Board of Directors: Public

Schedule	Thursday 1 August 2024, 9:30 AM — 12:00 PM BST
Venue	Barnsley College, Business Centre, Room CBC01
Organiser	Angela Wendzicha

Agenda

	4.2. Trust Objectives 2024/25 Quarter One Report For Assurance - Presented by Bob Kirton		320
	4.3. Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance For Assurance - Presented by Sarah Moppett		346
10:55 AM	Break	(10 mins)	373
11:05 AM	5. Governance	(20 mins)	374
	5.1. Board Assurance Framework/Corporate Risk Register To Review/Approve - Presented by Angela Wendzicha		375
11:25 AM	6. System & Partnership To Note	(10 mins)	414
	6.1. System and Partnership Report To Note - Presented by Bob Kirton		415
	6.2. Barnsley Place Partnership: verbal To Note - Presented by Bob Kirton		425
11:35 AM	7. For Information	(10 mins)	426
	7.1. Chair Report For Information - Presented by Sheena McDonnell		427
	7.2. Chief Executive Report: verbal For Information - Presented by Sheena McDonnell		435
	7.3. NHS Horizon Report For Information - Presented by Emma Parkes		436

	7.4. 2024/25 Work Plan To Note - Presented by Sheena McDonnell		440
11:45 AM	8. Any Other Business	(10 mins)	449
	8.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		450
	8.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		451
	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.		452
	Date of next meeting: Thursday 3 October 2023, 9.30 am		453

1. Introduction

1.1. Welcome and Apologies

Apologies: Richard Jenkins, Chris Thickett, Mark Strong

In attendance: Robert Paskell

To Note

Presented by Sheena McDonnell

1.2. Declarations of Interest

To Note

Presented by Sheena McDonnell

1.3. Minutes of the Previous Meeting: 6 June 2024

To Review/Approve

Presented by Sheena McDonnell

Minutes of the meeting of the Board of Directors Public Session
Thursday 6 June 2024 at 9.30 am, Lecture Theatre 1 & 2,
Barnsley Hospital NHS Foundation Trust

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Managing Director
	Simon Enright	Medical Director
	Sarah Moppett	Director of Nursing, Midwifery and AHPs
	Chris Thickett	Director of Finance
	Steve Ned	Director of People
	Lorraine Burnett	Chief Operating Officer
	Stephen Radford	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	Gary Francis	Non-Executive Director
	David Plotts	Non-Executive Director
	Alison Knowles	Non-Executive Director
	Nicky Clarke	Non-Executive Director
	Grant Whiteside	Associate Non-Executive Director
	Mark Strong	Associate Non-Executive Director
IN ATTENDANCE:	Tom Davidson	Director of ICT
	Liz Close	Deputy Director of Communications & Marketing
	Angela Wendzicha	Director of Corporate Affairs
	Lindsay Watson	Corporate Governance Manager
	Theresa Rastall	Freedom to Speak Up Guardian, min ref: 24/34
	Sara Collier-Hield	Associate Director of Midwifery, min ref: 24/44 & 24/45
OBSERVING:	Nick White	Corporate Governance Officer
	Tom Wood	Lead Governor, Council of Governors
	Jo Newing	Local Authority Governor, Council of Governors
	Rob Lawson	Public Governor, Council of Governors
APOLOGIES:	Emma Parkes	Director of Communications & Marketing

	Introduction	
BoD: 24/29	**Welcome and Apologies** Sheena McDonnell welcomed members, attendees and observers to the public session of the Board meeting. A warm welcome was given to Liz Close and the newly appointed Board Members following their recent appointment to the Trust. Apologies were noted as above. The Board acknowledged events that were being held to mark the 80th	

	anniversary of D-day. Due to the calling of the General Election, Board members were also reminded that we are currently in the pre-election period, previously known as Purdah.	
BoD: 24/30	**Declarations of Interest** The standing declarations of interest were noted by Richard Jenkins, Chief Executive Officer, Angela Wendzicha, Director of Corporate Affairs and Liz Close, Deputy Director of Communications for their joint roles between Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). Lorraine Burnett and David Plotts as Directors of Barnsley Facilities Services (BFS) also noted a declaration of interest. Nicky Clarke, Chief of People at the Northern Care Alliance NHS Foundation Trust made a declaration of interest.	
BoD: 24/31	**Minutes of the Previous Meeting: 4 April 2024** The minutes of the meeting held on Thursday 4 April 2024 were reviewed and approved as an accurate record of events.	
BoD: 24/32	**Action Log** The action log from the previous meeting was reviewed and progress against outstanding/completed actions was duly noted. Regarding the question raised on behalf of the Council of Governors (CoG) about research and development, Angela Wendzicha confirmed additional information will be circulated next week.	
	Culture	
BoD: 24/33	**Patient Story** Sarah Moppett introduced the patient's story which was shared via video; the patient had provided consent for his story to be heard in the public domain. The patient shared his experience of the excellent care and treatment he had received while being an inpatient in the Intensive Care Unit. He was also supported by the Critical Care Rehabilitation Team, both physically and psychologically following his period of hospitalisation, which included teaching the patient how to walk. The patient acknowledged all staff who were involved in his care. The Board noted that a key focus area for the Trust this year is the prevention of deconditioning, the story today was a reminder as to the importance of the work being undertaken. Within critical care, the Trust has been pulled out as an exemplar regionally for the environment and services provided. The Board expressed its appreciation to all staff involved and thanked the patient for sharing his experience.	

BoD: 24/34	**Freedom to Speak Up Annual Report: Theresa Rastall in attendance** Theresa Rastall was in attendance to present the Freedom to Speak Up (FTSU) Annual Report 2023/24. Arising from the report, the following key highlights were noted: • During the reporting period 80 concerns were raised, with an increase noted in quarters three and four. The Allied Healthcare Professionals Group raised the most concerns reported at 31, followed by Nursing & Midwifery with a total of 14 concerns. • From the concerns raised, the highest reported category related to patient safety by inappropriate behaviours. • Core training for FTSU is reported at 72%, noting a month-on-month increase. • Staff Survey results have reported a year-on-year increase with staff raising concerns over a 3 year period. The Trust had the second highest score in the North East and Yorkshire region for the theme "Voice that Counts", reported at 7.08%, 0.8% behind the highest scorer in the country. • There are a total of 20 champions across all Clinical Business Units (CBU) at the Trust, with work currently ongoing to have more diversity within the champion groups. In response to a question regarding how to increase the reporting of concerns within the Medical and Dental Group; the Board noted working relationship has been formed with the Guardian of Safe Working where discussions have been held on how to work together going forward to raise the awareness. Simon Enright also noted that the Junior Doctors are supported by the Medical Education Lead and Educational Supervisors as well as regular General Medical Council surveys being undertaken. The Trust also has a Joint Negotiating Committee, attended by the Medical Director and Chief Executive, which is a forum where medical staff can raise and escalate concerns. Concerning the recent changes to the Pathology Workforce, the Board noted the FTSU Guardian had been actively involved in providing support to staff, where positive feedback was received on how the process had been managed. The Board thanked Theresa Rastall for her support to the Trust, along with Nick Mapstone, previous FTSU Non-Executive Director (NED) Champion, who left the Trust at the end of May 2024. The annual report was received and noted by the Board.	
	Assurance	
BoD: 24/35	**Audit Committee Chair's Log** Stephen Radford presented the chair's log from the meeting held on 24 April 2024 which was noted and received by the Board. The Board was pleased to note that the Head of Internal Audit provided a significant assurance	

	opinion, for the seventh consecutive year. The Board was made aware that limited assurance opinion had been provided for the processes and policy which support nutrition and hydration; this had been delegated to the Quality and Governance Committee for oversight of the delivery of management actions. Gary Francis, Chair of the Quality and Governance Committee, informed the audit opinion was received by the Committee in May 2024, which noted the actions being taken to address the areas of non-compliance.	
BoD: 24/36	**Audit Committee: Terms of Reference** The revised Terms of Reference were received and endorsed by the Board.	
BoD: 24/37	**Quality and Governance Committee Chair's Log: 24 April/29 May 2024** Kevin Clifford and Gary Francis presented the chair's logs from the meetings held on 24 April and 29 May 2024 which were noted and received by the Board. April 2024: several reports were received which included an update on the actions following a recent Health and Safety visit and the approval of the Non-Clinical Incident Management Policy. May 2024: several reports and presentations were received which included; improving public health and reducing inequalities and internal audit report regarding nutrition and hydration. The annual effectiveness reports for several groups which feed into the committee were also received. The general feedback was positive with common emerging themes, work is ongoing to address these which included agenda length and size of the documents. The Infection Prevention and Control (IPC) Annual Report was presented, noting the Trust had no reported cases of MRSA within the year. The IPC Team was thanked for their continued support and hard work.	
BoD: 24/38	**Infection Prevention and Control Annual Report & Annual Programme** Sarah Moppett introduced the annual report for 2023/24 and the annual programme for 2024/25, providing an overview of all Infection Prevention and Control (IPC) activities. A question was raised asking how IPC is managed alongside operational pressures and has any learning been identified; the Board noted that during the winter period, winter wards and escalation beds had been opened as additional capacity to help with the operational pressures. Assurance was provided that mitigations are in place to ensure the safety of patients at times during periods of increased activity. The Board noted and received the annual report for 2023/24 and the annual programme for 2024/25.	
BoD: 24/39	**Finance & Performance Committee Chair's Log: 25 April/30 May 2024** Stephen Radford presented the chair's logs from the meetings held on 25	

	April and 30 May 2024 which were noted and received by the Board. Several reports were presented at both meetings including the latest update on the financial position of the Trust, Urgent and Emergency Care update and the financial recovery plan for 2024/25, which is to be discussed in further detail at the private session later this morning. The Committee was assured of the level of financial controls within the Trust, noting year position was on the forecast and the efficiency and productivity programme had been delivered. The Board noted that Stephen Radford would be handing over the Chairing of the Committee to Alison Knowles, effective June 2024. Stephen Radford was thanked for his support to the Committee. A question was raised in terms of the high agency spend reported at 3.7% over the gap, asking what control measures are in place to keep this under control. The Board was informed several measures are in place which include weekly agency spend meetings, attended by the Director of Finance and the Medical Director, along with weekly check and challenge meetings with the Nursing Directorate, to review the processes in place. Chris Thickett advised challenges are experienced in a few specialities, which we are having to backfill with expensive agency staff. A business case has been presented to the Executive Team (ET) to address the junior doctor challenges, which should see a reduction in agency spend backfill. In response to a question regarding overachievement on the non-pay side; Chris Thickett informed that recurrent pay spend is currently a challenge for the Trust; all Trusts are experiencing higher levels of sickness, and additional capacity is required due to operational pressures, which increases spend.	
BoD: 24/40	**Information Governance Annual Report** Tom Davidson introduced the Annual Information Governance (IG) Report which was noted and received by the Board. The Board noted that there had been a reduction in the confidentiality incidents on Datix; the narrative reported a 20% breach of patient confidentiality and nearly 40% categorised as other types of information. Arising from the discussion, the Board requested a breakdown of the categories of the breaches. ***Action:*** *breakdown of categories of the breaches to be provided for information.* The Board was informed that the Data Security and Protection Tool Kit, which measures the effectiveness of controls in place by the Public Sector Internal Audit Standards, had been received from 360 Assurance which provided a *moderate assurance* opinion. Following the recent media coverage of the recent cyber security attack in London, a question was asked if the Trust is connected with the provider concerned. The Board was informed the Trust is not connected with the	TD

	provider. Richard Jenkins advised in-depth discussions had been held at the recent ET meeting, noting mechanisms are in place as to how the Trust would manage and respond to a cyber-attack. In response to a question raised regarding the risk to the Trust in not responding within the 20 days' timeframe for the Freedom of Information (FOI) requests; the Board noted communication with the individual is made to provide a clear explanation for the delay and generally, this is due to the complexity of the information requested. The Information Commissioners Office (ICO) can fine the Trust for failing to comply with the FOI request in the agreed timescales.	
BoD: 24/41	**People Committee Chair's Log: 28 May 2024** Gary Francis presented the chair's log from the meeting held on 28 May 2024 which was noted and received by the Board. Several reports have been presented including the workforce insight report which demonstrated high compliance rates against mandatory training, the Independent Review of Greater Manchester Mental Health Trust: The Shanley Report and the annual Health and Well-being Report. The Committee received and approved the Fit and Proper Person Policy, with the recommendation for approval of its implementation by the Remuneration and Nomination Committee, before being recommended to the Board for ratification. ***Action:*** *Fit and Proper Person implementation will be presented to the Board of Directors for approval.* **Northwest Black, Asian and Minority Ethnic (BAME) Assembly Antiracist Framework:** the Board agreed for the Trust to adopt the framework, proceeding to assessment against the framework.	SN
BoD: 24/42	**Barnsley Facilities Services Chair's Log** David Plotts introduced the chair's logs from the meetings held in April and May 2024. The key highlights to note from the reports were that BFS achieved financial projections for the year, a donation of £375,000 was made to Barnsley Hospital Charity and the relocation of the Acorn Unit to Ward 12 has been completed. The Board noted positive feedback had been received from both staff and patients following the move. The Board commended the BFS team and colleagues for their support and hard work with the relocation of the Acorn Unit.	
BoD: 24/43	**Executive Team Report and Chair's Log** Richard Jenkins introduced the chair's logs from meetings held throughout April and May 2024 which were noted and received by the Board. No matters required escalation for the attention of the Board.	
	Performance	
BoD: 24/44	**Maternity Services Board Measures Minimum Data Set** Sara Collier-Hield was in attendance to provide an update on the maternity services board measures minimum data set, to maintain oversight of	

	services within Barnsley. Arising from the report the following key points were raised: • A review of the MBRRACE perinatal mortality report is currently ongoing by the Perinatal Lead, the findings will be presented to ET in June 2024. • In March 2024, one Patient Safety Incident Investigation (PSII) was declared, with three ongoing in March/April 2024. • Mandatory training for the maternity establishment is maintained above 90%. Level 3 Safeguarding is also above the target of 90%. The medical staff group remains below the compliance target; seven colleagues who require training had recently commenced on the Vocational Training Scheme in April 2024, and will be allocated the next available session. Compliance in five of the staff groups for PROMPT training remains at over 90%. • Attain cases were reported to be above the target of 5% in March, reported at 7.17% (16 babies) • Staffing: Following a review of the Midwifery Staffing, approval has been given to over recruitment of newly qualified midwives as a result of maternity leave, long-term sickness absence and staff turnover. Plans in place to increase the Obstetric Staffing establishment. • Clinical Negligence Scheme Year 6 standards, including Saving Babies Lives V3, were published on 2 April 2024, meetings have already commenced with the leads for all ten safety actions. Submission of the Board declaration to NHS Resolution is mid-day on 3 March 2025. In response to a question asking what the Trust is doing to ensure mothers from a non-white ethnicity are appropriately assessed; Sarah Collier-Hield advised four immediate actions have been issued to the Trust and have been implemented. The Board noted BadgerNet had gone live across Maternity this week, noting no concerns had been escalated, Sara-Collier-Hield was acknowledged for her support. In response to a question raised about the PSII incident relating to antenatal transfer to ITU and IT connectivity in the community hubs; the Board was informed new processes have been implemented within the Team following the recent connectivity issues. It was also noted that BadgerNet works better offline, with no barriers for staff being able to access GP records therefore in any location. Tom Davidson advised the Trust is working with the Community Midwives at BMBC to ensure all issues are resolved. The Board formally acknowledged Kevin Clifford for his support during his time as the Midwifery NED Champion as he handed over the Champion role to David Plotts.	
BoD: 24/45	**Midwifery Workforce Staffing Report** Sara Collier-Hield introduced the six-monthly staffing report which was	

	received and noted by the Board. In response to a question regarding the budget for the additional care workers; Sara Collier-Hield explained that this has not been secured at this time. The staffing model on the ward has not been changed, as this requires further investment. The senior midwifery team are working with colleagues in finance to explore any potential options. A review of the staffing to ensure safe care is provided is regularly undertaken to ensure safe patient care is provided. Richard Jenkins asked about the Trust's plans relating to the ethnicity of the midwifery workforce; Sara Collier-Hield confirmed the Senior Leadership Team has BAME colleagues, and confirmed this would be included within future reports for information.	
BoD: 24/45	**Trust Objectives 2023/24 End of Year Report** Bob Kirton presented the end-of-year report providing a high-level summary of the key highlights and concerns for the Trust. The report had also been scrutinised and discussed in detail at the recent Assurance Committees. Good progress had been made throughout the year despite the operational pressures faced, which included industrial action and urgent and emergency pressures. The Board noted and approved the report as an assurance of progress made against the Trust Objectives.	
BoD: 24/46	**Integrated Performance Report** Lorraine Burnett presented the Integrated Performance Report (IPR) for April 2024 which was noted and received by the Board. The report, which had been presented at the recent Assurance Committees, provided an overview of performance challenges throughout the Trust. A question was asked regarding the staff turnover rate given the excellent staff survey results recently received; Steve Ned confirmed that the figure remains within the target of 12%, the agreed metric rate of 10 – 12%, with review mechanisms in place by the People and Engagement Group. Richard Jenkins noted that the recent rise is a result of the recent changes in the Pathology workforce.	
	Governance	
BoD: 24/47	**Board Assurance Framework / Corporate Risk Register** Angela Wendzicha introduced the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), providing an update on the latest position, informing both documents had been presented for review at the ET meeting and Assurance Committees. BAF: There are 13 risks aligned to the BAF, all risks were reviewed with the Executive Director/Risk Leads to ensure they accurately reflect the current position. Risk 1201 regarding the risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development; following	

	discussion by the People Committee, it is proposed the residual risk score is reduced from 12 to 9. The CRR was reviewed, noting there are no recommendations for the residual scores. The Board received and approved the updated BAF/CRR, endorsing the reduction in the residual score of Risk 1201.	
BoD: 24/48	**Risk Management Policy** Angela Wendzicha introduced the revised Risk Management Policy which was being presented for approval by the Board. The Board was informed, following approval today, that a programme of additional training sessions will be provided to staff for risk management over the next 12 months. The Board received and approved the policy.	
BoD: 24/49	**Constitution Review** Angela Wendzicha introduced the Trust Constitution, which had been updated in line with the changes from the Health and Care Act 2022 and the new regulatory guidance issued by NHS England. The document will be circulated to the new Board members following the meeting. ***Action:*** *Constitution to be circulated to the newly appointed Non-Executive Directors.* The Board was asked to provide any proposed changes and additional recommendations to the Constitution, which would be subject to further scrutiny and approval by the CoG. Following discussion, a proposal was made for the inclusion of vacancies on partner governors and the make-up governors to be documented, along with consistent terminology referencing the Vice Chair. Subject to the minor amendments above and any additions; the Board approved the Trust Constitution, with the recommendation of approval by the CoG.	AW
BoD: 24/50	**Annual Review of Standing Orders** Angela Wendzicha presented the Standing Orders for review as part of the annual cycle of business. Subject to minor formatting and typographical amendments, the Board received and endorsed the revised Standing Orders.	
BoD: 24/51	**Scheme of Delegation** The Scheme of Delegation has been deferred to the August Board meeting.	
BoD: 24/52	**Non-Executive Director Champion Roles**	

	Sheena McDonnell introduced the paper, which outlined the approach to ensure the Board retains oversight of important issues; by the retention of some Champion roles, and discharging the activities and responsibilities previously held by some of the NEDs through the Assurance Committee structure. Following discussion, the following points were raised: • Emergency Preparedness/Security Management: oversight is currently with the Quality and Governance Committee; the Board noted further discussions will be held by ET as to whether this remains with the Quality and Governance, or delegated for oversight by the Finance and Performance Committee. • Doctors Disciplinary Champion, it was suggested to rename this to Doctors in Distress. • Maternity Safety Champion: discussions to be held offline regarding the potential inclusion of an addendum to the current post holder's job description. • ToR: to be circulated for information to each of the Champion roles. ***Action:*** *ToR to be circulated.* The Board received and endorsed the following recommendations: • Nicky Clarke: Wellbeing Guardian • Kevin Clifford: Freedom to Speak up • Gary Francis: Doctors Disciplinary • David Plotts: Maternity Board Safety • Stephen Radford: Security Management • The Board also agreed that reference would be made to Stephen Radford as the Senior Independent Director, and Kevin Clifford as Vice Chair within the Champion Roles. • The champion roles were agreed with a recommendation to the Council of Governors remuneration and nomination committee to support the proposals at a future meeting.	
	System & Partnership Update	
BoD: 24/53	**System & Partnership Report** Bob Kirton provided a verbal update on the latest developments within the Acute Federation (AF); a Senior Leaders Development session was held earlier in the week, with a focus on strengthening relationships, connections and creating a shared vision across the AF. A system report will be provided at the next Board meeting in August 2024. **Action:** System report to be added to the work plan for August 2024. Further discussions will be held in the Private Session of the meeting concerning the financial aspects. The Chief Executive Report from the ICB Chief Executive was included for information.	BK
BoD:	**Barnsley Place Partnership: verbal**	

24/54	Bob Kirton informed due to the timing of the Barnsley 2030 Board meeting, no updates are available. Richard Jenkins informed at the Barnsley Place Board last week, that further discussions were held surrounding the future of the Acorn Unit; an agreement has been made for this to be on the Trust's site for a 2 year period. The Barnsley Place Update for May has been included for information.	
	For Information	
BoD: 24/55	**Chair Report** Sheena McDonnell introduced the chair's report which provided a summary of events, meetings, publications, and decisions that require bringing to the attention of the Board. The Board noted and received the report.	
BoD: 24/55	**Chief Executive Report** Richard Jenkins presented his report providing information on several internal, regional, and national matters that had occurred following the last Board meeting. The report highlighted the Heart Awards, which is an annual event to celebrate and recognise the work of colleagues; the Board congratulated all nominees and the winners of the awards. The Board noted and received the update.	
BoD: 24/56	**NHS Horizon Report** The report provided an overview of NHS Choices Reviews; reviews of strategic developments and national and regional initiatives were noted and received by the Board.	
BoD: 24/57	**2024/25 Work Plan** The work plan, which sets out the structure of the year ahead was included for information which was noted by the Board.	
	Any Other Business	
BoD: 24/58	**Questions from the Governors regarding the Business of the Meeting** No questions had been submitted on behalf of the Council of Governors.	
BoD: 24/59	**Questions from the Public regarding the Business of the Meeting** Before the meeting, a statement had been published on the Trust's website inviting questions from members of the public. No questions were submitted.	
BoD: 24/59	**Date of next meeting** The next Board of Directors Public Session is to be held on Thursday 8 August 2024, at 9.30 am in Room CBC01 Business Centre, Barnsley College, County Way, Barnsley, S70 2JW	

	Post meeting note: *The next Board of Directors meeting will be held on Thursday 1 August 2024, at 9.30 am in Room CBC01 Business Centre, Barnsley College, County Way, Barnsley, S70 2JW.* In accordance with the Trust's constitution and Standing Orders, it was resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.	

1.4. Action Log

To Review

Presented by Sheena McDonnell

1.5 Public Board of Directors Action Log

Meeting Date	Agenda	Action	Assigned To	Due Date	Progress / Notes	Status
01-Feb-24	Questions from the Governors regarding the Business of the Meeting	Research and Development: A previous query had been raised by a member of the Council of Governors, regarding processes and compliance; it was asked if an action plan was in place. The Board requested further information to be submitted which would be reviewed outside the meeting.	Angela Wendzicha	01-Aug-24	In progress: additional information being sought.	In progress
06-Jun-24	Information Governance Annual Report	Breakdown of categories of the breaches is to be provided for information.	Tom Davidson	01-Aug-24	In progress	In progress
06-Jun-24	Constitution Review	Constitution to be circulated to the newly appointed Non-Executive Directors.	Angela Wendzicha	01-Aug-24	Circulated.	Complete
06-Jun-24	People Committee Chair's Log: 28 May 2024	Fit and Proper Person Policy to be presented to the Board of Directors for approval.	Steve Ned	01-Aug-24	Added to the work plan, will be presented at a future date.	Complete
06-Jun-24	System & Partnership Report	System report to be added to the work plan for August 2024.	Bob Kirton	01-Aug-24	Added to the agenda for the Public Board meeting on 1 August 2024.	Complete

2. Patient Story

To Note

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/2

SUBJECT:	**PATIENT STORY**					
DATE:	1 August 2024					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval			*Assurance*	✓	
	For review			*Governance*	✓	
	For information	✓		*Strategy*		
PREPARED BY:	Leanne Sagar, Patient & Carer Experience Lead					
SPONSORED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs					
PRESENTED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs					

STRATEGIC CONTEXT

The delivery of the patient story at Trust Board supports the Trust Quality priority of ensuring that the patient voice is heard and considered in support of quality improvement discussions at both strategic and operational levels.

EXECUTIVE SUMMARY

This patient story via the link below describes Kaiden and the support he may need when attending hospital.

PWC24-994 BH Patient Story (4) Learning Disability and Autism Support [FINAL] on Vimeo

Feedback from the Board of Directors will be shared with Kaiden and his family via the Patient Experience Team.

RECOMMENDATION

The Board of Directors is asked to be assured that services continue to provide person centred care.

3. Assurance

3.1. Audit Committee Chair's Log: 10 July 2024

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.1

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Stephen Radford, Chair of the Audit Committee				
SPONSORED BY:	Stephen Radford, Chair of the Audit Committee				
PRESENTED BY:	Stephen Radford, Chair of the Audit Committee				

STRATEGIC CONTEXT

The Audit Committee advises the Board on the effectiveness of arrangements to manage organisational risk and actions being taken to remedy any weaknesses that are identified through the work of Internal and External Audit.

EXECUTIVE SUMMARY

The Audit Committee (AC) received 3 audit reports, two of which had Limited Assurance – CBU3 Governance and Recruitment/Onboarding (Medical/ Non-Medical Staff). Both reports raised concerns and will require assurance / over-sight through the Quality & Governance and People Committees. In future, the AC will request the Executive Director responsible to attend the Committee meeting where the audit opinion is only Limited Assurance. The Committee asked for updates on both areas with Limited Assurance at its next meeting.

The Committee received the Counter Fraud, Bribery and Corruption Annual Report 2023/24 and noted the status of the Trust remains at 'green' across all assessed areas, and continues to remain so in Q1, 2024-25.

The Committee reviewed Single Tenders report noting that in the period under consideration there were 4 waivers requested and approved. These related to courier logistics, provision of specialist support to a patient with mental health issues and lighting. This was an increase of 3 since the last report. All waivers have been agreed with Procurement input.

The Committee received and discussed the Audit Committee Annual Effectiveness Review 2023-24. Although only a small response, the Committee deemed itself effective and agreed to the suggestion to review the Committee Agenda/Planner and Terms of Reference.

RECOMMENDATIONS

The Board of Directors is asked to receive and review the attached log.

Subject:	AUDIT COMMITTEE ASSURANCE REPORT	Ref:	BoD: 24/08/01/3.1

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	10 July 2024	Stephen Radford

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate to receiving body
2.1	**Internal Audit Progress Report:** The Audit Committee received the latest Internal Audit progress report in which updates were provided on the 3 audits completed since the last report in April 2024: These were: • Recruitment and onboarding - Limited Assurance • CBU governance - focus on CBU 3 - Limited Assurance • Data Security and Protection Toolkit (DSPT) - Moderate Assurance (NHS England rating) Concerns were discussed regarding the Limited Assurance and the types of issues identified in the Recruitment/On-boarding and CBU governance audits. Both reports will be progressed through the People's Committee and Quality & Governance Assurance Committees respectively. In discussion, it was emphasised any learning from the Governance Audit of CBU3 should as a priority be shared across all units where applicable. A further update on actions being taken will be reported to the next Audit Committee meeting. It was agreed that in future that the Executive Director responsible would be invited to the Audit Committee to discuss internal reports where Limited Assurance has been received. Terms of reference have been agreed for the following forthcoming audits: • Mandatory training • Discharge management	Board of Directors	For Information & Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate to receiving body
	• Patient Safety Incident Response Framework • Safeguarding The Committee noted and approved planned changes to the Internal Audit plan for 2024/25 and that the Trust's action tracking/follow up rate so far for 2024/25 stands at 92%. The Committee were also notified of changes to the Terms of Reference for our 2024/25 Head of Internal Audit Opinion.		
2.2	**Counter Fraud Progress Report:** The Committee received the latest Counter Fraud Progress Report, From the report it was noted that: • The Counter Fraud Service (CFS) has issued 5 local alerts/ fraud prevention notices to relevant Trust officers • The CFS prepared the Trust's Counter Fraud Functional Standard Return 2023-24 (CFFSR) for submission. • The CFS received two new fraud referrals during the reporting period – Both related to False Representation • For 2024 Counter Fraud Functional Standard Return (CFFSR) the current position is 'green' across all areas being assessed	Board of Directors	For Information & Assurance
2.3	**2023/24 Counter Fraud, Bribery and Corruption Annual Report:** The Committee received and noted the report. The Trust position is assessed as 'green' across all areas being assessed.	Board of Directors	For Information & Assurance
3.1	**Single Tenders/ Tenders Awarded Other Than the Lowest:** The Committee reviewed the report prior to ratification by the Board relating to single tender actions. The Committee noted that in the period under consideration, there were 4 waivers requested and approved. These related to courier logistics, provision of specialist support to a patient with mental health issues and lighting. This was an increase of 3 since the last report. All waivers have been agreed with Procurement input.	Board of Directors	For Information & Assurance

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate to receiving body
3.2	**Losses and Special Payments:** The Audit Committee received and noted the latest Losses & Special Payments report that details the losses and special payments made by the Trust in the period following the previous Audit Committee. Losses incurred on Wagestream were discussed and referred via the Minutes to the People's Committee for consideration.	Board of Directors	For Information & Assurance
4.1	**Audit Committee Annual Effectiveness Review 2023-24:** The Committee received the annual review survey conducted via Convene on the effectiveness of the Committee from 1 April 2023 – 31 March 2024. Although only a small response, the report findings were generally favourable and endorsed the effectiveness of the Committee. Suggestions were made around better alignment between the Audit Committee's agenda and its Terms of Reference. It was agreed that these would be reviewed and recommendations presented at the next meeting.	Board of Directors	For Information & Assurance
4.2	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR):** The BAF and CRR were presented and noted by the Committee. Both documents are going through a review cycle by the Executive, the Board and other assurance committees.	Board of Directors	For Information and Assurance

3.2. Quality and Governance Committee Chair's Log: 26 June/24 July 2024

For Assurance

Presented by Gary Francis

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.2

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair				
SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key Committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 26 June 2024 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance. Q&G's agenda included consideration of the following items:

- Learning Disability and Autism Annual Report 2023/24
- Radiation Safety Policy- Ionizing Radiation
- Clinical Effectiveness Group Chair's Log
- CQC Adult In-patient Survey 2023
- Patient Safety & Harm Group: Chair's Log and Martha's Law application update
- Nursing, Midwifery, Therapies & Medical Staffing Reports
- Maternity Services Board Measures Minimum Data Set
- NHSi Medical Staffing Safeguards Report
- Health Care Scientists Update
- Violence and Aggression Update
- Corporate Performance Reports
- Infection Prevention and Control Chair's Log
- Medicines Management Committee Chair's Log and Minutes
- Integrated Performance Report

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	BoD: 24/08/01/3.2

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 26 June 2024	**Chair:** Gary Francis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Learning Disability and Autism Annual Report 2023/24	The Learning Disability and Autism Annual Report was presented. It described the enormous amount of work undertaken to improve the experience of patients with Learning Disabilities or Autism when they come to Barnsley Hospital. Of particular note is that approximately half of all staff have received Oliver McGowan training and 'Green Bags' made available for patients with these conditions. Some of the challenges hindering further progress was described including community engagement and the need to increase the number of Learning Disability and Autism champions within the trust	Board of Directors	Assurance
2	Radiation Safety Policy- Ionizing Radiation	This updated policy was presented for approval. Amendments have been added to take account of changing regulations and standards expected in regulation. The Committee approved the policy subject to review by subject matter experts to coincide with the visit by CQC.	Board of Directors	Assurance
3	Clinical Effectiveness Group Chair's Log	The chair's log was discussed. Reference was made to the work led by the recently appointed trauma lead. Attention was drawn to the identified need to appoint a trauma coordinator. Reference was made to the considerable work performed by the Data Quality Group to validate patient pathways	Board of Directors	Assurance

4	CQC Adult In-patient Survey 2023	The report, which is still subject to embargo pending release in September was considered by the Committee.	Board of Directors	Assurance
5	Patient Safety & Harm Group: Chair's Log and Martha's Law application update	Reference was made to the increasing numbers of Quality Improvement projects highlighted at the recent 'Give-it-A Go' week events. Badgernet has been successfully introduced in maternity and has been well received. Following the Limited Assurance report in Nutrition and Hydration the Committee was pleased to learn that Malnutrition Universal Screening Tool had reached 94%. Lying and Standing blood pressure measurements are now captured in 94% of in-patients. The Committee was appraised of the preparatory work to participate in the Martha's Rule pilot for which the trust has been selected to participate.	Board of Directors	Assurance
6	Nursing, Midwifery, Therapies & Medical Staffing Reports	Ongoing recruitment and retention difficulties to Orthopaedic ACPs has resulted in a business case option appraisal to be produced which will be presented to the Executive Team. The Committee noted, with concern, the persistent need to open unfunded beds on ward 36. The matter has been referred to the People Committee.	Board of Directors	Assurance
7	Maternity Services Board Measures Minimum Data Set	Foetal monitoring compliance remains high. No perinatal incidents were reported during the reporting period. A relative lack of Safeguarding training slots has resulted in compliance falling. Discussions have taken place with the Safeguarding Team to provide more sessions for staff to attend.	Board of Directors	Assurance

8	NHSi Medical Staffing Safeguards Report	Hot spot areas for recruitment remain in Anaesthesia, Dermatology, Haematology, Radiology (consultants), Oral/orthodontics. The Committee was advised that General Practice Voluntary Training scheme vacancies have emerged as a result of a reduction in the number of training practices within Barnsley. Trust appointments are being sought to address the shortfall. Training grade recruitment otherwise is good.	Board of Directors	Assurance
9	Health Care Scientists Update	Recruitment of Health Care Scientists remains a national issue. Mitigations to alleviate this problem were described, including participation in a national rotational apprenticeship programme. In relation to recruitment and retention difficulties the Committee was made aware that, unlike other professional groups, Health Care Scientists are not in receipt of Continuing Professional Development funding. This matter was referred to the People Committee to consider.	Board of Directors	Assurance
10	Violence and Aggression Update	To help address the issue Violence and Aggression training has been made mandatory by the Executive Team. A piece of work is being developed to address non-deliberate violence and aggression de-escalation training.	Board of Directors	Assurance
11	Corporate Performance Reports	CBU Performance meetings have been revamped and a progress report will be provided to Q&G in July.	Board of Directors	Assurance
12	Infection Prevention and Control Chair's Log	The increased incidence of surgical site infections (SSIs) in orthopaedics (prosthetic surgery) was considered along with the action plan to address these.	Board of Directors	Assurance
13	Medicines Management Committee Chair's Log and Minutes	The chair's log was noted.	Board of Directors	Assurance

14	Integrated Performance Report	Note was made of the sustained improvement in pressure ulcers, falls and harms resulting from falls and the improving performance in 4-hour AED waits (71%) and improvement in RTT (71.4%). 166 patients were waiting more than 52 weeks for treatment.	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.2i

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair				
SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key Committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 24 July 2024 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance. Q&G's agenda included consideration of the following items:

- Quarterly Research and Development Update
- Mortality Report
- Annual Clinical Audit & NICE Compliance work plan
- Sentinel Stroke National Audit Programme
- Nursing, Therapy and Radiology Staffing Report
- Nursing, Therapy and Radiology Staffing Report
- Maternity Services Board Measures Minimum Dataset (exception) report
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)
- Thematic analysis of Stillbirths and Neonatal Deaths in Barnsley (1 January 2022- 31 December 2022
- Trust Objectives 2024/25: Progress Report
- BAF & CRR
- Q&G Committee Annual Effectiveness Report
- 360 Assurance: Limited Assurance CBU3 Governance Report
- IPR
- Chairs logs and minutes (CEG; PSHG; PEEIG; CBU Performance; IPC)

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	BoD: 24/08/01/3.2i

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 24 July 2024	**Chair:** Gary Francis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Quarterly Research and Development Update	The Quarterly R&D update was received. A note was made of the ongoing recruitment of patients to clinical trials, the increased number of principal investigators and an increased diversity within the department. Some of the space constraints are being addressed, although meeting accommodation remains an issue. The team has been shortlisted for a Nursing Times award.	Board of Directors	Information/Assurance
2	Mortality Report	The rebase of mortality statistics is imminent. It is expected there will be a rebase of approximately 8. Coding work continues. The Learning from Deaths programme was highlighted to demonstrate how lessons are being shared across the organisation.	Board of Directors	Assurance
3	Annual Clinical Audit & NICE Compliance work plan	The Annual Clinical Audit and NICE compliance work plan was presented. Increased recruitment has enabled greater support to clinical teams which have increased the number of audit projects (212 complete and 218 registered).	Board of Directors	Information/Assurance

		An increasing number of Priority 1 and 2 projects are being added to the work plan year on year which will present a challenge. The team is committed to supporting all projects which have relevance to the Trust. Efficiency can be improved by increasing the amount of data captured electronically; this is subject to discussion with colleagues in IT.		
4	Sentinel Stroke National Audit Programme	The current rating has fallen from B to C owing to the number of attendees at the stroke unit, which has triggered the threshold to be considered a Hyper Acute Stroke Unit (HASU) rather than an Acute Stroke Unit (ASU). Self-presentation rather than dialling 999 has exacerbated this issue. Such incidents are subject to a Datix entry. Speech and Language Therapy capacity remains an issue, with mitigations in place to offset this (joint virtual MDT with Kendray).	Board of Directors	Assurance
5	Nursing, Therapy and Radiology Staffing Report	The business case for additional Emergency Department (ED) staffing in CBU 1 has been approved by the Executive Team; the Committee expressed its thanks to ET for supporting this business case despite the severe financial pressures. June saw an unprecedented increase in activity resulting in the temporary opening of the winter escalation ward. Staffing vacancies in CBU 2 are being addressed by a job description review to align the skill mix to grade. It is expected that some of the SLT vacancies will be filled by autumn after a successful recruitment initiative. Following successful recruitment waiting times for CT and breast radiology have been falling.	Board of Directors	Assurance

6	NHSE Medical Staffing Safeguards Report	Substantive recruitment has been achieved in CBU 1 (11 posts) and the previously reported gaps in GP VTS posts have been filled.	Board of Directors	Assurance
7	Maternity Services Board Measures Minimum Dataset (exception) report	The in-depth report was considered. One Perinatal Mortality Review Tool (PMRT) and one moderate harm (resulting from return to the neonatal unit) were reported for May, which have been subject to investigation and actions implemented. Elements of mandatory training remain high in most domains except PROMPT training for medical (anaesthesia) staff; additional training sessions are being added to address this shortfall. The implementation of Badgernet has been well received. Smoking cessation rates have improved (currently 7.2%).	Board of Directors	Assurance
8	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE): Thematic analysis of Stillbirths and Neonatal Deaths in Barnsley (1 January 2022- 31 December 2022)	The Committee received and considered the findings of the thematic analysis of neonatal deaths in 2022. The committee was assured that there had been a thorough and considered deep-dive into the deaths associated with deprivation and off pathway births. No common themes were identified. This was historical data and the Committee were informed there have been 4 neonatal deaths in the current financial year.	Board of Directors	Assurance
9	Trust Objectives 2024/25: Progress Report	The progress report on the Trust Objectives was noted in the context of the ongoing financial and operational pressures confronting the organisation.	Board of Directors	Information
10	BAF & CRR	The Committee confirmed the unchanged BAF risk rating for addressing health inequalities (2605) and CRR risk ratings for leadership and service delivery in OMFS (3014) and delivery of haematology services (2803).	Board of Directors	Information/Assurance

11	Q&G Committee Annual Effectiveness Report	This item was deferred on account of the poor response rate (38%). The survey will be recirculated to members of the Committee. Suggested improvements to the current survey and format were made and will be considered.	Board of Directors	Assurance
12	360 Assurance: Limited Assurance CBU Governance: focus on CBU3 Report	The Committee received the limited assurance rating by 360 Assurance in relation to the governance arrangements in BCY+U3. The recommendations have been accepted in full and a comprehensive action plan has been agreed to address these. Whilst this was a governance review of CBU3 it was recognised that the other CBUs might learn from this limited assurance. Work is already ongoing to look at this and a progress report will be brought to the committee separate from the action plan for CBU3.	Board of Directors	Assurance
13	Charis's Logs and minutes (CEG; PSHG; PEEIG; CBU Performance; IPC)	Individual Chair's logs, together with their respective minutes, were received by the committee. CEG: Gradual improvement in mortality in the National Hip Fracture Database statistics. Colonoscopy audit statistics are being addressed. PSHG: Improvements noted in overdue completed SIs/PSIIs actions and out of date TADs. Sustained improvements in Falls (tenth successive month of below average falls per 1000 bed days) and Pressure Ulcers per 1000 bed days. Work to address nutrition issues previously highlighted, including the trial of Pre-meal huddles.	Board of Directors	Information/Assurance

		PEEIG: 91% satisfaction in FFT. A review of the Trust's complaint KPI's is currently underway and will be presented to ET shortly. First Chaplaincy Effectiveness Report received. PICKER improvement plan discussed. CQC inpatient survey results are currently embargoed.		
14	IPR	The Committee felt that all relevant matters had been considered within the agenda.	Board of Directors	Information

3.2.1. Patient Experience Annual Report 2023/24

For Assurance/Approval

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS – Public	REF:	BoD: 24/08/01/3.2ii

SUBJECT:	**PATIENT EXPERIENCE ANNUAL REPORT 2023/24**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Terri Milligan, Patient Experience & Engagement Manager Nicola Dent, Patient Advice and Complaints Manager				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery & AHPs				
PRESENTED BY:	Sarah Moppett, Director of Nursing, Midwifery & AHPs				

STRATEGIC CONTEXT

This report provides a summary of user experience and feedback drawn from comments, compliments and wider patient experience feedback during the period April 2023- March 2024. The report highlights the initiatives, workstreams and programmes of work undertaken throughout this period in response to feedback and to enhance patient experience across the organization.

The Patient Experience Annual Report provides assurance that we strive to be the Best for Patients and the Public.

EXECUTIVE SUMMARY

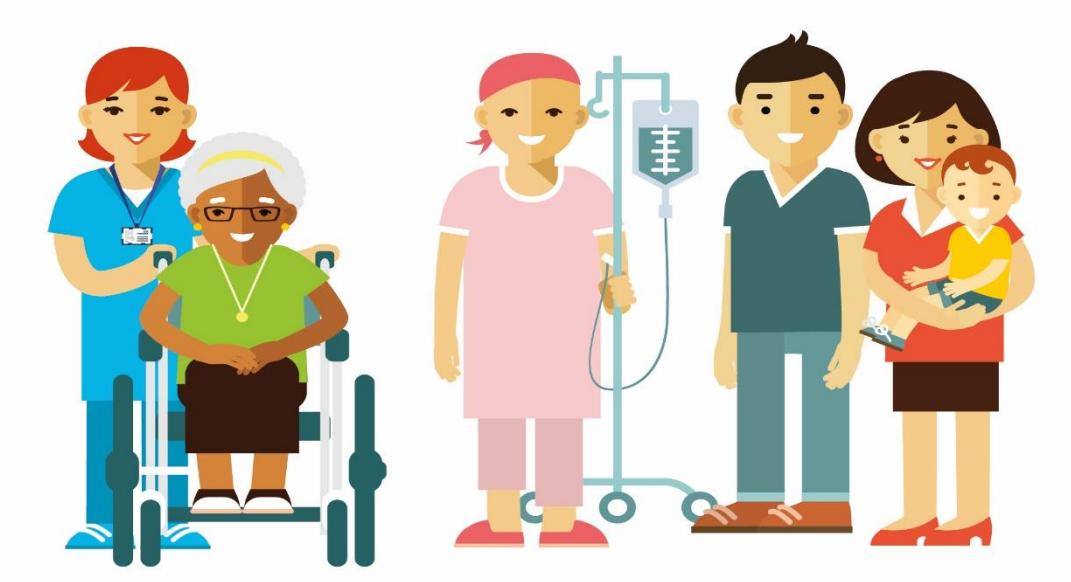
- The following report highlight trends in patient feedback during 2023/24.
- This report gives a summary of patient engagement work undertaken by the Patient Experience team within this timeframe.

RECOMMENDATION(S)

The Board of Director is asked to note the content of this report.

Patient Experience Annual Report 2023/24

Best for Patients and the Public



Main switchboard **01226 730000**

@barnshospital barnsleyhospital

PROUD to care

NHS
Barnsley Hospital
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Contents

1. Introduction

Barnsley Hospital is committed to do what is best for our patients and the public through continued service improvement based on feedback and local community engagement to enhance their experience and the quality of care we provide.

This is the annual patient experience report for Barnsley Hospital NHS Foundation Trust covering the period from 1 April 2023 to 31 March 2024. The report meets the requirements of Regulation 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which require NHS bodies to provide an annual report and a copy of which must be available to the public.

The Trust engages with and learns from patients, families and carers, through feedback from a number of sources. The Trust's patient experience programme seeks feedback in hospital, clinic or in the patient's home. Patients are able to provide their feedback through social media, Trust website, NHS Choices, postal surveys, national surveys, local surveys, compliments, focus groups, face-to-face engagement, PALS/complaints and, of course, routinely throughout the Trust via the Friends and Family Test (FFT). As part of that engagement our aim is:

- Delivery of our patient experience plan and annual work programme.
- Compliance with the mandatory national Friends and Family Test (FFT).
- Compliance with the Statutory requirements in relation to NHS complaints handling.
- Reporting and demonstrating that we have used patient experience feedback to improve the experience of care.

In 2023/24 we delivered

178, 409 episodes of care*

And received 18,301 pieces of patient feedback

79%	Was either positive feedback via FFT or a compliment
12%	Of contacts associated with a PALS concern or comment
1.5	(292) Of contacts were investigated as a formal

**episodes of care could have been an outpatient appointment, attendance at Emergency Department, a Midwifery episode or an inpatient episode of care.*

Throughout the report, there will be sections of, 'you said…., we listened…', that look at areas of feedback where specific improvements have been made.

2. Complaints and Concerns

As a Trust we welcome feedback from patients, their families and carers, and complaints and concerns are handled by our Patient Advice & Complaints Team (PA&CT). The Trust values complaints and wider patient feedback as a valuable opportunity to learn and make improvements to the services and care we provide. A customer-focused, responsive complaints service is important to the patients who use our services and we aim to be open and honest in our investigation process and committed to identifying actions and learning as a result of complaint investigations.

The Trust has a Policy for Handling Concerns and Complaints which provides guidance and a framework for investigations in line with legislation and best practice guidance. The Trust's Policy is available to all staff via the Trust's Approved Document (TAD) web-page.

Handling Concerns and Complaints.pdf (trent.nhs.uk)

The below table shows the number of formal complaints, concerns and general enquiries that we have received during the financial year April 2023 – March 2024.

Table 1:0: Annual Comparative Feedback Data

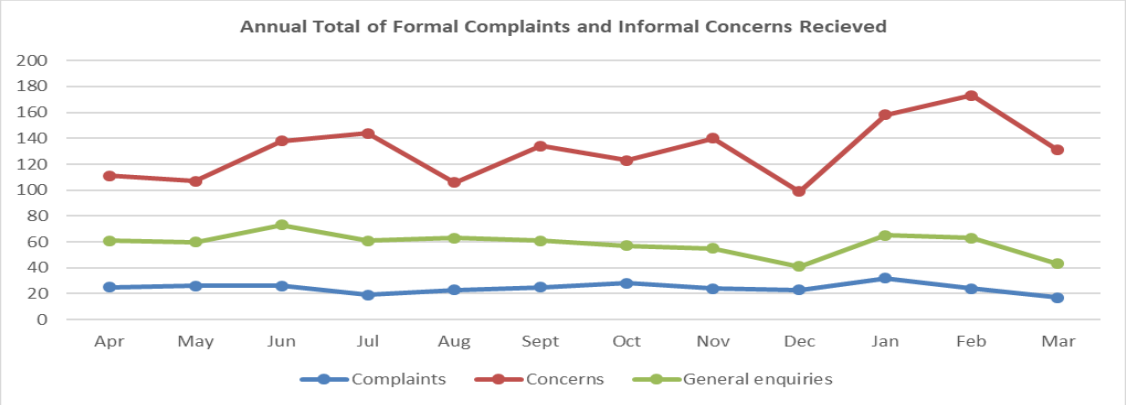
	2023/2024	2022/23	2021/22
Complaints:	**292**	**291**	**305**
Q1	77	71	81
Q2	67	67	69
Q3	75	75	82
Q4	73	78	73
Concerns:	**1564**	**2012**	**2111**
Q1	356	562	420
Q2	384	581	567
Q3	362	454	526
Q4	462	415	598
Advice/Info/Feedback:	**703**	**919**	**943**
Q1	194	228	243
Q2	185	241	239
Q3	153	221	234
Q4	171	229	227
Total Contacts:	**2559**	**3202**	**3359**
Q1	627	861	744
Q2	631	889	875
Q3	590	736	842
Q4	706	711	898

2.1 Complaints Performance

100% of formal complaints received in 2023/24 were acknowledged within three days of receipt.

