optimisation: Reviewing occupancy and throughput to ensure efficient use of beds aligned with clinical need.
 - Contract & Finance: Strengthening engagement with commissioning partners to clarify expectations, funding, and service delivery.
 - Clinically Ready for Discharge: Enhancing processes for identifying and progressing patients ready for discharge, reducing delays, and supporting recovery pathways.
 - Governance - These workstreams will be supported by cross-functional teams and progress will be monitored through existing governance structures.
- The service has successfully discharged five service users over the summer period.

Advise

Community

- Following the successful pilot of the 'Keeping My Chest Healthy' initiative, the service is now committed to rolling out the programme across all localities.
- Recruitment to Speech and Language Therapy (SaLT) posts continues to be a challenge.
- ADHD Assessments – Commissioners have requested a proof of concept for the ADHD assessment pathway. This will demonstrate the proposed model's effectiveness, feasibility, and potential impact on waiting times and service quality.

Assessment and Treatment Unit

- A review of the current establishment is planned to ensure staffing structures and resource allocation remain aligned with service delivery needs and strategic priorities. Further details will be shared as the review progresses.
- While the service has successfully discharged a number of service users recently, challenges persist in securing suitable accommodation to meet the needs of this service user group.
- Mandatory Training – the service is reaching the threshold for all mandatory training. Appraisal compliance has increased from last month to 86%, Supervision levels are at 87.6%
- Quality improvement - work continues, with ongoing focus on care planning and FIRM Risk Assessment. Notable improvements in compliance have already been observed.

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 performance was 98% for the month.

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Barnsley Physical Health and Wellbeing Care Group

Headlines

The Care Group continue to perform well against most metrics, however, there remains an issue with performance against the national 6 week wait for diagnostics (Paediatric audiology) which is a national issue and the Care Group continue to discuss with commissioners.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	93.9%	94.4%	93.5%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	33% (1/3)	100% (1/1)	 
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	93.1%	78.1%	94.4%	 
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	81.3%	80.7%	80.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.8%	89.5%	 
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%	98.0%	98.5%	98.5%	 
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.8%	97.7%	97.5%	 
Safer staffing (Overall)	Best Quality	Safe	90%	106.5%	107.9%	91.2%	 
Safer staffing (Registered)	Best Quality	Safe	80%	108.2%	108.8%	92.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.0%	4.1%	3.6%	 
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	99%	40.2%	46.5%	52.1%	 
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,887	6,989	7,116	
Total number of reported incidents	Best Quality	Safe	Trend monitor	225	326	235	

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Barnsley Physical Health and Wellbeing Care Group

Alert/Action

- Paediatric Audiology 6-week target for diagnostic procedures has seen a further slight improvement in August from 46.5% to 52.1% against the target of 99%. We are also continuing to see a decrease in the actual number of patients waiting. The Director of Services has highlighted to the Executive Management Team that this target of 99% is not achievable and this is reflected nationally.
- Average wait time continues to be monitored closely by the service and Service Manager is looking at maximising the use of current appointment slots. The team have also volunteered to join the SystmOne pilot to help address DNA (Did Not Attend) rates.
- Agency cover continues until end of September to maintain service delivery, whilst new staff member completes their induction period.
- We are still awaiting the outcome of the business case approved at EMT and submitted to the Barnsley Integrated Care Board (ICB) Deputy Chief Nurse to request investment into the service aligned to Quality National Standards.

Advise

- One instance of feedback with staff values and behaviours as an issue has been recorded during August. This relates to our Urgent Community Response Team (UCR) and we are currently awaiting consent from the family via the Trust's Customer Service Team. In the meantime, a timeline and fact find has commenced internally to investigate the concerns in order to proceed with further investigation once the scope is agreed; this will enable us to ascertain if the complaint is upheld.
- Medical Equipment Service compliance is a focus for our Board due to the number of devices used in our care group. Whilst compliance remains at 69%, slight improvements have been made on all years based on July data which was received mid-August.

Assure

- Appraisals - for August, the overall care group figure is 93.5% which exceeds the target of 90%.
- Staff receiving supervision - ongoing focus with a drive to improve recording and increased numbers of trained supervisors. August figure is achieving compliance at 80.4% with improvement continuing into September data. To note: 2 sessions of Clinical Supervisor Training have been cancelled recently which has an impact on our ability to achieve compliance in some teams.
- Overall sickness rates continue to improve and in August the care group is achieving compliance at 3.6%.
- Urgent Community Response Service 2-hour target is 91.9% at end of August 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) – 97.45% for August 2025.
- People dying in their place of choosing has increased in August and is achieving 94.44% compliancy against the threshold of 80%.
- Information Governance training maintains compliance at 98.5%.
- Friends and Family Test (FFT) 97% of people would recommend community services.
- CPR training maintains compliance at 89.5% for August.
- Virtual ward occupancy rate maintains compliancy at 90.7% which continues to be above the target of 80%.
- The Trust's first T Level student (business and management) secured a substantive role within our Community Administration Team at Kendray.
- Our Care Group registered interest with NHS England to be part of the national evaluation of Virtual wards, and we have been selected to take part.
- The waiting list for Long Term Conditions (LTC) Occupational Therapy is now reduced to 8 weeks (19 patients waiting), which is the lowest it has been for some time and demonstrates the team's commitment to patient care.
- Notes from The Nest (RSPB Nature Prescriptions e-newsletter) references our Integrated Community Stroke Team in the August edition. Both the ward and community elements of the service have been trialling Nature Prescription for several years with positive outcomes. The theme of nature connection has been brought into the Stroke Support Cafes. In our ward setting, all rooms have access to the ward garden encouraging time outside and engagement with nature for our patients supported by our staff.

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Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue - 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.

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

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	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	84.3%	85.8%	79.4%	 
% Bed occupancy (incl leave)	Best Quality	Safe	90%	81.9%	85.3%	85.3%	 
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	66% (2/3)	0% (0/1)	 
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.4%	88.1%	87.3%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	100.0%	98.9%	97.9%	 
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.1%	86.3%	86.5%	 
% 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%	50.0%	0.0%	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%	96.8%	92.3%	90.5%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.2%	96.5%	97.6%	 
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	5	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	20	16	9	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.5%	88.0%	86.8%	 
Restraint incidents	Best Quality	Safe	Trend Monitor	34	38	15	
Safer staffing (Overall)	Best Quality	Safe	90%	118.1%	120.7%	129.7%	 
Safer staffing (Registered)	Best Quality	Safe	80%	100.6%	102.5%	98.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	7.5%	8.8%	7.4%	 
Average length of stay	Best Quality	Safe	Trend Monitor	670	1309	1899	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	232	246	224	

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Forensic - West Yorkshire:

Alert/Action

Forensic Community Transition Team

The Forensic Community Transition Team currently operates without designated funding from the West Yorkshire Provider Collaborative and has not received investment for community service development. Despite escalation, the issue was reviewed at the Adult Secure Services Board in July, where it was confirmed that funding for the service will not be supported going forward. In response, the service will complete a Decision Tree analysis to inform discussion at the upcoming Value for Money meeting on 20th October 2025.

Bed Occupancy

Occupancy levels across medium secure services remain below commissioned capacity, with the most notable underutilisation seen in the Learning Disabilities (LD) and Women's pathways, where there are currently no active waiting lists. This continues to present challenges around service efficiency and the optimal use of resources.

Conversely, referrals for male medium secure beds have increased significantly, resulting in a growing waiting list and contributing positively to overall utilisation. This shift in referral patterns may reflect emerging trends in demand and warrants close attention in future service planning and pathway development.

In response to these dynamics, the service has commenced more detailed discussions around bed modelling to better align provision with current and projected needs across pathways.

- Newton Lodge: 86.38% – Increased referrals in the male pathway; occupancy spans learning disability and women's services.
- Bretton Centre: 87.27% – Admissions are pending due to legal processes.
- Newhaven: 74.19% – Reflects ongoing underoccupancy.

Appraisals

Appraisal completion remains a key workforce priority, reflecting the service's commitment to staff development, engagement, and accountability. Significant progress has been made, with current completion rates at 80.9% for inpatient services and 71.4% for community services. The recent dip in performance is attributed to an increased number of staff requiring appraisal in September.

To support improvement and ensure thresholds are met, the Care Group is working closely with the People Business Partner, who is providing targeted support to managers across services.

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Advise

Sickness Absence

Service Overview

Sickness absence rates remain above the expected threshold across several service areas, with current year-to-date figures as follows:

- Newton Lodge: 6.9%
- Bretton Centre: 8.2%
- Newhaven: 13.4%

Workforce stability and resilience remain areas of focus, with ongoing challenges particularly evident at Newhaven, where absence levels have been significantly elevated. The service continues to work closely with the People Relations team to explore underlying causes and identify targeted interventions. This includes reviewing absence patterns, enhancing wellbeing and support mechanisms, and ensuring managers are equipped to respond proactively.

Encouragingly, in-month absence rates have reduced across all three inpatient services, with current figures at:

- Newton Lodge: 6.6%
- Bretton Centre: 8.8%
- Newhaven: 9.5%

Further updates will be provided as improvement plans are developed and implemented

Mandatory training overall compliance:

- Newton Lodge – 94.2%
- Bretton – 94.9%
- Newhaven – 95%

To note all mandatory training is above the threshold across the three inpatient services.

Forensic Improvement Programme – is well underway with several workstreams focusing on improved service user experience and outcomes and improved efficiencies.

FIRM Risk Assessment – a quality improvement initiative is underway to strengthen compliance with the FIRM Risk Assessment process. Early indications show that compliance is already improving, supporting safer and more consistent clinical decision-making.

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%.
- The percentage of Service Users on Care Programme Approach with a formal review within the previous 12 months – 100%

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Forensic - South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	May 88% June 89% July 90%	84.4%	94.3%	95.3%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	78.3%	81.2%	84.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/1)	0% (0/1)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	81.0%	94.6%	96.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.4%	76.9%	75.5%	
% of clients clinically ready for discharge	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%	96.2%	94.0%	89.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	2	1	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	10	8	3	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.3%	85.3%	85.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	15	16	11	
Safer staffing (Overall)	Best Quality	Safe	90%	123.0%	122.1%	131.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	94.6%	96.3%	101.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	5.1%	4.7%	3.8%	
Average length of stay	Best Quality	Safe	Trend Monitor	2637	1077	851	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	121	107	131	

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Forensic - South Yorkshire:

Alert/Action

- Wentbridge (ASD ward) - Following heavy rainfall, a roof leak on Wentbridge Ward necessitated the evacuation of the ward. Initially, service users were temporarily accommodated across the service while Estates and Facilities colleagues carried out remedial work on Hamilton Ward, where service users will now remain until repairs to Wentbridge are completed. The roof works are estimated to take approximately six months.
 - Water Quality - Water quality remains an ongoing risk, and all admissions are subject to a water hygiene risk assessment as part of standard procedures. This risk is actively monitored and reviewed on both the Estates and Facilities Risk Register and the Cheswold Park Hospital Programme Group Risk Register, ensuring visibility and oversight at multiple governance levels.
 - Bed Occupancy - Following its reopening under SWYPFT in October 2024, Cheswold Park has steadily resumed operations, including both admissions and discharges. The service has continued to support new admissions throughout the reopening phase, gradually rebuilding capacity and stabilising core functions.
- Current Bed Occupancy is 76. Including patients requiring a warrant, there are an additional 11 admissions planned by 31 October 2025. Informed by lessons from previous admissions, regular updates on warrant progress are being requested to support timely and coordinated transfers.
- There are currently three planned discharges with identified onward pathways, also scheduled to take place by 31 October 2025.
- If all planned admissions and discharges proceed as expected, occupancy will reach 84 by the end of October. It is important to note that all planned admissions are subject to successful medical staff recruitment. The Chief Medical Officer is working closely with the medical clinical lead to support this process.
- Cardio pulmonary resuscitation (CPR) training compliance - 75.5% with a recovery plan to be above threshold and mitigating actions to ensure CPR trained staff are on duty at all times.
 - Information Governance training compliance is 89.8%

Advise

Cheswold Park – Integration and Service Development Update

- Cheswold Park continues to make steady progress in its integration into the Forensic Care Group, aligning with Trust-wide governance structures and operational frameworks. This integration is supporting greater consistency in standards, oversight, and strategic direction.
 - A corporate services establishment review has now been completed, providing clarity on resource requirements and supporting future planning.
 - Quality and safety oversight is maintained through the internal Quality Improvement Group, which now meets quarterly to provide structured assurance and a forum for continuous improvement.
- External oversight from NHS England and the South Yorkshire Provider Collaborative remains at a routine monitoring level, reflecting confidence in the service's progress.
- Strategic priorities have been defined for the next six months across both the Programme Group and Clinical/Operational services, with a clear focus on stabilisation, development, and future planning.
 - Work is underway to develop a clear clinical and operational model to guide future service delivery and inform workforce planning. A medical workforce business case has been submitted to the extended management team and approved, supporting future admissions in line with the overarching business case. Additional business cases for Psychology, Allied Health Professionals, and Pharmacy are in development to strengthen multidisciplinary provision.
 - The service is also progressing with policy and procedure alignment to meet Trust, CQC, and secure service standards. A ward manager development programme is underway to enhance leadership capability and align roles with Trust-wide expectations.
 - Support is being provided to improve internal and external reporting mechanisms, enhancing performance monitoring. Additionally, access to the Trust bank has now been established, improving the sustainability and flexibility of ward staffing.

Assure

- Turnover remains at a low level reporting 1.1%.
- Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority.

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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

- 15 wards have achieved the 90% threshold target in August.
- Beamshaw (80%) remained below compliance threshold, impacted by clinical acuity and ward manager absence (maternity leave). The matron is maintaining oversight to ensure completion of outstanding appraisals and current compliance is above threshold (95.2% as of 18/09/25).
- Melton (73.9%) also remained below compliance threshold, impacted by clinical acuity, and the ward manager working in clinical numbers, meaning that planned appraisals needed to be rescheduled. Targeted work is ongoing, and current compliance is 87% (as of 18/09/25).
- Matrons continue to work closely with ward managers to ensure outstanding appraisals are booked.

Sickness

- 5 wards have sickness rates below 5% compliance threshold.
- Sickness improved to below threshold in August on Ward 19 (Female) following the return of staff from long term sickness.
- Sickness increased to above threshold on Ward 18 (7.0%) and Beechdale (7.5%) due to both short term and long-term sickness, no themes.
- Although still above threshold, sickness on Poplars (6%) and Lyndhurst (6.8%) has reduced following the return of staff from long term sickness.
- Nostell (9.7%), Elmdale (10.8%), Crofton (6.7%) Enfield Down (8.8%), sickness has increased due to a mixture of both long and short-term sickness, no themes.
- Sickness on Melton (13.3%) and Walton (13.3%) has increased due a mixture of both long and short-term sickness. A short-term sickness theme is cold and flu symptoms.
- Sickness on Ashdale has increased (18.5%) and continues to be impacted by long-term sickness with themes of personal and work-related stress, work related injury, and long-term physical health conditions.
- Sickness on Willow has also reduced but remains above threshold at 12.9%. This is impacted by both short and long-term sickness, with cold and flu symptoms being a theme for short-term sickness.
- Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision

- 14 wards are above 80% compliance target for August, 9 of those wards are at 100% supervision compliance.
- Ward 18 (70.0%) and Lyndhurst (78.6%) are below compliance however focused work has been undertaken by the ward leadership teams and both wards are above the 80% threshold in September (as of 18/09/25).
- Melton (63.6%) are below compliance and as described above, this is impacted by clinical acuity, the ward manager working in clinical numbers, and scheduled supervision needing to be rearranged. Targeted work is being undertaken, overseen by the matron, to prioritise supervision for staff outside of compliance.
- The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting.

Mandatory Training

Information Governance

- 16 wards are above 95% compliance target for August, 12 of those wards are at 100% information governance training compliance
- Walton is just below target at 92.5%. Staff out of compliance are being supported to complete their e-learning training and current compliance is above threshold (95.1% as of 18/09/2025).
- Ward managers, with oversight from matrons, continue to ensure outstanding staff complete information governance training.

Cardio Pulmonary Resuscitation

- 15 wards are above the CPR training compliance threshold.
- Elmdale (78.6%) dropped below compliance in August. Staff have attended recent training, and current compliance is 81.5% (as of 18/09/2025).
- Walton (77.5%) remains below compliance threshold in August. Staff with outstanding training are booked to attend courses in September and October.

Reducing restrictive practice interventions

- 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

- 16 wards are above fire safety training compliance threshold.
- Walton (82.5%) dropped below compliance in August. Staff have either attended recent fire training sessions or are booked to attend upcoming dates and current compliance is above threshold at 85.4% (as of 18/09/2025).

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

Bed Occupancy

- Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
- Melton high bed occupancy (111.8%) reflects one service user with complex needs and high risk being nursed in the extra care area.
- Where the bed occupancy exceeds 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:
 - Melton CRFD is 28.97% in August. This is 2 service users awaiting placements.
 - Poplars CRFD has increased to 25.7% and is reflective of 7 service users awaiting placements, 5 of whom have now been discharged.
 - Clark CRFD is 21.14% reflecting 3 service users awaiting placements, 1 of whom has been recently discharged.
- 9 other wards are above the threshold for CRFD with Beamshaw, Walton, Ward 19 (Male), Willow and Enfield Down above 10%. Beechdale, Nostell, Stanley, and Ward 18 and 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.
- Overall compliance in August was 85% for 24hr target and 91.7% completed within 48hrs. During August, Stanley, Crofton, and Ward 19 Male had 1 FIRM breach each. Clark (2), Nostell (2), Elmdale (2), Ward 19 Male, Ward 18 (3), and Ashdale (5), and had multiple.
- In line with the Risk Assessment and Risk Management policy, the team who assessed the service user as requiring admission have a responsibility to update the FIRM risk assessment to reflect the change in risk necessitating inpatient admission.
- Compliance monitoring dashboards support oversight and a deep dive will be conducted by the inpatient matron for each breach to identify learning and inform improvement. This will be shared with Quality and Governance Leads in community to ensure a collaborative approach to 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. A Staying Safe risk management care plan is also implemented within 24hrs of admission.

Physical violence

- There were 22 incidents of patient-on-patient physical violence throughout August. 8 of these incidents were on Ward 18 and related to a small number of service users with a risk profile of violence and aggression.
- Service users are supported on an individual basis by staff teams and risks are managed through individual care planning. Appropriate safeguarding actions taken by ward teams, including liaison with trust safeguarding specialist advisors and reporting to the police.
- 14 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.
- 13 incidents of patient on staff physical violence at Ward 18. 10 of those incidents relate to one specific service user 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

- Higher incidence on Nostell (14) is reflective of current patient population and the presentation and risk profile of service users.
- Higher incidence on Poplars (29) is linked to a small number of service users with cognitive impairment who present with risks of violence and aggression during personal care interventions.

Prone restraint incidents

- 10 incidents of prone restraint in August across Beamshaw (4), Nostell (1), and Walton (5) all of which were under 3 minutes duration.
- The main reason for prone restraint use was exiting seclusion. The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administering intra-muscular medication.
- The one incident of prone restraint on Nostell was patient preference.

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Jun-25	Jul-25	Aug-25	Clark Suite Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	75.0%	80.0%	94.4%	89.5%	95.0%
Sickness	Best place to work and learn	Well led	5.0%	6.9%	0.5%	3.0%	2.7%	4.2%	2.5%
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%	100.0%	100.0%	96.4%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	87.0%	85.7%	95.2%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.3%	91.3%	82.1%	95.2%	95.0%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	87.0%	85.7%	100.0%	100.0%	87.5%
Bed occupancy**	Best Quality	Safe	85%	106.0%	107.1%	106.2%	106.0%	107.1%	106.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	77	73	58	64	83	42
Safer staffing (Overall)	Best Quality	Safe	90%	139.1%	122.4%	136.2%	135.5%	119.8%	103.5%
Safer staffing (Registered)	Best Quality	Safe	80%	100.4%	99.1%	92.6%	108.7%	106.1%	101.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	10.7%	13.0%	19.2%	18.3%	15.2%	21.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	80.0%	100.0%	75.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0	3	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	2	5	7	7	2
Restraint incidents	Best Quality	Safe	Trend Monitor	7	2	10	16	11	8
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	2	0	4	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	19	37	11	11	17

** Bed occupancy is combined with Clark Suite due to use of swing beds

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite			Nostell Jun-25	Jul-25	Aug-25
				Jun-25	Jul-25	Aug-25			
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	87.5%	75.0%	73.9%	95.0%	100.0%	95.0%
Sickness	Best place to work and learn	Well led	5.0%	4.8%	5.9%	13.3%	10.4%	7.9%	9.7%
Supervision	Best place to work and learn	Well led	80%	92.3%	80.0%	63.6%	85.7%	64.3%	92.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	100.0%	100.0%	100.0%	100.0%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	96.4%	78.3%	87.5%	85.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	95.8%	96.4%	82.6%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.5%	87.5%	89.3%	95.7%	95.8%	100.0%
Bed occupancy	Best Quality	Safe	85%	106.7%	120.3%	111.8%	98.9%	99.0%	99.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	104	N/A	221	59	56	67
Safer staffing (Overall)	Best Quality	Safe	90%	138.5%	176.0%	153.8%	134.7%	120.4%	97.4%
Safer staffing (Registered)	Best Quality	Safe	80%	92.1%	93.9%	86.9%	102.8%	106.5%	98.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	15.6%	27.2%	29.0%	7.9%	10.6%	4.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	N/A	100.0%	100.0%	85.7%	71.4%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	2	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	2	2	8	3	3
Restraint incidents	Best Quality	Safe	Trend Monitor	12	22	4	34	14	14
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	3	0	1
Unfilled Shifts	Best Quality	Safe	Trend Monitor	23	34	41	21	17	10

**** Bed occupancy is combined with Stanley due to use of swing beds**

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Stanley Jun-25	Jul-25	Aug-25	Walton Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	95.8%	100.0%	87.9%	93.8%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.9%	4.5%	2.2%	8.9%	9.4%	13.3%
Supervision	Best place to work and learn	Well led	80%	92.9%	92.3%	100.0%	88.2%	64.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.1%	97.1%	92.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	96.2%	93.8%	91.4%	94.3%	92.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.5%	96.9%	74.3%	74.3%	77.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.3%	96.2%	100.0%	85.7%	88.6%	82.5%
Bed occupancy**	Best Quality	Safe	85%	98.9%	99.0%	99.9%	103.3%	99.3%	101.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	53	38	46	80	70	69
Safer staffing (Overall)	Best Quality	Safe	90%	117.5%	113.6%	107.5%	127.5%	126.2%	125.5%
Safer staffing (Registered)	Best Quality	Safe	80%	97.1%	93.6%	99.4%	94.7%	89.7%	94.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	14.1%	3.9%	5.6%	31.1%	16.5%	18.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	66.7%	90.0%	90.9%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	1	1	2	2	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	2	1	4	3
Restraint incidents	Best Quality	Safe	Trend Monitor	2	5	8	6	7	11
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	0	3	1	5
Unfilled Shifts	Best Quality	Safe	Trend Monitor	17	12	11	11	15	21

** Bed occupancy is combined with Nostell due to use of swing beds

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Jun-25	Jul-25	Aug-25	Ward 18 Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	92.0%	92.3%	91.7%	95.8%	96.0%	96.0%
Sickness	Best place to work and learn	Well led	5.0%	21.8%	14.5%	18.5%	2.2%	2.1%	7.0%
Supervision	Best place to work and learn	Well led	80%	86.7%	86.7%	80.0%	90.9%	90.0%	70.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	80.0%	74.1%	82.1%	82.1%	86.2%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	92.6%	82.1%	71.4%	86.2%	90.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.0%	100.0%	100.0%	96.4%	96.6%	100.0%
Bed occupancy	Best Quality	Safe	85%	99.7%	98.7%	99.6%	103.9%	100.8%	99.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	60	46	56	40	29	65
Safer staffing (Overall)	Best Quality	Safe	90%	115.7%	107.0%	100.0%	105.3%	104.9%	102.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.3%	99.6%	95.5%	97.5%	104.7%	96.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.1%	2.8%	0.0%	3.5%	4.2%	3.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	57.1%	69.2%	37.5%	70.0%	77.3%	77.8%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	4	7	4	0	3	8
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	1	2	2	10	13
Restraint incidents	Best Quality	Safe	Trend Monitor	3	12	5	3	31	11
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	6	2	4	3	2

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Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	95.8%	96.0%
Sickness	Best place to work and learn	Well led	5.0%	8.6%	10.0%	10.8%
Supervision	Best place to work and learn	Well led	80%	85.7%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	96.0%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	80.0%	78.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	74.1%	96.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	103.3%	98.5%	96.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	60	29
Safer staffing (Overall)	Best Quality	Safe	90%	102.6%	105.3%	99.0%
Safer staffing (Registered)	Best Quality	Safe	80%	93.6%	97.9%	93.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	1.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	69.2%	84.6%	86.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	4	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	7	6
Restraint incidents	Best Quality	Safe	Trend Monitor	16	24	11
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	14	5

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Jun-25	Jul-25	Aug-25	Poplars CUE Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	95.5%	90.9%	90.9%	100.0%	96.4%	96.6%
Sickness	Best place to work and learn	Well led	5.0%	4.7%	6.6%	6.7%	4.6%	9.7%	6.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	83.3%	100.0%	90.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.0%	90.0%	95.5%	80.0%	89.3%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.0%	100.0%	100.0%	96.7%	92.9%	89.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	100.0%	100.0%	100.0%	93.1%	96.6%
Bed occupancy	Best Quality	Safe	85%	105.8%	96.6%	89.5%	74.2%	68.0%	69.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	68	65	100	123	91
Safer staffing (Overall)	Best Quality	Safe	90%	168.7%	169.0%	175.8%	225.6%	191.6%	178.5%
Safer staffing (Registered)	Best Quality	Safe	80%	138.4%	143.1%	140.5%	104.4%	102.3%	100.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	27.5%	17.0%	25.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	83.3%	87.5%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	1	2	4	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	11	1	9	11	14
Restraint incidents	Best Quality	Safe	Trend Monitor	0	11	2	8	12	29
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	29	35	27	23	26	11

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Jun-25	Jul-25	Aug-25	Beechdale Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	95.0%	95.2%	95.5%	100.0%	95.5%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	17.8%	13.2%	12.9%	7.1%	4.5%	7.5%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	92.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	86.4%	87.0%	91.3%	84.0%	92.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.4%	95.5%	91.3%	100.0%	91.7%	95.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	95.5%	95.7%	82.6%	88.0%	92.0%
Bed occupancy	Best Quality	Safe	85%	105.0%	94.5%	89.4%	106.0%	97.4%	94.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	99	44	56	70	124	105
Safer staffing (Overall)	Best Quality	Safe	90%	119.9%	113.6%	125.9%	113.1%	136.0%	134.4%
Safer staffing (Registered)	Best Quality	Safe	80%	81.3%	85.5%	93.5%	94.2%	107.8%	103.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.9%	0.3%	10.3%	4.3%	5.7%	5.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	85.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	3	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	2	0	2	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	0	3	3	1
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	11	22	2	8	10

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Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.9%	4.7%	5.0%	4.8%	5.7%	4.0%
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%	95.8%	95.8%	100.0%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	83.3%	84.0%	91.3%	91.3%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	95.8%	92.0%	91.3%	95.7%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.8%	95.8%	96.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	105.1%	99.8%	96.1%	98.4%	93.1%	84.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	64	80	138	105	39	91
Safer staffing (Overall)	Best Quality	Safe	90%	111.3%	123.3%	115.1%	96.2%	107.9%	112.9%
Safer staffing (Registered)	Best Quality	Safe	80%	82.5%	85.6%	81.9%	113.3%	103.9%	98.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.1%	12.0%	15.2%	0.2%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	66.7%	71.4%	100.0%	60.0%	100.0%
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	2	1	3	2	1	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	3	4	1	3	4
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	3		2	13	

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Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Jun-25	Jul-25	Aug-25	Lyndhurst Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	93.3%	87.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.6%	7.9%	8.8%	5.1%	7.5%	6.8%
Supervision	Best place to work and learn	Well led	80%	96.3%	100.0%	100.0%	87.5%	100.0%	78.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.7%	89.4%	87.5%	79.3%	85.7%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.5%	95.3%	86.4%	100.0%	96.4%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.0%	95.8%	91.8%	96.6%	100.0%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	59.6%	51.6%	50.8%	66.2%	59.4%	56.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	265	1058	N/A	821	N/A	305
Safer staffing (Overall)	Best Quality	Safe	90%	96.0%	104.3%	97.0%	102.9%	97.1%	97.3%
Safer staffing (Registered)	Best Quality	Safe	80%	101.2%	96.7%	95.7%	102.7%	101.0%	100.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.4%	11.9%	11.8%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	N/A	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	3	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	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	0	11	1	4	2	0

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Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

- Six of the seven wards are above supervision compliance (Bronte, Appleton, Chippendale, Waterton, Johnson and Priestley). Hepworth (64.3%) is under compliance and understood to be a recording issue that is currently under review by the Ward Manager.
- Some noted improvements in sickness absence noted Priestley (0.7%), Johnson (1.1%), Hepworth (2.6%). Appleton (5.4%) also remains within compliance. Some improvements also noted on Bronte (7.9%) with an expectation for an improving trajectory. Chippendale (9.7%) and Waterton (18.7%) have both noted an increase in sickness absence. 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.
- An ongoing focus on quality appraisals is a service priority. Four wards currently remain above compliance (Bronte, Chippendale, Hepworth and Johnson). Hotspots have been identified on Waterton (85.7%), Priestley (68.2%) and Appleton (66.7%). Review has highlighted some recording and systems challenges alongside a spike in appraisal acuity. A session has been arranged with the People Planning and Performance Lead on Dashboards, Data and Workforce to support understanding and rectification of any system challenges.
- Good compliance is noted for mandatory training across the medium secure service. Hotspots are evident for RRPI on Johnson (79.3%) and CPR on Waterton (75%) with plans in place on both areas to address compliance.
- Bed occupancy on Appleton (66.7%) is below compliance and due to a reduction in overall learning disability referrals to secure care. Occupancy in the women's service (Johnson medium secure 73.3%) is also low but has noted a slight improvement. Neither of these services have a waiting list. Bed occupancy on the male pathway has increased significantly due to a spike in medium secure referrals.
- 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. An improving trajectory has evidenced improved performance that will be monitored to support embedding.

Low Secure

- Sickness across all wards monitored closely, and ward managers are working closely with people directorate colleagues and the clinical service manager. Improvement has been noted on Thornhill (3.2%). Newhaven (9.5%) is related to three long term sickness and absence. A plan is in place with the People Directorate and additional Occupational Health Support using the CRISP approach which has seen two staff return from LTS. Increases in sickness absence noted on Sandal (14.9%) which is related to a long-term sickness absence. Plans are in place to support a number of these staff return to work. Ryburn (16.2%) is impacted by the size of the team and has two staff on long term sickness absence with support plans in place with the People Directorate.
- Mandatory training compliance remains positive across the service. Some hotspots are identified on Sandal for IG (91.7%) with a plan in place and improving trajectory and CPR (79.2%). On review of the CPR this includes three staff who require CPR and three staff BLS with a plan in place with the Ward Manager to ensure all are prioritised to attend.
- An ongoing focus on quality appraisals is a service priority. Sandal remains within compliance at 90.9%. There has been a reduction in compliance for Ryburn (77.8%), Newhaven (84.4%) and Thornhill (85.2%). Review has highlighted some recording and systems challenges alongside a spike in appraisal acuity. A session has been arranged with the People Planning and Performance Lead on Dashboards, Data and Workforce to support understanding and rectification of any system challenges.
- The Inpatient risk assessment completed within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gate keeping process to support planning. Communication has been shared to ensure that this is reviewed, and all parts are being signed off again as part of the admission process. This should support
- Bed occupancy has increased across all 4 wards in low secure, with Ryburn (100%) and Sandal (86.5%). The service is currently working to support transitions to Thornhill (82.5%) to support capacity for admissions. Newhaven (74. 2%) continues to experience lower level of referrals and has no waiting list.
- There has been one prone incident on Sandal and was under 3 minutes in duration. The reason for prone restraint use was exiting seclusion. The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administering intra-muscular medication.
- Supervision is above compliance on Ryburn (100%), Sandal (100%) and Newhaven (86.7%). Thornhill (50%) have experienced a drop in performance, which has been reviewed by the service and understood. and the service is taking action to identify the causes and take action.

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Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Jun-25	Jul-25	Aug-25	Bronte Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	86.7%	80.0%	66.7%	94.4%	95.0%	90.5%
Sickness	Best place to work and learn	Well led	5.4%	4.4%	3.3%	5.4%	4.7%	8.0%	7.9%
Supervision	Best place to work and learn	Well led	80%	90.9%	83.3%	90.0%	100.0%	92.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.2%	100.0%	95.7%	95.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	81.0%	85.0%	84.0%	81.8%	82.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	95.2%	90.0%	95.7%	95.5%	91.3%
Bed occupancy	Best Quality	Safe	90%	62.5%	58.9%	52.0%	83.3%	96.3%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1511	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	125.7%	126.0%	136.2%	97.7%	94.1%	94.5%
Safer staffing (Registered)	Best Quality	Safe	80%	92.5%	93.4%	89.6%	102.0%	87.0%	87.2%
% 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%	N/A	N/A	100.0%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	2	3	3	3	1
Restraint incidents	Best Quality	Safe	Trend Monitor	18	10	4	1	6	4
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	22	26	19	2	1	0

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Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale Jun-25	Jul-25	Aug-25	Hepworth Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	89.5%	95.0%	95.0%	95.8%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	6.4%	4.8%	9.7%	4.8%	3.4%	2.6%
Supervision	Best place to work and learn	Well led	80%	93.3%	100.0%	100.0%	88.9%	81.3%	64.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.5%	100.0%	100.0%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	91.3%	91.3%	88.5%	88.5%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	87.0%	91.3%	92.3%	92.3%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	91.3%	95.7%	96.2%	96.2%	91.7%
Bed occupancy	Best Quality	Safe	90%	96.7%	100.0%	100.0%	88.9%	81.7%	79.1%
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%	118.8%	103.6%	141.4%	89.8%	91.5%	94.9%
Safer staffing (Registered)	Best Quality	Safe	80%	114.1%	97.3%	116.8%	85.9%	90.2%	89.7%
% 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%	N/A	N/A	N/A	0.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	0	1	0	3
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	23	7	30	0	0	3

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Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Jun-25	Jul-25	Aug-25	Priestley Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	92.3%	76.2%	69.6%	68.2%
Sickness	Best place to work and learn	Well led	5.4%	10.1%	8.4%	1.1%	5.3%	2.2%	0.7%
Supervision	Best place to work and learn	Well led	80%	94.1%	93.3%	93.8%	87.5%	81.3%	93.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.4%	96.6%	88.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	85.2%	78.6%	79.3%	82.6%	87.5%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	82.1%	86.2%	82.6%	83.3%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.6%	96.4%	93.1%	80.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	73.1%	73.3%	73.3%	96.7%	94.1%	96.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	722	790	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	113.0%	119.6%	118.8%	93.0%	86.5%	92.9%
Safer staffing (Registered)	Best Quality	Safe	80%	88.3%	89.6%	91.4%	99.4%	101.7%	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%
% 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
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	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	16	17	4	1	2	4

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Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	85.0%	90.0%	85.7%
Sickness	Best place to work and learn	Well led	5.4%	12.6%	16.1%	18.7%
Supervision	Best place to work and learn	Well led	80%	84.6%	84.6%	84.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.7%	90.9%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.7%	81.8%	75.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	78.9%	86.4%	90.0%
Bed occupancy	Best Quality	Safe	90%	89.2%	100.0%	96.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	679	N/A	1431
Safer staffing (Overall)	Best Quality	Safe	90%	163.1%	156.3%	151.9%
Safer staffing (Registered)	Best Quality	Safe	80%	98.2%	99.4%	89.4%
% 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%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	0
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	25	21

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Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Jun-25	Jul-25	Aug-25	Sandal Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	94.7%	100.0%	85.2%	95.7%	91.3%	90.9%
Sickness	Best place to work and learn	Well led	5.4%	5.7%	4.7%	3.2%	8.0%	11.5%	14.1%
Supervision	Best place to work and learn	Well led	80%	75.0%	50.0%	50.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	92.0%	91.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	93.3%	90.6%	96.2%	92.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.4%	90.0%	93.8%	92.3%	84.0%	79.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	96.2%	92.0%	95.8%
Bed occupancy	Best Quality	Safe	85%	75.8%	83.0%	82.2%	76.9%	85.3%	86.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	45	N/A	2366	1235	594	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	113.7%	110.7%	115.3%	110.9%	125.9%	154.0%
Safer staffing (Registered)	Best Quality	Safe	80%	100.0%	104.7%	104.1%	104.3%	104.7%	99.5%
% 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%	N/A	N/A	N/A	50.0%	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	2	2	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	5	8	4
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	2	1	1
Unfilled Shifts	Best Quality	Safe	Trend Monitor	13	8	6	25	27	26

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Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Jun-25	Jul-25	Aug-25	Newhaven Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	77.8%	90.3%	96.3%	84.4%
Sickness	Best place to work and learn	Well led	5.4%	20.3%	12.8%	16.2%	13.4%	15.2%	9.5%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	89.5%	93.3%	86.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.0%	96.8%	96.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	80.0%	88.9%	88.9%	93.1%	88.9%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	100.0%	100.0%	79.3%	92.6%	85.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	88.9%	90.9%	90.3%	90.6%
Bed occupancy	Best Quality	Safe	85%	85.7%	87.1%	100.0%	68.1%	74.2%	74.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	2342	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	97.7%	97.6%	99.2%	124.0%	132.2%	138.2%
Safer staffing (Registered)	Best Quality	Safe	80%	96.5%	96.8%	98.4%	102.9%	104.1%	92.0%
% 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%	N/A	N/A	N/A	N/A	N/A	100.0%
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	6	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	8	11	0
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	0	26	23	24

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Inpatients - Non-Mental Health

• Appraisal rate:

NRU rate is showing a slight decrease at 82.9% for August figures. When reviewing details at individual level, it appears some completed appraisals have not pulled through despite showing as completed on ESR; senior team to investigate further and escalate.

SRU rate has maintained compliance this month at 95.2% for August.

• Sickness:

NRU – sickness has continued to improve considerably from 6.8% in July to achieve compliance at 2% for August.

SRU – Sickness for August has continued to improve and has decreased from 5.2% to 4.3% to achieve compliance. The current position still includes two instances of LTS:

- 1 due to anxiety - until end of October
- 1 due to planned surgery - until September

Sickness absence for both units continues to be managed via HR processes and sickness reviews.

• Supervision:

NRU has seen further improvement in August to reach 89.5% compliance with continuing improvement into September.

SRU figures have seen a decrease in August to 71.4%. However, as of 22.9.25, the unit has increased to 82.9% for September.

• Information Governance:

Both wards continue to maintain compliancy for August.

• Cardiopulmonary resuscitation (CPR):

NRU is showing a small decrease at 76.3%. Some staff have completed the training during week commencing 8.9.25 and further staff are booked within the next 4 weeks.

To note: maternity leave cannot be excluded from training statistics and NRU currently has 3 staff on mat leave.

SRU continues to exceed the compliancy level.

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 are achieving compliance in August.

Summary	Quality & Safety	People	National Metrics	Care Groups	Ward Detail	Finance/ Contracts

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit			Stroke Rehabilitation Unit		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	79.4%	78.9%	82.9%	93.5%	93.8%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	10.4%	6.8%	2.0%	7.0%	5.2%	4.3%
Supervision	Best place to work and learn	Well led	80%	70.0%	81.0%	89.5%	80.5%	82.9%	71.4%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.7%	88.9%	76.3%	91.0%	92.5%	94.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.1%	84.2%	90.2%	92.9%	92.9%	97.1%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	66.9%	65.1%	47.3%	83.6%	90.6%	80.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	45	55	38	26	25	24
Safer staffing (Overall)	Best Quality	Safe	90%	119.2%	117.8%	102.0%	96.8%	100.3%	83.1%
Safer staffing (Registered)	Best Quality	Safe	80%	94.5%	98.6%	90.2%	120.2%	117.4%	94.7%
% 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	1	66	57	30

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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, and compliance remains good.
- Mandatory training compliance remains positive, with CPR now being achieved. Training delivery continues, and mitigating actions are in place to ensure that a CPR-trained staff member is on duty at all times, maintaining safety and clinical standards
- Sickness absence has increased in month.
- In terms of patient flow, the number of service users clinically ready for discharge remains high and 3 individuals were clinically ready for discharge during the month but delayed. Identifying suitable community placements continues to be a challenge, which may impact future discharge planning and throughput.
- Risk assessment compliance has dropped during the month, this related to one admission where a risk assessment was completed but outside the 24 hour target.
- Due to the current acuity and individual needs of service users, the service has required additional staffing, reflected in the overall safer staffing and registered safer staffing figures.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.8%	3.0%	6.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	95.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.4%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.6%	92.1%	97.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	64.9%	76.3%	84.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	97.4%	97.5%	95.0%
Bed occupancy	Best Quality	Safe	N/A	32.1%	40.7%	43.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	114	333	27
Safer staffing (Overall)	Best Quality	Safe	90%	104.5%	115.4%	118.9%
Safer staffing (Registered)	Best Quality	Safe	80%	172.9%	170.5%	171.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	81.8%	44.6%	56.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	0% (0/1)
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	8	1
Restraint incidents	Best Quality	Safe	Trend Monitor	11	5	4
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	21	21	10

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Inpatients - Forensic South Yorkshire

Medium Secure

- Supervision is above compliance Skipton and Foss (100%).
- The transition to Trust systems for recording appraisals is ongoing as part of integration and will bring the services in line with Trustwide appraisal reporting standards.
- Sickness absence is above target for Foss (14.7%) and Skipton (6.3%). This is now being closely monitored by ward managers with support from the People Directorate.
- Safer staffing is within compliance and is reviewed by service management on a daily basis.
- Good compliance against mandatory training however CPR (66.7%) and IG (83.3%) on Foss below target. Plans in place to support completion of this training.
- Bed occupancy on Skipton (71.5%) demonstrates significant improvement comparative to 58.3% last month. Foss bed occupancy at 74.7% and in line with overall hospital admissions plan.
- There were no prone restraints.
- Risk assessment data is not currently captured as Cheswold Park Hospital do not currently complete FIRM risk assessments; this is within the improvement plan.

Low Secure

- Supervision compliance is above threshold for all low secure wards expect Don which is slightly below at 79.2%.
- The transition to Trust systems for recording appraisals is ongoing as part of integration and will bring the services in line with Trustwide appraisal reporting standards.
- Sickness absence has improved across all low secure wards, all now within current threshold. Notable improvements on Aire and Don.
- Good compliance against mandatory training is noted across all areas. Information governance compliance has remains below compliance on Aire (83.3%) and Don (76%) with plans in place to improve. Some challenges with CPR compliance are noted and have been reviewed by the service. Whilst Immediate Life Support (ILS) training is noted to be positive (100%), the challenges are noted to be with Basic Life Support (BLS). A new approach has been introduced to support BLS training and will be reviewed.
- Bed occupancy has improved across all low secure wards and only Esk (80.2%) drops slightly below the threshold. This is in line with the overall hospital admissions plan.
- There were no prone restraints.
- Risk assessment data is not currently captured as Cheswold Park Hospital do not currently complete FIRM risk assessments, this is within the improvement plan.

				Medium Secure Services					
				Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	89.7%	93.6%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	6.4%	8.7%	14.7%	12.2%	7.3%	6.3%
Supervision	Best place to work and learn	Well led	80%	51.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	93.5%	83.3%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.7%	86.7%	86.7%	86.2%	86.2%	86.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.9%	67.7%	66.7%	86.2%	82.1%	71.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.1%	87.1%	83.3%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	81.0%	78.6%	74.7%	53.1%	58.3%	71.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	749	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	102.2%	113.5%	101.8%	108.2%	105.1%	163.5%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	107.6%	109.1%	87.1%	84.1%	107.8%
% 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	1	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	3	0	3	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	7	0	5	8	9
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

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Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Wentbridge		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	73.7%	100.0%	0.0%	78.0%	95.0%	97.5%
Sickness	Best place to work and learn	Well led	5.4%	2.6%	4.6%	2.9%	7.5%	3.1%	2.0%
Supervision	Best place to work and learn	Well led	80%	86.4%	95.0%	100.0%	95.5%	92.5%	97.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.0%	95.2%	87.0%	100.0%	100.0%	97.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.0%	90.5%	91.3%	90.5%	90.5%	87.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.6%	76.2%	81.8%	61.9%	72.5%	65.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	91.3%	88.1%	85.7%	78.0%
Bed occupancy	Best Quality	Safe	90%	69.8%	76.6%	80.2%	80.0%	87.5%	91.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	4525	N/A	50	N/A	N/A	1662
Safer staffing (Overall)	Best Quality	Safe	90%	116.8%	108.5%	99.6%	150.7%	149.9%	151.1%
Safer staffing (Registered)	Best Quality	Safe	80%	92.5%	94.6%	98.8%	94.9%	100.0%	91.2%
% 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	1	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	1	2	0	1
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

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Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire			Don		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	80.6%	100.0%	N/A	68.0%	76.9%	75.0%
Sickness	Best place to work and learn	Well led	5.4%	2.2%	8.3%	2.1%	7.1%	6.1%	1.2%
Supervision	Best place to work and learn	Well led	80%	62.9%	95.0%	100.0%	48.0%	80.8%	79.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	93.9%	83.3%	88.5%	80.0%	76.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.3%	75.8%	70.0%	92.3%	96.0%	92.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	81.8%	67.7%	76.9%	76.0%	64.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.6%	84.8%	76.7%	92.3%	92.0%	88.0%
Bed occupancy	Best Quality	Safe	90%	77.8%	76.3%	90.1%	95.3%	97.0%	91.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	1077	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.2%	91.9%	88.8%	132.6%	122.8%	132.0%
Safer staffing (Registered)	Best Quality	Safe	80%	90.7%	89.8%	85.4%	102.3%	94.3%	100.0%
% 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	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	1		0	0	
Restraint incidents	Best Quality	Safe	Trend Monitor	3	1	0	2	0	0
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

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Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder		
				Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	4.4%	3.8%	3.4%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	79.4%	93.8%	95.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	840
Safer staffing (Overall)	Best Quality	Safe	90%	107.1%	106.4%	92.2%
Safer staffing (Registered)	Best Quality	Safe	80%	81.3%	84.7%	68.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor			

Summary

Quality & Safety

People

National Metrics

Care Groups

Ward Detail

Finance/ Contracts

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	(£1.7m)	£0m	The financial performance for August 2025 is a surplus of £367k which is £0.8m better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staffing numbers and the payment of the pay award being less than originally estimated. The year-to-date position is a deficit of £1.7m which is now £0.7m favourable to plan.
2	Agency Spend	Best Value	Well Led	£1.7m	£3.3m	Agency spend remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
3	Bank Spend	Best Value	Well Led	£10.1m	£21.2m	Trust bank expenditure has continued to increase . The forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
4	Corporate Spend	Best Value	Well Led	£27.2m	£67.6m	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, as per the Trust reporting hierarchy, with the RAG rating as a comparison against plan following agreed budgetary reductions. In a continuation of the run rate August spend is £0.4m less than planned.
5	Financial sustainability and efficiencies	Best Value	Well Led	£7.6m	£28.2m	Value for money schemes have performed better than plan in August which has helped to reduce the year to date shortfall from £0.7m to £0.6m. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
6	Cash	Best Value	Well Led	£60.1m	£52.7m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position. The position is forecast to reduce in future months due to the timing of capital expenditure.
7	Capital Spend	Best Value	Well Led	£1.2m	£19.3m	Capital spend is behind plan for the year to date and work continues on the major older people scheme. This has impacted on the overall spend profile and as such other schemes are being brought forward to ensure that the allocation is appropriately utilised.
8	Better Payment Practice Code	Best Value	Well Led	97%		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

	Objective	CQC Domain	Trust Threshold	Jun-25	Jul-25	Aug-25
Mandatory Training - TOTAL	Improving Care		>=80%	96.0%	96.0%	94.0%
Mandatory Training - Reducing Restrictive Practice Interventions				86.3%	85.3%	85.6%
Mandatory Training - Cardiopulmonary Resuscitation				79.4%	76.9%	75.5%
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				99.3%	98.6%	97.9%
Mandatory Training - Fire Safety			>=85%	95.2%	92.6%	86.9%
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				95.0%	94.5%	90.6%
Mandatory Training - Information Governance (Data Security)			>=95%	96.2%	94.0%	89.8%
Mandatory Training - Moving & Handling			>=80%	95.2%	92.6%	86.9%
Mandatory Training - Mental Capacity Act/Dols				93.7%	94.7%	90.7%
Mandatory Training - Mental Health Act				93.7%	94.7%	90.7%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				99.0%	98.9%	98.9%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				93.8%	92.5%	86.4%
Mandatory Training - Safeguarding Children				93.8%	92.5%	86.4%



South West
Yorkshire Partnership
NHS Foundation Trust



Finance Report

Month 5 (2025 / 26)



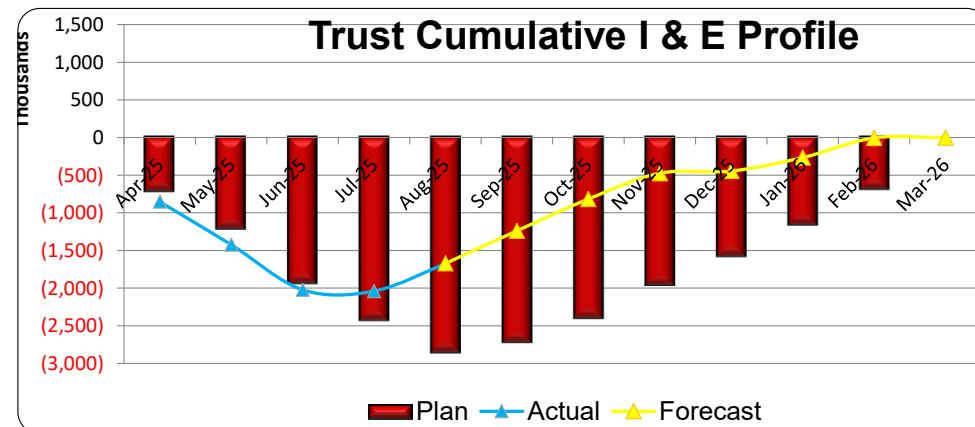
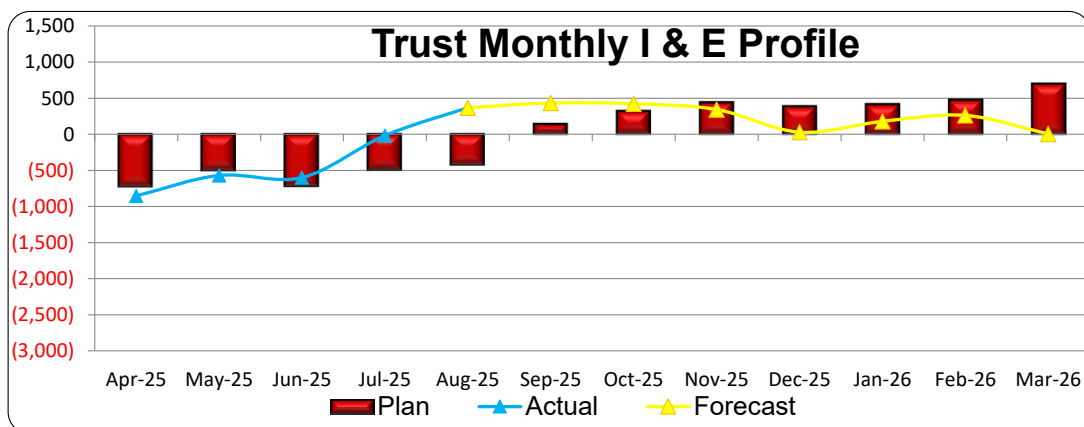
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With **all of us** in mind.

1.0		Executive Summary / Key Performance Indicators		
Key Performance Indicator		Year to Date	Forecast 2025 / 26	Narrative
1	Surplus / (Deficit)	(£1.7m)	£0m	The financial performance for August 2025 is a surplus of £367k which is £791k better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staff worked less than planned and the payment of the pay award being less than estimated.
2	Agency Spend	£1.7m	£3.3m	Agency spend in August is £281k. This remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
3	Bank Spend	£10.1m	£21.2m	Bank usage, primarily for unregistered nurses, has continued to increase and the forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
4	Corporate Spend	£27.2m	£67.6m	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, as per the Trust reporting hierarchy, with the RAG rating as a comparison against plan following agreed budgetary reductions. In a continuation of the run rate August spend is £0.4m less than planned.
5	Financial sustainability and efficiencies	£7.6m	£28.2m	Value for money schemes have performed better than plan in August which has helped to reduce the year to date shortfall from £0.7m to £0.6m. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
6	Cash	£60.1m	£52.7m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position. The position is forecast to reduce in future months due to the timing of capital expenditure.
7	Capital	£1.2m	£19.3m	Spend on capital and leases is less than planned for the year to date. Leases annual revaluations have been actioned, but are less than planned, whilst work continues on the Older People Scheme. The forecast position, still assuming full utilisation of the various allocations. As such some schemes have been brought forward from future years.
8	Better Payment Practice Code	97%		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		

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust. This incorporates its role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes its 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					37,888	38,092	204	188,934	189,216	282	455,890	456,629	739
Other Operating Revenue					1,326	1,369	43	6,381	6,638	257	15,498	15,878	380
Total Revenue					39,214	39,461	247	195,315	195,854	539	471,388	472,507	1,119
Pay Costs	5,398	5,330	(68)	1.3%	(25,211)	(24,302)	909	(125,316)	(123,872)	1,444	(300,822)	(297,088)	3,734
Non Pay Costs					(13,615)	(14,008)	(393)	(68,805)	(69,712)	(906)	(160,662)	(165,236)	(4,574)
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	5,398	5,330	(68)	-1.3%	(38,826)	(38,310)	516	(194,122)	(193,583)	538	(461,484)	(462,324)	(840)
EBITDA	5,398	5,330	(68)	-1.3%	388	1,151	763	1,194	2,271	1,077	9,904	10,183	279
Depreciation					(615)	(659)	(45)	(3,067)	(3,302)	(235)	(7,447)	(8,368)	(921)
PDC Paid					(378)	(382)	(4)	(1,889)	(1,910)	(21)	(4,534)	(4,584)	(50)
Interest Received					181	258	77	917	1,269	351	2,077	2,769	692
Surplus / (Deficit) - ICB performance measure	5,398	5,330	(68)	-1.3%	(423)	367	791	(2,845)	(1,672)	1,173	0	0	0
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(44)	(25)	18	(94)	(61)	33
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	5,398	5,330	(68)	-1.3%	(432)	362	794	(2,889)	(1,698)	1,191	(94)	(61)	33



Income & Expenditure Position 2025 / 26

**The Trust surplus in August 2025 is £367k.
This is £791k better than plan.**

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. Financial performance 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)	5,375	5,305	(70)	1.3%	(754)	349	1,103	(3,798)	(1,525)	2,273	(7,232)	(4,448)	2,784
Provider Collaboratives	23	25	2	7.6%	2	(1)	(3)	11	(255)	(266)	26	(96)	(122)
Budgets held centrally	0	0	0	0.0%	329	19	(310)	942	107	(835)	7,206	4,544	(2,662)
Total - Consolidated position (ICB performance measure)	5,398	5,330	(68)	-1.3%	(423)	367	791	(2,845)	(1,672)	1,173	0	0	0

August 2025 is the second consecutive month where the core Trust has reported a surplus. This was £14k in July increasing to £349k in August and is a continuation of an improving run rate in previous months. In turn this reduces the year to date deficit position. The improvements seen, as described later in this report, have supported an improvement in the baseline forecast deficit; reducing from £5,603k to £4,448k (a £1,155k improvement).