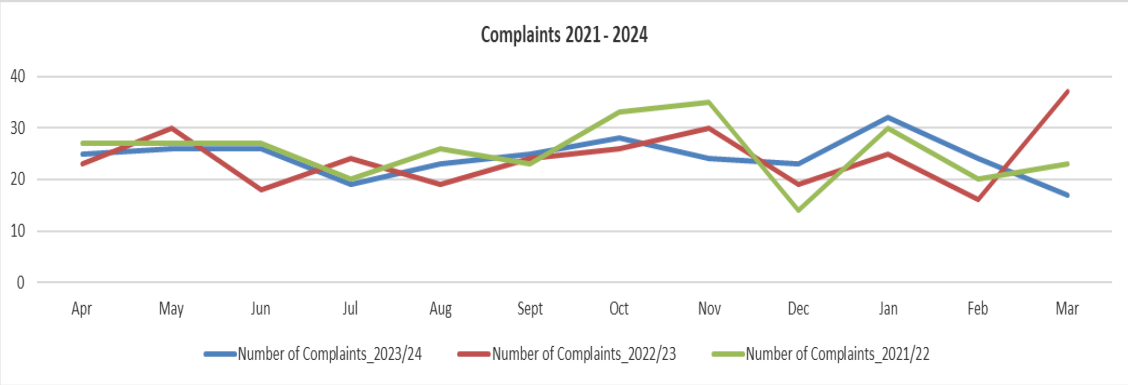
The Trust received 292 formal complaints during 2023/24.

Graph 1.0: Number of formal complaints, concerns and enquiries received during 2023/14



The number of formal complaints received during 2023/24 are comparable with those received in 2022/23 (291 cases) and 2021/22 (305 cases)

Graph 2.0: Number of formal complaints received 2021/22 – 2023/24



2.2 Clinical Business Unit and Speciality Performance

The Trust is split into Clinical Business Units (CBU), all serving their own purpose in the delivery of patient care and speciality areas. All formal complaints and concerns are investigated in conjunction with the relevant CBU.

Of the 292 formal complaints received in 2023/24

52% →	Were reported under CBU 1 – Medicine*
26% →	Were reported under CBU 2 - Surgery
18% →	Were reported under CBU 3 – Women's, Children's and Clinical Support Services
4% →	Were reported under CBU 4 – Corporate and Support Departments

**CBU 1 consistently has the highest volume of formal complaints due to the number of wards and specialties that are managed under this business unit.*

Formal complaints can consist of a number of different 'subjects' in relation to the concerns raised. Throughout 2023/24 there are five key categories under which formal complaints have been reported:

- **All aspects of clinical treatment**
- **Communication**
- **Patient Care**
- **Values and Behaviours (staff)**
- **Admissions and Discharges**

Table 2.0: Categories of formal complaints

All aspects of clinical treatment (35%)	Delay or failure in treatment/procedure (20%) Delay or failure to diagnose (inc e.g. missed fracture (18%)
Communication (16%)	Communication with patient (30%) Communication with relatives/carers (15%)
Patient Care (13%)	Care needs not adequately met (51%) Inadequate support provided (13%)
Values and Behaviours (staff) (11%)	Attitude of medical staff (46%) Attitude of nursing staff (28%)
Admissions and Discharges (8%)	Discharged too early (39%) Discharge arrangements (inc lack of or poor planning) (17%)

At the time of receipt all formal complaints are risk graded based on the content of the complaint, and this grading is reviewed and confirmed following investigation. The final risk gradings of complaints closed in the financial year were as below:

	2023/24	2022/23	2021/22
Low Risk	79%	76%	72%
Moderate Risk	17%	23%	27%
High Risk	4%	1%	1%

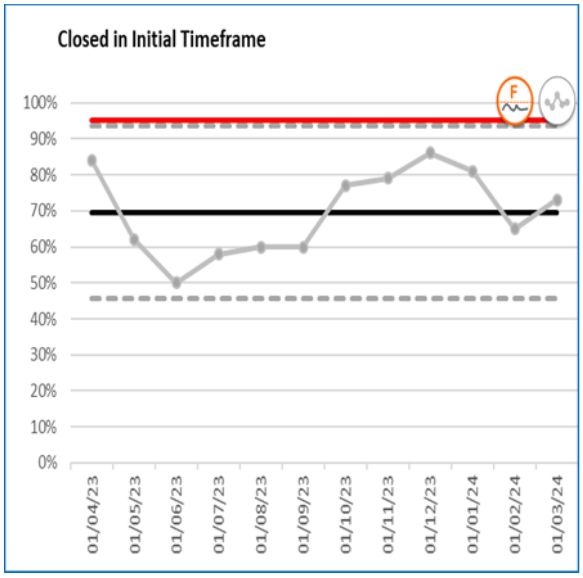
After investigations have taken place and as part of the formal complaints process, the learning and outcomes are recorded and action/improvement plans are devised where appropriate. All action/improvement plans are incorporated into improvement workstreams within the specialities and monitored though Trust-wide governance meetings to ensure they have been delivered.

2.3 Response Timeframes

All formal complaints have an initial agreed response time of 40 working days.

This 40 working day target is a challenge for the Trust to achieve however we recognise the importance of responding to concerns and complaints raised in a timely manner whilst maintaining appropriate detail and high quality in our written responses. Processes for escalation are in place and performance at both corporate and local level are reported through the Trust wide governance framework under the leadership of the Director of Nursing, Midwifery and AHPs.

The below SPC chart shows the achieved targets by month for the complaints received.



March 2024
70% is the average closed within the initial timeframe for the year.
Variance Type
Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
90%
Target Achievement
Measure is failing the target.

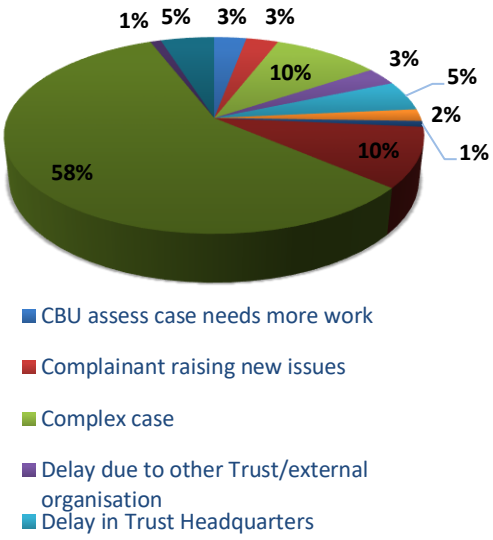
During 2023/24, all formal complaints were investigated and closed with within an average of 43-working days (just slightly above our KPI of 40 working days).

58% of the formal complaints that did not meet the initial timeframe, were due to delays in statements received from Clinical Business Units (this is based on a 15-day working timeframe):

- 16% → Were in CBU 1 - Medicine
- 26% → Were in CBU 2 - Surgery
- 25% → Were in Women's, Children's and Support
- 11% → Were in Corporate Departments

The reasons for delay (diagram 1.0) and breach of the 40-working day KPI are monitored throughout the year..

Diagram 1.0: Delay reason



	Count of Complexity Rating
> 55 working days (COMPLEX)	6
Between 46-55 working days (MID-COMPLEXITY)	46
</= 45 Working days (SIMPLE)	168
Grand Total	**220**

Following investigation, complaints are allocated an outcome of 'upheld', 'partially upheld', or 'not upheld'. If all issues raised in the complaint are found to be substantiated then a complaint is 'upheld'. If any single issue raised in a complaint is found to be substantiated, but some or all of the other issues are not, the complaint is 'partially upheld'. If none of the issues in the complaint are found to be substantiated then the complaint is 'not upheld'. The Trust upheld or partly upheld 63% of the cases it investigated during 2023/24. This is a reduction from 2022/23 when 71% were upheld/partly upheld.

Two formal complaints were reopened for further investigation during the reporting period. If a complaint is re-opened, there may be a number of reasons why this may happen. These can be varied and are detailed below:

- Accepts investigation findings but wants further action taken
- Feel issues of concern have not been addressed.
- Joint agreement to keep a complaint open for further review at a later stage.
- Raises new issues of concern.

2.4 Demographics

The PA&CT routinely record demographic data relating to formal complaints.

Diagram 2.0: Demographic data by age group of formal complainants in 2023/24

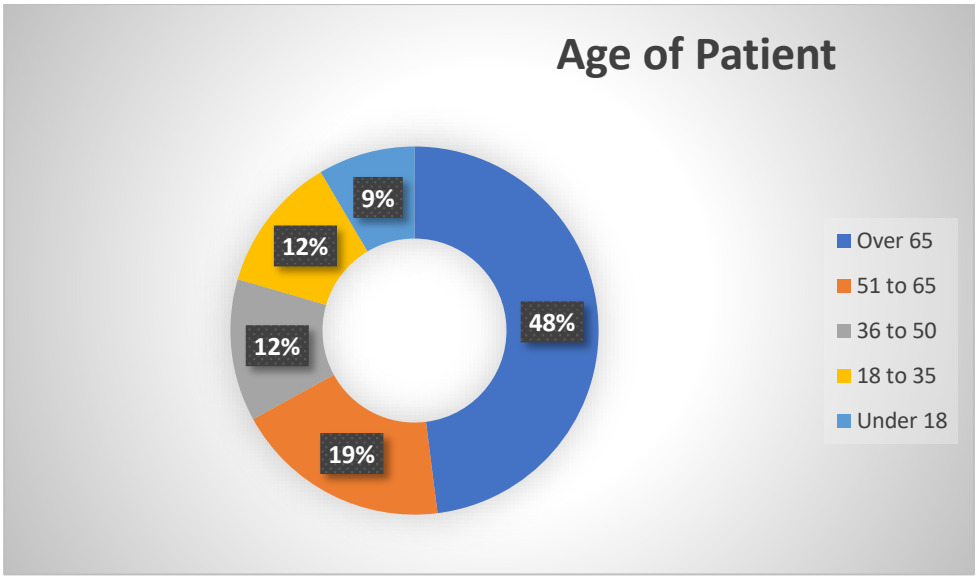
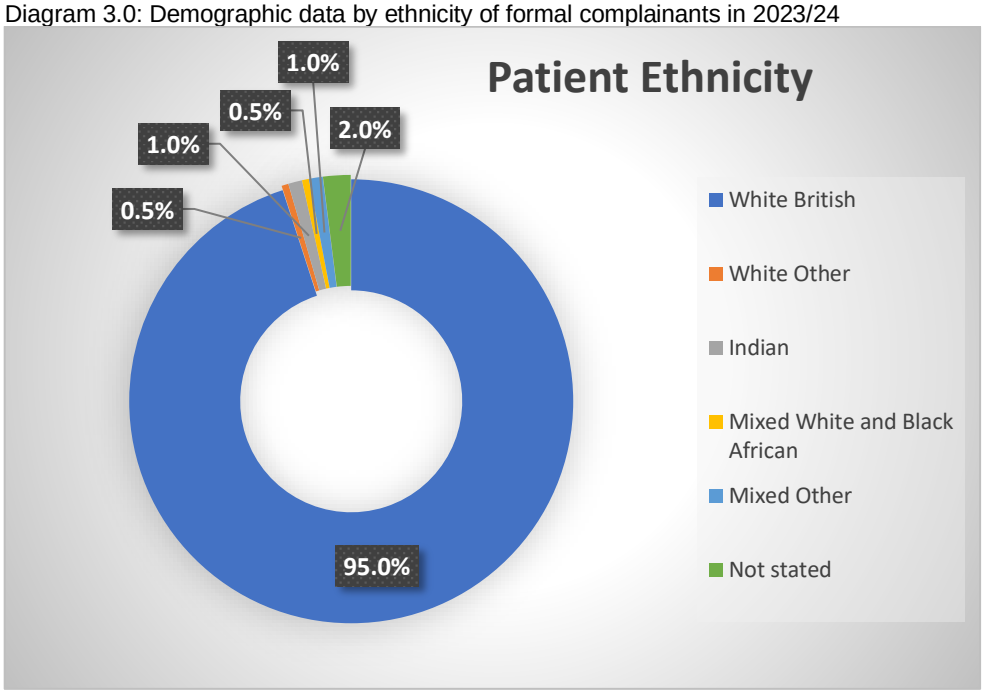


Diagram 3.0: Demographic data by ethnicity of formal complainants in 2023/24



2.5 Actions resulting from formal complaints

During 2023/24 there were 175 actions identified from formal complaint investigations. 88% of these have been actioned and closed. The remaining 12% whilst still open, show 10% are still within the initial agreed timescales. The CBUs are informed of any actions at the end of a formal complaint investigation. All open actions are monitored for implementation and completion.

Where actions and learning are identified within the investigation process these are jointly agreed with the relevant service area and recorded via the patient safety software system. Actions are reported to local CBU governance meetings, and through monthly and quarterly patient experience feedback reports. In order to be open and publicise that complaints and patient feedback

is important for learning and improvement, the Trust also publishes a quarterly "you said, we listened" page on the public internet.

You said……	We listened……
Formal Complaint: Patient Care *Multiple concerns regarding patient's stay on Ward 19. Including patient being left in soiled clothing, not being mobilised, and developing a pressure ulcer.*	*Undertook improvement work, including the development of an action plan and increased training compliance, in order to address the highlighted concerns.* *As a Trust we will continue to embed the Care Partner initiative and the team will attend the Matron, Lead Nurse and Midwives timeout sessions to offer further awareness and training to staff.*
Formal Complaint: Education/Training *We could improve our teams' knowledge relating to jaundice in new-born babies*	*An educational bulletin for community midwives was created regarding jaundice protocol, and additional education on jaundice and NICE guidelines was added to the junior doctor induction training.*
Formal Complaint: Education/Training *We could learn more about topical steroid withdrawal as a newly recognised condition*	*Presented a case study at the North Trent Dermatology Group meeting for discussion with specialists, and then fed this back to our wider Dermatology team for education.*
Formal Complaint: Privacy and Dignity *Patients were being transferred between wards in lifts with members of the public, compromising their privacy and dignity*	*Implemented a trial of using separate lifts whereby inpatient transfers and equipment use different lifts to members of the public and other staff, which was subsequently made permanent.*
Formal Complaint: Signage *The Emergency Stop button for the outpatient escalators was not easily identifiable*	*New signage has been fitted to ensure that the stop button can be quickly located in case of an emergency.*

2.6 Concerns

The PA&CT handled a total of 2267 contacts. 1564 of these were logged as a concern and the remainder were advice/information/general enquiries. Real-time concerns are addressed within a five working day timeframe and the main issues that were raised during this financial year were:

Communications (43%)	Phones not answered (33%) Communication with patient (24%) Communication with relative/carers (12%) Delay in giving information/results (9%)

Appointments (22%)	Appointment delay (inc length of wait) (34%) Appointment cancellations (17%) Appointment – failure to provide a follow-up (12%) Appointment availability (inc urgent) (10%)
Values and Behaviours (staff) (8%)	Attitude of medical staff (42%) Attitude of nursing staff (28%) Attitude of admin/clerical staff (10%)
All Aspects of Clinical Treatment (7%)	Delay or failure in treatment or procedure (37%) Delay or failure to diagnose (inc missed fracture) (12%) Lack of treatment (8%)
Admissions and Discharges (5%)	Discharge arrangements (inc lack of or poor planning) (29%) Cancelled/rescheduled surgery/procedure (15%) Discharged without appropriate paperwork/medication (9%)
Patient Care (4%)	Care needs not adequately met (78%)
Waiting Times (4%)	Wait for operation/procedure (48%)

You said……	We listened……
Concerns: Phones not answered *Patient has been trying to call Imaging for 12 days to book an X-ray but the calls have gone unanswered.*	*voicemail message has been added to the general medical imaging enquiry line. The message gives the following info:* *- details of opening times* *- quieter times to call* *- alternative numbers to call for different modalities* *- website address and directions to contact us form*
Concerns: Phones not answered *Patient cannot get through to book an appointment with Phlebotomy, the phone just rings out.*	*Introduction of an appointment booking online system for patients on specific pathways has shown a major reduction in the amount of concerns received.*
Concerns: Appointments *Patient was seen in glaucoma clinic in May last year and told they would bring her back in 6 months time. Patient hasn't heard anything and can't get through to speak to the department.*	*Senior leadership led improvement programme in place with monitoring and oversight via the Executive Team.*

2.7 Governance and Reporting

All trend data on complaints and concerns received is reported via the Trust's Integrated Performance Report (IPR), the monthly CBU Patient Feedback

reports and quarterly Learning from Experience (LFE) reports. The Patient Advice and Complaints Manager provides weekly 'round up' information for the CBUs to quickly identify any emerging trends and allow for prompt action where needed. Additional reports are produced as required to inform wider quality and service improvement work across the Trust. Complaint performance reports are submitted to the Trust's Patient Experience, Engagement and Insight Group (PEEIG).

2.8 Parliamentary and Health Service Ombudsman

The Parliamentary and Service Ombudsman (PHSO) is an independent body that NHS complaints investigations, and can give recommendations to Trusts based on their findings.

In the financial year 2023/24, three new referrals were made to the PHSO and accepted for investigation. In the same period, the PHSO completed investigations in to five complaints. Of the five completed investigations, four cases were not upheld by the PHSO and no recommendations were made.

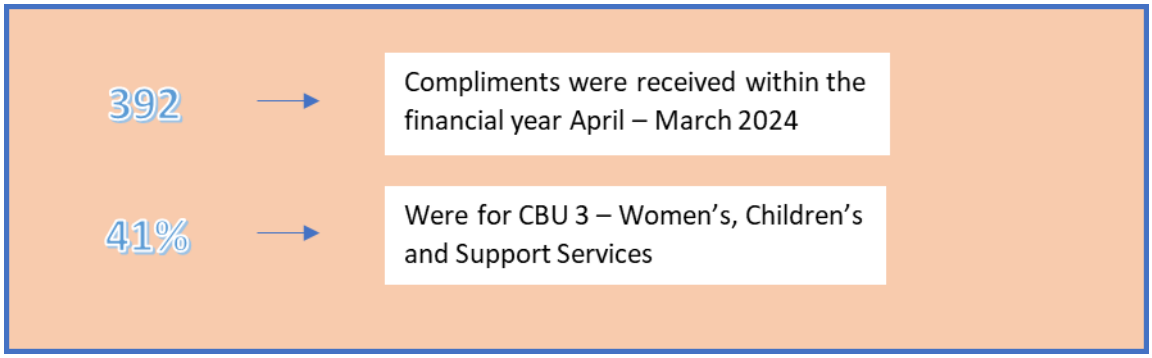
One case investigated by the PHSO was partly upheld. The finding of the PHSO was that there was a delay in performing an investigative scan for the patient, which would not have changed the outcome of the case but caused distress. The PHSO recommended that the Trust pay the patient a monetary recompense, and the case was presented at a Morbidity and Mortality meeting to share the learning identified by the PHSO.

3. Compliments

Whilst sources of feedback such as complaints and concerns help us to understand what we need to do better, compliments are an invaluable way of letting us know what we do well and demonstrates the impact of staff dedication to providing high quality care.

All compliments and informal compliments, such as gifts, thank you cards, verbal and social media comments shared with staff and teams via a link on the Barnsley Hospital staff intranet page.

The Patient Experience team continue to promote and encourage the use of the Compliments repository so that the achievements of staff can be recognised. The team also use positive feedback to inform nominations for the Brilliant Awards that are presented monthly to staff by the Executive Team.



4. Friends and Family Test (FFT)

4.1 FFT

The Patient Experience team continue to work with ICT to develop digital methods of collecting FFT data in a move towards capturing and reporting real-time feedback.

SMS is now used across all key touchpoints:

- Emergency Department
- Inpatient Services
- Outpatient Services
- Maternity Services
- Day Case Services

SMS with a link to FFT forms are sent out 24 hours post discharge for all services except for service users of Maternity who will receive their SMS two weeks post discharge.

Internally all wards and department have been provided with a mobile device to collect feedback and QR posters are displayed in key areas for service users wishing to provide feedback using their own devices.

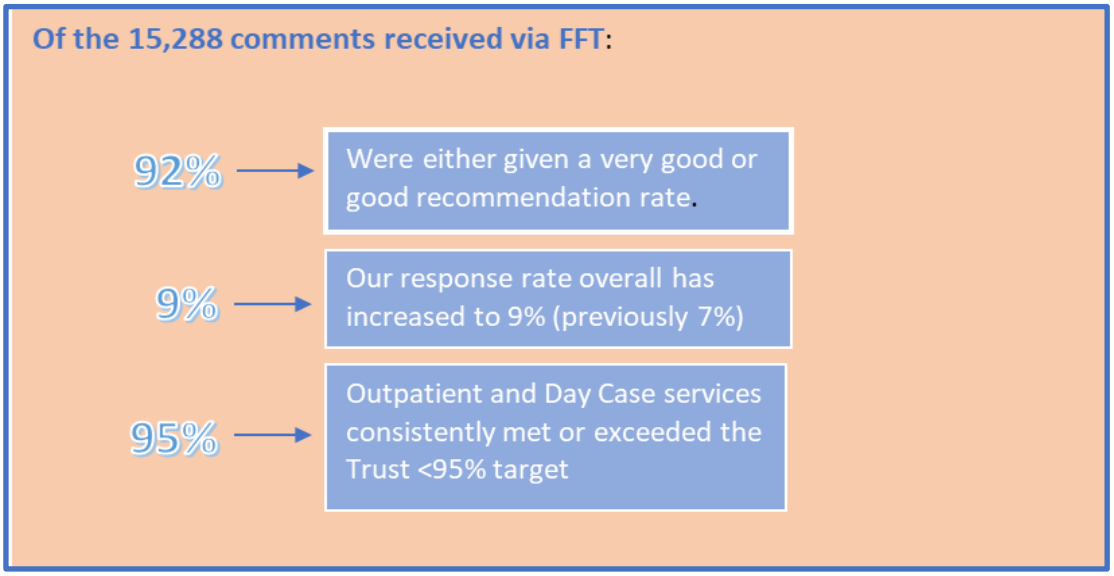
FFT feedback forms, for each touchpoint, can be accessed via the Barnsley Hospital website.

In 2023/24, the Trust captured 15,288 individual pieces of FFT feedback using the digital methods explained above. This is an increase of 3,134 responses on the previous year where 12,154 responses were received (Table 3.0).

Table 3.0: FFT Responses by touchpoint 2023/24

	Very good	Good	Neither good nor poor	Poor	Very Poor	Don't Know	Grand Total
Emergency Department	3128	728	263	250	194	8	4571
Inpatient	3133	647	157	98	96	4	4135
Outpatient	4305	468	48	16	33	14	4884

Maternity	262	33	6	4	5	0	310
Day Case	1213	141	18	5	9	2	1388
Totals	12,041	2017	492	373	337	28	**15,288**



During the financial year 2023/24, **92%** of our service users reported a positive experience across Barnsley Hospital services and below feedback highlights some of the reasons why:

"No questions unanswered, very open, helpful in understanding my wife's condition and progress. Immaculate care and attention of her comfort and needs." ***(Inpatients)***

"Staff were lovely, very informative and handed our case over well so things didn't need explaining from us each handover." ***(Maternity)***

"Excellent from start to finish. Wasn't waiting for my appointment. Staff were all really friendly and welcoming. The procedure was thoroughly explained to me beforehand and throughout. They made me feel comfortable throughout. Staff really made me feel at ease and the procedure was very straightforward and quick. The aftercare was explained thoroughly and with a handout for me to refer back to at home with relevant contact information if I needed it." ***(Outpatients)***

"Cared about the patient - my father is deaf, which makes understanding (both ways) difficult. The staff could not have been anymore helpful." ***(Daycase)***

"I cannot praise the staff enough for their professionalism and caring nature. Despite being busy my care was efficient and any follow up arranged swiftly. Many thanks to the nurses and consultants on shift that night." ***(Emergency Department)***

Detailed reports highlighting areas for improvement are provided to each CBU who report resulting actions through the PEEIG. The following details the main themes of negative feedback and the actions taken to improve the services.

You said.....	We listened.....
FFT: Waiting Times Ophthalmology *"Booked in for half past eight in the morning but not seen until eleven am, patient eighty three years old, not good enough."*	*It is acknowledged that the volume of negative feedback in relation to the number of Ophthalmology service users coming through the department is relatively low, however the team have taken steps to manage expectations around waiting times.* *The service is in the process of reviewing their appointment letter templates to include an expected length of stay so that service users are well informed before they arrive. The Ophthalmology page on the Trust website is also being updated to provide useful information in relation to wait times.*
FFT: Noise at night – Acute Medical Unit (AMU) *"The staff are loud in the corridor and if they bring new patients onto the ward they just banged open the doors with the bed."*	*Noise at night remains a challenge to resolve due to new patients arriving from the Emergency Department, having medical clerking and treatments administered. Staff are being encouraged to give explanations to patients around the AMU function. Welcome packs provided upon admission offer eye masks and ear plugs for patients, the Lead nurse is developing a leaflet around a 'good sleep' and a Noise at Night Task and Finish Group has been established to implement and monitor improvement workstreams.*
FFT: Waiting Times – Emergency Department *Post initial assessment you are left to wait without communication or further interaction , I left after approx 5 hours without seeing or talking to anyone. I presumed if I was classed urgent someone would have spoken to me after 5 hours.*	*The information screen within the Emergency Department reception has been updated and now displays the waiting times for patients and relatives and the team are looking into publicising the minor injuries service opening times.* *To improve and focus on staff attitude the department have now facilitated a band 6 'out day' to enable the teams to reflect on their own personalities, practices and impact in the department, recognise their own strengths and weaknesses and encourage open culture. A facilitated follow up meeting will be planned with the Lead Nurse team following this.*

5. NHS.UK

Service users of Barnsley Hospital are able to leave a review about their Care and Treatment on the national NHS.UK website.

All comments via NHS.UK are circulated to the relevant service lead for their information and logged on the Trust's patient safety software system.

Feedback is anonymous however, individuals who raise issues of concern via NHS Choices receive a prompt acknowledgement and an offer to engage with the Patient Advice & Complaints Team.

2023/24	Reviews
Quarter 1	15
Quarter 2	19
Quarter 3	18
Quarter 4	23

A total of 75 reviews were posted on the NHS.Uk website during 2023/24 of which 85% received a 5* rating.

31% of reviews received were positive reviews of the care and treatment provided by the Emergency Department. The service received zero negative reviews.

"Went into A&E on advice of GP. Seen very quickly. Staff caring and efficient. Prompt action taken. Admitted later where care continued to be very good. The people here care about patients and are very professional."

"I attended BGH A&E department as I fell at work banging my head. The staff were truly amazing so caring and very professional, couldn't have asked for any more. Hardly any waiting time which was a bonus. Thank you to all the staff, keep up the good work in these hard times."

Negative reviews received in other areas were minimal and identified no specific areas of concern in terms of location and or theme. However, these reviews are shared with service leads to consider actions/improvement.

6. National Patient Experience Surveys for Acute Trusts

6.1 Adult Inpatient Survey 2022

The commitment to enhancing services for our patients at Barnsley Hospital is reflected in the year-on-year improvements highlighted in the Adult Inpatient Survey results.

The survey results published in September 2023 and completed by 407 patients showed a significant improvement in the following key areas:

- Were you ever prevented from sleeping at night by noise from hospital staff?
- Beforehand, how well did hospital staff answer your questions about the operations or procedures?
- Were you given enough privacy when being examined or treated?

6.2 Urgent and Emergency Care Survey

Barnsley Hospital had much to celebrate as they were rated one of the top performing Acute Trusts, of the 122 Trusts involved, in the National Urgent and Emergency Care survey 2022, published in July 2023.

Comparison with other Trusts in the Region

6.3 Maternity Survey 2023

The Maternity Survey was published in February 2024 and is based on the feedback of Maternity service users who had a live birth in early 2023.

The published results highlight the key areas where Maternity service users reported their experience was best:

Where maternity service users' experience is best

- ✓ Maternity service users (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- ✓ Maternity service users discharge from hospital not being delayed on the day they leave hospital.
- ✓ Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Maternity service users feeling that healthcare professionals did everything they could to manage their pain during labour and birth.
- ✓ Maternity service users receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.

6.4 Patient Experience workstreams in response to National Patient Surveys

The hospital has developed a multi-disciplinary team improvement plan to ensure that a collaborative organisational approach is taken to develop, implement and embed those workstreams aimed at improving the experience

of patients highlighted as requiring improvement through the national patient surveys.

Our Always Events, detailed in section 9.0 of this report, support some of the improvements identified in the action plan and below are examples of other initiatives that have been introduced in response to the survey results.

Tea for Two – Nutrition and Hydration

Tea for two forms part of the wider Eat, Drink, Dress, Move initiative aimed at supporting patients to stay well in hospital.

.

Tea for two invites staff to spend time with patients who may otherwise not have a visitor, to eat, drink and chat. This encourages patients to drink more so that they stay well hydrated, whilst at the same time enjoying social interaction to promote their physical and psychological wellbeing.

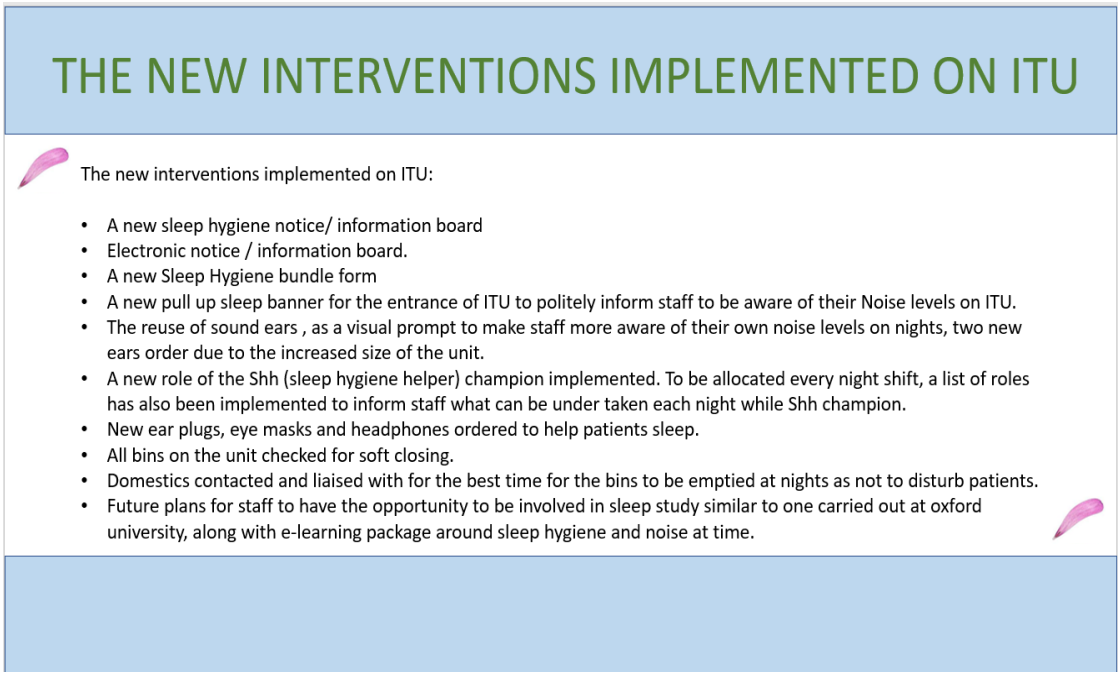
Care Partners – Maternity

The Maternity department have adapted the Care Partner policy to support Maternity Service users in enabling 'enabling partners to stay with them as long as they want'. The service now accommodates partners to stay over night where the service user has had a caesarean section or is in the early stages of labour and struggling with pain and feeling vulnerable.

Sleep Hygiene

A Trust wide Sleep Hygiene task and finish group is in place which aims to reduce 'noise at night' and support patients to have a good night's rest to promote wellbeing and aid recovery.

The group are looking to adapt the Sleep Hygiene initiative which was successfully implemented and embedded on the Intensive Care Unit.



7. Healthwatch

In October 2023 Healthwatch Barnsley published and shared with us a patient experience survey they had carried out on the Acorn Rehabilitation Assessment Unit. Healthwatch contacted service users via telephone following their discharge to talk about their experiences on the unit.

On the whole the feedback was extremely positive.

"They took care of my dad like I would. He always looked smart, well dressed and they really thought about this. He was always dressed appropriate for the weather and was always clean."

Whilst there were some concerns about the environment, décor, fixtures and fittings, these issues have been addressed as part of the service relocation back to the Barnsley Hospital site.

The Trust have a good working relationship with our local Healthwatch who provide representation on some of our governance meetings, get involved in focus groups such as PLACE Assessments and work collaboratively with us on relevant engagement projects within the Barnsley community.

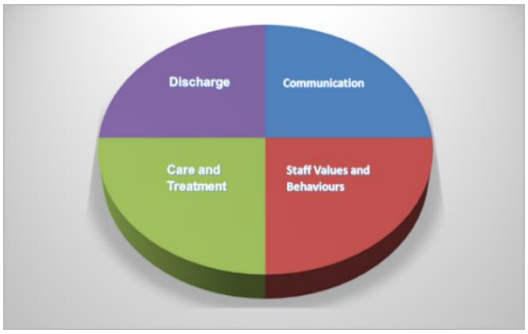
8. Barnsley PLACE Assessment 2023

PLACE assessments took place in November 2023 in all areas of the Trust. These assessments were conducted by a team of volunteers and members of Healthwatch to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

Barnsley Hospital scored top in the region and were in the top 10 for its PLACE audit in the whole country.

9. Patient Engagement and Experience Improvement Workstreams

9.1 Always Event Initiatives



The following Patient Experience initiatives have been implemented to address those areas of improvement that service users told us 'mattered most to them' and these became our Always Events. Always Events fall under the following key complaints/concerns themes of identified improvement:

Care Partners

Barnsley Hospital NHS Foundation Trust (BHNFT) is keen to support people who would like to be involved in the care of their relative or friend during their time in hospital, who needs help because of their illness, frailty, disability, a mental health problem or an addiction.

We recognise that carers have a significant role in the effective and safe delivery of treatment and care of patients in hospital; this role will often cross the boundaries between the patient's home and the hospital setting. It is important that we identify, involve and support carers in the clinical setting to get the care of the patient right.

With knowledge, understanding and honest communication, staff and carers can work in partnership as Care Partners to improve the hospital experience for patients, carers, and staff.

The policy and charter to develop the Care Partners approach was developed through engagement with staff and the Barnsley Carers and Barnardo's Young Carers services.

The Care Partner Policy and Charter was launched during carers week in June 2023 at the Barnsley Carers Roadshow which gave the Patient Experience team the opportunity to engage and raise the profile of the work.

A support tool has been developed for staff on how to identify and support carers. This includes a training video and leaflets that can be shared that promote the policy and the support available for carer partners in the Trust and to promote an understanding of what the role means to patients, carers and staff themselves.

Since the implementation of Care Partners, the initiative has been adapted in support of service users in areas such as Maternity and Gynaecology.

NHS England colleagues visited the organisation in March 2024 to look at how well the processes have been embedded and to understand the learning in support of the National Policy. The team had only positive things to say about the work undertaken at the Trust with the work at Barnsley Hospital being used to inform and develop the national Care Partner policy

The work has also been shared regionally as part of 'Experience of Care' week.

'I only have positive things to say about the care partner program.

…I had to act as an advocate for my mum due to her reduced cognitive capacity. I was made to feel more than welcome by all who came into contact with us on the ward. I was included and engaged with and felt very comfortable and at ease.' (Care Partner)

Young Carers

To support young carers within the hospital setting to have their voice and be involved as Care Partners, the Barnsley Hospital Safeguarding Team have been working with Barnardo's Young Carers to develop the Young Carer Passport.

The Young Carers Passport is due to be launched following local governance approval. During the development of the passport, one of the young carers, instrumental in this work sadly lost her Mum and it was agreed to incorporate a pink flower into the design of the passport in her memory.

Welcome Packs

Welcome packs were implemented to provide information to patients/relatives/carers, including ward contact details, information about their hospital stay and discharge information.

The packs are provided to patients upon admission and contain information about the availability of eye masks and ear plugs to support patients to have a good night's sleep.

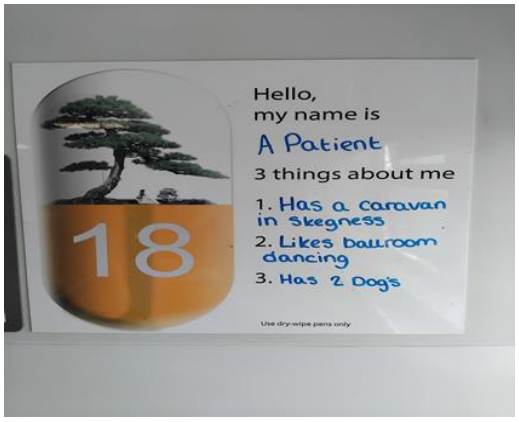
Access to information and 'noise at night' were some of the elements of the Adult Inpatient survey requiring improvement.

Almost 100% of patients receiving a welcome pack consistently tell us that they found the information within the pack useful.

In the coming year we will be looking at a digital resource to ensure the pack is more widely accessible.

Three things about me

What is it:
Three things about me is an Always Event initiative that aims to explore a way of promoting communication that is centred around the person rather than the 'patient'.
Why we did it:
To aid communication and to promote conversation.
To personalise care
To promote care and compassion in practice.

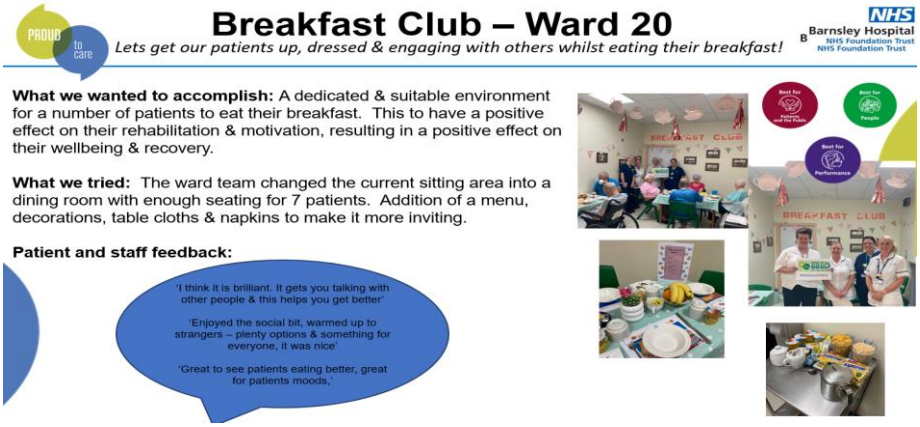


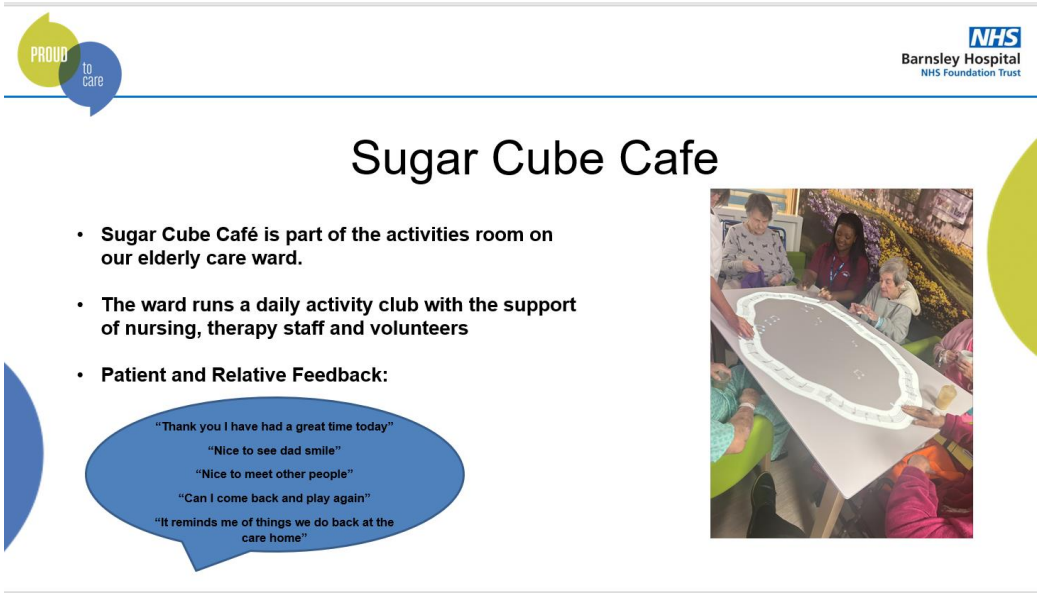
How we delivered it:
Interactive teaching session on wards.
Executive team members were invited to attend and share the experience and participate in group discussions.

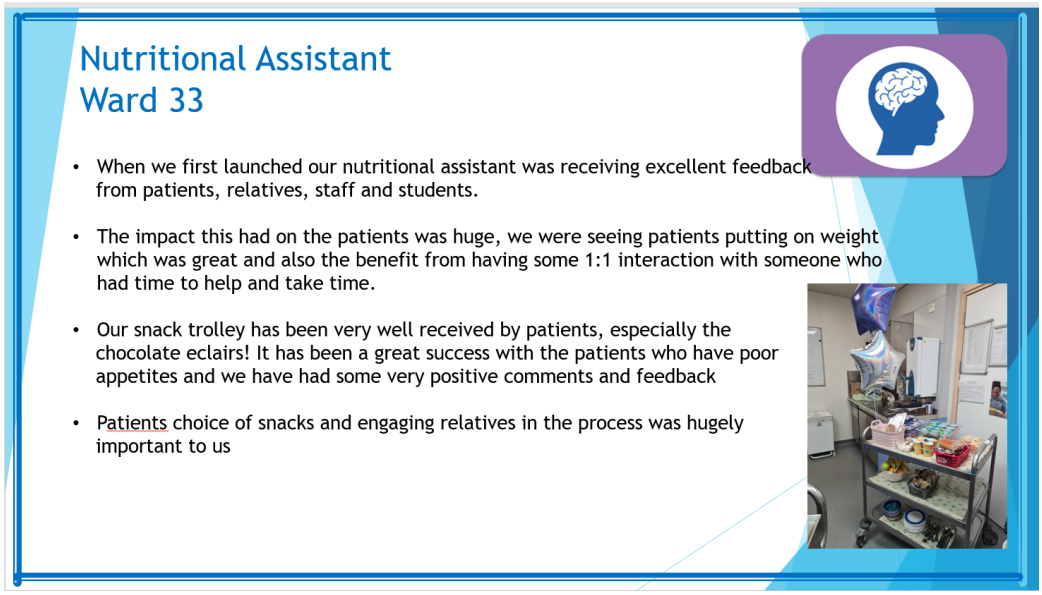
Volunteer participation - representing the patient and delivering the poem '*Look Closer Nurse' / 'Crabbit Old Woman'*

9.2 CBU Initiatives

CBU's have implemented some fantastic initiatives to enhance patient experience in their specialist areas during 20233/24. Here are just a few examples of want they have achieved:







9.3 Hearing the Voice

The Patient Experience team spend time out in the community to 'hear the voice' of Barnsley Hospital service users and the public. This is invaluable qualitative feedback which allows us to understand what matters to our patients, carers, families and friends, the challenges people may face when coming into the hospital environment, particularly within hard to reach groups and those facing health inequalities. It also allows the team to share the good work and support already on-going at the hospital that they may not otherwise have accessed or been aware of.

What we learn through community involvement is fed back into services so that improvements can be made. These established relationships allow us to continue to support our service users and provide assurance to them that they have been heard and that their voice truly matters.

Dementia

Representatives of Barnsley Carers Forum with lived experience of caring for someone with Dementia, undertook a walk-round of the Emergency Department in October 2023.

Since the visit and in response to feedback, a refurbishment programme of the department toilets was undertaken and grab rails are now installed.

The Patient Experience and Clinical Systems teams are working together to ensure that the Dementia Alert is available on the 'front sheet' of the patients notes so that it is visible to staff members involved in the patients care.

The team continue to attend Barnsley Carers Forum and provide updates on continuous improvements.

In January 2024 the Lead Admiral Nurse and the Patient Experience Team attended BIADS Carers Support Group to share information about the Butterfly Scheme, Care Partners and the Buddy System. This provided an opportunity for carers of people with dementia to ask questions about dementia support when their loved one is in hospital.

In March 2024 the Let's Talk about Dementia Conference took place at the Barnsley Metrodome. This event included information stalls and guest speakers. The Patient Experience Team and Lead Admiral Nurse attended to share information in relation to attending hospital. The Butterfly Scheme information and REACH out to me documents were shared with people with dementia, their family carers and staff from services within Barnsley who support people with dementia.

The Patient Experience Team along with the Lead Admiral Nurse joined the carers from the DISC (Dementia Information and Support for Carers) group at their monthly coffee afternoon to update the carers on the ongoing improvements around support for people with dementia and their carers.

Veterans

In 2023 BHNFT achieved Veteran Aware accreditation which means the Trust takes active note of the needs of the Armed Forces Community, having met standards laid down by the Veterans Covenant Healthcare Alliance (VCHA), a national NHS team.

As part of our commitment to being the best for patients and the public, the Patient Experience team met with Barnsley Veterans at their Breakfast Club to understand the challenges they face when accessing the hospital setting and to discuss available support and relevant initiatives that have been implemented at the hospital.

Learning Disability

Care Bags:- The Patient Experience Team and the Learning Disabilities and Autism Liaison Nurse have worked together with Barnsley Hospital Charity, with involvement from service users, to support a project for Care Bags in the Emergency Department. These bags are to support anyone with a Learning Disability or an Autistic person who attends the department and contain items to help navigate what can be a stressful environment in the busy Emergency Department waiting areas. Service users were involved in choosing the design and agreeing the content of the care bags which include ear defenders, activities, fidgets and much more.

Community Diagnostic Centre (CDC):- As part of the phase two of the CDC expansion engagement, during learning disabilities week in June 2023 the Learning Disabilities and Autism Liaison Nurse and the SWYPFT Strategic Health Facilitator invited service users and carers to meet at the CDC and show them the breast screening department to support service users with learning disabilities to attend for their mammography appointments. During the visit,

reasonable adjustments were discussed and identified and will be taken forward to enable these service users to attend their appointments going forward.

Talkin Tarn: - Together with the Trust's Learning Disabilities and Autism Liaison Nurse members of the Patient Experience Team attended the community group for SEND parents and carers. Following feedback from the group regarding community dental services, in January 2024 the Community dentistry service, supported by the team and the Trust's Learning Disabilities & Autism Liaison Nurse, attended the group meeting to hear their concerns to inform service improvements.

Carers

Following a survey conducted with Barnsley Carers we learned that almost half of those surveyed had missed at least one hospital appointment due to their caring responsibilities. In response we developed the 'Buddy System' which through a risk assessment process carried out by our Learning Disability and Autism Liaison and the Admiral Nurse, allows volunteers to support the person being cared for in the hospital setting to allow the carer to attend their hospital appointment.

Virtual outpatient appointments, where appropriate, also support carers where they are unable to physically attend.

Mental Health

The team continues to strengthen links with Barnsley Mental Health forum, who have recently undertaken a survey to identify whether the 'All Age Mental Health and Wellbeing Strategy' is making a difference to service users. The survey includes a question around A&E support in a mental health crisis and the forum will share the results once the feedback period closes.

Appointment letters

During June 2023 representatives from the Outpatients, Clinical Systems and Patient Experience and Engagement Teams met with members of the patient panel to hear their feedback about the Trust's current appointment letters and propose changes to make them more accessible.

Engagement with Thursday's Voice (a group for adults living with a learning disability, autism or both) and Barnsley Blind and Partially Sighted Association also took place.

All groups were given the opportunity to feedback on letter content, text/font, paper (e.g. colour paper for visual impairment), easy read and additional useful information.

Work continued throughout 2023/24 and the Outpatient team has now developed a new letter template with support from the Clinical Systems team. This was shared again with service users for comment before going live.

Ward 37 Modernisation Programme

In conjunction with the CBU 1 Matron the Patient Experience Team invited service users to be involved in a focus group to give their feedback about proposed plans for the re-design of ward 37. The ward successfully opened in December 2023 and service users were invited to visit the ward and discuss potential artwork.

9.4 Patient Stories

Patient stories are presented to the Trust Board to share experience and to learn from those experience's whether the story has a positive or negative focus.

One such story presented in the last financial year was Diane's story. Diane's story originated from a complaint and highlighted failings in her pain management when she was stepped down from Intensive Care into a ward environment. After hearing Diane's story, the ward is working on training and education in collaboration with the pain management team to drive improvements in this area.

10. Interpreting and Translation

The Patient Experience Team continued to support departments with interpreting and translation requests. 3018 requests were made during the financial year.

The Patient Experience team have worked collaboratively with DA Languages to introduce a video-interpreting platform making interpreters more accessible,

particularly where interpreting requirements have not been identified in advance of the service user attendance.

11. Voluntary Services

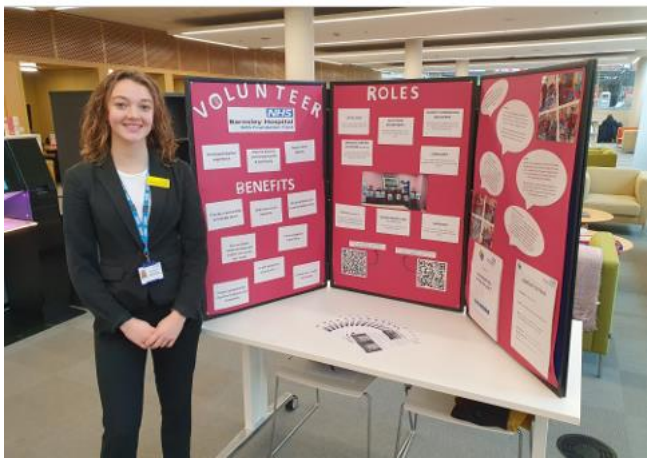
From 1 April 2023 to 31 March 2024, 86 new volunteers were trained and implemented across the Trust, resulting in 207 active volunteers. There has been a continued emphasis on recruiting Enhanced Support Volunteers to inpatient wards and the Emergency Department, which has been supported by an Enhanced Support Volunteer Coordinator on a fixed term contract.

Enhanced Support Volunteers receive specialised training including nutritional support and end of life care.

In collaboration with other teams across the Trust, the Voluntary Services team has introduced new roles, including a Pharmacy Volunteer role to support with distribution of medication to inpatient wards to allow quicker discharges of patients.

The Macmillan Pod also launched in January 2024, supported by volunteers and Cancer Services to offer an information hub to the public. This has seen increased attendances from patients, staff and visitors gaining information on what is available to them.

The Barnsley Hospital Charity volunteers are invaluable in the support they provide to the team. Not only do they assist the team in arranging charity events they also hold their own fundraising events and go the extra mile to raise money for the hospital charity from taking a cold water plunge to wing walking.



To continue to promote opportunities across hard to reach groups, the team have attended regular recruitment events across the community. Events have included presentations at Northern College and Barnsley Job Centres, and stalls at recruitment workshops at Central Library, Barnsley Metrodome, Barnsley College and Barnsley Job Centres.

The Voluntary Services team has continued to emphasise wellbeing support across the volunteering workforce, and as a result have seen an increase in wellbeing sessions and referrals for additional support. In the annual volunteer's survey, 98.6% of responding volunteers felt their health and wellbeing is supported.

We continue to celebrate the contributions of volunteers by sharing positive stories, and hosting volunteer celebration events including a winter social event, and a volunteer social event which celebrated a specific volunteers' 50 years of volunteering in August 2023.

12. Strategic developments and improvements in patient experience

Barnsley Metropolitan Borough Council (BMBC)

The Patient Experience team are involved and aligned to the Barnsley Carers Strategy led by Barnsley Metropolitan Borough Council (BMBC). The focus in the last financial year has been on the first priority of the strategy in identifying carers. A Barnsley-wide communications plan is in development to define the role of a carer and to share the support available from each service involved in the strategy.

Barnsley PLACE

The Patient Experience team are a member of the Barnsley Involvement and Equality Leads Group who bring together relevant colleagues across the Barnsley Place Partnership to work together to avoid duplication and to share best practice in relation to patient and public involvement. The Group links into the Barnsley Place Committee and Partnership Board who oversees the development and delivery of the different work programmes and key priorities included within the Barnsley Place Plan.

The group are in the process of reviewing and updating their priorities for the 2024/25 financial year.

South Yorkshire Integrated Care Board (SYICB)

The NHS South Yorkshire ICB have developed the 'Start with People Strategy' in which the priorities align to the Joint Forward Plan.

Priority 1	Priority 2	Priority 3
Put the voices of people and communities at the centre of decision-making.	Embed mechanisms to enable citizen involvement to play a key role in the system focus on tackling health inequalities.	Work with people and communities on the priorities identified in the Joint Forward Plan.

The strategy includes patient and public involvement at Barnsley Place level and includes links to the Patient Experience team to 'get involved' with our workstreams.

The Patient Experience Team are involved in the South Yorkshire ICB 'Commitment to Carers' and are supporting the strategic planning of this group going forward.

The above strategies are recently implemented or have been revised and refreshed and therefore achievements will be noted at the end of the 2024/25 financial year.

Berneslai Homes Engagement Team

Members of the Patient Experience Team met with members of the Berneslai Homes Engagement Team to understand the remit of each team and to share details of ongoing projects. The teams have agreed to keep in touch and consider ways to maximise engagement opportunities with our respective service user panels.

Barnsley Healthcare Federation (BHF) – Patient Council

The Patient Experience Team was invited to join the patient council meeting held in December 2023. Information was shared about the support available to carers, including Care Partners, support for carers when attending their own hospital appointments and blue badge parking. The Primary Care Manager is assisting with promoting this support in the BHF GP surgeries. Joanne King, Critical Care Rehabilitation Lead Nurse, also joined the meeting and shared information and a video of the new Intensive Care Unit. The team's attendance at the meeting was welcomed with an agreement to continue to strengthen the working relationship with the BHF.

Migration Partnership

Links have also been established with the Migration Partnership through their Multi-Agency drop in sessions for Barnsley Migrant Communities.

13. The Year ahead – 2024/25

13.1 Planned Improvement Activity

Quarter one of 2024/25 has already seen some exciting new workstreams, initiatives and programmes of work that has really seen staff, patients, families, carers and the public come together in support of driving improvements across the organisation.

Deconditioning

Initiatives aimed at preventing the deconditioning of patients whilst in hospital by encouraging them to eat, drink, dress and move.

Information

The Associate Director of Nursing is working to provide useful information relating to an inpatient stay, for patients, carers and families. This work will include the installation of an information display board outside the entrance of each ward area and a ward booklet which will be placed at each patient's bedside.

Patient and Carer Experience Navigators

The Patient Experience team are in the process of recruiting two Patient and Carer Experience Navigators as part of a pilot to ensure that, patient experience feedback processes and initiatives are implemented and embedded in ward areas.

Health on the High Street

Plans are in place for Barnsley Hospital to deliver some of our outpatient services located within a new Health and Wellbeing Hub at the Alhambra shopping centre in Barnsley town centre.

Feedback from staff and patients has consistently demonstrated Barnsley town centre is a popular and convenient location for healthcare appointments. Located within a short distance from bus routes and with easy access to nearby parking, bringing healthcare to the high street will not only help reduce missed appointments, but will also improve health outcomes for people who will be more able to access these services in a place familiar to them.

Service users will have the opportunity to engage with us on this new development.

13.2 Patient Experience Objectives 24/25

Our Patient Experience priorities for 2024/25 highlight our commitment to continued service improvement:

- We will conduct formal assurance reviews on all high risk, upheld complaints, and offer formal feedback on the findings of these to the original complainant.
- We will communicate and document improvements via a portfolio of *"You said, we listened"* as a result of concerns, formal complaints, insight and engagement.
- As a result of concerns, formal complaints, insight and engagement we will identify local improvement initiatives regarding patient communication.
- As a result of concerns, formal complaints, insight and engagement we will implement new innovations to support improved person-centred care and support CBU improvement initiatives aimed at addressing deconditioning, improved discharge, high quality and sustained nutrition.
- We will continue to implement, embed and evaluate patient experience improvement initiatives underpinning the Trust-wide approved Always Events.
- We will support the development of a patient passport for people with Autism and Learning Disabilities.
- We will work in partnership across South Yorkshire to align the ICS and ICB Patient and Public involvement priorities into the work of the Trust and to share learning.
- We will establish robust qualitative and quantitative analysis to evaluate the impact and effectiveness of the wider patient experience improvement initiatives.

14. Conclusion

Throughout 2023/24 the Trust has received a massive 21,672 individual pieces of quantitative feedback, this does not include the significant amount of qualitative feedback received through engagement activity.

The Patient Experience and Patient Advice and Complaints team work collaboratively to analyse this feedback and identify the themes which tell us where to focus our service improvement activity in addition to the individual actions resulting from complaints.

These themes are highlighted and shared with each CBU in their Patient Experience reports which provides the opportunity for them to implement focused workstreams within individual service areas. Progress is reported back through the quarterly Patient Experience, Engagement and Insight Group so that we can be assured that the feedback loop has been effectively addressed.

The Patient and Carer Experience leads work closely with CBU and ward leads to support or collaboratively develop and implement Trust-wide and local initiatives to enhance patient experience.

The Trust ensure that the public are informed of service improvement in response to their feedback via a number of mechanisms including:

- Individual Complaint Responses
- A programme of 'You said-we listened'
- Community Engagement
- Social Media posts and general communications
- The Trust Membership
- The Patient Panel

A dataset has been included with the Mandatory Friends and Family question to ensure that actions taken towards improvements identified in the National Patient Surveys are monitored for effectiveness and workstreams reviewed as appropriate.

A consistent <90% feedback rate through the Friends and Family Test, positive feedback via NHS.UK, compliments and good ratings in the National Patient Surveys are all good indications of the positive patient experience provided at Barnsley Hospital.

However, we will continue to provide improvement in those areas where feedback highlights that we could do better.

We would like to take this opportunity to sincerely thank all of our staff, volunteers, service users, their family and friends, community groups and the general public who have been dedicated in supporting the enhancement of patient experience throughout 2023/24 and who are committed to help us drive continued service improvement throughout 2024/25 to ensure that Barnsley hospital is the Best for its patients and the public.

3.2.2. Mortality Report (6/12 update)

For Assurance

Presented by Simon Enright

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.2ii

SUBJECT:	**MORTALITY REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alex Walton, Information Analyst Amy Sylvester, PSQI Officer Tracey Radnall, Associate Director for PSQI				
SPONSORED BY:	Simon Enright, Medical Director				
PRESENTED BY:	Simon Enright, Medical Director				

STRATEGIC CONTEXT

The Trust has a quality target to keep the overall Hospital Standardised Mortality Ratio (HSMR) within the statistically set limits for our hospital (Statistically set at ≥77.9 and ≤136.2).

EXECUTIVE SUMMARY

Crude mortality: Latest analysed year to date data (to the end of June) is 22.28.
SHMI: The latest rolling month to February 2024 is 95.50 (classified as expected). Please note the methodological changes to the SHMI published May 2024.
HSMR: Latest data from CHKS is to March 2024 and reports 90.35 for the preceding 12-month period (classified as within limits).
Learning from Deaths compliance: All non-coronial deaths are reviewed by the Medical Examiner Service and all requested SJR's have been completed.
Escalations to PSP: In the closed period February to April 2024, six deaths were escalated to the Patient Safety Panel with a panel decision for further investigation, feedback or to share learning as detailed in section 2b. A further two have since been escalated for deaths in the open May 2024 period. There are seven SJR's within the Mortality Overview Group (MOG) processes in relation to deaths in the period from April to June 2024. One from April, one from May and five from June.
Learning from Deaths & Statistics improvements: The HSMR T&F group chaired by the Medical Director specifically to support the changes needed in the electronic patient records to ensure episodes are recorded correctly is being reduced in frequency. The data quality remit will be managed as business as usual as part of the mortality variance group meeting.
Assurance level offered: Good
*Report and Statistical data correct as of **12/07/2024***

RECOMMENDATION(S)

The Board of Directors is asked to review and receive the report.

1: MORTALITY STATISTICS

1a: Summary Table

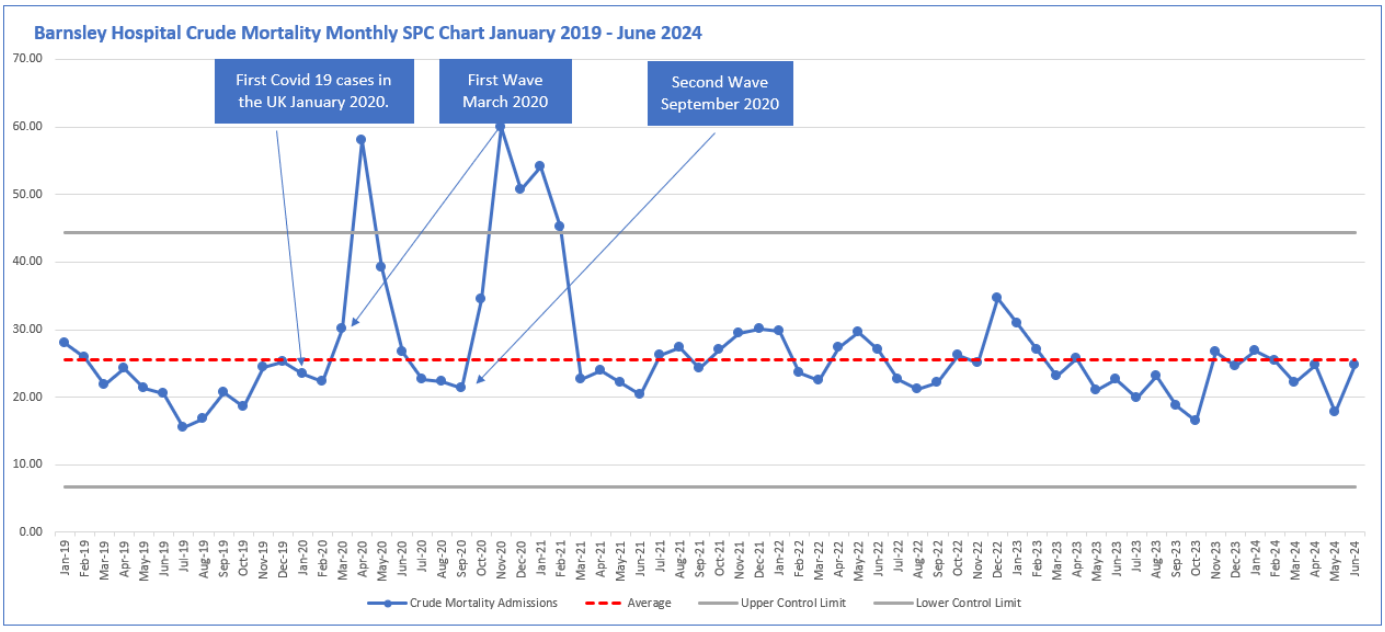
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Admissions	3809	4086	4058	4029	4064	4147	4239	4323	4522	4499	4407	4616	4276	4556	3962
Deaths (HSMR)	81	67	74	57	77	59	57	97	80	86	86	26			
Expected Deaths (HSMR)	73	71	72	72	85	68	80	102	95	97	95	25.7			
Covid Deaths	9	6	3	2	4	5	1	9	5	15	13	2	6	5	7
HSMR 12 Month Rolling	114.34	111.59	108.52	104.83	102.66	100.20	96.70	96.01	92.22	91.39	90.33	90.35			
SHMI	101.95	101.15	100.06	100.54	100.93	100.23	97.20	97.02	95.72	95.59	95.50				

1b: Crude Mortality Rate per 1000 Admissions: Overall year to date is 22.28

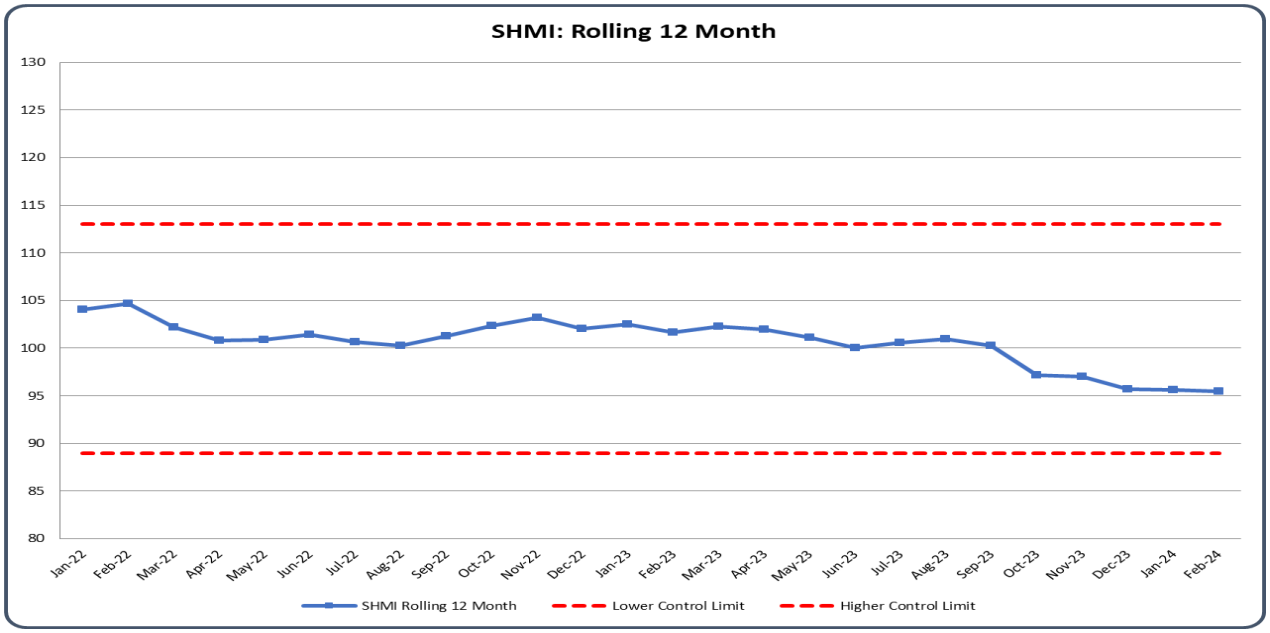
Crude, weekend and weekday mortality is calculated using a rate per 1000 admissions:
There is no national mandated crude mortality indicator and it is not an externally reported metric but was initiated in 2017 in response to the “NHS weekend effect” Please note the admission data for June is flex data and the position may change.

	Overall Crude Mortality			Weekend Crude Mortality			Weekday Crude Mortality		
Year	All Deaths	All Admissions	Crude Mortality *(All Deaths divided by All Admissions multiplied by 1000)*	Weekend Deaths	Weekend Admissions	Weekend Crude Mortality *(Patients Admitted on a weekend that went on to die / Weekend Admissions)*	Weekday Deaths	Weekday Admission	Weekday Crude Mortality *(Patients admitted on a weekday that went on to die/Weekday Admissions)*
2016/2017	969	41516	23.29	271	11960	23.83	698	29556	23.62
2017/2018	1066	43224	24.73	292	12872	21.36	774	30352	25.50
2018/2019	1067	45855	23.26	316	12843	20.95	751	33012	22.75
2019/2020	1049	48224	21.68	278	14136	18.25	771	34088	22.62
2020/2021	1386	37133	37.46	416	9729	26.62	970	27404	35.40
2021/2022	1188	46345	25.63	343	10481	32.73	845	35864	23.56
2022/2023	1263	47844	26.40	363	14383	25.24	900	33461	26.90
2023/2024	1159	50799	22.82	316	14264	22.15	843	36535	23.07
2024 to date	285	12794	22.28	67	3657	18.32	218	9137	23.86

In Month overall crude mortality trend since Jan 2019:

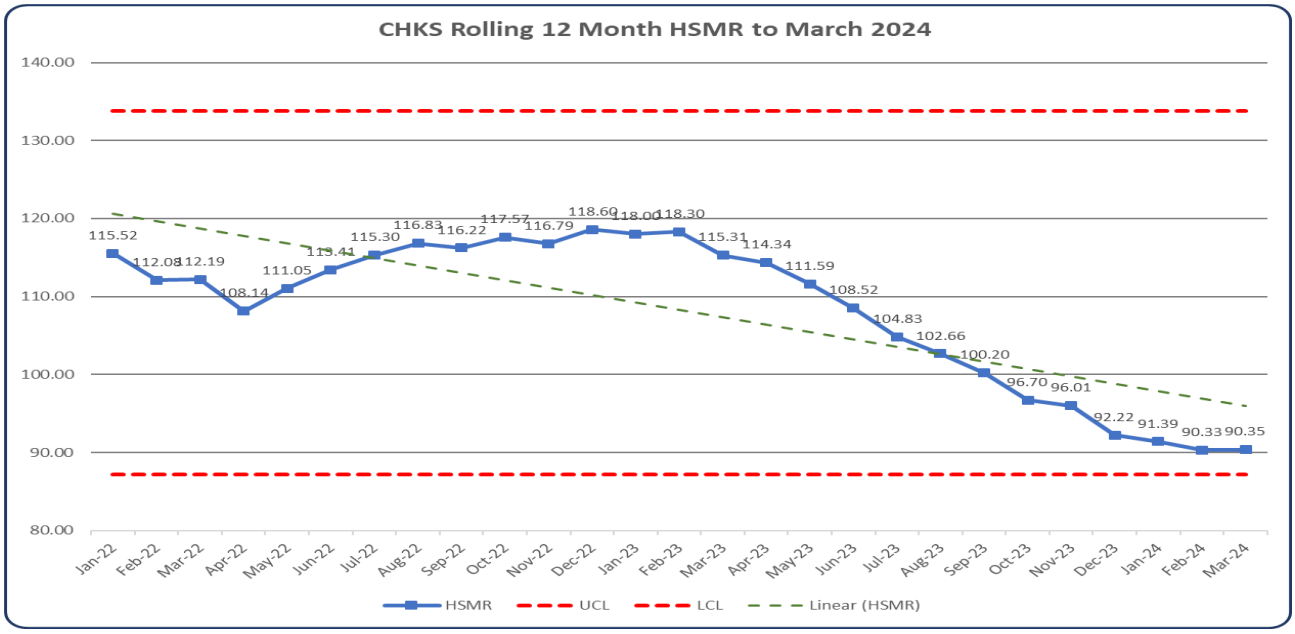


1c: SUMMARY HOSPITAL-BASED MORTALITY INDICATOR (SHMI): 95.50 to February 2024



- Latest data to February 2024 is 95.50. The SHMI data at BHNFT is banded 'as expected' and within the upper and lower control limits set by NHS Digital (Lower: 0.89, Upper: 1.16).
- The SHMI is a ratio of the observed number of all in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths.
- The SHMI is not influenced by palliative care coding.
- The SHMI cannot be used to directly compare mortality outcomes between trusts. It is inappropriate to rank trusts according to their SHMI. About the Summary Hospital-level Mortality Indicator (SHMI) - NHS Digital NHS Digital accessed 02/04/2024.
- Announcement of **methodological changes to the Summary Hospital-level Mortality Indicator** (SHMI) May 2024 SHMI+-+methodological+changes+May+2024+publication.pdf:
    - The first publication to be affected by this change will be the May 2024 release, which will cover discharges in the period January 2023 – December 2023.
    - COVID-19 activity with a discharge date on or after 1 September 2021 will be included in the SHMI. This date was chosen because the death rate for COVID-19 stabilised from mid-2021 onwards
    - The methodology will be updated to use the first primary diagnosis which isn't a symptom or sign. This is because increasingly, trusts have models of care where there may be several short episodes at the beginning of the spell, meaning that the diagnosis may not be known until the third episode (or later). If all of the episodes in the spell have a primary diagnosis which is a symptom or sign, then the first episode in the spell will be used.
    - Provider spells with an invalid primary diagnosis will be moved to a new separate diagnosis group to allow the impact of these data quality issues on the SHMI to be more easily identified

1d: HOSPITAL STANDARDISED MORTALITY RATIO (HSMR): 90.35



- The 12-month rolling HSMR to March 2024 is 90.35 and within limits set by the external analytics company (confidence limits will be reset when the data is rebased).
- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths.
- Only Covid-19 activity recorded in the first finished consultant episode is excluded from the HSMR
- The HSMR is sensitive to Specialist Palliative Care (SPC) coding. The higher percentage of deaths coded with specialist palliative care the lower the HSMR will be.

	Rolling 12 Month Benchmark Similar Profile Peer Group April 2023 - March 2024	HSMR
The matched peer is revised by CHKs in consideration of any changes in the comparison organisations and has been accepted by the Learning from Deaths Group	Chesterfield Royal Hospital NHS Foundation Trust	136.84
	South Tyneside and Sunderland NHS Foundation Trust	126.34
	Sherwood Forest Hospitals NHS Foundation Trust	109.28
	James Paget University Hospitals NHS Foundation Trust	102.32
	Harrogate and District NHS Foundation Trust	98.49
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	96.31
	Airedale NHS Foundation Trust	95.08
	Barnsley Hospital NHS Foundation Trust	**90.35**
	The Rotherham NHS Foundation Trust	88.80
	Mid Cheshire Hospitals NHS Foundation Trust	84.91
	Warrington and Halton Hospitals NHS Foundation Trust	79.38
	Yeovil District Hospital NHS Foundation Trust	NO DATA

1e: Variance between the HSMR and SHMI:

Both the SHMI and HSMR are used for trend analysis. The ME escalations, SJRs and escalations for review to PSP remain the most reliable assurance mechanism regarding patient care.

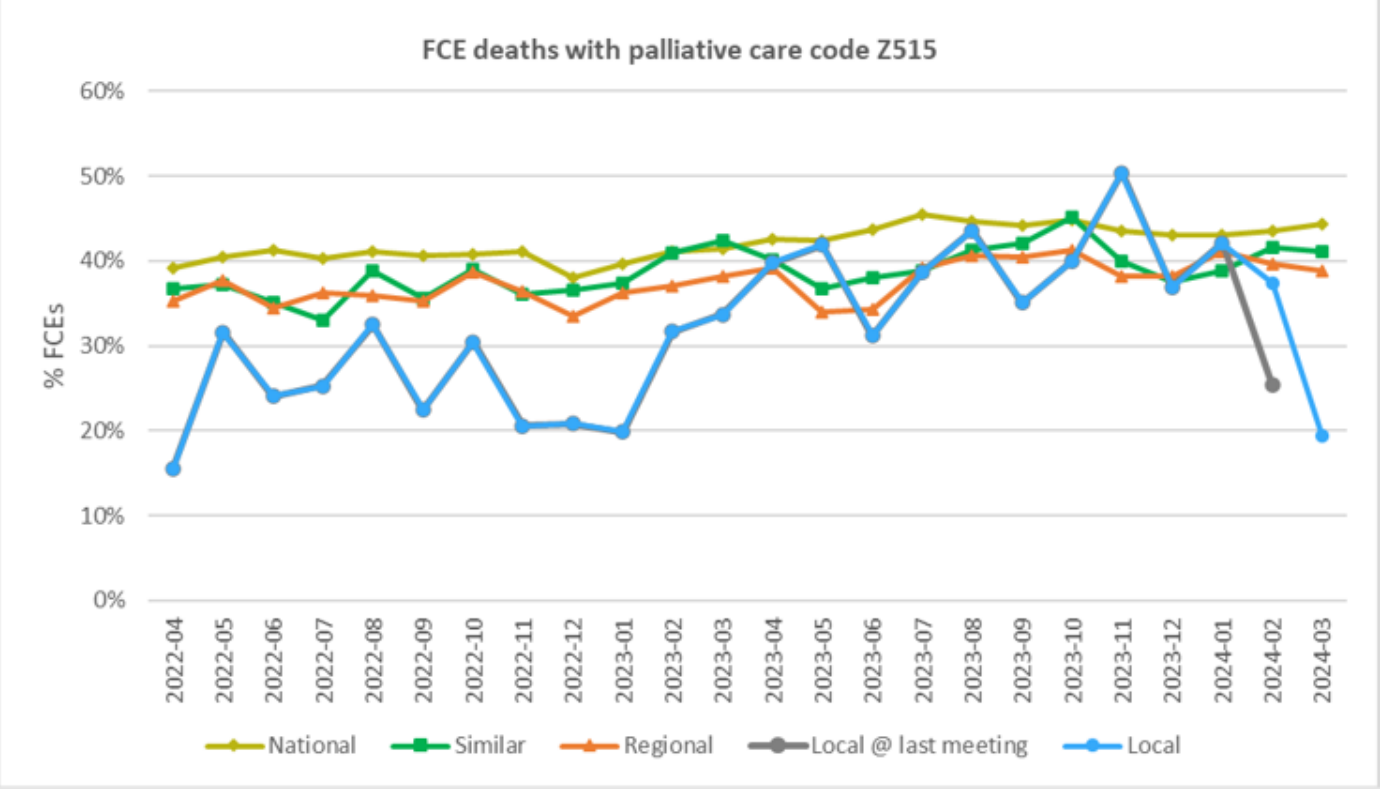
The SHMI and the HSMR are currently at a good position for BHNFT however the HSMR can be adversely affected by:

- Lower average percentage of deaths coded with specialist palliative care (average was 25% at BHNFT, now at 35% compared to national of 45% affecting the relative risk of death calculation. Work has been taking place to ensure the opportunity to record SPC activity is taken. (Please note the local data drops on the last point due to the flex position of the data and so should not be taken as a final percentage for that month)

- However, a decrease has been seen since the introduction of electronic case notes – see section 2 improvement projects. A digital fix has been implemented and will be monitored

- As it currently stands Covid deaths are not included within HSMR if it is the primary diagnosis, but any patients with Covid19 in the secondary or any other position will be included.

- Short and multiple finished consultant episodes reduce the opportunity to code an accurate diagnosis. This was an issue which has been improved. The information and data quality team are working on a solution to manage this as part of business as usual.



1f: TASK AND FINISH GROUP

Work is ongoing with the information team, coding team and palliative care team to address the identified HSMR issues including:

- The HSMR T&F group continues, chaired by the Medical Director, which reports into the CEG. The group meeting is being reduced in frequency. The data quality remit will be managed as business as usual as part of the mortality variance group meeting.

- A focus on reducing the number of false FCE's generated.
- Providing the coding team with reliable sources from which to code. The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken
- Implementing the recently reviewed Specialist Palliative Care Coding policy from to ensure all opportunities to code specialist palliative care are available to the coding department.
- Ensuring data submission deadlines to SUS are understood and the impact of these on the HSMR. The closing down of the SUS (secondary users set) means that any retrospective changes made to coding cannot be seen until after the HES refresh that takes place in May each year, usually seen in July's published statistics.
- Continue monthly Flex and Freeze reviews and monthly data quality checks with CHKS (mortality variance meetings)

Comparisons and Limitations of the statistics are detailed in **Section 2h**.

1g: Coding:

The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken

Clinical Coding receives the Official National Code changes including standards and guidance every April from the WHO. Any new changes to coding practice or any new codes that might have an impact on the Trust's mortality statistics are communicated to MOG and will form part of the Coding report to the LfM group.

1h: Rebase:

The CHKs HSMR is due to be rebased. Rebasing takes place because mortality indices fall over time. This is largely because coding contains more and more detail of patients' conditions, generally suggesting greater risk of death. When these indices are rebased the England average will shift upwards to approximately 100.

The current pre-rebase HSMR England average is currently 92, meaning that the new HSMR may be shifting upwards by around 8.

Overall, Trusts will remain in similar positions in the peer distributions, but there may be more significant variances at the clinical classification software (CCS) diagnosis group level.

The rebase will include reference data from the pandemic which given the high volume of Covid cases in the Barnsley area is a concern.

However, Barnsley data represents only a tiny fraction of the cases in the reference data. This includes data from all acute trusts in England. For the upcoming rebase that includes 1.05 million deaths and 38.2 million cases covering 5 years' worth of HES.

If any cases during the pandemic were wrongly assigned to 'pneumonia' instead of to 'covid', then sites with typical volumes of pneumonia patients would all be similarly affected because expected deaths for pneumonia would be slightly overstated, which we have seen in our HSMR and has already occurred. This will continue to be the case when the model is rebased.

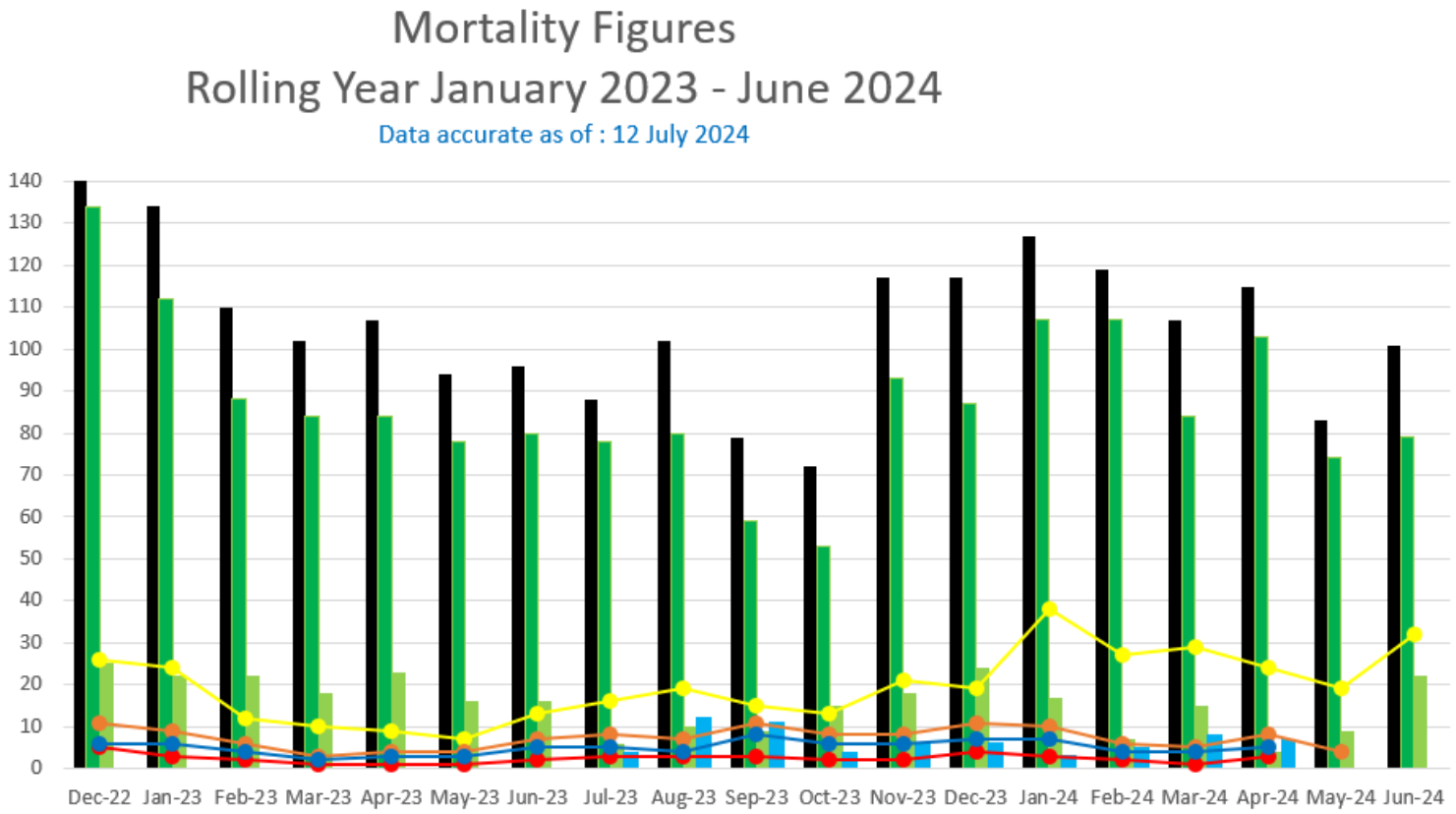
2: LEARNING FROM DEATHS

GOVERNANCE: Learning continues to be discussed at the weekly mortality overview group with escalation to the Patient Safety Panel if required. The MOG action log is reviewed at LfM and where appropriate in the chairs log to CEG

2a: Sharing learning:

Learning from Deaths Bulletins	Jan 2024	• Edition 101 – What Does Good End of Life Care Involve • Edition 102 – Consultant Responsibilities in Managing a Deteriorating Patient
	Feb 2024	• Edition 103 – Critical Medication not stocked on the ward • Edition 104 – People with Learning Disabilities
	Mar 2024	• Edition 105 – Recording deaths on EPR
	Apr 2024	• Edition 106 – Commencing My Care Plan
	May 2024	• Edition 107 – Delirium and Constipation
	Jun 2024	• Edition 108 – Iatrogenic Illness and Medication Reviews • Edition 109 – Hypernatraemia
CBU speciality reports	CBU speciality level HSMR reports are now available on IRIS	
Mental Health SJR Report	The Mental Health SJR report is shared quarterly with the Mental Health Steering Group	
Learning Disabilities & Autism SJR Report	Learning Disabilities and/or Autism report is shared quarterly with the safeguarding lead.	
End of Life SJR findings report	This report shares the findings of End of Life Care within mortality reviews on deceased patients where a Structured Judgment Review was requested.	
Escalations from the SJR's	Any identified periods of poor care in SJR's are escalated by Mortality Overview Group to Patient Safety Panel.	
Thematic review of escalations to the PSP	Thematic review of escalations to the PSP are reported on bi-annually to the LfMG and shared with the relevant governance group such the deteriorating patient group, medicines management group and End of Life Group.	
NMTR (TARN)	Any escalations and/or SJR's for patients submitted to the National Major Trauma Registry (NMTR - previously TARN) are shared with the NMTR clinical lead	
NHFD	Any escalations and/or SJR's for patients submitted to NHFD are shared with the NHFD clinical lead and the ortho-geriatrician	

2b Compliance:



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Number of Deaths	159	134	110	102	107	94	96	88	102	79	72	117	117	127	119	107	115	83	101
Scrutiny only	134	112	88	84	84	78	80	78	80	59	53	93	87	107	107	84	103	74	79
Coroner Referral with Scrutiny	25	22	22	18	23	16	16	6	10	9	15	18	24	17	7	15	4	9	22
Coroner Referral only	0	0	0	0	0	0	0	4	12	11	4	6	6	3	5	8	7	0	0
Number of ME Escalations to MOG	26	24	12	10	9	7	13	16	19	15	13	21	19	38	27	29	24	19	32
Number of SJR Requests	11	9	6	3	4	4	7	8	7	11	8	8	11	10	6	5	8	4	MOG Processes
Number of Esclations to PSP	5	3	2	1	1	1	2	3	3	3	2	2	4	3	2	1	3	MOG Processes	MOG Processes
Number NOT Esclations to PSP	6	6	4	2	3	3	5	5	4	8	6	6	7	7	4	4	5	MOG Processes	MOG Processes

The information in the above chart shows MOG processes for the deaths which occurred in each calendar month.

PSP Decision As of 12 July 2024	
January 2024 Deaths	• Share with consultant team and Learning from Death Bulletin • PSII • Feedback to EoL and Consultant Team and Learning from Death Bulletin
February 2024 Deaths	• ED/EoL/Cons Feedback • Incident to be reported on Datix - INC-133295 (2/4/24 PSII Agreed)
March 2024 Deaths	• Further information required by Clinical Team
April 2024 Deaths	• Stroke MDT ; Speciality Review • Learning to be taken into Complaint Investigation • Abdo Pain Trust Work (Dr Walker) Awaiting x1 SJR to be returned
May 2024 Deaths	• Share learning with Consultant Team, CCIO and Patient Flow • Governance Team to review further and bring back in two week for a decision on further investigation (INC-136615) Awaiting x1 SJR to be returned
June 2024 Deaths	Awaiting x5 SJR to be returned

2c: Improvement Projects

Child Deaths	As part of the Child Death Overview Panel (CDOP) governance, the safeguarding children advisor provides reports to the learning from deaths group to highlight recent deaths, give more context and information to the deaths that have occurred and summaries with future learning and actions that may need to be taken. The case of Patient D was discussed at the January 2024 meeting and a number of good practises where identified; • Excellent leadership and team working- clear delegation, team inclusion • Major haemorrhage protocol activated appropriately, excellent support from haematology colleagues In addition, the minutes of the paediatric morbidity and mortality meeting are shared with the group. The Medical Examiner Service is to link with Paediatric colleagues in relation the process going forward the scrutiny of child deaths has been made statutory. The minutes of the paediatric morbidity and mortality meeting are shared with the LfM group.
Bereavement Office	The ET has approved the trial relocation of the bereavement office functions and staff associated with it to be permanent. HR and Finance work is underway to make this happen A new electronic way for the ward/departments to notify the office of a death is currently being devised and will be trialled on Ward 19 and Ward 20/ASU. Patients Property Policy is currently being updated and will go through the relevant approval processes before being added to the Trust Approved Documents.

End of Life (Respiratory)	Guidance for Withdrawal of Respiratory Support in Conscious Patients at the End of Life: A piece of work is ongoing with the team from respiratory and specialist palliative care to develop guidance on withdrawing respiratory support for patients receiving end of life care.
HSMR T&F Group	This group is chaired by the Medical Director and has started specifically to review the issues around the multiple finished consultant episodes that our Trust has in comparison to other Trusts (see below). The group provides a chairs log direct to CEG As well as addressing the issues on FCE's the group has supported the progress being made to ensure that past medical history and co-morbidities are automatically pulled through to the D1 discharge summary. A draft is in user acceptance testing stage but none of the proformas are live yet. The group is reducing the frequency of meetings as the data quality aspects are now part of the mortality variance meeting
'False' Finished Consultant Episode	To improve this further, when the coding team identify 'false' finished consultant episodes, the data quality team work with the wards to rectify this prior to the episode being coded. In addition, the information team are working on a BAU method of identifying and reducing these prior to the episodes being available to the coders. This work is monitored through the mortality variance group
Variance meetings (Trust and external provider)	Data variance meetings take place between the trust and the external informatics provider to ensure the trust is not submitting incorrect or duplicate data to the secondary users set. This can sometimes occur if a patient spell crosses submission date. This has allowed resubmissions to be made to ensure no un-coded episodes are submitted, thereby having a positive impact on the HSMR
Specialist Palliative Care Comparison to Peers – Local Coding Policy	A revised SPC local coding process has been approved and has been in use from April 2023 The specialist palliative care coding has increased by 10% and is having a positive impact on the HSMR, the national average of specialist palliative coding is 40%; when work was commenced the Trust was just above 20%, but are now closer to 30% which is showing massive improvements. However, a drop has been seen with the introduction of digital clerking due to the loss of the SPC sticker – a digital solution has been found for this and it is hoped the upwards trajectory will recommence. The solution has been approved by the Medical Director and added to the local coding policy
Desktop reviews of patient notes for alerting groups	Where any groups are outside of the statistically set limits provided by the external informatics company, a desktop review takes place supported by the patient safety team whereby the head of coding will review opportunity to improve the quality of coding. • From December 2023 to February 2024, 127 patient notes were reviewed and 29 coding amendments made • From March and April 2024, 93 patient notes were reviewed and 25 coding amendments made.
Deaths within 48 Hours of Admission	The HSMR T&F group heard of the work undertaken by Dr Shakespeare on whether or not admissions of patients who die within 48hrs could be avoided. It was agreed that this work should be shared more widely through the Barnsley place quality and safety committee to gain GP engagement. Dr Shakespeare is awaiting confirmation of a place on the most appropriate GP agenda
ID2823: Outlier notification review: NELA mortality	Workstream leads: Mr Ghosh and Dr Chaurasia Notification received of a high in-hospital mortality after emergency laparotomy. However, after a review of the submitted data an error was found (live patient information submitted as deceased). On correction of the error the outlier notification no longer stands.

D2752: Outlier notification review: National hip fracture audit (NHFD).	Workstream lead: Mr Sheikh Notification received of a higher than expected case-mix adjusted 30-day mortality up to and including the second and third quarters of 2023. The clinical effectiveness and quality team instigated Mortality Outlier Notification Status policy, the medical director held meetings with key staff and the NHFD clinical lead instigated initial fact finding in order to develop an action plan for improvement. Multiple investigative workstreams have been agreed and action plan has been developed to respond to the findings. All work and actions will be captured in the response report, which will be shared with all appropriate governance groups. The action plan will be monitored for progress on a monthly basis. An initial update was provided to CEG in February and a detailed action plan delivered in March. A further update will take place in July 2024 with the next set of data due to be published in October 2024.

2d: Medical Examiner Service:

Scrutinies are triaged as follows:

- Any concerns raised by relatives
- Any concerns raised by the qualified attending practitioner
- Any concerns from the medical or nursing team
- Any relevant datixes
- Any that might require referral to the coroner
- Any concerns from any other sources

Staffing:

Medical Examiner Officers: recruitment changes have been undertaken to ensure staffing is compliant with the national funding model ahead of statutory status.
Medical Examiners: there are seven substantive medical examiners including the lead ME and three ad hoc MEs which includes two GPs.

Community Expansion:

As of June 2024, there are just two GP practices left to confirm a start date:
- Burleigh Medical Centre
- High Street Royston

Statutory start date: Is now confirmed as the 9th September 2024. Regulations are currently available in legal format and will be shared in layman's terms by the national team in due course. Communications about the changes will go out in the Trust from the end of July.

2f: Regional:

The last regional Mortality meeting was held on the 4th April 2024 with the 13th June meeting occurring after this paper was drafted.

The meeting is hosted by the Improvement Academy and is attended by those involved in the learning from deaths across the region including Dr Andrew Gibson, the clinical lead for patient safety at the Royal College of Physicians (RCP)

Further discussion took place on the variability in coronial process nationally and the impact of this on trust learning from deaths processes

In addition, the Regional Mortality group continued discussion on reaching a consensus on what should be included in mortality reports with a view to standardising mortality reports across the region.

NCEPOD conduct twice yearly mandatory national studies on patient safety issues. The topics for these studies can be proposed by anyone. The group is considering putting forward a proposal for a future study.

2g: National:

The link to the latest (March) edition of the NME bulletin is available here: March NME bulletin.

The bulletin includes:

Good Practice Series – Palliative and End of Life Care
Employing General Practitioners (GPs) as medical examiners
Podcast
Independent Healthcare Providers Network
Section 251 support for sharing patient records
Implementation in Wales
Funding letters and quarterly reporting – England
Training and events

- **Statutory medical examiner system**

The statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice. From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. The changes, which form part of the Department of Health's Death Certification Reforms, were announced by the government on 15 April 2024, and come into force on 9 September 2024.

- **Medical certificate of cause of death:**

From September 2024, a new MCCD will replace the existing certificate to reflect the introduction of medical examiners, who will scrutinise the proposed cause of death.

The main benefits of doing so are to improve:

- efficiency in the death certification system
- mortality data for use at a local level and nationally

- **Medical examiner certification:**

In line with the framework set out in the Coroners and Justice Act 2009 and the medical certificate of cause of death regulations, the NME service are introducing medical examiner certification for the exceptional circumstances where either:

- there is no attending practitioner
- an attending practitioner is not available within a reasonable time

In either of these circumstances, the death is referred to the senior coroner by a referring medical practitioner (not a medical examiner).

In these circumstances only, where the senior coroner decides not to investigate, they should refer the case to a medical examiner to certify the death by completing a medical examiner MCCD.

- **Implementation plan and timetable:**

DHSC will continue to work closely with stakeholders to raise awareness of the new reforms and listen to any feedback on the approach taken.

Between April and September 2024:

- face-to-face training for medical examiners and medical examiner officers will be provided by the Royal College of Pathologists and online training provided by NHS England
- existing guidance, including guidance from the national medical examiner's office and office of the chief coroner, will be updated to reflect the statutory changes
- the new paper MCCD will be made available in preparation for use
- development of the digital MCCD will continue

2h: Hospital Mortality Measures – Comparisons and Limitations:

At BHNFT we use the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) to measure whether the mortality rate at a hospital is higher or lower than expected. A high or low HSMR or SHMI is not indicative of poor or good care but it can be a signal that further investigation is required. The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths. The SHMI is a ratio of the observed number of in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths. As of May 2024 COVID-19 activity with a discharge date on or after 1 September 2021 will be included in the SHMI. This date was chosen because the death rate for COVID-19 stabilised from mid-2021 onwards

Common Features:

Both of the measures feature primary determinants for the risk of death;
Age (though numbers of groups vary), Admission type (elective or non-elective), Diagnosis (numbers of groups vary, but all now use CCS1 as basis), Sex (M/F), Comorbidity (albeit different methods).

None of the reported statistics are based on death certification data but instead are based on the ***primary diagnosis. In the HSMR this is in first episode of care*** If this is a 'symptom' or 'sign' then the second episode of care is used***, in the SHMI it is the first primary diagnosis which isn't a symptom or sign***.

A sign or symptom has a low risk of death and so if a patient is admitted with a headache and then goes onto to die, this will adversely affect the mortality statistic. If, however the patient is admitted with a headache due to a probable stroke with a history of previous strokes, dementia and type 2 diabetes, with an advanced care plan and established palliative therapies, this will more accurately reflect the risk of death. Accurate record keeping with clarity on the working diagnosis – probable not query- is essential if the statistics are to be reliable

Common limitations of all models:

A lack of information on severity represents a major limitation of all risk-adjusted mortality models, particularly at individual patient level. In using any of the models at trust level, the implied assumption is that differences in each condition's severity 'average out', and/or that thresholds for admission in terms of

severity, are the same across all hospitals. The user needs to be aware that, in the context of their particular analysis, this assumption about severity may or may not be reasonable.