This does remain a deficit and therefore needs to be considered in conjunction with budgets held centrally. These are primarily the targets for value for money which need to be realised and, where possible, allocated into the core Trust. Due to the nature of actions included within the Trust forecast scenario modelling this will not be possible for all especially those which are non-recurrent in nature. The implications of this are considered within the Trust underlying financial position.

Provider collaboratives are in line with plan in month and are forecast to maintain for the remainder of the financial year. As confirmed in other reporting these areas remain volatile; small changes in activity can result in significant financial changes and will continue to be monitored.

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					28,548	28,488	(60)	142,520	142,552	32	344,097	343,839	(258)
Other Operating Revenue					1,246	1,269	23	5,983	6,213	230	14,543	14,915	372
Total Revenue					29,794	29,758	(37)	148,503	148,765	262	358,640	358,753	114
Pay Costs	5,375	5,305	(70)	1.3%	(24,983)	(24,150)	833	(124,175)	(123,142)	1,033	(298,084)	(295,373)	2,712
Non Pay Costs					(4,754)	(4,475)	279	(24,087)	(23,205)	882	(57,883)	(57,646)	237
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	5,375	5,305	(70)	-1.3%	(29,737)	(28,625)	1,113	(148,262)	(146,347)	1,915	(355,967)	(353,019)	2,949
EBITDA	5,375	5,305	(70)	-1.3%	57	1,133	1,076	241	2,418	2,177	2,672	5,735	3,063
Depreciation					(615)	(659)	(45)	(3,067)	(3,302)	(235)	(7,447)	(8,368)	(921)
PDC Paid					(378)	(382)	(4)	(1,889)	(1,910)	(21)	(4,534)	(4,584)	(50)
Interest Received					181	258	77	917	1,269	351	2,077	2,769	692
Surplus / (Deficit) - ICB performance measure	5,375	5,305	(70)	-1.3%	(754)	349	1,103	(3,798)	(1,525)	2,273	(7,232)	(4,448)	2,784
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(44)	(25)	18	(94)	(61)	33
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	5,375	5,305	(70)	-1.3%	(763)	344	1,107	(3,841)	(1,550)	2,291	(7,326)	(4,509)	2,817

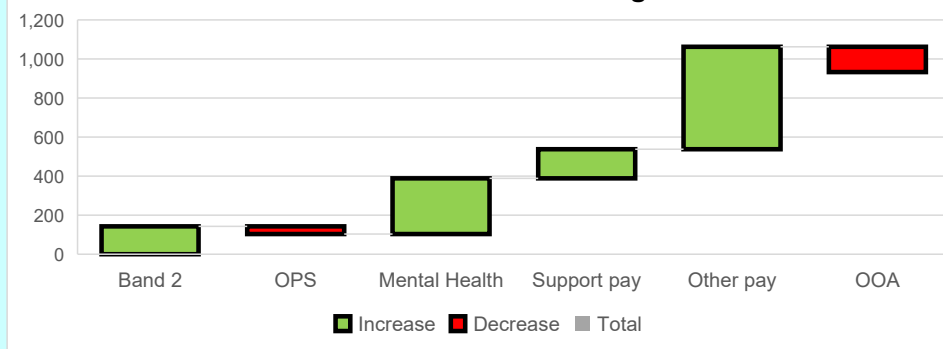
The Trust plan for 2025 / 26 is profiled with a deficit in the early part of the year and reducing as value for money schemes have an impact. The budget deficit arises, following a period of small surpluses in the monthly run rate in late 2024 / 25, due to inflationary cost pressures such as pay award assumptions and national insurance changes set by government.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:

£k

Agenda for Change pay award accrual - Band 2	142
Staffing - greater than plan. Older People Inpatient (Barn & Wake)	(40)
Staffing - Mental health care group. Largest underspend	285
Staffing - Support. Majority of service lines spending less than plan	149
Staffing - most care groups underspend against pay in month.	525
Out of area placements higher than planned	(129)

In month variance - bridge



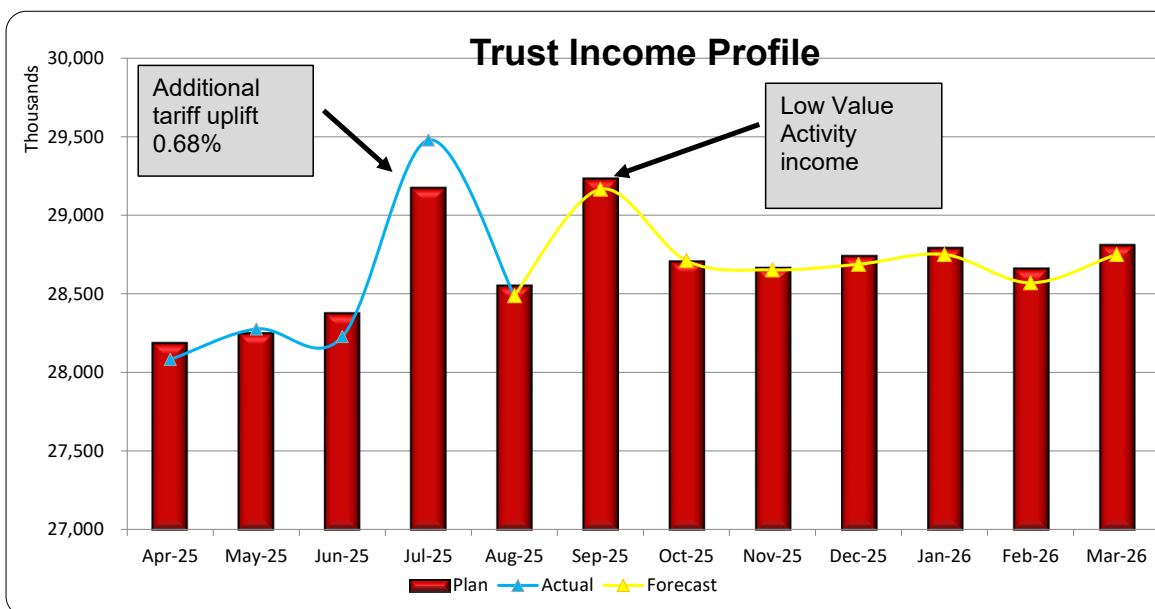
2.1

Income Information

The Trust receives income from its 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	22,849	23,546	22,847	23,580	22,979	22,979	22,979	22,979	22,979	22,980	276,060	276,094	(33)
Specialist Commissioner	36,788	4,697	4,723	4,666	4,861	4,956	4,790	4,928	4,877	4,928	4,990	4,833	4,990	58,240	57,587	653
Local Authority	5,141	318	465	314	680	303	417	417	417	395	395	395	395	4,912	5,250	(339)
Partnerships	2,940	248	251	243	251	233	226	233	226	233	233	211	233	2,821	3,099	(278)
Other Contract Income	1,583	127	168	155	141	149	152	152	152	152	152	152	152	1,806	2,066	(261)
Total	312,292	28,082	28,276	28,227	29,479	28,488	29,166	28,710	28,652	28,688	28,750	28,570	28,750	343,839	344,097	(258)
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	9,196	9,452	9,604	9,761	9,396	9,393	9,396	9,396	9,387	9,396	112,790		
Total	312,292	37,286	37,484	37,424	38,930	38,092	38,927	38,107	38,046	38,084	38,147	37,957	38,147	456,629		



As highlighted last month income, and expenditure, have been updated to reflect the impact of the additional tariff uplift. This has been included in signed contracts with commissioners for 2025 / 26.

Income is forecast to increase next month with the receipt of low value activity income for the year. This is a key movement towards delivering the breakeven target.

The forecast variance is primarily due to :

* Additional roles reimbursement Forecast £247k
Recharge of salary based on staff in post

* Local Authority - Yorkshire Smokefree £339k
Payment by results on some Smokefree contracts and recharge of actual prescribing costs

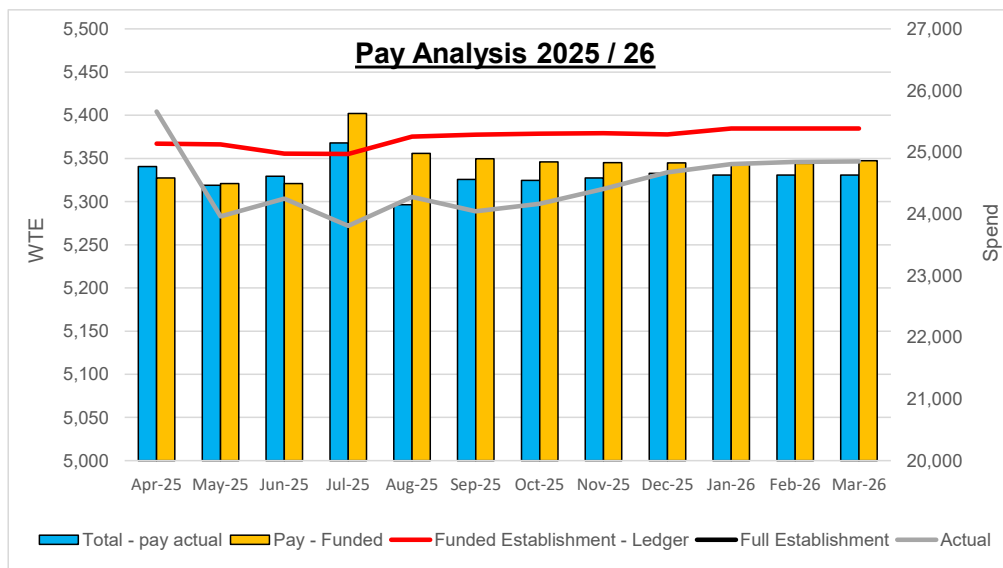
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	22,290	22,734	21,955	22,558	22,704	22,795	22,863	22,842	22,861	22,867	270,851
Bank & Locum	2,216	1,926	1,964	2,057	1,913	1,719	1,605	1,575	1,575	1,571	1,558	1,540	21,218
Agency	352	355	356	361	281	281	233	212	219	217	213	221	3,303
Total	24,768	24,463	24,610	25,151	24,150	24,558	24,542	24,583	24,657	24,630	24,632	24,629	295,373
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%	8.0%	8.2%	7.9%	7.0%	6.5%	6.4%	6.4%	6.4%	6.3%	6.3%	7.2%
Agency as % (in month)	1.4%	1.5%	1.4%	1.4%	1.2%	1.1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,837	4,809	4,810	4,785	4,783	4,869	4,907	4,931	4,949	4,959	4,964	4,968	4,881
Bank & Locum	528	443	452	452	487	388	365	361	361	360	358	355	409
Agency	39	31	42	35	35	32	26	23	24	24	24	24	30
Total	5,404	5,283	5,303	5,272	5,305	5,289	5,297	5,315	5,334	5,343	5,346	5,346	5,320
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



Pay awards, with arrears to April 2025, have been paid in August. This was lower than previously estimated. The largest variance was on band 2 staff where uplifts were actually paid from April to ensure that all staff were above the higher national minimum wage rates. As such the uplift percentage in August was lower with no arrears. This has been updated into forecast position.

Although only a reduction of 2 worked WTE substantive staff has continued to follow the reducing trend of previous months. This is forecast to increase, and support the forecast reduction in bank staff, as conversion of posts are realised.

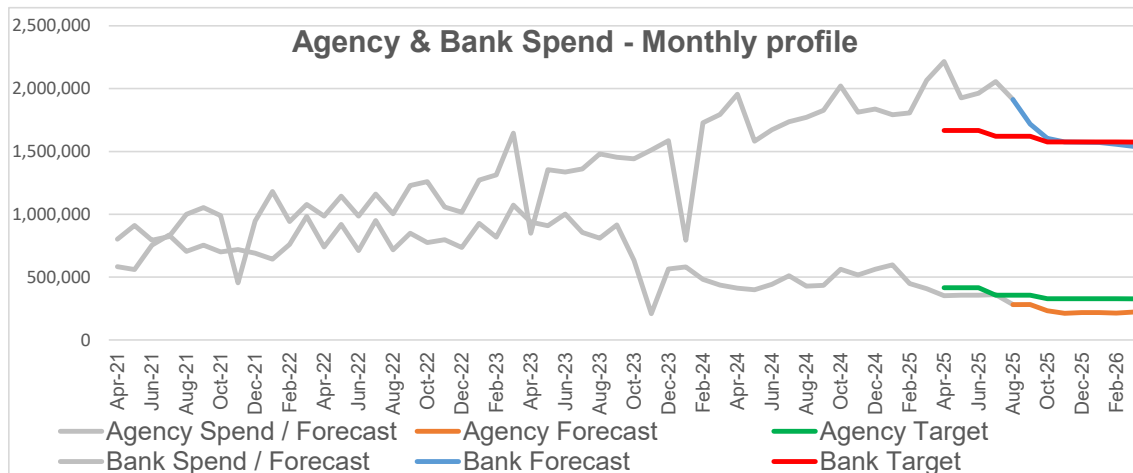
In month bank staff has increased by 35. This is highest month in year with the exception of April (which is traditionally high due to year end actions).

The operational impact of this continues to be understood within the Trust including weekly insight through the Trust Temporary Staffing Scrutiny and Management group.

Trust spend in August 2025:
Agency £281k
Bank £1,913k

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 solely agency staff to total temporary staffing costs especially those which are paid a premium rate when compared 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 £k	Bank £k	Total £k
Consultant	805	283	1,088
Other Medical	480	190	670
Reg Nursing	34	2,467	2,501
UnReg Nursing	287	6,436	6,723
Other Clinical	98	298	396
A & C	2	401	404
Other	0	0	0
Total	1,706	10,076	11,782
Lead Provider Collaborative	25	2	28
Budgets held centrally		11	11
Total	1,732	10,089	11,821

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 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 and as overall key financial performance indicators (KPI). These are considered as absolute values and not in the context of other pay expenditure movements.

Agency spend continues to be under plan for the year to date with spend in August reducing to £281k. This is primarily due to reductions medical agency spend. Individual exit plans have been updated and this supports the continued forecast reductions in future months. Decisions and actions previously taken continue to be in place and relevant. As such there is compliance with national guidance and spend is limited to medical and nursing staff in August.

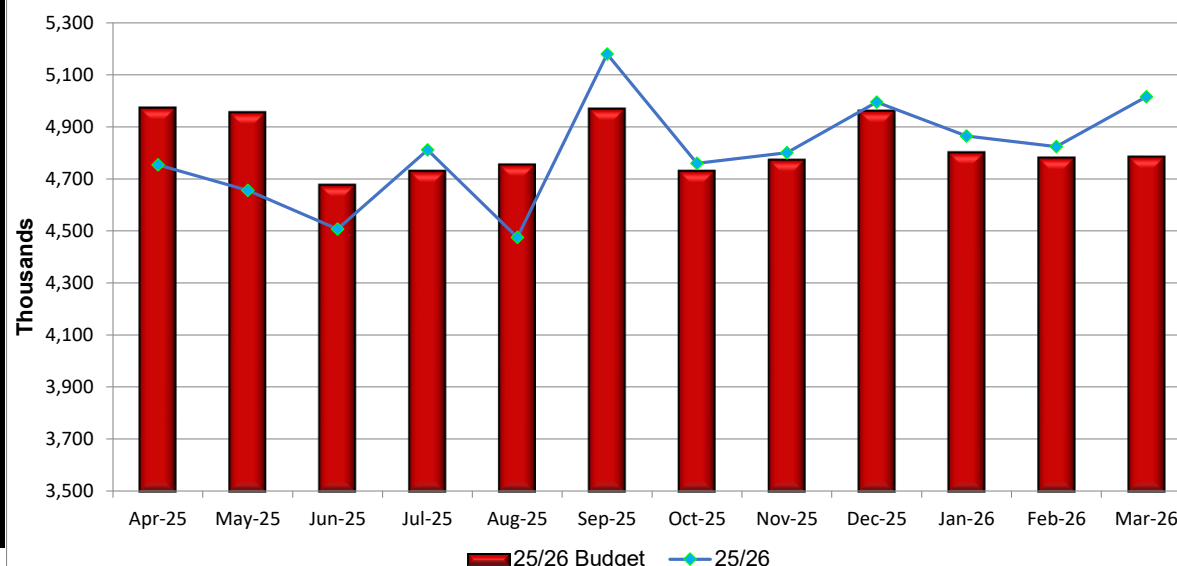
As per the standard operating procedure bank usage is the first option to meet operational requirements. Although spend has reduced (see previous comments on the impact of actual agenda for change pay award) usage has increased from 452 worked WTE to 487 WTE. The operational requirements are scrutinised in detail with an improved, clear understanding at a detailed level through the Trust Temporary Staffing Group. This is forecast to reduce, to a level broadly in line with the plan run rate, for the remainder of the year.

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	4,507	4,812	4,475	5,180	4,760	4,801	4,995	4,865	4,824	5,016	57,646
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	Actual	Variance
	Year to date	Year to date	
	£k	£k	£k
Drugs	1,877	1,850	(27)
Establishment	4,087	3,812	(274)
Lease & Property Rental	3,741	3,567	(174)
Premises (inc. rates)	2,274	2,301	27
Utilities	1,143	1,178	36
Purchase of Healthcare	2,739	2,937	198
Travel & vehicles	2,760	2,602	(158)
Supplies & Services	3,758	3,616	(142)
Training & Education	381	254	(127)
Clinical Negligence & Insurance	731	604	(127)
Other non pay	597	483	(114)
Total	24,087	23,205	(882)
Total Excl OOA and Drugs	19,471	18,418	(1,053)



Key Messages

Non pay expenditure, excluding provider collaboratives and budgets held centrally, has returned to a run rate in line with the rest of the year. As reported in July 2025 the increased expenditure primarily related to the timing of computer equipment replacement programme purchases (was planned but later than originally intended). As such expenditure is less than planned in month.

The largest overspend relates to the purchase of healthcare which has increased to £198k, from £106k, overspent for the year to date. Out of area placements (both acute and PICU) have remained higher than plan and are reflective of the operational pressures being experienced in order to meet the demand for our inpatient services. Whilst this is a relatively low variance to plan, especially when considering historical levels of spend, this does remain a financial pressure which requires mitigation. Potential changes in activity are included within the Trust forecast scenario modelling.

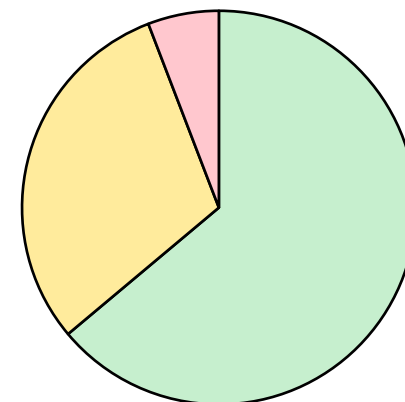
Other non pay costs are currently being managed within budgets and this will continue to be monitored.

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.

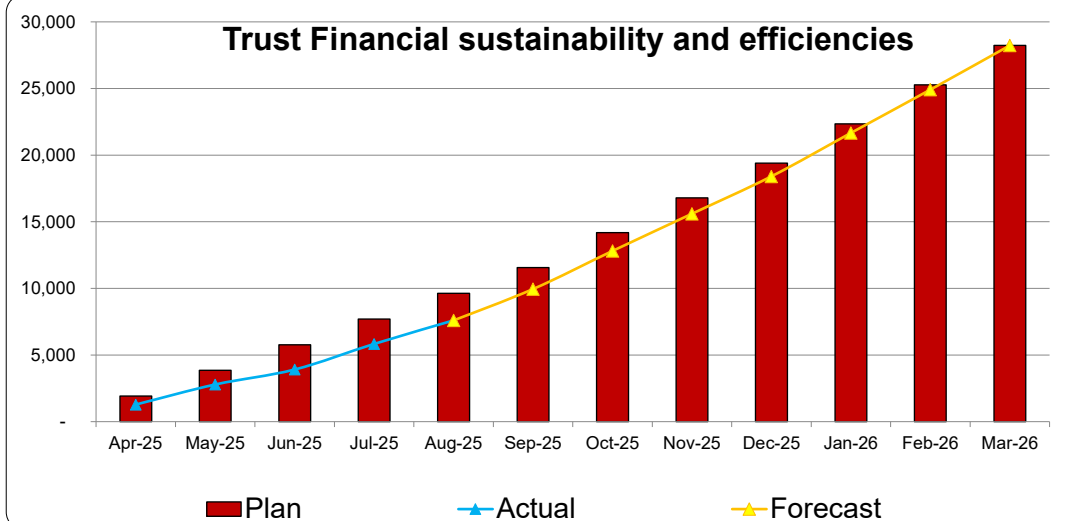
This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date						Forecast				
Group	Key lines of enquiry	Target	Achieved Recurrent	Achieved Non Recurrent	Variance	Original Target	Adjust	Revised Target	Green	Amber	Red	Variance
		£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Pay	Workforce	3,146	0	3,148	2	10,500	0	10,500	3,148	7,230		(122)
	Unallocated	0	0		(0)	3,400	(3,400)	0			0	(0)
	Fixed Term Contracts	210	41		(169)	500	0	500	362			(138)
	Corp / non clinical	665	819	657	811	2,000	1,000	3,000	2,703			(297)
	Productivity	0	0		0	1,100	0	1,100	0		646	(454)
	Temporary Staffing	1,625	745		(880)	3,900	0	3,900	2,795	0		(1,105)
	Difficult Decisions	0	0		0	1,000	0	1,000	0		1,000	0
Non Pay	Non Pay	425	286		(139)	1,130	0	1,130	267	796		(67)
Other	Corporate Services	710	725		15	1,700	0	1,700	1,745			45
	Provider Collaboratives	625	885		260	1,500	0	1,500	2,121			621
	Bed Sales	0	0		0	500	0	500	500			0
	Income	294	294		0	0	705	705	705			0
	Misc income - overage	520		0	(520)	0	520	520		520		0
	Technical	0		0	0	1,000	1,175	2,175	3,692			1,517
Total		8,220	3,795	3,805	(621)	28,230	0	28,230	18,038	8,546	1,646	0
Recurrent		4,429	3,795		(634)	16,430	(2,695)	14,735	13,347	8,026	1,646	8,284
Non Recurrent		3,791		3,805	14	11,800	2,695	13,495	4,691	520	0	(8,284)

Value for Money
Forecast Risk Rating



Green Amber Red



The Trust value for money plan, as submitted in April 2025, included £3.4m high risk / unallocated. By month 3 (June 2025) schemes have progressed, and this value has been allocated, meaning that there is no unallocated value within the Trust programme. An adjustment column has been added to the table above to show these reallocations.

The original plan profile has been retained for consistency of reporting with external returns.

At August 2025 there are 2 schemes which are RAG rated as red. These relate to productivity and loss making services. Progress continues on both but it is unlikely they will deliver their full planned savings in year. In August this value has reduced as other mitigations, albeit non-recurrent, have been identified.

The implications of this, and potential timing changes into 2025 / 26, are considered as part of the Trust annual planning and underlying financial position work.

Balance Sheet / Statement of Financial Position (SOFP)	2024 / 2025 £k	Current £k	Note
Non-Current (Fixed) Assets	197,434	191,828	
Current Assets			
Inventories & Work in Progress	248	248	
NHS Trade Receivables (Debtors)	2,453	147	
Non NHS Trade Receivables (Debtors)	989	753	
Prepayments	2,863	5,431	1
Accrued Income	6,235	6,579	2
Cash and Cash Equivalents	55,748	60,064	Pg 15
Total Current Assets	68,537	73,223	
Current Liabilities			
Trade Payables (Creditors)	(10,899)	(3,754)	3
Capital Payables (Creditors)	(1,551)	(1,275)	
Tax, NI, Pension Payables, PDC	(9,478)	(11,675)	
Accruals	(14,054)	(15,591)	4
Deferred Income	(644)	(3,764)	5
Other Liabilities (IFRS 16 / leases)	(48,793)	(50,238)	
Total Current Liabilities	(85,419)	(86,297)	
Net Current Assets/Liabilities	(16,882)	(13,075)	
Total Assets less Current Liabilities	180,552	178,753	
Provisions for Liabilities	(3,357)	(3,281)	
Total Net Assets/(Liabilities)	177,195	175,472	
Taxpayers' Equity			
Public Dividend Capital	76,344	76,344	
Revaluation Reserve	21,306	14,152	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	74,325	79,755	
Total Taxpayers' Equity	177,195	175,472	

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 has increased by £1m since last month, £3m of the balance relates to monies agreed with NHS England in relation to Cheswold. Discussions continues to realise payment of these values.

3. As is normal Trade creditors were exceptionally high at year end and have now reduced. 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.

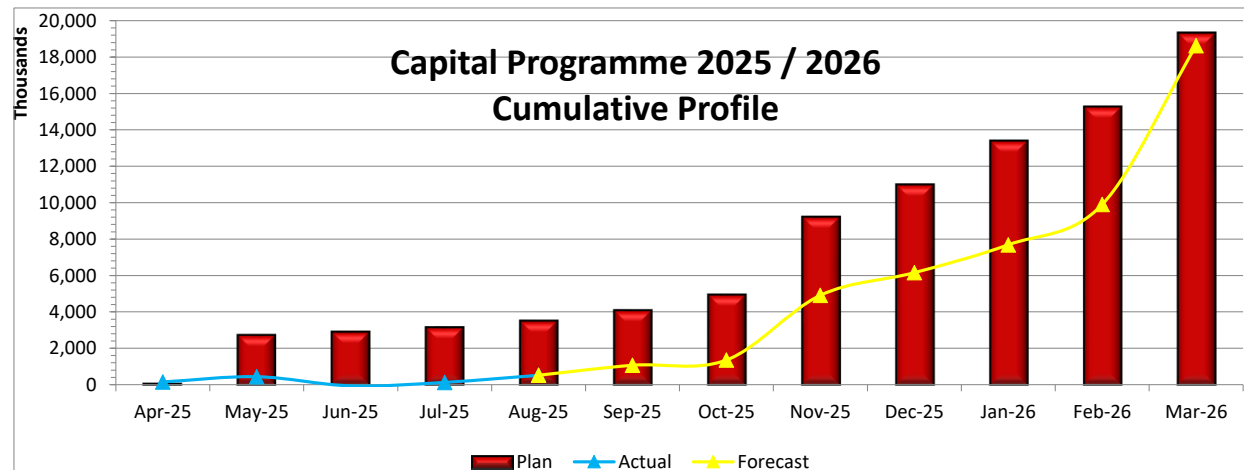
4. Accruals continue to be monitored to ensure that they are in line with accounting standards and that issues, or areas of uncertainty, are allowed to build up.

5. Deferred income, the largest element is the timing of education training funding from NHS England (£1.0m) and £0.6m in relation to the Research and Development capital scheme and £0.5m in relation to low value activity income.

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	800	209	(591)	7,425	3,825	(3,600)
Estates safety	0	0	0	675	675	0
Backlog Maintenance	0	22	22	0	1,523	1,523
Equipment	0	0	0	0	45	45
Vehicles	0	0	0	0	36	36
IM & T	0	396	396	0	1,139	1,139
Other	0	217	217	0	1,347	1,347
Leases (IFRS 16)	2,706	317	(2,389)	6,148	4,158	(1,990)
TOTALS	3,506	1,161	(2,345)	14,248	12,748	(1,500)
Additional allocations						
Net Zero (solar funding)	0	0	0	1,952	1,952	0
Cheswold - seclusion room	0	4	4	1,000	2,000	1,000
Cheswold - Minor Capital	0	0	0	2,082	2,582	500
Cheswold - IM & T	0	0	0			0
TOTALS	3,506	1,165	(2,341)	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 are included within the single allocation value and are being managed as such.

There has been minimal spend to date. For leases the annual revaluations have been completed but were less than planned.

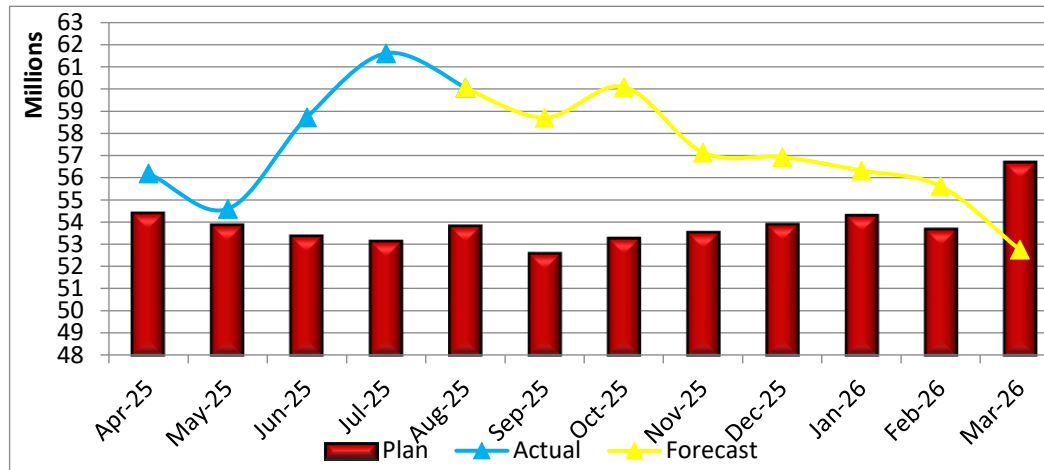
Development, with the Trust construction partner, continues for the Older People Transformation programme. The expenditure profile was updated in July and this continues to be validated.

This change facilitates other schemes within the Trust Estates Strategy to be brought forward and this will be reviewed to ensure that the allocation is fully utilised in year.

The impact of these changes are included into the longer term capital plan.

4.2

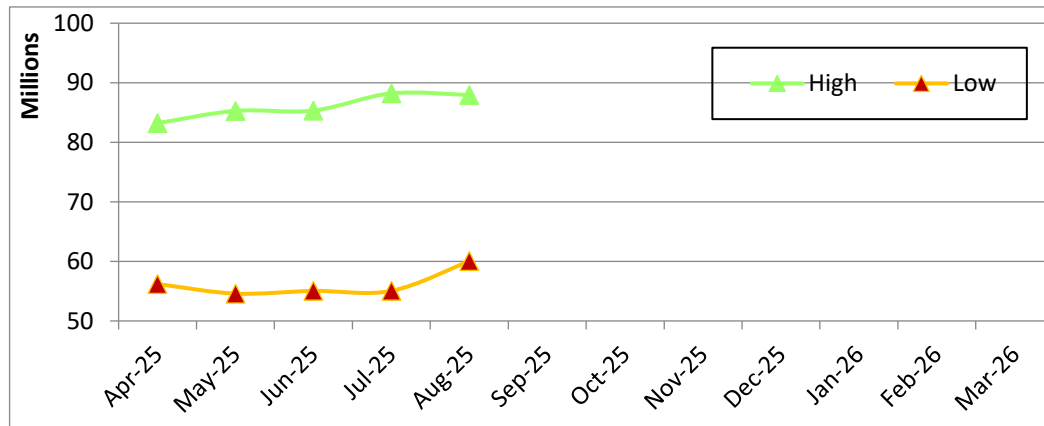
Cash Flow & Cash Flow Forecast 2025 / 2026



Cash remains above plan

There is a focus on cash nationally and within the Integrated care system. To support this guidance and instructions on working capital management, and the reporting on cash, are being re-reviewed.

	Plan £k	Actual £k	Variance £k
Opening Balance	55,839	55,839	
Closing Balance	53,814	60,064	6,249



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: £87.9m

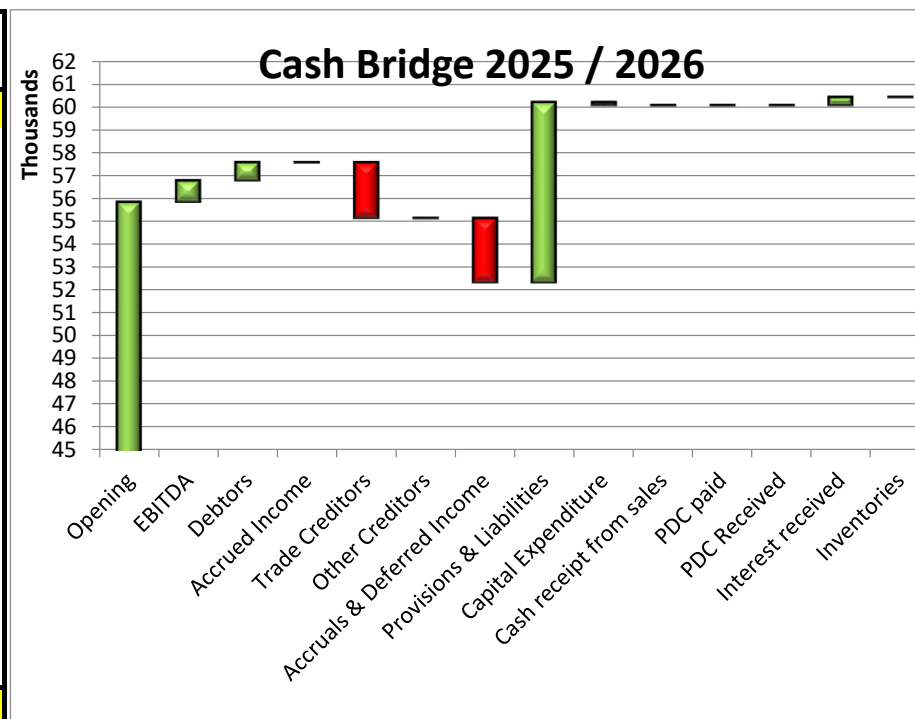
The lowest balance is: £60.1m

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)	5,015	5,951	936	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	1,550	2,355	805	
Trade Payables (Creditors)	250	(2,194)	(2,444)	
Accruals & Deferred income	0	(2,816)	(2,816)	
Provisions & Liabilities	(4,850)	3,037	7,887	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,000)	(1,124)	(124)	
Cash receipts from asset sales	0	0	0	
Leases	(3,906)	(2,253)	1,653	
PDC Dividends paid	0	0	0	
PDC Dividends received	0	0	0	
Interest (paid)/ received	917	1,269	351	
Closing Balances	53,814	60,064	6,249	



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.

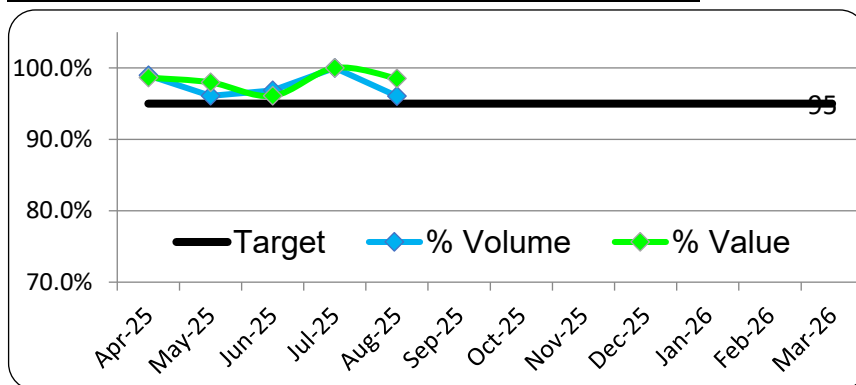
5.0

Better Payment Practice Code

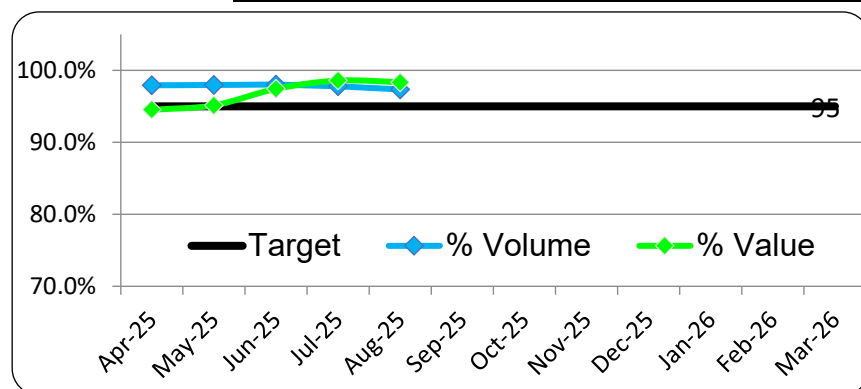
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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%	99%
Cumulative Year to Date	98%	98%



Non NHS	Number %	Value %
In Month	97%	98%
Cumulative Year to Date	98%	96%



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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 (£)
12-Aug-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000059249	734,353
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004939	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004940	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004941	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004942	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004962	717,325
21-Aug-25	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710181964	408,526
21-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	CYGWYS61	400,000
04-Aug-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010341	377,540
28-Aug-25	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0133839	362,659
21-Aug-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001804	341,793
06-Aug-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400003335	246,499
21-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	CYGSYS38	240,000
05-Aug-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 302	226,385
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	168,614
27-Aug-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34042980	120,000
20-Aug-25	NHS Recharge	Barnsley	Mid Yorkshire Hospitals NHS Trust	1600037617	119,921
01-Aug-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010338	110,541
20-Aug-25	IT Services	Trustwide	Wavenet Ltd	1378852	108,300
11-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	WYS059SN	100,552
19-Aug-25	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	330393	76,226
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004934	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004935	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004936	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004937	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004938	69,872
29-Aug-25	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710181965	69,669
08-Aug-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34042399	62,491
29-Aug-25	Purchase of Healthcare	Trustwide	Cygnnet Behavioural Health Ltd	KHS0420255	58,404
20-Aug-25	Drugs	Trustwide	NHS Business Services Authority	1000085407	55,494

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
11-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnnet Health Care Ltd	WYS059INV	55,150
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	50,169
21-Aug-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001806	49,819
15-Aug-25	Utilities	Trustwide	Edf Energy Customers Ltd	000024500785	41,124
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	36,774
08-Aug-25	Purchase of Healthcare	Trustwide	Cygnnet Behavioural Health Ltd	APL0419771	35,961
20-Aug-25	Purchase of Healthcare	Trustwide	Caireach Ltd	WDH0418871	33,185
08-Aug-25	Purchase of Healthcare	Trustwide	Cygnnet Behavioural Health Ltd	KHS0420274	32,860
20-Aug-25	Purchase of Healthcare	Trustwide	Cygnnet Behavioural Health Ltd	APL0419758	32,860
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	31,536
06-Aug-25	Drugs	Doncaster	Speeds Healthcare Ltd	INV162046	27,895
08-Aug-25	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0133699	27,172
07-Aug-25	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72490335	26,170
27-Aug-25	Interpretation	Trustwide	Word360 Ltd	130489	25,679
06-Aug-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90154059	25,019
06-Aug-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90154061	25,019

- * 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

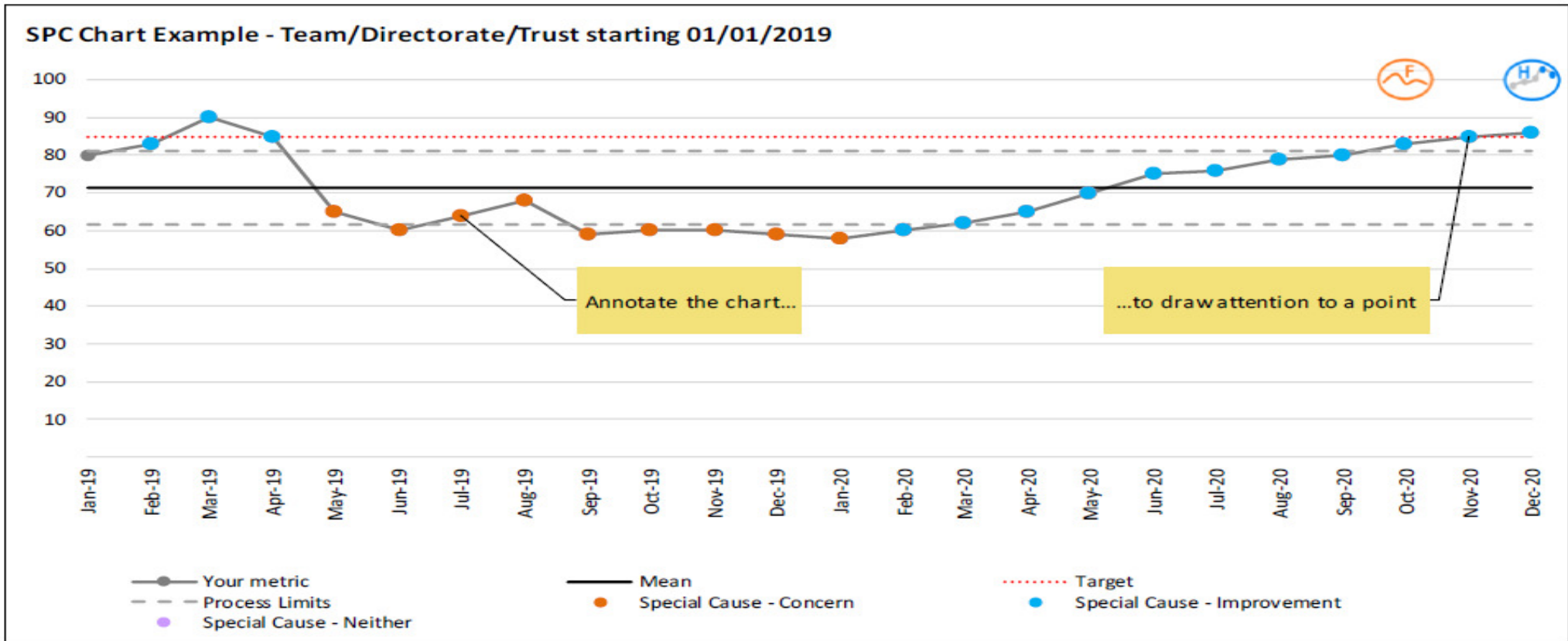
natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting 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 base 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 (I) 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 significant 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 significant change in process. This process is not in control.

Trust Board
30 September 2025
Agenda item 10.2

Private/Public paper:	Public Paper			
Title:	Care Group Dashboards: Attention Deficit Disorder, Autism Spectrum Disorder and Learning Disability Services			
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 services the trust delivers for attention deficit disorder (ADHD), autism spectrum disorder (ASD) and Learning Disability (LD). The action being taken to deliver high quality care and any areas for improvements. 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 ADHD, ADD and LD services contributes to managing all the risks on the Board Assurance Framework and makes a specific contribution to actions to address the following risks: Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 2.3 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.			

	Risk 2.4 - Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce, leading to poor service user and staff experience and the inability to sustain safer staffing levels. Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience, meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	These services are provided across West and South Yorkshire although each place commission services differently and for a range of people. ADHD services the trust provides is as follows: Wakefield – Adults Barnsley – Adults and Children Calderdale –Children’s (adults can choose to be seen by the trust via right to choose but contract) Kirklees- Adults and Children ASD Wakefield – Adults Barnsley – Adults Calderdale – Adults and Children’s Kirklees- Adults and Children The Trust provides Learning Disability Services across all places for all ages with exception of Barnsley that does not currently provide Learning Disability services for children and young people, although they have in August agreed a business case for two LD nurses so a service can be established
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the public Board meetings. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing greater 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 preparation.
Executive summary:	<u>Summary: Adult ADHD Service</u> Screening & Triage: • 835 individuals are awaiting ADHD triage. • Introduced in Kirklees and Wakefield (Summer 2024) to improve referral quality. • Early data shows reduced waiting list growth in Wakefield (from 3.7% to 1.2%). • Barnsley and Calderdale have not yet commissioned triage but have requested updated business cases. Assessment Waiting List: • Over 6,500 people are waiting, with some waiting up to three years. • The service is on track to meet its annual target of 430 assessments; 126 (29%) have started since April 2025.

2025/26 Capacity & Commissioning:

- Capacity remains at 430 assessments.
- Only 330 places commissioned by Barnsley, Kirklees, and Wakefield.
- Remaining capacity offered to Calderdale, with reimbursement expected via Patient Choice.

Summary: Adult Autism Pathways**Referral Growth & Triage:**

- Referrals in Barnsley, Kirklees, and Wakefield have more than doubled since 2019/20, with projected volumes exceeding 1,300 in 2024/25.
- All three areas have commissioned a triage model, where autism specialists review referral information and health records to determine clinical appropriateness.
- While feedback from some patient groups has been mixed, the model aligns with NHS England's April 2023 guidance for all-age autism pathways.
- Despite increased referrals, there has not been a corresponding rise in clinically appropriate cases, helping to keep waiting times relatively low.

Calderdale Pathway:

- Waiting times have increased significantly.
- ICB funding originally allocated for triage was redirected to expand assessment capacity (from 30 to 55 cases/year).
- However, demand continues to exceed capacity by over threefold, resulting in a growing waiting list.

Shared Care for ADHD Medication – Service Summary

The service has been delivering shared care for ADHD medication in Barnsley, Kirklees, and Wakefield for several years, and has recently expanded to include Calderdale following agreement with the ICB.

Barnsley 17+ Autism Pathway

The Service has been invited to submit a business case to deliver approximately 20 autism assessments for 17-year-olds in Barnsley. This proposal mirrors a successful project delivered last year and aims to reduce waiting times for young people currently on the paediatric caseload at Barnsley Hospital NHS Foundation Trust.

The service strives to continually improve to meet the needs of our services users. This so far has included the Triage model in Wakefield and Kirklees, with positive outcomes from early results.

A digitised questionnaire is being developed to optimise clinical time and improve patient outcomes and experience

West Yorkshire ICB are out to consultation on a proposal for a Hub model, with the services being actively involved.

The ADHS and ASD services have strong performance across all people and training metrics

	Learning Disability Services. There has been a sustainable improvement of waiting times for LD services. Community • To support the Autism Diagnostic Observation Schedule (ADOS) assessment the service has trained 22 more colleagues to undertake the assessment to improve the waiting list. Strong clinician engagement and embedded culture of waiting list management. • Following the successful pilot of the 'Keeping My Chest Healthy' initiative, the service is now committed to rolling out the programme across all localities. • Recruitment to Speech and Language Therapy (SaLT) posts continues to be a challenge. • Implementation of 'Waiting Well' and 'Waiting Fairly' approaches to accelerate progress on lower-priority cases. Calderdale Physiotherapy: • Service transitioned to the Trust on 1 April 2025. • Contract limits caseload to 12 open cases, contributing to a growing waiting list. • Three service users have exceeded the 18-week wait, with one waiting over 50 weeks. • Clinical Acuity - Community Teams continue to report high levels of LD service users in crisis. Work and support within teams is on-going. Assessment and Treatment Unit • A review of the current establishment is planned to ensure staffing structures and resource allocation remain aligned with service delivery needs and strategic priorities. Further details will be shared as the review progresses. • While the service has successfully discharged a number of service users recently, challenges persist in securing suitable accommodation to meet the needs of this service user group. Mandatory Training – the service is reaching the threshold for all mandatory training. Appraisal – 86%↑ Supervision – 87.6% Quality improvement - work continues, with ongoing focus on care planning and FIRM Risk Assessment. Notable improvements in compliance have already been observed.
Recommendation:	Trust Board members are asked to: RECEIVE and NOTE the report.

ADHD/ASD/LD Care Group



July 2025

With **all of us** in mind.

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

Learning Disability Services

The Trust's Learning Disability (LD) provision is delivered through four locality-based multidisciplinary teams in Wakefield, Barnsley, Calderdale, and Kirklees. Each team comprises psychiatry, psychology, specialist LD nursing, therapy services, and an intensive support function. These teams provide specialist care to adults with learning disabilities who are unable to access mainstream health services, with a focus on improving health outcomes and overall wellbeing.

The service operates in close collaboration with partner agencies and is supported by Strategic Health Facilitators in each locality. A newly established Out of Hours service enhances responsiveness to urgent needs. Inpatient assessment and treatment is provided at the Horizon Unit, coordinated in partnership with Bradford District Care Trust, serving the wider West Yorkshire footprint.

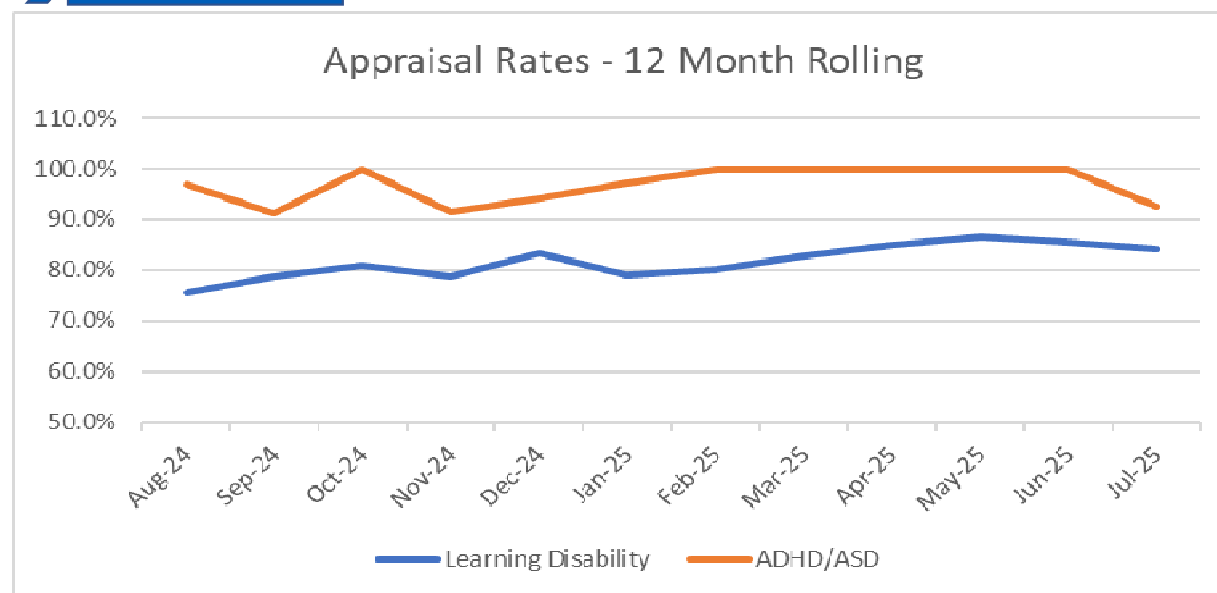
Adult ADHD and Autism Services

The Adult ADHD/ASD service delivers person-centred care for individuals aged 18 and over with a diagnosis of ADHD and/or Autism. The service aims to support individuals to achieve their potential and maintain wellbeing within their communities.

Provision includes comprehensive diagnostic assessments, access to appropriate psychological interventions, and tailored support for both service users and carers. The service is integrated with local authority pathways to ensure coordinated care and access to wider support networks.

Workforce

Appraisals



Insights

Appraisal is a critical component of workforce development, providing a structured opportunity for staff to reflect on their performance, receive feedback, and align personal objectives with organisational priorities. Both services recognise the role it plays in:

Enhancing Performance, Promoting Wellbeing, Strengthening Engagement: Informing Workforce Planning.

Appraisal compliance is reviewed regularly within the service and forms part of the wider Care Group governance discussions to ensure quality standards are maintained.

LD - July 84.1% Appraisal compliance within the Learning Disability service has been impacted by clinical pressures, waiting list demands, and staffing vacancies, and is regularly reviewed at Care Group meetings to support improvement.

The service has adopted some focused interventions to improve the July position which include:

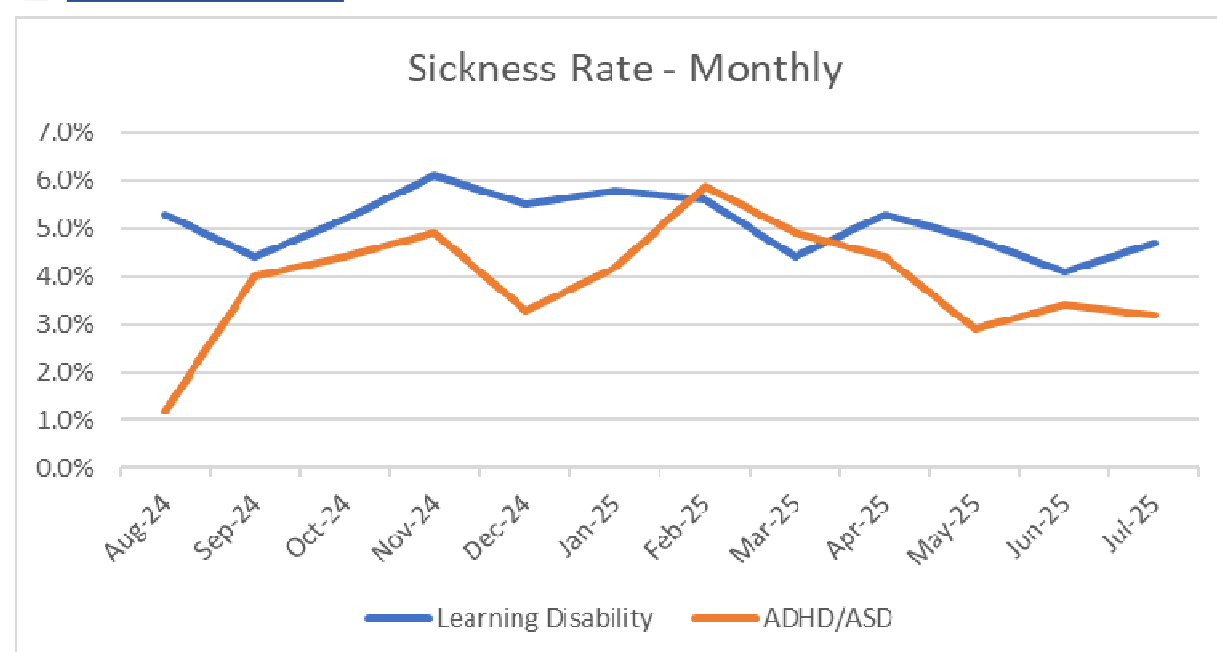
Protected Time: Allocate dedicated time within staff rotas to complete appraisals, ensuring they are not deprioritised due to clinical demands.

Performance Dashboards: Incorporate appraisal compliance into team-level dashboards reviewed monthly, enabling timely oversight and targeted support.

Leadership Messaging: Reinforce the value of appraisals through senior leadership communications, positioning them as essential for staff development and wellbeing rather than a compliance task.

ADHD/ASD - July 92.5% The ADHD/ASD service maintains consistently high appraisal compliance, supported by strong staff satisfaction reflected in NHS surveys; appraisals and supervision are routinely scheduled in staff diaries, facilitated by the team's single-base working model.

Sickness



Insights

LD - The July position for sickness absence is 4.7%.

Sickness absence continues to be monitored across services, with variations observed between teams. In the Learning Disability service, pressures related to vacancies and caseload complexity may be contributing factors.