To be confident of a rate (to within 10 percentage points) approximately 1,000 deaths must be included in the dataset – BHNFT has an average above this but the degree of confidence in the underlying rate is less than a larger hospital with more deaths. For this reason, mortality rates should never be relied upon as an 'early warning' on their own and should always be presented with correctly calculated confidence intervals.

Further information on the statistics can be found Corporate - Patient Safety Education (trent.nhs.uk) and a presentation Mortality metrics overview (vimeo.com) please note this is pre the SHMI methodology update

2i: Conclusion:

There is no single measure to directly relate care quality and mortality outcomes. Mortality metrics can be used as 'smoke signals' for further investigation within the wider context of coding, case mix and care. A higher than expected measure does not equate to poor care and a lower does not equate to good care. The greater assurance comes from the medical examiner system and learning from deaths process which offers first stage scrutiny and a more in-depth review of individual patient care where indicated. Combining the two is the best approach to promote understanding and improvement.

This report demonstrates:

- mortality statistics are within statistically expected limits
- compliance with the ME and LfD processes
- any identified poor care is escalated to the PSP for further action
- learning themes are shared
- improvement projects are undertaken in line with either mortality statistics or learning from deaths

and therefore, offers **Good Assurance**.

Good Assurance *if all of the criteria are met*	• mortality statistics are within statistically expected limits • compliance with the ME and LfD processes • poor care is escalated to the PSP for further action • learning themes are shared • improvement projects are undertaken in line with either mortality statistics or learning from deaths
Limited Assurance *if one or more of the criteria are not met*	• Mortality statistics are outside of statistically expected limits • Poor compliance (<75%) with the ME and/or LfD processes • Failure to escalate poor care • Failure to share learning • Failure to undertake remedial actions/improvement projects

3.3. Finance & Performance Committee Chair's Log: 27 June/25 July 2024

For Assurance

Presented by Alison Knowles

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.3

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alison Knowles, Non-Executive Director/Chair				
SPONSORED BY:	Alison Knowles, Non-Executive Director/Chair				
PRESENTED BY:	Alison Knowles, Non-Executive Director/Chair				

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns if required, and make recommendations on the BAF, ICT, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY: £k= thousands £m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on Thursday 27 June 2024 via teams. The following topics were the focus of discussion:

- Integrated Performance Report including emergency pressures, the introduction of new national cancer standards and the delivery of the national ambition that no patient should wait more than 65 weeks for planned care by the end of September.
- The development of the "Waiting Healthy, a List Equity System" to minimise inequities in waiting times for planned care
- The Finance position at month 2 including progress on the Efficiency & Productivity Programme.
- An update on the Trust's IM&T programme including the planned update to the LIMS system in July 2024.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

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Subject:	Finance and Performance Committee Chair's Log	REF:	BoD: 24/08/01/3.3

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	Date	Chair
Finance and Performance Committee	27 June 2024	Alison Knowles, Non-Executive Director

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Integrated Performance Report	Pressure in the Trust's urgent & emergency care services remains high with admissions having increased compared to May 2023. The Trust is focussing on improving bed occupancy through work with Place partners and on support to staffing in the Emergency Department. The Trust is now reporting cancer delivery against the three national standards: • Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 29 days of referral (75%) • 31-day Treatment Standard: commence treatment within 31 days of a decision to treat (96%) • 62-day Treatment Standard: commence treatment within 62 days of being referred (85%) The Trust is meeting the 28 day and 31-day standards and working with partners across the South Yorkshire Cancer Alliance on actions to improve the delivery of the 62-day standard. The Trust is working towards meeting the national ambition that by end of September, no patient should wait more 65 weeks for planned care. There are 114 patients who need to be treated by the end of quarter 2 to meet the ambition with plans in place for each of them. The Trust is working to a local ambition that no patient should wait more than 52 weeks for planned care by the end of 2024/25. There are just over 8600 patients who will need to be treated with the majority requiring non-admitted (outpatient or diagnostic) care.	Board of Directors	For Assurance
Finance Report	At month 2, the Trust is reporting an adverse position compared to plan principally due to emergency pressures and the continued use of agency / non-contracted staff. Plans are in place to improve the staffing position and to deliver the Trust's Efficiency & Productivity Programme for the year.	Board of Directors	For Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Information and Communications Technology (ICT)	The Trust will be upgrading its LIMS system in Pathology in July 2024 and is reviewing the cyber-security of key supplier organisations in order to implement the lessons from the recent cyber-attack on the NHS in London.	Board of Directors	For Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.3i

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alison Knowles, Non-Executive Director/Chair				
SPONSORED BY:	Alison Knowles, Non-Executive Director/Chair				
PRESENTED BY:	Alison Knowles, Non-Executive Director/Chair				

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns if required, and make recommendations on the BAF, ICT, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY: £k= thousands
£m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on Thursday 25 July 2024 via teams. The following topics were the focus of discussion:

- Financial Position at Month 3
- Efficiency & Productivity Programme
- Integrated Performance Report including urgent & emergency care delivery, planned care and 65 week ambition, and cancer waiting time delivery
- Workforce Attendance Report
- Pathology LIMS upgrade
- Robotic Process Automation – progress update
- BAF and corporate risk register

RECOMMENDATIONS

The Board of Directors is asked to receive and review the attached log.

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**BoD: 24/08/01/3.3i**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	**Date**	**Chair**
Finance and Performance Committee	**25 July 2024**	**Alison Knowles, Non-Executive Director**

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Finance Report	The Trust is reporting a £3.1m deficit at month 3 which is £300k adverse to plan. The committee discussed the increased costs in the Trust driven by pressures in the urgent and emergency care pathways and the continuing costs around temporary staffing. The committee noted that theatre utilisation and utilisation of the Community Diagnostic Centre remain below plan which is adding financial and delivery risk to the Trust's overall position. The Efficiency & Productivity Programme is profiled to impact from month 5 onwards and the Committee discussion emphasised the importance of delivering each element of this programme to the Trust's year-end financial position.	Board of Directors	For Assurance
Efficiency & Productivity Programme	The Committee discussed the revised governance for the programme in response to the South Yorkshire ICB's participation in the NHSE Investigation and Intervention Programme. The Committee noted the ongoing work on establishing individual efficiency programmes and discussed how savings might be risk-adjusted to improve forecasting. In addition to the core programme, the executive updated the Committee on work to identify additional savings opportunities and on the opportunities to improve the capacity and capability within the operational management team to secure delivery of the programme.	Board of Directors	For Assurance
Integrated Performance Report	Urgent & Emergency Care – The Committee received an update on the continuing pressures in these services. The Trust delivered 73.2% in month 3 and is aiming for 80% at the end of the year. Attendances continue at a high level with some days touching 400 and admissions are up 15%. The work on improving discharge arrangements continues and bed occupancy has improved to 92% largely due to this focussed work. The number of bed days lost due to delayed discharges is now the best in the North East & Yorkshire region and there is a continued focus on ensuring discharges happen early each day,	Board of Directors	For Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Planned Care and Diagnostics – the Committee received assurance that the Trust will deliver the national ambition that no patient should wait more than 65 weeks at the end of September. The Trust is continuing to focus on increasing activity levels including utilising the Community Diagnostic Centre and the Mexborough Elective Orthopaedic Centre. Inpatient activity remains below plan largely due to increased trauma and maternity activity taking priority for theatre sessions.		
Information and Communication Technology	The Committee received assurance that the upgrade to the Pathology LIMS had been undertaken successfully on 7 July and that the risk to the Trust's services had, therefore been reduced. The Committee discussed a progress report on Robotic Process Automation and noted the opportunities for wider roll-out into operational services across the Trust.	Board of Directors	For Assurance

3.4. People Committee Chair's Log: 23 July 2024

For Assurance

Presented by Kevin Clifford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/08/01/3.4

SUBJECT:	**PEOPLE COMMITTEE CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director / Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director / Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director / Committee Chair				

STRATEGIC CONTEXT

The People Committee is a Committee of the Board responsible for oversight and scrutiny of the Trust's development and delivery of workforce, organisational development and cultural change strategies supporting the Trust's strategic priorities. Its purpose is to provide detailed scrutiny, to provide assurance and to raise concerns (if appropriate) to the Board of Directors in relation to matters within its remit.

EXECUTIVE SUMMARY

The People Committee met on Tuesday 23 July 2024 and considered the following major items:

- Workforce Insight Report
- Director of People Update
- Board Assurance Framework and Corporate Risk Register Update
- Sickness and Absence Management Audit Actions Progress Report
- Sub Group Chair's Logs and Update

RECOMMENDATION(S)

The Board of Directors is asked to note and receive the attached log.

Subject:	PEOPLE COMMITTEE CHAIRS LOG	REF:	BoD: 24/08/01/3.4

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee (PC)	Date: 23 July 2024	Chair: Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Workforce Insight Report	The Committee received the latest report which now reflects the staffing changes relating to the transfer of Pathology Services staff. For Board to note these changes will be reflected in the IPR from next month. Discussion at the committee was varied but with a significant focus on sickness absence, reflecting the improved position in relation to long term sickness while acknowledging the challenges currently associated with our current high overall position. Mandatory training targets are being met but unfortunately Appraisal compliance has not yet been achieved. A specific issue relating to VTS doctors, where employment is with ourselves but Appraisal is with other organisations, makes a significant impact on overall compliance levels. If these doctors are excluded compliance for Medical staff increases to over 96%.	Board of Directors	Assurance
2	Director of People Update	Steve Ned updated the Committee on a range of external people issues including the recent information relating to the ongoing Junior Doctors pay dispute and the media coverage regarding the AfC pay review. Emma Lavery informed the Committee that the Trust had been shortlisted for the Healthcare People Management Association (HPMA) Excellence in Organisational Development (OD) award.	Board of Directors	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	Barnsley Strategic Workforce Plan Development	The Committee received an update on the Barnsley Strategic Workforce Plan.	Board of Directors	Assurance
4	Barnsley Strategic Workforce Group: Proud to Care Hub Update	The Committee received an update on the Proud to Care Hub.	Board of Directors	Assurance
5	BAF / CRR Update	The Committee reviewed the BAF and CRR people related risks and confirmed no change in the risk level on this occasion.	Board of Directors	Assurance
6	Sickness Absence Management Audits Actions Progress Report	The Committee received a further update on the Action Plan and all actions are now completed.	Board of Directors	Assurance
7	People and Engagement Group Chair's Log	The Committee received the Chair's Log from the recent meeting of the People and Engagement Group.	Board of Directors	Assurance
8	Proud to Care Cultural Leadership Steering Group Chair's Log	The Committee received the Chair's Log from the recent meeting of the Proud to Care Cultural Leadership Steering Group The Board are asked to note the planned conference for staff which will be held on two days in September. Take up of places has been very good and all places are expected to be filled.	Board of Directors	Assurance
9	Trust Objectives Progress Report 2024/ 25	The Committee reviewed the progress on the people related aspects of the Trust Objectives prior to their presentation to the Board.	Board of Directors	Assurance

3.4.1. Fit and Proper Person Test Report

For Assurance

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS – Public	REF:	BoD: 24/08/01/3.4i

SUBJECT:	**DIRECTOR FIT AND PROPER PERSON ASSESSMENTS**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Steve Ned, Director of People				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Steve Ned, Director of People				

STRATEGIC CONTEXT

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his review of the FPPT (the Kark review). The purpose of the Framework is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

EXECUTIVE SUMMARY

This paper sets out the steps taken by the Chair of Barnsley Hospital NHS Foundation Trust to assess Board Directors against the FPPT Framework.

RECOMMENDATION

The Board of Directors is asked to note the assessment by the Chair of Board Directors against the requirements of the FPPT Framework.

1. Introduction

1.1 NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

1.2 The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

1.3 The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations. The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

1.4 The Framework applies to the board members of NHS organisations. The term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

2. FPPT requirements

2.1 The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal *(a report on Director appraisals and objectives is scheduled for discussion on the agenda for the committee meeting on 16th July, 2024)*.

2.2 Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in schedule 4 of the regulations.

2.3 Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes. As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role.

2.4 A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements – will be needed for new appointments to Board roles. FPPT assessments are also required on an annual basis for directors already in post. These assessments include an assessment of the following:

- *Good character*
- *Possessing the qualifications, competence, skills required and experience*
- *Financial soundness*
- *Self attestation*

2.5 In summary, the following checks will be made both on appointment and on an annual basis for directors already in post (the checks marked with an Asterix are not required on an annual basis unless a specific reason applies):

First name*

Second name/surname*

Organisation* (that is, current employer)

Staff group*

Job title* (that is, current job description)

Occupation code*

Position title*

Employment history: *

This would include detail of all job titles, organisation departments, dates, and role descriptions. Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.

Training and development

References: *

Available references from previous employers, board member references, including resignations or early retirement.

Last appraisal and date

Disciplinary findings

That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding. Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.

Type of DBS disclosed*

Date DBS received*

Disqualified directors register check

Date of medical clearance* (including confirmation of OHA)

Date of professional register check (e.g. membership of professional bodies)

Insolvency check

Settlement agreements

Self-attestation form signed

Social media check

Employment tribunal judgement check

Disqualification from being a charity trustee check

Board member reference*

Sign-off by chair/CEO.

2.6 Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system. In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

3. Responsibilities of the Chair

3.1 Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a. Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b. Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c. Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d. Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e. Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f. On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g. Conclude whether the board member is fit and proper.

h. Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i. Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

4. Declaration and conclusion

4.1 As Chair of Barnsley Hospital NHS Foundation Trust (BHNFT) I can confirm that the FPPT requirements set out at paragraph 3.1 have been completed and adhered to for the year 2024/25. I have determined, based on those checks, that all Board members of BHNFT are deemed Fit and Proper Persons in accordance with the framework set out by NHS England.

4.2 In respect of joint appointments, I can confirm that I have sought (and received) confirmation from the Chair of The Rotherham NHS Foundation Trust (TRFT) that there is no information that they are aware of (in respect of the 2 Board members employed by BHNFT who have responsibilities at TRFT) that would impact on my judgement that they are Fit and Proper Persons. I have provided similar assurances to the Chair of TRFT for the one Board member employed by TRFT who has responsibilities at BHNFT.

4.3 I have completed the annual submission to NHS England's Regional Director to confirm that the FPPT process has been undertaken at BHNFT (see attached Appendix)

4.4 The Board of Directors is asked to note the declaration that the FPPT requirements (in respect of Executive Directors and Directors) as set out in the NHSE Framework have been duly completed for BHNFT for 2024/25.

Sheena McDonnell

Chair

July 2024

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Barnsley NHS Foundation Trust	Sheena McDonnell	June 2024

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Board Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Board member reference completed and retained? Yes/No
Chair/NED board members	9	9		None	2	Yes
Executive board members	9	9		None		
Partner members (ICBs)	n/a					
Total	18	18		None		

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC	n/a			
Other, e.g., internal audit, review board, etc.	n/a			

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR BARNSLEY HOSPITAL NHS FOUNDATION TRUST - 2024					
For the SID/deputy chair to complete:					
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No	
	Senior Independent Director	Stephen Radford 	28th June, 2024	Yes	
For the chair to complete:					
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:			
	Yes				
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:			
	No				
As Chair of Barnsley Hospital NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.					
Chair signature:	 Sheena McDonnell				
Date signed:	28th June, 2024				
For the regional director to complete:					
Name:					
Signature:					
Date:					

3.4.2. Independent Review Of Greater Manchester Mental Health NHS Foundation Trust: The Shanley Report

For Information

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.4iv

SUBJECT:	**INDEPENDENT REVIEW OF GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST – THE SHANLEY REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Steven Ned, Director of People				
SPONSORED BY:	Steven Ned, Director of People				
PRESENTED BY:	Steven Ned, Director of People				

STRATEGIC CONTEXT

This paper relates to our strategic objective 'Best for People' and 'Best for Patients and the Public'.

EXECUTIVE SUMMARY

In September 2022 the BBC broadcast the current affairs programme Panorama. The programme showed appalling levels of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich, which is part of Greater Manchester Mental Health NHS Foundation Trust (GMMH). In response to the concerns identified by BBC Panorama, NHS England subsequently commissioned an independent review, led by Professor Oliver Shanley, OBE to understand what took place, how and why.

The attached, detailed report sets out the findings of the independent review and details lessons learned, not only for GMMH but for other similar organisations. The report makes a number of recommendations. Set out below are the recommendations that may be pertinent to our Trust:

Recommendation 1: The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services.
Recommendation 2: A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.
Recommendation 3: The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor. This culture must ensure that no staff experience discrimination.
Recommendation 4: The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the stability of nursing staff. The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.
Recommendation 5: The Trust needs to have a better understanding of the quality of its

estate and the impact of this on the delivery of high-quality care, including providing a safe environment. It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

Recommendation 6: The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

RECOMMENDATION(S)

The Board of Directors is asked to receive and note the Shanley Report. The recommendations highlighted in this report will be reviewed and addressed by the Executive team.

Independent Review of Greater Manchester Mental Health NHS Foundation Trust

Final Report, January 2024

Important note:

This is a detailed report which contains information about mental health care and treatment which some people may find distressing. This report also contains non-attributable direct quotes and feedback from some of the people who have been in receipt of those services under review. Whilst we have made every effort to limit the use of descriptive or distressing content, it was deemed necessary to include some of this information to place an emphasis on certain findings. We advise strongly that, if you might find some of this information triggering, you are supported to read this report in a safe way.

An ‘easy read’ version of this report is also available.

Foreword

In September 2022 the BBC broadcast the current affairs programme Panorama. The programme showed appalling levels of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich, which is part of Greater Manchester Mental Health NHS Foundation Trust (GMMH). The horror of what was shown could not fail to touch anyone who watched the programme. In response to the concerns identified by BBC Panorama, NHS England subsequently commissioned this independent review to understand what took place, how and why. We were also asked by NHS England to look at other areas of concern regarding the quality of care within the Trust.

From the outset I want to say thank you to the patients, families, staff, and other interested and involved parties who gave their time so freely to me and my colleagues. As a review team we felt that most spoke with absolute candour about their experiences of Edenfield and GMMH. I am certain that without people speaking so freely and openly, the true extent of what took place may not have been known. When talking to people we hoped to create a space in which they could speak safely about their experiences. We wanted to listen appreciatively, and endeavoured to understand what was being shared with us. Perhaps not unexpectedly, many people became upset when sharing their experiences. What did surprise us was the level of distress displayed by so many GMMH staff.

As a review team we firmly believe that the vast majority of healthcare staff come to work to do a good job. Most of the staff we spoke to appeared committed to delivering compassionate care to those who needed their services. We wanted to understand what had gone so badly wrong, why this might have happened and to reduce the possibility of this happening again; not only in GMMH, but also in other organisations providing similar services. The need to achieve this learning was important for the review team. The NHS has experienced numerous opportunities to learn from adverse events. Reports are written, recommendations made, but this does not always lead to sustained improvement. We hope that our approach to this review may create an opportunity for improvements that will make a meaningful impact to the people the NHS is there to serve.

We have tried to write a report that feels human, is less technical, and that tries to capture the experience of what it was like to receive and provide care in GMMH. Throughout our work, we have tried to describe what the reality of care is like, versus care ‘as imagined’ by the Trust. Some patients and families described not being believed when they raised concerns or complained about the care received. We were told that they sometimes experienced unkindness, a lack of compassion and respect, and abuse by staff. Others shared how they did not always feel safe to disclose concerns, with many accounts of feeling intimidated, undermined, ignored, or fearful that ‘bad news’ was not welcomed. Sadly, we heard from many staff who said they were once proud to work for GMMH and that this had diminished over recent years. Within the timetable that was set for us by NHS England, we met over 400 people.

This report identifies what was happening across the Edenfield Centre and the broader Trust in recent years. We found a Trust that was not sufficiently focused on understanding the experience of patients, families and carers. Our interviews with senior staff, as well as our review of Board papers, found that the GMMH Board, while having many competing objectives, focused more on matters such as expansion, reputation and meeting operational targets rather than the quality of care provided. This led to insufficient oversight of the quality of care, with the Trust relying disproportionately on the periodic opinions of external regulators, rather than forming its own views based on strong governance. We found that there was insufficient curiosity about the ongoing patient and staff experience across the Trust. The lack of both curiosity and focus on improvement led to missed opportunities for organisational learning across a number of services.

As with many organisations nationally, we found a Trust that was facing significant workforce challenges; however, many staff described feeling exasperated, tired of not being listened to and disconnected from the Trust leadership. We were told that these concerns started long before the scope of this review. We heard that staff have felt fearful to speak up for many years, and that the full extent of Edenfield's nursing shortages and their consequences have been masked and ignored. Over time, this culture and way of working have led to many staff from across various disciplines leaving the organisation. Nursing levels had become unsafe; the ability to deliver safe and timely care was severely compromised. The inadequate governance systems and the wider Trust culture contributed to the purported 'invisibility' of these deteriorations. We found it was difficult to discern how this workforce crisis was acknowledged in GMMH: there was an absence of an effective response to these concerns. We also observed that some of the concerns identified within Edenfield existed across other parts of GMMH inpatient services.

We make several findings and recommendations that we hope will ensure learning will take place, enabling a sustainable approach to quality across the Trust. We also make some recommendations for the external partners whose role should be to support and challenge the Trust. In making these recommendations we are informed by the voices of the people who spoke so passionately about what must happen to ensure improvement. We met with many talented and dedicated staff who told us they want to work in an organisation that values people and the quality of care. They want to ensure they can meet the needs of the communities they serve and, in doing so, feel supported by the Trust. We have seen some signs that GMMH has started to focus on improvement, and this is encouraging. This will need to continue and will require a relentless focus on the quality of its services to maintain the progress that is needed.

I want to give thanks to the team that worked alongside me and who worked so diligently in trying to give voice to the truths we heard. I want to again thank all the patients, families, carers, and staff who shared their experiences with the team; without them this review would not have been possible.

Professor Oliver Shanley OBE

This Final Report has been written in line with the terms of reference as set out in Appendix 1 of this report. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out of date. Our report has not been written in line with any UK or other (overseas) auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review, and therefore cannot attest to the reliability or accuracy of that data or information.

This is an independent report which has been prepared for NHS England and has been written for the purposes of publication. No other party may place any reliability whatsoever on this report, as this report has not been written for their contractual purposes.

Different versions of this report may exist in both hard copy and electronic formats, and therefore only the final signed and dated version of this report should be regarded as definitive.

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List of figures and tables

Chapter 1 Executive summary

1.1 In September 2022 the BBC broadcast their current affairs programme Panorama which showed evidence of the most shocking abuse and poor care of patients within the Edenfield Centre in Prestwich, Greater Manchester. Patients were humiliated, bullied, and verbally abused. The Edenfield Centre is a mental health medium and low secure service, supporting patients with a range of complex needs. Section 3.15 onwards describes the nature of services provided at Edenfield. The centre is part of Greater Manchester Mental Health NHS Foundation Trust (GMMH).

1.2 In November 2022, NHS England commissioned an Independent Review of the Trust. The review was asked primarily to focus on what had happened at Edenfield, but also to consider if similar concerns could be happening elsewhere in GMMH. Furthermore, the review was to determine how the broader healthcare system that is there to support the Trust had let concerns at Edenfield, and in other services, go either unnoticed or without a sufficient response.

1.3 We wanted to ensure our review was grounded in the reality of patients, families, carers and staff. We spoke to over 400 people during the course of this review. What was striking was the level of distress we found among patients, families and staff. Most of our conversations prompted some level of upset and stirred up very difficult memories for people. We thank them unreservedly for their contribution to our review. Given the distress that some people were experiencing, we asked GMMH to revisit what emotional support was available for staff. We also arranged with NHS England and the Integrated Care Board (ICB) for the Greater Manchester Resilience Hub to provide support for families and carers for those who expressed a need for additional support.

1.4 Patient care at GMMH has, at times, been poor, and the work of BBC Panorama has made this very clear. In some services, patients have been denied basic dignity and their human rights. At the same time, we also encountered a great many members of staff who were passionate, evidently talented and highly committed to their patients. It has been our task throughout this work to hold both of these facts in mind, and to remember that both of these things can co-exist. For the Trust to move forward and improve for its patients, these committed and passionate staff will need to be assured that things can change, and that the leadership of the Trust wants to make this happen.

1.5 We wanted to ensure that we placed patients, families and carers at the heart of this review. In Chapter 4 we describe what they told us. We have concluded that a large part of what was exposed through BBC Panorama was due to the lack of value placed on the patient's voice in GMMH, as well as a frequent disregard for the experiences of families and carers. It is clear that patients and their loved ones had raised, on various occasions, serious concerns about the care provided at Edenfield and elsewhere in the Trust, and that this had not aways been taken seriously. At all levels of the organisation, we struggled to see how the patient experience had been embedded into structures and processes, so that Trust leaders had a clear picture of how people who use their services experience care.

1.6 Patients at Edenfield are vulnerable. They are in a locked setting, away from the people most important to them and are typically detained under the Mental Health Act. This creates an inevitable disconnect for those patients and this was made much worse by COVID-19 and subsequent responses to the pandemic. This should have meant that special efforts were made to ensure that their voices were heard and respected, but this did not occur. Most people we spoke with, including those charged with oversight of the Trust, recognised this and reflected that the only way to stop this from happening again is to build patients' feedback about their care into the core of governance and regulatory processes.

1.7 Within the Trust, there were repeated missed opportunities to act on concerns raised at Edenfield. This included, for example, National Staff Survey results, information relating to levels of restrictive practice[1], a cultural audit in 2019 which raised concerns, staff vacancies, the instability of ward management and high consultant turnover. The almost complete absence of other intelligence,

[1] Restrictive practice limits a patient's movement or freedom in order to keep the patient or others safe (Mental Health Act Code of Practice, 2015)

including safeguarding referrals and concerns raised, was also something which could and should have been explored. Poor leadership visibility[2] in the service, as well as weak governance processes and a practice of suppressing 'bad news' in the organisation, enabled this to happen.

1.8 We found a service that had all the hallmarks of a closed culture, including an absence of psychological safety,[3] incivility between staff, poor leadership, and a lack of teamworking. These conditions allowed what we saw on BBC Panorama both to happen and to go unchecked. The extent to which the Board has recognised this is variable, and in some cases, limited. We do not know the extent to which similar issues may be happening in other forensic services in England, particularly due to their 'locked' nature.

1.9 In Chapter 5 and Chapter 6 we discuss the leadership and culture of GMMH respectively. We know that the 'tone' of an organisation should be set by the board of directors and the executive team. We heard that the Board itself has been disconnected from the reality of what it was like for patients to receive, and for staff to deliver, care at GMMH. Board members had been visible in few services and Edenfield in particular, despite the high-risk nature of services delivered there, was a blind spot for the Board. During our review, we heard that the interim CEO and interim Chair were now seen often in the organisation, which was welcomed. The interim Chair was mentioned as being seen regularly at Edenfield.

1.10 During our fieldwork and within our terms of reference timescale we found that there has been an insufficient focus on quality, which was in part driven by the growth of the organisation. We heard that the expansion of the Trust had not seen a corresponding investment in quality oversight, and many staff said that since the acquisition of services, there has been an insidious decline in quality across several parts of the Trust. We were told by several Board and Executive Team members that both groups were concerned about their reputation, and that this had impacted on the transparency of what was shared both internally and externally. We heard that healthy debate and challenge had been discouraged, and that information provided to the Board was often poor and provided insufficient or inaccurate information to underpin Board assurance. The executive team did not work well together, and this was most notable between operational services and clinical leaders. The value, ability and effectiveness of the clinical voice was minimised or ignored. Within this vacuum, the operational voice became dominant, and the executive team and the board of directors allowed this to happen and made no effective intervention to address this.

1.11 A number of the Trust's leaders have lacked compassion and empathy. We heard repeated stories of senior managers treating staff poorly and fostering a culture of fear and intimidation in order to maintain performance standards. Staff throughout the organisation and at all levels gave us examples of how the clinical voice and quality of care suffered directly as a result of this. Several leaders identified by staff as displaying these behaviours remain in senior and influential posts; our review found that some of these individuals do not appear to understand how their behaviours might have contributed to the problems at GMMH. The Trust has commissioned separate independent investigations into some of these HR matters, and some of these investigations remain ongoing at the time of writing. That said, many staff are dismayed to see some of these individuals still in very senior roles. It is crucial that the Trust assures itself that all of its leaders are consistently role modelling the values and behaviours needed, to confirm that the Trust truly understands the impact of some of its leadership behaviours on staff and patients.

1.12 Diversity, in its broadest sense, has been lacking. We found that leaders had not received effective leadership development support, particularly in relation to values-based leadership styles. Many senior leaders in the organisation have spent the majority of their careers at GMMH and in its predecessor organisations. As such, some have a narrow experience of different leadership styles and ways of doing things. Several spent a significant part of their career working at Edenfield.

1.13 Making positive changes in all of the areas outlined in the chapters on Culture and Leadership is essential and we consider the importance of the workforce in enabling these changes in Chapter 7.

[2] Visible leaders make efforts to spend time with, get to know and engage their staff.

[3] Psychological safety is "a shared belief held by members of a team that it's OK to take risks, to express their ideas and concerns, to speak up with questions, and to admit mistakes — all without fear of negative consequences." (Harvard Business Review, 2023).

The enormous workforce challenge in the NHS is well known, and GMMH has had higher vacancies than the national average in some professional groups, notably nursing and medicine. The workforce information the Board received was insufficient and there was not a clear strategy to address either the recruitment or retention of staff. The reports that were presented to the Board on inpatient nursing staffing levels were vague, overly optimistic, and often contained information that did not reflect the reality for inpatient services in GMMH. Encouragingly, we have seen improvements in the Safe Staffing Report to the Board.

1.14 Prior to BBC Panorama, and until interventions were taken, at Edenfield it was not uncommon for a single qualified nurse to have to assume responsibility for three wards. We heard of newly qualified nurses taking on leadership roles that they were ill equipped to deal with, often with little practical support or supervision. We heard of high levels of turnover across all disciplines, but especially among consultant psychiatrists. These workforce pressures likely had a significant impact on the safety, experience and effectiveness of the care provided.

1.15 We heard that relationships across the consultant medical body were poor, and the impact of BBC Panorama led to a further deterioration in relationships. This had a significant adverse effect on their ability to provide the leadership and direction that the service required. We were so concerned about the distress of the doctors that we escalated this to the interim Chair and former Chief Executive of GMMH. We had also previously raised our concerns about the level of general distress across the workforce, the possibility of trauma, and the need for greater support for staff.

1.16 To enable GMMH to move forward it is imperative that it pays a much greater attention to the value and importance it places on its workforce, including the compassion shown towards them. This must be underlined by clear unambiguous information to the Board that sets out the impact of the workforce challenges and what this means to provide and receive care in the Trust.

1.17 In Chapter 8 we consider the effectiveness of the governance within GMMH. The Trust's governance framework failed to identify and escalate the issues presenting in Edenfield, to enable them to be surfaced and dealt with in a timely way. The information that was submitted to those Board subcommittees charged with quality and workforce was insufficient to provide assurance in these areas. We heard that reports presented to Board subcommittees would sometimes undergo various iterations before being presented to non-executive directors. It was not always clear what the rationale for these changes was, but there were occasions where the lack of information finally presented would have undoubtedly impacted on the ability of the non-executive directors to understand fully the extent of concerns.

1.18 We also witnessed missed opportunities to challenge or interrogate relevant data presented, which might have enabled more robust debate around quality concerns. The Trust has restructured its governance framework, and it is critical that the new model and processes enable concerns to be identified, acted on, and learned from quickly when things go wrong. This will involve ensuring that information can flow readily through the organisation, which is also contingent on developing a culture of openness and willingness to learn and improve. It is essential that this is done in a culture of transparency which, at times, appears to have been lacking.

1.19 A key determinant of how effective an organisation's governance is, is its ability to respond and learn when things go wrong. The provision of healthcare is complicated and has various inherently high risks. This is why learning and a commitment to improving are essential. In Chapter 9 we wanted to assess this in a concrete way. We therefore chose a small number of case studies to look at, where clear concerns had been raised. We looked at:

- how the organisation (and its partners) responded to concerns raised by a patient in its secure services;
- inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events;
- how the Trust has responded following the death of a person in its inpatient care, and;
- the Trust's improvement plan, and how well this enables learning.

1.20 We found some commonalities in the Trust's management of significant concerns being raised to them. These included:

- **A slow pace of change** – Some of these issues are very long-standing, have been known about for a long time and yet improvements are difficult to identify.
- **A lack of transparency and/or clarity in reporting** – Across three of the case studies we found that management information (whether in the form of incident reporting, quality metrics or board/committee reporting) has been opaque. In all three cases we looked at, it was difficult to get to the heart of the issue, or what had actually happened.
- **A lack of scrutiny of key information** – We found a need for more effective scrutiny of information presented to key forums (including sharing this with clinicians at an early stage), and a clearer and more coherent response from management and executives to challenge posed by non-executive directors. Openness and transparency are critical conditions if the Trust is to create a culture conducive to improvement and learning.
- **A lack of rigour in the monitoring of change** – There has been a tendency for the organisation to be overly optimistic in its reporting of changes made since all of these events. An example of this is the auditing of observations in child and adolescent mental health services (CAMHS) (see Chapter 9).This has, on some occasions, been challenged by senior staff or non-executive directors in the organisation, but we also found examples of key information being missed, which would suggest that existing plans are not having the desired impact and may be putting other patients at risk of harm.

1.21 As part of our assessment of organisational learning, we also reviewed the Trust's improvement plan. This showed a positive commitment to organisational change. We were concerned, however, that the improvement plan is driven by inputs and processes, and the Trust is trying to make a great many changes as quickly as possible. In reality, in its current form, the improvement plan is proposing simple solutions for what this review has found to be highly complex problems. There is an insufficient focus in the plan on the cultural and leadership changes needed in the organisation, which are crucial to ensuring that everything else can work well. These things are much harder to change, take longer to embed and are more difficult to measure.

1.22 As well as considering organisational learning we wanted to know whether similar concerns found in Edenfield about quality, safety and staffing existed elsewhere in the Trust. We explore this in Chapter 10. At Edenfield there were a number of factors that enabled the poor care and abuse to take place. These included:

- patients, their families and/or carers not being listened to or taken seriously;
- a weak and fragmented clinical voice;
- unsafe levels of staffing and high use of temporary staff;
- a poor physical environment;
- poor culture, including a lack of psychological safety and low morale, including unsupportive leadership behaviours, unsound HR practices including perceived unfair recruitment and promotion, and a lack of transparency about formal investigations;
- conditions leading staff to not adhere to clinical policies such as record keeping and observations; and
- some staff described being treated unfairly because of a protected characteristic.[4]

1.23 We wanted to understand if this could happen elsewhere in the Trust and undertook a high-level review of three areas: an acute adult inpatients site, an older people's inpatient site, and the child

[4] These are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. (Equality and Human Rights Commission).

and adolescent mental health services (CAMHS) inpatient service. We selected these areas due to publicly available information regarding quality concerns.

1.24 It was clear that these services face some significant challenges, many of which are reflective of those we found at Edenfield and could potentially lead to similar outcomes for patients. In some of these services we found indicators of closed culture environments. Staffing is low at all of these sites, some have low morale, and we found evidence of staff being discriminated against based on race and ethnicity. In this part of the review, we have not been able to fully assess the scale of the risks in these services and make a recommendation about further work to determine their safety and quality.

1.25 In seeking to understand what happened within GMMH, it was essential to also look at the effectiveness of the governance processes of those charged with oversight of the Trust. GMMH does not work in a vacuum and those who commission and regulate services also have an important obligation to the patients and people they serve. In Chapter 11 we look at the system response, what partners knew and what they did. We believe there were some missed opportunities for the system to have supported GMMH at an earlier stage in response to various quality concerns that were emerging from the Trust. A timeline of key events, as well as a supporting detailed chronology, is set out at Appendix 5.

1.26 This was almost certainly impacted by these organisations recovering from the pandemic and being part of wider structural and legislative changes within the NHS. That said, the potential impact of change on quality is well known, and this was not paid sufficient regard. There were many indicators that the culture, safety and patient experience in Edenfield and elsewhere in the Trust were poor. These, as well as feedback from external reports, and inquest findings, were not identified, pieced together or acted upon by those charged with oversight and regulation of the Trust. It is clear that the usual protocols within each oversight or regulatory body for identifying a service in distress sufficiently early have not worked well enough.

1.27 System partners in Greater Manchester have, at times, relied on the opinion of the Care Quality Commission (CQC) without corroborating this with their own opinion, based on strong quality governance processes. We were left unconvinced that regulators and commissioners of GMMH have sufficiently strong structures in place (as well as the necessary mental health expertise) to have a clear understanding of existing and emerging risks in the Trust. Leaders of these organisations need to reflect on this with openness and humility to ensure that this does not happen again and ensure genuine learning takes place.

Conclusion and recommendations

1.28 The Trust and its partners have placed significant resource into improving GMMH services following the BBC Panorama exposé. Those charged with doing this at GMMH are working in a difficult environment; its executive team has several important gaps, many of its key leaders are in temporary roles, its workforce is depleted, and morale is low. There is also significant (and justified) scrutiny of the organisation from many stakeholders. These are difficult circumstances for those trying to make the necessary changes to work in, and those charged with overseeing the organisation need to be mindful of this.

1.29 Making change is, nonetheless, fundamental to ensure that the Trust can rebuild, retain its many talented and committed staff, and provide better care for its patients. Values-driven and transparent leadership, strong structures and processes, and a joined up and supportive system response are what is now needed for the Trust to deliver this.

1.30 We make a number of recommendations in this report that we hope will lead to positive change; these are outlined in Chapter 12. We have been struck throughout our review by the candour and bravery of the patients, families and carers we listened to. We also recognise how difficult this has been for so many GMMH staff. We noticed the very high levels of distress in many of those we heard from. We thank them for all of their support in enabling our review to take place and hope that this report has provided assurances through our findings and recommendations to enable a more positive and safe service.

1.31 The Trust is aware that it has a significant amount of work to undertake to improve, and this is reflected in the scale and breadth of its improvement plan. We have intentionally focused our recommendations on the areas in which we think that the most impact can be made over the next 12 to 18 months. We have tried to group these thematically, rather than making a high number of narrower recommendations, which are likely to overwhelm an organisation which is already working under high levels of scrutiny and without the right leadership and delivery capacity.

1.32 We also seek to address the cause of problems we have identified, rather than their impact. The problems we have identified are long-standing and will not be fixed by easy tasks. Rather, the Trust and its partners now need to address the underlying issues, so that they can make sustainable changes for the benefit of patients and staff. In implementing our recommendations, a fundamental component will be supporting GMMH in continuing to create a culture of improvement. This will not happen overnight, and stakeholders and partners will need to work alongside each other in enabling GMMH to thrive.

Chapter 2 Introduction

Background to this review

2.1 In November 2022, NHS England commissioned an independent review of Greater Manchester Mental Health NHS FT ('GMMH', or 'the Trust') which was led regionally by NHS England North West. This was done in response to failings in care given to patients at the Edenfield Centre in Prestwich in Salford. Professor Oliver Shanley OBE was appointed as Chair of this independent review in January 2023.

2.2 On 28 September 2022, the BBC broadcast a programme (Panorama) (BBC, 2022) which shocked and saddened those who watched it. An investigative journalist had worked in an undercover capacity in a care support role for some months at the Edenfield Centre. The Edenfield Centre provides forensic mental health services for men and women. It provides assessment, treatment and aftercare for people with complex mental health needs, many of whom are transferred from within the criminal justice system, or whose care and treatment needs cannot be met in other mental health services. This is usually because they are considered to have behaviours that put others and themselves at serious risk of harm.

2.3 The programme showed patients being abused, physically and emotionally by some members of staff. Patients were mocked, restrained inappropriately, and secluded for long periods. Staff were seen swearing, acting in an uncaring manner to and about patients, and sleeping during their shifts.

2.4 Following the broadcast of the programme, the Trust and NHS England took a number of actions:

- NHS England North West put in place a Rapid Quality Review to prioritise support and take immediate actions to improve patient safety.
- The unit was immediately closed to new admissions and remains so at the time of this report being published.
- Some affected patients were moved to other hospitals.
- Many staff were suspended, and some were ultimately dismissed from the Trust.
- When the Trust was placed in Segment 4[5], NHS England sent support teams in to help the Trust to improve.
- The Trust Board commissioned its own independent reviews to discover how this was allowed to happen.
- GMMH moved a number of patients who were not directly involved in the programme to facilitate ward closures and enable the redistribution of staff to ensure progress on safer staffing.

2.5 A police investigation into what the undercover reporter saw, some of which was shown on BBC Panorama, remains ongoing.

Terms of reference

2.6 The terms of reference for this review define what the review team (described as 'we' throughout this report) was tasked with looking at. These are described in full at Appendix 1. We spent six weeks consulting with various people affected by what was shown in BBC Panorama to agree what the focus of this review should be. This included conversations with:

- Patients and their families and carers

[5] The national Recovery Support Programme (RSP), provided to all trusts and integrated care boards (ICBs) in segment 4 of the NHS Oversight Framework 2022/23 was launched on 13 July 2021. Organisations are placed in one of four 'segments' with four being the lowest performing, and defined as 'Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support' (NHS England).

- The families of two young people who died while in Trust inpatient services in 2020
- Patient groups
- Trust staff
- Trust commissioners (those who fund GMMH)

2.7 The views of these parties, together with feedback from NHS England and our own experience, resulted in the following terms of reference:

1. An independent assessment of what has happened within the Trust's secure services to identify conclusions and lessons. This assessment will ensure it identifies the actual reality of care for patients and staff.
2. An assessment of the culture, leadership, workforce planning and governance that may have impacted on the ability of the Trust to improve patient safety, treatment, and care, including how the Trust involved patients and families. This will include observations on culture that may have led to failures in professional standards.
3. An assessment of the adequacy of the actions taken by the Trust since the concerns were raised. This will include whether the Trust can demonstrate broader organisational learning to improve the quality of its services.
4. The review will consider whether the processes, actions, and responses of regulators, local commissioners, NHS England's Specialised Commissioning function, and other stakeholders relevant to the provision of secure services were satisfactory in responding to and predicting concerns about the quality of care.
5. Whether the Trust's current systems, processes and controls would give rise to the identification of similar issues now (and going forward) in all areas of care delivery.

Review approach

Review team

2.8 The review was led by Professor Oliver Shanley. Oliver is a mental health nurse by background and spent most of his career working in southern England. Oliver has held various Chief Nurse and Director of Nursing roles in provider organisations. More latterly, before retiring from the NHS, he was also the Regional Chief Nurse for London at NHS England and a Chief Executive Officer of a mental health trust.

2.9 Professor Shanley appointed a team of experts to support him in his work:

- **Dr Sarah Markham** is a visiting researcher at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. Sarah is a patient reviewer for the Quality Network for Forensic Mental Health Services at the Royal College of Psychiatrists and has lived experience of using forensic services. She acts as a patient representative for NHS England, the Care Quality Commission and the Healthcare Quality Improvement Partnership. Originally a mathematician, Dr Markham was awarded a PhD in Pure Mathematics from the University of Durham in 2003 after achieving undergraduate and postgraduate degrees from the University of Cambridge.
- **Dr Helen Smith** is a consultant forensic psychiatrist at an NHS trust where she was also formerly the Executive Medical Director. She is the former National Clinical Advisor in mental health to NHS England's Safety directorate team.
- **Jonathan Warren** is a mental health nurse by background and spent most of his career working in London. He is an experienced NHS executive and leader. Jonathan retired from the NHS in 2021, having been the Chief Nurse and Deputy Chief Executive Officer at a mental health trust for ten years, and latterly as Interim Chief Executive Officer of another mental health trust. Jonathan was formerly a National Professional Advisor for mental health nursing for the CQC.

2.10 The review team were also supported by two associates:

- **Priscilla Nzounhenda** is a mental health nurse manager who currently works in a forensic mental health service. She also chairs her Trust's Black and Minority Ethnic Network.
- **Dr Jeremy Kenney-Herbert** is a consultant forensic psychiatrist. He is the former Clinical Programme Director for a provider collaborative and Vice Chair of the Faculty of Forensic Psychiatry at the Royal College of Psychiatrists.

2.11 Support, investigative and governance expertise was provided to the review team by Niche Health and Social Care Consulting[6]. Niche is an employee-owned trust and a B-Corp[7] which specialises in providing independent patient safety reviews and investigations in the NHS. The Niche team consisted of:

- **Kate Jury**, Managing Partner - Kate is a healthcare governance expert and has worked with over 350 organisations in support of all aspects of governance; she also continues to write national guidance on the topic. Kate is also the Managing Partner of Niche and has led on several high-profile investigations and reviews.
- **Danni Sweeney**, Director - Danni is a Director at Niche where she specialises in NHS corporate and clinical governance. She is a certified Executive Coach and works with NHS organisations to improve their culture.
- **Sarah Dunnett**, Senior Investigator - Sarah joined Niche from the CQC where she worked for over 14 years in a number of roles, most recently in a senior role in acute sector regulation in the Midlands. Sarah maintains her NMC registration as a dual Registered Nurse in Mental Health and Adult nursing.
- **Gosia Davies,** Deputy Business Manager - Gosia is an experienced project manager. She joined Niche after eight years of running and overseeing a range of projects with complex partnership arrangements for a global insurer.

Review guiding principles

2.12 This review was complex, touched many different services and agencies and, understandably, provoked emotional responses in many people we spoke with. In designing our approach, we wanted to ensure that our work was guided by a set of principles (see 2.145) which would be reflective of the latest guidance and thinking around quality and safety, and that our work built on previous independent reviews in the NHS. These principles were guided by the following statements:

"Place the quality of patient care, especially patient safety, above all other aims".

"Engage, empower, and hear patients and carers at all times".

"Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work".

"Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge".

2.13 These statements start the executive summary in the Berwick Report (2013), '*A promise to learn, a commitment to act: improving the safety of patients in England'*, which was written in response to the Mid-Staffordshire tragedy. This report highlights, among other things that:

[6] https://www.nicheconsult.co.uk/

[7] Certified B Corporations are businesses that meet the highest standards of verified social and environmental performance, public transparency, and legal accountability to balance profit and purpose.

a. In the vast majority of patient safety incidents, NHS staff are not to blame; it is systems, procedures, conditions, environment and constraints that they face that lead to patient safety problems.

b. Fear is toxic to both safety and improvement.

2.14 The NHS England Patient Safety Strategy (NHS England and Improvement, 2019) embraces these principles and recognises that while some progress has been made there is still much to do to improve the safety of services. This strategy focuses not only on creating safer systems for care, but also on doing this within a just culture. In short, we have not yet conquered fear within our healthcare systems and blame is a natural and easy response to mistakes and violations in care.

2.15 The work of Sidney Dekker sets out some key steps needed to make this shift. This work highlighted:

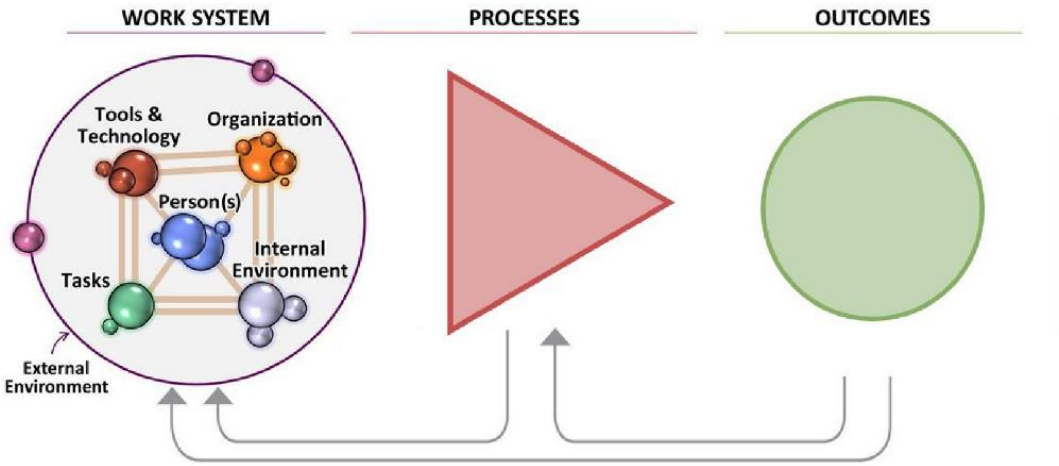
1. **Don't ask who is responsible, ask what is responsible.** Human factors show that people's actions and assessments make sense once we understand critical features of the world in which they work. There are well-known cases in NHS history (and indeed recently, in the case of Countess of Chester Hospital) of individuals who have deliberately set out to cause harm to patients. These are incomprehensible and rightly cause the public anxiety. They represent, however, a minute proportion of the overall care delivered by the NHS and should not set the overall context of how we review poor care.
2. **Understand the difference between work as imagined and work as takes place**. People are too often judged by those who do not understand the work that they do. They do not know the messy detail, they lack technical knowledge, and misunderstand the subtleties of what it is like working in a health system.
3. **People do not come to work to do a bad job.** It is important to understand the importance of restorative vs retributive justice; retributive justice focuses on error and violation of individuals. It suggests that if error or violation has hurt someone then the response should hurt as well. This can provide some comfort to those who have been harmed, as well as to their loved ones. Restorative justice, on the other hand, suggests that if error and violations cause hurt then the response should heal. Restorative justice fosters a dialogue between the individuals and communities involved, rather than a break in relationships through sanction and punishment.
4. **People are not the problem to control but the solution to harness**. Backward accountability means blaming people for past events, 'holding people to account' for what has already happened. This approach doesn't change what has happened and only achieves a sense of anxiety in others. This does not work to improve safety, and what actually happens is that people are motivated to be more careful about reporting and disclosure. Forward accountability changes the question being asked to "*what should be done about the problem, and who should be accountable for implementing those changes and assessing whether they are working in future*?"
5. **Supporting second victims and reducing the negative consequences and creating personal and organisational resilience.** Second victims are those who have been involved in error or violations where people have been harmed. Strong social and organisational support systems have proven critical to contain the negative consequences of safety incidents. The opportunity to recount the experiences first hand can be healing, if taken seriously and not linked to retribution. The lived experience of second victims represents a treasure trove of data about how safety is made and broken at the very heart of an organisation.

2.16 Some of the actions we saw staff take in BBC Panorama were dehumanising, degrading and may be found to be criminal in some cases. It is for the criminal justice system to make a judgement on criminality and for GMMH to decide whether their actions breached their contracts of employment and warrant further action. Our report seeks to understand how the conditions were created in which this behaviour could happen and could go unchecked and unnoticed.

2.17 We used a tool called the System Engineering Initiative for Patient Safety (SEIPS) to help develop an understanding of this. SEIPS provides a structure that supports an understanding of the different

systems within healthcare, their interactions with each other, and with the people who work within them.

Figure 1: Overview of the SEIPS framework



2.18 This framework helped us to identify and explore the interactions between all the various parts of the healthcare system in Edenfield and GMMH more widely. It consistently reminded us how complex this system is and steered us away from drawing simplistic 'cause and effect' conclusions. Most importantly, it reminded us that, other than in exceptional circumstances, people cannot be separated from their work system. Deliberate placement of 'persons' at the centre of the model above reminds us that healthcare systems should support (not replace or compensate for) people.

Method

2.19 Most of our work took place between February and September 2023. During this time, we met over 400 people to listen to their experiences of the Trust. The overwhelming majority of people approached to speak to us did so willingly. People were incredibly generous with their time, and for many this meant recalling distressing events at some personal cost. Those who did so underlined that they were sharing their stories so that the Trust could improve and so that patients would have better experiences in the future. We would like to sincerely thank all the people who met with us and shared their stories with such openness and candour.

2.20 Our approach to delivering the terms of reference described above has comprised:

1. Speaking to over 50 patients, families, and carers through interviews, focus groups and our visits to services.
2. Speaking to around 200 Trust staff, either in one-to-one interviews, during our visits to services, or in focus group environments.
3. Undertaking a series of visits to both Edenfield and other Trust services to see the care environment in its reality.
4. A focus group with members of the Council of Governors.
5. Reviewing a wide range of documentation from the Trust, including strategies, policies, meeting minutes and emails.
6. Reviewing documentation from the Trust's partners, including regulators and oversight bodies. This included documents and reports from the CQC.
7. Undertaking a series of interviews with around 50 of the Trust's stakeholders, including those from NHS England, the CQC and patient groups.
8. Analysing key data from the Trust. This included staffing and activity data and some financial information.

9. Undertaking a case note audit of 20 sets of patient notes from the Edenfield Centre (described in more detail at Appendix 3).

10. 'Sampling' other areas of the Trust where we identified early signs of concern, to understand the potential scale of issues, compared to what we found at Edenfield. Findings from this exercise are set out in Chapter 10.

11. Finally, we set up an independent email address where staff and other stakeholders from the Trust could contact us anonymously to tell us about their relevant experiences. This email address was shared with all Trust staff on three separate occasions.

2.21 Our work used Edenfield as its starting point by seeking to understand how the conditions for what was shown on BBC Panorama were able to develop. Using intelligence from the methods described above, we went on to explore three other services to understand any immediate quality or safety concerns. These were:

- Junction 17 and the Gardener Unit, which provide CAMHS in acute and medium secure settings, respectively;
- Woodlands Hospital, which provides care for older people with mental health needs; and
- Park House, which provides a number of services including acute care for adults of working age, wards for older people with mental health needs, and a rehabilitation ward.

2.22 This report tells the story of how the events of Edenfield came to occur and, in doing so, reflects the experience of many people, including patients, families and carers, staff, stakeholders and system partners.

Chapter 3 Context

This chapter of the report seeks to describe the environment which GMMH is operating in, both nationally and locally.

Mental health services in England

3.1 The goals for how mental health care should be provided in England were set out in the NHS Long Term Plan (NHS, 2019). Following COVID-19, the government published a recovery plan (HM Government, 2021) on how it was going to support the NHS to recover and deliver on the commitments made in the Long Term Plan.

3.2 Despite the increased funding provided through the COVID-19 Mental Health and Wellbeing Recovery Action Plan, mental health services remain under considerable pressure. Nationally, current vacancy rates stand at 9.9% for registered nurses (excluding vacancies filled by temporary workers) (NHS, 2023), and there is a shortage of medical staff working in mental health (NHS Digital data). We explore this further in Chapter 7.

3.3 In 2022, Parliament passed the Health and Care Act (legislation.gov.uk, 2022), which aimed to make it easier for services to work together to provide joined-up care for patients. This formalised the work of integrated care systems (ICSs). These are partnerships, consisting of NHS services, social care, and other organisations, which together provide care in defined geographical areas. Each ICS has an integrated care board (ICB), which determines what care is needed and how funding will be allocated to the various bodies in the ICS, including mental health trusts. One of the effects of this Act is that oversight of services now sits at a much higher level than under the previous clinical commissioning groups (CCGs). For example, in Greater Manchester, the ten CCGs have been replaced by one ICS. These represent significant shifts to how commissioners worked under previous arrangements, and we will come on to describe the impact of commissioning changes on GMMH in this report.

3.4 Alongside the national policy direction, there has been a heightened recognition of the need to improve mental health inpatient services. This has included important developments regarding restrictive practice, with greater requirements placed on mental health trusts through the implementation of the Mental Health Units (Use of Force) Act 2018. This sets out the oversight and management of the appropriate use of force in mental health and learning disability wards.

3.5 Other recent developments include:

- the publication of Rapid review into data on mental health inpatient settings: final report and recommendations (Dept of Health and Social Care, 2023);
- the publication of Acute inpatient mental health care for adults and older adults – Guidance to support the commissioning and delivery of timely access to high-quality therapeutic inpatient care, close to home and in the least restrictive setting possible (NHS England, 2023 a); and
- the launch by NHS England of the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (NHS England, 2023).

These reports set out how inpatient services must look to improve the overall experiences for people who require inpatient services. Importantly, they call for mental health providers to place a greater emphasis on listening to the voices of people with a lived experience and underline the role that the Trust Board has in the oversight of the quality of care.

The COVID-19 pandemic

3.6 The impact of the COVID-19 pandemic on the nation's mental health is still being realised and the full impact may remain to be seen for some time, particularly on children and young people. It is clear that a great many staff suffered high levels of distress as a result of their continued working throughout the pandemic. Supporting patients within mental health inpatient services and trying to keep them safe from the virus was enormously stressful for all staff.

3.7 GMMH experienced similar considerable challenges as the result of the pandemic, and, as an example, Woodlands Hospital (which cares for older people with mental health needs) had several patients who sadly died as a result of the pandemic. For staff across the NHS, there has been no time to 'recover' from what they experienced during the pandemic, and this has further added to the sense of stress and burnout for many. (Pollitt and Pow, 2022).

3.8 In its monitoring of the Mental Health Act (MHA), (legislation.gov.uk,1983) the CQC sought to understand the impact of COVID-19 on mental health care provision. Its report, Monitoring the Mental Health Act in 2021 to 2022, confirmed that workforce issues and staffing shortages remained the greatest challenge for the sector. Issues highlighted include the following:

- understaffing that affects the safety of patients and staff, with a lack of therapeutic treatment leading to an increased risk of violence and aggression on wards;
- chronic staffing shortages leading to challenges around the ability of staff to respond to incidents;
- untrained staff being asked to take on responsibilities they may not be able to carry out safely, and the impact of this on staff wellbeing;
- staffing shortages leading to a lack of patient involvement in decisions about care, reduction in ward activities, and patients' leave[8] being cancelled;
- increased risk of closed cultures developing;
- an adverse impact on therapeutic relationships if temporary staff are used frequently; and
- a 32% rise in 2021/22 in the number of under 18 year olds admitted to adult psychiatric wards because of lack of beds in CAMHS.

3.9 The report also underlines long-standing inequalities in mental health care provision, with:

- black or black British people over four times more likely than white people to be detained under the MHA, more likely to have repeated admissions and more likely to be subject to police holding powers under the MHA; and
- people living in the most deprived areas more than 3.5 times more likely to be detained than those in the least deprived areas.

About GMMH

3.10 GMMH provides mental health care services for people living in Manchester, Salford, Bolton, Trafford and Wigan. It also provides mental health and addiction services across Greater Manchester and more widely, as well as mental health care for patients in prison settings. The Trust employs around 6,400 members of staff across 109 locations. It has an annual income of £522 million.

3.11 In January 2017, the Trust (which had previously been known as Greater Manchester West Mental Health NHS Foundation Trust, or 'GMW') acquired Manchester Mental Health and Social Care NHS Trust, and GMMH was formed. This meant that the Trust became significantly bigger in a short period of time. The Trust grew further in April 2021, when it took on Wigan mental health services,

[8] Patients who are detained under the MHA have rights to leave their ward or hospital for short periods of time, under certain conditions.

and a small number of Bolton and Greater Manchester-wide services. These had previously been managed by an organisation called North West Boroughs Healthcare NHS Foundation Trust.

3.12 At this point, the Trust changed its management structure, from 11 'divisions' to four 'care groups':

- Specialist Services Care Group (which included Adult Forensic Services and Edenfield)
- Wigan Addictions and Bolton Care Group
- Salford, Trafford and Therapies Care Group
- Manchester and Rehabilitation Care Group

3.13 More recently, following the screening of BBC Panorama, a fifth care group was created – Adult Forensic Services – so that these services would have additional oversight and resources.

3.14 The CQC is the main regulator of health services in England. Until October 2022, the Trust had been rated 'Good' overall by the CQC and was understood to be a high-performing organisation by many partners and oversight bodies.

About secure services

3.15 Forensic adult psychiatric services provide assessment and treatment for people aged 18 and over with mental disorders. These disorders include mental illness, personality disorders and neurodevelopmental disorders, including learning disabilities and autism. People often have more than one disorder.

3.16 People are liable to be detained under either part II or part III of the MHA 1983, civil sections or sections initiated through the criminal justice system and a significant number will have Home Office restrictions as part of their detention orders. People generally have complex mental health disorders which are linked to offending or seriously harmful behaviours. Assessment and treatment should be provided by a skilled multidisciplinary team of mental healthcare professionals.

3.17 Three levels of security exist across the forensic psychiatric hospital system: high, medium, and low security. Each provides a range of physical, procedural, and relational security measures to ensure effective treatment and care while providing for the safety of the patient and others, including other patients, staff, and the general public. Edenfield provides one of the larger forensic services in England. It has medium and low secure services for men, a blended medium and low secure service and an enhanced medium secure service for women. Edenfield has nine wards open currently within its medium secure building. Six wards for male patients: Dovedale (16 beds), Rydal (16 beds), Ferndale (17 beds), Silverdale (16 beds), Keswick (13 beds) and Newlands (6 beds). Three wards for females: Borrowdale (12 beds) and Derwent (6 beds) that provide a blended medium and low secure service, and Buttermere (5 beds) that provides an enhanced women's medium secure service. There are two low secure male wards: Delaney (15 beds) and Isherwood (15 beds) which are part of the Lowry Centre.

3.18 In the immediate aftermath of the BBC Panorama programme, five medium secure wards were closed. Originally there were a total of 18 wards across all services with a total of 164 beds; currently there are 13 wards open with a total of 102 beds. There are 92 male beds open and 24 female beds within this service. The unit is currently under-occupied, having closed to admissions after the Panorama programme in September 2022. There is also a community-based service called the Forensic Advice and Support Team (FAST).

3.19 Wards have changed their function over this time period and the current ward provision of care looks different to that provided pre-Panorama. This accommodates closed wards and wards moving as they are refurbished.

3.20 People accessing this service range between the ages of 18 to 70 years old, the majority being between the ages of 21 and 40. The ethnicity of the majority in all services is white; however, in the female services, nearly 17% are from black and minority ethnic groups and a further 7% identify as mixed heritage. Within the male services, 27% of those using medium secure services identify as

from a black minority group and 7% identify with mixed heritage; and in the male low secure group, 17% are from a black minority group and 3% from a mixed heritage (see Appendix 4). It is not uncommon for forensic services to have an over-representation of people from a black minority ethnic group.

3.21 There are a variety of pathways into secure care. Some people access the services via the criminal justice system, arriving in secure services as prisoners on remand or post-sentencing and a few from police custody. Others will enter services as a step up in current security from an open or low secure environment, or a step down from a high secure or medium secure environment. There will be some transfers from another hospital with the same level of security. Services work closely with partner agencies to share information at key stages of an individual's journey through secure services, to ensure that safety is maintained for the public and that individual. These include the law courts, tribunals, parole boards, the Home Office, multi-agency public protection arrangements (MAPPA) and His Majesty's Prison and Probation services. (Appendix 4 gives more information about the people using Edenfield's service.)

3.22 The nature of people's presentations using these services is such that every service needs to carefully consider how it uses restrictive practices (defined at 3.22). The use of these practices must be balanced with an individual's human rights. Consideration must always be given to providing care with the least restrictive practice and this should be kept under continuous review. The Mental Health Act Code of Practice 2015 states that "*any restrictive practice (e.g., restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights*."

3.23 For the purposes of this report, we are particularly concerned with the following types of restrictive practice [9]:

- Physical restraint is any direct physical contact where the intention of the person intervening is to prevent, restrict or subdue movement of the body, or part of the body of another person.
- Seclusion is the supervised containment and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others.
- Rapid tranquillisation is the use of medication by the parenteral[10] route (usually intramuscularly or exceptionally, intravenously) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

3.24 It is important to note that any of these practices are harmful to patients and should only be used as a last resort. All efforts should be made to work with patients to manage their distress and de-escalate behaviours that may result in a restrictive practice at an early stage.

Greater Manchester health and care system

3.25 GMMH is part of the Greater Manchester ICS, although partnership working pre-dated the 2022 Health and Care Act. The region was seen as a trailblazer for partnership working, and in 2014, a Devolution Agreement (HM Treasury, 2014) was signed with Government, providing the region with additional powers and accountability through an elected mayor. Six devolution deals were agreed between 2014 and 2017, including the bringing together of health and social care budgets, with an associated £450m of additional funding in 2015.

3.26 Various changes followed to the way health and social care services were set up in the city, with NHS England overseeing transitional arrangements. Changes included:

[9] Operational definitions: National Reducing Restrictive Practice Safety Improvement Programme

[10] Parenteral route means any non-oral means of administration.

- The formation of the Northern Care Alliance Group in 2016 (composed of Salford Royal NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust). The Northern Care Alliance merged formally in October 2021.
- The establishment of Manchester University NHS Foundation Trust (MFT) in 2017, following the merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. These two acute hospital trusts are now among the largest in the country and hold significant activity and budgets.
- The establishment of the Manchester Local Care Organisation in 2018. This is a partnership organisation, which provides all community care across the city of Manchester, and includes GMMH, Manchester City Council, the acute trusts and other bodies.
- The changes to how GMMH services have been configured are outlined at 3.111 above.

3.27 In short, there have been significant and consistent strategic changes to how health and care have been delivered in Greater Manchester in recent years. These changes, which were closely followed by the COVID-19 pandemic, have meant that the system (like many others) has been operating in a state of change for some time.

Finance

3.28 This review has not included a detailed financial analysis, although we have sought to understand, at a high level, any particular financial risks the Trust is carrying, which may have impacted or be impacting on patient care.

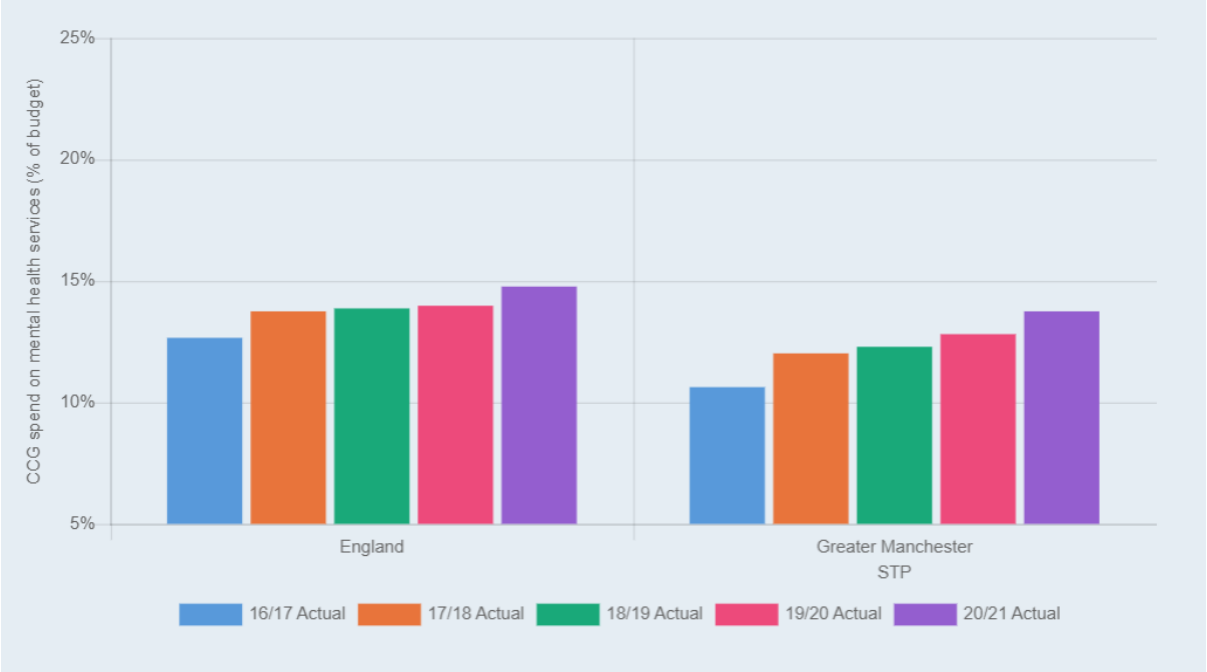
3.29 Data from the Royal College of Psychiatrists shows that spend on mental health services is lower in Greater Manchester than in other parts of the country. This data is not available at a Trust level.

Figure 2: Spend on mental health services per capita (adjusted for mental health need) across England and Greater Manchester

Source: Royal College of Psychiatrists

3.30 The chart above shows that mental health funding per person in Greater Manchester (adjusted for mental health need) is significantly lower than the national average and has been since this data began to be collected in 2018/19.

Figure 3: Proportion of commissioning spend on mental health services by area



Source: Royal College of Psychiatrists

Note: STPs are what are now known as ICSs

3.31 In Greater Manchester, the proportion of healthcare spend on mental health services is lower than the national average, although this gap has narrowed in recent years.

3.32 At GMMH level, the Trust appears to be experiencing increasing financial challenges. Although meeting its break-even target in 2021/22, margins have been significantly eroded over the last six years, which leaves less scope for investment in inpatient care. Most of the Trust's income is via a "block contract" (88% in 2021/22) which means that it receives a set amount of money, for certain services it provides, regardless of how busy these services are. This kind of contract typically carries risk for providers, as funding is effectively capped regardless of activity, unless there are additional measures in place to mitigate this.

3.33 Income increased significantly (by approximately 70%) with the formation of GMMH (following the integration of GMW and Manchester Mental Health and Social Care Trust (MMHSCT) from 1 January 2017). The acquisition of Wigan-based services from April 2021 brought additional income to the Trust of approximately £35m in 2021/22 (almost 9% of total patient care income in 2021/22). However, the associated operating costs for the enlarged organisation have increased disproportionately to income. We also found less than inflationary increases in funding from Salford CCG, and that local authority income remained static over the period.

3.34 Staff costs represent most of the operating expenditure; they have increased in absolute terms and reflect the acquisition of services. However, as a proportion of total expenditure, staff costs have reduced by 5% over the period since 2015/16.

3.35 Overall, the Trust is managing its resources but in an extremely challenged financial environment, which in the context of significant quality concerns, will require focused leadership and support from both within the Trust and its partner agencies.

3.36 More widely, the ICB is also facing serious financial and performance-related challenges, and recently commissioned an independent review of the current leadership and governance arrangements at the Trust to identify any areas of improvement as there has been a deterioration in its financial position in the past few years. Efficiency measures are required to break even in 2023/24. The ICB reported a deficit of £125m after the first four months of 2023/24, which has been

reported as more than £100m worse than planned. The ICB has been placed in the ‘mandated support’ category of NHS England’s regulatory regime.

3.37 This chapter has described the environment in which the Trust provides its services. In the following chapter, we recount what we have heard about the experiences of patients, families and carers who use these services.

Chapter 4 The voice of patients, families, and carers

> *"I tried to discuss the risks and concerns with them … but the Trust seem like they are firefighting and walking from room to room with fire, and petrol already in the room, smoking a cigarette."*
>
> Patient's close family member

Introduction

4.1 In undertaking our review, we wanted to ensure that our starting point was trying to understand the experiences of people who received services from GMMH, notably Edenfield, and those who support their loved one in receipt of care. Had we had more time to undertake our work, we know that we could have met more people. We are also aware that GMMH serves a huge population and we do not claim that our findings will be representative of all that is happening across the organisation. The people we could speak with, however, set out some of the lived experiences of people who have been involved with a range of services, and whose voices need to be recognised to ensure learning can take place from the range of distressing events that have occurred within GMMH.

4.2 We listened to their experiences and have tried to capture the themes that emerged. We recognised that many of their accounts were distressing, also how privileged we were to hear their, at times, very personal stories. We were told often of the absence of kindness and compassion from some of those who were responsible for caring. For some people, this included very concerning descriptions of harm and abuse. Their accounts were compelling, often tragic, and were frequently a portrayal of a lack of consistent organisational oversight of quality over a sustained period of time.

4.3 We recognise that, while many of the people we spoke to had concerns, we were also struck by the level of understanding and regard they showed to some of the staff at GMMH in trying to deliver care in sometimes very difficult circumstances. Several spoke positively about those staff who had responsibility for developing patient and carer involvement, either in Trust-wide roles, or service-specific staff, such as those in Edenfield.

4.4 We repeatedly heard about the importance of co-production and the need for inclusion of people with a lived experience of mental illness, their families and loved ones. People wanted and want to be seen and treated as equal in the planning and delivery of care.

Why hearing and responding to the voice of patients and their loved ones is important

4.5 Patient-centred care has been defined as the provision of care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. It has become the focus of policy documents and mission statements, including the NHS Long Term Plan. The Recovery Model is predominant in mental health service policy, as is the recognition of the importance of person-centred practice and the positive impact it can have on outcomes for patients. Recovery-oriented mental health policy and practice aim to enhance the agency of the individual, prioritising self-determination, strengths-based practice and collaborative working. The NHS Long Term Plan commits to making personalised care 'business as usual' for 2.5 million people. (Markham 2020).

4.6 Inherent within patient-centred care are the principles of co-production. NHS England states that good co-production looks like this:

- Starting from what matters most to people who use and work in services.
- Working with people who have relevant lived experience (patients, unpaid carers and people in paid lived experience roles) and with staff.

- Building equal and reciprocal partnerships with people who have relevant lived experience and staff, including with those from disadvantaged and minority communities.

4.7 Drawing upon these policy positions we have asked ourselves how this aligns to what people have shared with us.

The GMMH approach to patient engagement and co-production

4.8 GMMH developed a service user engagement strategy (GMMH Together Strategy, 2022) that was published in 2022 and builds upon previous strategies. The new strategy sets out how the Trust aims to work in collaboration with "everyone" including the wider community. GMMH stated that the strategy was developed following extensive engagement with all relevant stakeholders and is, in its view, in line with all relevant national policies.

4.9 The strategy sets out four key ambitions:

1. **Meet your needs together** – Working with service users, their family and carers, and the wider community to deliver seamless care, promote choice and empowerment.
2. **Learn together** – Learning from lived experience and professional experience to support and maintain good mental health and recovery from addictions.
3. **Listen to your views and develop services together** – Listening to our service users, their family and carers, and the wider community, to improve service provision and access.
4. **Work together** – Co-producing and co-delivering services with people with lived experience and the Voluntary, Community, Social Enterprise (VCSE) sector to better meet people's needs.

4.10 There are several very positive areas within the strategy, that, if achieved, will undoubtedly improve listening to and learning from people with a lived experience. This could build upon some of the previous successes GMMH has achieved in developing services that are genuinely built around meeting the needs of the people it serves. This is an essential part of the Trust's improvement plan and has to be treated as high priority.

4.11 Recognising the expressed intent of the strategy and the hard work of the relevant organisational leads, we heard several accounts questioning the Trust's genuine commitment to engagement and co-production. We heard from GMMH staff who said that some managers were not committed to this agenda, and this made their work difficult to make meaningful changes.

4.12 We heard from patients, families, and partner organisations that the Trust needed to show more commitment to valuing the contribution of people with a lived experience. As a small but symbolic example, we were told about a patient story being prepared for the board of directors. This was to be the first patient story presented to the public board in several years, which required extensive support for the patient involved. At late notice the patient story was deferred and this, sadly, reinforced the perception that the Trust was not committed to hearing the authentic voice of service users. The Chair offered to meet with the patient's mother to hear the story personally and to be able to learn and respond; this meeting has now taken place. Subsequently, a patient story has been presented to the Board in July and September 2023, but the previous decision to defer would appear to have caused further concern to both patients and staff.

Raising concerns and complaints

4.13 An important element of co-production is the ability to respond to concerns raised. It became clear through a variety of sources that, until recently, the Trust had provided insufficient resource to adequately address complaints and concerns raised. The GMMH staff we spoke to were clearly working hard to meet the needs of the complainants but were challenged by a lack of resource and poor process. Staff told us that the Trust had grown significantly in recent years which had led to more complaints and concerns being received, but resource had not grown to match this.

4.14 A report was written by the NHS England North West Regional Nursing Team to GMMH that raises several concerns in this area including the following:

"*There was a lack of clarity and accountability throughout all the complaints process including an overly complicated tiering system.*

The information provided to the Trust Board was not sufficient to ensure effective scrutiny by Trust Board members; however, there should have been greater challenge by the Board regarding the lack of robust data.

There was a lack of clarity regarding 'Ward to Board' reporting. The Board appears to receive performance data in the form of run charts, but we did not see that themes, trends, learning, or actions undertaken by the Trust were shared in relation to complaints received.

There was limited evidence of a consistent approach to sharing learning and/or action planning; therefore, there is a clear risk of the Trust not being able to prevent reoccurrence."

4.15 However, it was recognised by the North West Regional Nursing Team that "*good practice was evident in some areas and most responses reviewed were of good quality and contained an apology*". Several recommendations have been made by the Improvement Team to enhance the governance and oversight of the complaints process. For example, it is highly unusual that the Trust has not had a Patient Advice and Liaison Service (PALS). It will be essential that the Trust acts upon these recommendations to improve insight and learning from complaints.

4.16 When listening to the experiences of people who complained, associated with other GMMH services, we heard various concerns including:

"Not feeling listened to or valued, a sense that raising a concern was inconvenient to busy staff or that the professional voice was more important than the complainant."

4.17 Other examples of what we heard include:

"*Silencing dissent and not listening to criticism or properly dealing with complaints – blaming illness or the person making the complaint becomes the problem.*"

"*They talk down to you and it falls on deaf ears, try to talk you out of complaining, managers would say that they (the patient) are playing us off against each other.*"

4.18 We also heard numerous accounts where busy services did not always pay sufficient attention to the needs of patients, families and carers and these concerns were not fully addressed. Their accounts included the following:

"Patients being discharged home in the middle of the night without any conversation with family. We were told the ward could not cope so they had to send [patient] home."

"Said it wasn't just me that it affected it was him as well. He saw the unit firsthand because he was there every day bar one. For those five and a half weeks, he saw exactly what was going on. And he had to leave me there. He said that was the hardest thing. He couldn't say anything because he didn't know what they'd do. So if he said anything, he just wanted me home." (Charm[11]).

"A family being asked to attend the emergency department following a serious self-harm incident and then being left unaccompanied by GMMH staff."

"But they still, when I was in hospital, put men in my bedroom at the end of my bed. Where I've requested many a time I don't want a man in my bedroom. And they said we haven't got the staff. We've got to. We haven't got the staff." (Charm).

"I tried to discuss the risks and concerns with them … but the Trust seem like they are fire fighting and walking from room to room with fire, and petrol already in the room, smoking a cigarette."

[11] Charm Storybank, https://charmmentalhealth.org/

4.19 While there is some clear signalling of intent to place a greater value on the needs and voice of the patient, the actual reality of care for the people we spoke to was starkly different. The recommendations identified by the Improvement Team are important next steps to strengthen the complaints process but should be undertaken with a consistent view that every concern raised should be listened to and valued.

Patient experience at Edenfield

4.20 We listened to patients describe their past and present experiences at Edenfield. Many of them were upset and distressed by the BBC Panorama documentary and were grateful to the staff who had watched it with them and supported them with this. Some patients, when sharing their experiences with us, echoed what had been observed on Panorama. However, a number of the male patients we spoke to reported that the documentary was not representative of their experience of care at the Edenfield Centre and that they felt the programme "exaggerated things". Other patients spoke about experiencing worse treatment during their time in secure care than that which was evidenced on Panorama. We were told that patients' expectations of the system and staff had diminished over time and that poor standards of care had become normalised. In essence, for some, we felt this meant they would not always recognise what good care should look like.

4.21 Patients from ethnic minorities we spoke to reported that, although they hadn't received any racial abuse from other patients, they sometimes perceived those patients from a white British background received preferential treatment in terms of having their needs met first. One example frequently cited was faster access to psychological therapies. In a meeting with staff from ethnic minorities, they described how patients who were other than white had fewer opportunities for recovery than their white peers, such as white patients having access to leave prioritised in times of low staffing.

4.22 Staff described how disruptive behaviours enacted by white patients were more likely to be attributed to their illness, whereas for patients from ethnic minorities, it was perceived as more likely to be dealt with in a punitive non-therapeutic manner. We were told that this was more likely to result in restraint, seclusion, and rapid tranquilisation. One example included a black staff member being verbally abused by a white patient, and the ward manager diminished the incident, saying that it was because of the patient's illness. In another example, a white patient attacked a black patient and the response team arrived and wanted to remove the black patient who was the victim of the attack.

4.23 Although patients praised certain day staff (including receptionists) for being caring and responsive, there was concern across wards regarding some bank and agency staff employed by the service, mostly on night shifts. Patients reported that some bank and agency night staff would spend their time on the ward playing with their mobile phones and often sleeping. They described how some temporary staff were not responsive to routine requests for support made by the patients and instead often told the patients not to bother them or ask someone else. Members of our review team also witnessed day staff being unresponsive and at times rude to patients requesting their support.

4.24 The patients we listened to at Edenfield told us about the lack of meaningful daily activities with which they could engage and how this was particularly bad at the weekend when there was nothing to do other than watch TV and listen to music. They also spoke about their escorted Section 17 leave being regularly cancelled and how this impacted negatively on their wellbeing and recovery.

4.25 Some patients we spoke to were very positive about the Recovery Academy[12], its staff and the resources and opportunities it provided, but reported that too often a lack of staff to take them to the Recovery Academy meant they were unable to use it and had to remain on the ward, where there was little to do. Patients also told us that only a minimum of the full range of Recovery Academy courses were being run. From a centre-wide audit of a sample of care plans it appears that there is limited patient-staff co-produced care planning, risk assessment and risk management plans. This is

[12]The Recovery Academy provides educational courses and resources for patients, families and carers and staff.

very disappointing given the excellent course on risk assessment offered but regrettably currently not being run by the Recovery Academy.

Raising concerns, governance and oversight at Edenfield

4.26 Raising a complaint or concern is difficult for patients, and perhaps even more so in secure services. We undertook some analysis of key data which showed that in total, 144 complaints were received by Adult Forensic Services between April 2020 and March 2023. Of these, 53% of complaints (77) were not upheld, 23% (34) were partially upheld, 13% (19) were withdrawn, and 10% (14) were upheld. We also looked at safeguarding data submitted to the local authority. Based upon the information provided to us, and prior to September 2022, the referrals were negligible despite the data showing that violence or abuse to patients represented 12% of all incident data between April 2020 and March 2023. Furthermore, we reviewed the incident data which revealed 102 allegations of violence, aggression, abuse or harassment by staff on patients.

4.27 It is clear to us that the governance system in both the local services and Trust-wide was unable to triangulate this data. We heard the Trust safeguarding team had not seen any significant growth in its resourcing, despite the increased size of the Trust. This impeded their ability to provide robust oversight of services, compounded by differing approaches across local authority settings. They described to us how they would not be routinely alerted to referrals made to the local authority by local services, which is compounded by the poorly developed safeguarding component of the incident reporting system.

4.28 We found, for example, that the central safeguarding team did not have a clear or complete oversight of the number or nature of referrals being made by various services across the Trust, including Edenfield. This affected the Trust's ability to provide routine monitoring information to the governance structure in GMMH. We believe this meant that the ability of patients to raise concerns was impeded and the opportunity for additional external scrutiny through safeguarding was diminished. We understand that the ICB, the CQC and the provider collaborative have identified an opportunity to strengthen the safeguarding arrangements for patient care.

4.29 Advocacy services are also important to understanding patient experience, and these can often act as an early warning signal of poor care. The advocacy service in Edenfield is well resourced, with six whole-time equivalent staff and a manager who has been in post since 2001. Each advocate covers two wards, which should give ample resource to be able to support people to clearly express their wishes and to help patients stand up for their rights. We understand that, pre-Panorama, the advocacy service would supply a quarterly report to the service manager and the advocates themselves had regular meetings with ward managers. These reports continue and highlight areas for improvement.

4.30 The advocacy service had a number of very experienced advocates who made considerable effort to advocate on behalf of the service users; despite this, some patients reported that the service was unable to achieve the outcomes they desired.

4.31 Good advocacy services require senior clinicians and leaders to want to hear the patient experience, wishes and rights, and act accordingly. It appears that over time this relationship had been unable to effectively challenge and change the prevailing practice, either due to a tacit acceptance of the circumstances by the Trust or through a lack of willingness to hear the effect of the circumstances on patients. Our view is that there is potential to improve the role that advocacy can play in ensuring the voice of the patient is at the forefront of clinical and operational decision-making.

4.32 We have also looked at several complaints raised by families and carers following the BBC Panorama programme. To the credit of the new leadership team at Edenfield, they commissioned an external review of these complaints, some of which pertained to events prior to the Panorama programme. There was a wide range of serious concerns, including the overuse of seclusion and restraint, poor communication with families and carers, inadequate staffing impacting on patient care and the suboptimal environment. The Trust upheld or partially upheld several of the concerns and subsequently apologised for the quality of care that patients had received.

4.33 The aspect of families and carers raising historical concerns post-Panorama is an important point. We heard from staff, patients and families that making a complaint was discouraged. Families told us they felt they were not always listened to or able to communicate with either loved ones or key staff members, all adding to a sense they lacked a voice. This was evident in various ways and we heard examples such as:

"*Staff members complain that since the phone system was changed a few years ago it doesn't really work. Ringing reception and getting through to the ward isn't possible and the ward phone often goes unanswered. There is a patient phone but it often doesn't work. I have personally had the phone put down on me several times – intentionally – by rude staff. The overall impression when ringing Edenfield is anything but professional.*"

"*We felt that trying to access in either person or phone was extremely difficult. We met with hostility, incivility, rudeness and uncertain if any messages were conveyed to XX .*"

"*Every time I deal with Edenfield, and certainly when I visit, I am always left with a distinctly negative feeling. The lack of communication and clarity is draining… The gaps in information and lapses in sharing pathways and action plans feels disorganised at best, and somewhat apathetic.*"

4.34 We also heard how many staff tried hard to be compassionate and caring and respond to concerns. We were told that:

"*I am generally very satisfied with the care XX is receiving – all the staff whom I have met appear to have a positive and caring attitude…. is being offered a wide range of therapeutic, developmental and recreational activities, and… is deriving much benefit from them. I particularly commend a member of staff named XX, who has been most caring and diligent in support.*"

4.35 A number of the people we spoke to expressed their concern for the staff working at Edenfield. They recognised that it could be a very stressful and challenging environment, often compounded by a lack of staff. They said that this, aligned to what they described as a lack of leadership oversight, could have played a significant part in some of the concerns they raised. We heard examples such as:

"*I think staff need more support for their distress including simple things like rest rooms.*"

"*We don't believe there are enough staff and this makes it so difficult for them and for us, that can't be right."*

Summary

4.36 One of the most fundamental elements of supporting people who experience mental ill health, namely compassion and kindness, was often missing in the accounts from patients and their loved ones. We also heard that some patients, families and carers were not universally treated with dignity and respect. At times this went far further and for some this amounted to the most appalling abuse. We are mindful that a police investigation is continuing.

4.37 The Trust is attempting to build upon its work on co-production and ensuring the voice and experience of patients, families and carers are heard. This is most evident through the Trust service user engagement strategy. The Trust is also fortunate to have some excellent staff who are working hard to facilitate improvements in listening and responding to the patient voice. Based on the multiple accounts we heard, however, there remains significant room for improvement.

4.38 All of this will require senior leaders to demonstrate that they are genuinely committed to seeing patients, families and carers as equal partners in every aspect of the organisation.

4.39 Moving on from the experience of those receiving care, we will now discuss how the Trust was led.

Chapter 5 Leadership

Overview

5.1 Leadership is crucial in the successful running of any organisation. There is a significant focus on leadership in the NHS because the style of leadership adopted sets the tone for how staff interact with each other. This in turn determines the kind of culture an organisation will have, and in healthcare, evidence shows that culture has a significant impact on the quality of care provided.

Board of directors

5.2 This section considers the impact of the Board on the leadership of the organisation. We discuss its impact on the governance of the Trust in Chapter 8. As regards leadership, the role of the board of directors in an NHS trust is to set and lead a positive culture in the organisation. (NHS Providers, 2015). Since the BBC's exposé, the composition of the Board has changed substantially, and the CEO and Chair have both stepped down. A number of interim executive directors are in post.

5.3 There is an expectation in NHS trusts that the Board acts as a unitary body. This means that:

"*Within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.*" (NHS England, 2022).

5.4 This did not always happen at GMMH. In reality, many non-executive directors told us they felt that at times challenge had been unwelcome at the Board, and that reasonable questioning could be interpreted as unfair and disproportionate. This, in our view, led to the effectiveness of non-executive directors being reduced over time, to the extent that some executives and senior leaders in the organisation told us that they did not feel held to account by the non-executives. This may be due to the lack of credence given to the non-executive directors by the executives. Our observations of the Board and its subcommittees confirmed a need for greater levels of appropriate challenge, to ensure that information presented is being scrutinised properly. This lack of cohesion is mirrored in other forums and teams throughout the Trust and is looked at in detail at Chapter 8.

5.5 The ability of the Board to challenge management effectively was also hampered by its lack of visibility in the organisation which is likely to have limited its understanding of the nature and breadth of the services provided by the organisation. A significant feature of our conversations with staff was that most were completely unfamiliar with the Board. This has meant that staff lacked faith that the Board really understood their services or their experiences. Furthermore, Board members had a reduced ability to corroborate what they read in formal papers with what they see and feel 'on the ground' in services. Non-executive directors told us, during interviews, that they had been surprised by the lack of expectation that they visit services to speak to staff and patients. We were told that visits had reduced following the pandemic and had taken a long time to return to their former frequency. This is important as it reduces the gap between the perceived reality of service delivery and the actual reality of care. We are aware that the new interim Chair and interim Chief Executive have been more visible; current practice includes a monthly Town Hall session for all staff to hear from and raise questions with them and a weekly note to staff is written by the interim Chief Executive.

5.6 Going forward, it is critical that Board members role model (to each other as well as the wider organisation) a culture of compassionate, inclusive and transformative leadership. Visibility is an important part of this, but it needs to have a purpose, which includes ensuring that Board members set the tone for how other leaders in the organisation should behave.

Executive team

5.7 The executive team of an NHS trust leads the day-to-day management of all aspects of the trust's business, including patient care services, operations, finance, and all the corporate support

functions which enable services to run. As the most senior management in the organisation, they (along with their Board colleagues) set the tone for all other leaders in a trust.

5.8 At the time of writing, the executive team of GMMH is in a state of transition and therefore there is not currently a stable leadership team. Notably:

- The Chief Executive Officer is in an interim position, with the previous role-holder having resigned and left the role on 30 June 2023. The present post-holder was recruited and contracted to stay until March 2024 to enable recruitment and safe handover to a substantive Chief Executive. The recruitment to the Chief Executive role is underway.
- The Chief Operating Officer is interim. We understand that recruitment to this position is ongoing.
- The Chief Nurse retired in August 2023, and there is an Interim Chief Nurse currently in post and recruitment to the substantive post is underway.
- The Medical Director left the organisation in late July 2023 and an interim covered the post. A new Medical Director joined the Trust in September 2023.
- The Acting Human Resources Director left the organisation in July 2023 and the substantive Executive Director of HR returned to the role at this time.

5.9 While there is some stability brought by executives in corporate support functions (including finance, performance and also the Deputy CEO), it is crucial that a substantive executive team is brought together as soon as possible to provide stability for the organisation during this difficult period, to reset the organisational culture, to support staff, and to deliver the improvements needed. The substantive new appointments need to bring the right blend of values, skills, capability and experience. While recruitment is ongoing, it is imperative that the existing leadership continue to drive the improvements needed.

5.10 We were consistently told that previous executive directors have not worked cohesively, collaboratively or effectively together in the past, and that this has had a significant and detrimental impact on team working and wider culture throughout the organisation. Clinical leadership in particular has had insufficient prominence in the Trust, and there is a widespread belief that the organisation has prioritised performance over a strong clinical voice. This is further explored in Chapter 6. Team cohesion will be crucial as new appointments are made as this will role model the expected dynamics for care group leaders and multi-professional teams throughout the Trust.

5.11 We also heard that the executive team was not visible in the organisation. We have seen written evidence from a member of staff in Edenfield raising concerns to members of the executive team about worrying working practices and behaviours in Edenfield. Their email expressly outlined the need for executives to visit the service and see these issues for themselves. They received no response for six months and the eventual response did not address all of the issues raised by this individual.

Senior leaders

5.12 As described in the introduction to this report, in 2022 the organisation moved to a care group management structure. Care groups are now managed by a multi-professional team consisting of an operational lead, a senior doctor, and a senior nurse. The latter was a late addition and had previously been described as a ‘quality’ role. This is reflective, in our view, of the historical lack of prominence given to nurse leadership throughout the Trust. The former ‘divisions’ did not have these senior and prominent clinical roles, and instead, all management responsibility sat with the Associate Director of Operations (ADO). The portfolio for these roles appears to have been unfeasibly large, and we support the move to the trio structure which should help to distribute workload, better utilise expertise (particularly relating to quality and safety), and better serve to champion clinical leadership in decision-making.

5.13 There has historically been a lack of ethnic diversity among the Trust's leadership. While this has recently improved somewhat, work remains to ensure that the Trust's leadership is more representative of the populations it serves. Additionally, we were told that there was a lack of diverse perspectives, leadership styles and external experience among operational managers and clinical leaders. Every staff group we spoke to described a culture of having to "*toe the line*" and adhere to expected norms and behaviours. Key comments in this area included:

- "*You'd be promoted if your "face fit". I knew mine did, and so I was ok, but I saw people who didn't fit the mould, and they'd be treated very differently.*"
- "*We did psychometric testing and most of us came out with the same personalities and styles.*"
- "*I "grew up" in GMMH; I just thought that's how leaders behaved.*"

5.14 Staff throughout the organisation consistently described to us worrying behaviours from several senior leaders in the organisation. Some of these concerns had been reported to the Freedom to Speak Up Guardian (FTSUG)[13]. Examples of poor behaviour described to us included: shouting, swearing, telling staff to retract incident reports and to withdraw written staffing concerns, over-riding clinicians' decisions made based on patient safety, and fostering an attitude of intimidation.

5.15 Several of these people have been subject to or are currently undergoing independent HR investigations. Many of them remain in very senior positions in the organisation. It is critical that the Trust assures itself that those in senior leadership positions now are exhibiting and role modelling the values and behaviours the Trust requires, in order to reset and reshape its culture to one which can provide safe services.

5.16 During our interviews, a small number of these senior leaders reflected on their own management styles following the Panorama broadcast. Some of those we spoke to have since received developmental support to adapt their leadership style. Some key comments in this area include:

- "*Looking back over time, I can see now that some of my behaviours weren't right.*"
- "*I thought that's just how management acted. I didn't know any different.*"
- Someone also described to us how leadership behaviours coming from Edenfield had a "*mushroom cloud-like"* effect on the organisation, as many of the Trust's senior leaders came from Forensic services.

5.17 Others, however, displayed a lack of reflection and awareness of the effect that their behaviours had had on staff, and the potential impact of this on the care they delivered to patients. These people were more likely to blame clinicians for not reporting more incidents, or for not delivering care in line with clinical standards. These attitudes left us with the impression that much more personal reflection was needed.

5.18 Equally important is that the Trust realises the benefits of having a multi-professional team leading each care group. We were consistently told that the Trust had disproportionately prioritised operational performance, to the detriment of clinical quality. We were told that the opinions of doctors, nurses and other professionals simply had not been heard or valued in the organisation. There is a clear opportunity now to reset this through the care group leadership structure, together with learning from what went wrong at Edenfield. It is crucial that the Trust seizes this opportunity to make the changes now needed.

5.19 We understand that a care group development programme was commenced but has since stalled. Senior leaders we spoke to hoped that this would be reinstated so that they have protected time to reflect on (and start to embed) different ways of working to support a change in culture. We would expect, given the organisation's challenges with its staff engagement and culture, that any programme of this nature would have a significant focus on compassionate and inclusive

[13]Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to in other ways. https://nationalguardian.org.uk/

leadership, and making the Trust's values real. This does not appear to have featured in the care group leaders' appointment processes, development or job descriptions to date.

Leadership within Edenfield

5.20 As in the Trust more widely, we heard that the model of ward leadership and multi-professional working was not always cohesive and sufficiently focused on the quality of care. We repeatedly heard that the 'operational voice' was too dominant and paid insufficient attention to those in clinical roles. We believe there is a need for much closer, multi-professional working between the consultant and ward manager, which is supplemented by specialist input from other members of the nursing team, psychologists and therapists. A more coherent and stronger clinical voice is essential in ensuring that the leadership focus is based on quality and meeting the needs of patients.

5.21 Clinical leadership at Edenfield has been disjointed, with a number of medical leadership roles within this service. We understand that this was a deliberate strategy to attempt to strengthen medical leadership, given the Trust's practice of allowing insufficient time for clinical leadership roles. In practice, this did not work, and we found an unclear medical leadership model, confusion around roles and a perceived lack of openness and transparency around appointments to some of the leadership roles described. When combined with the primacy and dominance of the operational voice described above, it is not difficult to see how the service lost its clinical conscience in decision-making over time.

5.22 Clinicians we spoke to gave us various examples of their being closed out of important decision-making, or else over-ridden by operational management. For example:

- managers closing a ward without increasing the beds or staffing on other wards, or ensuring adequate physical space to meet patients' needs; and
- a manager giving an e-cigarette to a patient with a known associated risk of arson, without reference to the clinical team.

5.23 Doctors told us about long-standing issues about the reporting of nurse staffing numbers to the Board and Specialised Commissioning, with doctors concerned that the numbers being reported did not fit with their everyday experience of the ward environment. Every member of consultant staff in the inpatient service told us that they raised concerns about the number of nursing staff on their wards.

5.24 When raised with management, these concerns were not listened to, or were dismissed or minimised. We also heard that management told doctors that the MHOST[14] was being used and that some areas were overstaffed and over-establishment[15]. The manager is reported to have said "*s**t rolls down hills*" which was interpreted as meaning that they feared reprisals from those more senior than them in the organisation if they pushed this matter. One consultant described being told that they needed to "*stop siding with the nursing staff*". The national nursing shortage was often quoted as the reason for any perceived understaffing, with no possible solution in this context.

5.25 Additionally, there was a lack of visible leadership on the wards, all of which supported the development of a closed culture. We were frequently told that key leaders, including consultants, senior nurses and ward managers were typically based in their offices or, as a possible legacy of COVID-19 working, virtually from home, ostensibly doing administrative tasks. The impact of this was threefold:

1. Many managers and clinical leaders were disconnected from the everyday challenges of direct care staff. This made it easier for them to minimise or dismiss concerns raised.

[14] MHOST is a tool developed to support Mental Health Trusts to measure patient acuity and dependency levels in order to inform evidence-based decision making on resourcing/establishment setting, alongside professional judgement.