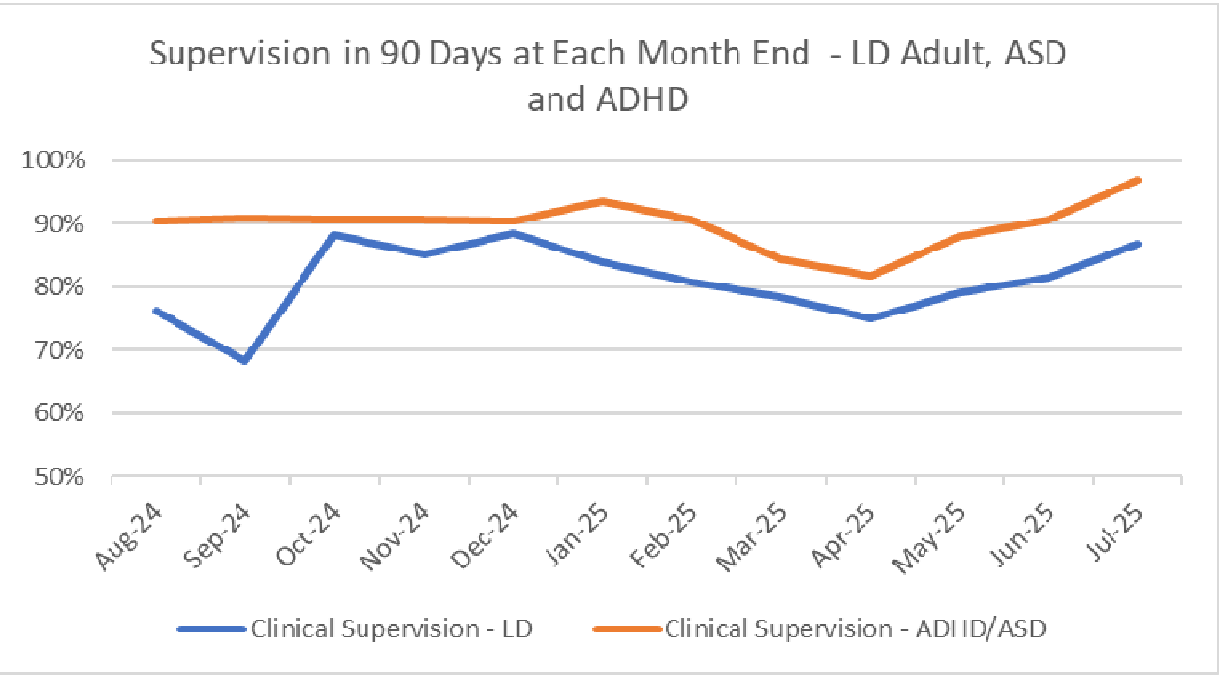
Sickness absence remains just below the Trust threshold overall and is monitored through Team and Care Group meetings. Managers continue to be supported by the People Relations team to manage absence and maintain staff wellbeing.

ADHD/ASD - The July position for sickness absence is 3.2%

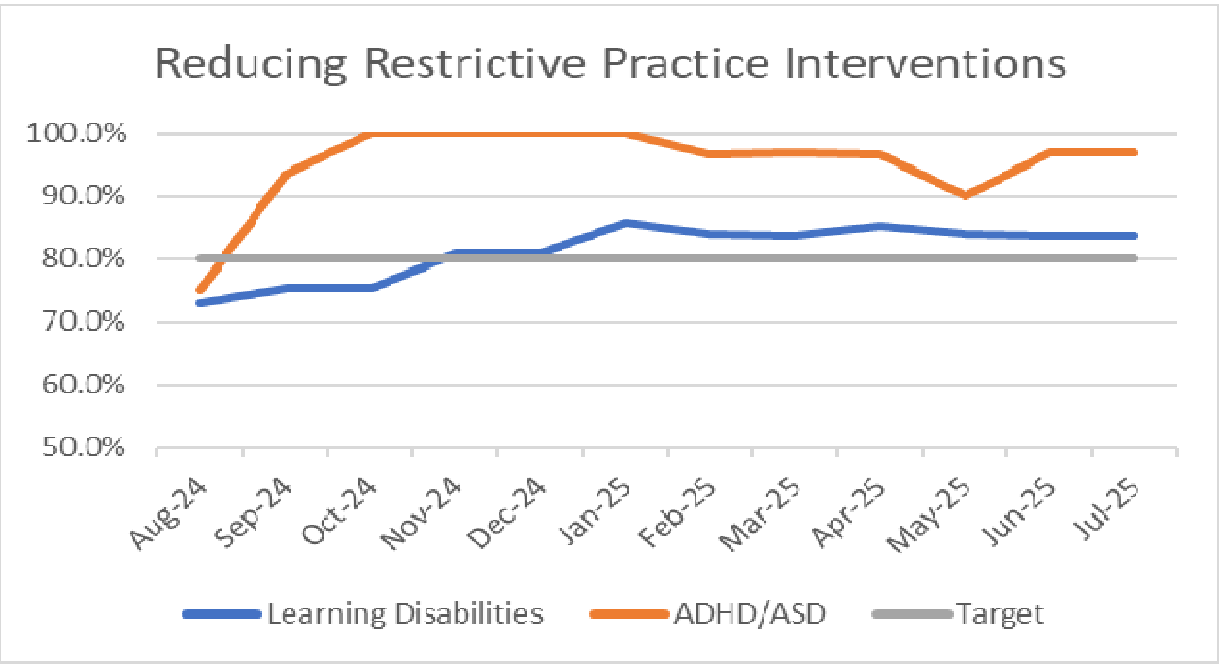
Generally sickness absence within ADHD/ASD service is below the Trust threshold.

Both the Learning Disability and ADHD/ASD services recognise the impact of sickness absence on service delivery. Managers are supported by the People Relations Team and Business Partner to address absence and promote wellbeing. Both services maintain a strong focus on staff wellbeing, with dedicated support and wellbeing events forming an integral part of their approach to staff engagement and retention.

Supervision



Mandatory Training



Insights

Clinical supervision is a structured form of reflective practice designed to enhance the delivery of safe and effective care. Through professional support and learning, it contributes to both personal and professional development. The Trust has set a compliance target of 80%, with ongoing efforts to embed supervision as a core element of staff support and quality assurance.

LD - July position is 86.7%.
Clinical supervision compliance across the Learning Disability service is now above the Trust threshold, with the Horizon Centre consistently achieving 100%. Improvements have been embedded across all teams, supported by more accurate recording of team supervision and reflective practice. Supervision performance is routinely monitored through team meetings and Care Group governance structures, enabling any dips in compliance to be identified and addressed promptly and effectively.

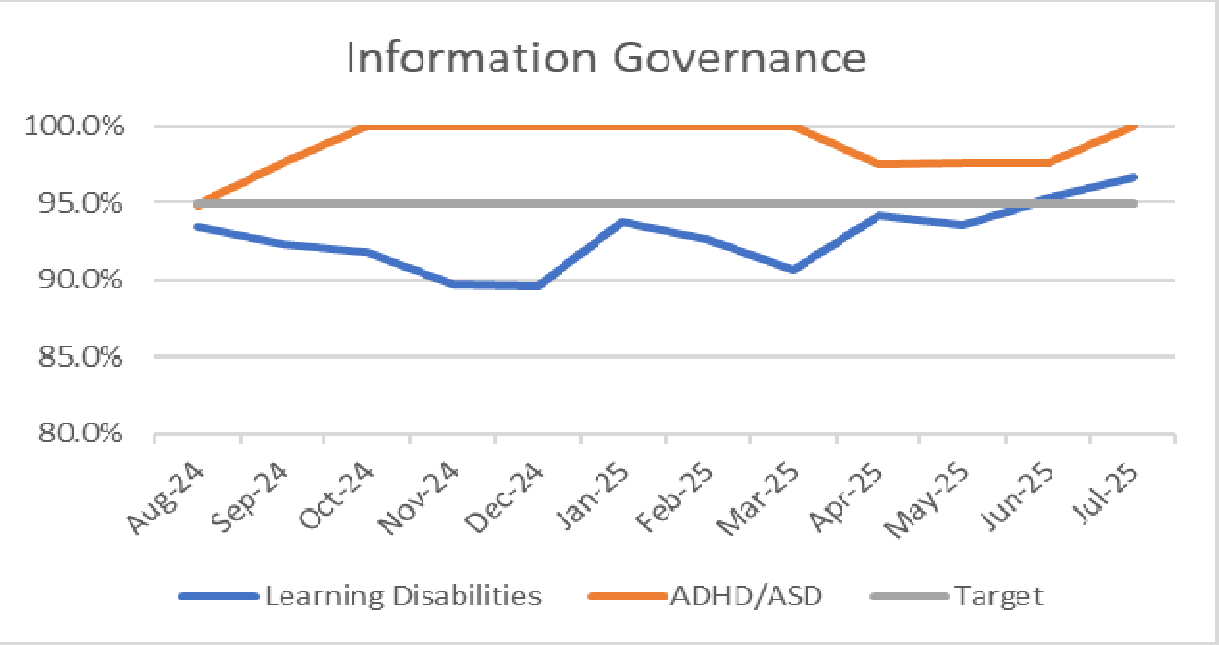
ADHD/ASD - July position is 96.9%
The ADHD/ASD service has a well-established and embedded culture of prioritising clinical supervision, with data demonstrating strong compliance throughout the past year. This commitment has had a positive impact on staff wellbeing, with a notable correlation between high supervision compliance and low sickness absence. The service benefits from a single-base working model, which supports consistent scheduling and delivery of supervision..

Insights

LD - July performance 83.7% which is above the Trust Target of 80%.
The Learning Disability service has addressed previous challenges in achieving compliance with Reducing Restrictive Practice Interventions (RRPI), as noted in the last deep dive. In response, the service has used performance data to target individuals requiring training and prioritised them accordingly. This focused approach has led to improved compliance, and managers remain committed to maintaining current levels. Ongoing monitoring and targeted support continue to be embedded within team and Care Group governance processes.

ADHD/ASD - July performance is 96.8%. The ADHD/ASD service previously experienced challenges in accessing Breakaway and Personal Safety training courses. These issues have since been resolved, and the service has now achieved full compliance which has been maintained consistently.

Mandatory Training



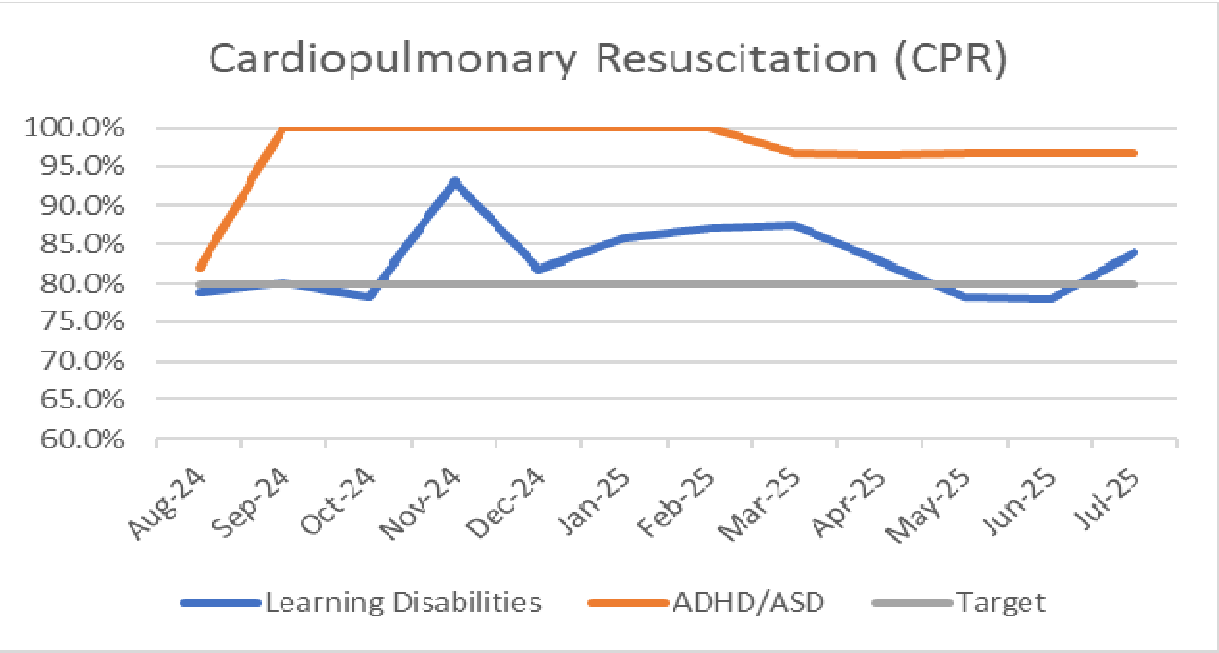
Insights

Information Governance is essential to NHS services, ensuring that personal data is handled securely, legally, and ethically. It protects patient confidentiality, supports safe care delivery, and underpins public trust and digital innovation.

LD - July compliance is 96.6% which is above the 95% target.
Compliance with Information Governance (IG) training has been consistent within the Learning Disability service, with monthly rates not dropping below 90%. The team is actively exploring strategies to strengthen compliance and embed IG training as a routine part of workforce development. Planned actions include:
Visibility: Share team-level compliance data at Care Group meetings to maintain oversight.
Protected Time: Allocate time in staff rotas for IG training, especially during quieter periods.
Accountability: Embed IG training checks into supervision and appraisal discussions.
Accessibility: Gather staff feedback on barriers and review the usability of training platforms.

ADHD/ASD - July compliance is 100% and therefore above the Trust target of 95%. The ADHD/ASD service has demonstrated strong and sustained compliance with Information Governance training over an extended period, reflecting a well-embedded culture of data protection and accountability.

Mandatory Training

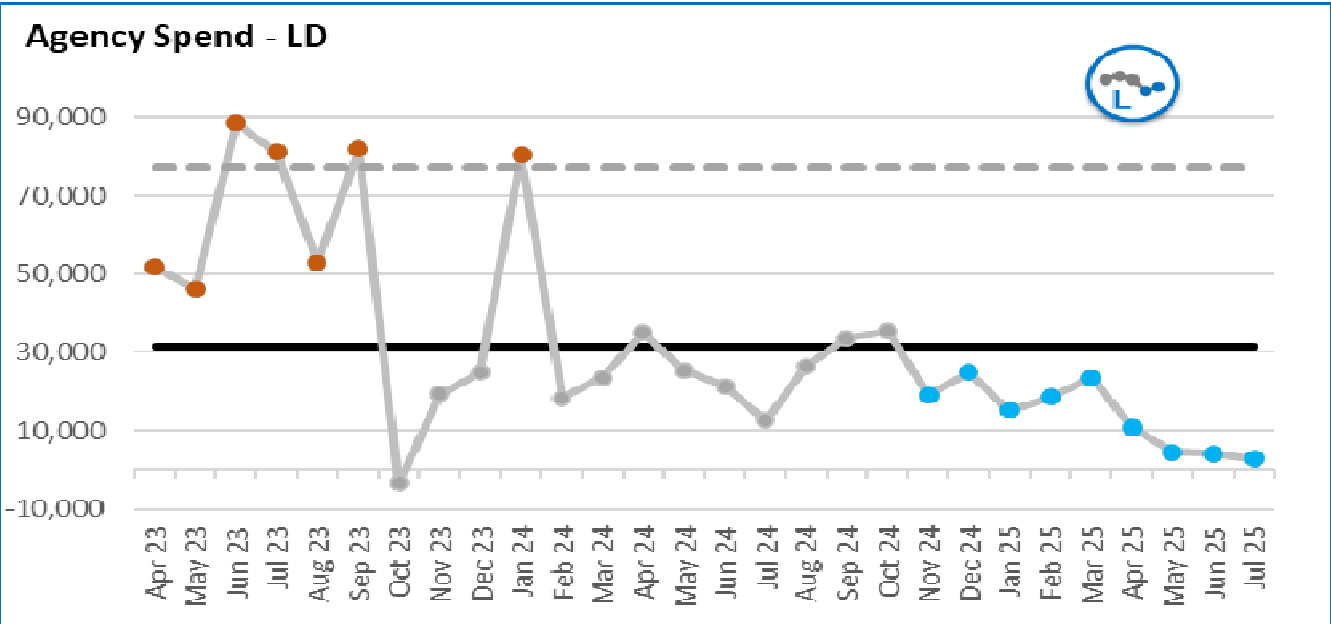


Insights

Learning Disability Service – CPR Training Compliance
CPR training compliance was 83.9% in July, exceeding the 80% target. A dip in performance was noted with actions identified to support improvement. Compliance is monitored monthly by team managers who have adopted a proactive approach to ensure staff are booked onto training in a timely manner, supporting sustained improvement.

ADHD/ASD Service – Training Compliance
Training compliance remains consistently above the 80% target, currently at 96.8%. Managers are proactively working with staff to ensure smoother scheduling of renewals in future cycles, aiming to avoid similar dips next year.

Agency Spend



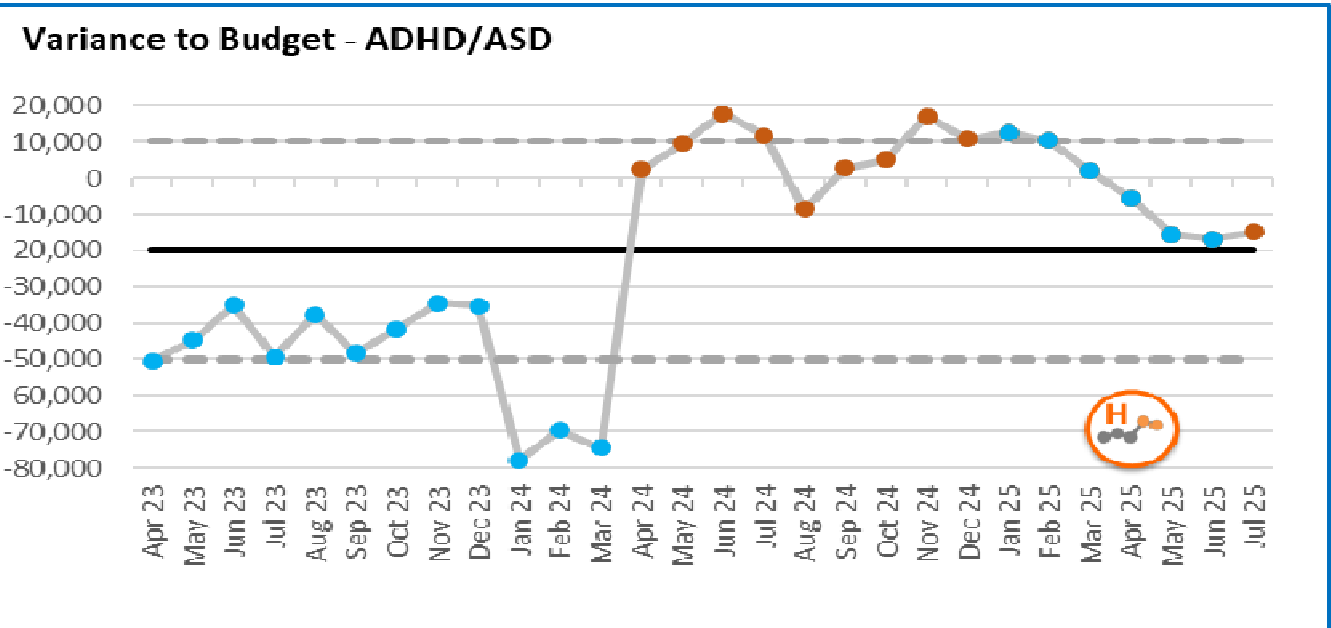
Insights

LD - In a previous deep dive LD reported high levels of medical agency accounting for 64% of agency spend. A recruitment plans was initiated by the medical clinical lead and at the time of writing the service has only one medical locum with an exit strategy in place from October 2025.

There has been closer scrutiny of agency usage on the inpatient ward, and encouragingly, a reducing trajectory is evident. This improvement has been achieved through proactive vacancy management and regular review of observation levels. However, the inpatient ward continues to rely heavily on bank staff due to the high observation requirements of the client group. When benchmarked against similar inpatient services nationally, this remains a consistent picture. A service review of the Assessment and Treatment model is currently underway across West Yorkshire to support future workforce planning and care delivery. Notably, there is no further use of agency staff within locality community teams.

ADHD/ASD - No agency spend.

Variance to Budget



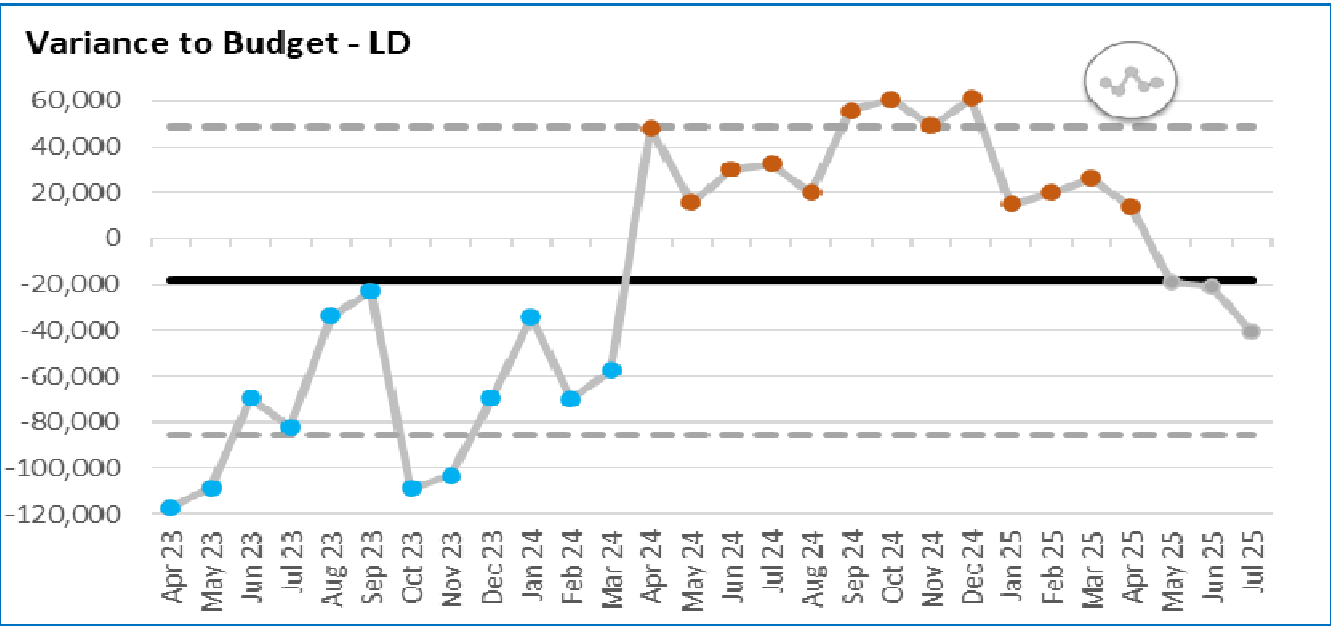
Insights

The year to date position shows an underspend of £15k in month, £53k year to date and £158k forecast. Staffing is broadly in line with the net plan.

While ADHD services received investment in previous financial years, no funding has been secured so far this year. Costings have been submitted to commissioners for both ADHD and Autism pathways. Should funding be approved, recruitment will be required to support delivery of the expanded service offer.

Finance

Variance to Budget



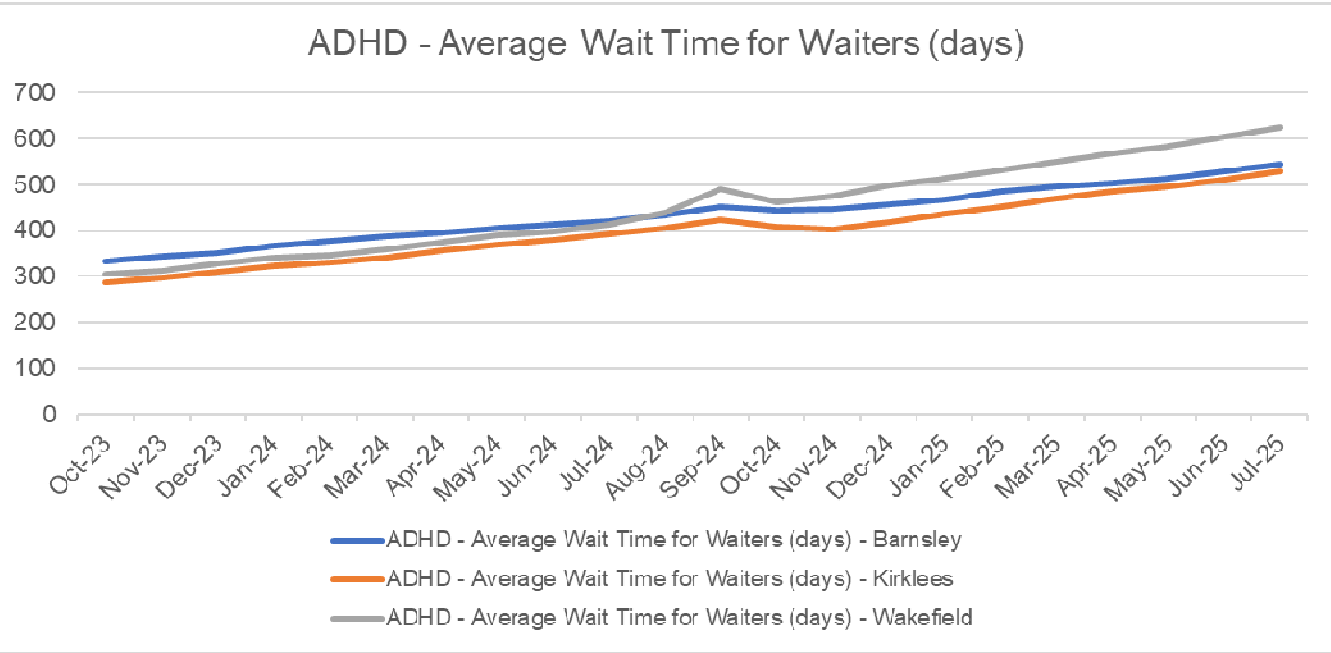
Insights

The year to date position shows an underspend of £40k in month, £67k year to date and £52k forecast.

Community service lines across all four localities are on track to fully achieve their staff vacancy factor targets. However, medical staffing continues to forecast an overspend, with repeated attempts to secure additional commissioner funding over the past two years proving unsuccessful. The Horizon unit remains in an overspend position. Further work is underway with system partners to determine the most clinically appropriate and cost-effective model. While reduced occupancy has lessened the overspend compared to the previous year, this is expected to rise as admissions increase.

Access

ADHD - Average waiting time (days)



Insights

Adult ADHD – Waiting Lists, Capacity and Commissioning

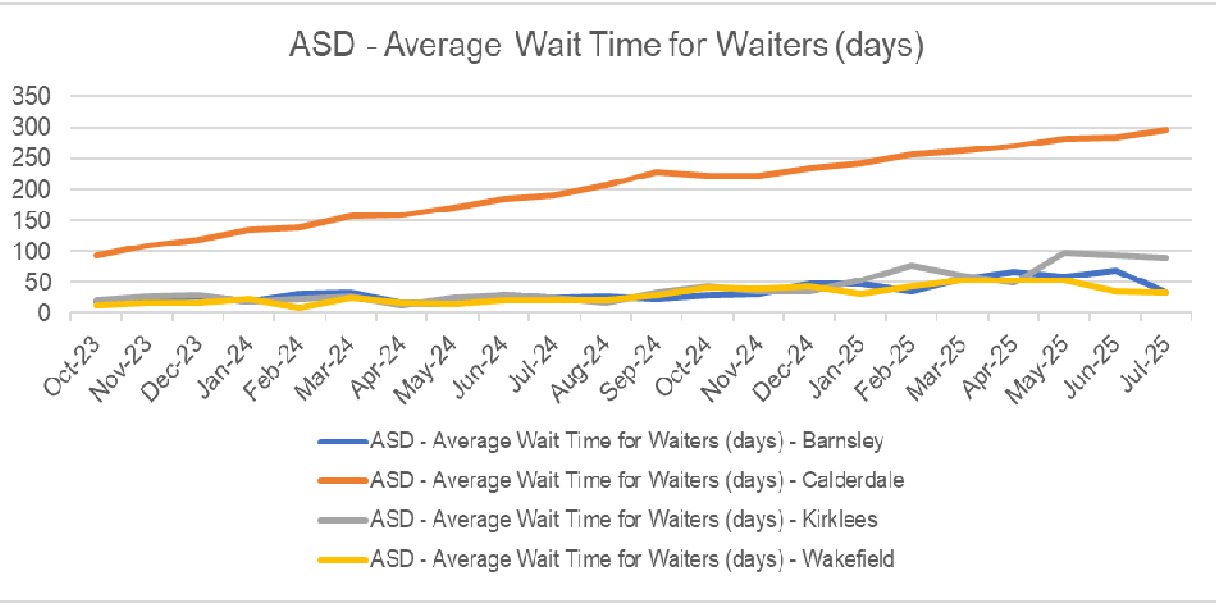
People are not necessarily seen based on chronological receipt of the referral. In order to manage the waiting list safely, people are initially prioritised based on clinical needs related to ADHD and also, multi disciplinary team may agree to expedite an assessment should it be requested by the referrer

Screening & Triage - The service currently has 835 individuals awaiting an ADHD triage appointment. This triage step, introduced in Kirklees and Wakefield in summer 2024, is an innovative approach designed to ensure only clinically appropriate referrals progress to assessment. Early analysis shows a positive impact, with Wakefield's monthly assessment waiting list growth reducing from 3.7% to 1.2% since implementation. Barnsley and Calderdale have not yet commissioned this step but have requested updated business cases.

Adult Assessments - There are currently over 6,500 people waiting for an ADHD assessment, with the longest waits typically around three years. Despite this, the service continues to deliver contracted activity and is on track to meet its annual target of 430 assessments. Since April 2025, 126 individuals (29%) have commenced the assessment process.

2025/26 Capacity and Commissioning - The service expects to maintain capacity for 430 new assessments in 2025/26. However, only 330 places have been commissioned to date by Barnsley, Kirklees, and Wakefield. The remaining capacity is being offered to Calderdale, with reimbursement expected via Patient Choice.

ASD - Average waiting time (days)



Insights

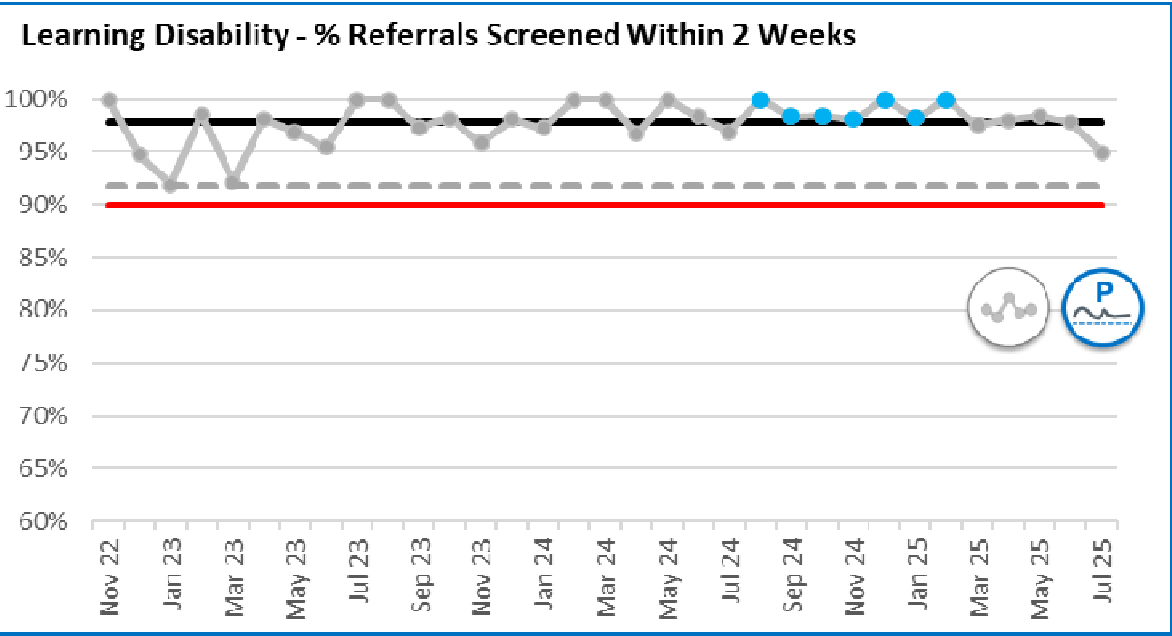
Adult Autism Pathways – Referral Trends, Commissioning and Waiting Times
Referral Growth and Triage Model

Autism pathways in Barnsley, Kirklees, and Wakefield have experienced a significant increase in referrals, with projected volumes for 2024/25 exceeding 1,300 referrals—more than double the rate seen in 2019/20. Each pathway includes a commissioned triage step, where referral information and health records are reviewed by a panel of autism specialists to determine clinical appropriateness for assessment. While this step has received mixed feedback from some patient groups, it remains compliant with NHS England's April 2023 operational guidance for all-age autism assessment pathways. Despite the rise in referrals, there has not been a corresponding increase in clinically appropriate cases, and as a result, waiting times for assessment remain relatively low in these areas.

Calderdale Pathway and Waiting Times

In contrast, Calderdale has seen a marked increase in waiting times. Although ICB investment for Calderdale's screening and triage was reallocated to increase assessment capacity (from 30 to approximately 55 cases per year), demand continues to exceed capacity by more than threefold, resulting in a growing waiting list.

LD - Referrals screened within 2 weeks

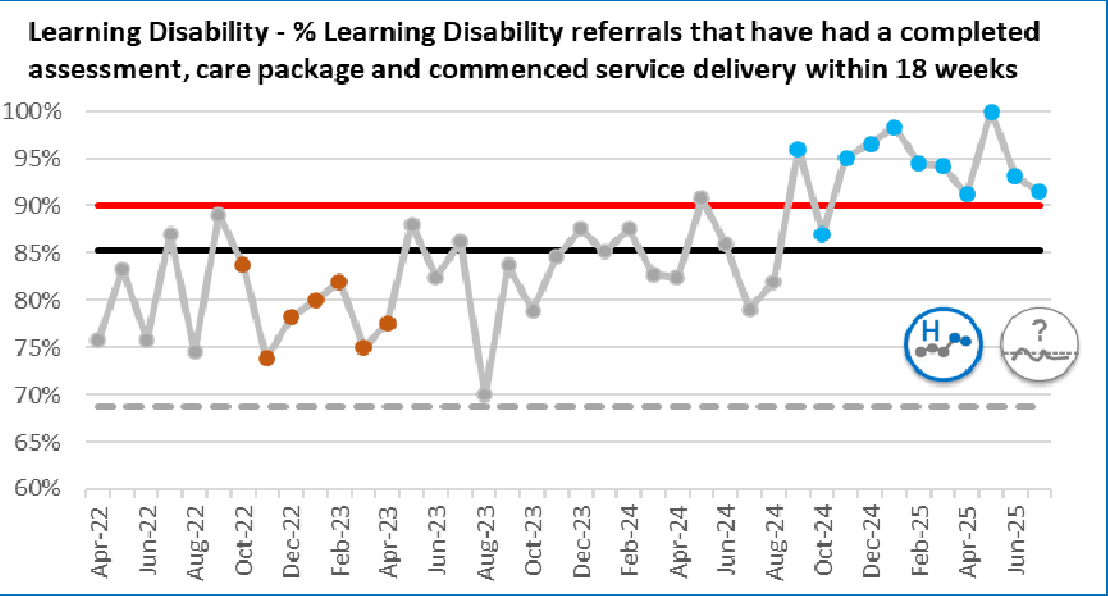


Insights

All areas are consistently exceeding the 90% target.

Access

LD - Face to Face Contact within 18 Weeks



Insights

July 2025 - Barnsley - 92.9%, **Calderdale - 75%**, Kirklees - 100%, Wakefield - 91.7%

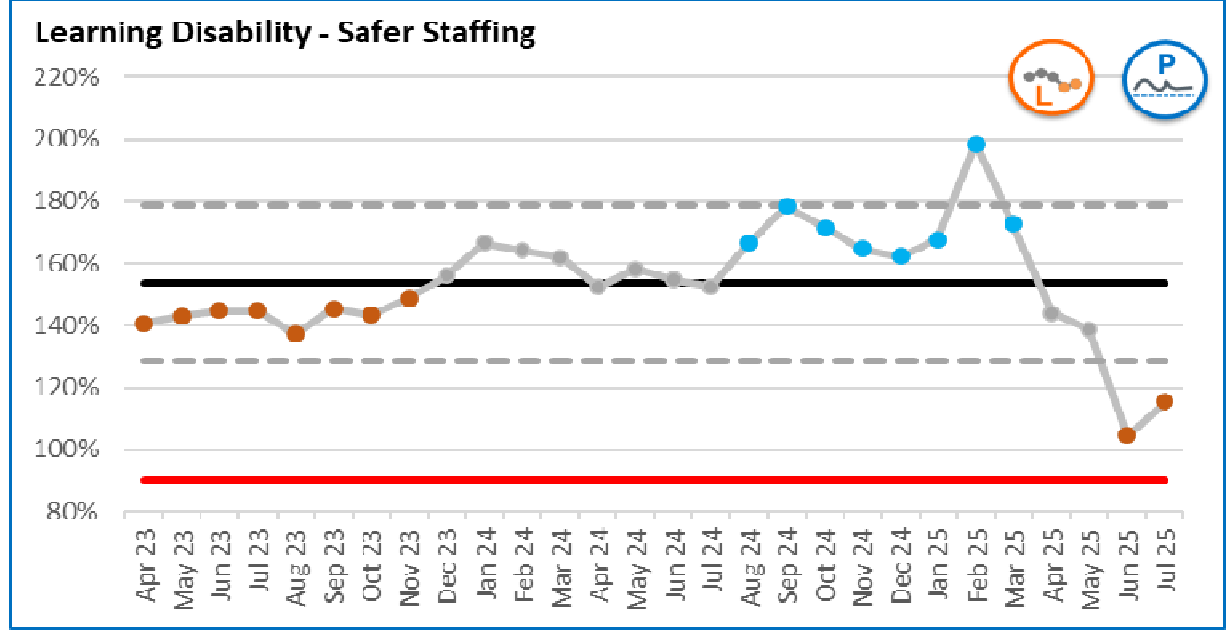
Learning Disability Community Teams – Waiting Times and Quality Improvement
Throughout 2024/25, the service has undertaken a significant programme of **quality improvement** focused on reducing the longest waits within the Learning Disability community teams. Since **March 2024**, notable progress has been made. Steps taken include:

- Targeted resource deployment** across localities, e.g. Wakefield nursing staff (with no breaches over 18 weeks) supported Barnsley nursing teams experiencing vacancies and breaches.
- Short-term locum cover** secured for Speech and Language Therapy, temporary staff prioritising dysphagia assessments to free up core speech and language therapists for long-wait communication assessments.
- Training of 22 additional staff** to deliver ADOS (Autism Diagnostic Observation Schedule) assessments for people with a learning disability, enabling better management of autism-related waiting lists.
- Clinician engagement at all levels** to prioritise waiting list management and breach prevention—this cultural shift is now well embedded.
- Implementation of 'Waiting Well' and 'Waiting Fairly' approaches** across multiple disciplines, helping to accelerate progress on lower-priority cases.
- Review of clinical activity**, with non-urgent work paused to focus on reducing waits—while some challenges remain, improvements are evident.
- Enhanced caseload planning and allocation**, with team managers working closely with discipline leads to ensure clear allocation processes that support ongoing reduction of longest waits.

Calderdale Physiotherapy – Commissioning and Capacity - On **1st April 2025**, Calderdale physiotherapy services transitioned from Calderdale and Huddersfield NHS Foundation Trust to the Trust.
A clause in the contract limits the caseload to **12 open cases**, which contributes to a growing waiting list. Currently, **three service users** have exceeded the **18-week wait**, with one individual waiting between 50 and 90 weeks.

Quality and Safety

Safer Staffing



Insights

LD - This indicator relates only to the Horizon inpatient ATU.

Horizon Unit – Observations, Discharges and Staffing
The Horizon unit continues to experience **high levels of observation** for service users. While a number remain **clinically ready for discharge**, there have been several successful discharges over spring and summer 2025, attributed to **proactive clinical engagement with commissioners**.

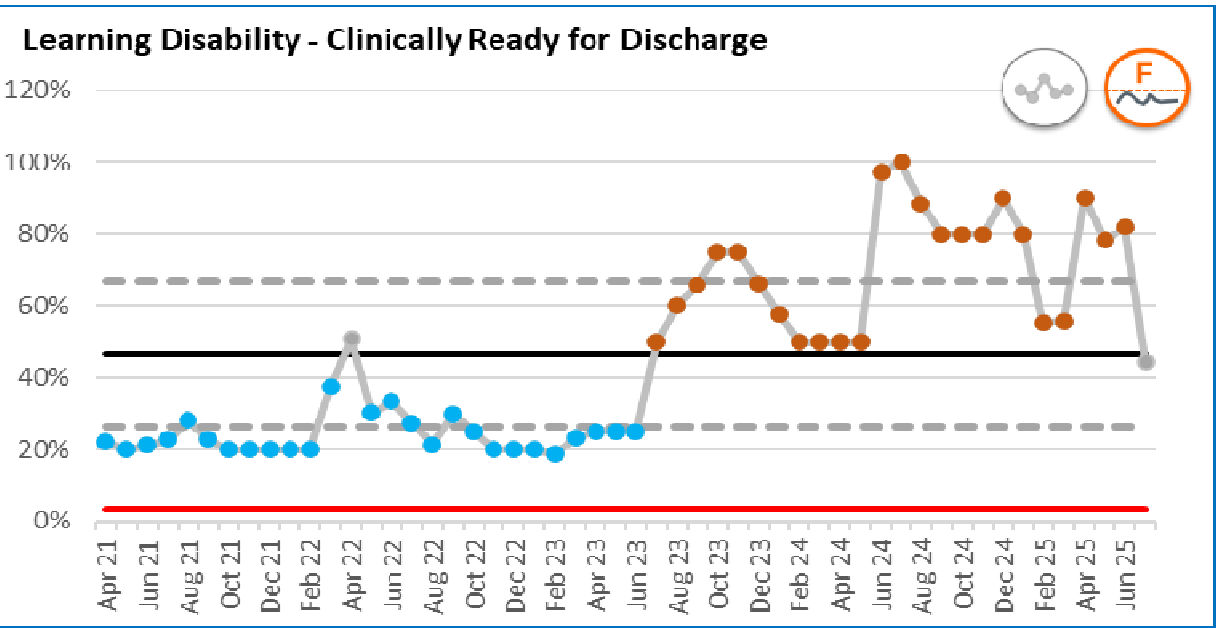
Although **occupancy has fluctuated**, overall observation levels remain high. In response, the service has implemented a number of initiatives to ensure safe staffing and reduce reliance on temporary staff, including:

- Enhanced workforce planning**, with regular reviews of observation levels and staffing requirements.
- Increased recruitment to permanent posts**, supported by targeted campaigns and internal development pathways.
- Improved rostering practices**, including proactive shift planning and use of e-rostering data to identify gaps early.
- Strengthened bank staff engagement** - direct support from bank staff office to fill gaps in a timely manner.

These measures are helping to stabilise staffing and ensure continuity of care, despite ongoing clinical pressures

Quality and Safety

Clinically Ready for Discharge

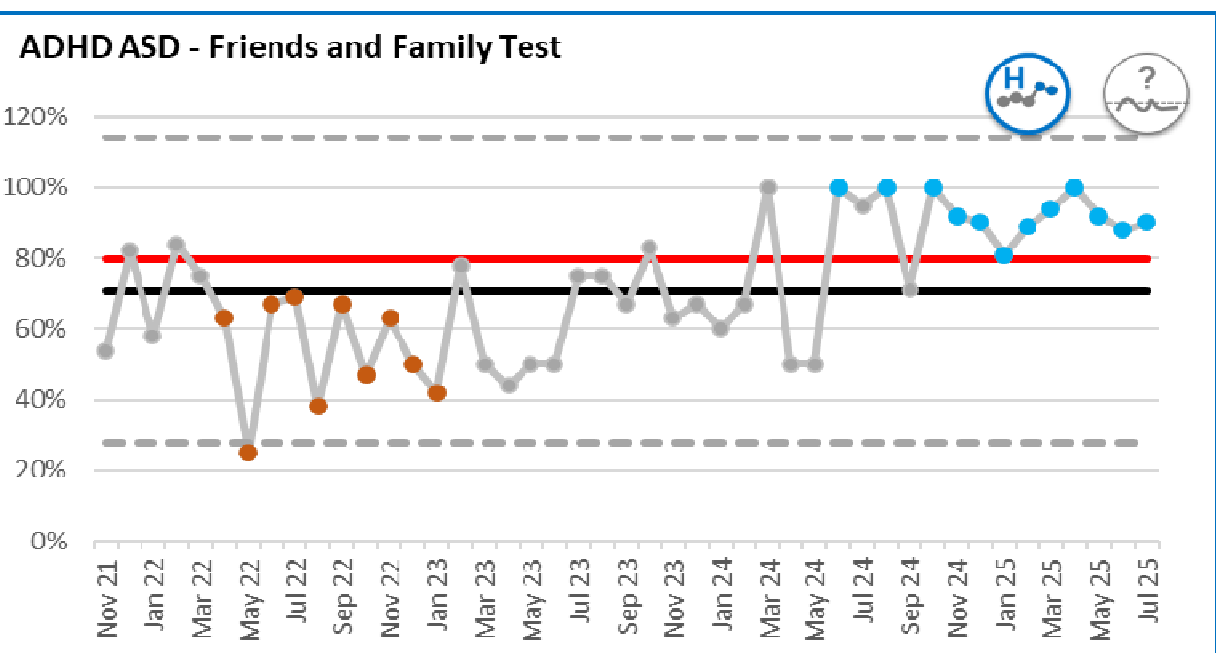


Insights

Discharge Delays and Community Placement Challenges – Horizon Unit

The Horizon unit continues to face significant challenges in securing appropriate community placements for individuals with a learning disability who are clinically ready for discharge (CRFD). These service users typically require bespoke, specialist packages of care, which are in high demand and subject to long waiting lists — a challenge consistent with similar units nationally. The number of service users who are clinically ready for discharge currently stands at 80%, with ongoing discussions taking place with commissioners and system partners to address delays. It is important to note that clinical readiness for discharge does not equate to reduced support needs. For example, individuals requiring 2:1 staffing for observation and engagement may continue to need this level of support in the community. Remaining on the Horizon unit beyond the point of clinical readiness does not reduce these needs and may, in some cases, exacerbate them — particularly for those assessed as requiring private space. This issue is being considered as part of the West Yorkshire Assessment & Treatment Unit (ATU) service review, which will include a focus on discharge pathways and CRFD processes.

Friends and Family Test

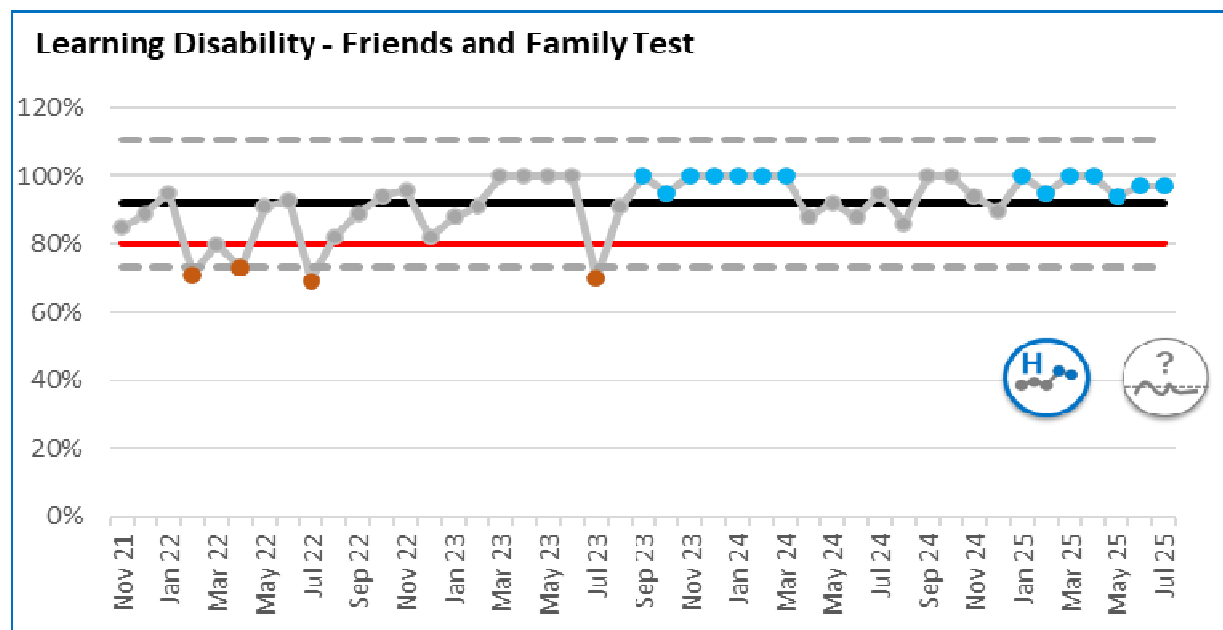


Insights

Friends and Family Test – Service User Feedback

The service is committed to increasing service user feedback and has seen a substantial and sustained improvement in Friends and Family Test (FFT) returns over recent months. This has been achieved through active promotion and engagement with service users. To further enhance feedback opportunities, the service has purchased a Chat Pad and is working with the Quality Governance Team (QGT) to implement digital real-time feedback. Volunteers and clinicians are also supporting feedback collection during care delivery, and people are encouraged to share their views through a range of accessible methods. All feedback—positive and negative—is reviewed and acted upon where appropriate. Positive feedback is routinely shared with staff to recognise good practice and support team morale.

Friends and Family Test



Insights

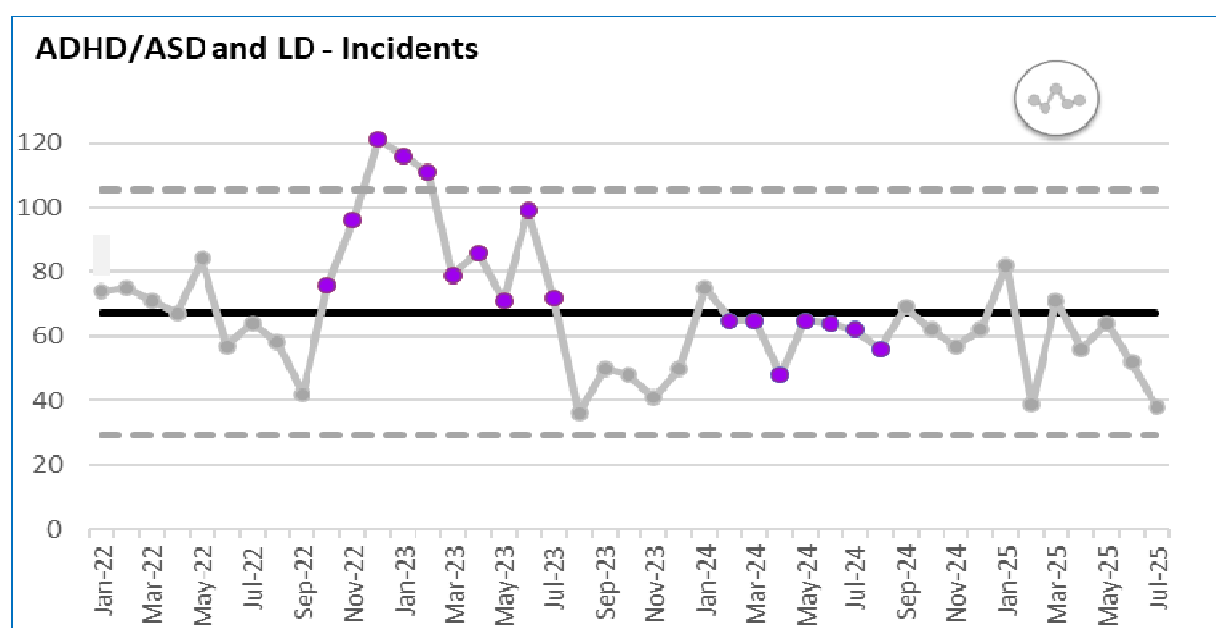
Learning Disability Services – Friends and Family Test (FFT) Feedback

Since September 2024, the Learning Disability service has seen a substantial and sustained improvement in both the volume and quality of Friends and Family Test (FFT) feedback. This improvement has been driven by innovative approaches to engaging service users and carers, including the successful use of volunteers in clinic settings to support completion of feedback.

The service continues to explore digital solutions, such as ChatPads, to enable real-time feedback collection, and remains committed to ensuring feedback is accessible, acted upon, and used to inform service improvements. Positive feedback is routinely shared with staff to recognise good practice and support team morale.

Quality and Safety

Incidents



Insights

Incident Reporting:

The SPC chart shows incident numbers remain within common cause variation.

72.3% of incidents occurred in inpatient services, with 26.3% in community LD services and 1% in the ADHD/ASD service.

The increase in incidents since August 2023 correlates with new inpatient admissions, while the recent reduction is attributed to the discharge of two service users.

Severity & Safety Culture:

94.7% of incidents were no/low harm, reflecting a positive safety culture and high reporting standards

Governance & Learning:

Incidents are reviewed through:

- Multi disciplinary team meetings

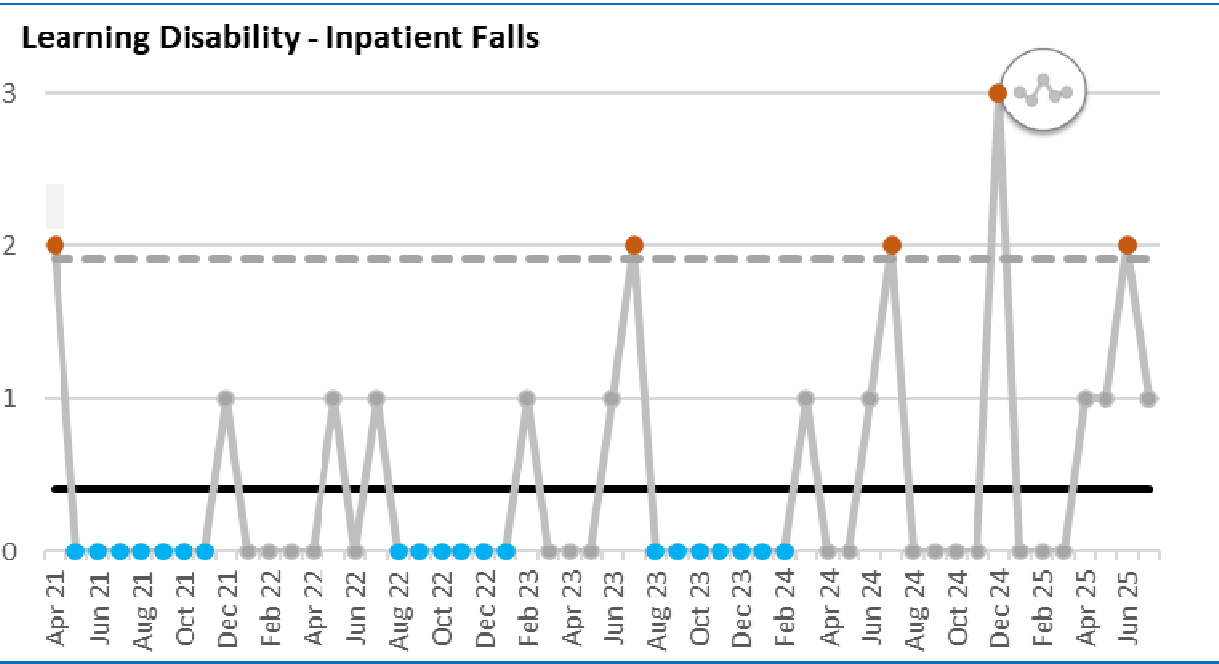
- Weekly Patient Safety Incident Response Framework reviews

- Care Group Governance meetings

Learning is shared across teams, supporting continuous improvement and safety awareness.

Quality and Safety

Falls



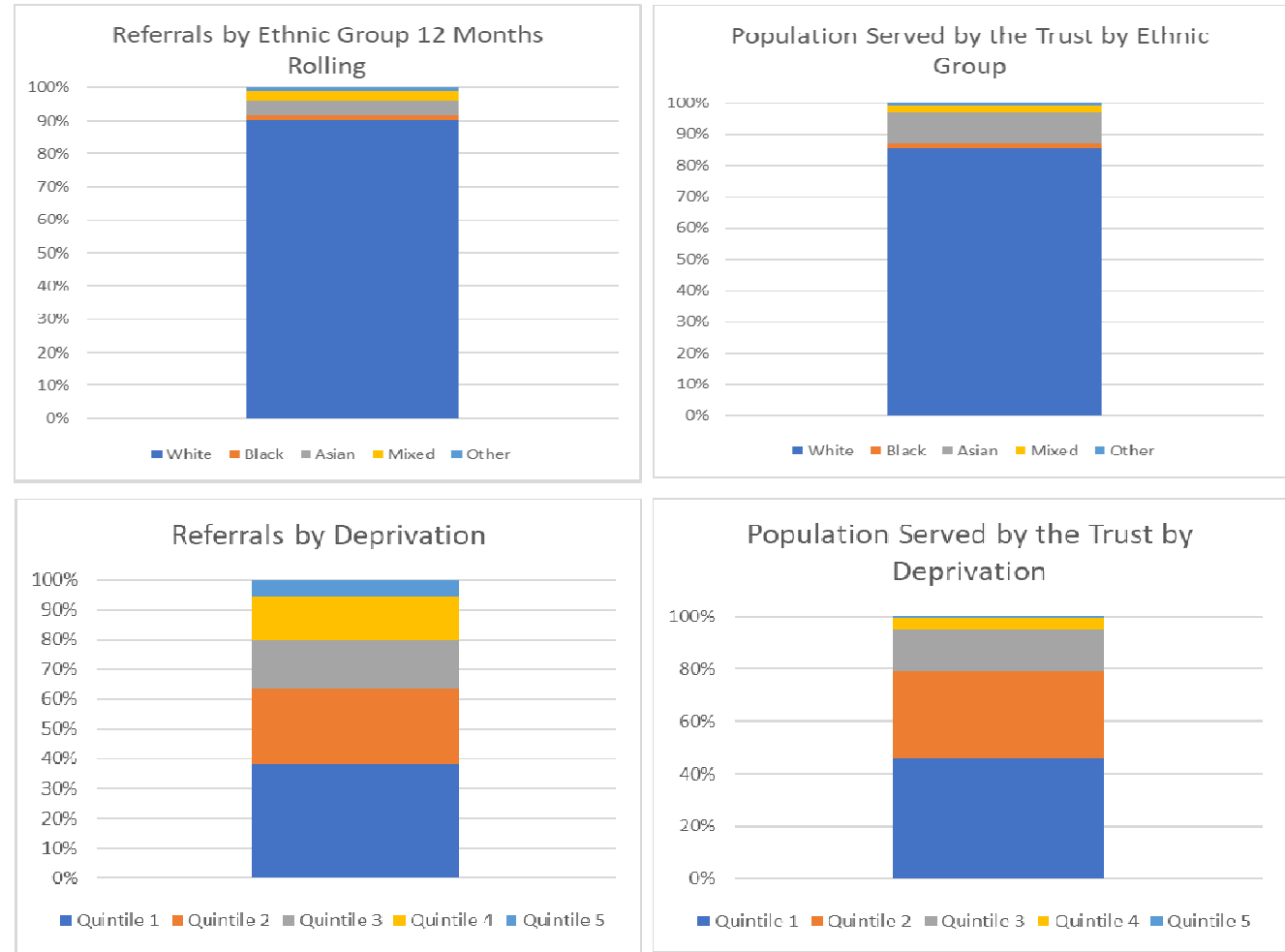
Insights

Falls and Incident Reporting Overview

Falls:
Inpatient falls remain low in number.
All service users receive a falls screening assessment on admission.
Risk assessments and care plans are in place for individuals identified as at risk.
Where incidents occur, they are typically trips linked to mobility unsteadiness, rather than significant falls.

Inequalities

ADHD and ASD Referrals



Insights

There is a marked underrepresentation of referrals from the Asian community, consistent with patterns observed in previous years. This year's data reflects a continuation of this trend, suggesting a persistent disparity in access or engagement.

Background & Context:
Pre-pandemic, the service actively engaged with community groups to promote its offer, which supported more inclusive access. Current capacity constraints limit the ability to engage at the same level, though the service is now working with local partnership groups who recognise this as a wider issue across healthcare.

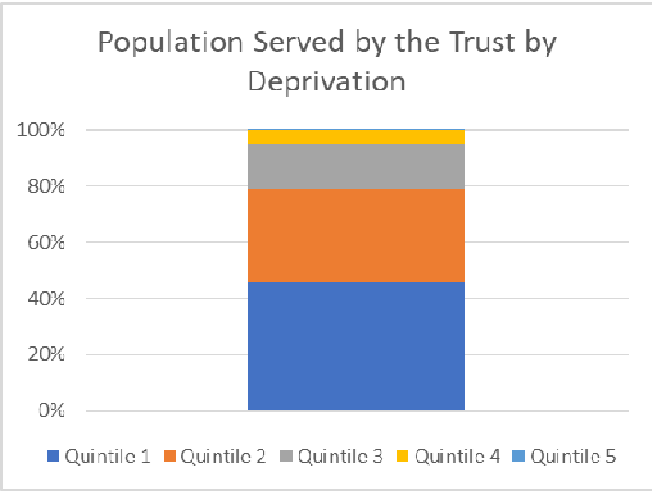
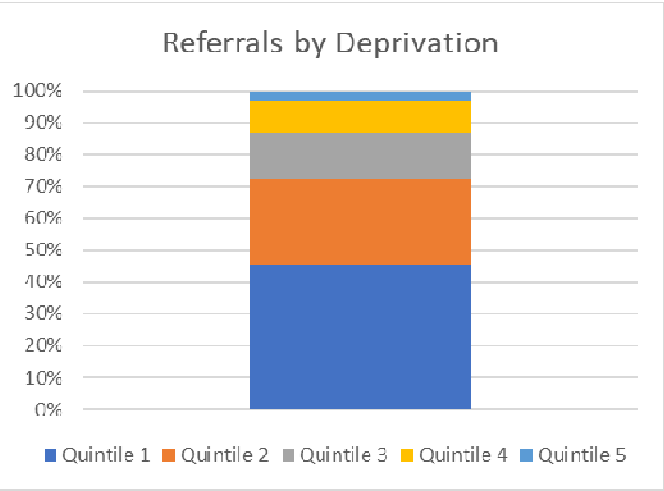
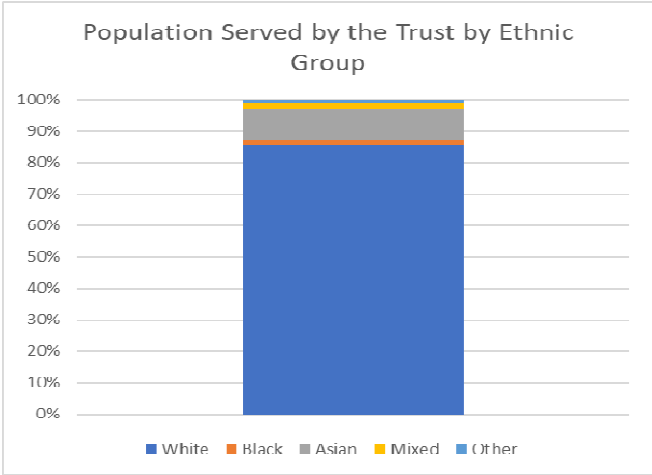
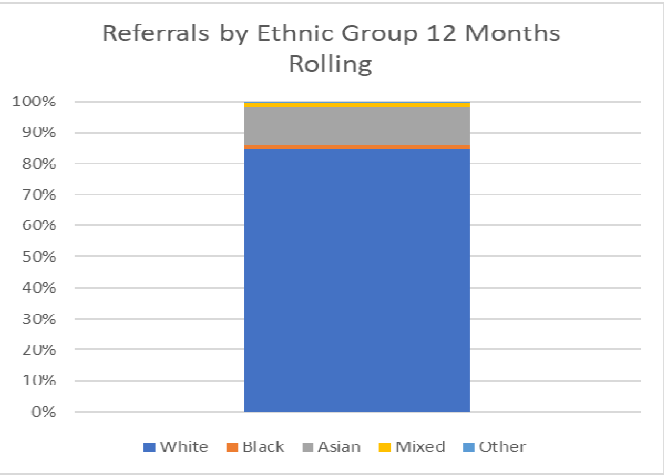
System-Level Response:
The West Yorkshire ICB Neurodiversity programme has acknowledged this disparity. The work seeks to :
Raise awareness within underrepresented communities.
Support service redesign to improve accessibility and cultural responsiveness.

Referral Patterns and Socioeconomic Representation
Analysis of referral data shows a correlation between quintiles 1–3, representing areas of higher deprivation. However, quintiles 4–5 (less deprived areas) appear to be overrepresented, particularly in recent referral activity. This pattern aligns with national trends observed in other regions, suggesting systemic factors may be influencing access and referral pathways.

Next Steps:
Further analysis is required to understand the drivers behind this shift.
Potential areas for exploration include:
Awareness and access to services across different socioeconomic groups.
Referral behaviours of professionals and families.
Cultural perceptions of neurodiversity and mental health.
Barriers to engagement in more deprived communities.

This insight complements ongoing work to address ethnic disparities, particularly underrepresentation from the Asian community, and aligns with the West Yorkshire ICB Neurodiversity programme.

LD Referrals



Insights

Ethnicity and Socioeconomic Representation in Referrals

Ethnicity:
Referral data shows good correlation between the ethnic profile of the population served by the Trust and those referred into the service.
This suggests that, overall, the service is reaching ethnically representative groups, though underrepresentation from the Asian community remains a concern (as previously noted).
The Assessment and Treatment Unit (ATU) serves a wider geographical remit across West Yorkshire, and further drill-down analysis is planned to understand the impact of referrals from Leeds and Bradford on the overall data.

Socioeconomic Representation:
There is some correlation between referrals and quintiles 1–3 (more deprived areas).
However, quintiles 4–5 (less deprived areas) are overrepresented, particularly in recent referral activity — a trend that mirrors national patterns.
Further work is required to understand the drivers behind this shift, including potential barriers to access in more deprived communities.

Socioeconomic Representation in Referrals (Aug 2024 – Jul 2025)

Analysis of referral data over the past 12 months indicates:
Some correlation with quintiles 1–3, representing areas of higher deprivation.
Quintiles 4–5 (less deprived areas) appear to be overrepresented, particularly in recent referral activity.
This overrepresentation is not yet fully understood, and further work is required to explore potential contributing factors. This may include:
Differences in awareness, access, or referral pathways.
Variations in help-seeking behaviours across socioeconomic groups.
The influence of service design or commissioning arrangements.
This analysis will complement ongoing work on ethnic representation and equality impact assessments, ensuring that service development remains responsive to population needs.

Learning Disability (LD) Service: Health Equity and Improvement Initiatives

Annual Health Checks:
Community locality teams and **Strategic Health Facilitators** have worked closely with **General Practitioners** to increase uptake of **annual health checks** for people with a learning disability.
All localities **exceeded the 75% target for 2025/26** and are **on track to achieve this year’s target**.
Further work is underway to improve **accessible communication** for service users, particularly around the importance of **health screening** (e.g. cancer awareness).

STOMP (Stopping Over-Medication of People):
The **STOMP project** is progressing across **all four localities**.
It has enabled **medication reductions** for some service users, supporting **safe discharge to GP care**.

Reducing Health Inequalities:
The service has an established **Reducing Health Inequalities Group** that:
Shares tools and information to **prevent early death**.
Reviews **current deaths** (rather than waiting for annual LeDeR reports) to ensure **timely and responsive interventions**.
Shares relevant learning **Trust-wide**.

Greenlight Champions:
In collaboration with the wider Trust, the service has introduced **Greenlight Champions** to improve support for people with **learning disabilities and/or autism** accessing **non-specialist LD services**.

Statistical Process Control (SPC) Charts Explained

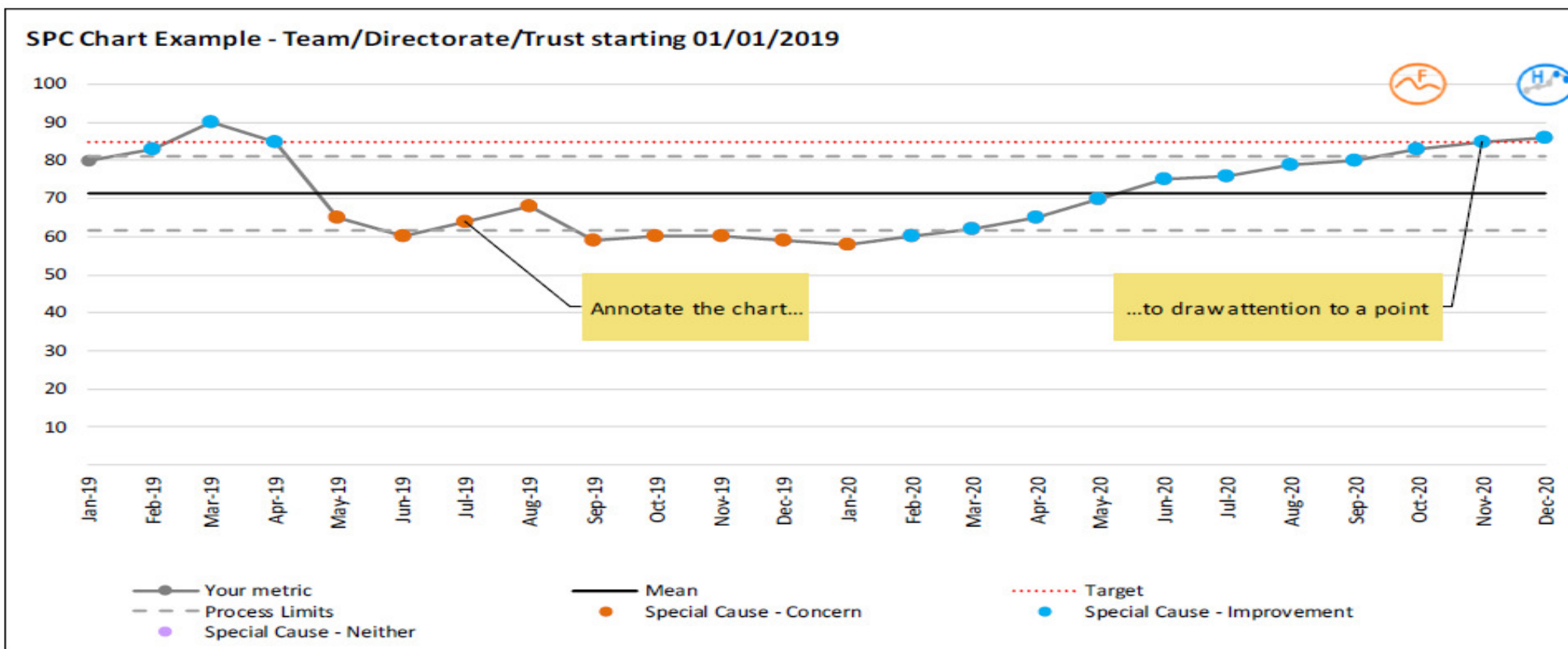
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 (I) 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 significant 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 significant change in process. This process is not in control.

Trust Board
30 September 2025
Agenda item 10.3

Private/Public paper:	Public		
Title:	Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions		
Lead Director:	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 Quality and Safety Committee and Trust Board with an update and assurance regarding the Trust approach to CQC concerns. This is a highlight paper which contains only actions which remain open and it provides a trajectory for completion of each action.		
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. 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:	The full paper, containing detailed information about each CQC action has been shared previously with quality and safety committee, executive management team and Trust Board over the last two years. Of note, the actions were recently reviewed by the executive management team, and work continues to ensure that the actions have maintained a focus on the expectations of the original action, and that the trajectory dates cannot be further reviewed. The outcome of these discussions will be shared with members of the Quality and Safety Committee.

Executive summary:

On Wednesday 6th 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 information about the actions ('must do' and 'should do') which remains open across the three action plans (including the CQC action plan which was given to Riverside Healthcare for Cheswold Park Hospital prior to the Trust taking over services).

Current progress

In total (across the three action plans) there are 16 must do actions and one should do actions which remain open and in progress. This is from an original total of 39 must do actions and 31 should do actions.

It is anticipated that by the end of October 2025, a further five actions will be closed. A number of the Cheswold Park actions (eight) have a completion date of 31/03/26 and it is anticipated that all the remain actions will also be completed by this point.

Of the actions which remain open there is Trust wide work, which is supporting the completion of these actions, such as the work around reducing prone restraint. Of note, this action was discussed in both the executive management team and the Quality and Safety Committee, and will be discussed further to consider if the action (to reduce use of prone restraint) can be reviewed whilst recognising the Trust's continuing ambition and improvement work to ensure zero use of prone restraint where staff have purposefully placed the person in the prone position.

Acute mental health/psychiatric intensive care units (PICU)

There were 16 Must do actions, of which 11 are now complete. Five actions remain open and in progress. There were 12 Should do actions, all of these are now complete.

Forensic and secure services

There were seven Must do actions, of which six are now complete. One is complete but awaiting further evidence from the Care Group to enable it to be signed off as embedded in practice.

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 the Trust was the provider.
Recommendation:	Trust Board members are asked to: RECEIVE the Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions.

**Care Quality Commission (CQC) Action Plan update
September 2025**

1. Purpose

This paper is intended to provide an overview, including a trajectory for closure, for the CQC actions which remain open. This will cover the CQC inspections which took place in May 2023 for the acute and psychiatric intensive care units (mental health care group) and forensic and secure services, as well as the action plan, which was given to Cheswold Park hospital, prior to the Trust taking over the provision of services in November 2024.

A full report and detail on each action is available separately and the most recent version was presented to Executive Management Team (EMT) on the 21st August 2025. Further work is underway, further to EMT discussion, to consider if for any of the actions there has been any drift away from the initial concerns raised by the CQC, or to consider if it is reasonable to sign off any action even if this is before the required 7 data points of evidence, as per the Making Data Count initiative. Therefore, these proposed dates might be amended in response to further EMT discussion.

2. Overview

The actions from CQC inspections are reviewed with the care group leads on a bi-monthly basis to assess progress, evidence and the level of assurance around actions being embedded. In intervening periods, the Quality Governance Manager has regular catch ups with the care group leads.

In total (across the three action plans) there are 16 must do actions and one should do actions which remain open and in progress. This is from an original total of 39 must do actions and 31 should do actions.

It is anticipated that by the end of October 2025, a further five actions will be closed. A number of the Cheswold Park actions (eight) have a completion date of 31/03/26 and it is anticipated that all the remain actions will also be completed by this point.

Of the actions which remain open there is Trust wide work, which is supporting the completion of these actions, such as the work around reducing prone restraint.

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

Acute/PICU actions	Current status		Proposed trajectory date for completion
9.1 - care planning			31/12/25
9.2 - service user and carer voice			31/12/25
12.1 – reduction of prone restraint			31/03/26 – in line with Trust's improvement trajectory for this metric
17.3 – seclusion reviews			31/10/25
18.3 – reduction in bank and agency staffing			31/03/26 – in line with the Trust-wide workstreams as part of the Value for Money programme

Forensic actions	Current status		Proposed trajectory date for completion
9 – Positive behaviour and support (PBS) plans			31/10/25
Should do – blanket restrictions			31/10/25

Cheswold Park Hospital

Whilst separate to the Trust's CQC inspections, below is the Trust's progress against the actions that were allocated to the previous provider at Cheswold Park Hospital, Riverside Healthcare.

Cheswold Park Hospital actions	Current status		Proposed trajectory date for completion
9.1 – access to appropriate meaningful activities.			31/03/26
12.1 – prescribing and administration of controlled drugs			31/03/26
15.1 – Keepmoat and Lakeside seclusion rooms			31/10/25
15.1 – Door observation panels			Proposed for closure
17.1 – Clinical record keeping - record complete and up to date, risk assessments, PBS plans			31/03/26
17.1 – Mental capacity act audits and training			31/03/26
17.1 – ligature audits			30/11/25
17.1 – policies			31/03/26
18.1 – staffing – suitable numbers of staff with the required knowledge			31/03/26
18.2 – training, support, supervision and appraisals			31/03/26

3. Acute mental health / PICU actions

There were 16 Must do actions, of which 11 are now complete. Five actions remain open and in progress. There were 12 Should do actions, all of these are now complete. The following actions remain open:

Two Actions – 9.1 and 9.2 – person centred care – care planning and the service user and carer voice.

Current status – amber

Current position – new care plans were implemented at the start of January 2025. As a result, there has been a delay in the completion of these actions. These actions originally had an embedded by date of March 2025. Seven data points to demonstrate improvement, compliance with the new care plans and quality of these care plans are required, in line with making data count.

Further evidence required – Seven data points (over seven consecutive months) to demonstrate improvements of care plan monthly audits.

Trajectory for completion – these actions now have a completion/embedded by date of 31 December 2025.

Action – 12.1 – safe care and treatment – reduction of the use of prone restraint.

Current status – blue/green

Current position – in line with the requirement of the action, prone restraint has reduced within the care groups since the inspection and there are several Trust wide workstreams focussing on this. This action has been amended to align with the Trust wide trajectory and ambition for zero use of prone restraint (which exceeds the requirement of the CQC action).

Further evidence required – data which demonstrates a continuing reduction in prone restraint across inpatient wards, with a reducing target over the coming months and an ambition of zero use of prone restraint that has been instigated by the ward team by the end of March 2026.

Trajectory for completion – 31 March 2026, in line with the Trust trajectory.

Action -17.3 – good governance – seclusion reviews

Current status – blue/green

Current position – more robust processes are now in place and improvements have been made with nursing checks. There continue to be some performance issues with independent reviews and there are actions to improve in this area. This will continue to be monitored for 7 months, in line with making data count expectations.

Further evidence required – data to provide assurance around medical reviews for a person in seclusion.

Trajectory for completion – 31 October 2025.

Action – 18.3 – staffing – use of bank and agency staffing.

Current status – blue/green

Current position – interim establishment review completed and the care group have seen a reduction in the use of agency staff. The recruitment of healthcare support workers is expected to support a reduction in the use of bank staff and there is a rolling programme of healthcare support worker recruitment until March 2026.

Further evidence required – data to demonstrate a sustained reduction in use of bank staff.

Trajectory for completion – 31 March 2026.

4. Forensic and secure services

There were seven Must do actions, of which six are now complete. One is complete but awaiting further evidence from the Care Group to enable it to be signed off as embedded in practice.

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.

Action – 09 – person centred care – people who require them have positive behavioural support plans in place.

Current status – blue/green

Current position – data gives good assurance and there are now processes in place to screen new service users to understand if they require a PBS plan.

Further evidence required – final review of data to provide assurance of this being embedded.

Trajectory for completion – 31 October 2025.

Should do action – restrictions should be individually assessed and that restrictions are proportionate to the risks posed.

Current status – amber

Current position – A Trust wide audit of restrictions across mental health and secure wards has been completed. The only variance from expected practice is with regards to access to outside spaces. This is for discussion at operational management group, with Care Groups reviewing their own restrictions around access to outside spaces and an updated position is expected to be presented to the executive management team (EMT) in October 2025.

Further evidence required – final position following EMT presentation.

Trajectory for completion – 31 October 2025.

5. 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 the Trust was the provider.

Action – 9.1 – access to appropriate meaningful activities.

Current status – green

Current position – 25 hours of structures activity and associate recording is now available on SystmOne. This will allow for seven data points to be captured to demonstrate compliance and embedding of this action.

Further evidence required – seven data points (over seven months) to demonstrate sustained compliance with 25 hours of meaningful activity.

Trajectory for completion – 31 March 2026.

Action – 12.1 – prescribing and administration of controlled drugs.

Current status – green

Current position – A number of actions have been taken to ensure that the prescribing and administration of controlled drugs is in line with legal requirements and safety. EPMA will be implemented into Cheswold Park and will support compliance with this actions.

Further evidence required – evidence of accurate recording of prescriptions and administration of controlled drugs, for a sustained period of time.

Trajectory for completion – 31 March 2026.

Action – 15.1 – Keepmoat and Lakeside seclusion rooms.

Current status – green

Current position – a standard operating procedure is being developed to support staff and service users if there are incidences where the seclusion rooms need to be used.

Further evidence required – standard operating procedure.

Trajectory for completion – 31 October 2025.

Action – 15.1 – Door observation panels.

Current status – Green

Current position – to be overseen by the door replacement programme, with timescales reported into EMT. Propose to close this action and progress as part of the estates work.

Further evidence required – proposal for closure.

Trajectory for completion – proposal to close from this action plan.

Action - 17.1 – Clinical record keeping - record complete and up to date, risk assessments, PBS plans.

Current status – blue/green

Current position - audit data being reviewed for assurance and action.

Further evidence required – seven audit data points (over seven months).

Trajectory for completion – 31 March 2026.

Action – 17.1 – Mental capacity act audits and training.

Current status – green

Current position – audit data being reviewed for assurance and action.

Further evidence required - seven audit data points (over seven months).

Trajectory for completion – 31 March 2026.

Action – 17.1 – ligature audits.

Current status – blue/green.

Current position - all audits are now complete. The next step is to review the evidence for sign off.

Further evidence required – review of evidence for sign off.

Trajectory for completion – 30 November 2025.

Action – 17.1 – policies.

Current status – blue/green.

Current position – programme of policy introduction underway and this is being overseen by the senior leadership team.

Further evidence required – aligned with policy implementation.

Trajectory for completion – 31 March 2026.

Action – 18.1 – staffing – suitable numbers of staff with the required knowledge.

Current status – green.

Current position – continue with staffing initiatives in line with Trust standards and new admission schedule. Learning needs analysis for entire staff group is planned.

Further evidence required – completion of learning needs analysis and sustained staffing numbers.

Trajectory for completion – 31 March 2026.

Action – 18.2 – training, support, supervision and appraisals.

Current status – green.

Current position - improvement in supervision, appraisals and mandatory training figures. Plans to move to Trust appraisal process, mandatory training and appraisal system.

Further evidence required – sustained compliance with the above, seven data points.

Trajectory for completion – 31 March 2026.

6. Summary

The actions from CQC inspections are reviewed with the care group leads on a bi-monthly basis to assess progress, evidence and the level of assurance around actions being embedded. In intervening periods, the Quality Governance Manager has regular catch ups with the Care Group leads.

In total (across the three action plans) there are 16 Must do actions and one Should do actions which remain open and in progress. This is from a total of 39 Must do actions and 31 Should do actions.

For Mental Health and Forensic Care Groups, of the actions which remain open there is Trust wide work, which is supporting the completion of these actions, such as work around reducing prone restraint.

It is anticipated that by the end of October 2025, a further five actions will be closed. A number of the Cheswold Park actions (eight) have a completion date of 31/03/26. Therefore, all CQC actions are anticipated to be closed with assurance of the embedding of improvements and governance processes to monitor by the 31st March 2026.

Trust Board
30 September 2025
Agenda item 11.1

Private/Public paper:	Public		
Title:	Patient Safety Oversight Report Quarter 1 2025/26 incorporating the Learning from Healthcare Deaths Report for Quarter 1 2025/26		
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. 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):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships 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, 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:	Quality and Safety Committee and Trust Board have previously received quarterly and annual patient safety oversight reports, learning from healthcare deaths reports and patient safety updates. NHS England PSIRF oversight guidance asks that trusts move towards a focus on learning and improvement and the content of this report reflects this. This report was reviewed in Quality and Safety Committee on 9 September 2025 and recommended to be received by Trust Board. The learning from healthcare deaths report for Quarter 1 2025/26 is included in Appendix F.
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. Incident data is presented in statistical process control chart form in Appendix A of the report to ensure we focus on longer term trend. It should be noted that the data in the SPC charts in Appendix A does not include Cheswold Park Hospital who joined the Trust on 1 October 2024, because data for the 24 month period is not available. Trends are being monitored separately at Cheswold Park. 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' that met the national definition within the reporting period. The continued development of the Patient safety improvement group has seen 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, there are some areas of special cause variation in some of the priority areas and these have been analysed and explored further. There are no further patterns or trends to report at this point in time. Work continues to develop for how we close the loop and capture outputs/themes/trends as a workstream in our PSIRF review. Positive progress has been made with a range of patient safety initiatives, including the achievement of sustained compliance above 80% with patient safety training and sharing our patient safety incidents with the national Learn From Patient Safety Events (LFPSE) team. The PSIRF review is underway and aims to learn from experiences of implementation so far and make improvements for the future. This work is being approached under four main workstreams aligned with the aims of PSIRF: • Systems based approaches to learning – this includes refining our learning responses and when they will be applied.

- **Engagement and involvement of those affected** – this includes reviewing the approach to Being Open, work on cases where there are family questions or customer services involvement. Learning and reflections from the Trust's Family Liaison Officer (FLO) are being incorporated into the review to ensure the voice of bereaved families is included. The FLO has continued to work with a number of bereaved families and positive feedback continues to be received.
- **Proportionate responses** – the review is focussing on developing information to support staff with understanding when a learning response or improvement response may be required. 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.
- **Oversight** – the Trust's oversight processes are being revisited and strengthened further. This includes the patient safety oversight group (PSOG) which 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. The Patient Safety Improvement Group has moved to a bi-monthly frequency to support a cycle of collective reflection and learning, focussed around the patient safety priority areas. The learning network, also bi-monthly (alternate months), is functioning alongside the Patient Safety Improvement Group.

Of note, further to this report being submitted to the Quality and Safety Committee, we have been notified that the Trust has been successful in being accredited for the second time by the Royal College of Psychiatrists' Safety Incident Response Accreditation Network (SIRAN), which will be place until May 2028. SIRAN is a quality improvement and accreditation network for mental health organisations' patient safety and serious incident response processes. Further information is available [here](#).

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.

A review of the Mortality review group took place as part of the review of our Patient Safety Incident Response Plan. It was identified that the majority of the meeting's content focussed on processes rather than learning themes from our own deaths. As such it was felt that themes emerging from deaths was more appropriate to incorporate into the Patient Safety Improvement Group.

Summary

A key aspect of Trust patient safety work is the consistent and robust use of data which underpins assurance. This analysis also supports our improvement work and subsequent monitoring. The 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. The Patient Safety are undertaking further focussed work to ensure patient safety learning is

	embedded with improvements sustained over the longer term to support a safety culture. As part of PSIRF there is a move to thinking about systems learning rather than individuals and where we can strengthen systems to improve safety. Engagement with affected people has improved with positive feedback received. Clinical teams report valuing being included in reviews and being able to be part of improvements. 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 • 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 and to NOTE the next steps identified.

Patient Safety Oversight Report

**Quarter 1 2025/26
(1 April 2025 to 30 June 2025)**

Prepared by Patient Safety Support Team

Quality and Safety Committee – 9 September 2025

Trust Board – 30 September 2025

With **all of us** in mind.

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1. Purpose of the report and introduction

This 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.

Where content has been provided in previous reports and there is no change, this is now included in Appendix C.

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 (SPC) chart form in Appendix A of the report to ensure we focus on longer term trend. It should be noted that the data in the SPC charts in Appendix A does not include Cheswold Park Hospital who joined the Trust on 1 October 2024, because data for the 24 month period is not available. Trends are being monitored separately for Cheswold Park Hospital.

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.

As previously reported, discussion about incidents has increased with the introduction of PSIRF and will, in turn, be encouraging incident reporting by raising awareness. There were no 'Never Events' that met the national definition within the reporting period. In relation to specific patient safety priorities (see table on page 6 and Appendix A), there are some areas of special cause variation in some of the priority areas, these have been analysed and explored further. We continue 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. Our review of our Patient Safety Incident Response Framework plan is currently underway to refine for the year ahead.

Ethnicity -When inequalities cause or increase the risk of harm to patients in healthcare, they are considered to be patient safety healthcare inequalities. Viewing healthcare inequalities through the lens of patient safety identifies an important line of action for which healthcare professionals and systems have a clear responsibility.

Our PSIRF review is underway and aims to learn from our experiences of implementation so far and make improvements for the future. This work is being approached under four main workstreams aligned with the aims of PSIRF:

- **Systems based approaches to learning** – this includes refining our learning responses and when they will be applied
- **Engagement and involvement of those affected** – this includes reviewing the approach to Being Open, work on cases where there are family questions or customer services involvement. Learning and reflections from the Trust's Family Liaison Officer (FLO) are being incorporated into the review to ensure the voice of bereaved families is included
- **Proportionate responses** – the review is focussing on developing information to support staff with understanding when a learning response or improvement response may be required
- **Oversight** – the Trust's oversight processes are being revisited and strengthened further. This includes the patient safety oversight group (PSOG) which 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. The Patient Safety

Improvement Group has moved to a bi-monthly frequency to support a cycle of collective reflection and learning, focussed around the patient safety priority areas. The learning network, also bi-monthly (alternate months), is functioning alongside the Patient Safety Improvement 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. Safety incident overview position across the Trust

2.1.1. 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 (PSST) 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 is held in various groups to aid understanding. This includes (but not limited to) the Patient Safety Oversight Group, Care Groups, Patient Safety Support Team and Patient Safety Improvement Group. Further details on some of these groups is included in [section 3.4](#).

2.1.2. 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 includes the ethnicity of inpatient deaths, which is contained in the Learning from Healthcare Deaths section of this report (Appendix F).

When inequalities cause or increase the risk of harm to patients in healthcare, they are considered to be patient safety healthcare inequalities. Viewing healthcare inequalities through the lens of patient safety identifies an important line of action for which healthcare professionals and systems have a clear responsibility. We know that different population groups experience patient safety events unequally (The King's Fund, 2020) and those experienced disproportionately by marginalised patient groups exacerbate healthcare inequalities (Green et al, 2010; Chin, 2020, Wade et al, 2022). The Patient and carer race equality framework (PCREF) sets out to improve the experience and outcomes of people from ethnic minorities who are on mental health pathways. Trusts are mandated to implement PCREF, part of which is to coproduce service plans and care treatment plans with racialised and ethnically and culturally diverse communities which address:

- Language translation service needs and or other accessible information
- Different cultural food requirements

- Different faith requirements, such as access to prayer spaces and spiritual support
- Trauma informed practice
- The type of aftercare mental health provisions offered

A factual understanding of who we are involving and engaging with via the systematic collection and analysis of data (both numbers and voice) according to protected characteristics will develop understanding and act as a basis for our decisions in making changes to reduce patient safety healthcare inequalities.

This report contains patient safety data using SPC (see [Appendix A](#)). Breakdown of patient safety incident data and inpatient deaths 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 and is where we can also consider through an ethnicity lens.

We 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 the previous financial year 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 (the Trust-wide electronic incident reporting system) 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 continue to:

- Share data for review 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 with the Trust's Intelligence Change Partner and Business Intelligence Team will continue to explore how incident data could be considered in light of population information.
- Liaise with the Trust's Procurement team regarding supplier of 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.

2.1.3. Disseminating learning for patient safety across the Trust / PSIRF

Our PSIRF plan includes our patient safety priority areas, extracted from our PSIRF plan, summarised below:

Extract of patient safety priorities (Trust patient safety incident response plan December 2023)

Patient safety issue	Service area	Improvement plan?
Self-harm	Mental health & learning disability inpatient and community settings	Improvement plan in place
Inpatient falls	All inpatient services	Improvement plan in place
Medication errors	All services	Improvement plan in place
Violence and aggression against patients	Mental health & learning disability inpatient & community settings	Improvement plan in place
Pressure ulcers	Community physical health services	Improvement plan in place
Apparent suicides	Mental health & learning disability inpatient & community settings	Improvement plan in place
Clinical risk assessment (FIRM)	All services	Improvement plan in place
Physical health/mental health	Mental health & learning disability inpatient & community settings	Improvement plan in place
Patient absent without leave (AWOL)	Mental health and Learning disability inpatient settings	To gather additional knowledge to inform further improvement plan
Transitions in care	All services	To gather additional knowledge to inform further improvement plan

[Appendix B](#) gives an illustration of our recent learning grouped under the above headings, and shares some of the outputs from learning responses completed during Quarter 1 2025/26 alongside improvement work updates.

From some completed learning responses, community teams are developing guidance for staff when assessing service users under the influence of alcohol or substances to ensure a consistent approach and to determine interventions that may be required and ensure that where applicable plans for assessment are shared with families and clear documentation is completed around decision making. Other elements of identified improvements have been fed into ongoing workstreams with outcomes to be shared through Patient safety Improvement Group.

Internally, the full set of slides are available on the Trust's intranet pages for staff in wards and teams, along with previous learning.

3. Patient Safety Incident Response Framework developments

The Trust began working under the Patient Safety Incident Response Framework (PSIRF) from 1 December 2023 in line with NHS England guidance (see [Appendix C](#) for background information).

Our [PSIRF plan](#) is available on our website. The PSIRF plan sets out how the Trust will respond to patient safety priorities with a focus on learning and improvement and the associated policy describes the systems and processes the Trust will use to learn and improve following a patient safety incident.

The Trust recognised in our plan that implementing PSIRF was going to be a learning experience, and revisions would need to be made as we applied the plan and policy into practice. This was acknowledged as a valid step by NHS England.

Overview of the PSIRF review

We are now reviewing our PSIRF plan, policy and working procedures. We aim to learn from our experiences so we can make improvements for the future. PSIRF systems learning approaches are being used to reflect on what has worked well and where we can improve going forward. Learning identified during the review will be used to update the Trust PSIRF plan, policy and associated procedures, ensuring this is consulted on with stakeholders.

We will be considering how our PSIRF plan compares with what a good plan looks like and if we have achieved what we set out to do in the last 18 months.

This work is being approached under four main workstreams aligned with the aims of PSIRF:

- 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

Each workstream is set out below with an update of some of the work that is under way or planned. As the review progresses, updates will be provided in future reports.

3.1. Compassionate engagement and involvement of those affected by patient safety incidents

This part of the review is currently focussing on:

- revisiting the Being Open guidance (called engagement and involvement under PSIRF) to ensure our staff keep the Trust's value of being open, honest and transparent at the heart of communication with those affected by patient safety incidents
- flowcharts are being developed that aim to support staff with understanding the practical steps to take
- this work considers situations where there is or is not a learning response happening and what various roles and responsibilities are. It also considers where there are questions raised directly with a team or through customer services team and how we will respond
- seeking feedback from those affected after they have been involved in a learning response has been introduced. Feedback received through this process so far has given good insights into what is working well and where we can improve
- learning and reflections from the Trust's Family Liaison Officer (FLO) are being incorporated into the review to ensure the voice of bereaved families is included.

3.2. Application of a range of system-based approaches to learning from patient safety incidents

This part of the review is currently focussing on refining our systems based approaches to:

- redefining our learning responses tools (for example, we are considering renaming a team debrief to align with the national terminology)
- revising guidance for each learning response tool including templates
- revising processes to help us understand what is known already to help us make a robust decision
- defining who will lead each type of learning response.

3.3. Considered and proportionate responses to patient safety incidents and safety issues

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 should use our resources to address these through improvement work rather than undertaking individual responses.

As part of the review, we have reflected on our use of different learning responses. We have found there have been cases where another learning response may have been more beneficial, or where we have conducted a learning response that did not deliver any new learning or improvement because this was already known. This learning is being taken forward in the below work:

- developing a new decision making process to support staff with understanding when a learning response or improvement activity may be required. This will include where a learning response is needed, choosing the most appropriate response
- revised flowcharts are being developed to support this
- exploring how we can improve how we capture improvement activity and extracting outcomes from Datix.

3.4. Supportive oversight focused on strengthening response system functioning and improvement

During our development of PSIRF during the last 18 months, we have continued to refine the existing oversight processes in light of PSIRF. This consists of the existing Patient Safety Oversight Group and Patient Safety Improvement Group. During August 2025, we are trialling a Patient Safety Executive Group that will work alongside the two aforementioned groups. These are described further below:

Patient Safety Oversight Group

The weekly Trust wide Patient Safety Oversight Group (PSOG) continues to meet; this is where recent patient safety risks are discussed. This group receives content from local Care Group Patient Safety Oversight Groups for discussion and assurance. It also facilitates cross organisational learning and improvement.

An agenda item has been introduced during July where each week we consider if there are any patient safety themes, messages or reminders to give to staff. These are being collated on a monthly basis and shared with staff through monthly internal Trust communication 'The Brief'. As this evolves, we aim to include content in the learning presentation (Appendix B).

Patient Safety Improvement Group

The Trust Patient Safety Improvement Group was relaunched in July 2025 after a four-month pause. The meeting is attended by patient safety leads, care group representatives, specialists and

improvement leads. Our patient safety partner also attends, and they regularly offer feedback and challenge on content.

The meeting will now be bi-monthly, with the Learning Network held between meetings and these two forums will work closely together.

The Patient Safety Improvement Group discussion will now focus on the patient safety priority areas (see page 6). A discussion in the last meeting found that our current patient safety priority areas remain current and should continue into our revised plan, however some refining of wording may be made.

Discussion on each priority area (including any emerging issues) will be centred around:

- reflections on what has gone before
- new intelligence from recent activity/hotspots and any longer term trend
- understanding any changes in data
- learning from near misses/good catches
- learning response outcomes
- local and trust wide improvement work
- learning from national guidance and reports.

The Group will also have oversight of trust wide actions.

We will continue to use a Plan, Do, Study, Act (PDSA) approach to refine our approach over time.

Patient Safety Executive Group

During August 2025, we began trialling a Patient Safety Executive Group that will work alongside the two aforementioned groups. This is a small group of patient safety specialists and executive directors with responsibility for patient safety, where oversight of high level learning responses can be maintained through regular discussion.

This is an evolving group which will develop over time.

Terms of reference for all three meetings are being developed and will be available by the end of Quarter 2 2025/26.

4. Other patient safety activity

During Quarter 1 2025/26, 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.

4.1. Safety Incident Response Accreditation Network (SIRAN)

During 2024/25 and in Quarter 1 2025/26, 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.

There are two standards out of 59 where evidence remains outstanding. 57 standards have been achieved so far. The outstanding areas relate to feedback from staff and patients/families involved in learning responses. Additional evidence was submitted to the accreditation committee in August 2025. We await feedback after the committee review the additional evidence.

4.2. 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. New reports published during the quarter are included at [Appendix D](#). These are available to staff on the patient safety intranet pages.

4.3. 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)

During Quarter 1 2025/26 further work has been carried out to identify patient safety incidents reportable to LFPSE. Further work will be carried out on this during Quarter 2 2025/26 to map the patient safety incident 'type' and configure the incident reporting form to always show the national LFPSE questions for the patient safety incidents identified. In order for this improvement work to be completed, the Datix system will need to be upgraded once v6 of the LFPSE taxonomy is available on Datixweb. RL Datix are due to release this in Summer 2025. The v6 release will include enhanced LFPSE functionality.

LFPSE data quality and integrity validation has taken place in line with a national request. During Q2 2025/26 feedback will be given to NHS England on the outcome of the LFPSE validation exercise and any remaining issues reported.

4.4. Developments on Datix

During Quarter 1 2025/26, 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
- delivery of Datix training sessions for managers on promoting incident reporting and reviewing incidents
- continued work with colleagues in Performance and Business Intelligence on the automation of Datix IPR metrics
- incident reporting templates, Datix saved queries and dashboards amended to include Cheswold Park Hospital incident data from 1 April 2025
- development of new duty of candour monitoring dashboards and data dashboards for confirmed Notifiable Safety Incidents for Care Groups
- amendments made to the Feedback module to collect satisfaction survey data
- working with the RRPI team to improve data quality, reporting and developing dashboards for incidents involving restraint
- development of new dashboard for pressure ulcer incidents that have been reported by our inpatient wards
- improvement work on safety alerts module and distribution lists. Further work on this will continue during Q2 2025/26 to improve and streamline the safety alerts process
- upgrade carried out on the Datixweb test environment and preparation work for an upgrade and downtime to the Datixweb live system to take place in Quarter 2 2025/26.

4.5. 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 Quarter 1 2025/26 are available in [Appendix E](#).

Although many alerts are not applicable to the Trust, they will go through the same level of scrutiny. In these cases, we may share information with staff so they can support patients who may be impacted.

4.6. 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 has been mandatory from November 2023. Data from the electronic staff record (to end of June 2025) shows:
 - Level 1a – Patient safety essentials for all staff – 97.9%
 - Level 1b – Patient safety for senior managers and board members – 93.3%
- as part of the PSIRF review, consideration will be given to what further training opportunities there may be to strengthen PSIRF knowledge and skills for staff who have specific roles within the Trust.

4.7. Patient safety partners (PSP)

Our Patient Safety Partners (PSPs) work with us 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 and at all levels in the organisation. The Trust sees the PSP 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 examining and developing to ensure that the patient voice is heard throughout, that services are open and transparent and quality is of a high standard.

So far, our patient safety partners have been supporting pieces of work including:

- attending our Patient Safety Improvement Group
- reviewing and providing feedback on the quarterly report and learning journeys that as an organisation we have undertaken
- supporting the PSST with reviewing and updating key documents for the implementation of PSIRF
- supporting embedding the PSIRF framework and supporting the development of processes to align with such; providing a patient voice and ensuring that safety initiatives are grounded in real-world patient concerns, helping to identify risks that might otherwise be overlooked by clinical staff
- enhancing trust and transparency: being visibly involved in safety work and clinical improvements that impact patient safety; providing updates and insights into National Policy around patient safety.

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. We are also looking at a structure for PSP reimbursement recognising their vital contribution to patient safety.

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.

4.8. Improving safety culture

Being fair tool: Supporting staff following a patient safety incident

NHS England patient safety team have developed new guidance which replaces the previous 'just culture guide'. The [Being fair tool: Supporting staff following a patient safety incident](#) better aligns with the core principles of the Patient Safety Incident Response Framework (PSIRF). This is being considered during the PSIRF review process.

We review NHS Staff Survey responses associated with safety culture. From the 2024 report, several questions remained above the national average, these were as follows:

- my organisation acts on concerns raised by patients/service users
- I feel safe to speak up about anything that concerns me
- if I spoke up about something that concerned me, I am confident my organisation would address my concern
- the last time you experienced physical violence at work, did you or a colleague report it?

There are no identified areas that require specific attention. We continue to encourage a culture of openness, learning, improvement and reflection.

4.9. Learning from healthcare deaths

The Trust's learning from health care deaths report for Quarter 1 is available in [Appendix F](#). Once approved at Trust Board this will be published separately on the Trust website. We are working towards integrating learning from deaths with our patient safety improvement agenda.

5. Conclusion and next steps

The content of this report reflects the transition to working under the Patient Safety Incident Response Framework (PSIRF) from the 1 December 2023 to 30 June 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 has seen 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 18 to 31), 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 as described overleaf.

In relation to self-harm, the exception relates to an increase in the number of self-harm incidents between November 2024 and January 2025. Data has been analysed from September 2024 to February 2025 and concluded that the number of actual self-harm incidents were predominantly due to small number of service users across mental health inpatient wards. The majority of the incidents occurred on three wards with 98% of these incidents resulting in no harm or low harm.

Inpatient falls were shown to increase in April 2025 and relate to falls on older people inpatient wards, with a small number of patients with a multiple number of falls; the care and treatment of each individual was reviewed and appropriate care plans, risk assessments and actions were in place to prevent future falls.

There has been a reduction in the number of medication errors with a downward trend in incidents continuing in Quarter 1 2025/26. Incidents recorded for the use of intra-muscular medication to manage aggression were re-categorised within Datix from medication incident type to violence and aggression incident.

Patient on patient physical violence, pressure ulcers and absent without leave incidents (detained under the Mental Health Act (MHA)) all 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 continue to develop the group.

Over the next 6-12 months, the Patient Safety Support Team (PSST) 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 • Closing the loop at the end of learning responses to enhance the focus on themes and outputs
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 meeting the national requirements for PSPs to attend patient safety groups
Data quality and information management	• Embedding actions from our review of reporting to Learn from Patient Safety Events (LFPSE)

to enhance recording of themes, trends and analysis	• 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 to meet PCREF requirements • 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 and Sam Johnson
Patient Safety Specialists
On behalf of Patient Safety Support Team
August 2025

Appendix A Statistical process charts of incidents reported

Rolling 24-month data to 30 June 2025. Note that the data in the charts does not include Cheswold Park as we do not have 24 months data and to include limited data would affect the variation in the charts.

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

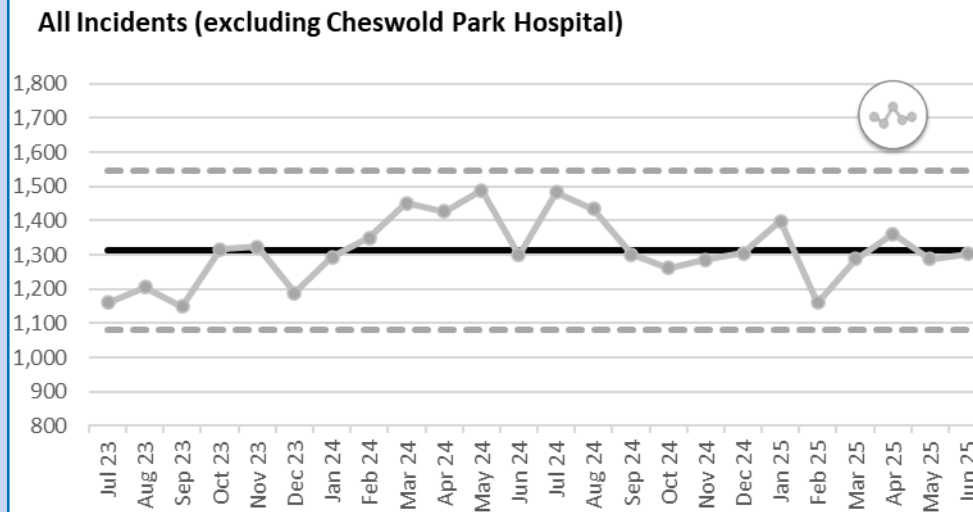
Variation/Performance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	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.	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 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!	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 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?
	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.	Investigate to find out what is happening/ happened. Is it a one-off event that you can explain? Or can you celebrate a success or improvement?

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 24 and August 24 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.

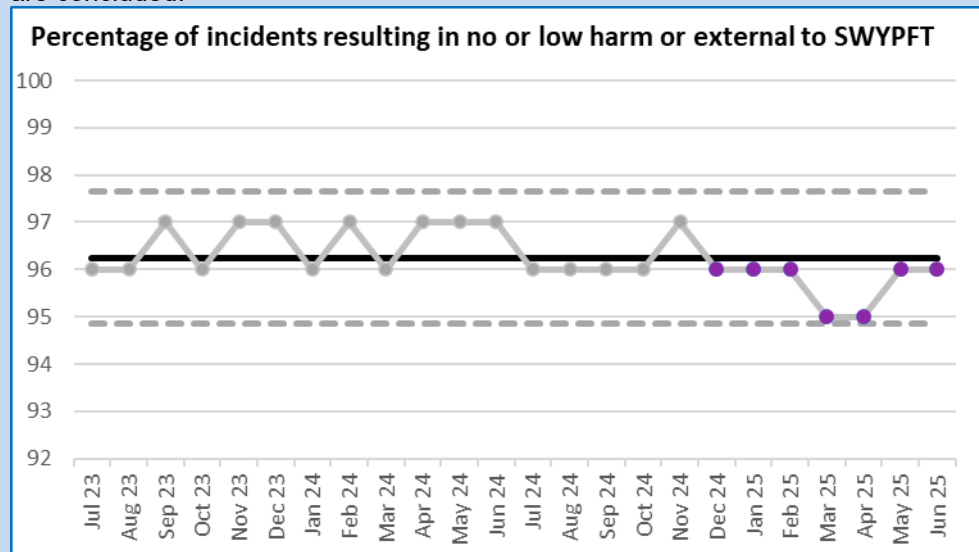
The Patient Safety Support Team will continue to monitor data.

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 30 June 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.



Note

Harm levels are not always confirmed at the time when Patient Safety Support Team (PSST) extract data for this chart, and therefore, managers may not have had the opportunity to review/revised harm levels. This may result in some cases remaining with an upwardly biased harm level.

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.

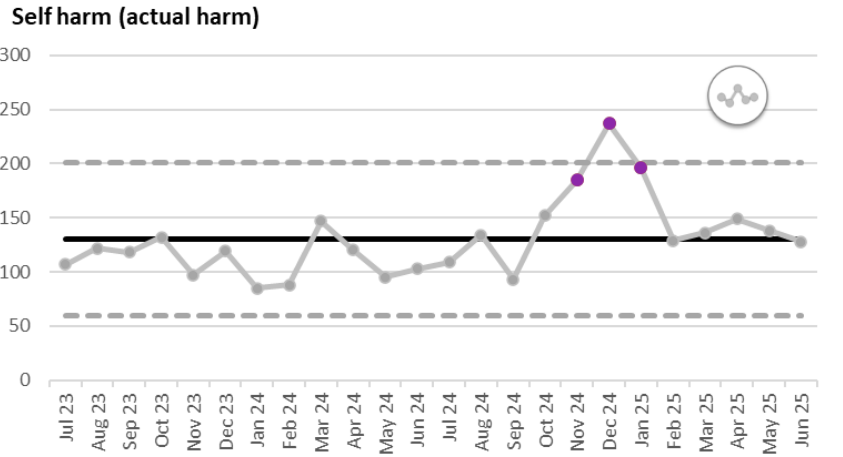
Part B Patient safety incidents

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.