[15] Staff establishment means the posts which have been created for the normal and regular requirements of the organisation: over-establishment is when more staff are permanently employed than the number which has been agreed as necessary.

2. There were missed opportunities for managers and clinical leaders to consistently role model expectations, and to offer on-hand guidance and support. This is particularly the case for temporary and new staff, and preceptees (recently qualified nurses), who would have required closer supervision and direction to develop the skills needed to care well for Edenfield patients.

3. There were missed opportunities for those in more senior roles to challenge practice which fell below expected standards. This was clear in the Panorama documentary, in which healthcare assistants featured can be heard saying "*we wouldn't get away with this with the managers here*".

5.26 Leaders set the tone of an organisation and have a significant impact on its culture. The following chapter considers in detail the culture of GMMH and Edenfield.

Chapter 6 Culture

Introduction

6.1 Organisational culture describes the shared ways of thinking, feeling and behaving in an organisation (Mannion and Davies, 2018). Safety culture in NHS organisations has been a key and recurring theme in reports where there has been poor care for example in the Francis Report (Francis, 2015), Morecambe Bay (Kirkup, 2015) and the Ockenden Report (Ockenden, 2022). The dominant features of the culture of GMMH, and more specifically Edenfield, will be described in this chapter, in which we also pay particular attention to the safety culture.

6.2 Culture is everywhere, making it difficult to understand precisely what it is and how best to assess it. If we see organisational culture as a dynamic social construct and consider the culture of an organisation to develop through interactions between individuals within teams and between different teams, this helps improve understanding. Organisations have typically focused on more process-driven measures, to consider how individuals or teams work together, rather than the quality of work people do together. It is often only when outcomes are poor or relationships break down that organisations try to understand how teams are working together, as a reactive response.

6.3 Trust boards have a responsibility to set and lead a healthy culture (see 8.3). The importance of compassionate leadership in supporting the delivery of high-quality care and innovation in healthcare and the role that leaders play in establishing this culture is well recognised. (West et al, 2017):" What *leaders focus on, talk about, pay attention to, reward and seek to influence, tells those in the organisation what the leadership values and therefore what they, as organisation members, should value."*

6.4 The role that a compassionate and inclusive culture plays in staff health and wellbeing and retention is further underlined in NHS People Plan (NHS England, 2020).

The Trust

6.5 For NHS boards and executive teams to function well and in a unitary capacity, the voices and perspectives of all members must be heard and respected. Equally, individual and collective roles should be understood and valued. This principle is echoed in the GMMH strapline: "*Clinically-led, operationally partnered, academically informed*". Throughout our work, however, the opposite was described to us, with a predominantly operational voice and weak clinical leadership. We heard how the culture of the Trust was one that was more interested in organisational growth, maintaining a positive external reputation and achieving performance targets.

6.6 We were told that this manifested in the Board and the executive team enabling operational services to have too great an influence across the Trust. We also heard that the Board and the executive team paid insufficient attention to the importance of quality across the Trust, and that the value, ability and effectiveness of clinical leaders was minimised. This was shared with us on multiple occasions and seen as a key element of the culture that the Board and executive team set across the Trust.

6.7 The annual National Staff Survey (NSS) gives every Board a window on the culture of the organisation and allows comparisons to be made with peer organisations regionally and nationally. This allows NHS trusts to consider how they are functioning and formulate plans to improve any areas of concern.

6.8 GMMH NSS results for 2022 are among the lowest for all mental health trusts in England across many measures. We analysed the 2021 results too, to act as a control for what might be perceived as a 'Panorama effect' (i.e., if the broadcast had affected morale and engagement Trust-wide). While there was a slight deterioration from the previous year, 2021 results were also generally very low. Throughout this chapter, and in Appendix 2, we have highlighted some of the most notable results.

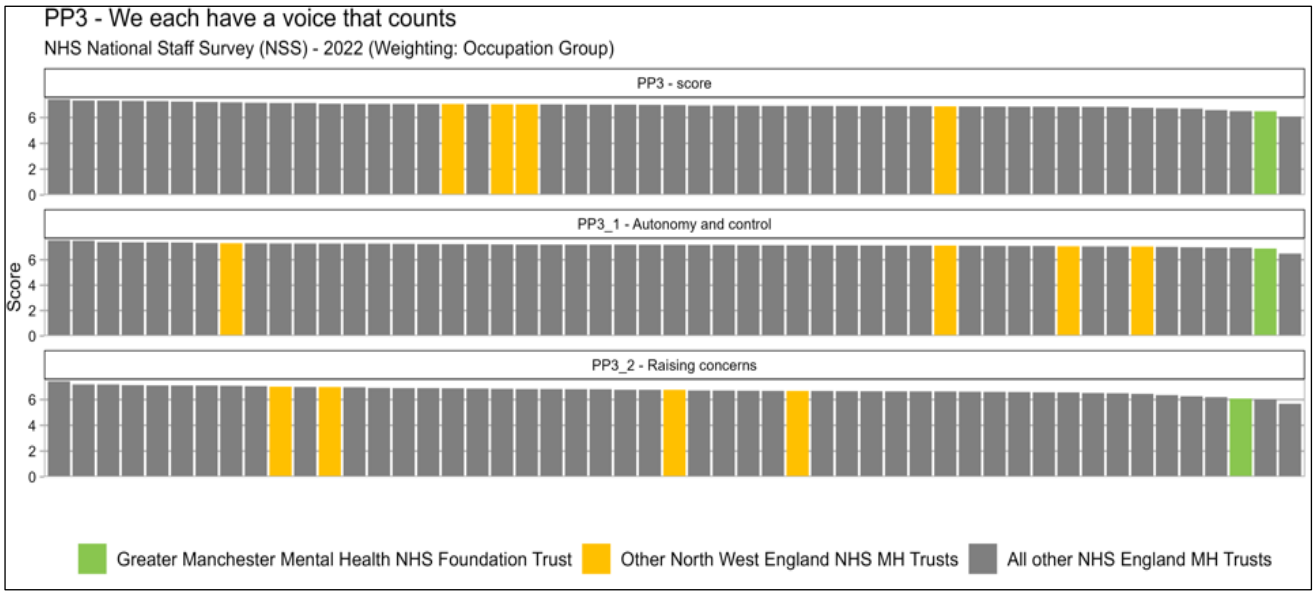
6.9 The Trust has also sought to understand its culture through the commissioning of an Organisational Behaviour Audit delivered by an external company, in 2019. It was piloted in the Specialist Services Care Group, which contains Forensic Services, among others, in response to concerns raised via Freedom to Speak Up (FTSU). The audit was completed by 273 of 813 staff, which is a response rate of 34%.

6.10 This report signals concerns in Forensic Services, which we explore further below. We have seen little evidence of how the findings of this review have been progressed across either specialist services or the Trust. This has been fed back to the Trust in other recent external reviews. Of note, the report states that:

- "*Key findings across specialist services also included 'unacceptable' levels of stress, work overload, a sense of disempowerment and pockets of unsupportive management.*
- *"… Content analysis of the qualitative data (comments) highlighted a number of themes and it can be seen that perceptions of poor management, difficulty to speak out, understaffing and work overload/stress occur most frequently, across the five departments. Thematic analysis by work unit identified that most comments were made by the Forensic Mental Health unit, where the above issues were most commonly cited. More specifically, issues of understaffing, poor management, difficulty to speak out and work overload/stress seemed to trouble most respondents. That being said, there were some respondents who did not identify their work unit. Thus, caution should be taken when interpreting the results.*"

6.11 These themes continue to feature in the Trust's 2022 NSS results:

Figure 4: National Staff Survey – People Promise (PP) 3: We each have a voice that counts



6.12 This is the second lowest score out of all English mental health trusts and is a decrease of 0.3 from 2021.

6.13 Clinical leadership has been undervalued in the organisation historically. An example of this is poor management of leadership supporting professional activities (SPA) afforded to medical leaders to undertake their roles (too diffusely distributed or inadequate), and in the fact that nurse leadership roles have only very recently been introduced into the care group leadership model.

6.14 Instead, there was a strong view at all levels that operational performance and finance were the organisation's key priorities. It is important, from our perspective, to highlight that strong performance had served the organisation well historically. In many ways the organisation was viewed positively in the Greater Manchester health and care system, and it had been rated Good by the CQC. This culture, however, led to and was shaped by various behaviours which may have impacted on quality of care, including:

- A strong drive from the Trust's leadership to maintain their positive reputation with partners. An example in this area was a pressure from the Trust's leadership to admit patients from local emergency departments, even if people in the community were in greater clinical need of an inpatient bed.
- Various cases of operational managers over-riding clinical decisions made, particularly in relation to reducing the number of staff needed to support a patient in various clinical situations. We heard that one manager reduced observation levels so that fewer staff were needed, contrary to clinical decisions made.
- Clinicians not being invited to (and indeed, feeling explicitly unwelcome at) key meetings. Where clinicians were invited, such as to the Commissioning Committee, not all disciplines were included (no doctor was invited) and the clinician who was invited did not always attend.
- An overall sense that all staff should paint the Trust in a positive light when dealing with regulatory and oversight bodies, including NHS England, commissioners and the CQC. Staff felt that this was "*just the way things were done*" and that they couldn't be fully transparent in these interactions about the pressures their services were facing.
- A lack of diversity in leadership styles, with a perception that some staff were promoted to senior roles based on the extent to which their management behaviours reflected the dominant norms. This was a leadership style which was at times aggressive and lacked compassion and patient-focus in its approach.
- Staff recruitment processes were frequently described as lacking openness and transparency, and lack of equality experienced by minority ethnic staff all contribute to deficiencies in the inclusive behaviours that support the safest cultures.

Positive safety culture and speaking up

6.15 There are well-recognised factors which engender a positive safety culture, which include, among other things: inclusivity and civility, teamwork, and psychological safety. People who feel psychologically safe are confident about telling the truth and vulnerabilities are welcome in their workplace. They believe that they will not be punished or humiliated for speaking up about concerns or mistakes, or with questions or ideas. The extent to which staff feel able to raise concerns openly is a key determinant of how safe a healthcare culture is. Again, this can be measured through the NSS. GMMH's NSS results in this area are some of the poorest results nationally.

Figure 5: National Staff Survey – I would feel secure raising concerns about unsafe clinical practice

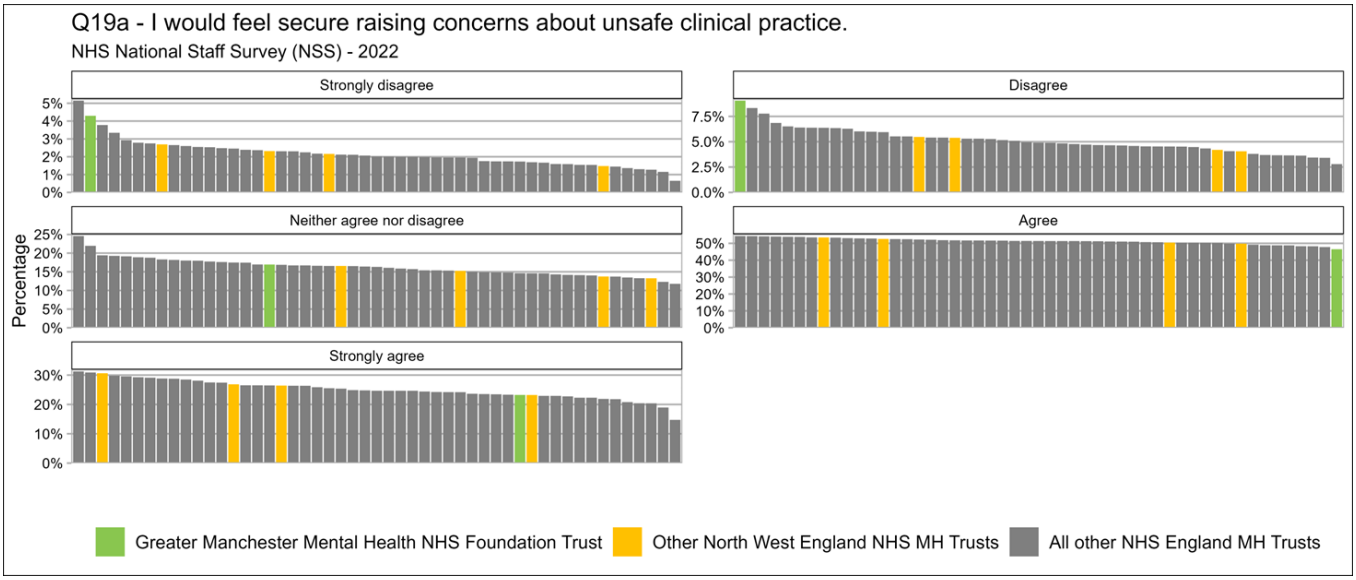
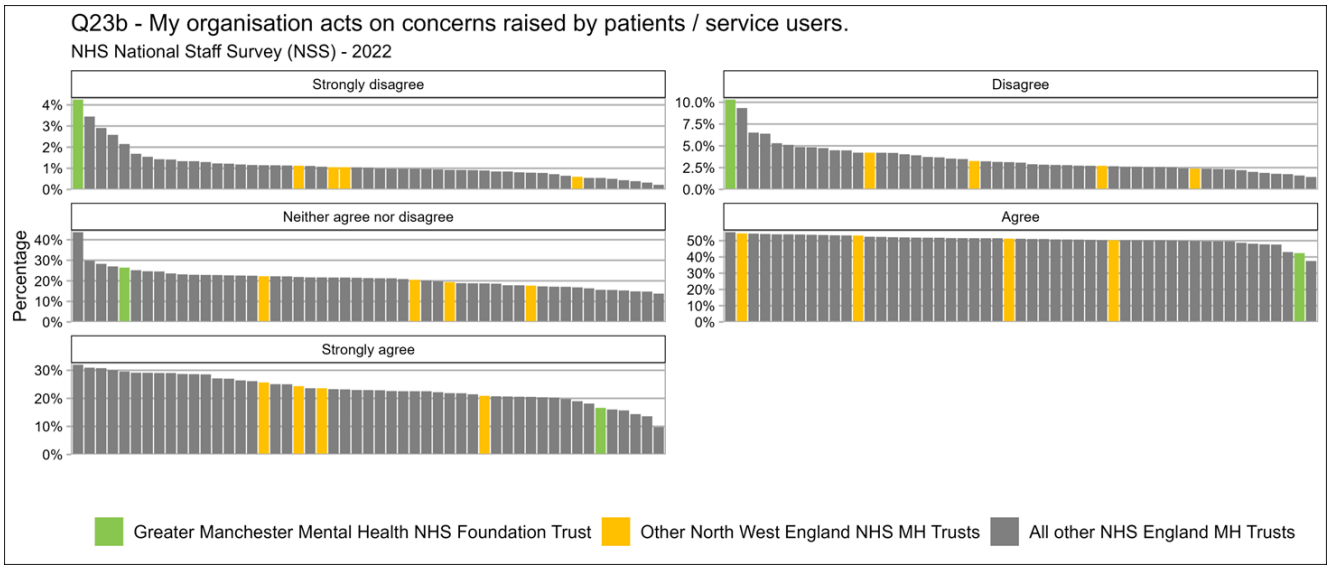


Figure 6: National Staff Survey – My organisation acts on concerns raised by patients/service users



6.16 We heard, consistently and at every level of the organisation, that raising concerns was unwelcome. Many people we spoke to described incivility and belittling if they raised concerns. This is reflected in the number of cases raised via FTSU, which appears to have been low for an organisation the size of GMMH. Indeed, the Organisational Behaviour Audit described above at 6.9 was, in part, commissioned to understand if staff knew about FTSU.

6.17 We also note that many staff from Edenfield raised concerns directly to the CQC rather than via the organisation's internal routes. This could suggest a lack of faith in the internal structure. At the time of the broadcast, there was an Associate Director with responsibility for FTSU. This person was also the substantive Associate Director of HR, which we believe posed a conflict of interest with their full-time role. The Francis Report (Francis 2015) described the importance of the FTSUG as being independent and impartial, and this has been repeated in guidance since Francis from the National Guardian's Office (2022).

6.18 While the Trust has since recognised and remedied this, it is concerning that a need for impartiality and independence had not been safeguarded in this important function. There is now a full-time middle-management level (Band 8B) FTSUG in place, which is more reflective of good practice, as well as a Band 6 Deputy in the team. Various Board members meet with the Guardian to go through cases raised and seek to understand the information coming through.

6.19 Some senior staff said during interviews that the organisation interpreted low speak-up numbers as positive assurance, when in fact, this may have been a missed opportunity to explore why staff might not be using the service. We note at Edenfield, for example, that in spite of the scale of known cultural issues, no cases had been taken through FTSU in the last three years, although concerns were raised directly to the CQC from Forensic Services. The FTSU report Q3 2022 (following Panorama), states there was "*a 400% increase in contacts to the FTSUG"* (73 contacts in total) compared with the same quarter in 2021. The vast majority of these were linked to staffing and patient safety. This is suggestive of the broadcast and the new management team having given staff 'permission' and a voice to speak up about their concerns across the Trust.

6.20 That said, our review of FTSU reports to the People Culture and Development Committee and Board found that information they contained was limited in how useful it might be in understanding the Trust's culture. For example, rolling data for the number of cases raised is only provided in-year, and by quarter, so it is difficult to see how the volume of cases is rising or falling over a longer time period. There is little intelligence on the content of issues raised and where they come from in the organisation, nor how this is used alongside other workforce intelligence (such as turnover, grievances or NSS) to identify services potentially in distress. There is little information to tell the reader what has changed as a result of staff speaking up, or what the impact of the service is on the organisation's culture.

Discrimination

6.21 The Trust is aware that it has issues relating to how staff with protected characteristics, particularly race, are treated at work. This has been reported through the staff survey, the recent report at Park House and data collected through the Workforce Race Equality Standard (WRES). Our analysis of WRES data found that, in 2023:

- 19% of the Trust's staff are ethnically diverse, but only 9% of staff at middle manager grade and above (Band 8A+) are other than white, for clinical management roles. This number is even lower in non-clinical management roles, at 3%.
- Ethnically diverse staff are 13% more likely than white staff to experience harassment, bullying or abuse from colleagues.
- Ethnically diverse staff are 1.62 times more likely to enter into formal disciplinary processes, compared with white staff.
- White applicants are 0.83 times more likely to be appointed from shortlisting for jobs compared with ethnically diverse applicants.
- White staff are 1.66 times more likely to access non-mandatory training and professional development opportunities than ethnically diverse staff.

6.22 We were also told about experiences of staff from ethnic minorities at Edenfield who said that some colleagues would encourage patients to say racially abusive things to them. Staff described seeing staff from ethnic minorities being undermined by white colleagues.

6.23 Black staff told us that they had been told there was no point applying for promotions. When a black member of staff had decided to apply in the face of this advice, they were not told the outcome of an interview for several months, and only heard they had not got the job when they asked one of the interviewers directly.

6.24 Following particular concerns being raised about racism towards staff working at Park House, an internal review was commissioned, which reported to the Board in July 2023. Chapter 10 describes this work. The improvement plan that we reviewed (see Chapter 9) considered this issue specifically at Park House, with action plans focusing on this site specifically. However, the Trust has publicly acknowledged that the issue is Trust-wide and has established a Board committee to address equality, diversity and inclusion issues within the Trust. In the section below, we discuss what this was like for staff with protected characteristics, working in Edenfield.

The culture at Edenfield

Introduction to Forensic Services

6.25 To understand the culture at Edenfield, we must first describe what it is like to work in secure psychiatric services.

6.26 In Forensic Services, the environment that staff work in is unique to other mental health services, in that patients are invariably detained under the Mental Health Act, have very little or no say in their admission to services and are often admitted because they have exhibited behaviours that are a serious risk to themselves or to those around them. Many are admitted in the most tragic of circumstances. At their best, forensic care roles can be immensely rewarding, but at their worst, they can be damaging and destructive, with staff being fearful of coming to work, traumatised, demoralised, stressed and burned out.

6.27 At the very least, in the early parts of admission to services, many patients are distressed, do not want to be there and mistrust the system that is working to support them. Many of them have extensive histories of trauma and other adverse childhood experiences. People who use secure mental health services are the ones who pose the highest risk among those using the mental health system, but they are also some of the most vulnerable in our society.

6.28 Forensic psychiatric services provide care that supports these people to recover from their mental health problems, to manage their own mental health and safety, and to reintegrate back into their communities, reducing the risk of the behaviours that brought them into services from reoccurring in the future.

6.29 The potential for Edenfield to have developed a closed culture, by the very nature of the services it provides, is also material; services are physically locked with obvious physical security measures, patients are removed from their loved ones and communities (and other protective factors) and stay for months or years.

Shortness of staffing and impact on culture

6.30 In late 2018, a concern was raised with the FTSUG about staffing levels in the Specialist Services Network (now Specialist Services Care Group). This includes CAMHS, Forensic Services, Substance Misuse Services and Mental Health Deaf Services. The concerns were escalated to the CEO who commissioned an internal review, to be carried out by a senior leader in the Trust. This looked at 24 wards within the network. The Trust was unable to provide a final copy of the report and in this chapter, we are referring to the draft report which was shared with us.

6.31 The findings included that:

- across the network, there were conflicting systems for recording staffing levels, which led to confusion for managers;
- data did not clearly identify where the staffing shortfalls were. It was not unusual for wards to be left without registered nurses; and
- there was a ban on agency nurse use, there was a 15% shortfall of nurses and staff were not always reporting staffing issues.

6.32 With specific reference to Edenfield, the draft report states that: "*There is conflicting data and significant variation between what is being reported internally and externally in relation to planned and actual staffing levels. For example, Keswick Ward which appears to have the highest number of gaps in Registered Nurse cover does not appear to be reporting safe staffing exceptions at all. Managers who were interviewed said it is currently not unusual for shifts to operate without a Registered Nurse on duty, particularly within the Edenfield Centre.*" [16]

6.33 The draft report made four recommendations:

- *"Enable a transparent management culture where staff feel able to raise concerns.*
- *Simplify the system for planning, reporting and monitoring transparent and accountable staffing levels.*
- *Integrate the planning of shifts across the top and bottom Prestwich sites, with combined managerial oversight, a single Bronze on-call system, and an integrated duty management system.*
- *Lift the ban on using agency within the Edenfield Centre if all options have been systematically explored to meet minimum Registered Nurse cover."*

Our review of the action found mixed progress against agreed timescales.

Psychological safety at Edenfield

6.34 As described above, the ability for staff to learn from when things go wrong is linked to the concept of creating a just culture and psychological safety. This means creating an environment of fairness, transparency, and learning. It recognises that work is messy, mistakes happen, and people's actions

[16] Where patients are detained under the MHA, there should always be a registered nurse on duty in the ward. If there is not, this should be reported and escalated as a matter of urgency.

make sense only when we understand critical features of the world in which they work. There was no culture of psychological safety or just culture at Edenfield.

6.35 We were told of various examples, occurring over many years, where staff were ignored, their concerns were minimised, they were reprimanded or experienced professional retaliation for speaking up about poor practice. Reporting of concerns (such as unsafe nurse staffing levels) was actively discouraged and was described by numerous people as being "career limiting". One such example described to us include:

- A former staff member described "*a very punitive management ethos which seems to have relentless fault finding, in whatever form, as one of its main priorities. My experience is that such fault finding is not related to efforts to improve standards of patient care but is used as a more general means to retaliate against and otherwise silence anyone who is prepared to question aspects of practice that they consider are of concern.*"

6.36 There became an almost unanimous lack of faith among staff in Edenfield that anything would change as a result of raising concerns via all available routes. A great many staff, of all professions and levels, were highly distressed when telling their stories. Many said that this review was the first time anyone had spoken to them about their experience of working at the Edenfield Centre and wider GMMH.

6.37 At a service level, this looked like low reporting for staffing and 'no harm' incidents. At the most senior levels of the organisation, this looked like pressure to present performance in an opaque, vague and unduly positive light to reduce the Board's capacity to interrogate information effectively. Key comments in this area included:

- "*We were constantly told that staffing was fine at Edenfield. Once we were even told that we were overstaffed. You just stop mentioning it eventually... It was just the way things were.*"
- "*You just couldn't raise anything. The response would have been, 'well that's your job, why haven't you handled it?*"
- "*We just gave up in the end*".

Summary

6.38 The culture of an organisation is determined by its leaders who are, in an NHS trust, the Board. We have heard from Trust staff and seen through the lens of the National Staff Survey that there is significant room for improvement in the organisational culture of GMMH. Staff reported that they had not always felt safe raising concerns and that for many, their voice and opinions were not valued. They describe this as an organisation that facilitated operational services to be dominant and did not sufficiently value or regard the clinical voice or pay proper attention to the quality of some services.

6.39 This was further enabled by the Board not addressing the capacity and effectiveness of clinical leadership across the organisation. In the absence of direction from the Board and the executive team, we heard of fractures and divisions emerging, leading to a lack of cohesive leadership. We have been told during interviews that both the previous CEO and Chair had been told about concerns regarding the effectiveness of the working relationship between the Chief Operating Officer, the Chief Nurse and the Medical Director. We saw little evidence that this was effectively addressed. This dynamic was reflected in multi-professional relationships in various other parts of the organisation.

6.40 When examining the impact of culture on local services, notably Forensic Services, it cannot be looked at in isolation from leadership, staffing and governance, and indeed, other areas in the SEIPS model described in the introduction to this report. What is clear is that all of these facets had an interdependent and detrimental impact on each other, until the culture of Edenfield became toxic and harmful to the safety and wellbeing of the patients cared for there.

6.41 However, the issues described in this chapter must not be seen as specific only to Edenfield; they are reflective, in our opinion, of wider cultural challenges in the organisation. In its response to this report, it is imperative that the new Trust Board seek to understand this problem fully, alongside the complexity of these services. To do this will involve acknowledging the importance of leadership, staffing and governance in improving the overall culture of the organisation. These areas have been identified in the improvement plan which is discussed in Chapter 9.

6.42 This chapter has described the culture of the organisation and Edenfield specifically. In the following chapter we look at the importance of the workforce in delivering care.

Chapter 7 Workforce

National context

7.1 The influence of adequate staffing who know the patient is an important requirement for the maintenance of relational security, therapeutic alliances and successful outcomes for patients. (Royal College of Psychiatrists Centre for Quality Improvement, 3rd Edition 2023)[17]. Staff shortages are a long-standing challenge in the NHS. Data published by NHS Digital for mental health shows high vacancy rates across clinical nursing roles[18]. In the North West of England the vacancy rate is worse than nationally for medical vacancies, but better for nursing vacancies, as shown in the table below.

Figure 7: Vacancy rates in mental health: England overall and the North West

Role	England (mental health) total % vacancies (March 2023)	North West (mental health) total % vacancies (March 2023)
All roles	9.9	9.9
Nursing	18.1	15.9
Medical	14.0	17.5

7.2 The national context has placed considerable strain on services in mental health. Staff have had to adapt to working without sufficient numbers to try and keep services safe and maintain therapeutic alliances with patients. If services and trusts fail to recognise and plan for the impact of this short staffing, they are likely to struggle to maintain safety and quality.

Trust-wide nurse staffing

7.3 As stated above, the Trust is experiencing significant staffing pressures. Of note:

Vacancy rates – In June 2023 the Trust had a vacancy rate of 14.4%. The turnover rate was 15.4%, which is above the 12.5% Trust target. The most commonly stated reasons for leaving were promotion elsewhere (14 leavers), closely followed by work/life balance (13 leavers).

Agency use – Bank and agency staffing costs were 13.9% of the Trust pay costs in June.

Sickness – In June 2023, the sickness absence rate was above the Trust target, at 6.2% against a target of 5.6%; however, Forensic Services were a 'hotspot' at 9%. The top stated reasons for absence are mental health issues and musculoskeletal problems.

Safe staffing reporting

7.4 The Trust Board receives regular updates from the Chief Nurse on staffing levels. Since Panorama, the Trust has improved the quality of how it reports safer staffing, including that understaffed areas can now be more easily identified. However, further development is needed before the Board can be assured that there are sufficient nursing staff to deliver safe care. The report is now much more explicit in describing the Trust's staffing challenges, although it would be helpful if the quality and safety risks associated with this were also clearly articulated. During one observation of the Board, we also saw examples of understaffed wards reported, which was not questioned or probed by Board members.

7.5 For example, while the use of temporary staffing to backfill gaps in staffing is included and is on the improvement plan, this is not linked to the known risk that temporary nursing staff from NHS

[17] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-see-think-act-qnfmhs/see-think-act---3rd-edition.pdf?sfvrsn=f8cf3c24_4

[18] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey

Professionals are not trained in the use of Prevention and Management of Violence and Aggression (PMVA),[19] or the ability of a temporary workforce to develop therapeutic alliances with patients. The Trust told us that they had started training temporary staff in October 2022. We requested the PMVA training records of NHS Professional staff and the Trust told us in July 2023 that there were no records of this.

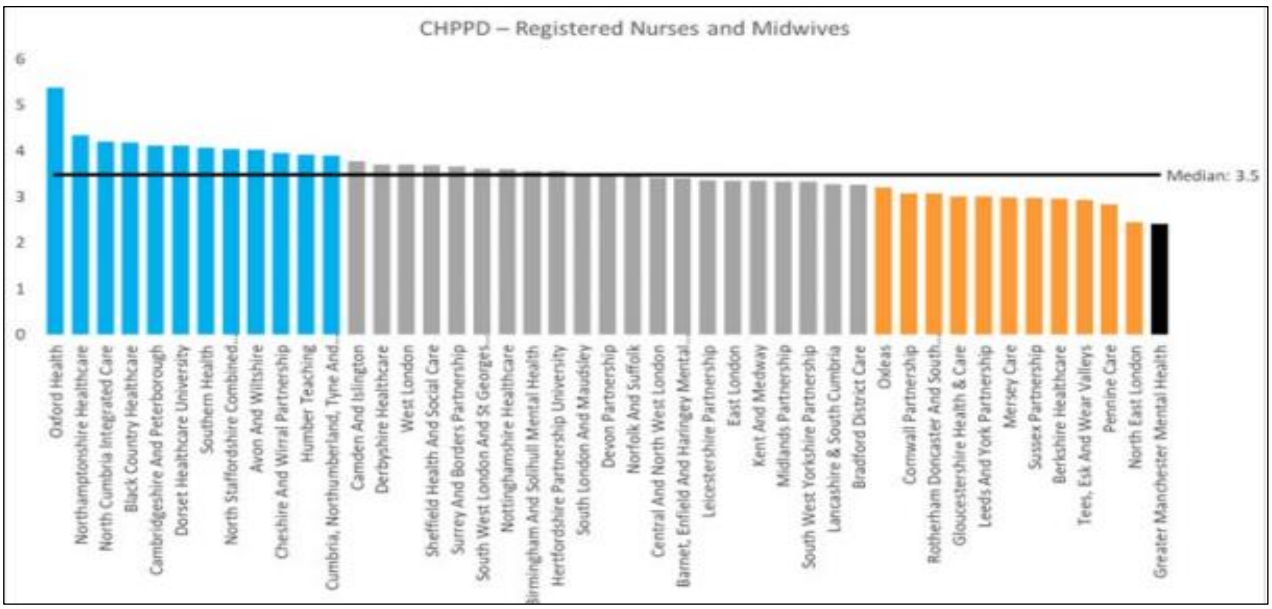
7.6 The ability to support patients who may be expressing distress is a fundamental and critically important skill for nursing staff working in a forensic setting. A reduction in this capability within a ward team will impact upon the ability to intervene and diffuse such behaviour early to try and prevent the episode escalating and requiring a more restrictive intervention. The situation is further compounded if the patient requires restrictive interventions because staff not trained in PMVA are not able to restrain people safely.

7.7 Staff described incidents on the wards where an alarm was raised that necessitated staff to attend from other units to support containment of a violent situation that the ward staff could not manage. On wards already depleted of staff, and with high levels of temporary staff, the inability to get a response when help is needed results in risks to the safety of patients and staff. This, in turn, contributes to a working environment in which staff feel fearful. The evidence to support this and knock-on impacts for patients and staff are described in the following chapters of this report.

7.8 The Trust has made progress in reviewing nurse staffing levels and has recently completed the MHOST on inpatient wards. The next step is to undertake structured establishment reviews for all inpatient wards. The Trust plans to use the Telford professional judgement model which also considers professional judgement, nursing practice, leadership, finance, and estate. It is likely when this is completed that the vacancy rate will be higher than it currently is because the current vacancy rate is measured against an establishment number which has not been calculated using a recognised tool.

7.9 The Trust is required to report on Care Hours per Patient Day (CHPPD)[20]. As shown below, for all nursing staff, the Trust is mitigating registered nurse shortfall by filling gaps with non-registered staff. GMMH had the lowest CHPPD for registered nurses, compared with all other mental health trusts in England, with 2.3 hours across all inpatient wards, which was 1.2 hours less than the national average.

Figure 8: Care hours per patient day



[19] Prevention and Management of Violence and Aggression, which is the Trust's approach to restraint reduction and reducing restrictive practice.

[20] This calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours available. CHPPD is calculated by taking actual hours worked, divided by the numbers of patients at midnight, split by all clinical wards' established workforce (qualified and unqualified).

7.10 It is good to see that the GMMH Safe Staffing Report to Board reflects the current position, although more can be done to triangulate the current staffing position with its impact on the quality of care for patients and the experience of direct care staff.

7.11 Until recently, Safe Staffing reports to the Board were vague, with an overly optimistic tone, and often contained information which did not reflect the reality on wards. As an example, a report from September 2021 stated:

"*Ward staffing establishments are locally set but are based on some common planning principles including the standard to have 2 registered nurses on duty*" (sec 3.4); and

"*No shifts left uncovered by Qualified staff and those with less than the planned were compensated by unregistered staff*" (sect 4.1*) …* "*With the exception of a few incidents all wards had at least one registered nurse on duty*" (sec 6.1).

7.12 This is not happening in practice, and it appears that staffing levels have historically been set from the available budget rather than from clinical need. A number of staff at Edenfield told us that there were many shifts without even a registered member of nursing staff planned to be on the rota (often on Keswick and Derwent wards), and that one qualified nurse would cover up to three wards. Our review of rotas and regulatory reports confirmed this.

7.13 The CQC inspection report, 2022 reviewed four weeks of rotas from Monday 23 May to 19 June 2022. Out of the 336 shifts on the female wards there were 72 shifts (21%) where there was no registered nurse on duty. These figures include Derwent and Keswick wards, where the establishment is set as no registered nurse on night shifts. It is telling that even having shut four wards post-Panorama, the unit was reporting to a minimum standard of one qualified nurse per shift. Between the week commencing 6 April 2023 and the week commencing 20 June 2023, there was a minimum of one registered nurse per shift 52.4% of the time, and two registered nurses 47.5% of the time. During this time period there were five occasions without a registered nurse. Since 25 September 2023, the Trust is now reporting to a minimum standard of two registered nurses per shift.

Staffing at Edenfield

7.14 Immediate actions taken after BBC Panorama meant that staffing improved following the closure of wards and redeployment of staff. Despite this positive improvement in workforce, staff described to us chronic concerns in regard to workforce which had been apparent for some considerable time. The new leadership team are working hard to address these matters but will require significant support given the size of the challenges.

7.15 The clinical model at Edenfield (as in every service) was designed based on the assumption that wards would be fully staffed by experienced, trained and supervised staff. In reality this is not happening. We were told by Edenfield managers that MHOST was used to review Edenfield staffing levels in 2019. We have not seen the outputs of this exercise but were told by management that it showed a clear staffing deficit on some wards (contrary to consultants' feedback on this, who said that management told them the service was overstaffed according to the tool). We have seen no evidence of actions taken as a result of this staffing review. The COVID-19 pandemic appears to have resulted in a loss of focus and attention on the staffing review. Since 2019, establishments and ward functions have changed, although the tool has only recently been used again by the NHS England support team.

7.16 In all our interviews with clinicians, staffing was the most commonly identified concern. Key issues raised included:

- Shifts planned with no qualified staff, which is contrary to any recognised standards for nursing practice.
- Qualified staff regularly holding keys for up to three medium secure wards both during the day and at night. In a review undertaken in 2019 following concerns raised, staff had reported holding keys for up to five wards. Ward keys include medicine keys so there may be a delay for

patients getting medicines if the nurse holding the keys is on another ward as they will have to do medicine rounds on more than one ward. They may not be able to respond quickly if a patient needs medicine outside of rounds.

- Newly qualified nurses (preceptees) working as the sole registered nurse on wards and some examples of preceptorship[21] nurses covering more than one ward. Preceptees should not be running wards until they have been signed off as competent. It remains regular practice that preceptee nurses are left as the sole registrant.
- Unregistered staff recounted to the review team regular examples of being left for periods as the only member of staff on the ward, working unsupervised and unsupported. Some told us that they had had to resort to locking themselves into offices to ensure their safety on occasion.

7.17 Consultants all told us that nursing levels were too low to manage the wards or the complexity of the patients and, at times, felt unsafe. There were descriptions of consultant staff having to relieve their nursing colleagues of keys and duties when nursing colleagues were not available to take over responsibilities at the end of shifts.

7.18 They said that patients reported that their observations were not being completed reliably, despite enhanced observations being in their care plans. In addition, staff moves were regular occurrences (sometimes two or three times a shift to maintain minimal staffing coverage) with staff describing not knowing which ward they would end up on when they arrived at work. Good relational security, which is critical to maintaining safety in Forensic Services, will be severely compromised by this practice.

7.19 Consultants described the impacts of these low staffing numbers and unstable staffing on care; nurses often did not know the patients on their wards well and they were unable to attend core clinical meetings about patients and share their input. This had a serious impact upon patient care with, on occasion, poor adherence to their care plans. As an example, a patient was able to fashion a ligature from clothing and choke on a piece of slipper while two nurses were providing continuous observations[22].

7.20 In addition to this lack of qualified staff, there have been high numbers of vacancies and high sickness rates.

[21] Preceptorship is a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning." Health Education England (2017).

[22] Three levels of observation are available:
- Level 1 observation: Continuous – within eyesight.
- Level 1 observation: Continuous – within arm's length.
- Level 2 observation: Intermittent.
- Level 3 observation: General Observation. From the GMMH Observation policy 2018: issue date 4.1.2023 due for review 9.5.2023

Figure 9: Adult Forensic Services sickness by staff group and financial year, April 2020 to March 2023

	Financial Year				
Staff Group	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**Total**
Additional Professional Scientific & Technical	1%	3%	8%	3%	**4%**
Additional Clinical Services	9%	9%	11%	14%	**11%**
Administrative and Clerical	7%	10%	9%	7%	**8%**
Allied Health Professionals	9%	7%	2%	10%	**7%**
Medical and Dental	1%	0%	0%	5%	**2%**
Nursing and Midwifery	6%	7%	9%	9%	**8%**
All Adult Forensic Service Staff	7%	8%	10%	11%	**9%**

7.21 Sickness rates are continuously high across staff groups. This has risen over time among allied health professionals in particular. It is extremely high among nursing staff.

Figure 10: Adult Forensic Services vacancies by staff group and financial year, April 2020 to March 2023

	Financial Year				
Staff Group	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**Total**
Additional Professional Scientific & Technical	27%	35%	21%	18%	**26%**
Additional Clinical Services	12%	20%	26%	30%	**22%**
Administrative and Clerical	19%	44%	47%	12%	**30%**
Allied Health Professionals	7%	2%	19%	16%	**11%**
Medical and Dental	13%	13%	9%	8%	**11%**
Nursing and Midwifery	29%	25%	25%	26%	**26%**
All Adult Forensic Service Staff	18%	21%	25%	27%	**23%**

7.22 Nursing vacancies are consistently high over the period reviewed. Despite these factors, we were told that managers were reluctant to use agency nursing as they would not understand the service. The vacancy rate is against an establishment figure that has not been calculated using a recognised tool.

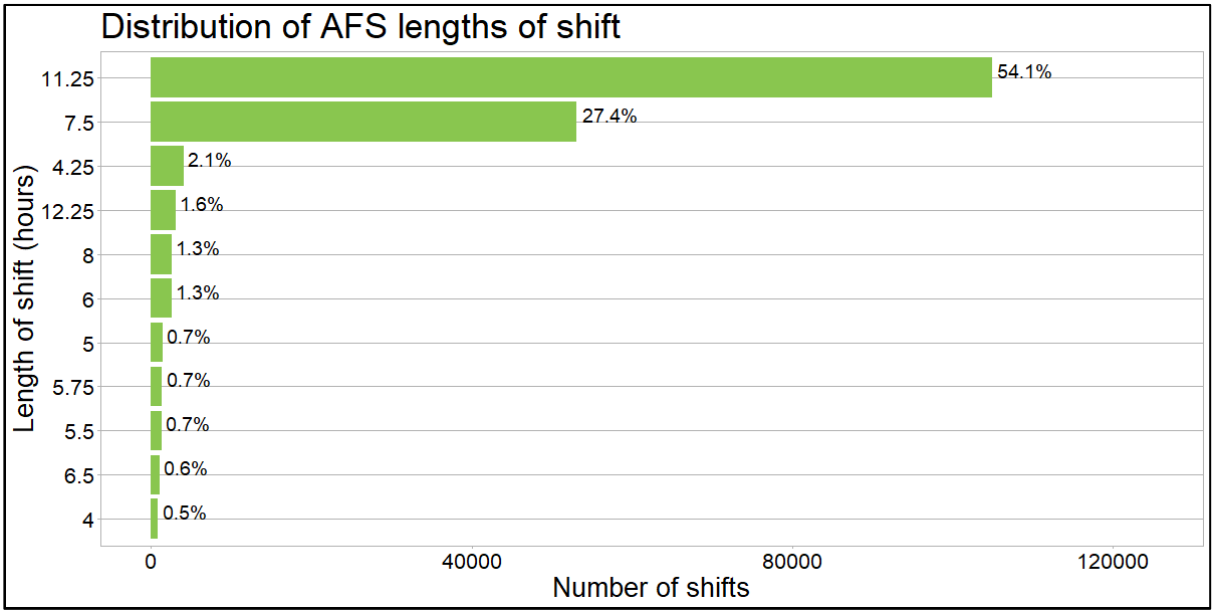
Shift patterns

7.23 Within this context, direct care staff at Edenfield often worked very long hours, with 13-hour shifts commonplace. Similar services in other trusts also have long shift patterns. However, at Edenfield, staff were working very long shifts like this, and:

- without a proper break;
- extending these hours even further due to a lack of staffing at the start of successive shifts;
- as the only qualified member of staff, and sometimes as a preceptee; and
- sometimes with responsibility for multiple wards due to staffing constraints.

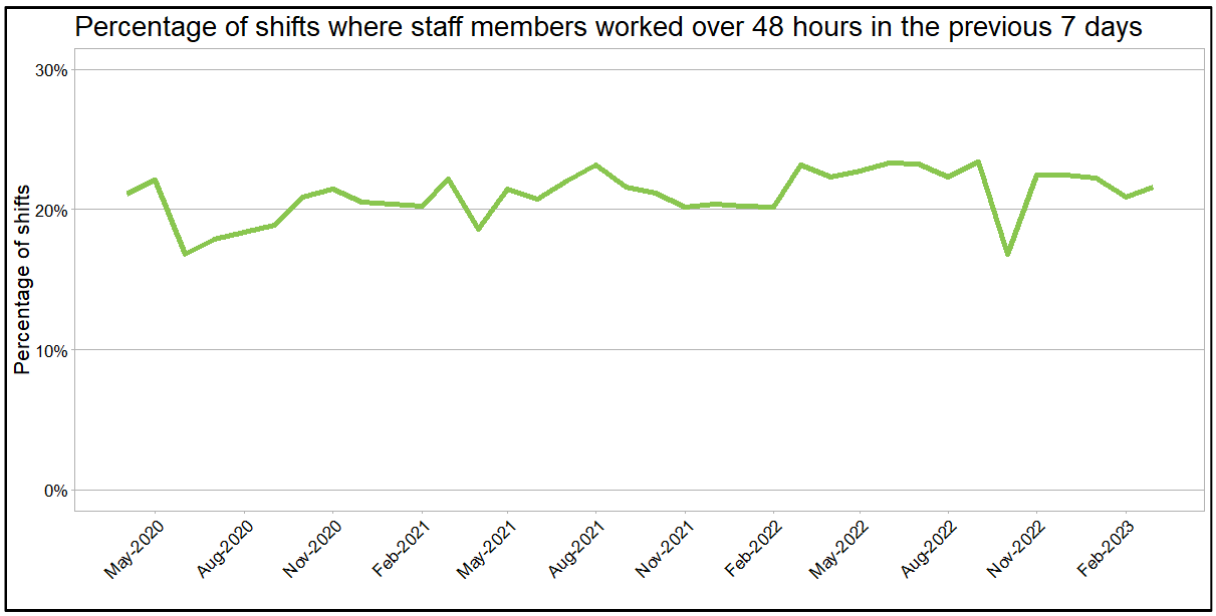
Working in these conditions is testament to the commitment of many staff to the service and their patients, but the link between long hours and shift work and a deterioration in staff concentration, empathy and own wellbeing is well known (Caruso, 2014).

Figure 11: Lengths of shifts worked in Adult Forensic Services



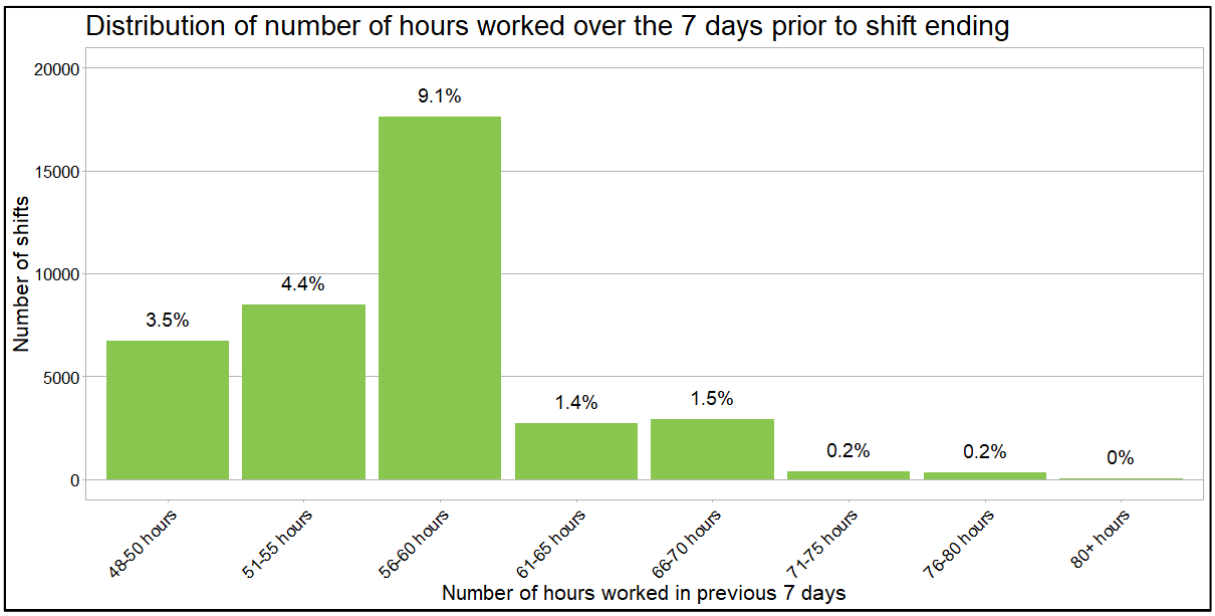
7.24 Our analysis in this area found that most shifts worked in Adult Forensic Services in the last three years have been over 11 hours.

Figure 12: Percentage of shifts worked where staff worked more than 48 hours per week in the previous 7 days



7.25 In addition, staff are regularly working over 48 hours per week at Edenfield (in the context described above at 7.23).

Figure 13: Distribution of number of hours worked over the 7 days prior to shift ending



7.26 Over 12% of all shifts completed over the three-year period were for staff having worked over 55 hours in the previous seven days.

7.27 We recognise that some of this data may be influenced by the impact of the pandemic. It is not difficult to imagine the toll that working over 60 hours per week in such a challenging environment might take on staff health and wellbeing, and the subsequent quality of care they were able to provide. It is crucial that we take this context into account when seeking to understand what BBC Panorama found, such as staff falling asleep while on duty.

7.28 Further analysis of the rotas shows that on any day at least one member of staff was working their sixth consecutive 11+ hour shift in Adult Forensic Services.

Staff support and development

7.29 Edenfield was, and remains, a complex unit which requires staff who are appropriately trained and supported. Staff need to have the skills and training to understand the population they work with and their needs, and to know how these needs are best met. It is the nature of these services that patients can respond violently when distressed; without a clear understanding of why people are responding in this manner, it can be difficult to deliver compassionate care.

7.30 Any ward needs to have a staff group with enough experience to manage the ward and to role model and support staff coming in new to the system. This is best achieved through:

- regular, effective supervision[23] that supports staff to do their jobs;
- regular reflective practice that they have time to attend, and which allows them to process their experiences and reflect on the dynamics and environment in which they are working;
- training that keeps staff up-to-date with contemporary practice and the core skills necessary for their roles;
- staff being led well and supported in the managing the complex tasks associated with keeping a secure ward safe;
- staff feeling that they are part of a team; and

[23] "Clinical supervision is a formal process of professional support, reflection and learning that contributes to individual development." (Butterworth, 2022).

- staff having the time and resource to get to know the people for whom they have responsibility for providing care.

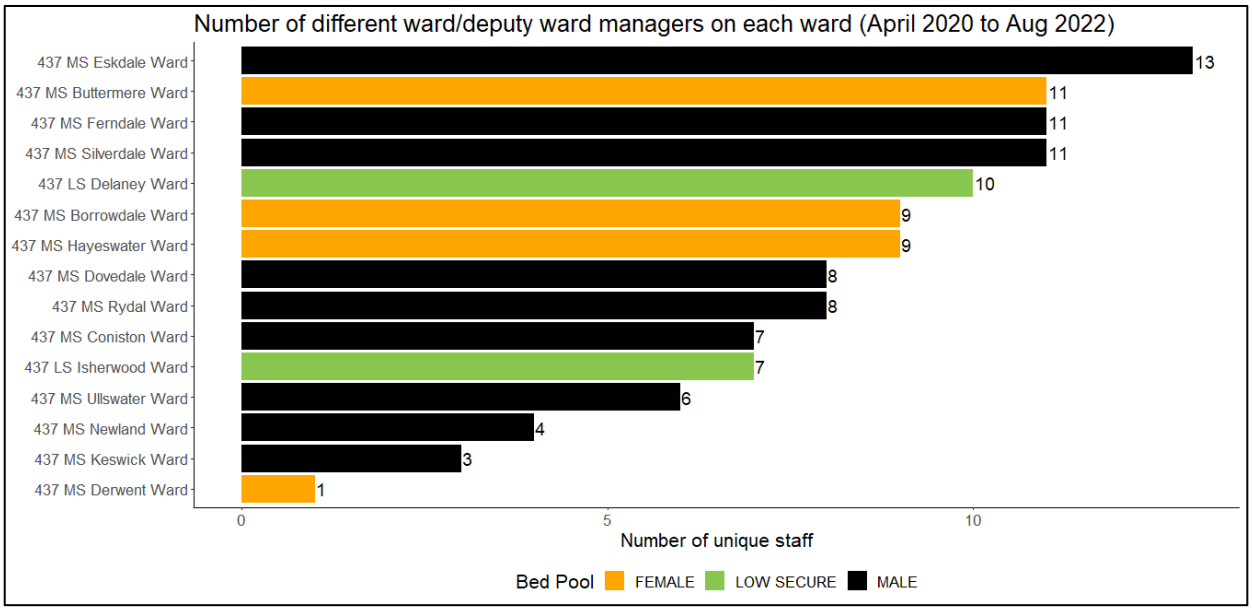
7.31 We have described clearly many reasons making care difficult, of which the most significant links back to dangerously low staffing levels. Fragmented working relationships among staff and a culture of repressing concerns further inhibited staff from managing their service effectively.

7.32 That said, some staff at Edenfield have received a lot of support in their career development. We heard of staff being supported to undertake external courses and accreditations, and of being promoted through managerial roles very quickly. We were told that the likelihood of being supported in this way related to a "*psychological contract*" in Edenfield which included: complying with maladaptive cultural norms and working practices (such as not raising concerns), not challenging unsafe practice or being seen not to "*cause problems*".

7.33 Staff were usually promoted from within the service, which meant limited external perspectives or opportunities to learn from elsewhere. Care group leaders and the former Chief Operating Officer had all come from Edenfield. Very junior staff had also been promoted quickly, and a perception emerged from our interviews that a number of these individuals quite quickly became 'out of their depth'.

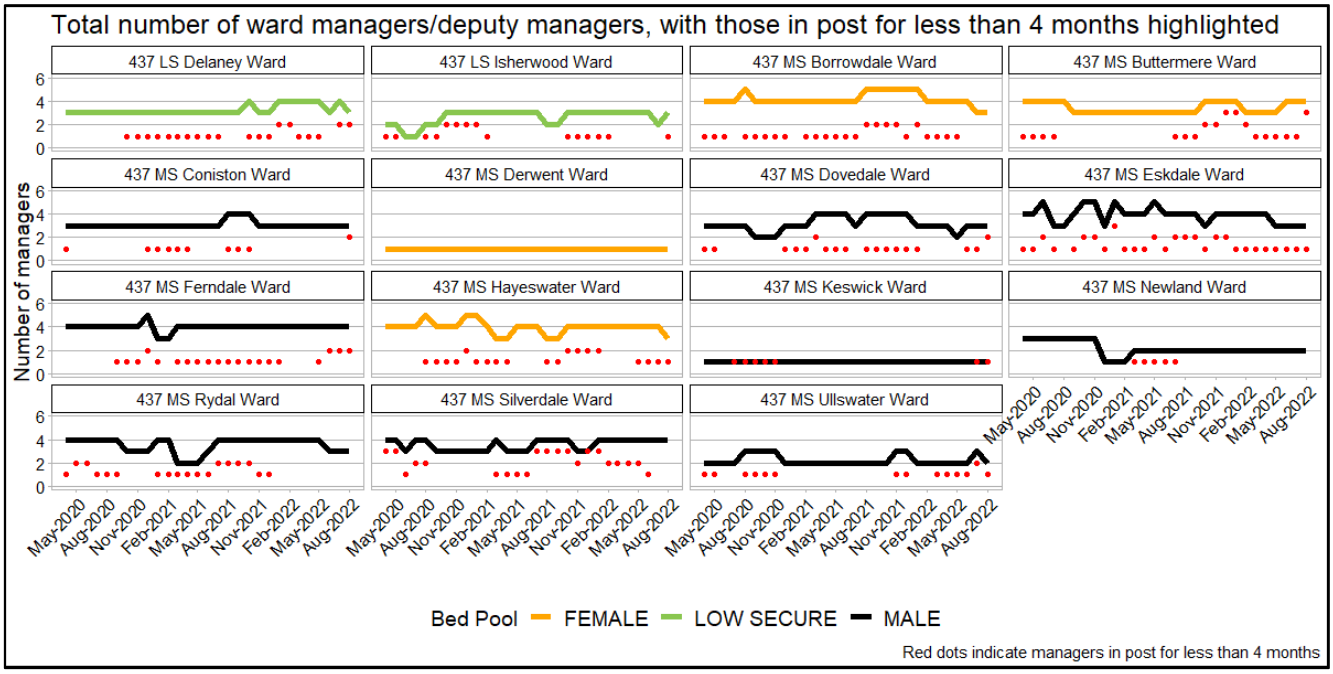
7.34 The turnover of ward management in Edenfield has been exceptionally high in some cases.

Figure 14: Band 6 and 7 ward and deputy ward manager turnover, April 2020 to August 2022



7.35 This has been most notable in Buttermere, Silverdale and Delaney wards, but has risen across almost all Edenfield wards over the last year.

Figure 15: Total number of ward and deputy ward managers in post by month, and those who were in post for less than 4 months, April 2020 to August 2022



7.36 The average retention of ward managers was variable across Edenfield wards, although a clear pattern emerged that most wards had been unable to retain a manager for more than 18 months.

7.37 We asked for the organisation training needs analysis and received a nil return. Instead, the Trust shared its statutory and mandatory training modules. This list was five years old (dated 2018) and is therefore unlikely to reflect the latest guidance and good practice in relation to the modules it covers. It remains unclear what the training offer is for Edenfield (non-medical) staff to ensure that their practice meets the needs of the specific patient group.

7.38 Supervision in Edenfield has seen a marked drop in the last three years and now stands at 58%. Within this data there are some significant ‘hotspots’, including compliance at only 6% on Wentworth Ward. Temporary staff do not receive supervision. Good quality, regular supervision is key to delivering high-quality care and retaining staff. This is particularly true in a challenging and specialist environment such as Forensic Services. Conversely, low supervision rates risk staff feeling unsupported with their challenges at work or wellbeing, and management being disconnected from the realities for staff delivering direct care. Few staff reported to us a positive experience of supervision or 'on job support'. Only a few preceptees could describe having time with a preceptor and formally signing off competencies.

Insufficient knowledge and skills to manage service complexity

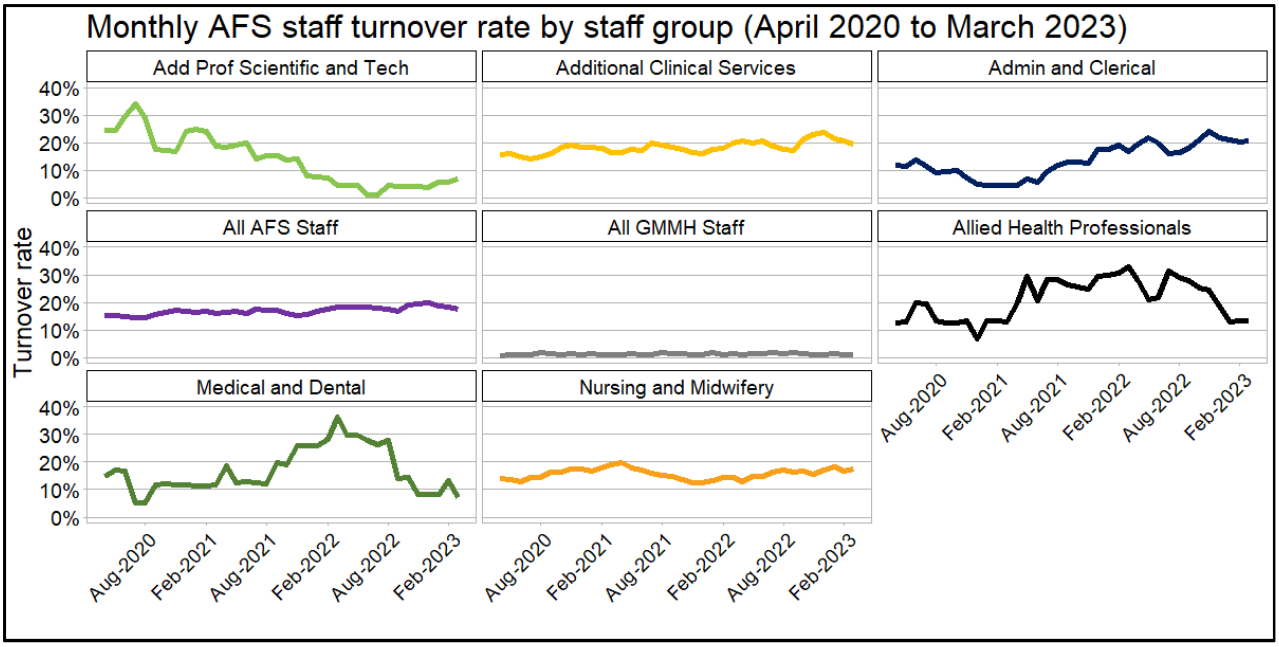
7.39 Staff at Edenfield often felt psychologically and physically unsafe in the delivery of their role. Insufficient supervision and support, coupled with a sometimes unkind management style, contributed to stress, burnout and ultimately the high turnover and absence of staff in the service. This is significant in considering how the conditions identified by BBC Panorama had been able to develop.

7.40 Staff working in secure services require specific skills and knowledge to develop the robust relational security required to care for individuals who have often suffered severe trauma and who can be of serious risk to themselves and others. These skills and knowledge require training over a number of years to develop and hone.

7.41 The clinical workforce at Edenfield had seen high levels of turnover across most disciplines, and difficulties in recruiting to these roles. We heard of year-on-year decreasing interest in jobs advertised in the service, which matches the picture in other forensic services and the health service nationally. We heard people describe a narrative that potential recruits knew that Edenfield

was not a good place to work. This led to the appointment of newly qualified nurses (preceptees) who had not gained the necessary experience to run a shift. We know that some of these preceptees quickly found themselves out of their depth, being the only registered staff member on a shift required to manage complex patients unsupervised.

Figure 16: Adult Forensic Services turnover rates by staff group, April 2020 to March 2023



7.42 The charts above display the overall staff turnover rates in Adult Forensic Services by month and staff group.

Medical workforce

7.43 Stress among the forensic consultant group was clear when we started this review. Three senior colleagues were on sick leave or on phased returns and one of these individuals had collapsed with serious illness at work.

7.44 The Trust drafted in additional senior medical support to support the service post-Panorama; this included a very senior experienced medical leader from their own organisation and a second very experienced medical leader from an external organisation. These people were crucial in working with the new management team in stabilising the service, keeping it running and starting to make improvements in governance and delivery. Their capacity was extremely limited in the context of the enormity of the task requirement.

7.45 Many consultants showed obvious distress during our interviews. The relative inexperience of this group, their lack of processing of the experience of Panorama and worsening dysfunction within this group meant they were unable to provide the leadership and direction that this service needed to support its recovery. We made the Interim Chair and CEO immediately aware of this issue and suggested that they get the support required to commence resolution of these issues. This is crucial to allow the group to function effectively together and lead and support the improvements in Forensic Services. Consultants presented as a diverse group with differing styles and interests; this is a desirable situation and should have been a bonus to the service. Instead, their inability to disagree well and to develop a shared common purpose served to limit their functionality and further weaken the medical voice.

7.46 Described to us by consultants present and past, and by forensic psychiatric trainees who have witnessed it, the dysfunction in the consultant workforce has been long-standing and pre-dates the 2021 timeframe of the review.

7.47 This dysfunction had been recognised previously, but actions to address the issues did not resolve them. There was a lack of trust and at times incivility between colleagues, with descriptions of a medical hierarchy and lack of transparency about internal appointment processes. There was inequitable sharing of resources, whether this be the completeness of a multi-professional team or the allocation of training doctors. We heard of a perception that less experienced colleagues had the heaviest clinical burden and more newly appointed consultants were responsible for the most acute and most unwell patients. This came into sharp focus for consultants during the pandemic. It is often true that more senior colleagues have more management responsibilities and fewer clinical or less burdensome clinical duties as they progress through their careers. It is crucial that this is openly and transparently managed in a service, to balance the responsibilities and ensure that everyone has opportunities to learn, develop and progress their careers.

7.48 The turnover of medical staff is the most striking characteristic of this professional group. Since April 2020, nine consultants left the trust to work in other organisations or elsewhere within the Trust. The Trust has appeared to exhibit little curiosity in this turnover. Consultants described having to ask for an exit interview or having exit interviews that focused on persuading them to stay rather than understanding why they were leaving. One consultant described sharing all of their concerns in a requested exit interview and being told "*that's just your perception*".

7.49 Elsewhere in this report, we have given examples of Edenfield consultants' clinical decisions being over-ridden by managers. Others include:

- the removal of a patient perceived by the clinical team as having a high level of risk of violence from seclusion, without any discussion with the responsible clinician; and
- a manager querying the levels of escorts that patients needed while off the unit, and repeatedly suggesting that patients did not need to be on high levels of observations.

7.50 Trainees noticed a change in the way seclusion had been used over the time they had been training in GMMH. They described how, as more junior trainees, they would carry out seclusion reviews out of hours and that many seclusion rooms would be unoccupied. However, in recent times, the use of seclusion rooms had markedly increased.

7.51 Every consultant described difficulties in getting their voice heard about the issues they were experiencing, or indeed about the potential solutions they were proposing. One consultant said they tried to share their experience of working on a more highly functioning unit as a means of improving the service at Edenfield, to no avail. Another wanted to lead work to understand the culture of the service, but it was made clear to them that there was not a shared common view of poor culture in the service. Consultants responded in different ways to the experience of not being heard when they tried to speak up; while some stayed, a significant number chose to leave, particularly those who were newly appointed. Some had made their feelings known prior to the Panorama programme.

"*I felt like I was working in an evolving inquiry*", and

"*I couldn't consciously stay as I did not want to become complicit in the drama.*"

7.52 GMMH and Edenfield lost many medical staff who had successfully trained and committed themselves to the service. Some of these had become frustrated and unwilling to tolerate the delivery of poor care and the impact this was having on their work life balance and personal mental health and wellbeing.

Occupational therapy

7.53 Both the occupational therapy team and the psychology team described not feeling valued by the service. They did not believe that the value that they brought to patients' treatment was properly understood by operational management colleagues and both described losing posts as part of annual cost improvement plans and not allowing for staff to be recruited to backfill colleagues on maternity leave.

7.54 Occupational therapists (OTs) said that they were often being counted in the ward staff numbers and described how some management colleagues viewed their role to be that of occupying the patients. They said they often stayed on to support nursing staff after their shifts were finished. Other colleagues have said that OTs were not able to carry out assessments of people's skills and needs and support patients with their rehabilitation needs. The OTs saw many experienced staff leaving and new staff being brought in with little investment in these new staff. They spoke of a focus appearing to be on quantity over quality.

7.55 They experienced a culture where staff were not encouraged to speak up and indeed described it as "*career suicide*" to do so. They described many violent incidents and little leadership to support staff to work well with challenging patients. There was frequent trading between patients on the wards, including of contraband items brought back following leave, that led to conflict between patients and staff and patients being hurt. They saw colleagues become demoralised and unable to take breaks. They described it as being "*bog standard*" for observations not to be undertaken correctly.

7.56 They described three different reviews of their services having been undertaken but said that they had never seen any of the outcomes.

Psychology

7.57 While the psychology department has had a reduction in whole time equivalent (WTEs) over the last ten years, it has been able to maintain an effective supervision and support structure for its team. There is considerable expertise within this team. They described some of the challenges that services featured in the BBC Panorama programme had experienced in the months leading to its airing. Three of their team had gone on maternity leave and there were insufficient staff to provide the service as intended. Arrangements were made to add additional support from elsewhere, but this did not match the deficit. The team were told that funding could not be provided to backfill these posts.

7.58 There has also been a lack of training in trauma-informed care. Prior to the pandemic, every staff member coming to work in the service had a day's training as part of their induction, and anyone working in the women's service had an additional two-day training in delivering trauma-informed care. During the pandemic all of this stopped. This coincided with the changes in the psychology team with ward-based psychology moving to team-based psychology. Training in trauma-informed care did not return as the psychology team did not have the capacity to facilitate this. The availability of this training is now being remedied but is not yet complete. Care was described as moving from a trauma-informed focus to a behavioural focus in this absence.

Pharmacy

7.59 Pharmacists play a key role in managing medicines safely and supporting patients to be well informed when considering and taking their medicines. Pharmacists work with nursing and medical staff to achieve this.

7.60 Low numbers of registered staff at Edenfield impacted their work. They described a lack of consistency in nurses' knowledge of their patients, and both this and the time taken to locate keys had an impact on how work was done. They also noted that the systems in place for ordering medications on the ward were inefficient, particularly in the context of low nursing numbers. There were concerns about low level medication errors and concerns about how many medication errors were reported, particularly during COVID-19. The department has recently appointed more staff to improve medicines safety, but at the time of this review, the pharmacy team were only able to provide input into 50% of the clinical teams working there.

Administrative support

7.61 There are high vacancy (30%) and sickness rates (11%) within the administrative team. This staff group is key to facilitating the smooth running of many aspects of clinical teams and especially consultant medical staff functioning. Forensic psychiatry and the role of the Responsible Clinician (RC) within this service require a large amount of statutory paperwork and multi-agency working. All

of this requires systems to ensure timely completion of these roles, meeting with families and carers, organising reviews, meeting with different statutory and non-statutory organisations and the support, preparation and sharing of associated essential information.

7.62 In reality, many of these activities have to take place whether or not administrative support is available. Essentially, if administrative support is not available, RCs end up completing many of these tasks themselves. This is an inefficient use of time, increases the risk of error and causes an unnecessary additional stress on the clinicians it affects.

The impact of workforce challenges on restrictive practice

7.63 Patients' human rights must be embedded in the delivery of care and always considered in the context of restrictive practice. To uphold human rights, providers must always assess and keep under review if there is a less restrictive option for the people they care for. We have defined restrictive practices earlier in this report; specifically, we are describing the use of restraint, segregation/seclusion and the use of rapid tranquilisation. In this review we are clear that restrictive practices cause harm to patients. They can have a marked impact on people's mental health, their physical health and emotional wellbeing, and for some patients these practices re-enact previous trauma. Therefore, they should only be used as a last resort when other avenues of support have been exhausted. The CQC report, Out of Sight – who cares? (CQC, 2020) highlights many of these issues.

7.64 Blanket restrictions fall outside this description but are of great importance in this environment. The National Mental Health Safety Improvement Programme (MHSIP) demonstrated that reducing unnecessary blanket restrictions resulted in marked reductions in the use of the restrictive practice described in this report.

7.65 There are a variety of resources available to trusts to support organisations to manage this practice well. These include the MHSIP and the Restraint Reduction Network (RRN) which created standards and assurance frameworks to support organisations in reducing and in managing these practices well. There are also powerful family voices, such as Aji and Conrad Lewis, the parents of Seni Lewis who died as a result of a restraint, who were instrumental in bringing the Mental Health Units (Use of Force) Act (2018)[24] into being. These families continuously strive to work with professionals to reduce restrictive practice.

7.66 Supporting and managing patients with distress and associated behavioural disturbance is a complex and highly skilled nursing intervention within a secure service, which should be supported by the wider multidisciplinary team. Anticipating and recognising signs of distress, distracting and de-escalation are complex but fundamental skills in a forensic environment. Working well with distressed people with the potential to become violent is heavily dependent on staff having the time, the skills and confidence to build trust and relationships with patients. These patients are often frightened, agitated, have a low tolerance to frustration and have mental states that can mean that they are viewing the world through a very different lens to when their mental health issues are better managed. The most significant finding in the MHSIP report was that the interventions that made the most difference to reducing restrictive practice in inpatient services were the ones that changed the relationships between the patients and staff.

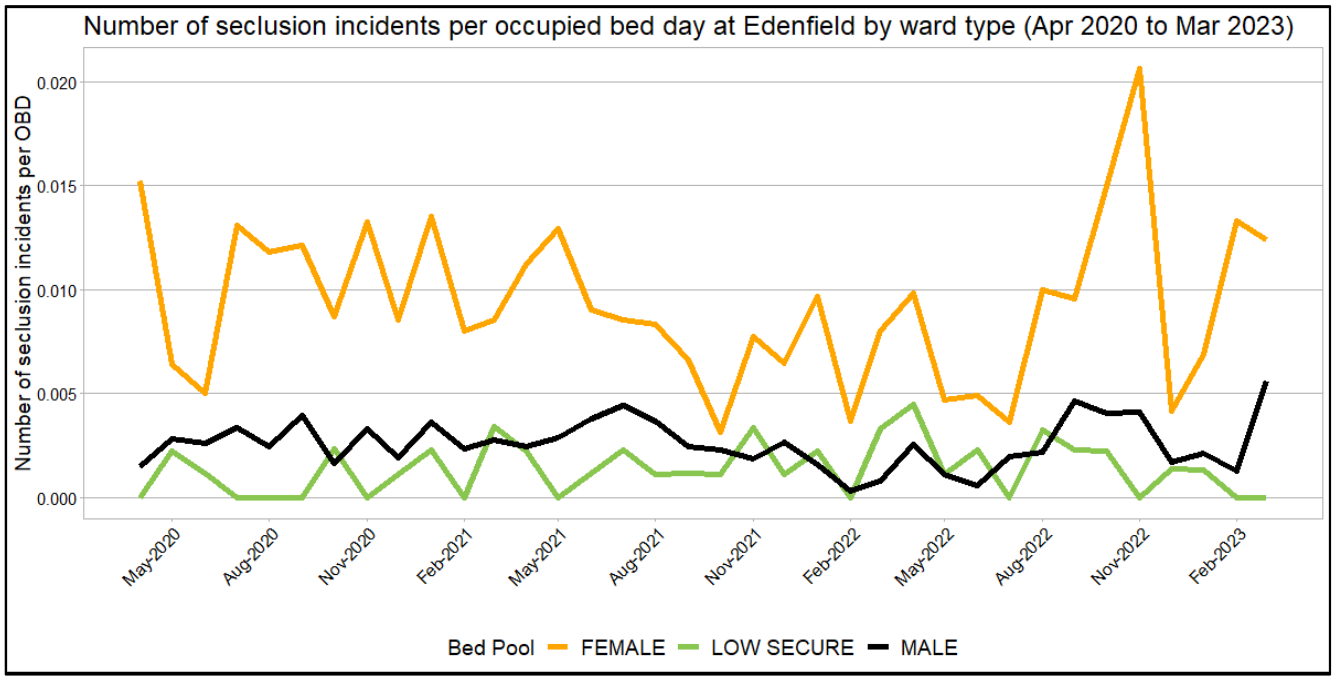
7.67 Effective early interventions can significantly reduce the need to use restrictive practice. It is easy to see, however, that in a forensic environment with staff in insufficient numbers and not having the appropriate skills, they can become frightened and resort to using seclusion/segregation or restraint with patients who they feel unable to manage safely.

7.68 Once in seclusion/segregation it is an equally skilled intervention to assess and support people to come out of this restricted environment back safely to the ward environment.

[24] https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales

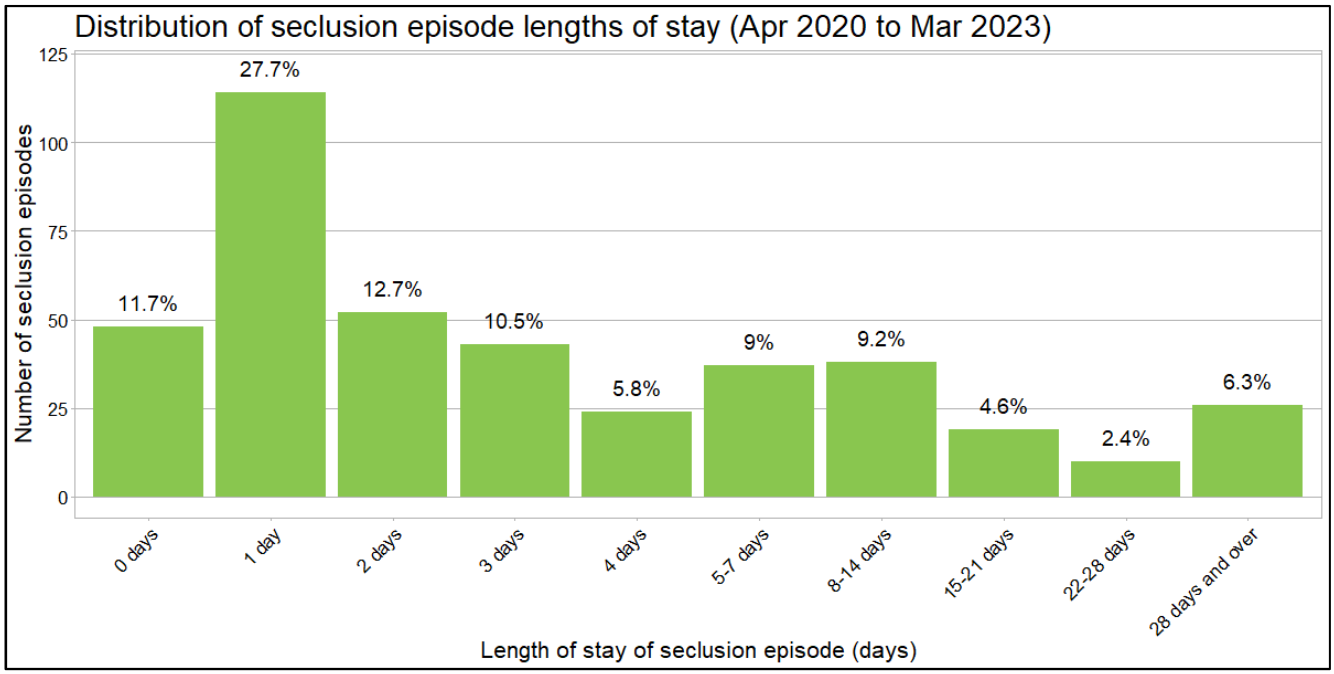
7.69 Data from Edenfield suggests that they have had a higher-than-expected use of restrictive practices on their male medium secure and women's services. This is particularly evident within their women's services.

Figure 17: Seclusion incidents per occupied bed day over time at Edenfield, April 2020 to March 2023



7.70 There also appear to have been a high number of prolonged seclusions/segregations.

Figure 18: Use of seclusion in Adult Forensic Services – length of episode



7.71 The average length of stay for the seclusion episodes was 8.8 days, with a median of 2 days, a lower quartile of 1 day and upper quartile of 7 days. The maximum recorded length of stay for seclusion was 257 days.

7.72 It is noteworthy that the Trust's Positive and Safe Practice Lead left the organisation in 2017 and was never replaced, with their role being subsumed into the role of a member of the PMVA training team.

7.73 The seclusion environment at Edenfield is of a very poor standard. We heard accounts of raw sewage leaking into seclusion rooms, and mould growing. We saw photographic evidence of some of this. Much of the environment we saw appeared to be poorly maintained. These factors had previously been reported, with little action taken until post-Panorama.

The impact of workforce challenges on care provided

7.74 Forensic services provide care and treatment for some of the most complex, high risk and vulnerable people using mental health services. When services are adequately staffed with professionals with the right skills, knowledge and experience, where teams work well together, information flows freely and the culture supports the delivery of high-quality, safe care, these are stimulating and rewarding places for both patients and staff. Not only do they provide the care that people need to recover, but they also provide a vibrant training ground for professionals to learn and discover the joys of working with the incredible people who use these services.

7.75 However, when this balance is upset, the voice of clinical staff is not welcomed (or is suppressed) and the focus on quality and safety is lost, these forensic services become frightening and hostile places for both patients and staff. The delivery of care really can become about "*surviving the shift*". Even the simplest tasks can become undoable and the more complex tasks of delivering trauma-informed care or maintaining the security of the ward are severely compromised.

7.76 Staffing levels, use of temporary staff, and the dilution of knowledge, skills and confidence over time have had a marked impact on how a nursing team complete the tasks that need doing on each shift.

7.77 In any shift there are a number of tasks that need to be completed. These range from tasks such as ensuring that patients have the necessary support to look after themselves and to keep their personal space clean and tidy, through to managing medicine administration safely, to the more complex forensic tasks of managing security on the ward. There need to be enough people with enough time to complete the task list and staff need to have the skills, knowledge and confidence to complete all of these tasks effectively.

7.78 We heard numerous accounts from every discipline and examples cited in reports from various sources to know that tasks were not safely and reliably completed. These range from the simplest to the most complex. Below are some of the issues which were identified in the quality reviews that were undertaken and fed back to leaders; however, little action was taken.

Concerns raised in the context of "*filthy bedding*" and messy and cluttered bedrooms.

"*staff feel afraid approaching/entering certain patients' bedrooms. Some wards feel uneasy. Staff are faced with patients displaying very aggressive behaviours. On the wards some staff fully occupied the offices and not the ward (almost a siege mentality)*"

"*staffing levels do not allow for tasks to be completed.*"

7.79 This review found that the most prominent staffing issue was that experienced by the nursing team. It was the issue that every clinician we spoke to described and it undoubtedly had a big impact on the quality, safety and experience of care within this service.

7.80 The value of the nursing expertise has dissipated over time to the point that nurses had become invisible. Nurses were not routinely considered as part of the multi-professional team. The difficulties with recruitment and high turnover of nursing staff, over time, depleted the service of forensic nursing experience. Nurses would be quickly promoted before they had gained the necessary skills or experience to fully deliver the more senior role. This, and the depletion of more senior nursing roles, led to less opportunity for supervision or mentoring from experienced skilled staff. We heard about a lack of adequate recognition, protection and clear process to support staff who were assaulted at work. The impact of these assaults on staff was not appreciated; staff did not feel cared for.

"*We need to get therapeutic levels of nursing care linked to outcomes rather than to a custodial level.*" (GMMH senior nurse)

7.81 The failure to adequately adapt to the national shortage of nurses and the impacts of COVID-19, alongside an operations management team who did not acknowledge (and at worst supressed) concerns from clinical staff when they were raised, led to a domino effect of deterioration within these services that started before the time period in this review and was accelerated by the pandemic.

7.82 Clinicians with longer affiliations to the service described a gradual weakening and breaking of academic links across disciplines and a loss of senior nursing roles.

7.83 Staff gain forensic knowledge and skills to do the job well from a variety of different sources: training, supervision and mentoring, and from doing the job in a team of other clinicians with more experience of the service, the ward and patients using this service. We have highlighted issues with lack of training for staff in restrictive practice and the reduced training opportunities in trauma-informed care. The knowledge shared among teams is an important and practical way of learning about how to do the job. As the skills, knowledge and experience of the workforce deteriorate over time, the tacit knowledge quickly follows suit. In this context, practice easily migrates away from best care and the ability to recognise what good care looks like diminishes over time.

7.84 Edenfield demonstrates that over time, staff are less reliably able to manage the core nursing interventions, from tasks such as supporting patients' personal space to be kept clean and uncluttered, to the more complex tasks of managing violence, aggression, and self-harm and relational security in ways that keep patients and staff safe. The use of seclusion is a poignant example of what can happen in these circumstances. If staff do not have the skills and confidence to manage well behaviour that challenges, whatever its origin, they are likely to resort early to secluding a patient.

7.85 Teamwork is crucial for effective safe care delivery; this is true from the top to the bottom of the service, from the senior management to the 24/7 care delivered by the nursing team. A strong consistent clinical voice is required at every level. This does not mean that staff should always agree with each other, in fact quite the contrary. In services managing complex patients there is a huge benefit to having professionals with different training and viewpoints who can challenge each other, robustly and respectfully, with a shared common purpose to provide safe, effective care in circumstances where a range of clinical management options are possible.

7.86 However, to achieve this requires that every person feels listened to and people need to have the skills to disagree agreeably and develop a consensus position that everyone can follow. We have seen that this was not the case in the medical consultant group, which led to the weakening of the medical voice and prevented this key voice being heard in the closed culture of this service. The multi-professional team at a service level has not included nurses adequately, if at all.

7.87 Within some services, the vacancies for other members of the multi-professional team and the turnover of consultant staff have compromised team functioning. The most extreme impact has been within ward-based nursing staff. Low numbers, high turnover, high levels of temporary staff and frequent staff movements have a marked impact on team functioning. Not only do these circumstances make it very difficult for nursing staff to get to know the patients they are responsible for, but they also impact upon the understanding of the dynamics between any combination of patients and staff. The experience of teamworking is crucial for safety in forensic services, as by their very nature they involve managing complex, often distressed, patients with a high propensity to cause harm to others and themselves.

7.88 Given that care was being delivered in this hugely challenging, and on occasion frightening and dangerous, context it is perhaps less surprising that care deviated so far from the expected norm. As a senior clinician within the service articulated:

"*People found their own way of managing demands placed on them which they were ill-equipped to cope with – by distancing themselves from clients too hard to understand and to whom the easiest response was denigration and dehumanisation*".

7.89 The new management team have worked well to start to increase the number of nursing staff working within this service, and there is organisational development work to improve the functioning of the medical consultant workforce. There has been development and recruitment to more senior nursing staff in the service. Governance systems are beginning to develop to ensure that staff have a better understanding of how well they are delivering care.

7.90 However, as this service considers when it will be safe to reopen, specific consideration must be given to addressing the skill, knowledge and experience deficits, particularly in the nursing team. The medical leads within the service are relatively newly appointed consultants who will need high-quality supervision and mentoring to support the development of the skills and experience required for such roles. Failure to do so is likely to result in a recurrence of the problems previously described.

7.91 As the service redesigns and improves, a clear expectation and shared understanding of the values and behaviours that each member of the multi-professional team should experience from each other will be critical. This will also be required from the senior management team in their work with those delivering direct care and support. Particular consideration needs to be given to how consultants work together with ward managers to deliver the care to the high quality that the service aspires to.

7.92 Many staff with longer service working in Edenfield have described it as having been a flagship service in forensic mental care, and everyone would like it to return to this position. To achieve this there needs to be absolute clarity of 'what good looks like' in forensic services, an understanding of where the service is now, the gap between the two, and a clear, visible plan for how this gap will be closed. This process will need appropriate forensic expertise within the care group to develop and deliver. The expertise needs to be present at each level within the service: at the point of care delivery, within the supervision and mentoring support to staff, and at senior management level. Not everyone needs specific expertise, but there does need to be a shared common understanding of what is required. Edenfield has some senior clinicians with considerable expertise, particularly in psychology and medical teams. Consideration of how best to draw upon this expertise and experience will be an important part of the development process.

7.93 In this chapter we have talked about the importance of the workforce in delivering care; we will now move on to discuss the processes that the Trust has in place to check on the quality of care it is providing.

Chapter 8 Governance

Introduction

8.1 This chapter looks at how the Trust is run and overseen at its highest level, including by its board of directors and committees. We call this organisational governance. Governance is the system by which an organisation is directed and controlled (UK Corporate Governance Code, 2015). During the course of our review, we noted that the organisation was in the middle of implementing significant changes to almost all of its key governance structures and processes. For example:

- A committee restructure is currently underway, with significant changes to committee terms of reference and workplans being made. During our meeting observations, senior staff often stated that it wasn't yet clear where specific matters should report to.
- The Board Assurance Framework, which is a statement of the Trust's key strategic risks and how these are being managed, was being overhauled and was not being used effectively.
- There had been an operational restructure in 2022, moving from 11 divisions to four care groups, with a new collective leadership model introduced, with a fifth care group added for Adult Forensic Services after Panorama aired. The move to care groups means new information flows and different local governance structures.

8.2 In short, there was still significant work to be done to establish a well-used and tested governance framework[25] which would allow for clear flows of information from 'ward to board'. We noted that a significant proportion of the time in key governance meetings we observed during the summer was spent discussing how the governance would work better in future, rather than providing assurance on changes to practice that have been made, the impact of these on quality of care, and lessons learned.

The impact of the Board

8.3 The role of the board of directors in an NHS Trust (NHS Providers, 2015) is to:

- Set the Trust's strategy (understand how the Trust's strategy is being implemented and to hold to account for delivery of the strategy);
- Exercise statutory duties under the Care Act and NHS Constitution;
- Oversee the work of the executive team and management in ensuring that strategy is delivered; it does this by ensuring that the Trust's systems of control are robust and reliable;
- Set and lead a positive culture in the organisation (as discussed in Chapter 6 Culture); and
- Give account to the work listed above to key stakeholders, including the Council of Governors.

8.4 At the time of the BBC's investigation into Edenfield, the Board of GMMH, like many of its peers, was overseeing the Trust's recovery from the pandemic. In addition, four new non-executive directors started in 2022. Although two of the new non-executive directors had been in a governor role at the Trust, the Board lost a significant amount of its Board organisational memory at this time. Since Panorama, the Board's composition has changed even further. As outlined in Chapter 3, the external and strategic landscape has also lacked stability and has been challenging. This is not specific to the Board of GMMH but is reflective of the NHS agenda nationally. It is likely significant that the Trust also effectively doubled in size after 2017, when it acquired Manchester and then Wigan mental health services.

[25] In this context we refer to a governance framework as the systems, process and controls which support board, corporate, operational and clinical governance.

8.5 That said, some of the systems and processes the Board was working with led to insufficient checks and balances to mitigate serious failings in care being allowed to happen, like those at Edenfield. Examples include:

- A notable lack of the voice of the patient in governance processes, including Board meetings. Patient stories, for example, were only re-introduced to the public Board in late summer 2023 after a significant gap. These have been consistent practice at most NHS trusts since the Mid Staffordshire public inquiry in 2013 (Francis, 2015). We observed little focus on patient experience at meetings of the Quality Improvement Committee (QIC) and noted that non-executive directors had raised this.
- The quality of Board papers has historically been poor, with data aggregated to a very high level and no obvious way of identifying potential 'hotspots'. Safe Staffing papers, until very recently, are good examples of this; there was no visibility at a ward level of understaffed services, and narrative contained in reports historically was sometimes inaccurate.
- Senior staff told us on various occasions that there was a clear expectation that reports for Board and committees were made 'palatable' and that positive news was underlined.
- On some occasions, there has been a notable lack of professional curiosity and probing of information presented to the Board. For example, the Trust's National Staff Survey results in 2021 and 2022 were extremely poor. We found little recognition of this in the Board and People Culture and Development Committee minutes, and Board members do not appear to have probed, for example, how the Trust's results compared with its peers, how the Trust was seeking to learn from the best to improve its results and what the results meant in terms of the Trust's culture of quality. During interviews, some Board members were quick to blame 'the pandemic' for these results. Even if this were true, the results are among the worst of all mental health trusts nationally. This did not sound the necessary alarm bells for the Board.
- As described in Chapter 9 on Organisational learning, some information regarding concerns at Edenfield had been reported to the Board and its committees months before the Panorama documentary was broadcast.
- Some non-executive directors told us that previously challenge has been suppressed, and that they had received feedback that they were "*overstepping*" or "*going too far*" with their questioning, which is likely to have stifled Board debate and important lines of enquiry being raised at Board.
- We heard that there was insufficient attention given at Board level to the impact of the expansion of the organisation, particularly in relation to culture, quality of care, and post-integration plans. We were also told that the expansion of the organisation did not have a corresponding investment in leadership or governance resource. It was not clear in our interviews with Board members that all of them were aware of this.

8.6 Commentary about Board cohesiveness and visibility (see Chapter 5) in the organisation have similarly limited the effectiveness of the Board in fulfilling its role.

Council of Governors

8.7 The role of the Council of Governors is "*to hold the non-executive directors individually and collectively to account for the performance of the board of directors*." (NHS England, 2022). Governors are not directly involved in the operational management of a trust, and would not be expected to be directly involved in specific staff or patient issues.

8.8 We met with a group of governors to seek their views on the Trust. We offered two sessions and, due to the limited uptake, met once with six governors. Separately, we also met with the lead governor, and with three different governors as part of developing the terms of reference and received several items of correspondence from other governors.

8.9 The most prevalent theme emerging from our discussions was a strong sense that GMMH needs to put more emphasis on listening and responding to the voice of service users, carers and families, aligned to a greater focus on co-production, recovery and achieving better clinical outcomes. Many spoke of concerns regarding the culture of the Trust, which they felt lacked openness and transparency. A clear view emerged that this will be key to the organisation rebuilding itself and rebuilding trust with patients and the public.

8.10 Governors we spoke to were highly committed to the Trust. Most agreed that the period following Panorama had placed a strain on dynamics, both among governors and also between the Council of Governors and Board members. While this has been improving in recent months, there remains work to be done to ensure that the voice of governors is heard and responded to.

8.11 Some governors were frustrated by the discipline of governance processes in the organisation, including the lack of timeliness of meeting papers being circulated, inaccuracies in capturing minutes and a general sense that their contribution had not always been acknowledged or appreciated.

Committee effectiveness

Quality Improvement Committee

8.12 Quality governance should serve to support the organisation in identifying potential areas of concern, identifying learning and sharing themes across the organisation. It should focus equitably on patient safety, clinical effectiveness and experience of care. We observed the QIC twice, and its supporting executive-led group (the Quality Improvement Operational Delivery Group) once.

8.13 The QIC is chaired by a non-executive director and is the key assurance-seeking committee in relation to the Trust's overall quality of care. We are of the opinion that the non-executive director leading the committee chairs this forum effectively; however, there is poor discipline in relation to the management and administration of the committee, which fundamentally inhibits non-executive directors from discharging their roles effectively. In particular:

- Papers are issued very late and often, we understand, not at all. This means, in practice, that non-executive directors are unable to prepare adequately to hold the executive and management to account. Care group deep dive presentations (which represent the largest focus on the meetings) have until very recently not been circulated in advance.
- There is a dearth of data provided to the meeting to support assertions made in papers and presentations. It is unclear how members would be supported to gauge performance trends over time, benchmark quality performance or identify outliers from the data presented. Our observation of the discussion of a paper relating to ligature deaths in June 2023 found that no committee members raised the fact that ligatures had risen significantly in the last year, despite management providing positive assurance in the paper.
- There is a tolerance for papers not being issued for vague reasons, such as changes to process or format, including key papers such as Safe Staffing (not sent to the June meeting), despite this being an extreme risk for the organisation. When asked about this in interviews, relevant personnel described the poor discipline around submission of papers as normal practice.
- Meetings are held virtually via MS Teams, which has become normal practice in the NHS since the pandemic. This, however, appears to have given rise to some informal practices which inhibit good governance. For example, we observed the chat function being used for members and attenders to continue debating previous topics, which is distracting and leads to important debate which is un-minuted. A key example in this area is a non-executive director using this chat sidebar (during the June 2023 meeting) to urge management to ensure that the Trust is being "*open and transparent*" in relation to its management of serious incidents. This would not be minuted.

- The committee is a significant outlier in its lack of consideration of patient experience data. We observed non-executive directors highlighting the lack of this on various occasions, although plans to remedy this remain unclear.
- While we did observe some useful points of challenge from non-executive directors, there remains significant scope for development in this area, with a focus on ensuring that demonstrable improvements are being made for patients. For example, a paper on deaths of children and young people in Prestwich has been submitted to the Board and QIC on various occasions due to non-executive directors being unhappy with its content and clarity. Repeated re-submission of assurance reports is highly unusual and is reflective, in our view, of a need for non-executive directors to be more decisive in their challenge and to more stringently hold management to account when standards and transparency fall below those which patients and the public would expect.

8.14 Similar issues apply to the key subgroup of the QIC, the Quality Improvement Operational Delivery Group (or QIODG). Papers for meetings are sent out very late (the day before the meeting in June). Again, there is a high number of verbal items which means that members are unable to prepare questions or hold each other to account for agreed priorities. Items we would expect to be core areas of focus in a meeting of this nature, such as risk registers, a quality dashboard, audits, patient experience reports, safe staffing intelligence and quality improvement updates were absent.

8.15 We understand there are various other senior quality related forums, and a Quality Risk and Assurance Group is also being introduced. We observed various conversations in which senior personnel expressed confusion about "*what is going where?*" and scope for duplication or gaps. Again, this represents in our view, a distraction from focusing on changes to practice in direct care.

People, Culture and Development Committee

8.16 The People, Culture and Development Committee (PCDC) oversees the delivery of the overall workforce strategy of the Trust which includes staffing, organisational development and education. We observed the PCDC and its supporting executive-led group, the People Delivery Group (PDG) once.

8.17 The PCDC is chaired by a non-executive director and is the key assurance-seeking committee in relation to all aspects of workforce. Similarly to the QIC, the meeting is well chaired; however, the poor meeting discipline and administration inhibit its effectiveness. For example:

- We observed the last-minute non-attendance of an executive director which resulted in two important papers not being discussed.
- As with QIC, papers are issued late and not all attenders had read all the papers in advance. We also observed the chat function being used for members and attenders to continue debating previous topics, which is distracting and leads to important debate which is un-minuted.
- While there was a large amount of data presented, it was not presented in a way which would help those who attend to grasp easily what the data meant. This means that there is a risk that attention will not be appropriately focused and actions may not be the most effective.
- Some items are presented as verbal items at the last minute, which means that non-executive directors cannot prepare questions or useful contributions in advance. We observed a degree of frustration about this in PCDC and other forums.
- We observed a lack of clarity about the role of PCDC and QIC in relation to seeking assurance on safe staffing levels. Given the scale of risk associated with this issue, it is key that the governance processes around this matter are clarified.

8.18 Similar issues apply to the key subgroup of the PCDC, the PDG. Projects to address staffing lacked detail on outcomes or reflection on what had been achieved already and therefore there was no consideration of how achievable the target was. We note the lack of a Recruitment and Retention Strategy to draw together and clarify this work. Not all professional groups who attended the

meeting contributed. Some of those who were attending appeared to be typing and various apologies were sent to the meeting.

8.19 Neither the PCDC nor its subgroup had identified signals that there was a problem at Edenfield, namely:

- significant staff shortages;
- high turnover of nursing and medical staff;
- very poor staff survey results; and
- high sickness rates.

Commissioning Committee

8.20 GMMH became the lead provider (LP) for adult secure services for Greater Manchester on 1 October 2021. The Board of Directors/Commissioning Committee assumed delegated responsibilities for clinical oversight and quality assurance from April 2022. The Commissioning Committee was set up as a board subcommittee with a delegated non-executive director Chair and Executive Director Lead to ensure that there was separation between the Trust as a provider of adult secure services and its role in commissioning as LP, which is essential to avoid conflicts of interest.

8.21 This committee's responsibilities were:

- Strategic planning and service development, with responsibility for addressing health inequalities.
- Clinical oversight, including pathway management.
- Quality assurance and improvement for all low and medium secure provision within Greater Manchester.
- Contractual, financial and informational oversight for all providers.
- Financial planning and budget management for the whole low and medium secure provision for Greater Manchester.
- Delivery of Long Term Plan targets and commitments for populations with learning disabilities and/or autism.

8.22 In reality, our review of meeting papers and minutes, as well as our observation, found that limited attention was given to service quality at this forum. This was inhibited, in our view, by the historical lack of clinical attendance at the meeting. It took the committee until March 2023 to state that they were proposing recruitment of a medical lead for the LP. The nominated nursing representative was not always in attendance, and where a deputy was nominated, they also did not attend.