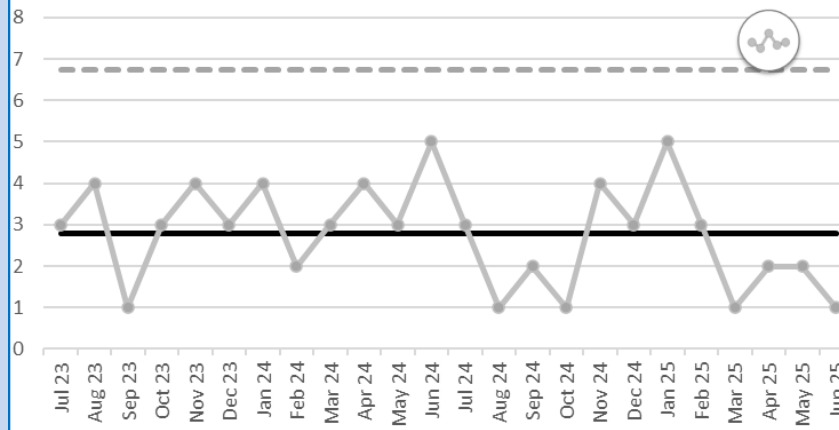
Patient safety priority	Statistical Process Control chart (where available)	Comments on data and PSIRF work																																																		
Self-harm PSIRF plan focus: - Inpatient – self harm associated with ligatures or swallowing objects - Community – overdose of prescribed medication	Self harm (actual harm)  <table><caption>Approximate data points from the SPC chart</caption><thead><tr><th>Month</th><th>Incidents</th></tr></thead><tbody><tr><td>Jul 23</td><td>110</td></tr><tr><td>Aug 23</td><td>120</td></tr><tr><td>Sep 23</td><td>120</td></tr><tr><td>Oct 23</td><td>130</td></tr><tr><td>Nov 23</td><td>100</td></tr><tr><td>Dec 23</td><td>120</td></tr><tr><td>Jan 24</td><td>90</td></tr><tr><td>Feb 24</td><td>90</td></tr><tr><td>Mar 24</td><td>150</td></tr><tr><td>Apr 24</td><td>120</td></tr><tr><td>May 24</td><td>100</td></tr><tr><td>Jun 24</td><td>110</td></tr><tr><td>Jul 24</td><td>110</td></tr><tr><td>Aug 24</td><td>130</td></tr><tr><td>Sep 24</td><td>100</td></tr><tr><td>Oct 24</td><td>150</td></tr><tr><td>Nov 24</td><td>180</td></tr><tr><td>Dec 24</td><td>240</td></tr><tr><td>Jan 25</td><td>200</td></tr><tr><td>Feb 25</td><td>130</td></tr><tr><td>Mar 25</td><td>140</td></tr><tr><td>Apr 25</td><td>150</td></tr><tr><td>May 25</td><td>140</td></tr><tr><td>Jun 25</td><td>130</td></tr></tbody></table>	Month	Incidents	Jul 23	110	Aug 23	120	Sep 23	120	Oct 23	130	Nov 23	100	Dec 23	120	Jan 24	90	Feb 24	90	Mar 24	150	Apr 24	120	May 24	100	Jun 24	110	Jul 24	110	Aug 24	130	Sep 24	100	Oct 24	150	Nov 24	180	Dec 24	240	Jan 25	200	Feb 25	130	Mar 25	140	Apr 25	150	May 25	140	Jun 25	130	Data analysis The Trust saw a period of special cause variation in the number of self-harm incidents between November 2024 and January 2025. We have analysed the data from September 2024 to February 2025 and concluded that the number of actual self-harm incidents were predominantly due to small number of service users across Mental Health inpatient wards. The majority of the incidents were on 3 wards – Nostell Ward, Elmdale Ward and Clark Ward. Of these incidents 96% resulted in no harm/low harm or unrelated to SWYPFT care and 4% resulted in moderate harm. In Q1 2025/26: MH inpatient 89% of incidents occurred in mental health inpatient setting. 97% of these resulted in no/low harm or were unrelated to SWYPFT care. 3% resulted in moderate harm requiring acute hospital treatment. 84% of these incidents recorded the person/s affected as being from a White - English/Welsh/Scottish/Northern Irish/British ethnicity. 6% were recorded as Asian/Asian British – Indian. 3% were recorded as the following ethnicities: Asian/Asian British – Pakistani Mixed/multiple ethnic groups - white and Asian Black/African/Caribbean/Black British – African Asian/Asian British - Any other Asian background 8% data was not recorded/not stated. MH community 11% of incidents were reported by mental health community teams. 62% of these resulted in no/low harm or were unrelated to SWYPFT care. 38% resulted in moderate harm.
Month	Incidents																																																			
Jul 23	110																																																			
Aug 23	120																																																			
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May 25	140																																																			
Jun 25	130																																																			
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 (01/4/2025 – 30/6/2025) <table><tr><td>Managers 48-hour review</td><td>20</td></tr><tr><td>Debriefs</td><td>56</td></tr></table> Sharing learning During Quarter 1 2025/26, learning relating to self-harm risks/methods have been shared with all staff including 2 Bluelight alerts			Managers 48-hour review	20	Debriefs	56																																														
Managers 48-hour review	20																																																			
Debriefs	56																																																			

	Moderate harm often reflects attendance at A&E for treatment. 84% of incidents recorded the person/s affected as being from a White - English/Welsh/Scottish/Northern Irish/British ethnicity. 13% data was not recorded/not stated. 2% were recorded as Black/African/Caribbean/Black British – African ethnicity.

Apparent suicides

PSIRF plan:
Focus on suicide
prevention at team
level

Apparent suicide



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.

100% of the apparent suicides in Quarter 1 2025/26 occurred in community mental health settings.

83% of those who died had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 17% data was not recorded/not stated.

SPC data is monitored monthly at the operational management group.

Improvement plan

During Q1 2025/26 we have:

- 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 report due September 2025

Future work:

- Ongoing work around the thematic review and workstreams continue to be identified
- Wound care work stream is being revisited as part of the thematic review with initial set up meetings taking place.
- Improvement group established around cables and environment and improvement work to come out of this to support reduction of risk

Learning responses completed to understand, reflect and learn (01/4/2025 – 30/6/2025)

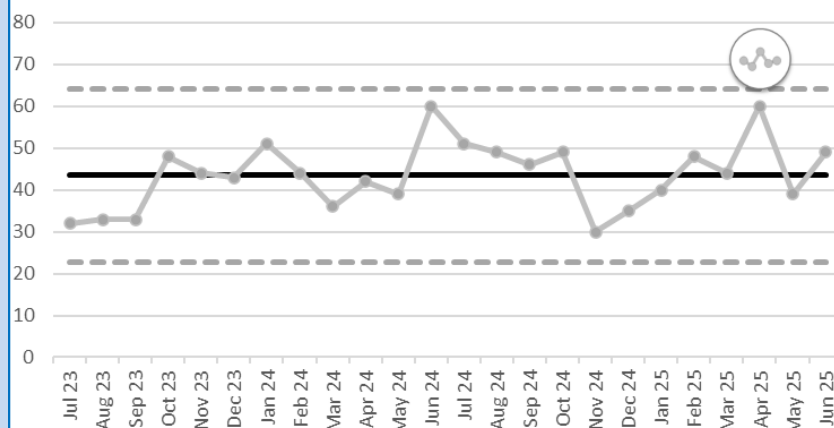
Managers 48-hour review	9
Debriefs	6
After Action Review	2
Specialist Learning Review	1
Structured Judgement Review	2

Inpatient falls

PSIRF Plan:

- Learning from well managed incidents and/or near misses
- Priority area covered by Improvement plan
- Learning response by exception only

Inpatient falls



Improvement plan

During Q1 2025/26 we have:

- Continued to review all falls related safety events for themes and learning
- NICE quality standard for falls reviews are supporting the implementation of physiotherapy screening and assessment tools. It is also auditing the quality of mobility plans for patients 65yrs and above
- Falls awareness week takes place week commencing 15th Sept 25, with lots of activities planned so far; fully supported by Barnsley integrated team, inpatient wards, Creative Minds and the Comms Team
- Highlighted that the Welsh health board Betsy Cadwaladre was fined by the Health and Safety Executive, and a report offering assurance and potential recommendations developed
- SBAR developed around medical devices and therapy equipment

Future work:

- NICE guideline (NG249) - 'Falls: assessment and prevention in older people and in people 50 and over at higher risk' was published 29 April 2025. This new guideline will be reviewed to support the update of Trust wide falls and bone health policy and the inpatient falls pathway
- eFalls work continues alongside the research and development team
- Bone health work is ongoing with a report being planned for the physical health operational steering group
- A review is underway regards the use of observations for falls risk

Data analysis

The Trust saw an increase in April 2025 for inpatient falls. This was attributed to falls on Older People inpatient wards. The majority of the falls resulted in no harm or low harm with three resulting in moderate 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 Quarter 1 2025/26:

90% occurred in mental health inpatient wards and 10% in general community wards.

83% had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British or other white background. 5% had a recorded ethnicity as Asian/Asian British - Indian. 3% had a recorded ethnicity as Asian/Asian British - Pakistani. 1% had a recorded ethnicity as Asian/Asian British - Any other Asian background. 1% had a recorded ethnicity as Black/African/Caribbean/Black British - Caribbean. 8% of data was not recorded/not stated.

65% of these resulted in no harm, 29% resulted in low harm, 6% resulted in moderate harm.

More detailed information is discussed at the Falls prevention and bone health group.

Sharing learning

During Quarter 1 2025/26, learning relating to falls risks have been shared with all staff including a learning summary regarding urinary incontinence and falls risk

**Learning responses to understand, reflect and learn
(01/4/2025 – 30/6/2025)**

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:

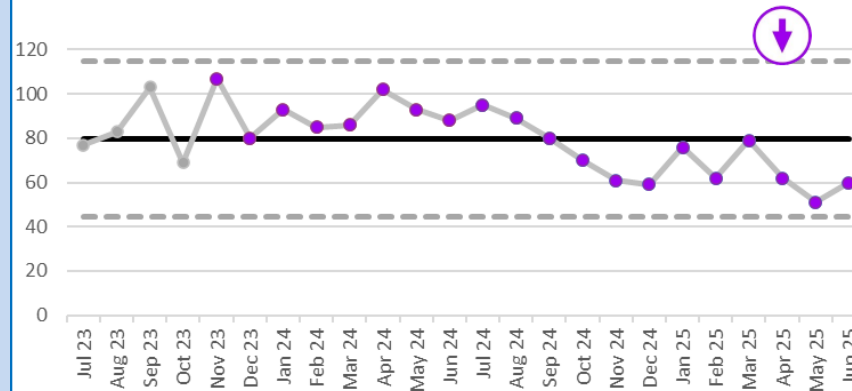
Managers 48-hour review	8
Debriefs	11

Medication errors

PSIRF plan:

- Administration of insulin
- Medication storage (fridges/clinic rooms)

Medication errors (excluding 3rd party)



Improvement plan

During Q1 2025/26 we have:

- EPMA – rolled out to all in patient areas and IHBTT in Kirklees and Wakefield. Plan to roll out to IHBTT Calderdale and Barnsley from September and the Cheswold park.
- Standardised stock list and out of hours stock list – reduces number of missed doses – now fully implemented except CPH.
- Discharge Medicines Service – about 10% of discharges have a referral to their community pharmacy to support with medicines on discharge and pick up issues with GP prescribing

Learning responses to understand, reflect and learn (01/4/2025 – 30/6/2025)

Managers 48-hour review	11
Debriefs	23

Data analysis

The Trust continues to see 'normal' variation in the number of medication errors with a downward trend in incidents continuing in Quarter 1 2025/26.

Work was carried out in Quarter 3 2024/25 to re-categorise incidents recorded for the use of intra-muscular medication to the manage aggression from medication incident type to violence and aggression category by RRPI TAG. These types of incidents are now excluded from the SPC chart for medication errors.

In Quarter 1 2025/26:

66% occurred in mental health inpatient wards

21% occurred in mental health community

12% occurred in general community

0% occurred in general community inpatient wards

1% occurred in trust wide pharmacy services

66% of medication errors in inpatient settings had a recorded ethnicity of White - English/Welsh/Scottish/ Northern Irish/British or other white background. 8% had a recorded ethnicity of Asian/Asian British – Pakistani, 2% were recorded as Black/African/Caribbean/Black British – African. 2% had a recorded ethnicity of Other ethnic group – Arab and 1% had a recorded ethnicity of Black/African/Caribbean/Black British – Caribbean.

21 % of ethnicity data was not recorded/not stated.

In community settings, 84% of medication errors affecting patients had a recorded ethnicity of White - English/Welsh/Scottish /Northern Irish/British or other white background. 2% had a recorded ethnicity of Mixed/multiple ethnic groups - white and Asian and 2% had a recorded ethnicity of Asian/Asian British – Pakistani. 12% data was not recorded/not stated.

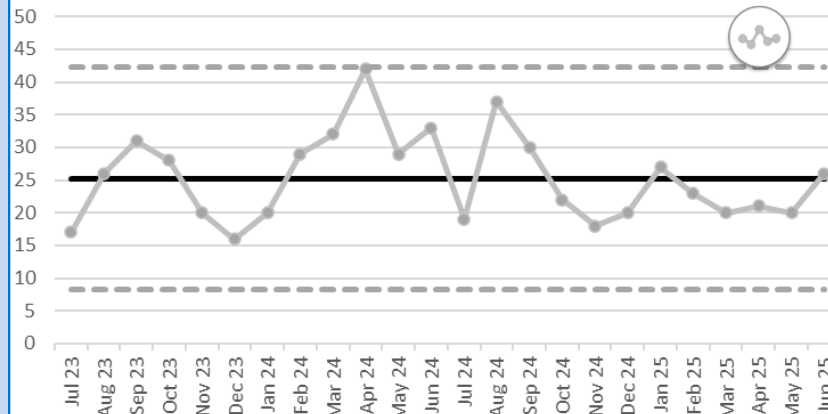
In all settings 89% of medication incidents resulted in no harm and 11% resulted in low harm.

More detailed information is discussed at the Safe medicines practice group.

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

Physical violence (contact made) against patients



Improvement plan

During Q1 2025/26 we have:

- Overarching ambition for the reduction of restrictive practices including restraint (including prone), seclusion and rapid tranquilisation supported by a quality improvement programme, this work is ongoing and reductions have been seen through Q1.
- Continued to embed an established Zero prone culture within RRPI training and Trust wide
- Continued to develop improvements for using data for evidence-based decision making to drive improvements including 136 suites
- We have started to align training requirements, policies and procedures with Cheswold Park Hospital

We have started to work in collaboration with the Trust psychologist and wider MDT to embed trauma informed approaches and formulation work:

- Rename the team as the Reducing Restrictive Practice (RRP) Team reflecting the broader focus of work to reduce restrictive practices.
- Launch of the new E-Learning package for alternative injection sites.
- Establish standardised audit for seclusion to strengthen the monitoring of policy compliance and quality of documentation. Incorporating feedback from 360 Audit
- Revisit Safewards and imbed 10 key interventions across all inpatient wards
- Develop an audit for the maintenance of the safety pod and any identified quality improvements
- Launch the Use of Force E-learning package and review
- To review training and align with Core skills Training Framework
- System review of Datix to positively impact on Service users experience

Data analysis

The Trust continues to see 'normal' variation in the data.

97% of incidents occurred in MH inpatient settings and 3% of incidents occurred in MH community settings during Quarter 1 2025/26.

70% of physical violence against patients had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British or other white background.

8% had a recorded ethnicity of Asian/Asian British – Pakistani. 5% had a recorded ethnicity of Asian/Asian British – Indian. 3% had a recorded ethnicity of Mixed/multiple ethnic groups - white and black Caribbean. 1% had a recorded ethnicity of Black/African/Caribbean/Black British – African and 1% had a recorded ethnicity of Other ethnic group - Arab 11% data was not recorded/not stated.

52% of violence against patient incidents resulted in no harm, 37% with low harm and 10% resulted in moderate harm.

More detailed information is discussed at the Reducing restrictive physical intervention group.

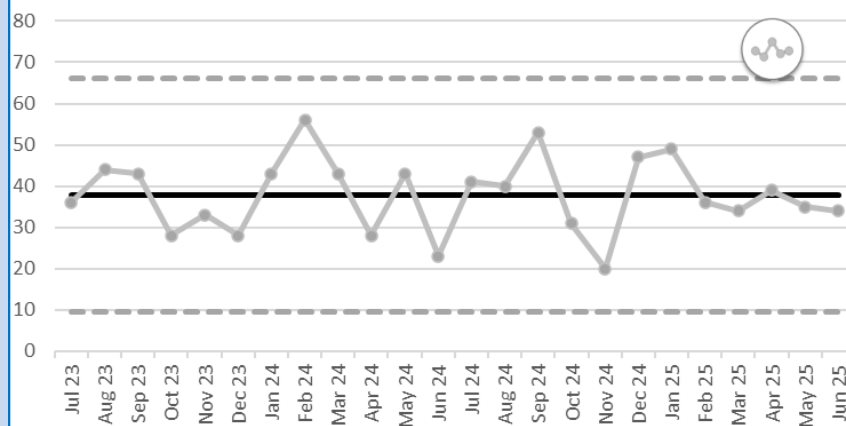
Learning responses used for decision making and reflection (01/4/2025 – 30/6/2025)

Managers 48-hour review	1
Debriefs	4

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

Pressure ulcers which developed/deteriorated under SWYPFT care



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 Quarter 1 2025/26 were reported by Barnsley physical health services. 2% (2) incidents were reported by Mental Health Care Group (Inpatient).

96% of incidents had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 4% data was not recorded/not stated.

58% of pressure ulcers resulted in low harm (typically Category 2), 42% with moderate harm (typically Category 3) and 0% were recorded as severe harm (typically Category 4). This is based on the pressure ulcer severity, rather than any identified problems in care.

Improvement plan

During Q1 2025/26 we have:

- **Purpose T** risk assessment is now fully rolled out across Barnsley physical health and the Waterlow risk assessment has been formally removed from SystmOne. All staff have been trained in Purpose T. There is ongoing evaluation of the project until September to fully understand the impact on the neighbourhood nursing service. Datix reporting will continue during this period in line with current practice and learning from incidents considered in the review
- The **home visiting guidance** has been produced in draft and approved by the TAG. The draft guidance will now need to go through the Trust and Primary Care Network (PCN) governance processes for approval and onward circulation to GP practices
- The **PSII** work around pressure ulcers is progressing and the joint leg ulcer and wound care template was approved at the care group clinical governance group in July and is now live in SystmOne. An initial meeting took place in July to progress with the project around care planning using a quality improvement methodology. A further meeting is to be held in August.

Future work:

The care group has noted issues relating to access to interpreters with community services during June. The care group will be monitoring any issues via the Datix reporting system and working with

Learning responses to understand, reflect and learn (01/4/2025 – 30/6/2025)

Managers 48-hour review	89
Debriefs	2

the Trust Equality and Involvement manager to resolve any issues. No incidents relating to interpreters were reported during the month of July.

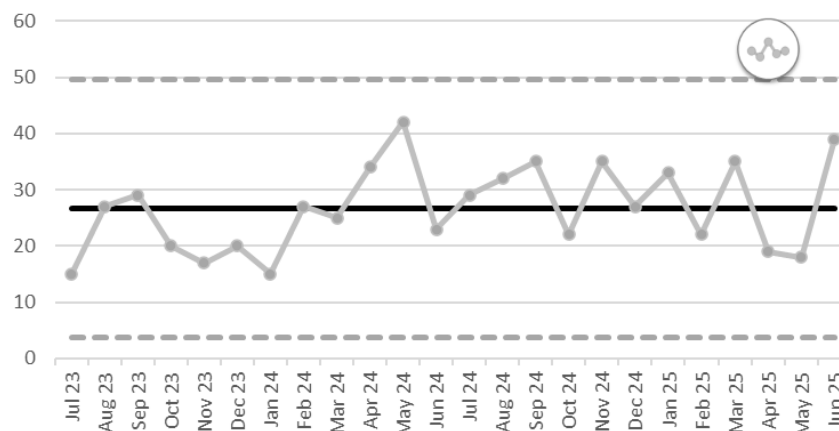
An increase in the number of category 4 incidents under the Trust care has been reported in July. The care group will continue to monitor and review for any areas for improvement. The 48-hour managers review for the incidents are provided to the CQC as requested.

There is an increase in threatened self-harm within the Live Well Wakefield team, to explore with the team whether this is due to increase in reporting via Datix or an increase in incidents.

Patients absent without leave (AWOL)

- Escape and attempted escapes from the fabric of the building
- Developing new intelligence

Patient absent without leave detained patients under Mental Health Act



Improvement plan During Q1 2025/26 we have:

- Work has commenced on the MISPER policy with development of processes to support staff when a MISPER has occurred.

Future work:

- Improvement work around police responses to be undertaken with YAS and police leads from localities to help inform policy

Sharing learning:

- Learning from an attempted escape from a secure unit courtyard has been shared in the learning library.

Data analysis

Incidents are within normal variation.

Analysis shows that the majority of AWOL incidents resulted in no harm (95%). The remaining incidents (5%) resulted in low harm.

Of the incidents in Quarter 1 2025/26:

33% failed to return from planned leave, 33% absconded from staff on escorted leave 5% escaped from inpatient units, 14% attempted escapes that were prevented, 9% were unauthorised leave e.g. in excess of S17 arrangements, 6% absconded for other reasons e.g. from acute hospital, from family whilst on leave.

Work was carried out in 24/25 to improve recording of AWOL incidents. Further work is planned for 25/26 to monitor completion of how the patient was returned to the ward on Datix.

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	35
Returned by police	40
Returned by hospital or other staff	23
Not completed	2

Learning responses to understand, review and reflect (01/4/2025 – 30/6/2025)		<table><tr><td>Returned with ambulance staff</td><td>3</td></tr></table> Please note that the above may not total 100% as there may be more than one option selected e.g. patient may have been returned by the police and by staff.	Returned with ambulance staff	3				
Returned with ambulance staff	3							
<table><tr><td>Managers 48-hour review</td><td>8</td></tr><tr><td>Debriefs</td><td>4</td></tr></table>	Managers 48-hour review	8	Debriefs	4	71% of incidents had a recorded ethnicity of White - English/Welsh/Scottish/Northern Irish/British background. 9% had a recorded ethnicity of Asian/Asian British – Pakistani. 3% had a recorded ethnicity of Asian/Asian British – Indian. 3% had a recorded ethnicity of Black/African/Caribbean/Black British – African. 3% had a recorded ethnicity of Any other ethnic group. 1% had a recorded ethnicity of Black/African/Caribbean/Black British - Any other Black background. 11% data was not recorded/not stated.			
Managers 48-hour review	8							
Debriefs	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 During Q1 2025/26 we have: - To further support the commitment to improving physical health within our services the Trust has a physical health operational steering group. This group provides support and will be a central repository for Physical health initiatives. There is multi-disciplinary membership, with shared interest and motivation and from all care groups and services, including specialist services - The purpose of the group is to promote a structured approach to the Trust physical health strategy to support the Trust in increasing and improving the quality of physical healthcare provided to patients / service users - To support the overarching strategic aims for physical health of people that access our mental health and learning disabilities services and links to other Trust physical health policies - To work in partnership with all other stakeholders - Learning from each other, including specialisms, care groups e.g. -physical health and well-being, mental health, forensics, children and young people - Endorse a one health approach to patients/service users care - Provide opportunity for share learning and improvement for all services and care groups - To support Trustwide governance systems that are in place and functioning efficiently whilst promoting the delivery of high-quality patient centred care to support one health patient /service user journey		Learning responses to understand, reflect and learn (01/4/2025 – 30/6/2025) <table><tr><td>Managers 48-hour review</td><td>4</td></tr><tr><td>Debriefs</td><td>6</td></tr><tr><td>After Action Review</td><td>1</td></tr></table> Sharing learning During Quarter 1 2025/26, learning from incidents has been shared including related to: Near miss choking event Patients declining to attend A&E	Managers 48-hour review	4	Debriefs	6	After Action Review	1
Managers 48-hour review	4							
Debriefs	6							
After Action Review	1							

- Review national initiative and implement as applicable

Future work:

- Training and awareness around physical health related conditions is being offered, e.g. vital signs / NEWS2, diabetes, falls, wound management, hydration, sepsis, long term condition management, Palliative care / end of life, ReSPECT training, Epilepsy, using multi methods of delivery – eLearning, clinical skill facilitators, workshops
- Review physical health Datix's, for actions, learning. Share learning with physical health forums and appropriate governance and operational forums
- Responsive processes for sharing the information, continuously improve the quality of services, accessibility and safeguard high standards
- Provide eligible vaccination to service users e.g. Flu vaccination, COVID, RSV
- Developing standard operational procedures and pathways to improve care:
 - Management of Diabetes Mellitus in adult inpatients- SOP
 - Mental health inpatient wound management
 - Visual A-E Assessment SOP - A-E assessment tool has been developed, approved and is being used
 - Head banging/ head injury procedure approved
- The Trust are exploring e-observations for clinical services. A digital solution to record the vital signs, NEWS etc of a patient. A mobile device is used by clinical staff to collect and store patient observations. This can be done at the bed side. It will also support clinical staff and specialist advisors away from the wards to keep track of or review patients from afar. This will increase staff communication and has the potential to make substantial patient safety improvement

Emerging theme – patients being discharged from acute hospitals to our inpatient mental health wards, without adequate plans in place to ensure continuity of physical health in a mental health setting.

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.	Learning responses to understand, reflect and learn (01/4/2025 – 30/6/2025) <table><tr><td>Managers 48-hour review</td><td>5</td></tr></table>	Managers 48-hour review	5
Managers 48-hour review	5			
Improvement plan During Q1 2025/26 we have: - Reviewed the transfer of care protocols which are in place between SWYPFT 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 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. Emerging theme – patients being discharged from acute hospitals to our inpatient mental health wards, without adequate plans in place to ensure continuity of physical health in a mental health setting				

Healthcare acquired infections	Four incidents between 1/7/2023 and 30/6/2025 therefore no SPC chart provided.	Learning responses to understand, reflect and learn (01/4/2025 – 30/6/2025)	
Improvement plan During Q1 2025/26 we have:		Managers 48 hour review	1
		Debrief	3
Quarter 1 quality improvement work has highlighted:		Sharing learning	
- Improvements with outbreak management, risk assessment tools for outbreak management, infectious isolation standard principles, SystmOne IPC (infection prevention and control) templates, urinary catheterisation and sampling procedures and training - All IPC Datix's are reviewed by the IPC Team specialist advisors and any actions and learning escalated and included in improvement plan - Continue to monitor cases of alert organisms / conditions, mandatorily reportable infections/conditions and areas of increased prevalence to inform the Trust on preventative measures and support patient safety - Utilise every opportunity to increase knowledge and awareness of IPC and monitor mandatory training compliance		During Quarter 1 2025/26 a learning summary was shared relating to water quality.	
Future work:			
- Annual plan is in place which includes anti-microbial resistance (AMR) - Monitoring of the IPC service provision takes place through IPC Trust action group (TAG) and service management - Annual quality assurance improvement schedule is in place - A thematic review of healthcare associated infections (HCAIs)from 2024/25 was undertaken and learning shared to respective governance groups to support practice - All standard operating procedures have been reviewed and are up to date			

Appendix B Learning from experience slides

Below is an illustration of our Learning journey presentation that brings together learning through Quarter 1 2025/26.



Our Learning journey

Quarter 1 2025/2026

Patient Safety Support Team
July 2025



With all of us in mind.

1



Patient Safety Incident Response Framework

18 months into our PSIRF journey, we are now reviewing our PSIRF plan, policy and working procedures based on our experiences and feedback.

The review is being approached under four main workstreams aligned with the aims of PSIRF. Workstreams and updates on work underway or planned is show below:

1) Compassionate engagement and involvement of those affected by patient safety incidents

- Revisiting our Being Open guidance (known as engagement and involvement under PSIRF)
- This includes the development of a flowchart to assist staff in the practical steps to take following a patient safety incident including when there isn't a learning response underway. It also considers where there may be family questions raised directly with a team or through customer services and how we will respond with a considered a streamlined approach.
- Introduction of seeking feedback from staff following involvement in a learning response and from bereaved families through our family liaison officer. Feedback received is being used to improve on our systems and processes.



Search for PSIRF on the intranet

2



Patient Safety Incident Response Framework

2) Application of a range of system-based approaches to learning from patient safety incidents

- Redefining our learning responses tools (for example, we are considering renaming a team debrief to align with the national terminology)
- Revising guidance for each learning response tool including templates
- Revising processes to help us understand what is known already to help us make a robust decision
- Defining who will lead each type of learning response

3) Considered and proportionate responses to patient safety incidents and safety issues

- Developing a new decision-making process to support staff with understanding when a learning response or improvement activity may be required. This includes a learning response decision making flowchart to support in choosing the most appropriate response.
- Improving DATIX for capturing improvement activity and extracting outcomes



Search for PSIRF on the intranet

3



Patient Safety Incident Response Framework

4) Supportive oversight focused on strengthening response system functioning and improvement

- We are continuing to refine the existing oversight processes in light of PSIRF – this consists of the Patient Safety Oversight Group and Patient Safety Improvement Group.
- During August 2025, we are trialling a Patient Safety Executive Group that will work alongside these two groups. This is a small group of patient safety specialists and executive directors with responsibility for patient safety, where oversight of high-level learning responses can be maintained through regular discussion. This is an evolving group which will develop over time.
- The terms of reference for all three meetings are in development to ensure each forum has a clear focus.



Search for PSIRF on the intranet

4



After Action Review

1 What did we expect to happen?
2 What actually happened?
3 Why was there a difference?
4 What have we learnt?

An After Action Review was completed with representation from the Single Point of Access (SPA) service, The Intensive Home Based Treatment Team (IHBT) service and the Mental Health Liaison team (MHLT) service from Calderdale and Kirklees area following the death of a gentleman who fell.

The After Action Review involved face to face meeting with staff impacted by the incident guided by lead patient safety specialist and had representation online.

We learned that

It was identified that there is no guidance for staff in relation to contact and assessments of service users who are under the influence of alcohol, it is down to the professional's judgement.

Consideration and review to be given to how services and practitioners can support the safe discharge of a service user, deemed to have capacity, where family or carers express concern in relation to risk management and/or are not in agreement with assessment outcome.

Quality and Governance lead to develop and implement a guidance document for IHBT and MHLT assessing service users presenting under the influence of alcohol or drugs in a mental health crisis for consistent and safe assessment and intervention.

The guidance will include the need to communicate any plans of assessment and care with family and carers where applicable and maintain documentation standards to support clear decision making and formulation.



Ref:2526Q1.1

5



After Action Review

1 What did we expect to happen?
2 What actually happened?
3 Why was there a difference?
4 What have we learnt?

An After Action Review was completed with representation from the Calderdale Child and Adolescent Mental Health Service (CAMHS) crisis team and external agencies following a death of a young person.

The After Action Review involved face to face meeting with staff impacted by the incident guided by lead patient safety specialist.

We learned that

Discussion with the young person to confirm their views prior to discharge is important and that managing differing expectations between service users and their family can be challenging.

Upon discharge young person should have been signposted to services as part of discharge plans.

Documentation in relation to referral, discharge and communication with partner agencies requires strengthening.

All actions identified from the review had already been highlighted through existing improvement work within the Children, Young People and Families Patient Safety Improvement Action Plan.



Ref:2526Q1.2

6

NHS South West Yorkshire Partnership NHS Foundation Trust

After Action Review WEB189287

An After Action Review (AAR) was completed with representation from multi-disciplinary staff on Beamshaw Ward at Kendray Hospital Barnsley, including support from occupational therapy. This was following the discovery of an inpatient having a seizure within the grounds of the hospital, whilst on ground leave, who had also sustained a head injury.

The After Action Review involved a face to face meeting with staff impacted by the incident guided by a lead patient safety specialist and had representation online. Staff had also completed memory capture documents prior to the AAR.

We learned that

There was a delayed response from staff on Beamshaw Ward as there is no protocol for using alarms outside of the fabric of the building. There is a panic alarm button behind reception which could have been used. The panic alarm button has been tested and reception teams have been reminded of using it in urgent situations.

There is no protocol or equipment available for moving and handling outside of the building. This area for improvement has been shared with the Trusts moving and handling specialist advisors for their consideration.

Staff are parking in designated no parking areas for easy access to their work areas. A Trust wide communication has been circulated to remind staff of the importance of not parking vehicles in designated areas where emergency services access may be required.

Support has been offered to peers and staff who witnessed the incident via Occupational health and psychology. The service user is very grateful to all staff involved for their care and support at the time of the seizure.

With all of us in mind.

Ref:2526Q1.3

7

NHS South West Yorkshire Partnership NHS Foundation Trust

After Action Review WEB191526

An After Action Review (AAR) was completed with representation from multi-disciplinary staff at Cheswold Park Hospital, Doncaster. The incident involved a delay in receiving and reviewing a patient's assay clozapine serum level over a period of 14 days, which then delayed treatment being ordered and administered to the patient.

We learned that

As a result of this, an on-call tray has been placed in the medical secretaries' office for all results for patients whose associate specialist is absent on that day, so that these can be reviewed by the on-call doctor and once read will be entered on SystmOne. The medical secretaries will email all doctors to inform them that post is present in the on-call tray.

There is an on-going liaison with external laboratory to discuss process for receiving results with possible change from post to email.

With all of us in mind.

Ref 2526Q1.4

8

NHS South West Yorkshire Partnership NHS Foundation Trust

Structured Judgement Review

A service user under the care of core team in Barnsley died by apparent suicide using prescribed medication. A structured judgement review was carried out by a clinician independent of the service. The service user had a diagnosis of bi-polar affective disorder. They had been under the care of the team for around 18 months prior to death. They had regular appointments with the practitioner and support worker. They had a number of physical health diagnoses. The service user was reviewed with the practitioner and support work and agreed to discontinue work. They had ceased working due to poor physical health. Their care transferred to the team psychiatrist to be seen as an outpatient.

The review identified:

- The service user had previously reported looking up her medication and didn't feel they would be beneficial. This was the medication used to take her own life.
- Risk assessment documentation could have been improved however there was evidence within the care records that her mental wellbeing was assessed on each visit.
- Care was recorded to be Excellent
- The quality of the records in ... Was records to be excellent.

With all of us in mind.

Ref 2526Q1.5

9

NHS South West Yorkshire Partnership NHS Foundation Trust

Structured Judgement Review

A service user under the care of Intensive Home Based Treatment Team (IHBT) in Barnsley died unexpectedly, cause unknown. The service user been receiving care from IHBT following GP reporting suicidal ideation. They were assessed by Single Point of Access Team and IHBT. They had regular contact with the team. There was no current evidence of suicidal thoughts. The team endeavoured to engage via phone and cold calls. Service user was due to go on a trip. Due to concerns for welfare raised, police were contacted for a welfare check. The service user was found deceased on entry to the home.

A Structured Judgement review was carried out by a clinician independent of the service.

The review found:

The service user received a good standard of care.

The service user did not always engage with services however engage with services, however the records evidence the team were persistent in their efforts to engage and when unable to contact by phone, would cold call at his home with success.

The teams good working relationship with the service user was noted. He was honest about drug and alcohol use.

When he expressed doubts about his diagnosis and the need to take medication, a face-to-face Consultant appointment was arranged at his request to discuss his concerns.

It is evidenced in the notes that staff allowed Mr X time to discuss his thoughts and fears and were able to reassure him and also provide education regarding his symptoms and plan of care.

Mr X held firm views which were thought have a delusional element to them by the staff caring for him. They contacted members of Mr X's family with his permission to gain background information about these beliefs which is good practice.

The conclusion was that there was some basis to Mr X's delusional thoughts.

Care was recorded to be excellent overall.

The quality of the patient record in enabling good quality care was assessed as being good.

With all of us in mind.

Ref 2526Q1.6

10

NHS South West Yorkshire Partnership NHS Foundation Trust

Structured Judgement Review

A service user under the care of Enhanced team East Wakefield died at home following a deterioration in their physical health. This was later reported to have been from pneumonia.

The service user had a history of homelessness, drug use and periods of non-engagement. There was a diagnosis of schizo affective disorder. There was a history of hospital admission and early intervention team. In the months leading up to death, there was some deterioration in mental state, ongoing drug and alcohol use, alongside difficulties engaging with staff and becoming homeless. Family reported sporadic engagement prior to death.

A Structured Judgement review was carried out by a clinician independent of the service.

The review found:

The service user received a good standard of care.

The quality of care from the team to the service user was needs led and with compassion and understanding, they appeared at times to work above and beyond, particularly in relation to his relationship with his family.

Record keeping was at times inconsistent or unclear but was reviewed.

Work was attempted on numerous occasions with little impact due to the situation the service user often put himself in.

Good robust assessments when he attended A&E and even when in other areas, good communication evident between teams to share relevant information.

Care was recorded to be good overall.

The quality of the patient record in enabling good quality care to be provided was assessed as being adequate.

With all of us in mind.

Ref 2526Q1.7

11

NHS South West Yorkshire Partnership NHS Foundation Trust

Patient Safety Incident Investigation (PSII)

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

- One PSII has been commissioned this quarter having been escalated from findings from a case note review.
- There are a small number of other PSII's that remain underway.
- There is an additional PSII going through the governance stage.
- There is a proposal for a new PSII review and sign off process at director level which is under review at the newly appointed patient safety executive group.

With all of us in mind.

12

Improvement work and care group updates



We are continuously trying to develop the ways in which we share learning and feedback from our improvement work.

Moving forward improvement leads and care group representatives will populate an update slide to share at the Patient Safety Improvement Group (PSIG) or provide a verbal update. Some examples are shared below.

These updates will then be shared within our quarterly patient safety oversight report and this learning journey moving forward.



With all of us in mind.

13

Improvement work update Falls and bone health



During Q1 2025/26 we have:

- ✓ Continued to review all falls related safety events for themes and learning
- ✓ NICE quality standard for falls reviews are supporting the implementation of physiotherapy screening and assessment tools. It is also auditing the quality of mobility plans for patients 65yrs and above
- ✓ Falls awareness week takes place week commencing 16th Sept 26, with lots of activities planned so far: fully supported by Barnsley integrated team, inpatient wards, Creative Minds and the Comms Team
- ✓ Highlighted that the Welsh health board Betsy Cadwaladre was fined by the Health and Safety Executive, and a report offering assurance and potential recommendations developed
- ✓ SBAR developed around medical devices and therapy equipment

Future work:

- NICE guideline (NG240) - 'Falls: assessment and prevention in older people and in people 50 and over at higher risk' was published 29 April 2025. This new guideline will be reviewed to support the update of Trustwide falls and bone health policy and the inpatient falls pathway
- eFalls work continues alongside the research and development team
- Bone health work is ongoing with a report being planned for the physical health operational steering group
- A review is underway regards the use of observations for falls risk



With all of us in mind.

14

Children, Young People and Families Care Group



- An audit completed in Child and Adolescent Mental Health Services (CAMHS) identified a pattern that learning from previous patient safety incidents wasn't being embedded across teams. As part of this piece of local oversight work, 5 common themes were identified to develop a CAMHS patient safety improvement plan.

- Some of the improvements to come from this were the development of an e-learning package around consent to share, improvement work around engagement and communication of crisis plans, ensuring they are shared with the young person rather than the family member.

- The above is an example of a local piece of oversight work which aims to demonstrate sustained improvements within CAMHS.



With all of us in mind.

15

Cheswold Park Hospital



Local improvement work

- **Medication Management Quality Improvement Work** – Involvement from the Trust Quality Team to understand the need for improvement at CPH and we are now at the stage of observing medication rounds to gain vital data. EPMA is on hold until March 2026.
- **Observation and Engagement Quality Improvement Work** – Involvement with the wider forensic care group to deliver training around changes within Observation and Engagement and support to implement the Trust policy into CPH.
- **Infection Prevention and Control Action Plans** – These are in place for each ward at CPH and IPC Team have oversight.
- **Plastic Bag Audits** – Implementation of an audit to review and reduce plastic bags within all inpatient wards at CPH.
- **Physical Health Forum** – This has been set up to improve patient's access to Physical Health interventions and monitoring at CPH.
- **Training** – Upskilling CPH staff in relation to clinical skills, such as, venepuncture, clinical record keeping and post-falls awareness training.



With all of us in mind.

16

Family Liaison Officer



- Launch of bereavement link supporter role has taken place.
- Interest in the role expressed by approximately 20 colleagues so far (1:1 meetings have taken place to further discuss the role).
- Full day information session for bereavement link supporters arranged for 20/10/25 with guest speakers attending.
- Involvement in discussions regarding development of a FLO training programme – a working group has been established with the first meeting taking place on 27/08/25.



With all of us in mind.

17

#alofusimprove and be outstanding Learning Library Q1 2025/26



Number of BlueLight alerts to share urgent learning

- [UK emergency alert test](#)
- [Risk associated with carpet threshold strips](#)
- [Learning from fire incident](#)
- [Use of batteries in service user areas](#)

Learning library -

- [WEB189917 Room out of use due to water quality issue](#)
- [Threats to staff secure CAMHS](#)
- [Focus on Falls - Urinary incontinence and falls issue](#)
- [Cheswold Park Hospital - Courtyard Garden SBAR](#)
- [Cheswold Park Hospital - Learning from incidents involving patients who require A & E intervention but decline to attend](#)
- [WEB187601 Cheswold Park Hospital - Near miss choking incident](#)



Search for Learning Library on the Intranet

With all of us in mind.

18

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Learning from healthcare deaths

During Quarter 1, a review of the Mortality review group took place as part of the review of our Patient Safety Incident Response Plan. It was identified that the majority of the meeting's content focussed on processes rather than learning themes from our own deaths. As such it was felt that themes emerging from deaths we have reviewed was more appropriate to link with the re-launched Patient Safety Improvement Group. A refreshed agenda which includes learning from deaths will commence from September 2025.



With all of us in mind.

19

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Thank you for supporting a patient safety culture



Contact the patient safety team: patientsafety@swyt.nhs.uk

With all of us in mind.

20

Appendix C Patient Safety Incident Response Framework background context

This appendix provides background context to PSIRF. Further details of the national documents are available [here](#).

Our Patient Safety Incident Response Framework (PSIRF) plan describes our 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, a 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. The Trust can equally learn from what has gone well and this is something we are developing and promote regularly at our learning network.

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.

Below is an overview of the four key PSIRF principles:

Compassionate engagement and involvement of those affected by patient safety incidents

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.

Through the PSIRF review, 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.

Application of a range of system-based approaches to learning from patient safety incidents

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 developed a range of systems tools, in line with the national toolkit, to help explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement. Although we have called some approaches by different names, the methodology remains the same.

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.

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.

Supportive oversight focused on strengthening response system functioning and improvement

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 leadership and management functions of Patient Safety Incident Response Framework (PSIRF) oversight are wider and more multifaceted compared to previous response approaches. We have been developing our processes to enable us to demonstrate improvement, and where we need to improve. The changes with PSIRF have also seen a change to oversight by Integrated Care Boards and provider collaboratives where their role has changed. Trust Board is now responsible for the approval of patient safety incident investigations.

Appendix D Healthcare Services Safety Investigation Branch reports during Quarter 1 2025/26

Information has been shared with specialist leads for consideration of any impact for the Trust services

Topic	Date published
Sepsis: investigating under the Patient Safety Incident Response Framework (PSIRF)	June 2025
Mental health inpatient settings	May 2025
The impact of staff fatigue on patient safety	April 2025
Workforce and patient safety: primary and community care co-ordination for people with long-term conditions	April 2025

Appendix E Patient safety alerts received and actioned during Quarter 1 2025/26

Reference	Title	Date issued by agency	Alert applicable?	Comments
NatPSA/2025/002/UKHSA	Potential contamination of non-sterile alcohol-free skin cleansing wipes with <i>Burkholderia</i> spp: measures to reduce patient risk	26/06/2025	Yes – circulated for information	

Appendix F Learning from healthcare deaths report Quarter 1 2025/26

Cumulative data covering the period 1/4/2025 – 30/6/2025

Background context

Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. The Trust has had a Learning from Healthcare Deaths policy in place since 2017 in line with the National Quality Board guidance. It sets out how we identify, report, review 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 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. A representative from the Patient Safety Support Team attends the quarterly Regional Mortality Meetings; this aims to facilitate the dissemination of good practice around learning from deaths between organisations.

This quarterly Learning from Healthcare Deaths paper will be an appendix to the quarterly Patient Safety Oversight Report that is submitted to Quality and Safety 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. The Trust's Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable and how they will be reviewed, and how we will engage with bereaved families.

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. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.

6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)

It should be noted that there will be some overlap in reporting with other providers due to complexities in healthcare provision.

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 rapid review (2) Structured Judgement Review (3) Case note review
3	Investigation/ learning response	The Trust began working under the Patient Safety Incident Response Framework on 1 December 2023 and reviews of deaths may 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

Reported deaths are mainly service users/patients who have died whilst receiving current care in the community, or where this was within the 6 months leading up to their death. All reported deaths are reviewed to understand if the death meets the criteria for being in scope for mortality review using the criteria described earlier.

Annual Cumulative Dashboard¹ Report 2025/26 covering the period 01/04/2025 – 30/06/2025

Figure 1 Summary of 2025/26 Annual Death reporting by financial quarter to 30/06/2025

Reporting criteria		2024/ 2025 total	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	2025/ 2026 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death ²	2150	456				456
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	101				101
3	Total Number of deaths which were in scope	282	74				74
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	27				27

Figure 2 Statistical Process Control charts for all deaths reported 01/07/2023 – 30/06/2025 by date reported and all deaths which were in scope for further review

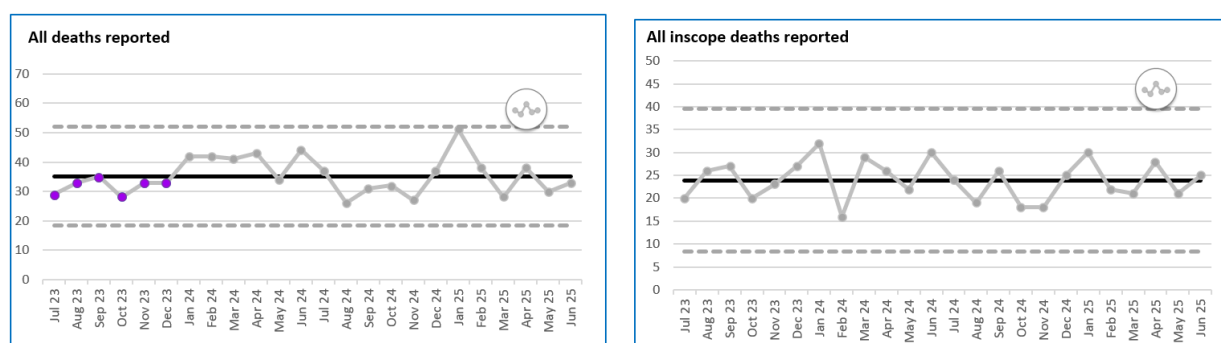


Figure 2 shows two Statistical Process Control charts over the period between 01/07/2023 - 30/06/2025. Firstly this shows all reported deaths (by reported date). There is natural variation in the data relating to those who have died which have been reported as incidents. January 2025 showed an increase in the number of deaths reported, however there are no areas of special cause variation that require further exploration at this time. Many of these deaths were not in scope in line with the criteria described above. The second chart shows those deaths which were in scope, and these were in normal variation.

¹ Dashboard format and content as agreed by Northern Alliance group.

² 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 2025/26 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Mental Health Care Group (Inpatient)	Mental Health Care Group (Community)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Cheswold Park Hospital	Children Young People and Families Care Group	Total
2025/26 Q1	0	4	59	10	0	1	0	74
2025/26 Q2								
2025/26 Q3								
2025/26 Q4								
Total	0	4	59	10	0	1	0	74

Figure 4 Summary of total number of all in scope deaths in 2025/26 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 (1 st 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	
2025/26 Q1	7	53	5	0	1	0	0	8	0	74
2025/26 Q2										
2025/26 Q3										
2025/26 Q4										
Total	7	53	5	0	1	0	0	8	0	74

Figure 3 above shows the total number of all in scope deaths in 2025/26 to date by care group. Figure 4 shows how those deaths were reviewed, with the majority of mortality reviews are undertaken through a first stage case record review (a Manager's 48 hour rapid review). This report has a singular review process for each death, although many will have also had other levels of review to aid decision making.

Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to the Learning from Life and Death Reviews LeDeR³ process. It should be noted that the figures in the sections below may not tally with the numbers by care group (in figure 3 above). This is because we

³ Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

identify Learning Disability and Autism diagnosis not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability or autism diagnosis, irrespective of where they were cared for. For example, in figure 6, of the 13 deaths, 10 patients were under the care of learning disability teams, and three were under Core Team care. Of those three patients, 2 were reported to have a learning disability, and one had an autism diagnosis.

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

Figure 5 below shows the number of learning disability/autism deaths and their status of being reported to the Learning from Life and Death Review Programme (LeDeR).

Figure 5 Summary of total number of in scope deaths in 2025/26 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
2025/26 Q1	12	1	0	13
2025/26 Q2				
2025/26 Q3				
2025/26 Q4				
Total	12	1	0	13

LeDeR reviews are led by colleagues outside of the Trust services, such as from an Integrated Care Board. This gives them objectivity and the ability to review the whole care provision of the person who has died. As these reviews can take some time to conclude, we as managers complete the Manager's 48-hour rapid review to ensure any internal learning and reflection can take place.

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not having a learning disability or autism diagnosis 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 2025/26 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response			Total
	Certification of death	Manager's 48-hour rapid review (1 st stage case note	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patient Safety Incident Investigation (PSII)	
2025/26 Q1	7	48	5	0	1	0	0	61
2025/26 Q2								
2025/26 Q3								
2025/26 Q4								
Total	7	48	5	0	1	0	0	61

Inpatient deaths

Figure 7 below shows that over the year 2025/26 to date there have been five 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 2025/26 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	
Mental Health Care Group (Inpatient)	Older People Inpatient	Beechdale	1				1
		Crofton	1				1
		Poplars	1				1
		Ward 19	1				1
Cheswold Park Hospital	Low secure	Esk Ward	1				1
Total			5				5

The inpatient related deaths in Quarter 1 all related to physical health causes. Two patients had been discharged from a mental health inpatient ward at the time of death (within 30 days of discharge and are reported in association with the ward in line with the learning from healthcare deaths policy. This is to ensure we can review to ensure any issues related to discharge can be reviewed. The other three deaths were of mental health inpatients who were detained patients, who were transferred to the acute hospital for treatment. Two of these patients died due to deterioration in their physical health. The third patient died suddenly whilst under the acute hospital care following surgery for a fractured neck of femur. The ethnicity of all five patients was the White - English/Welsh/Scottish/Northern Irish/British group.

Updates

- During Quarter 1, a review of the Mortality review group took place as part of the review of our Patient Safety Incident Response Plan. It was identified that the majority of the meeting's content focussed on processes rather than learning themes from our own deaths. As such it was felt that themes emerging from deaths we have reviewed was more appropriate to link with the re-launched Patient Safety Improvement Group. A refreshed agenda which includes learning from deaths will commence from September 2025. Processes that support the decision making around how we determine if a death resulting from a problem in care has also been reviewed in our PSIRF review.
- The outcome of Structured Judgement Reviews are reviewed/approved by care groups, and where needed, they will create action plans for identified areas of concern.
- Resource for maintaining the administration process of SJRs has reduced, adding pressure to the Patient Safety Support Team. Structured Judgement Review training continues to ensure we have staff in our pool of reviewers who can undertake reviews.
- The Bereavement Link Supporter role job description was launched on 5 May 2025 to coincide with the 'Dying Matters' week.
- Three sessions of Postvention Assisting those Bereaved By Suicide (PABBS) have been delivered this year, Feedback has been very positive.
- A questionnaire for family members about the experience of working with the Trust's family liaison officer has been developed and consulted on with Patient Safety Partners and the Quality Governance team. This is now ready to be rolled out for use by the family liaison officer when final contact with a family has taken place.
- Representatives from Patient Safety Support Team continue to attend both the Regional Mortality group (hosted by the Improvement Academy) and the Northern Alliance Group (mental health and learning disability Trusts). Both groups aim to support providers with sharing common themes across the region or Mental health settings.

Next steps

- Production of learning from deaths themes/data that will feed into the Patient Safety Improvement Group (PSIG) as described earlier
- Ensuring our PSIRF processes include identification of any case where a problem in care lead to a death occurring
- Reviewing the mortality agenda to ensure all aspects are covered.

Patient Safety Support Team
14 July 2025

Appendix G Suicide prevention update

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. There is a need for a task and finish group as an off shoot of the care planning improvement group to be created to help meet the NHSE recommendation of ensuring training incorporates the specifics of the safety from suicide guidance.

NHSE and authors of the guidance presented the information and next steps for organisations on 24th June 2025.

It is a difficult time of transition and change across the regional ICB's and NHSE's which has impacted on suicide prevention aims and objectives in West Yorkshire.

The regional 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.

SWYPFT updated guidance on supporting staff following critical or traumatic incident working guidance has been in development for 2+ years. Is now with People's Directorate for approval Also carefully shared with staff side representative who hoped to create a short paragraph of support offer not yet received.

There is now an urgent need for this document to be visible across all care teams given moves to patient safety incident response framework there has been a noted drift away from previously positive and robust response following serious incidents.

Education Funding has been received in to the organisation, a request needs to be made as a priority for the continued funding of suicide prevention training, SafeTALK and ASIST require independent trainers to support the delivery of 5 SafeTALK and 4 ASIST training in a 12 month period.

The success of the PABBS training and the excellent high rating of satisfaction from those completed also indicates a need for another 3 sessions in the next 12 months – this will be included in the investment ask from L&D

Suicide specific supervision offer will go live in July – this project which has been in development for over 2 years arose out of an ask from the workforce to have an additional offer of a safe psychological space to explore the impact of patient suicide on professionals working with or indirectly affected by suicide. 14 staff have offered to support the access and their names will be visible on the supervision section of the intranet by July 2025. The offer will be promoted and access/requests will be monitored. This also features in the new supervision operational procedural guidance document

Two Suicide prevention education and awareness sessions have been delivered this year, the third takes place on 9th July. Guest speakers have been from Leeds Mind postvention services, Amparo, postvention service, CGL – Tom Fitzsimmons, peer/community support and lived experiences and

for July Sessions – R;pple charity, Molly Rose Foundation and Papyrus. Topics are being driven by staff interest along with key priority areas for suicide prevention for the organisational strategy (due for renewal August 2025). Over 100 staff have used the sessions, access is enabled from partner organisations. More sessions are in the planning phase.

Internal near real time suicide surveillance round table review is being trialled – is early stages development but will feed into patient safety systems learning and wider mortality review processes.

Advise:

- Approval of the staff support following critical incident guidance by Peoples directorate senior leadership team is required.
- Director support required for continued delivery of suicide specific training is required.
- Assurance on information sharing protocols in place across all districts

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 – NS is to support the review on the ISA's that had been previously designed
- Drug and Alcohol Death Overview panels are utilising input from SWYPFT reviews of health care information – ISA in place for Calderdale and ISA for Barnsley is due a refresh, Kirklees is in development, Wakefield's is required for internal checking.
- Bereavement development work streams along with well-being of the workforce workstreams are including supporting staff following suicide and safety of the workforce from suicide.

Trust Board
30 September 2025
Agenda item 11.2

Private/Public paper:	Public		
Title:	Medical Appraisal and Revalidation Annual Board Report & Annual Organisational Audit (Statement of Compliance)		
Lead Director:	Professor Subha Thiyagesh – Chief Medical Officer / Responsible Officer		
Mission/values:	Ensuring that all medical staff are fit to practise and up to date supports the Trust’s mission to enable people to reach their potential and live well in the community and demonstrates the Trust’s commitment to delivering safe and effective services and being an environment that is a great place to work, and learn.		
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex A), which will be completed to complement the 2024-25 Annual Board report.		
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):	Live our Values: 1.2 - Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. Be the best we can be: 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. Be ambitious: 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	The Trust benchmarks against local and regional Trusts and uses this information to form any decisions to amend processes and policies that may		

System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	affect other organisations locally, in particular those within the 2 Integrated Care Systems. The Trust also collaborates with Barnsley Hospice to ensure objectives are aligned with regard to appraisal and revalidation processes due the Trust's Responsible Officer overseeing RO duties there also.
Any background papers / previously considered by:	Quarterly reports in the Integrated Performance Reports Previous Annual Board reports
Executive summary:	• 167 doctors had a prescribed connection with the Trust as of 31st March 2025. 7 of these doctors work in Barnsley Hospice. In addition, there was one doctor working in the Trust that is not connected to our designated body due to being on the GP specialist register, however undertook their appraisal within our Trust, and remains connected to NHS England's GP RO, as is usual practice. • It is important to note that not all doctors with a prescribed connection will be eligible for an appraisal during April 2024-March 2025. Reasons for this would include being on a short-term contract or being new to the UK during this time period and therefore calculated figures may not add up to 100% of doctors with a connection as of 31st March 2025. Please also note that the number of doctors with a GMC connection will fluctuate throughout the financial year. ○ Of the 150 Trust employed doctors (including our Chief Medical Officer/Responsible Officer) that were due to have their appraisal, over 99% (all but one) of these have successfully completed the appraisal process during the 2023/24 window, which is a slightly higher percentage than last year. ○ 4.5% of the doctors had late meetings or late submissions. All of these late submissions were approved and understood, by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate, and those that completed their appraisal within the timeframe are included in the 99% figure above. • 34 positive revalidation recommendations were made between 1st April 2024 and 31st March 2025. Two of these recommendations were in relation to Barnsley Hospice doctors. ○ There was one deferral during this period, for a doctor requiring additional time to collect multisource feedback, which is currently due for review in May 2025, and an updated decision will be made accordingly. ○ All of the positive recommendations led to revalidation of the doctors by the General Medical Council (GMC). <u>Risk appetite:</u> The Trust continues to have a robust governance system of reporting and investigating incidents including serious incidents. The following are areas of potential difficulty for the Trust: • The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other

	areas of work, doctors could withdraw from this role, thus threatening the appraisal process. • The additional risk to this is that currently doctors are not remunerated for Medical Appraiser duties in the Trust, although are asked to ensure there is allocated time within their job plans to conduct the duties effectively using their Supporting Professional Activities (SPA) time. <u>Mitigating factors:</u> • As above, appraisers are asked to ensure they have time allocated in their job plans for the medical appraiser role. • The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group. • Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained – this is monitored frequently and regular recruitment to this role is conducted. • All doctors are consistently requested to actively choose their appraiser as soon as their current appraisal has been completed, and no later than 6 months prior to their next appraisal, and regular notifications are sent by way of reminders. It should be acknowledged that due to varying factors, often outside of doctors' control, late appraisals and late submissions of appraisals by both the appraisees and the appraisers is likely to continue. The Appraisal Team actively monitors compliance and ensures support is available for any doctor struggling with engaging in the appraisal process in a timely manner. <u>Actions/Improvements Implemented 2024-25:</u> • In order to maintain high quality appraisals, a new one-day annual appraiser training event has been introduced, replacing the requirement to attend a half-day refresher session every two years, all appraisers being expected to attend annually. • Appropriate administrative checks are in place: ○ to ensure timely collection of multi-source feedback (MSF), using L2P or, for doctors working within Learning Disabilities, ACP360 as an alternative. Doctors are requested to continue to gather feedback on an ongoing basis and to commence requesting feedback as early as possible, up to 12 months prior to due date and collection can commence as early as 3 years prior to due date. Normal practice is not to release reports until the minimum number of 14 is achieved. ○ to review the appropriate minimum data set is uploaded and available for all appraisals and flag any omissions in a timely manner ○ to flag any low wellbeing scores so that these can be sensitively and confidentially reviewed within the Appraisal and Revalidation team • A review of Quality Improvement activity has been conducted for appraisal. Specifically, a manual search of appraisals was undertaken to review the number of completed audits, whether these were supervised or done jointly, evidence of POMH (Prescribing Observatory for Mental Health) audits and reflection on results, and other relevant QI activities. The outcome of this search showed a large amount of audit activity had been undertaken with the involvement of medical professionals.

	• The Trust now has 5 trained case investigators (doctors) to support investigations involving medical professionals in the Trust as appropriate. • By request, a new report has been created by the Datix team to flag incidents not linked to a consultant in order for the Appraisal and Revalidation team to review this on a monthly basis to ensure that all Red and Amber incidents are linked to a consultant as appropriate. <u>Next Steps (2025-26 Actions):</u> • A review of appraiser activity revealed that some appraisers would readily volunteer if doctors were struggling to identify an appraiser. This meant that they would in some cases carry out considerably more appraisals than the maximum advised seven per year, whereas some appraisers were doing less than this. In the interests of equity and maintaining appraiser skills, the minimum number of appraisals per appraiser each year has now been raised from three to five per year. Appraisers have all been asked to set their availability on the electronic system to facilitate this. It is hoped that this will minimise the likelihood of doctors having difficulty identifying an appraiser in good time. • Continue to monitor L2P in terms of ensuring doctors are pro-active when requesting their next year's appraiser in a timely manner • To conduct an annual in-person appraiser training development session for all appraisers to attend by way of refresher training, following the successful first session held in 2024. • The number of appraisers will continue to be monitored to ensure there is sufficient availability, with expressions of interest sent out periodically to maintain and increase numbers, , along with continuing to identify individuals expressing an interest or doctors with key qualities of a suitable future appraiser.
Recommendation:	Trust Board members are asked to: • APPROVE this report, noting that it will be shared with NHS England. • NOTE that the resource implications of medical revalidation are likely to continue to increase year on year, and with the added pressures of financial constraints, the stability of the medical appraisal processes should be prioritised.

MEDICAL APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2024-25

1. Introduction

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

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

In addition, the current arrangement is that the Responsible Officer for South West Yorkshire Partnership Foundation Trust (SWYPFT) is also RO for the medical workforce within Barnsley Hospice. An annual Service Level Agreement (SLA) is in place to support this process.

To note, SWYPFT purchased and officially adopted the services at Cheswold Park Hospital from 1st October 2024 as part of a funded agreement through NHS England. CPH medical professionals therefore became linked to the Responsible Officer and Designated body at SWYPFT during this reporting period.

The purpose of this paper is to inform the SYYPFT Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex D), which will be completed to complement the 2024-25 Annual Board report.

2. Executive Summary

- 2.1** 167 doctors had a prescribed connection with the Trust as of 31st March 2025. 7 of these doctors are doctors working in Barnsley Hospice, and, in addition, there was one doctor working in the Trust that is not connected to our designated body due to being on the GP specialist register, however undertook their appraisal within our Trust, and remains connected to NHS England's GP RO, as is usual practice.
- 2.2** It is important to note that not all doctors with a prescribed connection will be eligible for an appraisal during April 2024-March 2025. Reasons for

this would include being on a short-term contract or being new to the UK during this time period and therefore calculated figures may not add up to 100% of doctors with a connection as of 31st March 2025. Please also note that the number of doctors with a GMC connection will fluctuate throughout the financial year.

- Of the 150 Trust employed doctors (including our Chief Medical Officer/Responsible Officer) that were due to have their appraisal, over 99% (all but one) of these have successfully completed the appraisal process during the 2023/24 window, which is a slightly higher percentage than last year.
- 4.5% of the doctors had late meetings or late submissions. All of these late submissions were approved and understood, by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate, and those that completed their appraisal within the timeframe are included in the 99% figure above.

2.3 34 positive revalidation recommendations were made between 1st April 2024 and 31st March 2025. Two of these recommendations were in relation to Barnsley Hospice doctors.

- There was one deferral during this period, for a doctor requiring additional time to collect multisource feedback, which is currently due for review in May 2025 and an updated decision will be made accordingly.
- All of the positive recommendations led to revalidation of the doctors by the General Medical Council (GMC).

3. Purpose of Paper

This report is presented to the Board:

3.1 For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.

3.2 To inform of progress in medical appraisal and revalidation during 2024/25.

4. Background

4.1 2024/25 was the thirteenth year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession. As

this is the thirteenth year, most doctors in the Trust are into their third 5-year revalidation cycle.

- 4.2** L2P, the e-appraisal web-based system that the Trust continues to utilise, is based on NHS England's medical appraisal guide (MAG) 2022 model.
- 4.3** Each doctor must have a Responsible Officer (RO) who must oversee a range of processes including annual appraisal, and who will at five-yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.
- 4.4** The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.
- 4.5** The RO for SWYPFT is also the appointed RO for Barnsley Hospice through a Service Level Agreement.
- 4.6** Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards/executive teams will oversee compliance by:
 - 4.6.1** Monitoring the frequency and quality of medical appraisals in their organisation.
 - 4.6.2** Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
 - 4.6.3** Confirming that feedback from service users/patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
 - 4.6.4** Ensuring that appropriate pre-employment background checks (including pre-employment for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.
 - 4.6.5** Compliance with the Responsible Officer Regulations forms part of the Care Quality Commission inspection.

5. Governance

5.1 Trust's Appraisal and Revalidation Team

- Responsible Officer – Professor Subha Thiyagesh
- Associate Medical Director for Revalidation – Dr Mike Ventress
- Business Manager, Medical Directorate – Michelle Goth

- Medical Directorate Coordinator – Tracy McCaffrey
- People Directorate Representatives with responsibility to support Revalidation –Helen Cherry

5.2 Main Tools Utilised Centrally

- L2P (web based) – e-appraisal system
- Datix incident reporting system) – provision of incident, complaints and compliments data
- Electronic Staff Record (ESR) Manager Self-Service – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

5.3 Designated Body List

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

5.4 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. The Medical Directorate Business Manager, with the support of the Appraisal and Revalidation Team, completes the Annual Organisational Audit/Statement of Compliance (Annex D) along with quarterly reports to the Board and continues to submit quarterly reports that are included in the Integrated Performance Report (IPR)

5.5 Internal Oversight

- 5.5.1** The AMD, Business Manager and Coordinator meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes.
- 5.5.2** The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon, and to formally consider those doctors with a revalidation recommendation required within the following 12 months. Where a meeting is not possible, and if there are any urgent matters to discuss, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

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

5.5.4 The Revalidation Oversight Group has the aims:

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

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

5.6 Independent Verification

5.6.1 Independent verification is required to be undertaken every 5 years. Following a successful peer review with Leeds and York Partnership NHS Foundation Trust, a similar sized mental health Trust, in December 2022, the next review will be scheduled for 2027, in line with NHS England guidance.

6 Medical Appraisal

6.1a Appraisal and Revalidation Data – SWYPFT

	Consultant	SAS*	Fixed Term inc. Locum Appointment for Service (LAS) and Trust Grade appointments and International Fellows
Number of doctors expected to have an appraisal during the 24/25 reporting	85	46	12

period (including Chief Medical Officer)						
Number of completed appraisals during 2023/24:	82 (one doctor had 2 appraisals within this time period)	95.5 %	46 (one doctor had 2 appraisals within this time period)	98%	12	100 %
Number of missed/ incomplete or late appraisals during 2023/24 (see reasons in Appendix 1):	4	4.5 %	1	2%	0	0%
Number of doctors in remediation:	0	0%	0	0%	0	0%
Number of doctors in disciplinary processes	0	0%	0	0%	0	0%

*SAS – Specialty Doctors, Associate Specialist/Specialist doctors

NB: Please note that 2 doctors had 2 appraisals completed within the 1st April 2024 – 31st March 2025 window. This can sometimes occur due to bringing forward or postponing an appraisal slightly to accommodate periods of leave (e.g. maternity, sickness, or to align with future revalidation date).

6.1b Appraisal and Revalidation Data – Barnsley Hospice

Number of doctors as of 31 st March 2025 who have a prescribed connection to the Trust	7	
Number of completed appraisals during 2023/24:	5	71.5%
Number of missed/ incomplete or late appraisals during 2023/24(see reasons in appendix 1):	2	28.5%
Number of doctors in remediation:	0	0%
Number of doctors in disciplinary processes	0	0%

6.2 Appraisers as of 31st March 2025

6.2.1 Number of appraisers – 32 (23 consultants, including 1 from Barnsley Hospice, 9 SAS doctors)

6.2.2 The role of the appraiser is available for all substantive and some fixed term doctors to apply for, including Consultants, SAS doctors and International Fellows. There remains an active and continuous recruitment process to identify doctors who may be interested in the role. The interested doctors apply and are selected following an interview process. The Trust supports the appraisers through active job planning by their respective medical clinical leads in ensuring time is allocated. There is no additional remuneration for the role but appraisers are allocated 0.5PA in their job plan for it.

6.2.3 Support activities undertaken:

- A half day refresher training and appraiser development session was provided on 07.11.2024 for 23 appraisers and was facilitated by the AMD, along with 3 Trust appraiser trainers who are experienced Trust appraisers. In addition, a full day new appraiser training session was provided on 29.01.2025 for 4 new appraisers. To enhance the ongoing training of all appraisers, refresher training is now held on a single day annually for all appraisers. The next session is scheduled for October 2025.
- Medical Appraiser forums were held on 13.06.2024, 04.10.2024 and 20.01.2025. These sessions continue to provide an opportunity for appraisers to share ideas about good practice and discuss areas of concern/difficulty.

- Continuous improvement of the appraisal process in the Trust is also an important topic for discussion, and areas of good practice and reasons for appraisals being referred back for further work are highlighted by the AMD.

6.3 Quality Assurance Processes

- 6.3.1** There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion. In addition to this, the Trust's Medical Directorate Coordinator performs additional checks at the point of submission of a completed appraisal to ensure that there is an uploaded or completed document for each element of the minimum data set.
- 6.3.2** The Trust utilises the multisource feedback tool embedded within L2P for most doctors. This automatically flags with the doctors when they are required to undertake the colleague and patient feedback (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are only released to the doctor if they have gained the minimum number of responses (and undertaken their self-assessments) or a request for release to the Appraisal and Revalidation Team is agreed under exceptional circumstances.
- 6.3.3** The alternative ACP360tool, that the Trust adopted to obtain feedback from services users within Learning Disabilities or their carers is used by doctors within that specialty, with no reported negative feedback from users. There has been minimal use of this tool so far due to the small number of LD doctors and the timescales for their feedback due dates, and usage and feedback will be monitored as usage increases.
- 6.3.4** The Appraisal and Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (change is required after three consecutive appraisals with same appraiser). This occurs through automatic reminders to change appraiser through L2P and has continued to work successfully without issue
- 6.3.5** The AMD reviews all submitted appraisals (excluding those where the AMD is the appraiser). Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (Personal Development Plan (PDP), appraisal summary and sign-off) and where appropriate, the AMD will request further work be undertaken prior to recommending to the RO that annual appraisal is satisfactory.

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

- 6.3.6** The RO subsequently reviews completed appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.
- 6.3.7** Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 6.6). This process is embedded in the L2P system. This feedback is combined with other objective measures and observations of the AMD who provides feedback in writing to appraisers on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.
- 6.3.8** The reviews undertaken by the AMD and RO also often raise agenda items for the Medical Appraiser Forums, where particular themes are then discussed.
- 6.3.9** The appraisers receive further group feedback during Medical Appraiser Forum meetings.
- 6.3.10** Such issues are also discussed at the new appraiser and refresher training.
- 6.3.11** Due to previous issues of a minority of doctors leaving their request to have a particular appraiser until shortly before the appraisal meeting itself (which has meant appraisers may lack availability and therefore a delay in allocation or of the appraisal taking place), it has been agreed that appraisers should be chosen at least six months before the appraisal date, and doctors are advised to select next year's appraiser on L2P following their appraisal, in particular if the same appraiser is to be selected. A prompt is provided through L2P to this effect.
- 6.3.12** Doctors are asked to start collecting patient feedback at least a year in advance of the appraisal meeting, and in select specialities with limited patient contact or typically fewer patient responses, throughout the three-year feedback period.
- 6.3.13** Of note, in SWYPFT no doctor is appraised by their line manager, and this process was also adopted by Barnsley Hospice to

ensure consistency throughout. Both policies have been updated accordingly to reflect this.

- 6.3.14** In line with the implementation of the revised Good Medical Practice 2024 Guidance, there is an updated framework for Quality Assurance and Improvement from NHS England. This updated guidance has been referred to in our revised Medical Appraisal Policy, and the Appraisal and Revalidation Team have a proposed action plan in place in order to evidence application of this guidance within the Trust.

6.4 Access, security and confidentiality

- 6.4.1** The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2023/24.
- 6.4.2** Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Chief Medical Officer (CMO), AMD and the wider Appraisal and Revalidation Team, and any other person to whom the doctor provides access (via their own login).
- 6.4.3** Doctors are made aware via the L2P system that no patient identifiable information should be included in their appraisals. This is also stated in the Trust 's Medical Appraisal Policy.

6.5 Clinical Governance

- 6.5.1** All doctors are provided with a PDF formatted record (including a nil response if appropriate) of incidents, complaints and sickness for their appraisal year from the Appraisal and Revalidation Team. This data is directly uploaded to the doctor's appraisal record on L2P. Doctors are required to reflect on their involvement in incidents and complaints included in the reports and any others of which they are aware, but which may not have been linked to them via Datix.
- 6.5.2** The minimum requirement for the appraisal portfolio is provided in a Portfolio Minimum Data Set, which is reviewed every year.
- 6.5.3** Doctors are required to complete a checklist prior to submitting their appraisal to their appraiser and where key information (predominately the minimum data set) is missing, they are required to provide a reason for its absence.

6.6 Appraisal feedback

Of the 143 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	43% (54%)	52% (36%)	3% (9%)	0% (0%)	1% (1%)
Your professional development	50% (57%)	45% (37%)	3% (5%)	0% (0%)	1% (1%)
Your preparation for revalidation	55% (61%)	40% (31%)	4% (7%)	0% (1%)	1% (0%)
Promoting quality improvements in your work	44% (53%)	49% (37%)	6% (8%)	0% (1%)	1% (1%)
Improving patient care	45% (51%)	45% (35%)	8% (11%)	1% (2%)	1% (1%)

Number of hours	<1	1-2	2-3	3-4	>4
Duration of appraisal discussion	3% (4%)	69% (60%)	20% (25%)	3% (3%)	6% (7%)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The appraisal process was satisfactory	66% (73%)	32% (26%)	0% (0%)	1% (0%)	1% (1%)
I was able to collect all the necessary supporting information from the organisation	58% (59%)	37% (37%)	4% (1%)	0% (2%)	1% (1%)

*() are the 2023/24 results.

NB: 100% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again.

- 6.6.1** Every appraisee is invited to give confidential feedback after their appraisal. Each appraiser receives this feedback on an annual basis, generated by L2P, which contains both free text comments and

satisfaction scores, and which they can use for their own personal development as an appraiser. The AMD reviews these on an annual basis, both as aggregated results for the whole appraiser cohort and for individual appraisers. Any specific issues that arise are brought to the attention of appraisers by the AMD and appraisers receive a letter summarising their involvement in appraisal that year.

7. Revalidation Recommendations (1.4.24 to 31.3.25)

Number of recommendations	35 (including 2 x Hospice Doctors)
Recommendations completed on time	35
Positive recommendations	34
Deferral requests	1 (deferred into the next reporting year)
Non engagement notifications	0

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

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

See Appendix 3; Audit of revalidation recommendations

8 Recruitment and engagement background checks

8.1 Substantive and Fixed Term appointments

During 2024/25, the Trust employed 33 non-training doctors to include 7 consultants, 1 of which is a Specialty Doctor appointed into an acting consultant post, and 16 specialty doctors, 7 of which were GMC-sponsored international fellows on a mix of substantive and fixed term contracts, and including fixed term Trust grade and Locum Appointment for Specialty (LAS) posts to filling gaps in the various training rotations

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

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

- 8.1.3** For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.
- 8.1.4** Where appropriate, Medical Staffing checks the national database for Approved Clinician and Section 12 status. GMC registration is also checked.
- 8.1.5** Reference checks from the previous 3 years of employment are undertaken by Medical Staffing and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the referee is the appropriate person.
- 8.1.6** Medical Staffing would normally meet with the doctor to verify their ID using the acceptable documents list. In some circumstances, copies are requested in advance and the originals are then checked, copied, signed and scanned by the clinical lead on the doctors first day.
- 8.1.7** The Medical Directorate requests information from the doctor's current/last RO, where the doctor has had one. This includes information about the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's RO, prior to a final offer being made. Where this information is not received prior to the final offer being made*, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.
- 8.1.8** The Chief Medical Officer or delegate checks and approves the final offer letter prior to sending.
- 8.1.9** If a doctor is recruited with GMC conditions, further information from the GMC is requested.
*If requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

8.2 Supporting New Doctors

All newly appointed doctors into a non-training post receive a welcome and introduction session to appraisal and L2P, the platform used by the Trust. These sessions are conducted by the AMD for Appraisal and Revalidation within a few weeks of a doctor joining the Trust. These are usually group sessions for new starters to the Trust, and the sessions are

tailored to suit the doctors attending, bearing in mind any new doctors to the UK and NHS, such as our valuable international fellow workforce. There is ongoing back-up support for new doctors with the system support team (L2P) and the wider Appraisal and Revalidation team.

8.3 Agency Locum appointments

- 8.3.1** Agency locum doctors do not have a prescribed connection to the Trust. Their connection is with their locum agency. It is the agency's responsibility to ensure their doctors are appraised and revalidated. However, the Trust's processes to engage locums do include appraisal and revalidation checks.
- 8.3.2** The Trust engages with PlusUs, which offers a Direct Engagement service solution through a system which will source the market for available doctors across the framework suppliers and a direct engagement service which provides a temporary Trust contract that does not attract VAT. They also provide an on-line portal which advertises / searches temporary clinical roles across the full range of approved framework suppliers.
- 8.3.3** The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas, with the support of the Medical Directorate Recruitment Officer (MDRO). The MDRO provides additional support with collating and centralising data in connection to agency locums.
- 8.3.4** PlusUs provides suitable CVs and references through an online portal.
- 8.3.5** If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.
- 8.3.6** If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, Occupational Health clearance, Right To Work etc.
- 8.3.7** In line with the Trust guidance on booking locum doctors, the appropriate Clinical Lead is then required to undertake a telephone interview prior to commencement.
- 8.3.8** In line with Trust guidance on booking locum doctors, on their first day a locum doctor's identification should be verified through the checking of their passport or photo-card driving licence by the medical clinical lead or nominated person.

9. Monitoring Performance

- 9.1** Doctors are generally monitored through their team management structures.

- 9.2** In addition, a doctor's performance is monitored via the appraisal system, which includes a Trust requirement for multi-source feedback from service users and colleagues on a three-yearly basis, or within 12 months for a new doctor commencing work in the Trust. Please note that this stipulation is more frequent than the 5-yearly expectation from GMC guidance and will continue to be included in the Trust's Medical Appraisal Policy.
- 9.3** Information in relation to whether a doctor is involved in serious incidents or subject to complaints is also included in the appraisal system.
- 9.4** Serious incidents are investigated using the Trust's investigation procedures, carried out by trained investigators.
- 9.5** In the event that any concerns are raised, these are referred to the Responsible Officer who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

10. Responding to Concerns and Remediation

- 10.1.** The Trust has a Responding to Concerns and Remediation Policy which was previously reviewed and approved in September 2021. The next review of this policy has recently been conducted and is in the final stages of sign-off, due to a request for extension beyond September 2024. This was due to varying factors such as the adoption of Cheswold Park Hospital, and the fact that a thorough review was required following a streamlined review in 2021 post Covid.
- 10.2.** As at 31.3.25 the Trust has 1 trained Case Manager and 5 trained Case Investigators, all of whom are medical consultants, and conduct investigations as required in-keeping with MHPS process. Case investigators play a crucial part in responding to concerns about a doctor's practice. Their role is to examine relevant evidence in line with an investigation's terms of reference, determine findings of fact and produce a report.

The investigator will ask the practitioner for a response to the concerns raised, resolve any conflicts of evidence; determine the facts and produce a report which accurately captures all relevant details and findings. All investigators also have a duty to maintain confidentiality and ensure that the investigation is documented.

These case managers, often senior figures like Medical Directors, oversee the investigation process, appoint investigators, ensure proper procedure and confidentiality, and facilitate the development of support or remediation plans for the doctor, focusing on a fair and effective resolution while protecting patient safety.

- 10.3.** A Responding to Concerns Advisory Group meets monthly. It is chaired by the RO and is also attended by the Chief Medical Officer (currently both roles are held as one), Chief People Officer or Deputy, the AMD for Revalidation, Chief Nurse & Director of Quality and Professions or Deputy, and the Medical Directorate Business Manager or alternative cover as required. Relevant representatives may attend as and when required. This approach ensures a consistent and open view is taken across the Trust in the investigation and review of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.
- 10.4.** Remediation, when identified, is carried out on an individual basis, being tailored to the individual's needs.

11. Improvements Implemented 2024-25

- 11.1** In order to maintain high quality appraisals, a new one-day annual appraiser training event has been introduced, replacing the requirement to attend a half-day refresher session every two years, all appraisers being expected to attend annually. The sessions are facilitated by the AMD and appraiser trainers. This session is now much more interactive, with role-play, exercises and group discussion.
- 11.2** Now that we have a full time substantive Medical Directorate Coordinator who is fully up to speed, additional checks remain in place:
- to ensure timely collection of multi-source feedback (MSF), using L2P or, for doctors working within Learning Disabilities, ACP360 as an alternative. Doctors are requested to continue to gather feedback on an ongoing basis and to commence requesting feedback as early as possible, up to 12 months prior to due date and collection can commence as early as 3 years prior to due date. Normal practice is not to release reports until the minimum number of 14 is achieved.
 - to review the appropriate minimum data set is uploaded and available for all appraisals and flag any omissions in a timely manner
 - to flag any low wellbeing scores so that these can be sensitively and confidentially reviewed within the Appraisal and Revalidation team
- 11.3** A review of Quality Improvement activity has been conducted for appraisal. Specifically, a manual search of appraisals was undertaken to

review the number of completed audits, whether these were supervised or done jointly, evidence of POMH (Prescribing Observatory for Mental Health) audits and reflection on results, and other relevant QI activities. The outcome of this search showed a large amount of audit activity had been undertaken with the involvement of medical professionals.

- 11.4** The number of appraisers is monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance, and all appraisers are asked to encourage new doctors into the appraiser roles if there are qualities and interest highlighted in a doctor's appraisal.
- 11.5** The Trust has additional trained case investigators, to complement the existing Case Investigator, and so there are currently 5 doctors in the Trust who are appropriately trained in order to support investigations involving medical professionals in the Trust as appropriate.
- 11.6** The Trust has reviewed and updated the Medical Appraisal Policy in 2024.
- 11.7** As the Mandatory Training Matrix from ESR is no longer being sent by email to individuals, the Appraisal and Revalidation team now email and guidance to all doctors to remind that this needs to be added in the required format to appraisal on L2P. Appraisers are asked to ensure that this is being included as requested, and this has been added to the minimum data set for appraisal.
- 11.8** By request, a new report has been created by the Datix team to flag incidents not linked to a consultant in order for the Appraisal and Revalidation team to review this on a monthly basis to ensure that all Red and Amber incidents are linked to a consultant as appropriate.

12. Next Steps (2025-26 Actions)

- 12.1** A review of appraiser activity revealed that some appraisers would readily volunteer if doctors were struggling to identify an appraiser. This meant that they would in some cases carry out considerably more appraisals than the maximum advised seven per year, whereas some appraisers were doing less than this. In the interests of equity and maintaining appraiser skills, the minimum number of appraisals per appraiser each year has now been raised from three to five per year. Appraisers have all been asked to set their availability on the electronic system to facilitate this. It is hoped that this will minimise the likelihood of doctors having difficulty identifying an appraiser in good time.

- 12.2** Continue to monitor L2P in terms of ensuring doctors are pro-active when requesting their next year's appraiser in a timely manner
- 12.3** To conduct an annual in-person appraiser training development session for all appraisers to attend by way of refresher training, following the successful first session held in 2024. As an outstanding action from, there is still a commitment to record a session by the AMD to use during introduction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically.
- 12.4** The number of appraisers will continue to be monitored to ensure there is sufficient availability, with expressions of interest sent out periodically to maintain and increase numbers, , along with continuing to identify individuals expressing an interest or doctors with key qualities of a suitable future appraiser.

13. Recommendations

- 13.1** For the Quality and Safety Committee to receive and approve for review and approval by The Trust Board
- 13.2** The Trust Board is asked to recommend for approval and submission to NHS England.
- 13.3** The Trust Board is further asked to recognise that the resource implications of medical appraisal and revalidation processes are likely to continue to increase year on year.

APPENDIX 1
AUDIT OF LATE APPRAISALS DURING 2024/25

DOCTOR FACTORS	CONSULTANT PSYCHIATRISTS	SAS/TRUST GRADE/OTHER (including Hospice Staff)
Parental Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	0	0
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	0
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	0
Lack of engagement of doctor	0	0
Other doctor factor e.g. bereavement, sickness, or other time factors not applicable elsewhere	1 (meeting late by 4 months due to jury service and other ongoing work pressures)	0
APPRAISER FACTORS	NUMBER	
Unplanned absence of appraiser	2 (1 x late submission of Jan 2025 appraisal due to jury service of appraiser and other ongoing work pressures, 1 x late submission of Nov 2024 appraisal due to accident and then bereavement)	3 (2 x late submissions of Feb 2025 appraisals due to bereavement, 1 x late meeting and submission of Jan 2025 appraisal due to bereavement)
Lack of time of appraiser	1 (late submission by 5 months due to workload pressures)	0
Other appraiser factor (describe)		
ORGANISATION FACTORS	NUMBER	
Administration or management factors	0	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe) – suspension of appraisal due to Covid-19	0	0

NB: It should be acknowledged that there is an expectation that due to busy schedules and staffing vacancies, there is a likelihood that some late submissions will continue and the Appraisal and Revalidation team will continue to monitor this to ensure support is in place for doctors struggling to participate in the appraisal process in a timely manner.

**Appraisees are continually encouraged to request an appraiser early, in some cases the same appraiser can be requested immediately after completion of an appraiser. The Appraisal and Revalidation Team do not allocate appraiser; however, will step in to assist if a doctor is struggling to secure an appraiser within a timely manner.*

APPENDIX 2
QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED – 145*		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.24-31.3.25)	NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS
APPRAISAL INPUTS		
Scope of work	145	145
Is continuing professional development compliant with GMC requirements?	145	145
Is quality improvement activity compliant with GMC requirements?	145	145
Has a patient feedback exercise been completed?	145	140
Has a colleague feedback exercise been completed?	145	140
Have all complaints been included and appropriately reflected on?	145	145
Have all significant events been included and appropriately reflected on?	145	145
Is there sufficient supporting information from all the doctor's roles and places of work?	145	145
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	145	145
APPRAISAL OUTPUTS		
Appraisal summary	145	140
Appraiser statement	145	140
PDP	145	140

All deficits were addressed satisfactorily after the appraisal had been referred back.

*Please note two doctors had two appraisal meetings within the 2024/25 window.

APPENDIX 3

AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2024 to 31 March 2025)

Recommendations completed on time (within GMC recommendation window)	35
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	35
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe). Appraisal and Revalidation team meeting was missed due to short notice bank holiday given in May 2022. This resulted in a 1-day late recommendation. There were no implications with regard to this short delay and the recommendation was still within the GMC accepted timeframe.	0
TOTAL (sum of late and missed)	0

APPENDIX 4

AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTISE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTISE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	0	0	0
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short-term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.24 and 31.3.25)				0
Number of doctors who have had local restrictions placed on their practise in the last 12 months				0
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.24 and 31.3.25				0
Number of doctors who underwent or undergoing GMC Fitness to Practise procedures between 1.4.24 and 31.3.25				1
Number of doctors who had conditions placed on their practise by the GMC or undertakings agreed with the GMC between 1.4.24 and 31.3.25				1 (same doctor as above)
Number of doctors who had their registration / licence suspended by the GMC between 1.4.24 and 31.3.25				0
Number of doctors who were erased from the GMC register between 1.4.24 and 31.3.25				0
NHS Resolution ACTIONS				
Number of doctors about whom NHS Resolution has been contacted between 1.4.24 and 31.3.25				0
Reason for contacts:				
For advice				
For investigation				0
For assessment				0
Number of NCAS investigations performed				0
Number of NCAS assessments performed				0

Where 5 or more doctors have concerns about their practise in the year, a breakdown of appropriate protected characteristics will be provided

**Trust Board
30 September 2025
Agenda item 11.3**

Private/Public paper:	Public		
Title:	Guardian of Safe Working Annual Board Report		
Lead Director:	Professor Subha Thiyagesh		
Mission/values:	Ensuring that all resident doctors are able to fulfil their duties with all appropriate information, support and opportunities provided to enable individuals to reach their full potential in a safe and engaging environment, which supports the Trust's mission and commitment to delivering a service that enables people to reach their potential and live well in their community.		
Purpose:	The Purpose of this paper is to inform the People Remuneration Committee that all aspects of the Guardian of Safe Working role is being covered and supported by the postholder and wider Medical Education Department and Medical Directorate, in order to fulfil our contractual obligations and education duties and responsibilities to the resident doctors within the Trust.		
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):	Be the best we can be: 2.3 - Failure to create a learning environment leads to lack of innovation and to repeat incidents. 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. Be ambitious: 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	Our Trust provides placements for resident doctors spanning across West Yorkshire and South Yorkshire localities, including 2 integrated care systems		

Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	and several training programmes within NHSE Yorkshire & Humber, and work collaboratively and have close links to those organisations in order to focus on equity Trustwide and streamline processes by sharing good practice across all localities. The Trust accommodates fluctuating demand for expansion, and manages gaps in rotations effectively on an ongoing basis, and works continuously with other directorates including Medical HR/People Directorate in the organisation to enable us to fulfil our contractual obligations.
Any background papers / previously considered by:	Quarterly reports, Medical Education TAG meetings Previous GOSW annual reports
Executive summary:	The 2016 junior doctors' contract introduced stronger safeguards to prevent resident doctors from having to work excessive hours. All the Trust's generic work schedules include rota patterns that are compliant with the terms and conditions of this contract. There are Trust-wide processes to ensure that resident doctors doing extra shifts continue to work within safe limits. There have been very few Exception Reports (ERs) generated, with a total of 19 in this reporting year. This is not unusual compared to other Trusts providing mainly mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties. A framework agreement has been published outlining plans for exception reporting reform for resident doctors in England, with implementation planned for September 2025. The new exception report reforms may lead to a significant change in rates of exception reporting and the Guardian of Safe Working and Postgraduate Medical Education Lead are coordinating efforts to ensure the trust is ready for the changes. Engagement with resident doctors is extremely good with excellent attendance at the Resident Doctors Forum. Staffing and IT issues have made the timely production of rotas challenging, affecting trainees' ability to arrange study and annual leave in an appropriate way. There is now an agreement for the e-Rostering Team to take on the day-to-day management of rotas, with additional funding agreed to appoint sufficient staff. There is planned recruitment to assure that staffing within the People Directorate remains adequate to complete the timely production of Work Schedules.
Recommendation:	The Trust Board members are asked to: • RECEIVE and APPROVE this annual board report and data provided within it. • NOTE the ongoing challenges placed upon the Guardian of Safe Working post-holder and wider Medical Education Department, recognising that in

	order to continue to deliver our commitment to resident doctors and medical education, and to support the newly achieved teaching trust status that there is likely to be a requirement to increase resources both within Medical Education and also Medical Staffing/HR in order to accommodate continued expansions and be able to provide the best learning environment for our resident doctors that we can.

Annual Report on Safe Working Hours: Resident Doctors (April 2024 - March 2025)

Introduction

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is of paramount importance for the NHS and significant staff fatigue can pose a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours (GoSW). The GoSW is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The GoSW will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Guardian is independent of Trust management and the Guardian's main roles are to:

- Champion adherence to safe working hours.
- Oversee safety-related exception reports and monitor compliance with the system.
- Escalate issues for action where not addressed locally.
- Request work schedule reviews to be undertaken where necessary.
- Intervene as required to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Provide assurances on safe working and compliance with TCS.
- Submit a quarterly and an annual report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Resident Doctor's Forum (Formerly Junior Doctors' Forum)
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees / Medical Bank
- Actions taken
- Summary

High level data

Number of doctors in training (total):	81 although, this figure can fluctuate during the year, due to vacant posts
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Provided by the medical education team
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Challenges and Actions

A number of concerns have been raised by trainees about the process in the Trust for supplying them with details of their rota. It appears that there is insufficient time for administrative staff with rota coordinator responsibilities to supply personalised rotas and manage trainee leave. Good rostering guidance from the British Medical Association (BMA) and NHS England (NHSE) recommends that trainees should get their generic work schedule 8 weeks before commencing the post and their full personal rota 6 weeks before starting. They should also be allowed to preference annual leave dates prior to starting in a post. As a Trust we are not achieving this. This has led to concerns being raised by trainees with the local negotiating committee and the BMA. There have been other issues in certain localities within the Trust making it hard for trainees to get annual and study leave approved.

Meetings are on-going involving the Medical Directorate Business Manager, the Postgraduate Medical Education Lead and staff from the People Directorate, to try to find a workable solution to managing resident doctor rotas and make the process of arranging study and annual leave smoother for resident doctors. Specific examples include:

- 1) Calderdale and Kirklees Day Rota: Historically 9-5 cover has been organised differently from the out-of-hours rota, with resident doctors receiving short notice about their duties. This has created significant challenges in arranging study and annual leave. Following a number of discussions, as of August 2024, the trainee, named as on-call for that day now acts as the back-up for ward cover at the in-patient units. The rota will be circulated to resident doctors 6 weeks before they start their post. A decision was made to require resident doctors placed in the community on this rota to remain on-site. This created difficulties with their core placements and so from April 2025 they will attend their community placement and only attend the wards when needed. In addition, all the ward-based trainees have been supplied with mobile phones to ensure that the ward staff can contact them, rather than resorting to calling the on-call doctor, if they can't see their own medical staff on the ward.

- 2) Advance Notice of Rotas for FY2 starting in December: Historically, rota coordinators have generated rotas for the full 6-month placement of trainees on CT and GPVTS rotations. FY doctors rotate every 4 months and so trainees starting in December have been sent their rota for the first 2 months of their placement before starting but have had to wait until the February rota was completed to see the later part of their rota. Moving forwards, rota coordinators will be asked to send all trainees their full rota 6 weeks before they commence their post.
- 3) Advance Requests for Leave: Historically, when post-graduate administrative staff were creating rotas, they would ask trainees to preference annual leave before they started, so that rotas could accommodate leave. This is in keeping with good rostering guidance and trainees are used to this approach in other Trusts. Since this task has passed to staff with other administrative roles, outside of the Medical Education Team, these administrators do not have sufficient time to complete this. Once rota coordination sits within the e-Rostering Team, it is hoped that the system will be much more flexible.
- 4) Less Than Full-Time (LTFT) Rotas: Unfortunately, the IT system used by the Trust to create rotas (Allocate), does not currently generate bespoke rotas for LTFTs based on their working days and percentage of Full-Time (FT). It is hoped that the roll-out of e-rostering will address some of these issues, as the team become more familiar with how the medical staff work (eRostering has already been rolled out to Calderdale and Kirklees and will include Wakefield and Barnsley from August 2025).

Resident (Formerly Junior) Doctors' Forum

The setting up of a Resident Doctors' Forum is a key requirement of the new contract. The forum meets quarterly. The role of the forum is to advise the Guardian on all aspects of the role.

All resident doctors within the Trust are invited to the forum with over 40 attending the last meeting in February. Particular efforts have been made to ensure that representatives of all the Care Groups and rotas are able to attend. The other key attendees are the Associate Medical Director for Postgraduate Medical Education, The Postgraduate Medical Education Lead, The Champion of Less Than Full-Time Training, the Local Negotiating Committee Chair or representative and the People Directorate Representative. The local BMA industrial relations officer has also attended most of the meetings.

The Champion of Less Than Full-Time Training has been proactive, arranging drop-in sessions for Less Than Full-time Trainees and a WhatsApp group for them to stay in touch and raise any concerns they have.

Few of the issues raised at the forum relate to hours of work. The Wakefield 1st on-call rota remains the busiest and there is no easy solution to issues such as the travel time to The Poplars, which means that the trainee is away from the Fieldhead

site for prolonged periods of time. This issue will be addressed through the Transformation of Older Peoples Services programme and the closure of the Poplars over the next 12 months. The development of an additional rota for Foundation doctors to work alongside the Wakefield 1st on-call doctor at weekends should reduce pressure at the time when they are most stretched. Resident doctors on the Wakefield 2nd on-call rota have also raised concerns about the rota getting busier. A monitoring exercise has just been completed, to examine whether changes need to be made to this rota.

Other concerns raised relate to the challenges noted above regarding the timely provision of rotas and difficulties for resident doctors to arrange leave. Plans are in place to try to resolve this.

Where concerns do not relate directly to the contract, issues are raised with the relevant clinical lead or the associate medical director (AMD) for postgraduate medical education. For example, resident doctors raised concerns about medical cover for patients who needed to remain in the Section 136 suites for a prolonged period. As a result, the Guardian convened a meeting of senior medical staff to ensure that Trust procedures were updated to give clarity to resident doctors.

Foundation Year 1 (FY1) doctors in Barnsley continue to participate in the acute medical on-call rota within the acute Trust, unlike FY1 doctors in other parts of the Trust. This was noted as having an impact on time spent in their Psychiatry placement. Assurances were given that this commitment would be reduced but the Resident Doctors Forum was concerned to hear that Foundation doctors were being put under pressure to continue on the busy medical rota. Following meetings with acute Trust staff and the Training Programme Director, there were plans for Barnsley FY1s to be removed from the acute trust rota from August, but this has been delayed due to processes within the acute Trust.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Resident doctors from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Resident doctors are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by resident doctors. These are doctors from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme, although Barnsley's 1st on-call rota also includes non-training Specialty Doctors. The 2nd on-call rotas for each locality and at Newton Lodge are staffed partly by Higher Trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendix demonstrate the breakdown of the different grades of Resident doctors in each locality, also noting the areas where there are vacancies. Recruitment to all schemes has generally been good, although we do have vacancies at times or gaps associated with trainees on maternity leave. Recruitment to core training posts in Psychiatry has improved over the last couple of years. Expansion of Core and Foundation training has started with additional higher training posts promised over the next 12 months. This is especially welcome as historically, this Trust has had comparatively few higher training posts in comparison to neighbouring Trusts. This has an immediate impact on middle-tier rotas but is also important for consultant recruitment over the next few years.

Exception Reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: [Rota-rules-at-a-glance_0.pdf \(nhsemployers.org\)](https://www.nhsemployers.org/rota-rules-at-a-glance-0.pdf)

Each resident doctor receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a resident doctor is required to work beyond those hours, or if work commitments prevent them from attending required training, the resident doctor is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees to an ER regarding additional hours, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

There has been a total of 19 ERs in this reporting period, which is an increase from 13 ERs in the previous reporting year. There have only been a few ERs completed in SWYPFT since the introduction of the new contract (<80). This is to some extent reassuring, although there does appear to be a degree of reluctance amongst trainees to complete ERs. The results of a survey of trainees in 2021 show that for most trainees, this is because there had been nothing for them to report. However, others report various concerns; these include uncertainty as to how to complete the report or what would constitute an exception. Others were concerned that exception reporting would not achieve anything and might lead to them being seen as causing trouble. Trainees in other Trusts have related experiences where they were actively discouraged from exception reporting or even explicitly told that they must not do so whilst in a particular department. There have never been any reports of such behaviour within this Trust, but it does make it understandable that trainees experiencing such behaviour in other Trusts might be reluctant to use the system. In order to address these concerns, the GoSW now has longer sessions with new trainees at induction and has produced more detailed information about exception reporting in their induction pack. Admin staff also follow up the emails sending the login details for the Allocate system, to ensure that trainees have received them and understand how to access the system. The new changes to the exception reporting

system, due to be implemented by September 2025, should address some of these concerns.

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

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	7	7	0
GPVTS	0	1	1	0
CT1-3	0	10	10	0
ST4-6	0	1	1	0
Total	0	19	19	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	2	5	0
GPVTS	0	0	1	0
CT1-3	0	0	10	0
ST4-6	0	0	1	0
Total	0	2	17	0

For the exceptions noted in the tables above, the actions were:

- 1) In 12 cases, Resident doctors working additional hours were given time off in lieu.
- 2) In 3 cases payment for additional work was agreed.
- 3) 3 ERs were related to educational issues which were resolved following the supervisors return from emergency leave.
- 4) 1 ER was created in error by a trainee, who was confused about terminology (other types of ER are submitted to NHSE related to patient safety incidents).

There were issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. All clinical supervisors have addressed the ERs once prompted. However, some delays have been prolonged, in part due to difficulties organizing payment for resident doctors hosted by the Trust but employed by neighbouring Trusts.

Fines

Should certain of the hours and rest rules under the new contract be broken, a fine will be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to be used to improve training within the Trust. None of the ERs received so far have resulted in a fine. Despite no fines being levied at this stage, a decision has been made to identify a cost code and a member of finance personnel to support audit of any funds, should fines be levied.

Work schedule reviews

The new contract requires that generic work schedules, detailing work patterns and pay, be sent to trainees prior to commencement of the post and in most cases, this was achieved. Trainers have also been asked to specify in trainees' timetables, an hour a week for work on their training portfolio. On occasion, there have been issues relating to the responsibilities of the employing Trust and the host Trust to send this information to the trainees, but these have been addressed. Following commencement of the post, the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post. The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period.

Rota gaps and cover arrangements

The number of gaps on rotas has remained high again this year (See graph below), affecting all areas but especially Barnsley, Calderdale and Kirklees. The following table details rota gaps by area and how these have been covered. There were 3 shifts where it was not possible to obtain junior doctor cover, with 2nd on-call doctors stepping down to cover the role.

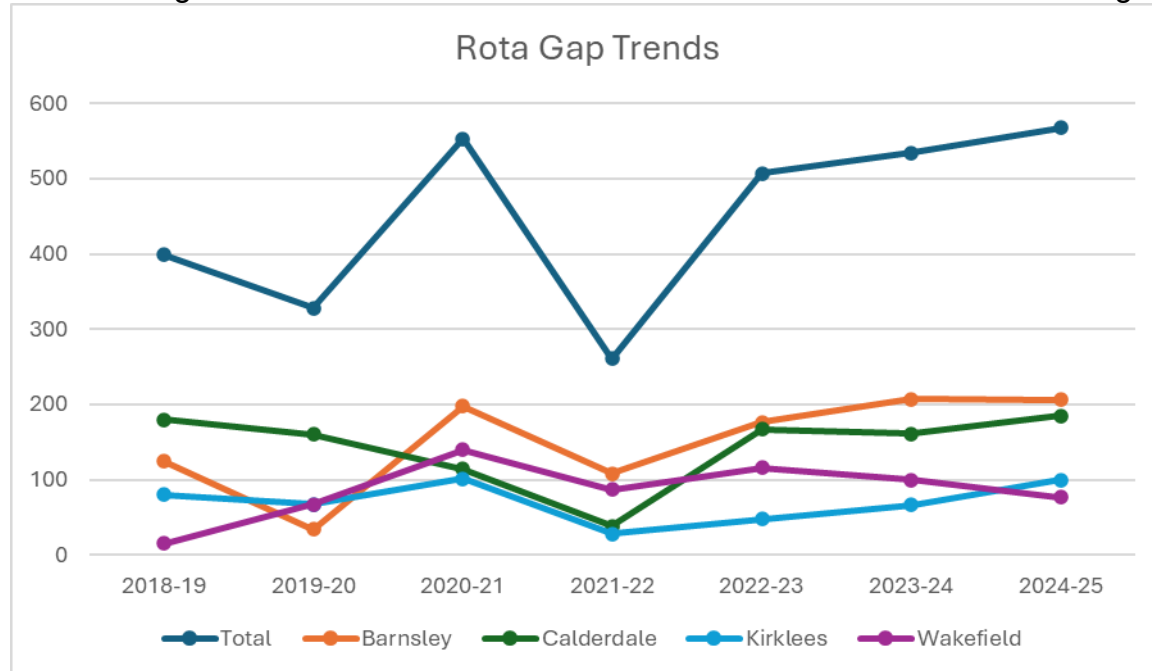
Gaps by rota April 2024 – March 2025					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other Trust staff	Number (%) vacant
Barnsley 1st	206 (28%)	206 (100%)	0	0	0
Calderdale 1st	185 (25%)	185 (100%)	0	0	0
Kirklees 1st	100 (27%)	100 (100%)	0	0	0
Wakefield 1st	77 (11%)	74 (96%)	0	0	3 (4%)
Total 1st	568 (22%)	565 (99%)	0	0	3 (1%)

Colleagues in Postgraduate Administration have been able to capture some information about the financial cost to the Trust of covering rota gaps.

Costs of Gaps by rota April 2024 – March 2025				
1 st On-Call Rotas	Shifts (Hours) Covered by Bank	Cost of Shifts Covered by Bank	Costs Directly attributable to COVID-19	Shifts (Cost (£)) Covered by Agency
Barnsley	206 (1860)	£70,780.00	0	0
Calderdale	185 (1987)	£89,524.75	0	0
Kirklees	100 (2022)	£70,770.00	0	0
Wakefield	77 (870.75)	£35,103.75	0	0
Total	568 (6739.5)	£266,178.50	0	0

The main reasons for gaps include sickness or occupational health recommendations, vacancies and the placement of LTFT resident doctors in a full-

time training slot. The industrial action did have a small effect during Q1.



Locum work carried out by Trainees / Medical Bank

The Trust is largely reliant on the current Resident doctors to do locum shifts to fill the gaps on the rota. However, a number of doctors who have worked with the Trust previously have joined the Medical Bank. This means that almost all shifts have been covered.

Postgraduate administrators and the Medical Bank staff ensure that resident doctors undertaking locum shifts, sign the European Working Time Directive (EWTd) waiver. This allows trainees to work up to an average of 56 hours a week instead of the usual 48 hours a week. Rota coordinators then monitor to ensure that individual doctors are not taking on excessive additional hours / shifts.

Actions taken to resolve issues

There have been no significant actions arising out of trainees' working hours. All ERs were dealt with appropriately and they did not require there to be fines or work schedule reviews.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract. The monitoring exercise for higher trainees in Wakefield will be examined to establish whether any changes need to be made to this rota.

The Postgraduate Medical Education Lead has implemented processes Trust-wide to ensure that resident doctors doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experience for our resident medical staff.

As described above, there have been very few ERs generated, with a total of 19 in this reporting year. This is not unusual compared to other Trusts providing mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties. The new exception report reforms may lead to a significant change in rates of exception reporting and the GoSW and Postgraduate Medical Education Lead are coordinating efforts to ensure the trust is ready for the changes.

Engagement with resident doctors remains extremely good. The attendance at the Resident Doctors Forum is excellent, generating lively discussion about issues affecting resident doctors and developing strategies to improve their experience of work and training with the Trust.

Staffing and IT issues have made the timely production of rotas challenging, affecting trainees' ability to arrange study and annual leave in an appropriate way. There is now an agreement for the e-Rostering Team to take on the day-to-day management of rotas, with additional funding agreed to appoint sufficient staff. There is planned recruitment to ensure that staffing within the People Directorate remains adequate to complete the timely production of Work Schedules.

Recommendation

Trust Board is asked to note this report and the challenges.

Appendix – Trainee distribution as of March 2025

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	3	3	Sheffield Health and Social Care Trust
GP Trainee	1	1.6	Barnsley Hospital NHS Foundation Trust
CT1-3	5	4.6	Sheffield Health and Social Care Trust
LAS	0	0	South West Yorkshire Partnership NHS FT
FY2	1	1	Barnsley Hospital NHS Foundation Trust
FY1	3	3	

Calderdale & Kirklees

Grade of Trainee	Number Expected	Number in Post (WTE)	Employer
ST4-6	4	3.6	South West Yorkshire Partnership NHS FT
GP Trainee	9	8.4	Calderdale and Huddersfield NHS FT
CT1-3	11	9.8	South West Yorkshire Partnership NHS FT
LAS	0	1	South West Yorkshire Partnership NHS FT
FY2	4	4	Calderdale and Huddersfield NHS FT
FY1	5	5	Calderdale and Huddersfield NHS FT

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	6	4.4	South West Yorkshire Partnership NHS FT
GP Trainee	4	3.3	Mid Yorkshire NHS Trust
CT1-3	10	8.6	South West Yorkshire Partnership NHS FT
LAS	N/A	0	South West Yorkshire Partnership NHS FT
FY2	2	2	Mid Yorkshire NHS Trust
FY1	4	4	Mid Yorkshire NHS Trust

Forensic: Newton Lodge /Bretton /Newhaven

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	7	6.6	South West Yorkshire Partnership NHS FT

CAMHS / LD

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6 CAMHS	2	2	South West Yorkshire Partnership NHS FT
ST4-6 LD	1	1	South West Yorkshire Partnership NHS FT

**Trust Board
30 September 2025
Agenda item 11.4**

Private/Public paper:	Public		
Title:	Green Plan 2025 – 2028		
Lead Director:	Dawn Lawson, Executive Director of Strategy, Inclusion and Change/Deputy Chief Executive		
Mission/values:	This work is in line with the Trust mission and values		
Purpose:	To share the proposed green plan for 2025 to 2028 for approval		
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):	4.4		
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 draft green plan is in line with the work on sustainability at both South and West Yorkshire integrated care systems A draft version of the plan was shared with both sustainability leads for their comments. Feedback has been received from the South Yorkshire lead that they have nothing to add as the plan covers everything that is required as a strategic high level document.		
Any background papers / previously considered by:	Social Responsibility and Sustainability annual report have previously included Green plan updates.		
Executive summary:	In line with the Trust strategy and the Social Responsibility and Sustainability strategy we have developed a green plan which sets out the key actions that South West Yorkshire Partnership Teaching NHS FT (the Trust) will take to deliver emissions reductions and support resilience to climate impacts over the next three years.		

	The plan describes our commitment to this agenda. It is set out under the headings for the green plan described in the national guidance for the document. Under each area we have described our achievements so far and identified the headline actions that we will take between now and 2028. The plan has been shared with the Equality, Involvement and Inclusion committee (EIIC). A more detailed delivery plan will be developed to ensure the actions in the plan are achieved. This delivery plan will be shared with the Equality, Involvement and Inclusion Committee at a future meeting and monitored through the regular reporting into this committee
Recommendation:	Trust Board members are asked to: • RECEIVE the proposed plan and APPROVE it for: ○ adoption ○ sharing with NHS England ○ publication on our Trust website

A large circular graphic composed of numerous blue brushstrokes of varying shades, arranged in concentric rings to form a textured, circular border around the central text.

Green Plan 2025 – 2028

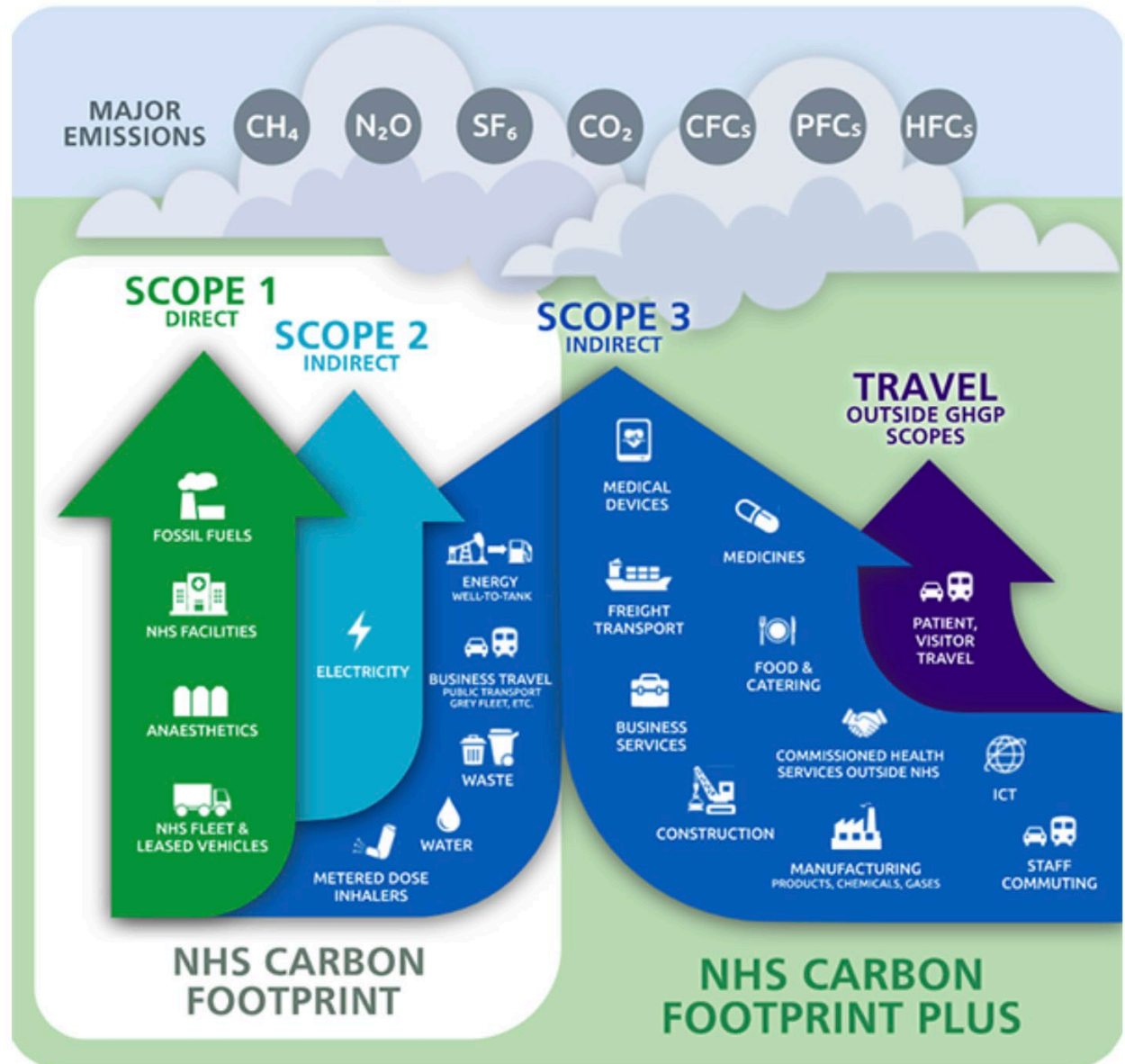
**Trust Board 30th
September 2025**

The purpose of the green plan, why we need it

The purpose of the green plan is to set out the key actions that South West Yorkshire Partnership NHS FT (the Trust) will take to deliver emissions reductions and support resilience to climate impacts over the next three years.

As an NHS organisation we need a green plan because:

- The NHS is the largest employer in the UK and the fifth in the world.
- The impact that the NHS has on the environment is enormous.
- We are already suffering the outcomes of climate change's extreme events that are occurring now.
- The NHS has a moral responsibility to eliminate the health service's carbon emissions.



For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

“Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists.”

Lord Darzi (2024)

This green plan is in line with the three shifts set out nationally and reiterated in the 10 year plan

- From hospital to community
- From analogue to digital
- From sickness to prevention



With **all of us** in mind.

Development of the plan



**South West
Yorkshire Partnership**
NHS Foundation Trust

In the development of this plan we have

- Reviewed our progress on the green agenda and engaged with key stakeholders both internal via our steering group and with regional and national colleagues
- Considered the national targets on sustainability for the NHS
- Confirmed our areas of focus, identified our achievements and key, headline actions for the next three years
- Confirmed our governance arrangements and processes for measurement and reporting
- Presented a draft to our Executive Management Team, our Equality, Involvement and Inclusion Committee and shared with our ICS leads in both South and West Yorkshire. This version includes any feedback from this process

This plan is a high level document which sets out the strategic context, our commitments and the priority areas of focus for the next 3 years

It will be supported by the development of a delivery plan which will contain the detailed plans and measures



With **all of us** in mind.



**South West
Yorkshire Partnership**
NHS Foundation Trust



Our strategic context

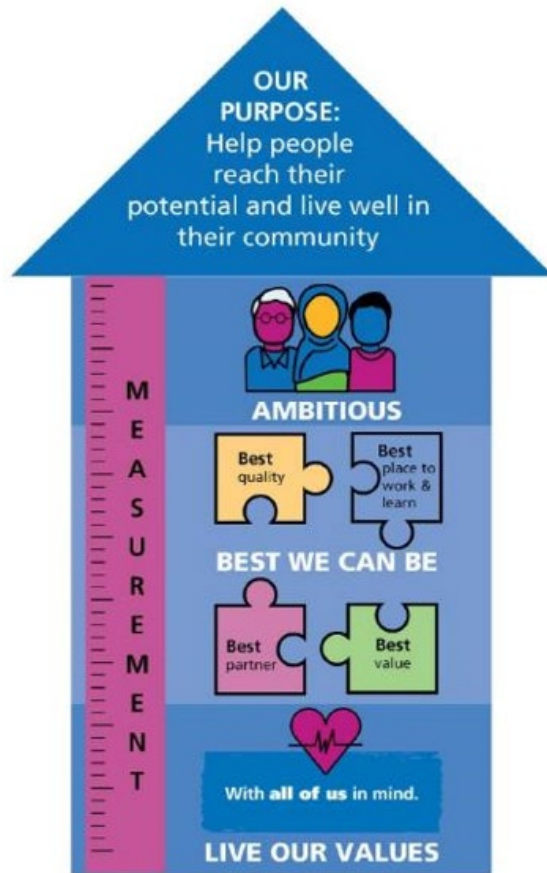


With **all of us** in mind.

Our Trust strategy



**South West
Yorkshire Partnership**
NHS Foundation Trust



Our strategic aims:

1. We will live our values
2. We will be the best we can be
3. We will be ambitious



On 1st October 2024, the Trust Board formally agreed the new Trust strategy to take the Trust up to 2030. Sustainability is a key component across the strategy and is clearly identified as part of strategic aim one (living our values) as well as strategic aim two (to be the best that we can be).

Our social responsibility and sustainability (SRS) strategy

Purpose and aims

Our SRS strategy was agreed in July 2022 and runs until 2027. It sets out the direction for our work on sustainability and carbon reduction. It identifies our commitment to this agenda, our ways of working and five headline initiatives for focussed effort and impact.

The aims of the strategy are:

- To use levers to maximise the benefits the Trust delivers to local people, communities, and places, especially those facing challenge and disadvantage
- To reduce disadvantage and inequalities, improve our environmental impact, and achieve the Trust's mission of helping people to reach their potential and live well in their communities



With **all of us** in mind.



South West
Yorkshire Partnership
NHS Foundation Trust



Our commitments



With **all of us** in mind.

Our green vision



South West
Yorkshire Partnership
NHS Foundation Trust

Our vision for being a socially responsible and sustainable organisation is set out in the SRS strategy

“We want to be a truly sustainable organisation that is relevant, that people want to use, that can be accessed by all and that is financially sound.”

Our Green Vision places carbon reduction at the heart of our strategy, recognising that climate change is a health emergency. By reducing emissions from our buildings, travel, clinical care, and supply chain, we aim to deliver more sustainable, equitable, and resilient healthcare for our population.

We will track our progress against a robust carbon baseline and prioritise actions that deliver both environmental and health benefits.

As part of the NHS’s world-leading commitment to reach net zero, our Trust recognises the urgent need to reduce our carbon footprint. We are committed to achieving net zero for our direct emissions (NHS Carbon Footprint) by 2040, and for our wider emissions (NHS Carbon Footprint Plus) by 2045, in line with national targets.

To help realise this vision we work collaboratively across both South and West Yorkshire to support and share and spread good practice.

Demonstrating our commitment



This commitment is demonstrated through:

Key roles

- an identified net zero Executive Lead – the Director of Strategy, Inclusion and Change/Deputy Chief Executive
- an identified Non-Executive Lead who acts as the Trust Board sustainability champion ensuring the issue is regularly considered at Trust Board
- an identified Sustainability Change Manager and responsibility assigned to a senior estates manager

Governance, reporting and delivery routes

- a steering group to lead the work to deliver the strategy.
- a carbon reduction group with executive senior leaders
- a six monthly report into the Equality, Involvement and Inclusion committee of the Trust Board
- an annual report into Trust Board
- A clear set of indicators and measures that we use to monitor and track progress and impact



South West
Yorkshire Partnership
NHS Foundation Trust



Our priority areas of focus

With **all of us** in mind.

Our SRS headline initiatives



**South West
Yorkshire Partnership**
NHS Foundation Trust

The SRS strategy identifies five focus areas as headline initiatives to be delivered in partnership with staff, service users and their families and carers:

- Partnerships, culture, and civic role
- Our role as an employer
- Procurement of goods and services
- Management of environmental impacts, our estate, and assets
- Engagement with less advantaged and diverse communities to maximise the responsiveness, value, inclusiveness, and uptake of our services

These headline initiatives help to provide strategic context and an indication of our areas of focus for the green agenda over the next 3 years

Initial headline initiatives



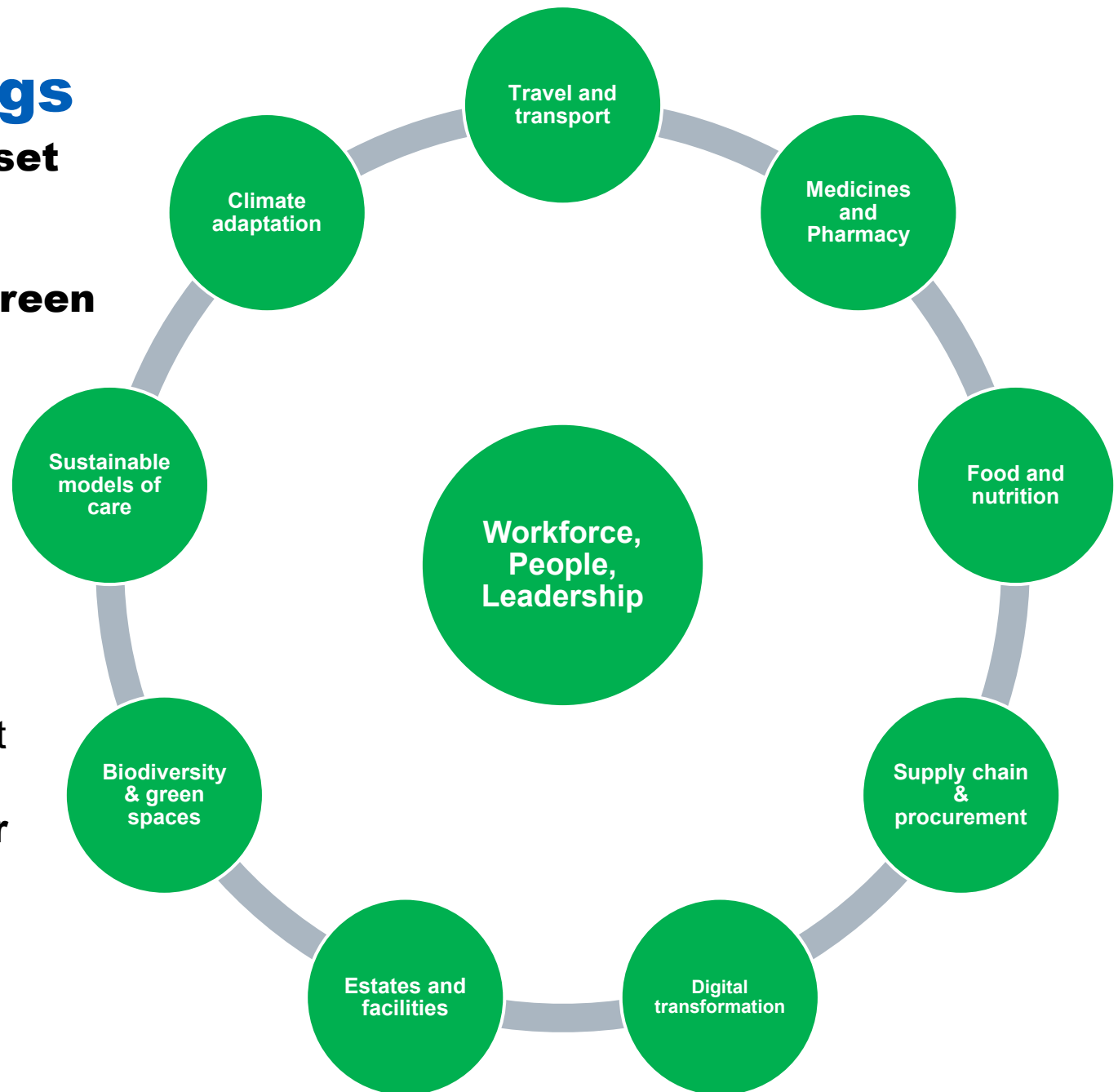
The green plan headings

Our green plan is set out under the recommended headings for the green plan

For each of these we have identified

- Our achievements to date
- Our proposed key actions for the next 3 years

These will be further developed in our delivery plan



Workforce, people and leadership

Our achievements to date

- Significant interest in our SRS strategy work from staff across the Trust, with 450 colleagues signing up involvement in Trust green teams
- Annual award for SRS as part of the Trust excellence awards for the last 2 years
- Engagement with sustainability in both South and West Yorkshire and all 4 Places
- Developed an SRS communication and engagement plan. This includes the development and distribution of a green team newsletter across the Trust
- Strong flexible working approaches with colleagues supported to work from home where possible has significantly reduced our overall carbon footprint.
- Sustainability is included in the induction programme for all new staff
- Carbon literacy training being available via ESR for over 450 staff. The training offer is making a difference by educating staff and providing guidance on action that can be taken
- Displayed 1000 “If it’s not in use, please switch it off” stickers across the Trust
- Introduced local recruitment and attraction campaigns and made connections into other local inclusive recruitment initiatives such as Proud to Care and Barnsley 2030. These are helping to reduce our carbon footprint by hiring local where possible.

Our key actions for the next 3 years

- Further integrate carbon literacy within the employee lifecycle to support and develop understanding of the agenda throughout our workforce
- Mobilise our green team and ensure SRS is part of our behaviours and our improvement priority work to truly live our values
- Consider the introduction of a new apprenticeship for sustainability (Level 4 corporate responsibility)
- Support the continuing development of local green teams and plans to enable carbon reduction activities to take place locally within teams and across sites
- Weave sustainability into our involvement approach so that we Engage staff and patients in sustainability initiatives and act together to make a difference.
- Continue to reward sustainability projects as part of our Trust excellence awards



**Workforce,
People,
Leadership**

Travel and transport

Our achievements to date

- Successful free e-Bike loans pilot to staff progressed to business as usual. We are now on our fourth cohort of staff who have used them to travel to work and to carry out their work duties.
- Close working with Modeshift STARS, which is the national accreditation scheme that recognises excellence in sustainable travel planning. For NHS organisations like ours, it offers a structured, evidence-based framework to embed active travel and sustainability into everyday operations, aligning with the NHS's broader goals of reducing carbon emissions, improving public health, and enhancing staff wellbeing
- EV charging point installations across our main Trust sites
- Strong links established to partners involved in active travel in each of our places
- Fleet vehicles being replaced with zero emission alternatives where possible
- Increase in hybrid and electric car users within the salary sacrifice schemes
- Fleet vehicles tracked in real time to enable the best possible route planning.

Our key actions for the next 3 years

- Continue to support local procurement where possible. Examples include support given to local taxi firms to be able to tender for our taxi contract
- Continue to develop links into the active travel work across all four of our places
- Develop a Trust specific sustainable travel plan by December 2026. Begin this work with an active travel plan, supported by Modeshift STARS, to encourage more sustainable travel and helps with the health and wellbeing of our colleagues, patients and service users
- Continue to work towards zero emission vehicles
 - In salary sacrifice schemes
 - For our Trust owned fleet in line with the requirement to transition to zero-emission-only vehicles by December 2027
- Continue to monitor emissions from staff vehicles and drive reductions in line with requirements .
- Constantly review the fleet size to ensure it is maximised efficiently to the Estate.



**Travel
and
transport**

Medicines and Pharmacy

Our achievements to date

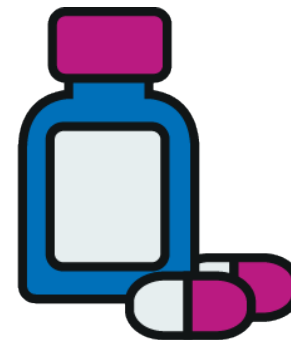
- We have introduced Structured Medicine Reviews (SMRs). These are an evidence-based and comprehensive review of a patient's medication, taking into consideration all aspects of their health. In a structured medication review, clinicians and patients work together as equal partners to understand the balance between the benefits, risks and alternatives to taking medicines. They are an important tool in tackling overprescribing and align with NHS productivity goals

100% of pharmacists working in Primary Care had completed their Structured Medicine Reviews (SMRs) training in the first 12 months of enrolment and inpatient pharmacist training is underway. Over 300 community reviews and / or follow ups have been completed since 2024, allowing people to have a better understanding of the medicines they take and reduced risk of any associated harm.

- To help reduce the number of medicines wasted, green bags are used across the Trust. in all localities. This allows patients and service users to bring their own medication into hospital , reducing waste
- We are phasing out the use of plastic bags in pharmacy.

Our key actions for the next 3 years

- Continue to structured medicine reviews across all care groups.
- Continue to explore alternatives to the current single use plastic medication pots
- Reduce the use of single use plastics in medicines supply by reducing reliance on multicompartment compliance aids
- Support, promote and participate in the reducing waste and safe disposal of medicines, public campaigns with both West Yorkshire and South Yorkshire ICBs
- Explore possibilities for recycling medicines packaging e.g. inhalers and tablet foils



**Medicines
and
Pharmacy**

Food and nutrition

Our achievements to date

- Work undertaken with NHS supply chain to use sustainability accredited suppliers
- Commitment that where possible we maximise the use of local suppliers. Achievements on this noted
- Reviewed menus to reduce food wastage
- Increased accuracy of recording of food wastage and removal of food waste to biogeneration
- Rollout of individual meal ordering to reduce food waste.
- Review of ward stocks to ensure maximising of stores and reduce food waste.
- Print out of individual food waste figures at ward level to target improvement.

Our key actions for the next 3 years

- Continue to measure food waste in line with the estates returns information collection (ERIC)
- Set further improvement plan to reduce food waste and promote sustainable food sourcing with targets, milestones and monitoring
- Coproduce a quality improvement programme on our menus with our inpatient forensic service users. The aim of this will be to improve our service user feedback on the choices whilst also making our menus healthier and lower carbon



**Food and
nutrition**

Supply chain and procurement

Our achievements to date

- Developed an enhanced approach to sustainability focused procurement to increase the emphasis on the purchase of environmentally friendly and sustainable products such as recycled paper, eco-friendly cleaning supplies and energy-efficient office equipment.
- Moved from 5% to 10% minimum social value rating on all high value procurement projects
- Agreed guidance for the sustainable procurement and purchase of promotional items.
- Developed a contractor framework that has sustainable activity as a clear part of delivery including the use of local resources as part of the ongoing measurement on performance.
- Established a highly effective Waste and Repurposing Group with responsibility for identifying improvements in our ordering processes. This includes how to recycle or best dispose of unwanted items and how to reduce waste from packaging.
- Carried out a stationary amnesty across our two main sites which saved the Trust £5000 and also benefited local community groups
- Worked with West Yorkshire partners to organise a “Buy the Buyer” event via our partner procurement hub: NHS North of England Commercial Procurement Collaborative. The aim of this was to support suppliers within our region to be able to bid for tendering opportunities for when they are published.

Our key actions for the next 3 years

- Embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored
- Continue to reduce our reliance on single use products
- Carry out a quality improvement project to consider how we reduce emissions from pharmaceuticals and medical devices.
- Consider how we implement circular economy principles in procurement and waste management.



**Supply chain
&
procurement**

Digital transformation

Our achievements to date

- A considerable proportion of the Trust's digital environment is cloud hosted which leverages efficiencies.
- The Trust's IT services has well-established ethical and environmentally friendly recycling processes in place for decommissioned IT equipment and continues to explore further enhancements.
- Across the Trust we have deployed smart charge capabilities for its end user computing estate which prolongs the longevity of laptop devices by using the device's internal battery more effectively when docked or plugged into the mains power and only initiates charging when required.
- Enhanced our digital training offer in keeping with service needs, reducing the need for unnecessary travel to attend training where appropriate.
- Trustwide deployment of digital dictation
- Reviewed post runs to maximise benefits and reduce emissions.
- Promoted the reduction of physical mail through trustwide communications,
- Combined any physical mail delivery with local ICB and partner healthcare organisations.
- Issued guidelines on reducing physical printing.

Our key actions for the next 3 years

- Continue to facilitate cloud hosting in line with our cloud-first approach.
- Deliver the 3P's project (reducing use of paper, printing and postage where possible).
- Implement the sustainability elements of the Trust Digital strategy
- Consider the digital maturity assessment and opportunities to embed sustainability in digital services
- Work with services, starting with Tissue Viability team in Barnsley to explore the possibility of introducing patient information films instead of leaflets



**Digital
transformation**

Estates and facilities (1) - achievements

Our achievements to date

- Development of a detailed and comprehensive decarbonisation plan for our two main sites. This plan provides a clear, evidence-based roadmap, identifying specific projects and interventions required to transition away from fossil fuels and significantly reduce our overall carbon footprint.
- Substantial progress in improving energy efficiency across our estate. Key measures include the full-scale replacement of our lighting systems with energy-efficient LED upgrades. Beyond lighting, we have conducted building fabric assessments to identify and address areas of poor thermal performance, which has led to a number of insulation and double-glazing upgrades
- Embedding sustainability considerations directly into all building design and refurbishment projects. This ensures that from the earliest stages of planning, we prioritise materials and systems that are both environmentally friendly and deliver long-term operational efficiency.
- Successfully implemented a new, comprehensive waste segregation scheme. This initiative goes beyond standard recycling, breaking down waste into specific streams to improve its quality and value, which in turn reduces our waste costs and improves our recycling rates. The financial savings from this scheme have made it largely self-funding.
- We are proud to have awarded our major capital projects for the 2024/25 period to small and medium enterprises (SMEs) and other local companies. This approach not only supports the local economy but also aligns with our broader social value commitments.
- We have appointed a major construction partner with a proven track record and strong sustainability plans. This collaboration is crucial for ensuring that our capital projects are delivered in a manner that aligns with and advances our environmental and social goals.



**Estates and
facilities**

Estates and facilities (2) – key actions

Our Key Actions for the Next 3 Years

- Continue to build on our achievements by implementing further energy-efficiency measures, including additional LED lighting retrofits, installing new insulation, and replacing single-glazed windows with energy-efficient double-glazed units where feasible.
- Ensure that all new leased and purchased properties meet a high Energy Performance Certificate (EPC) rating to guarantee their operational efficiency from day one. This is a critical step in controlling our future energy consumption.
- Ensure our heat decarbonisation plan is a key priority. We will be further developing this strategy, focusing on replacing fossil fuel heating systems with lower-carbon alternatives such as modern heat pumps or connecting to a regional heat network. Our goal is to phase out all fossil-fuel heating systems by the NHS deadline of 2032.
- Significantly increase our use of renewable energy by investing in on-site or near-site generation. We are actively exploring opportunities for solar installations and other renewable technologies to meet our energy demand and reduce reliance on the grid.
- All new buildings and major refurbishments will be designed and constructed to meet the NHS's net-zero carbon standard.
- Conduct a full review of our estate's use to maximise its utilisation and reduce our overall footprint. This will help us identify opportunities for consolidation and more efficient space management, leading to significant reductions in operational costs and emissions.



**Estates
and
facilities**

Biodiversity and green spaces

Our achievements to date

- The Trust recognises the importance of green spaces for recovery, support and rehabilitation for our patients, service users and carers. Consequently, we have developed excellent green spaces at our main sites through extensive tree planting and the introduction of diverse plant species.
- At the Fieldhead site, the Caring Garden includes raised beds for vegetables, seasonal flowers to support pollinators, and a forest area featuring a bog garden. Numerous native trees and hedges have been planted and bird boxes and bug hotels installed. In recognition of these efforts, the garden received the Yorkshire Wildlife Trust Gold Award in 2025. We have also recently been shortlisted for the 2025 NHS Forest Award in the greenspace for wellbeing category
- Over 500 trees planted in the last 2 years on our main sites to:
 - offset the impact of our activities and improve our green spaces,
 - improve privacy and shading
 - provide wildlife habitats and increased biodiversity
- Our garden areas, greenhouses, and log cabins are regularly used by our partners such as GROW Wakefield and the Therapy Group at Mid Yorkshire Trust.
- Our Mental Health Museum runs a Wildlife Club and maintains two small garden areas which are planted to provide nectar and pollen year-round for insects, butterflies, and bees. One garden is a history garden featuring heritage plants reflecting the region's history.

Our key actions for the next 3 years

- For our Mental Health Museum to develop information to enhance public engagement with the outdoor space
- Build on our green space and biodiversity work to date and develop a biodiversity pledge to improve how our sites support wildlife. To underpin our pledge with a set of key delivery actions.
- To explore how we can use the Nature Ranger posts created by the NHS Sustainable Healthcare organisation to further develop our understanding and actions



**Biodiversity
& green
spaces**

Sustainable models of care

Our achievements to date

- Implemented a new sustainability impact assessment and used this to inform design of major service change – for example, older people's inpatient transformation and Trust waste policy.
- Ongoing processes within community teams (both physical and mental health) to consider the travel implications for staff when assigning caseloads
- Successfully implemented digital platforms for therapy and assessments, which improve access while reducing travel-related emissions.
- Increased use of digital alternatives to support staff in more agile working
- Strengthened collaboration with primary care, social care, and VCSE partners, improving continuity of care and reducing duplication.
- Adopted trauma-informed principles and recovery oriented models across services, supporting long-term recovery and reducing high-intensity interventions.

Our key actions for the next 3 years

- Fully implement the sustainability impact assessment process so that our decision making is informed by an understanding of the impact on sustainability as well as equality, quality and finances.
- Expand digital consultation platforms and integrate virtual care into routine service delivery.
- Further develop alternatives to admission including crisis cafes and recovery colleges, targeting a reduction in inpatient crisis episodes.
- Co-develop joint care plans with ICS partners and VCSE organisations, reducing duplicated activity and improving outcomes.
- Ensure services embed trauma-informed frameworks, with measurable reductions in high-intensity admissions and improved recovery outcomes



**Sustainable
models of
care**

Climate adaptation

Our achievements to date

- Reviewed Business Continuity plans to include adaptation on any climate risks (focus on flooding).
- Considered the effect of climate change at design stage on major capital schemes.
- Implemented the communication of weather warnings across the Trust including reviews of any actions

Our key actions for the next 3 years

- Prepare for climate-related risks such as heatwaves and flooding.
- Review the estate for high risk locations
- Increase investment in schemes which reduce carbon emissions.



Governance

The governance of the delivery of this green plan is through:

- The responsible Executive Lead – the Director of Strategy, Inclusion and Change/Deputy Chief Executive
- Senior oversight is through the carbon reduction group with executive senior leaders present
- Delivery will be monitored through the existing SRS strategy routes.
- This will include a clear set of indicators and measures, aligned with ICS-level metrics and the Greener NHS dashboard. We will use these to track reductions in emissions and to monitor and track progress and impact. We will provide updates on this into the operational management group and the executive management team
- In 2024 we received the results of an internal audit report on the delivery of our SRS strategy which provided us with significant assurance. We will add the green plan update into these processes so that it is part of the SRS report to the Board committee on a six monthly basis with an annual report into Trust Board.



We will continue to connect into both the South and West Yorkshire systems

With **all of us** in mind.

Trust Board is asked to

Approve this plan for

- adoption
- sharing with NHS England
- publication on our Trust website

Note that we will develop a more detailed delivery plan which will be presented into the Equality, Involvement and Inclusion Committee. This plan will set out

- Key milestones and owners
- Our measures and frequency of reporting on indicators aligned with ICS-level metrics and the Greener NHS dashboard
- An understanding of how we will measure the impact of our plan on our patients, service users, carers, colleagues and communities
- A clear carbon baseline and trajectory for reduction.



With **all of us** in mind.

**Trust Board
30 September 2025
Agenda item 11.5**

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.		

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 30 April 2024. The most recent update in relation to Cheswold Park was provided to the Trust Board on 29th July 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). The Programme Group reports on a weekly basis into the Trust's Executive Management Team (EMT), who provide 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 twelve months following acquisition and 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.

**Trust Board 30 September 2025
Agenda item 11.5
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.

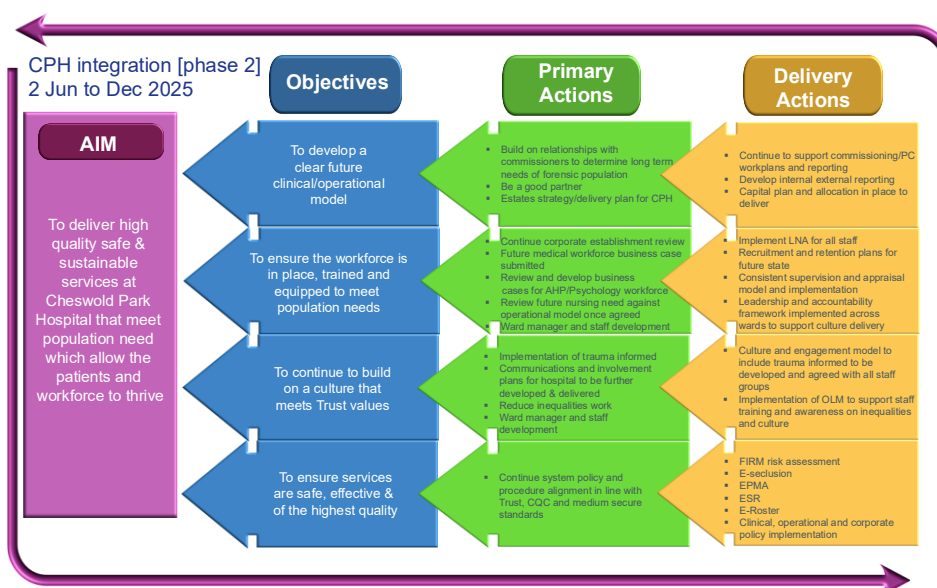
Workstreams have key objectives and timelines for these, as set out in a programme integration plan.

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 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 have now developed key tasks and identified owners for each objective/action.

An additional objective has been added for Estates and Facilities to support delivery of key works across the hospital.



All actions are currently on track.

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	• Staff at CPH will be offered the choice to transfer to Agenda for Change, with effect from the 1 November 2025. • Full time leadership presence on site. • 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. • Ways of working task and finish group to review roles and align to wider Trust has commenced. • Ward manager development continues.
Quality and safety	• Policy integration continues supported by training across services and involvement continues with Staffside and Comms throughout this process. • Medication Quality Improvement work - The Trust medicines with respect document is being rolled out throughout September 2025 which will support the registered nurses to practice safely when administering medication and will further enhance their skills prior to the implementation of Electronic Prescribing and Medicines Administration (EPMA) in January 2026. • The Trust safeguarding processes are being utilised in CPH with referrals to Doncaster Local Authority being made by the clinical team and oversight being maintained through Datix and the associate director of nursing, quality and professions. • The Trust complaints and compliments procedures are fully embedded into CPH practice with oversight from the associate director of operations. • The CPH local patient safety oversight group (PSOG) aims to integrate with the wider Forensic care group PSOG at the end of September 2025 to ensure shared learning across the care group. • Two members of staff have been supported to commence the Professional Nurse Advocate Course, starting in September 2025. • Further work has commenced with the friends and family and service user experience with a development session taking place with the ward managers. • Staff have been trained in e-seclusion (a monitoring system linked directly to the patient's clinical record system), the hardware is in place and full go live is planned by 30 September 2025.

Estates and facilities	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.																								
Finance, procurement and contracting	At the end of August 2025, Cheswold Park Hospital is underspent by £157k and forecast to underspend by £192k by the end of the financial year. The table below shows the variance to budget by service line for 2025 / 26. Low secure continues to be an area of focus due the significant overspend (£504k) however the spend each month has reduced since April. The reduction has partially been due to rota management. A business case has been approved by EMT to expand the substantive medical workforce and therefore funding needs to be identified from the existing care group budget to fund the posts agreed and remove the adverse variance. Medical costs are expected to reduce as locums are replaced with substantive consultants. Operational management is overspending due to additional resource been utilised to support the agenda for change roll out. <table><tr><th>Service Line</th><th>YTD (Surplus) / Deficit £k</th><th>Forecast (Surplus) / Deficit £k</th></tr><tr><td>Low Secure</td><td>226</td><td>504</td></tr><tr><td>Medical</td><td>299</td><td>666</td></tr><tr><td>Operational Management</td><td>52</td><td>165</td></tr><tr><td>Medium Secure</td><td>(103)</td><td>(154)</td></tr><tr><td>Support and Therapy</td><td>(161)</td><td>(393)</td></tr><tr><td>Corporate Services</td><td>(470)</td><td>(979)</td></tr><tr><td>Total</td><td>(157)</td><td>(192)</td></tr></table>	Service Line	YTD (Surplus) / Deficit £k	Forecast (Surplus) / Deficit £k	Low Secure	226	504	Medical	299	666	Operational Management	52	165	Medium Secure	(103)	(154)	Support and Therapy	(161)	(393)	Corporate Services	(470)	(979)	Total	(157)	(192)
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Corporate Services	(470)	(979)																							
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Month 5 2025/26																									
IMT & Reporting	- 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. - SystemOne 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. - The first meeting of the EPMA implementation group took place in early September.																								
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 several current risks associated with taking on delivery of services at Cheswold Park. The Trust has developed a full risk register. This is reviewed monthly at 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 continue 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.
- Preparation for further system implementation e.g. EPMA.
- Policy implementation plan in progress.
- Engagement continues with staff and staff-side colleagues.

Trust Board
30 September 2025
Agenda item 11.6

Private/Public paper:	Public		
Title:	Planning update		
Lead Director:	Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive Adrian Snarr – Executive Director of Finance and Resources		
Mission/values:	The development of our plan supports the effective use of resources and our wider strategic objectives to be the Best we can Be . By living our values we will ensure that we have the financial resources in place to deliver our mission to support people to reach their potential and live well in their community .		
Purpose:	The purpose of this paper is to provide Trust Board with an update on the planned approach to development of the Trust operating plan.		
Strategic aims:	Live Our Values	✓	The Trust's planning process supports all of 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):	2.6 Financial pressures in our systems could result in less focus on mental health, learning disability and autism, community services and/or Place. 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.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place	The paper highlights the opportunities available to the Trust to work with other partners to tackle shared challenges through a system approach to planning, and also developments and discussions in progress where relevant.		

based partnerships and partner organisation objectives at national regional or local level.	
Any background papers / previously considered by:	An update of the Trust planning process was shared with Finance, Investment and Performance Committee on 23 September 2025.
Executive summary:	In August 2025, NHSE shared the draft 'Planning Framework for the NHS in England'. The framework shifts the focus of planning towards a rolling five-year planning horizon and planning as a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10 Year Health Plan. All organisations will be asked to prepare integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. The attached paper provides an update on the proposed approach to Annual Planning for 2026/27 and outlines a planning timetable, which will be confirmed once guidance is received. The approach will learn from the Trust strategy refresh process and will ensure an aligned, clear focus across the organisation so that we are intentionally planning to be the Best we can be. The proposal will ensure a comprehensive plan ensuring that we clearly define our priorities and plans so that we will use our collective energy to work towards common goals. The process is designed to provide assurance that we will meet national and local planning requirements, whilst living our values and, being ambitious for the communities we serve and our colleagues. 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 approach to the development of, and timescales for, the Trust operating plan.

**Trust Board
23 September 2025**

Agenda item 11.6

Annual Planning Proposal

1. Introduction

The purpose of this paper is to provide Trust Board with an update on the planned approach to development of the Trust operational plan for 2026/27 onwards.

2. National context

In August 2025, NHSE shared the draft 'Planning Framework for the NHS in England'.

The framework shifts the focus of planning towards a rolling five-year planning Horizon, and planning as a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10 Year Health Plan.

All organisations will be asked to prepare integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term.

The National planning framework has 5 areas of focus for plans:

- Outcome-focused- Planning should be anchored in delivering tangible and measurable improvements in outcomes for patients and the public, and improved value for taxpayers. Involving patients, carers, and communities is critical for ensuring that plans deliver better outcomes and services that are responsive to local needs.
- Accountable and transparent- Effective planning requires clarity on roles, responsibilities, and accountabilities. Governance structures must support transparent decision-making, provide regular oversight and constructive challenge, and ensure alignment with strategic objectives at organisation, place and system level.
- Evidence-based- The decisions made as part of planning should be underpinned by robust analytical foundations, including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts. This should be informed by best practice and benchmarking.
- Multi-disciplinary- Planning must bring together staff from across different functional areas (finance, workforce, clinical etc) to ensure that work is co-ordinated and that those responsible for delivery have shaped its content.
- Credible and deliverable- Plans must set ambitious yet achievable goals. They should clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality is critical.

The planning guidance received indicates that:

- NHSE England and DHSC will work together to translate the 10YHP and spending review outcome into specific multi-year priorities and allocations.
- Phase two of planning will launch at the end of September / early October with the publication of multi-year guidance and financial allocations.
- ICBs and providers will then fully develop their medium-term plans and take them through board assurance and sign off processes in December.

3. **Our Trust approach to planning - principles**

To ensure that we deliver a plan that: meets the 5 areas of focus outlined above; that is in line with our values and strategic plan; and is owned across the organisation, the Executive Management Team agreed the following principles to underpin our planning approach. These are:

- Plan once, plan well; so that the plan can be used for the range of purposes that we need
- Plan comprehensively by using the intelligence that we have - the direction from our strategy, national guidance, equality, diversity and inclusion data, risk register, SWOT/PESTLE analysis, finance and people data to inform areas of focus and priority for the next 1-3 years.
- Ensure we clearly define our priorities and plans so that we are using our collective effort to work towards common goals.
- Provide as much certainty as possible about what we need to do, defining the difficult decisions such as service re-design.
- Link the relevant planning objectives to appraisals, so that all colleagues understand the contribution that they make, within year and across years.
- To use the annual planning process throughout the year as the 'one version of the truth' for performance discussions and planning within year and across years
- To align planning with our strategy, and our approach to governance so that they become an integral enablers that help us all to do our jobs better.
- Through this work, we need to be assured that we are meeting national and local planning requirements, **whilst living our values and, being ambitious for the communities we serve and our colleagues**

We recognise that the year ahead will present significant challenges both operationally and financially, it is therefore very important that the organisation is prepared for this and that we are prepared to corporately lead and manage proactively. Whilst there is much uncertainty in our external environment, providing as much certainty as possible internally regarding our approach and priorities is an important aspect of maintaining morale and hope.

We recognise that how we develop and execute our planning process is critically important, especially given the increased pressures that we face. We will strengthen the alignment between our strategy, governance and planning [please see figure 1].

Our strategy will act a 'given' which sets out our ambition and intent. Our governance will be an enabler which supports us to understand where our focus needs to be e.g. via intelligence from our Board Assurance Framework, Organisational Risk Register, Integrated Performance Report, and our planning- a way of using the intelligence we have to define how we will deliver our strategy.



Figure 1: The enablers of the annual planning process

4. The ‘What’, ‘how, and ‘so what’ of our 2026/27 planning process

4.1 The ‘what’

We have designed a planning process that has drawn upon the learning from the Strategy Refresh process. Our approach will:

- Connect or align everything together to avoid confusion, duplication or planning fatigue.
- Balance ‘top down’ givens, with ‘bottom up’ local development.
- A plan that is intentional in our actions for co-ordinated effort.
- Mean we have one plan which we use for future reporting and quarterly monitoring
- Centrally aggregate plans.
- Monitor progress throughout the year.
- Be the basis of the Annual Report

This means we will draw ideas, insight and evidence together from a range of sources as depicted in figure 2 below:



Figure 2: Sources of evidence, insight and evidence to build the annual report

Our approach will:

- Use the information and intelligence we have: Areas for improvement identified via IPR and other performance data, financial performance, people data, health inequalities toolkit, BAF, ORR etc.
- Listen to feedback from across the Trust in order to inform our plans- having a discursive approach to planning to ensure we capture key areas of focus informed by our services.
- Use insight from our communities and service user and carer feedback.

- Provide some 'givens' and expectations to ensure common direction of travel, and alignment to our strategy and national guidance.
- Ensure development of plans from local service/Care Group level aligned to our strategic ambitions.
- Ensure development of a plan that is intentional in our actions for co-ordinated effort.

4.2 the 'how'

We will empower our colleagues to proactively engage with their teams in the planning process by creating a clear and compelling narrative that means we will:

- Support the landing of challenging messages and difficult decisions across the organisation to support local leadership.
- Agree key 'givens' for plans e.g. any efficiency aims, areas of focus.
- Clear timescales and asks.
- Define and provide clear information and guidance to each care group/corporate service to support development of plans locally- slide set of national guidance, strategy, EDI data, SWOT/PESTLE, risk and finance data.
- Understand the local approach to plan development, aligned with our strategic aims and priorities.

There is a careful balance to strike which supports our leaders to be creative and responsive to the needs of service users, whilst having clear parameters within which they need to work.

As we have learned from the strategy refresh, engaging across the organisation will be an important aspect of defining the planning parameters across the organisation. We will develop an 'all of us' planning conversation that will ensure we engage with our leaders in the Operational Management Group, extended executive management group and executive management team. The conversation will be important to develop ideas on the 'art of the possible' as well as understanding our genuine limitations and difficult decisions that we need to make.

We will develop organisation wide communications relating to the 'all of us' planning conversation, which will be carefully and consistently linked to the value for money work programs. This will enable us to take clearer decisions to balance the financial challenges with the quality of our services, without every sacrificing safety, because we will have engaged with a wide range of colleagues and data sources. Whilst it is positive that the planning process has been brought forward, that does provide a challenge in that we have an awful lot to do in a short time.

Building on the learning from the strategy refresh we will establish a planning group. The group will: support us to coordinate the engagement process, bring together the critical financial analysis, define the 'top down' mandates and must-dos, develop the reporting templates and requirements of all directorates and teams, ensure that we are looking for opportunities to exploit digital and artificial intelligence and to ensure there is a strong clinical voice in our planning processes.

The planning group will meet weekly and will report directly to EMT. The group will be chaired by the Executive Director for Strategy, Inclusion and Change, with the Executive Director of Finance and Resources as deputy chair. This approach will ensure close coordination with the Value for Money Group which is chaired by the Director of Finance and Resources, with the Executive Director for Strategy, Inclusion and Change as deputy. This arrangement should ensure that the financial aspects of planning are central to the process,

but that the annual planning focus is broader. The proposed membership of the group is detailed below:

Planning Group members:

Planning oversight – Izzy Worswick; Workforce - Ellie Valentine; Finance- Rob Adamson & Jo Gawthorpe; Performance- Mel Wood; Quality + Safety - Amy Hartley; Medical- TBC; Operations-Sophie Hempsall, Amanda Miller, Jo Barber; Strategy and Change- Sue Barton, Sharon Kennedy; Governance- Andy Lister; Estates and Facilities- Kevin Gelder; IM&T- Paul Foster; Business development/contracting- Kelly Williams-Carr; Cheswold Park – Emma Robinson; Communications – Paul Cartwright; Administrative support- Corporate Governance Team

The group is by design, a cross section of colleagues, clinical, operational and corporate provide a breadth of input. This will also be a development opportunity for colleagues who will be engaging in the annual planning process and learning different skills as part of this.

4.3 The ‘so what?’

Our annual plan will:

- Enable us to meet all our planning obligations and will be aligned to our strategic ambitions.
 - Outline clear actions to support delivery of our strategy, with defined ownership, timescales and how progress will be monitored and impact demonstrated.
 - Be aggregated at Trust level, but recognisable by all Care Groups and directorates as it is made up of everyone’s plans.
 - Set out our financial plan.
 - Set out our workforce plan.
 - Be multi-year
 - Become a tool that helps us recognise our successes and address our challenges
-  Plan once, plan well

5. Oversight of the planning process

The planning process will be overseen by the Executive Director of Strategy, Inclusion and Change/Deputy Chief Executive and coordinated by the Assistant Director of Corporate Governance.

6. Internal Trust Planning Timetable

Our indicative planning timetable is shared below. This may change in light of national guidance.

Date	Key Milestones	Lead
September 2025	Initial national guidance received.	All
11 September 2025	Agreement of approach to planning at EMT time out	EMT
September 2025	Internal planning group established	Izzy Worswick
September 2025	Development of internal planning templates	Planning Group
September- October 2025	National planning guidance received	Planning Group

2 nd October 2025	Launch of planning process at Extended EMT	Dawn Lawson/Izzy Worswick
October 2025	Planning templates shared with all service areas	Izzy Worswick
October 2025	Planning conversations via OMG, Strategy Advisory Group, Directorate/Care Group Meetings	All of us
Mid-November 2025	Completion of Care Group/Directorate plans	All of us, led by Care Group Directors and Deputy Directors
End of November 2025	Development of overall Trust plan	Izzy Worswick
4 th December 2025	Plan shared with EMT	Izzy Worswick
w/c 8 th December 2025	Plan shared with FIP	Izzy Worswick
16 th December 2025	Final plan presented to Board	Izzy Worswick
December 2025 tbc	Submission of plan	Izzy Worswick

7. Next steps

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

- Receipt of national planning guidance.
- Launch of our planning process, the annual planning group and commencement of planning conversations across the Trust.

**Trust Board
30 September 2025
Agenda item 11.7**

Private/Public paper:	Public		
Title:	Monthly Performance review – NHS Oversight Framework 2025/26 – Q1		
Lead Director:	Adrian Snarr – Director of finance and resources		
Mission/values:	This report aligns to all Trust values.		
Purpose:	To provide the Finance, Investment & Performance Committee with an update on the implementation of the NHS Oversight Framework for 2025/26 and the Q1 position.		
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):	Trust performance against the NHS Oversight framework provides assurance to Trust Board on compliance with standards, identifying emerging issues and actions being taken for all strategic risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust performance management framework and reporting provides the ICBs 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:	An update on the NHS England Oversight Framework was presented to the July 2025 Finance, Investment, Performance committee and this update provided to the September 2025 committee.		
Executive summary:	This paper outlines the new NHS England Oversight Framework performance for the Trust for quarter 1.		

Following a period of testing at the end of June, Trust performance for quarter 1 was sent to the Trust at the end of August. This ranked the Trust with a segmentation score of 3. Due to the Trust reporting a financial deficit for June 2025 this resulted in the financial override rule coming into effect which means any organisation reporting a deficit can score no higher than a 3 regardless of performance on the other metrics.

The attached report shows Trust performance for each of the metrics for quarter 1.

The quarter 1 data is publicly available.

Key points to note:

- The Trusts segmentation score for Quarter 1 is 3.
- The Trusts position in the league table for non-acute hospital trusts (mental health and learning disability trusts, community trusts and care trusts) is 26 out of a total of 61 providers.
- The segmentation score of 3 is attributed to the Trust reporting a financial deficit for June 2025 and this has resulted in the financial override rule coming into effect.
- If the financial override rule had not been applied, the Trusts position would be 3 out of 61 based on an average score of 1.77 (best performing Trust score was 1.73, worst performing Trust score was 3.34).
- 12 metrics are applicable to the Trust in quarter 1.
- For 2 of the metrics, the Trust is the best performing Trust in the non-acute hospital trusts category.
 - Percentage of community services waiting list waiting over 52 weeks – 0% (low is better)
 - Urgent Community Response % achieving 2hr standard – 97.68% (higher is better).
- The lowest performing metric for the Trust in quarter 1 was ‘% change in number of under 18’s supported through NHS funded mental health with at least one contact in a rolling 12-month period’ (34 out of 46), Trust performance was an increase of 0.63% for the period June 24 - June 25 (higher is better). Best performing provider reported 47.68%, worst performing provider reported -22.79%.
- A number of the metrics are annual and therefore will not change until the measure is published for the new reporting period.
- The choice of metrics included in the framework has the potential to influence an organisational overall score and rank. Confidence intervals have been generated to quantify this uncertainty.
 - 95% confidence interval for average metrics score for the Trust is 1.41 to 2.17
 - The 95% confidence interval for Trust ranking is 23 to 32.

Performance is based on existing national data flows.

	We are aware of some data quality issues that are impacting on the operational measures these are being highlighted with operational services to ensure they are included within local data quality action plans and prioritised. Performance for quarter 2 is expected to be available in November, it is expected that the financial override rule will not be applied and if the Trust maintains or improves performance this is likely to mean a segmentation score of 1 or 2, a true forecast position is difficult to forecast as Trusts are ranked so a forecast in improvement in performance for our Trust may not be reflected in final scores if other Trusts also improve. Work is taking place to establish a system that locally monitors Trust performance against each of the metrics and will therefore be able to provide a forecast score based on more timely data. Trust performance will be routinely reported in the Integrated Performance Report.
Recommendation:	Trust Board members are asked to: • RECEIVE and DISCUSS this report.

NHS Oversight Framework 2025/26 Quarter 1 Performance

This paper outlines the new NHS England Oversight Framework performance for the Trust for quarter 1 2025/26.

Background

The new framework outlines a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts. It ensures public accountability for performance and is a foundation for how NHS England will work with systems and providers to support improvement:

- It is a 1-year framework and will be reviewed at the end of 2025/26.
- A range of agreed metrics will be used to assess performance.
 - These reflect the 2025/26 NHS priorities and operational planning guidance.
 - Not all metrics will be used to formulate the segmentation; some metrics are contextual metrics which will be used for consideration in NHS England's oversight response.
 - All metrics are split into domains: Access to services, Effectiveness and experience of care, Patient safety, People and workforce, Finance and productivity, improving health and reducing inequality.
- Assessment of the scoring metrics will determine a segmentation score.
- Segmentation scores will range from 1 (high performing) to 4 (low performing).
 - An additional segment (5) will be used if the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve; or an organisation is a challenged provider where NHS England has identified significant concerns.
- All organisations in deficit or in receipt of deficit support will be limited to an organisational delivery score of no greater than 3.
- Promotion of improvement and identification of support needs.
- Segmentation data will be reviewed at least quarterly as part of a review meeting and segments may be updated at any time based on emerging information.
- Data on Trust performance against the applicable metrics is made publicly available via NHS.co.uk. Quarter 1 data was published 9th September; it is anticipated quarter 2 data will be published in November.
-

Quarter 1 Performance

Following a period of testing at the end of June, Trust performance for quarter 1 was sent to the Trust at the end of August. This ranked the Trust with a segmentation score of 3. Due to the Trust reporting

a financial deficit for June 2025 this resulted in the financial override rule coming into effect which means any organisation reporting a deficit can score no higher than a 3 regardless of performance on the other metrics. The Trust clarified the guidance regarding the financial override as guidance documents had suggested that if a Trust had a planned deficit position and was meeting that plan during the year with a forecast/plan to achieve break-even or surplus by the end of the year then the financial override will not apply. NHS England clarified the financial override in the Oversight Framework works is based on three sequential gates as set out below.

1. Does a Trust have DSF? (If yes, the model stops, and the Trust is limited to segment three)
2. Does a Trust plan to break even? (If no, the model stops, and the Trust is limited to segment three)
3. Is the Trust on track against plan? (If no, the Trust is limited to segment three unless the Trust is off track against a surplus plan but still projecting a surplus an overall surplus after taking into account the amount off track in the YTD position)

It was clarified that for the Trust, the financial performance at month 3 was a year to date actual deficit of £2m against a YTD planned deficit of £1.9m and therefore off plan by £0.1m. As the overall plan is a breakeven plan for the Trust, the third gate has been triggered, and the financial override has been applied. The next assessment will be at month 6 for the Q2 ratings and the financial override will be reviewed again at this point presenting an opportunity to improve the rating depending on improvements in reported financial performance.

The following table shows the Trust performance for each of the metrics for quarter 1.

The quarter 1 data is publicly available via the NHS England website.

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST (RXG)							
	Quarter 1			Source	Validated	Q1 Ranking	Notes
	Performance	Score derived	Score				
Percentage of community services waiting list waiting over 52 weeks	0.00%	1.00		Comm services SitRep	Y	1/41	No issues identified, low / no risk.
% change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12 month period	0.63%	3.28		MHSDS	N	34/46	Unable to validate local data to national output. One reason could be national data counting individuals not providers so if an indiv know to another provider first would not be counted against our Trust figure but would be included in local count. Local Q1 figure 0.54%.
DOMAIN SCORE - Access to Services			2.14			Above average	
National CQC community mental health survey overall experience rating	As expected	2.00		NHS comm MH survey	Y		
Urgent Community Response % achieving 2hr standard	97.68%	1.00		CSDS	N	1/37	Unable to validate local data to national output - required further work. Risk of any change in performance minimal, exceeding national threshold of 70%. Low risk in terms of change in forecast.
Percentage of adult discharges with a length of stay above 60 days	22.09%	1.83		MHSDS		14/47	No issues with data (rounded in national data).
DOMAIN SCORE - Effectiveness and Experience			1.61				
NHS Staff Survey raising concerns sub-score (MHPRV)	6.92	2.00		NHS Staff survey	Y	21/61	
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours	72.24%	1.67		MHSDS		11/45	Unable to reconcile figures - anomaly with June - work taking place to resolve.
DOMAIN SCORE - Patient Safety			1.83				
Sickness absence rate	5.14%	2.19		ESR	Y	18/61	Data taken at a point on time from ESR so local data does not match unless ran on same day as NHSE extract (these dates are not known for future reporting)
NHS Staff Survey engagement sub-score (MHPRV)	7.19	2.10		NHS Staff survey	Y	23/61	
Crude rate of restrictive interventions per 1,000 occupied bed days				MHSDS	N		
DOMAIN SCORE - People and Workforce			2.15				
Planned surplus / deficit as a proportion of turnover	0.0%				Y	15/61	
YTD surplus / deficit	-0.1%				Y	52/61	
Aggregated finance score		1.00					
Relative cost difference	88.55	1.40			Y	10/60	
DOMAIN SCORE - Productivity and Value for Money			1.20				
Total score	19.47						
OVERALL AVERAGE SCORE			1.77			3/61	
FINAL SEGMENTATION	3					26/61	For month 4 onwards, forecast for no financial override.

Key points to note:

- The Trusts segmentation score for quarter 1 2025/26 is 3.
- The Trust's position in the league table for non-acute hospital trusts (mental health and learning disability trusts, community trusts and care trusts) is 26 out of a total of 61 providers.
- The segmentation score of 3 is attributed to the Trust reporting a financial deficit for June 2025 and this has resulted in the financial override rule coming into effect.
- If the financial override rule had not been applied, the Trusts position would be 3 out of 61 based on an average score of 1.77 (best performing Trust score was 1.73, worst performing Trust score was 3.34).
- 12 metrics are applicable to the Trust in quarter 1.
- For two of the metrics (see below), the Trust is the best performing Trust in the non-acute hospital trusts category:
 - Percentage of community services waiting list waiting over 52 weeks – 0% (low is better)
 - Urgent Community Response % achieving 2hr standard – 97.68% (higher is better).
- The lowest performing metric for the Trust in quarter 1 was '% change in number of under 18's supported through NHS funded mental health with at least one contact in a rolling 12-month period' (34 out of 46), Trust performance was an increase of 0.63% for the period June 24 - June 25 (higher is better). Best performing provider reported 47.68%, worst performing provider reported -22.79%.
- A number of the metrics are annual and therefore will not change until the measure is published for the new reporting period.
- The choice of metrics included in the framework has the potential to influence an organisational overall score and rank. Confidence intervals have been generated to quantify this uncertainty.
 - 95% confidence interval for average metrics score for the Trust is 1.41 to 2.17
 - The 95% confidence interval for Trust ranking is 23 to 32.

Performance is based on existing national data flows such as the MHSDS, CSDS, National Staff survey, Electronic Staff Record, NHSE Trust finance submissions, CQC national service users survey.

We are aware of some data quality issues that are impacting on the operational measures for mental health services in particular – these are being highlighted with operational services to ensure they are included within local data quality action plans and prioritised.

Performance for quarter 2 is expected to be available in November; it is expected that the financial override rule will not be applied and if the Trust maintains or improves performance this is likely to mean a segmentation score of 1 or 2, this however, depends on any changes in the performance of other providers as this will alter the ranking position and therefore the metric score for the Trust.

Actions taking place.

- Work is taking place to establish a system that locally monitors Trust performance against each of the metrics and so will be able to provide a forecast position based on more timely data. Trust performance will be routinely reported in the Integrated Performance Report.
- Detail behind each metric is being reviewed and shared with operational services, breaking this down to patient level where appropriate, for review and validation purposes. Operational services are being supported in reviewing this data and communications are being prepared to inform services what this means for them for the operational metrics.
- Work continues to validate any metrics where there is currently a discrepancy between local data and the national report. This currently relates to the following metrics:
 - % change in number of under 18's supported through NHS funded mental health with at least one contact in a rolling 12-month period
 - Urgent Community Response % achieving 2hr standard.
 - Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours.
- Further work is to take place to identify supporting metrics for each scoring metric.

Benchmarking

The following section of the report shows the benchmark position for each of the metrics in quarter 1 and has been sourced from the Model Hospital.

Access to services domain

Percentage of community services waiting list waiting over 52 weeks

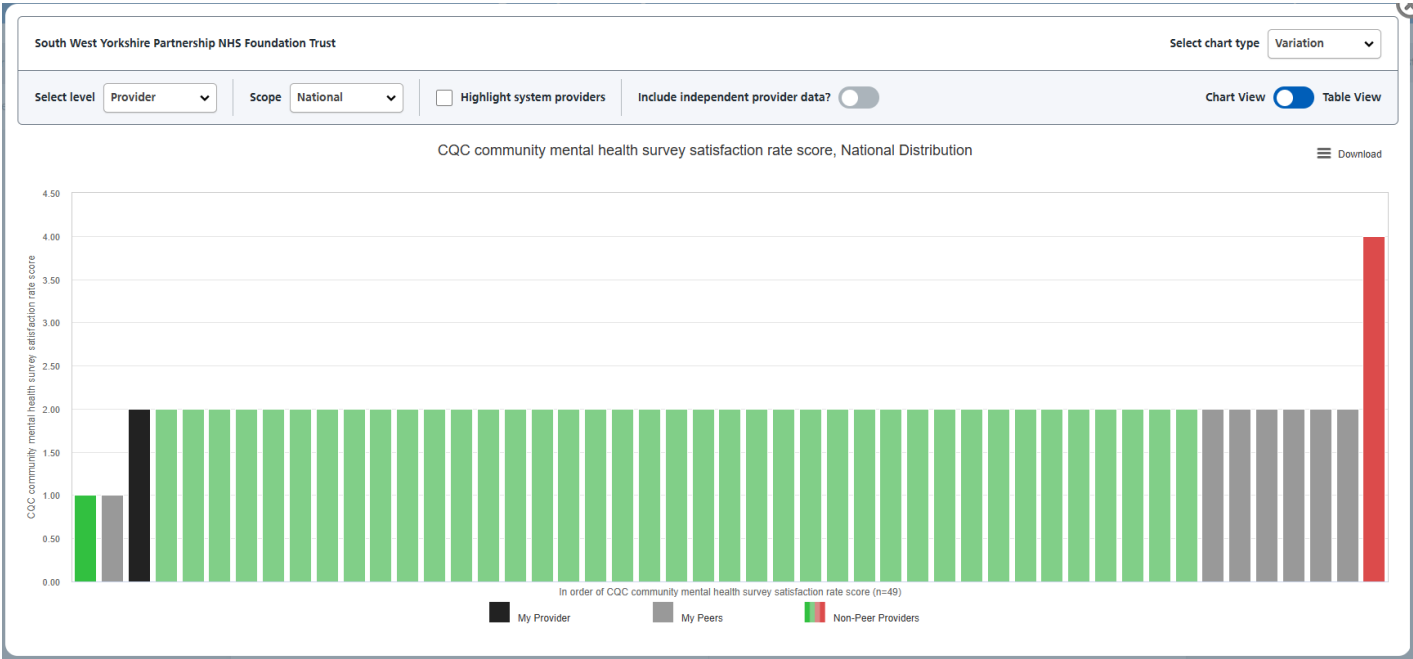


% change in number of under 18’s supported through NHS funded mental health with at least one contact in a rolling 12-month period

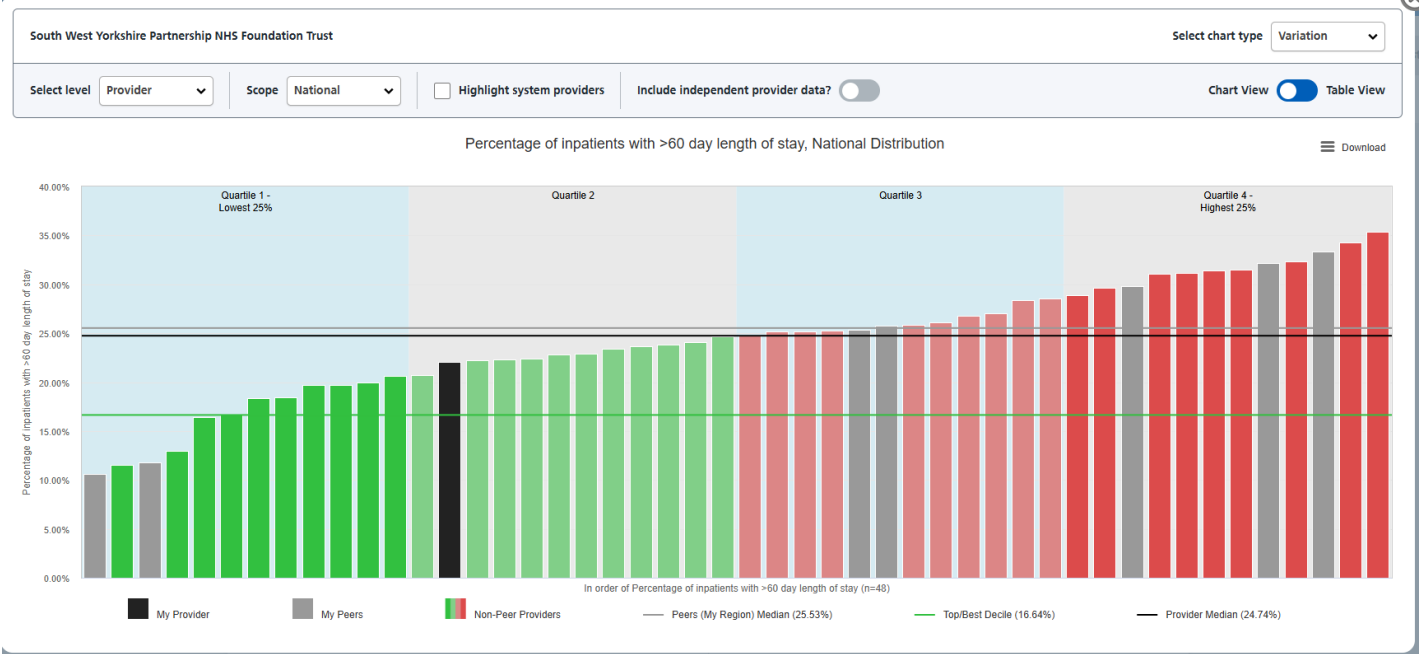


Effectiveness and experience of care domain

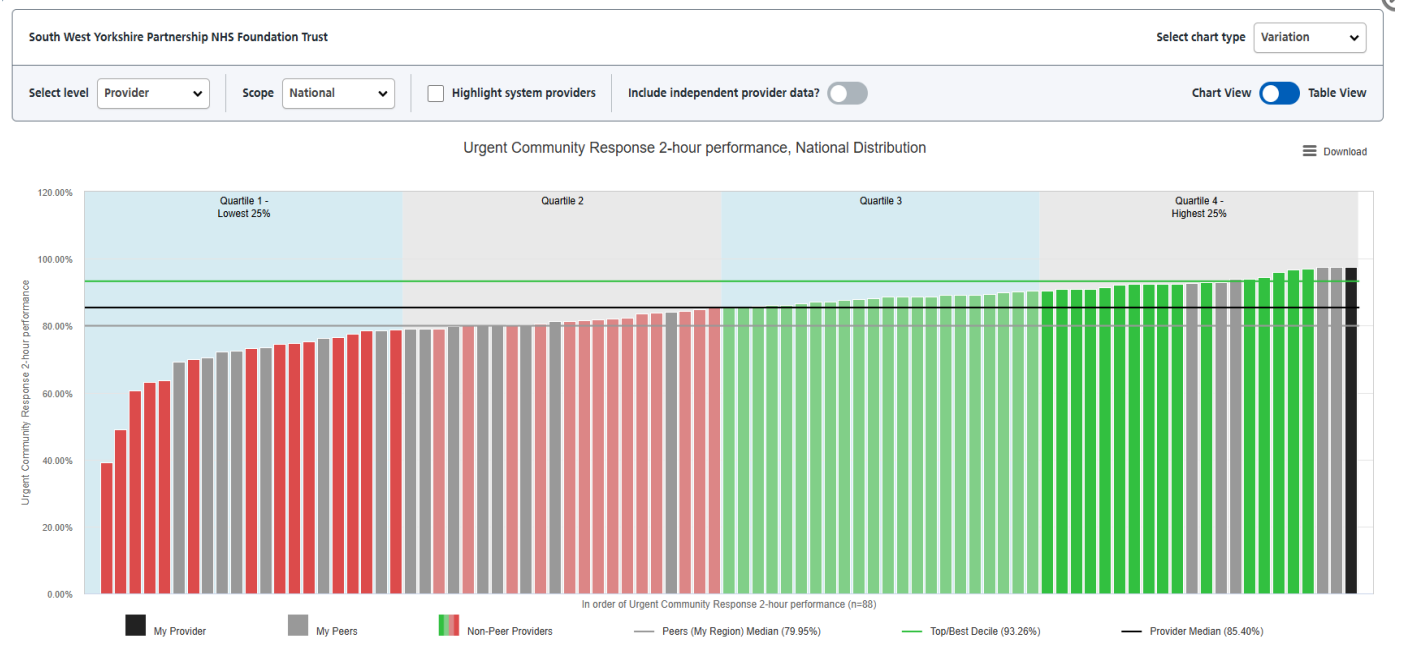
CQC community mental health survey satisfaction rate score



Percentage of inpatients with >60-day length of stay

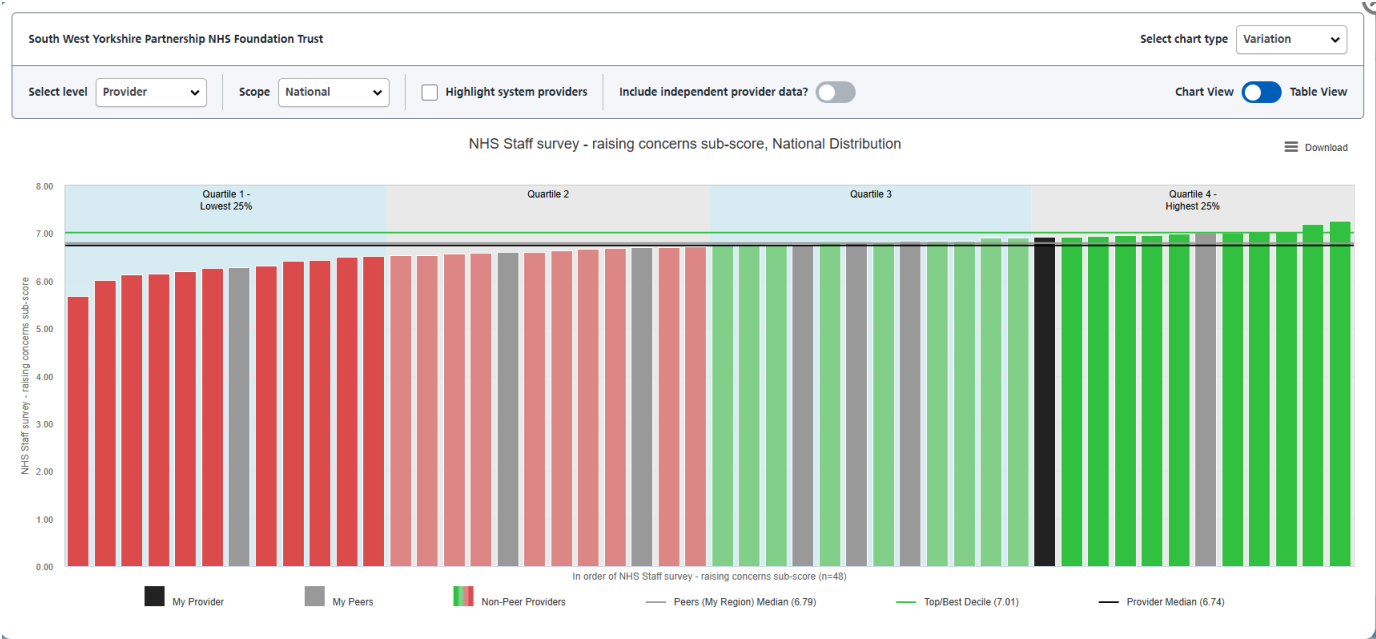


Urgent Community Response within 2 – hour

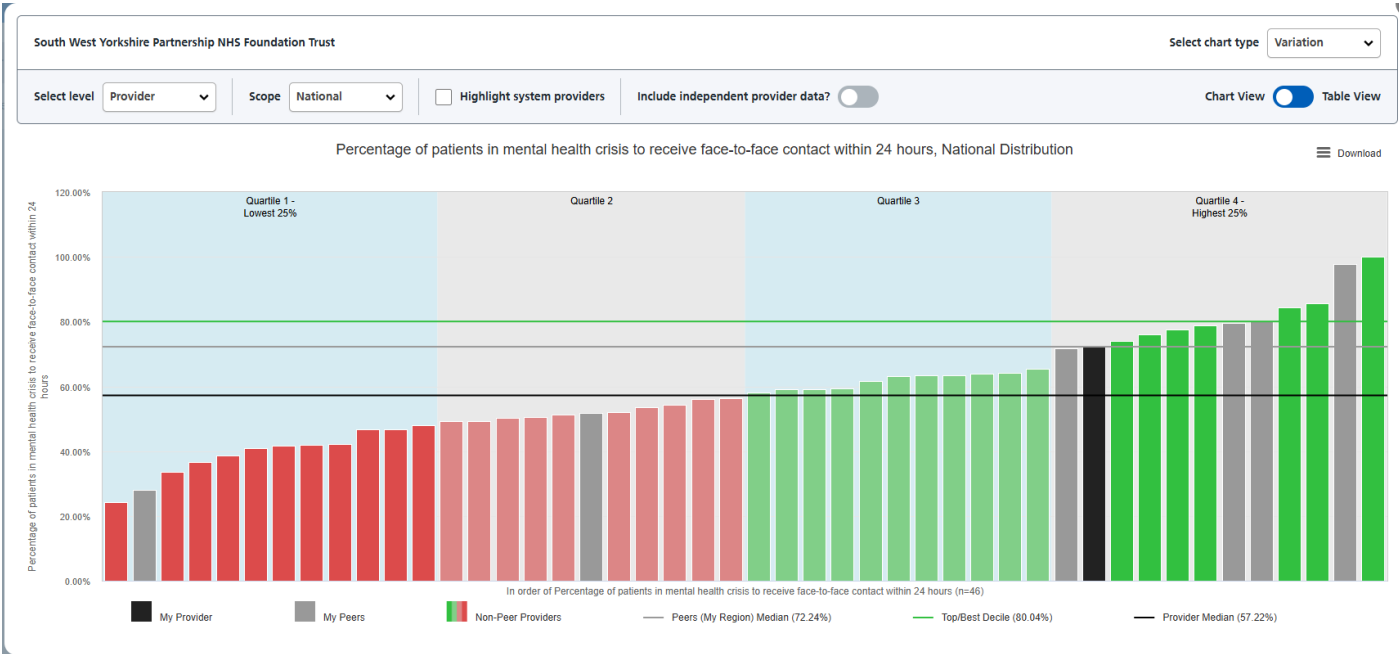


Patient safety domain

NHS staff survey 'raising concerns' sub-score

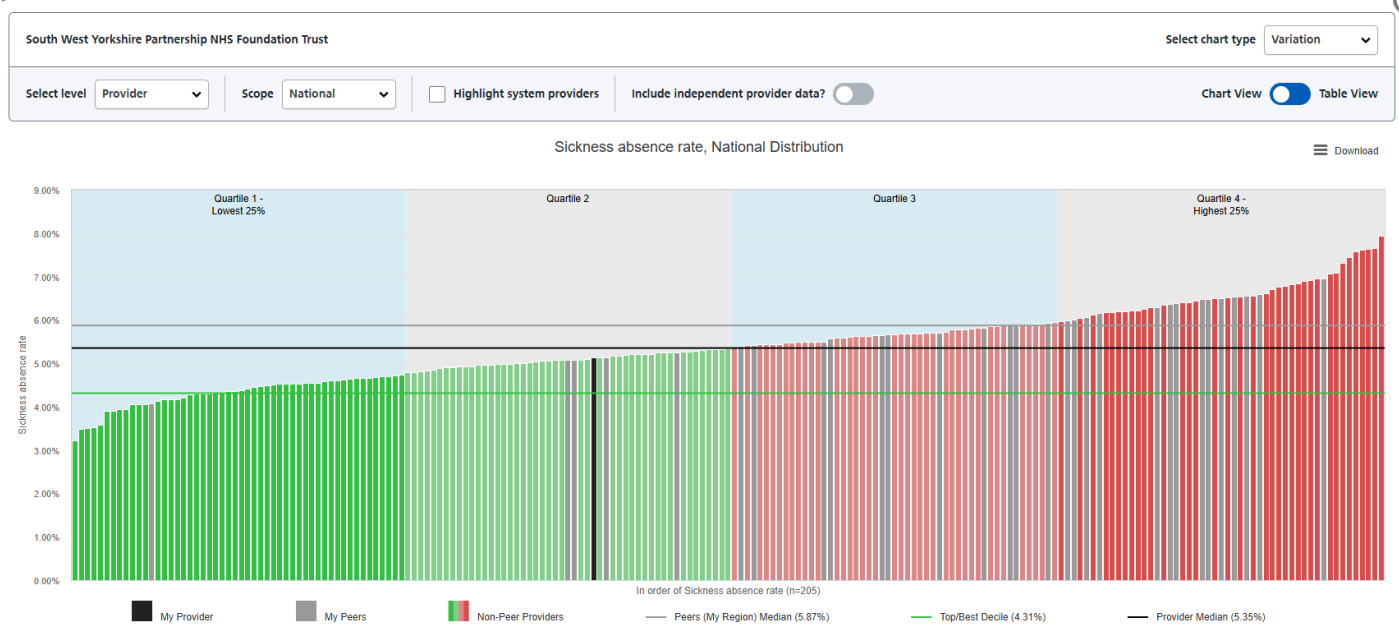


Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours

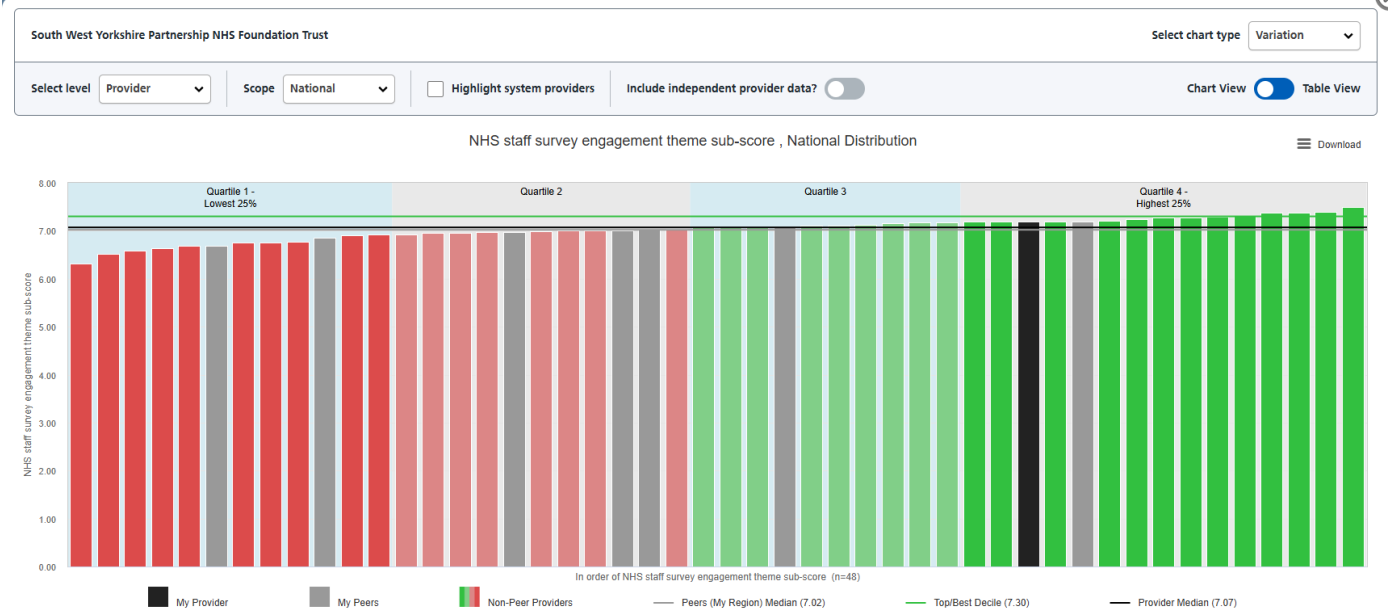


People and workforce domain

Sickness absence

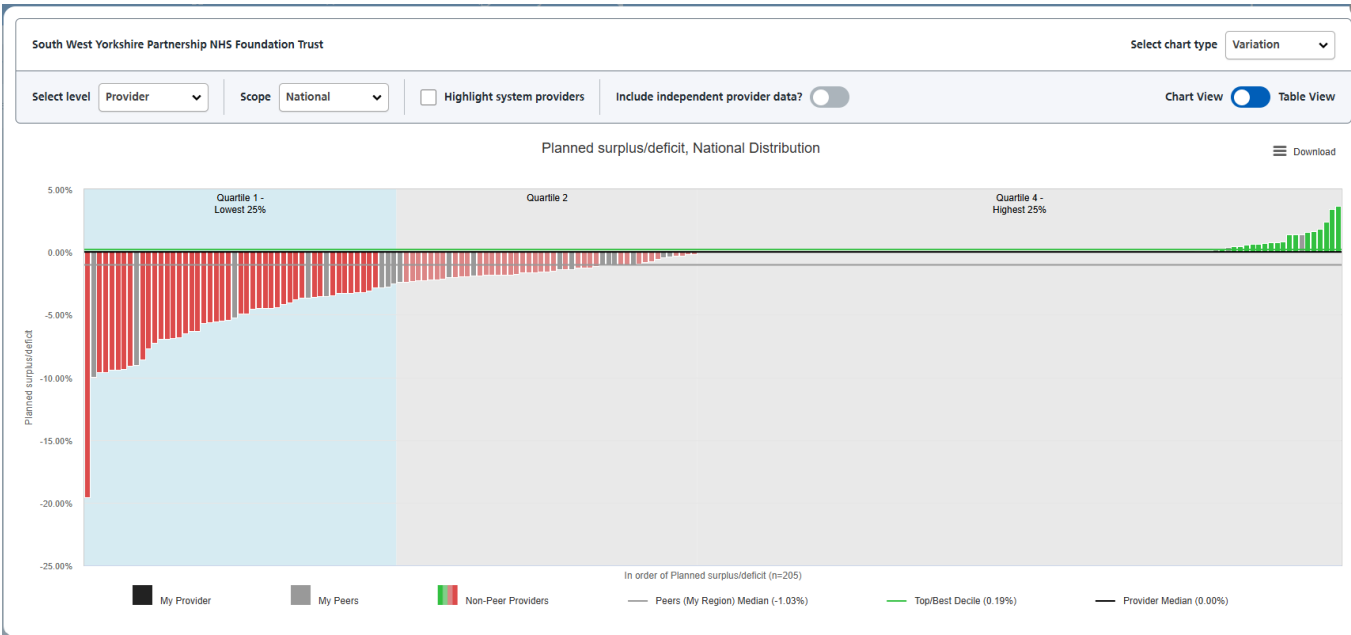


NHS staff survey engagement theme sub-score score



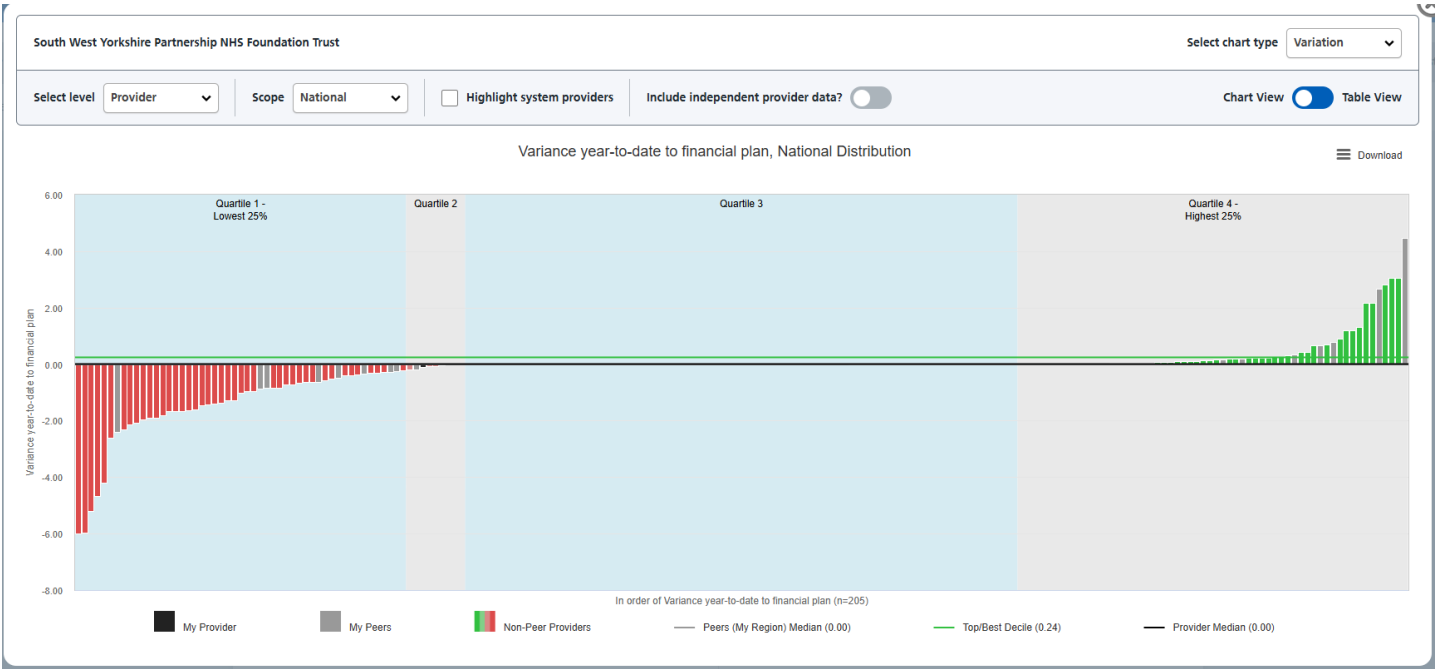
Finance and productivity domain.

Planned surplus/deficit



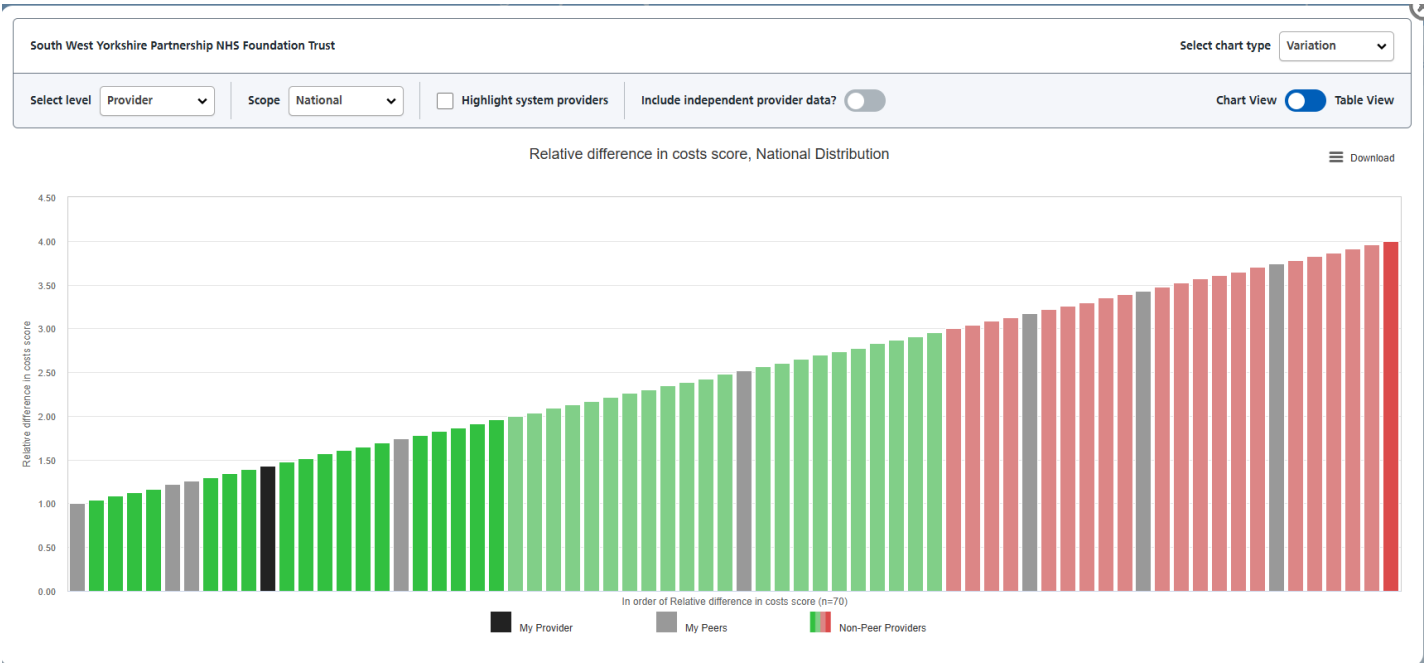
Trust position: Quartile 4, 0%

Variance year to date financial plan



Trust position: quartile 2, 0.09%

Relative difference in costs



Trust position: NOF Score 1.43

It is recommended that the Finance, Investment & Performance Committee note the quarter 1 performance and discuss this report.

Trust Board
30 September 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.
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 July 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.

**Trust Board
30 September 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 3 September 2025 Key agenda items included: • Story Telling: Experiences of healthcare from the LGB Community. • Chair's matters. • CEO Report- key updates included: ○ 10 Year Health Plan- it was updated that the Government has launched the 10 Year Health Plan which sets out how the nation's health will be transformed over the next decade and the role the NHS and care will play in this. The ICB has already started to consider the implications of the National 10 Year Health Plan and the new NHS Operating Model for the ICB in its re-defined role as strategic commissioner and for the South Yorkshire System. ○ National changes to ICBs- in July, the Board endorsed a proposal to start a formal consultation with ICB staff regarding the organisational change. However, shortly after the Board meeting the ICB received guidance from NHS England (NHSE) requiring them to pause the start of consultation to allow for a national discussion and agreement regarding how redundancy costs of this change would be met. ○ Financial position update- at the end of July (Month 4) all NHS organisations in South Yorkshire were on plan after adjusting for deficit support funding still to be received for Quarter 2.

	NHSE withheld release of deficit support funding in Quarter 2 because the South Yorkshire system was £2.9m off plan at the end of May This position will be reviewed at the end of August for potential receipt in Quarter 3. ○ Industrial action- Resident doctors from the British Medical Association took their first industrial action since achieving a mandate between 25-30 July 2025 and have a mandate for action valid for up to six months. ○ Integrated Care Partnership (ICP) Board- Partners from across the ICP are working together to boost sport and physical activity to improve health outcomes across South Yorkshire. ○ Health and Growth Accelerator- applications have opened for the South Yorkshire Health and Growth Accelerator Community Grants. ○ GP patient survey. ○ Publication of independent investigation report into the care of Yusuf Nazir. • South Yorkshire Board Assurance Framework and Corporate Risk Register. This will change in time given the revised role of the ICB. • Sport and Physical Activity Memorandum of Understanding • Place Partnership updates. • South Yorkshire- Delivering our Performance Objectives (IPR). • Emergency Preparedness Resilience and Response (EPRR) Framework. • NHS South Yorkshire Financial Delivery Report: ○ Month 4 Finance Report ○ ICB Efficiency Programme update • Specialist Commissioning Delegation Update. • Corporate Assurance Report and ICB Governance Items • Minutes of South Yorkshire Integrated Care Partnership (ICP) public meeting. • 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 5 November 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 10 September 2025. Agenda items included: • Update on work taking place across South Yorkshire regarding out of area bed placements. • Recognition of the 10-year health plan for England and how this may influence the work of the collaborative. • Agreement to review future operating model options for adult secure services. • Update received from the work taking place on Eating Disorders.
Date of next meeting	Next meeting scheduled for 13 November 2025

4. South Yorkshire Eating Disorder Joint Committee

Member	Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 8 September 2025. The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 8 September 2025. The main areas of discussion and subsequent actions are outlined below. • Inpatient care development- following previous presentations, the SYEDJC discussed an update paper on the future provision of inpatient care for adults with eating disorders, including learning from other national providers. The work done, which this time focused on adults, was well received and impressive – and it was clear the synergies that it could offer across the pathway. Committee requested that sole site/age separation were subject to specific risk assurance analysis; and agreed to review the updated financials/mobilisation plan in November 2025. Further papers outlining options for children and young people, including transitional care, are due at future meetings later in 2025. • Medical emergencies in eating disorders (MEED)- a proposal to fund enhancements to local MEED pathways was discussed, which re-highlighted the non-compliance with the MEED guidance published by the Royal College of Psychiatrists, and the high level of clinical risk for this cohort of patients. The Committee approved the redistribution of existing adult eating disorder funding to offer a more robust and consistent approach. The final two-phase implementation plan will be discussed to a conclusion at the October meeting. Work to ensure patients and community leaders are sighted on the changes are under way. The proposal presently does not assume a rationalisation of acute presentation sites,

	but discussions continue with acute Trust clinicians to explore the best practice we need to apply. • Adult community development- the Committee discussed options to enable equitable community day service provision for adults across South Yorkshire in line with the ambition of the Joint Committee to level-up care across South Yorkshire. A move to all-place access was agreed with effect from October 1, which aligns with the introduction of ICB funded community teams in all places – provided through SHSC. A proposal to expand and relocate services over time will be considered alongside the inpatient proposal later in 25/26. Waiting times will be added to the JC KPI scorecard recognising some adverse impact as all four places use the service. • Communications plan- a programme communications plan was reviewed and agreed. The plan outlines methodology for communicating with health and care professionals and people with lived experience regarding progress against the four key areas of the SYEDJC workplan. The communications plan will launch in October 2025. • Risk log- The SYEDJC reviewed the system-wide risk log which aims to enable oversight across provision of services. A number of risks relating to agenda items, namely inpatient care, MEED and involvement, were identified and are to be revised and/or added to the log. Further work on the experience of patients aged 17-19 will be considered in light of the risk log. • Data dashboard- The Committee reviewed a developing data dashboard. The dashboard aims to show performance and quality metrics across pathways including age transitions. The Committee discussed the need to focus on patient access and outcomes with further updates planned for the November meeting.
Date of next meeting	Next meeting to be confirmed.

5. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	There has been no further public meeting of the Barnsley Place Committee & Barnsley Place Partnership Board since the last update to Trust Board. A development session was held on 31 July 2025. This focused on: • 10 Year Health Plan and Neighbourhood Health. • Barnsley Place Task and Finish Group. • Place Partnership Delivery Group demand management. • Intermediate Care.

Date of next meeting	Next meeting scheduled for 25 September 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 9 September 2025 Agenda items included: • Strategic Involvement and Inclusion Group Update- an update of the work to date was shared and concerns shared relating to the profile of this work given the forthcoming changes to the ICB. It was agreed to explore how this group engages with other engagement groups across Barnsley to ensure good ongoing connections. • Ageing Well Programme Board Update- key achievements and impacts were shared, including that proactive care continues to ensure earlier identification of frailty and ensuring plans are in place to prevent further deterioration. The frailty multidisciplinary team (MDT) pilot clinic is underway and is being well received by patients and staff. Further discussions regarding expansion of the virtual way pathways are underway. • 2025 Approach to Addressing Health Inequalities- several options were discussed to utilise funding to work with high intensity Emergency Department users. • Strategic Health Inequalities and Intelligence Group Update- an update on the work of the group was provided and included: work on high intensity users, hyperlocal engagement with local elected members and area teams and work undertaken on diabetes was show cased. • VCSE Update. • Demand Management Update. • Escalations from other subgroups. • Escalations for Partnership Board. • It was updated that Barnsley was not successful in the application to be an NHSE Neighbourhood Pilot. However, Rotherham and Doncaster were and are closely aligned, so there is opportunity to benefit from shared learning.
Date of next meeting	Next meeting scheduled for 14 October 2025.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 27 August 2025 Key items discussed included: • Transformational Work– due to the historical challenges to connect provision across children’s services it was agreed that SWYPFT colleagues would explore a meeting with local authority colleagues. In relation to ARRS mental health roles (Additional Roles Re-imbursement Scheme), a working group continues to meet and has established two key workstreams to explore the ‘low-level’ mental health offer, seeking to understand our infrastructure and resource. Data analysis is underway to further understand patient flow. This will be used as a basis to discuss productivity and any improvements that could be made. • Review of ongoing workstreams and business- A creative approach to a drop in wound care clinic at breakfast club facility was outlined which has received positive feedback from patients and partners. The Connecting Care work is progressing well and will expand into a further neighbourhood. It was agreed that this work is a strong basis for neighbourhood care.
Date of next meeting	Next meeting to be confirmed.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/Deputy Chief Executive
Items discussed	Update from meeting on 11 September 2025 This was a special business meeting to consider and formally sign off the Pharmaceutical Needs Assessment (PNA).
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143
Date of next meeting	Next meeting scheduled for 9 October 2025. This will be a development session.

**Trust Board
30 September 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.		

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 1 July 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: ○ West Yorkshire Health and Care Partnership. ○ Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees. • NOTE the minutes of relevant partnership boards/committees.

Trust Board 30 September 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	There has been no further meeting of the West Yorkshire Integrated Care Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 23 September 2025.
Further information:	<u>Integrated Care Board :: West Yorkshire Health & Care Partnership</u>

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the West Yorkshire Health and Care Partnership Board since the last report to Trust Board.
Date of next meeting	Next meeting scheduled for 18 November 2025.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhppartnership.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

Members	Chief Operating Officer and Medical Director.
Items discussed	Update from meeting on 5 August 2025. Agenda items included: • Chair's update- the publication of the 10-Year Plan was highlighted and the development of Modern Service Frameworks, one of which will focus on mental health. Royal Assent of the Mental Health Act changes is anticipated in the autumn. The National Oversight Framework was discussed. • Work and Health Accelerator work update- an update was provided on this joint initiative across West Yorkshire, with interventions being delivered in all five places. To date, 25 of 56 proposed interventions have been mobilised, including rehabilitation services (e.g. long COVID and stroke rehabilitation), and support for carers. Each place has a delivery lead and contract lead. • Yorkshire and Humber Perinatal Mental Health Provider Collaborative. • Place and provider updates on Perinatal Mental Health. • Psychological Professions Strategy- the ongoing development and delivery of the West Yorkshire Psychological Professions Strategy was outlined, which is being implemented in close collaboration with acute colleagues across all West Yorkshire trusts. • Planning and performance update. • Escalation of AAA reports. Update from meeting on 11 September 2025. Agenda items included:

	• Chair's update. • Children and Young People's Mental Health (CYPMH) Provider Collaborative. • West Yorkshire CYPMH Programme work. • CYPMH Place work. • Right Care Right Person work plan. • NHSE Severe Mental Illness Submission. • Neurodiversity consultation. • Planning and performance update, including National Oversight Framework. • Talking Therapies System Development Funding. • Escalation of AAA reports. • West Yorkshire Local Transport Plan.
Date of next meeting	Next meeting scheduled for 16 October 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 9 September 2025. Agenda items included: • Wakefield Place Lead Quarterly Report- it was reported that: ○ The Board of the NHS West Yorkshire Integrated Care Board (WY ICB) met in June and heard reflections and themes from a series of health inequalities 'focus on' sessions produced by Healthwatch West Yorkshire. As part of the evaluation, the importance of three Cs – Communication, Coordination and Compassion – was highlighted. ○ The Government's 10-year Health Plan for England was published in July with focus on three shifts as core components (hospital to community, analogue to digital and sickness to prevention). In West Yorkshire more than 1,800 people shared their views on what they wanted to see in the 10-year plan. • Birth choices in the Wakefield District- the Committee supported the proposal to make permanent the temporary suspension of the birthing facility at Pontefract and to focus the service there on delivering comprehensive, high-quality ante-natal and post-natal care and family support.

	• Wakefield District Plan- it was noted that the development of the plan had been led by the Chief Officers of the constituent organisations of the Wakefield Together Partnership, who will be responsible for taking it forward. The Committee noted the inclusive partnership working that has led to the creation of the draft Wakefield District Plan, agreed to adopt and endorse the content of the draft plan and noted that the plan will ultimately be signed off by the Wakefield Together Partnership once all partners have endorsed it. • Provider Collaborative workstream and progress- a working group has been established under the leadership of the Chair of the Mental Health Alliance to take this work forward in Wakefield. A sponsor group of accountable officers for Calderdale, Kirklees and Wakefield (CKW) has also been established to ensure alignment across the three places. Work is ongoing to establish the functions that will be delegated to the provider alliance and the benefits to be derived from increased collaboration across providers. • Financial plan- it was reported that final submitted plans for Wakefield Place result in a deficit plan of £5.5m. • Quality, Safety and Experience Highlight Report- it was reported that the Care Quality Commission (CQC) has taken urgent enforcement action and issued warning notices against a nursing and residential care home in the district. The service is under significant scrutiny from Local Authority and ICB commissioners with input from the aligned GP Practice. The home has been escalated to formal enhanced quality oversight in line with our Quality Assurance Framework for Adult Social Care. • Performance Exception Report-Accident and Emergency (A&E) attendances to date report 0.5 per cent above the level planned, with July seeing a slight increase above plan. Whilst attendances are overall in-line with plan, activity at Pontefract Urgent Treatment Centre (UTC) reports 2 per cent above plan. • Quarterly Finance Highlight Report- Wakefield Place month 3 financial position is £1.1m behind plan. The focus is on recovering that position and on efficiencies in order to achieve the end-of-year position submitted. • 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 reported that the Business Intelligence team has supported the Neighbourhood Multidisciplinary Teams (NMDT) by developing a risk stratification model that predicts the risk of a patient from the NMDT cohorts (Chronic Obstructive Pulmonary Disease, Dementia and End-of-Life) being admitted in an emergency. Wakefield has also been announced as one of 43 areas across the country

	involved in the first wave of the National Neighbourhood Health Implementation Programme (NNHIP). • Better Care Fund Section 75 Partnership Agreement- the committee approved West Yorkshire Integrated Care Board (Wakefield Place) and Wakefield Council entering into a one-year Better Care Fund (BCF) partnership agreement for key functions of work in the Better Care Fund Plan. • High Level Risk Register and Board Assurance Framework.
Date of next meeting	Next meeting scheduled for 11 November 2025
Further information	Meeting papers are available here: <u>Committee meetings - Wakefield District Health & Care Partnership (wakefelddistricthcp.co.uk)</u>

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 28 August 2025. Key agenda items included: • Revised Terms of Reference. • West Yorkshire ICB Neighbourhood Health Update. • Wakefield Neighbourhood Health Highlight Reports: ○ Modern General Practice ○ Urgent Neighbourhood Services ○ Integrated Intermediate Care ○ Standardising Community Services • Escalation from Programmes/Alliances and Delegation to Programmes/Alliance. • Transformation Programmes and Alliances Review. • Economic Accelerator. • Items for escalation to Wakefield District Health and Care Partnership Committee.
Date of next meeting	Next meeting scheduled for 16 September 2025.

Wakefield Mental Health Alliance

Member	Director of Integrated Change - Wakefield (Chair), with Trust representative as a member.
Items discussed	Update from meeting on 27 August 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. • Mental Health Alliance next phase. • Dementia Strategy • 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 24 September 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 25 September 2025
Further information	Papers and draft minutes are available at: www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board

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 11 September 2025 Agenda items included: • Tackling Health Inequalities as a Board – inequality indicators discussion. • Special educational needs & disabilities (SEND) action plan/strategy. There is an aim to develop a new 200 place special free school • Place Lead Report which included neighbourhood health developments, winter planning, ICB organisational change, recent industrial action and the oversight framework • Risk Report. • Performance Report. • Calderdale and Huddersfield Winter Plan and Board Assurance Statement. • Finance Report. • Calderdale Cares Partnership Financial Strategy.

	• Quality and Safety AAA Report Assurance. • Review of Workplan. • Papers received for information: ○ Calderdale Quality Group Minutes. ○ Calderdale Primary Care Strategy Group Minutes. ○ WY&H Cancer Alliance Board Minutes.
Date of next meeting	Next meeting scheduled for 27 November 2025.
Further information	Further information and meeting minutes can be found here: <u>Calderdale Cares Partnership Board Papers - Calderdale Cares Partnership</u>

Calderdale Cares Community Programme Board

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	There has been no further meeting of the Calderdale Cares Community Programme Board since the last update to Trust Board.
Date of next meeting	Next meeting to be confirmed.
Further information	Papers are available on the Future NHS platform for those with an account. <u>https://future.nhs.uk/CalderdaleCCPBoard/view?objectId=36472912</u> Accounts can be set up at: https://future.nhs.uk/system/register

Calderdale Health and Wellbeing Board

Invited Observer	Director of Nursing & Quality
Items discussed	Update from meeting on 18 September 2025. ○ Agenda items included: ○ Developing Well. ○ Better Care Fund. ○ Winter Plans. ○ Forward plan and action logs.
Date of next meeting	Next meeting is scheduled for 11 December 2025.
Further information	Papers and minutes are available at: <u>https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0</u>

Kirklees

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 10 September 2025. This was a development session focused on the development of neighbourhood care and the provider alliance. Agenda items were: • Integrated Neighbourhood Teams Update- further update on progress in developing Integrated Neighbourhood Teams following discussions at previous development sessions. • Developing Provider Collaborative for Kirklees- update on progress in developing provider collaborative arrangements for Kirklees.
Date of next meeting	Next meeting scheduled for 8 October 2025.
Further information	Further information and papers are available at: <u>Kirklees Integrated Care Board Committee - NHS Kirklees HCP</u>

Kirklees Integrated Health and Care Partnership Forum

Member	Assistant Director of Corporate Governance
Items discussed	Update from meeting on 4 September 2025. Agenda items included: • Update on the work of Kirklees and Calderdale Care Association. • Update on the Work of Yorkshire Ambulance Service. • Kirklees Healthy Working Life Programme.
Date of next meeting	Next meeting scheduled for 4 December 2025.

Kirklees Health and Wellbeing Board

Invited Observer	Assistant Director of Corporate Governance
Items discussed	Update from meeting on 7 August 2025 Key agenda items included: • Changes to the Integrated Care Board landscape- it was updated that a West Yorkshire transitional Board has been established, meeting monthly, to oversee the changes. • Kirklees SEND Sufficiency for Kirklees 2025-2028- All local authorities have a legal duty to understand local needs and demands in terms of children and young people with

	Special Educational Needs and Disabilities (SEND). It was outlined that the SEND plan (The Big Plan) supports the system to ensure there are enough of the right type of learning places in Kirklees, and that these are the right type and quality placements. • Director of Public Health Annual Report 2024/25- the focus of this year's report is physical activity. The report will be published in August 2025. • Pharmaceutical Needs Assessment 2025-28 final sign-off- this was agreed. • Kirklees Joint Strategic Assessment (KJSA) update. • Partnership Framework review- a presentation was shared which set out background to the current Partnership Framework. Council officers are currently conducting a review, and there were a series of questions about the Framework for the Board's consideration.
Date of next meeting	Next meeting scheduled for 25 September 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 has been no further meeting 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	Update from meeting on 24 July 2025 Key agenda items included: • Winter planning and Crisis Pathway- a presentation was shared which set out the context (Urgent and Emergency Care Plan and 7 key metrics), overview of current position and next steps in development and sign off of winter plans. Key actions underway in relation to mental health were shared. These included the promotion of the Z card in Kirklees, investment in BLOSM team to try to avoid children and young people's attendances at A&E, focus on high intensity users, and establishment of mental health collaborative care group.

	• Integrated neighbourhood teams (INTs)- a presentation was shared. This outlined that key focuses of INTs in Kirklees are frailty and CYP, with mental health as core component of these. INTs in Kirklees are based around 9 PCNs. • Social connectivity and mental health.
Date of next meeting	Next meeting scheduled for 26 September 2025.

Trust Board
30 September 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 or partner, 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. 6.1- Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care. 6.2- 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.		

System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each of the provider collaboratives have reported a financial deficit at year end predominantly because of the use of out of area (OOA) placements, and enhanced care packages in adult secure care and CAMHS services.
Any background papers / previously considered by:	Previous reports to 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.

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:

- Increased activity with higher-than-average referrals into our male mental illness service to both the low and medium secure pathways has led to increased waiting times. The PC and through a collaborative approach in SPA are utilising the West Yorkshire bed base to support flow. Increase in referrals are from HMP into medium secure care and PICU services into LYPFT low secure service accounting for the pressure. A project is planned to work into LYPFT PICU to review referral rate, criteria, and interfaces. A new process is being developed with Yorkshire HMPs, Practice Plus group and secure services to improve interfaces and support to those waiting, with the aim to improve escalations and identification of those waiting of concern.
- Delayed transfers of care to high secure (retained services) remains a pressure both clinically through the management of patients in long terms seclusion and financially due to the pressure on OOA placements.
- 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 the male MI medium secure beds and high secure beds.
- Following the review of physical health care across WY secure services, all providers are developing specific actions plans to address areas of improvement. Plans are expected back in Q2 contract meetings.
- The new WY wide 'patient experience' questionnaire is currently being rolled out within services. Completed submissions are due in October 2025. With support of the WY involvement network, experience will be compared across services/providers. Plans have commenced to develop a patient AGM.

At month 5 (August) the Provider Collaborative was forecasting a surplus of £78k. This position includes the additional funding for 2025 / 26 in relation to the WEMMS service line (Women's Enhanced Medium Secure Services).

The most recent meeting of the Commissioning Committee (formerly Collaborative Committee) of the Trust Board took place on 5th August 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 MEED pathway. The service review is expected to be shared in Q3 of this year.

The current PC forecast is a surplus of £131k. The intention is for any surplus to be retained, and utilised, as an investment fund.

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 CYPS PC has realised efficiencies against plan in quarter 1 and has delivered a year-to-date underspend of £741k. This is largely driven by reduced OOA spend and associated EPCs.

The PC are 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.

The forecast underspend is currently £2,226k and this is dependent on EPC's and any changes in activity. As with the Adult Eating Disorder the PC intends to create an investment fund with any surplus.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire 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.
- Continuation of the Task & Finish Group to oversee repatriations back to Cheswold Park Hospital alongside facilitating new admissions to increase occupancy levels. A clinically coproduced timeline for repatriation of appropriate patients from across NEY to Cheswold Park Hospital has been presented and is reviewed for progress at the weekly bed management meeting. Discharges have served as a dominant factor in the overall bed numbers remaining at around 70, despite in excess of 17 admissions to the hospital since reopening. The Task and Finish Group will continue to steer admissions and facilitate timely discharges with the aim to operate at 80 beds by November 2025.
- Clinical oversight of patients that are clinically ready for transfer or discharge continues. Two patients that were awaiting high secure services with annual packages of care totalling £1.4m have been successfully transferred to Rampton Hospital. This will reduce the cost pressures for SYB Adult Secure Provider Collaborative.
- There remains a dedicated workstream focussed on the Women's Pathway, with plans to enhance the offer for women. Workshops, inclusive of female patients and service providers, are scoping out proposals for future need and how these could be met through existing service providers and estate. Included within this, is consideration for a focussed women's expansion of the Community Forensic Service. All proposals will be shared with the Adult Secure Provider Collaborative Oversight Group (PCOG) for agreement, prior to submission to NHSE.

- 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. The work of this group has positively impacted the spend on enhanced packages of care and ensuring the least restrictive practices are used for our patients.
- Agreement has been reached for an interim arrangement for provider reporting to the Commissioning Hub following the roll-out of PSIRF which was launched on 1st September 2025.
- Continuing the annual cycle of Quality Reviews with providers – All providers have had Annual Quality Reviews for 2025. Forest Lodge, part of Sheffield Health & Social Care NHS Foundation Trust, is currently in Enhanced Monitoring. All other providers remain in Routine Monitoring, with monthly progress reviews of their Action Plans. Updates and risk escalations are reported routinely to the monthly Patient Safety Quality Group and on to PCOG. There is a planned first review for Sheffield Community Forensic Service in November 2025.

Planning for 26/27 and onward has commenced with a deadline of December 2025 for outline commissioning and financial plans.

The SYB Provider Collaborative continues to report a deficit of £478k driven primarily by a £1.4m pressure relating to patients awaiting NHS retained services (High Secure). This has, however, now been resolved. A new pressure is highlighted, relating to the contracting arrangements for Amber Lodge, Low Secure Learning Disability & Autism beds, provided by RDASH NHS Foundation Trust. Executive discussions and formal contract negotiations continue.

To aid better sensitivity modelling for year-end projections, a detailed review of patient estimated discharge dates is taking place, with an expectation to refine year-end projections by the end of Quarter 3 25/26.

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

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 1st 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.

Trust Board
30 September 2025
Agenda item 13.1

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.		

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 one occasion since the last report to Board in July 2025. • Deed of rectification relating to Beckside Court to reflect updated lease plan to be submitted to the land registry.
Recommendation:	Trust Board members are asked to: NOTE the update to the Trust Seal since the last report in July 2025.

Trust Board annual work programme 2025-26

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
x	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
<u>Standing Items</u>												
Welcome, Introduction and Apologies	x	x	x	x	x	x	x	x	x	x	x	x
Declarations of Interest	x	x	x	x	x	x	x	x	x	x	x	x
Minutes from the previous meeting	x		x	x		x	x	x		x		x
Action log and matters arising from previous meeting	x	x	x	x	x	x	x	x	x	x	x	x
Service User/Staff Member/Carer Story	x		x	x		x	x	x		x		x
Chair's remarks	x		x	x		x	x	x		x		x

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	✕		✕	✕		✕	✕	✕		✕		✕
<u>Risk and Assurance</u>												
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)		x										
Annual Governance Statement	x											
Equality and diversity annual report										x		
Incident management annual report			x									
Health and safety annual report				x								
Patient Experience annual report			x									
Sustainability annual report						x						
Premises Assurance Model annual report				x								
PLACE assessment annual report				x								
EPRR Compliance report							x					
IPC BAF				x								x
PLACE report				x								
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	x		x	x		x	x	x		x		x
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	x		x	x		x	x	x		x		x
Provider Collaboratives and Alliances	x		x	x		x	x	x		x		x
<u>Performance reports</u>												
Integrated Performance Report (IPR)	x		x	x		x	x	x		x		x
Safer Staffing report			x							x		
Care Group Performance report	x		x	x		x	x	x		x		x

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
CQC action plan updates			✕			✕		✕				✕
<u>Strategic Direction</u>												
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)	✕		✕	✕		✕	✕	✕		✕		✕
<u>Governance</u>												
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)											✕	✕
<u>Strategies and Policies</u>												
Digital strategy (including IMT) 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
Estates strategy update				✗		✗				✗		
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*)
- 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 2028*)
- 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*)
- People Strategy (*October 2025*)
- Research and Development Strategy (*October 2025*)