8.23 The Trust made preparations to take on the responsibilities of the lead provider, with a Board Development session held in July 2021 to understand the role of commissioning responsibilities prior to delegation and a statement of readiness for the Board in September 2021. In reality, however, it appears that the role of the committee may not have been well understood, or that its function was not made a priority. This may be in part due to these being new arrangements for many organisations nationally. For example, planned meetings of the committee have not always taken place and meetings have been cancelled, and a decision was made to reduce quoracy due to individuals not always being able to attend. There was a missed opportunity to explore this further, with consideration given as to whether the meeting had the right attendance, its role was well understood, and what the potential impact may be of the lack of a strong expert and clinical voice at the meeting.

8.24 A member of our team attended the June 2023 meeting, where there was a Quality Lead (a social worker by background) who had started to identify data requirements to measure service quality.

While the Trust had made preparations to assume this responsibility, this was in the early stages. There was no other clinical member of staff present. The Trust has told us that further work has been undertaken to strengthen the approach, following the publication of national guidance.

8.25 The meeting was well chaired by the non-executive director and all present contributed well. It was evident that there was some work to be done to understand the role and functioning of the committee, particularly when dealing with quality issues within the lead provider's own organisation. For example, there was a discussion on whether GMMH was acting with sufficient pace to enact improvements. It was unclear what ethical walls had been put in place to ensure sufficient impartiality in discussions of this nature, particularly given that the committee is chaired by a GMMH non-executive director. These issues are not unique to GMMH, and a number of provider collaboratives are facing the same issues. This report and its findings offer an opportunity for others to take stock and review their processes.

Service-level governance

8.26 Governance at a service level is at various stages of maturity across the organisation. At Edenfield, clinicians told us that there had historically been a lack of data and intelligence for them to measure the effectiveness of their service. This has recently been addressed.

8.27 Services like Edenfield will escalate information as required to their relevant care group. Care group governance remains in development following the restructure. Our review of the former Specialist Services Care Group governance meeting minutes found insufficient attention given to quality and service risks. In some instances, quality had simply not been discussed due to it being scheduled at the end of a busy meeting agenda.

8.28 Regardless of the effectiveness of governance structures and processes, psychological safety and a learning culture are key to governance being able to support improvements. If service managers and leaders feel unsafe in escalating concerns and issues, information will continue to be stifled and service safety will suffer.

Summary

8.29 The Trust's governance framework has not functioned effectively in raising serious quality concerns to the Board and its committees, including those from Edenfield, in a timely way, to support safety and improvement. In our view, there were several reasons for this, including:

- a lack of helpful information available to frontline clinicians to help them understand the quality of care they were delivering;
- the absence of a culture of healthy escalation, with staff often too fearful to pass on 'bad news';
- unclear roles and responsibilities across committees, alongside a lack of grip;
- insufficient focus on quality at Board level; and
- insufficient rigour and probing of the information presented to key forums.

The Trust told us of the work it is undertaking to strengthen its governance framework which includes reviews of its committee structure and responsibilities. A new Equality Diversity and Inclusion Committee and a Service User/Carer Council are in the process of being established.

8.30 We have described how the Trust oversees quality in this chapter: next we will look at how the organisation learns and makes improvements.

Chapter 9 Organisational learning and responsiveness

Introduction

9.1 Part of our review was to understand how well the Trust learns when things go wrong. We wanted to make this as concrete as possible, so we chose a small number of case studies to look at, where clear concerns had been raised. We looked at:

- how the organisation (and its partners) responded to concerns raised by a patient in its secure services;
- inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events;
- how the Trust responds to and learns from Prevention of Future Deaths reports; and
- the Trust's improvement plan, and how well this enables learning.

9.2 The purpose of this chapter of the report is to assess whether the Trust can demonstrate the capacity to learn from concerns and incidents using real-life examples. All of these cases represent significant learning and improvement opportunities for the Trust, not least where GMMH patients have tragically died. While the case studies in themselves may have taken place across different services or sites, we nonetheless have found commonalities in the Trust's management of significant issues being raised to them. These are:

- **Pace of change** – Some of these issues are very long-standing, and yet improvements are difficult to identify. Some actions identified following the death of a patient in case study 3 have not been implemented almost three years on. The improvement plan already has overdue actions. Similarly, ligature incidents, in spite of the reduction plan, continue to rise. This is, in part, reflective of the need to create a more empowered workforce who are able to make the changes necessary at a service and patient level.
- **Lack of transparency and/or clarity in reporting** – Across case studies 1, 2 and 3, we found that management information (whether in the form of incident reporting, quality metrics or Board/committee reporting) has been opaque. In all three cases we looked at, it was difficult to get to the heart of the issue or what had actually happened. In case study 1, this was because language used to communicate to key forums was vague and unspecific. In the case of inpatient deaths, the baseline position and how this benchmarks to similar organisations was, and remains, unclear. In case study 3, it has been very difficult to ascertain who knew what, and when, in the incident response.
- **Poor governance processes, including consideration of the need for impartiality** – Across all three cases we found that there would have been benefit in having greater independence when reviewing the issues of concern. External perspectives may have identified more learning opportunities and better managed any real or perceived conflicts or risks to impartiality. Of particular concern is the fact that the internal review in case study 3 did not explicitly describe the falsification of records which was later reported.
- **Lack of scrutiny of key information** – Across case studies 1, 2 and 3, we found a need for more effective scrutiny of information presented to key forums, including review of key information by qualified and relevant clinicians. There is also a need for clearer and more coherent responses from management and executives to challenges posed by non-executive directors. Openness and transparency are critical conditions if the Trust is to create a culture conducive to improvement and learning.
- **Issues treated in an isolated way** – Across three of the four cases we looked at, we found examples of issues being identified without their being considered as potentially systemic. This risks them being treated locally, without management getting to the underlying cause of an issue. For example, we found no evidence to suggest that the treatment of the patient in case

study 1 was not happening more systemically in other inpatient services. Similar examples are reflected elsewhere in this report, including issues of racism and discrimination at Park House.

- **Rigour in the monitoring of change** – There has been a tendency for the organisation to be overly optimistic in its reporting of changes made since all of these events. This has, on some occasions, been challenged by senior staff or non-executive directors in the organisation, but we also found examples of key information being missed, which would suggest that existing plans are not having the desired impact and may be putting other patients at risk of harm. In case study 3, actions relating to observations remain incomplete almost three years after the death of the patient. A further example of the weakness of oversight of improvements is that the agreed audit of observations has not been happening as planned. The improvement plan does not always identify outcome measures which would really enable leaders to be assured that changes have been made and sustained. There is a risk that, by focusing on 'action', the Trust is not sufficiently looking at 'outcomes' and the differences made for its patients.

9.3 Below we describe each case study in turn, what we found, what happened and how the Trust (and, where relevant, its partners) responded, and what this tells us about the Trust's ability to learn from adverse events.

Case study 1: Concerns raised by a forensic inpatient

9.4 In June 2022, a Forensic Services patient made several allegations against the Trust. These were very similar in nature to those seen on Panorama in September 2022. This gave the Trust and regulatory bodies a significant period in which to act before they were aware of the broadcast. In this section, we sought to follow the allegations through the various layers of governance and communications to identify what actions were taken.

9.5 What we found was the following:

- A number of the issues raised by the patient were minimised or omitted in reports, and where actions were identified, we can find little evidence of them having been taken. A number of authors of reports gave us examples of being asked to change their report before presenting it to the relevant committee/board.
- It is clear that concerns about at least one ward in the relevant service were raised at the Trust Board, the Quality Improvement Committee and the Commissioning Committee; all of these have executive and non-executive members. All Trust committees appear to have accepted assurances that actions were being taken without appropriate challenge.
- There was a lack of consistent leadership in this particular ward, with six ward managers within an 18-month period. A review of the patient's segregation which was intended to be 'independent' was undertaken by a close relative of a senior member of staff in the service.

Background

9.6 The patient was admitted to Edenfield from a psychiatric intensive care unit. Progress reviews had been held every other month via Teams during the pandemic by the case management team, and numerous professional meetings had happened, which had included a number of internal and external partners. The clinical team at Edenfield had raised several concerns about their capacity and ability to meet the patients' needs and provide the best care for the patient. All agreed that the patient no longer required a secure pathway. A discharge was planned into supported accommodation.

9.7 The Greater Manchester Adult Secure provider collaborative is led by GMMH. A provider collaborative is a partnership between two or more providers to work at scale for the benefit of their population. GMMH was designated as the lead provider and, as such, held responsibility for the contract which included monitoring the quality of services. This was overseen by the Commissioning Committee within the Trust which was chaired by a non-executive director and was a subcommittee of the Board. They took responsibility for the quality of service provision on 1 April 2022, and

therefore the case managers[26] transferred to the Provider Collaborative Quality and Commissioning Hub at this time.

Timeline and commentary

9.8 6 April 2022 – A routine 'safe and wellbeing review' was completed for the patient. This is part of a national programme which checks the wellbeing of all people with a learning disability or autism diagnosis held in a mental health hospital. This identified that the patient was being nursed separately from their peers in what amounted to long-term segregation, which had not been recognised by the Trust. This led to an independent care and treatment review[27] (IC(E)TR) being commissioned. An IC(E)TR was booked on 29 June 2022, and it was agreed in the interim that GMMH would carry out a review of the segregation.

9.9 14 June 2022 – A formal complaint was made by the patient via their advocate to the Trust that staff were provoking them and pulling faces at them. It also detailed that they had been forcefully pulled into the seclusion area by multiple members of staff and that the level of force was unnecessary. Other incidents are alluded to. This complaint states that an earlier complaint made by the patient had taken in excess of a year to be responded to.

9.10 23 June 2022 – An 'Independent review of the use of long-term segregation' was carried out for the patient. The review was carried out by a former member of the Adult Forensic Services senior leadership team (SLT). This individual's close relative remained a member of that SLT. From a governance perspective, this does not meet best practice and may lead to questions regarding its objectivity (and stated independence of the review). Nevertheless, the review is comprehensive in nature and does encourage the ward team to look for the least restrictive options. It notes that if the patient is to remain segregated from their peers, then they are to be moved back to the Annex. This is a separate part of the ward that was historically used as a multipurpose activity space but was converted later to a bed area.

9.11 29 June 2022 – The IC(E)TR was carried out, during which the patient made several allegations relating broadly to 'bullying and mimicking/taunting' by staff. The list of allegations was long and detailed, including individual named members of staff taunting the patient; for example, saying that they were in seclusion because they are a baby, making a gun-like gesture to their head through the seclusion ward window and many more. They also highlighted some of the general restrictions and disruption on the ward, such as a lack of continuity in psychology staff, the ward environment being noisy, and a general lack of care.

9.12 The concerns raised in the IC(E)TR were so serious that the review Chair escalated them to the GMMH Adult Forensic Services SLT the same day. The IC(E)TR Chair notified the case manager the following day and confirmed they would be informing the NHS England Improving Quality team in the Learning Disability and Autism Programme, the NHS England NW Specialised Commissioning Nursing team and the CQC.

9.13 30th June 2022 – The Senior Case Manager met with the patient, safety was assured over the weekend and an alternative placement was sourced. The patient was moved to the new placement on 4 July 2022.

9.14 The relevant executives were informed of the allegations and a meeting of the Quality and Commissioning (Q&C) Hub senior leadership team took place, attended by representatives from NHS England Specialised Commissioning. A number of actions were agreed, including a full review of the patient by the Senior Case Manager and a review of the service to be undertaken by the Q&C Hub.

[26] The role of the case manager is to ensure that the service where a patient is placed is able to meet their needs and that the care plan is supportive in doing this. They also have a quality monitoring role of the provider.

[27] An IC(E)TR provides the opportunity to check that a patient's care and treatment are effective, the least restrictive possible, and that they are supported to leave hospital as soon as possible.

9.15 At this time, the Trust also indicated that formal investigations would be carried out on the individuals the patient had named in their detailed allegations.

9.16 1 to 6 July 2022 (written up on 20 July 2022) – A quality review of the service was undertaken by the case managers. The report described the following 11 themes and asks for assurance from the Trust:

1. **Staffing** – low numbers, lack of continuity and high sickness. Senior managers reported as not visible, and no action was taken when issues were raised with them. Staff reported no career progression, and many were actively seeking alternative employment.
2. **Environment** – a number of environmental issues were noted.
3. **Training and reflective practice** – a lack of training in learning disabilities and autism awareness. Some reflective practice was available.
4. **Care planning** – some care plans were sparse with no collaborative feel, with some noting instructions like 'minimum 24 hours in seclusion'. Some were more collaborative in nature.
5. **Restrictive practice** – significant examples of blanket restrictions were found.
6. **Seclusion** – advocacy noted prolonged periods of seclusion with few exit strategies.
7. **Use of PRN** – specific inappropriate examples of use of pro re nata (PRN) medication (prescribed for when they are needed rather than at set times) were noted on some wards.
8. **Equality and diversity** – the review identified a number of issues and wanted to see evidence of the Trust's values in practice.
9. **Freedom to speak up** –the review wanted to see evidence of opportunities to raise concerns with the leadership team or appropriate professionals including the FTSUG.
10. **General** – some patients echoed similar culture issues flagged by the IC(E)TR around staff interactions with patients. Two further patients on one ward described being sworn at and spoken to in a derogatory manner, and some patients described access to leave and restricted items not being supported depending on their engagement.
11. **Efficacy of the service** – the review wanted assurance that the service is in line with national aspirations.

A list of actions and assurances was requested from GMMH.

9.17 6 July 2022 – A briefing note was sent by NHS England to Directors of Learning Disabilities and Autism and Mental Health (presumably at NHS England) regarding the concerns raised about Edenfield. The NHS England Regional Director with responsibility for Mental Health and Learning Disability did not receive the letter and was not informed about it. The briefing states that, during an IC(E)TR, the person reported to the panel that staff bully and taunt them and gave several examples. It noted there were gaps in their care, a 'closed' culture on the unit, a safeguarding referral had been raised and that the case manager had visited. It reported that other patients had described similar experiences of bullying from staff to patients. This memo was not received by the NHS England Regional team.

9.18 The briefing then set out regional and national actions, which included the following:

1. escalation to senior managers within the hospital;
2. a safeguarding referral;
3. that the person has moved;
4. the regional lead, provider collaborative and ICS are all aware;
5. the case manager has visited; and

6. the Mental Health Act Reviewer from the IC(E)TR panel has escalated within the CQC.

Under the headline of 'Next steps and recommendations' the document notes that a senior intervenor[28] had been allocated to the person, and that the CQC is currently undertaking an inspection of the provider. The CQC completed its inspection of Forensic Services between 14 and 16 June 2022 (before the IC(E)TR). The well-led inspection[29] took place between 5 and 7 July 2022.

9.19 13 July 2022 – The Specialist Service Divisional Leads meeting was briefed, noting only concerns about staffing, environment, and the service model. No reference is made in the brief to the specific allegations. It notes that they are awaiting a written response from Specialised Commissioning.

9.20 18 July 2022 – The Commissioning Committee met for the first time since the allegations were made. As described above, the Commissioning Committee is a subcommittee of the Board, chaired by a non-executive director, and attended by an executive of the Trust and a second non-executive director. There is no specific item on the agenda regarding these allegations, but within a presentation on *Management of Failure/Quality Concern Scenarios, one bullet point notes "Concerns raised by an Independent IC(E)TR chair regarding the care of an individual patient placed with the lead provider which led to wider quality issues being identified"*. Two of the non-executive directors present described being alarmed by this and questioned further what exactly this meant. They were so concerned that they felt they should raise the issue as part of the report to the Trust Board.

9.21 20 July 2022 – Two preliminary investigations were undertaken into the allegations made by the patient. No formal action was recommended.

9.22 25 July 2022 – The Chair of the Commissioning Committee reported to the private part of the Trust Board that a safeguarding referral had been made following an IC(E)TR in the service. They highlighted the process the Commissioning Committee and Q&C Hub were undertaking. The Board discussed the roles and responsibilities of the various committees in overseeing the matter and resolved that the Quality Improvement Committee[30] (QIC) should have oversight of any significant incidents occurring in GMMH provider commissioned services. The QIC Chair confirmed that they would review the incident at the August committee.

9.23 3 August 2022 – A formal response was sent to the Quality and Commissioning Hub from the service, by way of a letter. Many of the issues raised are noted as already completed (such as environmental issues, advocacy, PMVA training). Other issues were noted as being part of an action plan (including a project on care planning); the letter also included details of how the service had escalated the inappropriate nature of the admission to the unit. It also noted that an investigation into the allegations was currently underway.

9.24 8 August 2022 – A high level plan was produced with actions and leads identified to address most of the issues highlighted in the review of the service. It noted that an investigation was to be undertaken into the specific allegations made.

9.25 A first draft of a report for the QIC was produced and reviewed by the relevant executive. Some amendments were requested as a result of this review.

9.26 10 August 2022 – Specialist Services Divisional Leads Meeting – No direct reference appears to have been made to the action plan and progress against it, although some of the elements were discussed, such as the environmental works.

9.27 14 August 2022 – The QIC met and a paper broadly outlining the concerns raised by the review of the service was presented. This had been submitted late and not included in the meeting papers, so it is unclear if members would have had time to read this in advance of the meeting. The specific allegations initially made by the patient are not included in the report, nor are some of the

[28] Senior Intervenors are independent experts who works to find solutions that may be preventing the individual from moving on to less restrictive settings.

[29] https://www.cqc.org.uk/sites/default/files/20200115_Trust_wide_well_led_inspection_framework_V7.pdf

[30] The Quality Improvement Committee is a subcommittee of the Board charged with oversight of all quality issues within the Trust.

confirmatory patient accounts of staff swearing at and bullying patients. It notes an action plan was underway with much work already completed.

9.28 30 August 2022 – The action plan was updated; it is evident that there were conflicting views regarding progress that had been made, with several comments by a senior member of Adult Forensic Services staff noting limited progress. Corporate nursing were asked to support a review of care, and a visit was planned by a senior nurse for early September; however, as they did not receive a reply to agree their visit, this did not go ahead.

9.29 9 September 2022 – GMMH received a letter from the BBC regarding allegations to be aired, including a long annex of witnessed events.

9.30 13 September 2022 – GMMH was due to feedback about IC(E)TR concerns and GMMH response to the provider collaborative. This was stood down, due to the requirement to address urgent issues raised by Panorama.

9.31 25 October 2022 – Email from a non-executive director to the Trust Chair expressing concern at the lack of transparency and that the breadth of the issues had not been shared at the previous Board or QIC meeting.

Commentary

9.32 On 29 June 2022 a patient made a number of allegations about their care and treatment to an IC(E)TR. As part of this case study, we have followed those allegations as they made their way through the governance of the organisation. A number of things were evident:

- The seriousness of the allegations was minimised and aggregated into generalised concerns as they passed through various forums and committees. Furthermore, the outcome of the two preliminary investigations into alleged bullying did not fully acknowledge the experience of the patient who had raised serious concerns. It could be argued that, without the attention of two non-executive directors at the Commissioning Committee who noted some concerns as part of a wider presentation, the allegations would not have been raised to the Trust Board or QIC. As outlined elsewhere in this report, we heard on a number of occasions where authors of reports were asked to change the tone and emphasis of reports for senior committees.

- Board members had information about the concerns on one of the wards in Edenfield available to interrogate at the Commissioning Committee of 18 July, the Board meeting of 27 July, and the QIC of 11 August.

- Part of the action plan included undertaking disciplinary investigations into the named individuals for taunting and bullying the patient. We have been given various accounts as to who undertook these investigations. We were told by one member of the Adult Forensic Services SLT that Human Resources had told them there was ‘no case to answer’ so the investigations didn’t proceed. We were later supplied with two ‘fact finding’ investigations which do not uphold the main body of the allegations, and no further disciplinary action is identified. We can find no assurance that this was followed up by any of the committees that were charged with overseeing the concerns raised.

- The issues passed through various forums and action plans were produced, but little change happened. The updated action plan of 30 August includes annotation by a member of the Adult Forensic Services SLT noting that some of the claimed progress in the first iteration needed revisiting. The matter was referred between committees, before QIC took responsibility for overseeing the case. A non-executive director felt obliged to email the Trust Chair in October to note that the action plan and report had not been to the Board or QIC.

- The CQC and Specialised Commissioning were aware of the allegations. Specialised Commissioners sent a briefing note nationally regarding the allegations to all Directors of Learning Disabilities, Autism and Mental Health. This was not received by regional NHS England. The CQC were aware, both from the Chair of the IC(E)TR and from NHS England who had informed them about the allegation and the extent of the patient’s claims.

- Due to emerging concerns, NHS England explored with the ICB whether there should be a single-item risk meeting to discuss these with the Trust in July 2022. This meeting did not happen, as the system already had an imminent planned meeting, known as the Quality Surveillance Group. In addition, it was highlighted that CQC was, at that time, inspecting GMMH. It was also underlined that where concerns had previously been raised by the system in relation to GMMH CAMHS, some partner agencies in the system had taken assurance from the positive published CQC report.
- The provider collaborative, commissioners, regulators and Trust Board each had disparate pieces of information or intelligence available to them about quality concerns in this service. These had not been 'pieced together' by these partners to understand what they were telling the system about the quality of care at Edenfield.
- There is no evidence the CQC's inspection of the Forensic Service in June 2022 led to it having serious concerns. The CQC did raise concerns with the Trust about ligature risks, but these concerns were not considered serious enough to be included in the s29A Warning Notice[31] that was sent to the Trust on 6 July 2022 about environmental concerns in acute inpatient services. For example, there is no direct mention of the service in the CQC's feedback letter to the Trust following the completion of its well-led inspection in July 2022.
- Concerted oversight and increased requests for assurance appear to have commenced after the broadcast of Panorama.

Case study 2: Inpatient suicides

9.33 The second case study we looked at was inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events. What we found was the following:

- There is a lack of clarity regarding the information and data relating to inpatient suicide and ligature deaths presented within the Trust.
- This leads to a lack of clarity about the current position on inpatient suicides and ligatures that the Board and its relevant committees can scrutinise and challenge. This makes it more difficult for senior leaders, including non-executive directors, to be assured about the actions and progress the Trust is making.
- There is a lack of understanding of the data that the Trust has available, and this may lead to a disconnect with their suicide/ligature reduction improvement plans and assurance of progress against the plan.
- There is an opportunity to strengthen the existing ligature reduction plan with a more systematic approach. This can be achieved by paying greater attention to workforce, culture, hearing the voice of the patient and family, and the implementation of key policies such as the observation policy.

Background to the concerns

9.34 We were made aware of concerns regarding suicides within inpatient services. During the review there were also two inpatient deaths, likely to be from suicide, with at least one further serious incident where a patient was unconscious and required transfer to the intensive care unit at a local hospital. All three incidents were because of the patient using a ligature to a fixed point that was weight-bearing.

[31] CQC a warning notice under section 29A of the Health and Social Care Act 2008 when they identify concerns across either the whole or part of an NHS trust or NHS foundation trust and decide that there is a need for significant improvements in the quality of healthcare.

9.35 Reducing ligature points is important in mental health inpatient settings as they are directly linked to an increased likelihood of death, with the majority of inpatients (80%) dying by hanging and strangulation (National Confidential Inquiry into Suicide and Safety in Mental Health, 2022).

9.36 The CQC has previously reported that the Trust was not always adhering to the relevant safety standards regarding the safe management of ligatures and, since November 2021, has required the Trust to make several improvements. Initially, the CQC issued a requirement notice in November 2021 following an inspection of the Trust's mental health acute wards for adults of working age and psychiatric intensive care units, stating:

'The Trust must ensure that all wards have an up to date ligature risk assessment and ensure that these are reviewed in line with trust policies and procedures. The trust must ensure that staff are aware of and consider all ligature risks on the wards. The ligature risk assessments must be meaningful and useful for staff.'

9.37 Since then, the CQC has highlighted a number of further concerns in relation to the Trust's management of ligature risks and its ability to make the required improvements at pace. These are set out in the communications and reports listed below:

Figure 19: CQC communications with the Trust regarding ligature risks

Date of inspection	Date of Action	Service	Action
13–17 June 2022	17 June 2022	Acute inpatients and Adult Forensic Services	The CQC fed back to Trust leaders their concerns about the management of ligatures and environment.
13–17 June 2022	6 July 2022	Acute inpatients/PICU	s29A Warning Notice
5–7 July 2022	24 Nov 2022	Well-led inspection	Inspection report published
16-17 Nov 2022	18 Nov 2022	Woodlands Hospital, Older people's inpatients ward	s31 Letter of intent: considering urgent action
16-17 Nov 2022	20 Dec 2022	Woodlands Hospital, Older people's inpatients ward	s29A Warning Notice
Jan-Feb 2023	17 March 2023	Acute inpatients	s31 Letter of intent: considering urgent action
Jan-Feb 2023	21 April 2023	Acute inpatients	s29A Warning Notice
31 Jan-6 Mar 2023	21 July 2023	Whole Trust	Inspection report published: '*We had significant on-going concerns in relation to how fire safety and ligature risks were not being effectively managed and mitigated on some wards we inspected. These were issues we had raised in our previous inspection which had resulted in the issuing of a Section 29A Warning Notice.'*

9.38 To better understand the current position regarding inpatient suicides, we asked the Trust for information relating to inpatient deaths through suicide and its response to deaths by ligature.

9.39 The Trust's Learning from Deaths Annual Report presented to the Quality Improvement Committee in July 2023 showed the Trust's own assessment based on the National Confidential Inquiry into Suicide and Safety in Mental Health (2022). This report states:

"*GMMH has been ranked as one of the 10 trusts with the highest patient suicide rate for the years 2017–2019. However, this does not necessarily reflect a safety problem within the organisation but potentially indicates something to be investigated by clinical risk and suicide prevention leads.*"

9.40 A separate report to the same committee meeting contained benchmarking data on inpatient deaths. It stated:

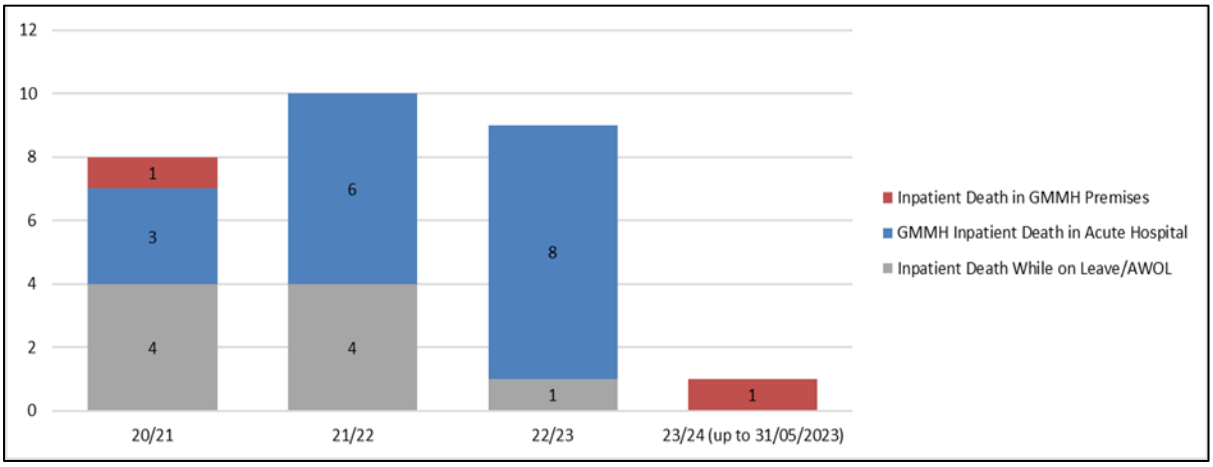
"*…data up to 31st March 2022 shows GMMH was not an outlier in terms of number of deaths, or rate of deaths, in inpatient bed types when compared to other mental health trusts. More recent internal data from the Mortality Report also confirms that unexpected deaths of inpatients are uncommon. In the 3 years to 31st March 2023, 12 deaths that were suspected to be inpatient suicides were recorded, out of a total of 38 unexpected inpatient deaths that occurred in a ward environment.*"

9.41 We also received information from the Trust training department regarding the ligature audit tool training, which stated that:

"*There are on average 19 suicides involving ligatures on inpatient wards in the UK each year – there were 5 inpatient suicides in GMMH involving ligatures in 2022… This means that, during 2022, the Trust had 26% of ligature deaths for the whole country!*"

This quote from a training slide within the Trust shows an awareness of the high numbers of inpatient suicides. We wanted to understand these statements in more detail and requested some further information on inpatient suicides from the Trust. We were provided with the data below:

Figure 20: All inpatient deaths as a result of taking own life



9.42 We were advised that the deaths in acute hospitals were patients under the care of GMMH that, as a result of an act of self-harm on a GMMH ward, sadly died when subsequently transferred to an acute hospital.

9.43 We then reviewed monthly incident reporting sent to the QIC. This report in July 2023 stated that:

"*Ligatures continue to be used as a way to self-harm and there [sic] 43.55% of the self-harm incidents reported during May can be attributed to inpatients using ligatures. The Trust has had 10 deaths of inpatients where ligatures were used since January 2022, with the number of inpatient deaths by ligature by year - 2021 = 2, 2022 =6, 2023 = 2*"

9.44 We requested information from NHS England to compare with the Trust data. This showed some inconsistencies with information provided to us by GMMH.

9.45 In summary, the Trust provided us with various pieces of information in relation to suicide, inpatient deaths and ligature reduction. The information showed that there was no significant reduction in inpatient deaths and an actual increase in deaths by ligature in 2022. This information was not always easy to understand, based upon the various reports provided.

9.46 The Trust had begun to implement plans to address the actions required of it; however, during our review, we remained concerned at the pace of the delivery of those planned actions. In relation to the information outlined above, we were also curious about how the Trust may be interpreting its own information with slightly different perspectives, depending on the author of the various reports.

9.47 When we asked key staff how the organisation was responding to concerns raised around ligatures, we were told that a 'deep dive review' was commissioned at the March 2022 Risk Management Committee, and an outline proposal was confirmed to do this at the Trust Ligature Group in April 2022. The deep dive reviewed data from a two-year period and identified themes arising from ligature-related incidents, along with actions aimed at addressing these.

The key themes identified from ligature incidents by the Trust were:

- Safe and supportive observations
- Accuracy of clinical rationale for level of clinical observations
- Staff understanding of responsibilities when undertaking observations including recording
- Handovers in respect of levels of observations
- Changes being made to observations where decisions have not followed policy
- Timing of observations and predictability
- Clinical risk
- Staff awareness of types of ligatures and risks
- Risk assessment and formulation
- Professional curiosity
- Awareness of escalation of risk, rehearsing, informing someone
- Anniversaries and significant dates
- Checking out and sharing risk information with carers and families
- Consideration of diagnosis and impact on risk
- Recognition of escalating risk, changes in types/frequency of self-harm

In response to their review and under the direction of the Trust Ligature Review Group, they identified a number of actions, as set out below.

Actions reportedly implemented by the Trust

1. Information page on its staff intranet specific to ligatures. This has links to environmental ligature risk assessments specific to the individual inpatient areas.
2. Work around storage and maintenance of ligature cutters, including a Trust-wide safety alert[32].
3. The Ligature Policy was revised and republished in August 2022. Ligature cutter specific training, including an educational video, was developed and is available on the staff intranet.
4. Ligature awareness, and the use of ligature cutters, has been added to the Trust-wide breakaway training.
5. A Trust-wide learning event in relation to management of ligature risks took place in July 2022.

[32] This was one of the Trust mechanisms for sharing learning internally.

9.48 In addition to these actions, the Trust told us that ligature risk in inpatient areas has been recognised within the Trust improvement plan with several actions included. These are:

- Review and, as required, update ligature audits across the Trust to ensure all risks in clinical areas and in low risk/communal areas are captured.
- Review and update ligature risk audit tool.
- Assess ligature risks associated with hand towel dispensers and soap dispensers and agree plans to replace or mitigate.
- Implement strategy to address all current prioritised high risk ligature items in 2022/23 capital programme.

9.49 The Trust told us that there is a schedule in place for ligature audit reviews across the year, prioritised according to the level of risk within each inpatient area.

9.50 The Trust internal auditors undertook a Ligature Point Risk Review which was issued to the Trust in April 2023. The auditors gave an opinion of limited assurance. The review found:

"*The Trust had a Ligature Policy in place which detailed the key roles and responsibilities with regards to ligature risk management. The Trust utilises an annual ligature audit/risk assessment process at ward level with all areas found to have undertaken the assessments. Issues were however identified in relation to the outputs and local and strategic action planning and monitoring of issues identified from the ligature audit/risk assessments. Risks were not found to be clearly triangulated with incident data and capital considerations for prioritisation, action and implementing and feeding back into the risk assessment*."

It is not clear how the outcome of the audit was conveyed to the Quality Improvement Committee.

Commentary

9.51 The Trust is now working to address the concerns regarding inpatient deaths, including those deaths by ligature points. There now appears to be a much clearer focus on resolving the concerns regarding these tragic events. The focus of the Trust has benefitted from the NHS England Mental Health Support Team who are able to provide additional expertise in this area. The Trust has provided ligature tool audit training to 104 members of staff in May and June 2023. Evaluation of the training shows that staff felt more confident in using the audit tool, which is used to identify and manage the risks of potential ligature points.

9.52 We are aware that in 2023, the Trust was told by NHS England about concerns regarding their approach to reducing inpatient deaths and specifically the ligature reduction method. These concerns were raised with senior clinical leaders regarding the pace and effectiveness of the Trust's response. A number of recommended actions were proposed to help support this work. We are unclear if all of these actions have been accepted by the Trust.

9.53 While recognising the general commitment from the Trust, we believe there are areas that remain of some concern. We have seen that the CQC raised concerns regarding the management of ligatures with the Trust in 2021 and several times since then. We also note in the most recent CQC report in July 2023 they stated that:

"*During this inspection we found some ligature and anchor points had been removed on some wards, for example, paper and soap dispensers, curtain rail tracks were replaced. However, some ligature points remained, such as not all toilets or en-suite doors had been replaced. The action for the uncompleted items in the ligature audits were documented on the maintenance reporting system as "job to be submitted". There was no timescale for completion. Senior leaders and ward managers discussed the priority criteria but there was not clear evidence of these being chased or followed.*"

9.54 We have listened to a range of GMMH staff and those who are there to support them. There is further room for improvement in developing a more systematic approach to ligature reduction. We heard and witnessed some differences across services and on occasion, on the same wards,

regarding the reduction of ligatures. This was most obvious on our site visit to Park House, acute inpatient services, where there were differences in the implementation of ligatures standards. We do note the aged estate on this site, and the plans for a new-build hospital to move out of Park House. The staff we spoke to were unable to give a clear rationale for the approach that had been taken by the Trust. We also heard from staff that the current training provided to clinical leaders on ligature reduction felt somewhat inconsistent.

9.55 While the ligature reduction plan is positive, there is more work required to ensure there is sustained improvement across the Trust. This should be focused on both ensuring a safe environment, alongside having sufficiently skilled staff present to support patients. We make observations elsewhere in our report regarding the workforce challenge and how this impacts on service safety. We know that lower staffing levels, lack of experienced staff and supporting high levels of people in acute distress can affect clinical staff's ability to always feel able to follow Trust policies relating to the observation of patients.

9.56 We reviewed the various data packs and reports presented to Trust committees and found scope to be more explicit about the scale of the existing risks, and how the Trust's performance in this area is or is not improving over time. There is an opportunity for the Trust to learn from others about how to present data in a more helpful way to enable organisational learning, and to understand if what is happening in GMMH is similar to what is found in other mental health trusts.

9.57 We did not always observe effective debate and scrutiny of this data. During our observation of the Quality Improvement Committee meeting, assurance was provided to the committee that the ligature reduction programme was making positive changes and that the CQC's warning notice in this area was likely to be lifted. The data presented to the committee stated that there was a 50% increase in suspended ligatures resulting in deaths and a significant increase in ligatures overall in-year. This was not challenged by members of the committee. This was an important opportunity to discuss the effectiveness of the plan as it suggests that the number of deaths has actually increased alongside the work of the action plan. There may be a lack of understanding of the data they have available, and therefore, this may lead to a disconnect with their improvement plans and assurance of progress against the plan.

9.58 The important work of the Quality Improvement Committee was likely compounded by various reports presenting the same or similar information sometimes in different ways. For example, the July Quality Improvement Committee had three different reports, all of which provided some information about inpatient suicides. This makes it more difficult to be confident regarding what the facts are. In trying to establish what is happening across the Trust, we found variation between the data the Trust provided and that shared with us by NHS England. This is likely indicative of a lack of clarity regarding what is happening within the Trust and how the system has responded.

9.59 Our analysis of this data in comparison with data available from the National Confidential Inquiry into Suicide and Safety in Mental Health (2022) (NCISH) suggests that GMMH accounted for approximately 11% to 15% of all inpatient deaths in England. This analysis must be caveated with the fact the time periods being compared are not the same and no adjustments have been made for differences in inpatient characteristics or other potential variables. The results nonetheless would indicate that GMMH may be atypical, and this requires more detailed analysis. The NCISH identifies that since 2015, on average, 19 deaths occur per year on inpatient wards. Acknowledging that these are small numbers, this would again suggest that the GMMH position is higher than expected.

9.60 We make observations elsewhere in our report about the lack of capacity across corporate services to focus on quality and sustained improvement. We think this still remains a factor and impedes the ability of the Trust to both understand what is happening and develop a coherent response. This lack of capacity likely meant that some of the senior clinical leaders who should be scrutinising this information were not able to do so effectively. In turn, this makes it more difficult for non-executive directors to understand and challenge the data presented to them.

9.61 At an organisational level, this has meant that the Trust struggles to learn when things go wrong, and has not been able to make the improvements needed at a pace that reduced the likelihood of further harm occurring.

Conclusion

9.62 The death of any patient under the care of NHS services is a tragedy. Deaths that occur on inpatient services can feel more profoundly distressing and patients, families and carers expect inpatient services to be a place of safety.

9.63 GMMH is trying to reduce the possibility of further deaths and has developed a plan to address these concerns. The plan could be strengthened and be more systematic in its implementation. This can be achieved by paying greater attention to workforce, culture, hearing the voice of the patient and families and the implementation of key clinical policies including the observation policy. We set out above that we have some concerns about the ability of the Trust to maintain pace and progress in making sustainable changes. We are also concerned about the Trust's ability to ensure that, where concerns arise, the Trust can check whether the issues are happening elsewhere and take the required action.

9.64 We have undertaken an initial analysis of the number of inpatient deaths. Due to the nature and timescale of this independent review we are unable to form a definitive view on whether this is commensurate with comparable organisations. Our initial view is that GMMH would appear to be atypical. The Trust has confirmed that following further review of the data by the Medical Director they acknowledge that they are an outlier for the number of inpatient deaths.

9.65 We have not looked at deaths in the community but several clinicians we spoke to raised concerns about community services and unexpected deaths. Further work is needed to fully understand these areas.

Case study 3: Death of a person in the Trust's inpatient care

Introduction

9.66 The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. Organisations are required to respond to a Regulation 28 report within 56 days of the date of the report. Regulation 28 reports, while not in themselves a judicial sanction, are a formal instruction to make improvements to protect life and if not implemented could lead to judicial action. Between January 2020 and February 2023, GMMH received 17 Regulation 28 reports.

9.67 This case study involves the tragic death of a person using the Trust's inpatient services. The purpose is to review how the Trust manages Regulation 28 reports and how the Trust's learning systems work. This review looks specifically at the use of observations and the Trust's internal management of abnormal blood results. We do not comment on the treatment plan for this individual, but focus our commentary on the governance processes. This review is limited to understanding how the organisation understood and managed those issues.

Summary

9.68 We found:

- The time taken between the identification, investigation, and implementation of improvement action in response to concerns has been considerable and is still not complete, two years and ten months after the event. There has been a change in the process for managing an abnormal blood result. This change includes a standard operating procedure and accompanying flowchart to support managing abnormal blood results safely. This change happened sometime between November 2022 and September 2023 (24 to nearly 34 months after the event). The Trust identified learning relating to the practice of observations in response to this event; however, there doesn't appear to be any substantial change to the Trust's current observation policy that relates to learning identified by the Trust in this case. One of the actions was that audits of observations would take place. The audit was not implemented with a supporting process and audits were not always being carried out. This had not been identified and the group with oversight had been told the audit was being implemented.

- A three-day report and an immediate management review undertaken within six days of this incident happening clearly state that there were no training or competency issues with regards to nursing staff undertaking the task of observations. All staff had been trained and their competency in this area tested prior to the incident. In the immediate aftermath, a member of the nursing team admitted to falsifying observation records. Subsequently, it was found that a number of the nursing team failed to follow the Trust's observation policy and falsely recorded observations in the medical records; this led to disciplinary proceedings for this individual. The management review recommended the need for a wider Trust inpatient audit to determine whether the poor practice they identified, of failing to record observations, was a practice present more widely in the Trust. It does not appear that this recommendation was enacted. This was a missed opportunity to uncover a practice subsequently identified at Edenfield. The management review does not specifically describe concerns with the falsification of records. However, we are aware that there are other concerns of this nature elsewhere in the Trust. The Trust did not give any recognition to the staff member who confessed to their falsification of the record.
- Despite this timely management review stating that there were no issues with staff training and competency in the Trust's observation practice, and the issue instead being related to a failure to carry out the task and then to falsify records, the focus of the Trust's improvement work was on improving the observation policy and staff training in delivering it. This was a missed opportunity to properly understand why staff were not carrying out the policy and then falsifying observations. We are aware that issues with observations have been mentioned by the coroner in other cases.
- Staff disciplinaries took place after the initial management review and, as a result, three staff were dismissed. Two appealed and were reinstated; the third individual did not attend the disciplinary and did not appeal. In both appeals, the staff member's inexperience was identified as a mitigating factor and the appeal panel also had concerns about evidence used in the original disciplinary panel: "*the audit concluded that there was not a negative culture around observations."*
- A serious incident investigation was carried out by an internal team ten months after the tragic incident. The sole recommendation concerning observation practice was that staff should be reminded of the importance of adherence to the Trust's observation policy.
- The serious incident investigation also made a recommendation to change the process of the acute hospital reporting back abnormal blood results to the inpatient unit. A Trust-wide safety alert was raised internally two months later (2021) to effect that change. This was issued 12 months after the serious incident happened.
- In the seven days after this Trust-wide safety alert was communicated, clinical concerns about the robustness of this proposed solution were raised and discussed by senior clinicians in the organisation via email. An alternative proposal was made that was considered to be a more robust and reliable solution. These concerns do not appear to have been acted on until at least a year later (2022/23).
- The coroner's inquest took place two years after this tragic incident and identified concerns about staff inexperience on the unit. It also raised concern that the Trust had missed an opportunity to properly understand the problems with observations. Despite the inexperience of staff on the unit having been a mitigating factor in the appeals staff made against their dismissals, the Trust took no action on this in their response to the coroner, citing their processes only.

Timeline commentary and additional relevant Information informing these conclusions

9.69 Background: in 2020, a person sadly lost their life while using an inpatient service within GMMH. The cause of their death was a physical health problem.

9.70 The three-day report comments that in the aftermath of this incident, a member of staff had confessed to a member of the management team that they had failed to undertake observations as

per policy but had signed to say that they had completed them, thus falsifying this record. Action was taken to communicate to staff about completing observations as per policy, clarify the role of the nurse in charge and undertake a review of the practice of allocation of observations. Audit processes were put in place to understand this practice more widely within this ward over the subsequent month.

9.71 The Trust put an automated response to an email address to improve communication.

9.72 An internal management review of observations was carried out six days after the event. This was completed by GMMH staff who were not part of this specialist service at the time they carried out their investigation.

9.73 The summary of its findings was that it was considered that there were enough staff on duty, but that some staff on duty on the day of the incident and, on further investigation of other days, some other staff did not carry out observations as per GMMH's observation policy. The staff identified included substantive qualified and unqualified staff and NHS Professionals staff. The investigators also reported that every member of staff had completed observation training and had their competency checked.

9.74 The only reference to probable falsification of records was:

"*…following a review of the observation sheets it was found that on the day of the incident the observations were not completed by all staff, namely 4 identified in CCTV footage and although the sheets were signed as being completed on the day of the incident it does not appear they were signed for contemporaneously as the Trust policy demands they should be.*"

9.75 This management review recommended that the staff who had failed to adhere to the Trust's observation policy should proceed to a disciplinary hearing. These staff were already suspended from duties. Changing the process of observations on the unit was suggested. The review also described increasing audit activity and retaining all CCTV footage for future scrutiny. In addition, it suggested reminding all staff of their responsibilities around completing observations, a change to induction training, and that this learning should be shared across the organisation. It also recommended that regular audits be undertaken of observation practice and CCTV footage retained.

9.76 In response to this management review, changes were made to the practice of observations on this unit alone. This included adopting a process from another similar unit, where the nurse designated the role of security undertook observations for their shift. It also recommended auditing observations and retaining CCTV footage to allow practice to be checked. This investigation also resulted in three staff proceeding to disciplinary management investigations on the grounds of gross misconduct (2020). Falsification of records was identified in these disciplinaries.

9.77 Three staff were investigated and disciplined. Two were dismissed but appealed, the third person did not appear at their disciplinary and so was dismissed in their absence and did not appeal. In 2021, the two preceptee members of nursing staff who appealed were reinstated. Within these appeals, mitigations to the original decisions were identified; these included concerns about skill mix on the day of the incident, and that the appeal panel had concerns about the conclusions of the observations audit used in the original disciplinary hearing. The appeal decision said: "*the audit concluded that there was not a negative culture around observations, the panel had some concerns about this"* and that no consideration had been given to the staff member who confessed to their error.

9.78 Later in 2021 (ten months after the event) an internal serious incident root cause analysis (RCA) was completed by staff employed within the Trust. This investigation considered the management of blood results. It described issues with communication between services that resulted in extreme difficulties in relaying crucial information to a clinician who could act promptly on abnormal blood results. Recommendations were made to remedy this.

9.79 The RCA also considered problems with patient observations; there was one reference to probable falsification of observations. This investigation confirmed that all staff were trained and competent in

delivering this skill and a recognition that the unit had put in place additional assurance using an audit within this service around observation practice. A recommendation was made that staff must adhere to the observation policy.

9.80 There was an associated action to share these findings in a learning event in the next eight weeks. It is not clear whether this learning event ever happened.

9.81 In 2021 (two months after the RCA) the Trust issued a safety alert re blood forms. This covered the recommendation made in the RCA report to ensure that when blood forms were filled in, they included the name of the unit/ward where the patient was placed.

9.82 In the days immediately after this alert, an email trail from senior doctors within the service to more senior medical staff raised concerns about the recommendation/safety alert suggesting that this was an unreliable solution and would not safely solve the problem identified. These emails identified that the abnormal blood result must be received by a clinician who could act on this result. A solution was suggested that would change the process and ensure that any abnormal blood result got actioned appropriately.

9.83 In 2022 (21 months after the event) an external review of deaths was undertaken and included this and other deaths in similar services. This was an independent review carried out by clinicians from outside the Trust. It was undertaken after a legal representative of the families involved wrote to the Chief Executive of NHS England requesting this review and the Trust agreed. This report was shared with the Trust Board members, commissioners, NHS England, the coroner, and the families of others who had died using similar services.

9.84 This was a tabletop exercise, and the purpose of the review was to provide assurance that the original investigation had followed the correct process, had been thorough and complete. and had developed comprehensive recommendations that provided further learning with reference to risk assessment, observations and monitoring of observations.

9.85 When we spoke to the external investigation team, they did not recall being made explicitly aware of the falsification of documentation. They described tight terms of reference that allowed them to look at the process of reviews but nothing outside. They had access to the previous reviews and no other material that they can remember. The review did not find any areas of concern with the Trust's investigations.

9.86 In 2022 (two years after the incident) a coroner's inquest took place. Matters of concern were raised and a Regulation 28 was issued. The coroner recorded a verdict of neglect, in that there was a failure to communicate the findings of blood tests analysed that showed a life-threatening abnormality. The matters of concern raised were about the actions the Trust had taken with regard to observations and about the levels of inexperience of staff working on the unit.

9.87 Evidence given at the coroner's court described the procedure for abnormal blood results management. This evidence suggests that the concerns raised by senior clinicians after a safety alert had been communicated in the previous year had not been actioned.

9.88 The Trust was required to respond to matters of concern raised in a Regulation 28 report within 56 days of receiving them. GMMH has a process for managing Regulation 28 – Prevention of Future Deaths reports. When such a regulation is received, the leads from the care group/service involved meet with the Trust's executive panel where an appropriate and proportionate response is agreed, and a response written to the coroner. Any actions arising are addressed via an action plan which will be undertaken and monitored by local leads. Learning resulting from Regulation 28 reports is shared more widely in the Trust through learning events, seven-minute briefings, and inclusion in a patient safety newsletter. The GMMH inquest team monitor actions arising and report on a monthly basis to both post-incident review meetings and the Quality Improvement Committee.

9.89 In 2022 the Trust held a workshop on service user observations in inpatient areas; the output of this event recognised need for more carer involvement.

9.90 After this workshop in 2022, the Trust responded to the coroner's Regulation 28: it responded with actions for two out of three of the matters for concern raised. It had no action against the issue raised about the inexperience of staff on the unit and described the current processes in managing staffing need within this service. This is despite the earlier disciplinary reviews raising concerns about the skills mix on the ward. It responded to the matters of concern about observations with actions to complete a thematic review, to review policy and practice and determine training needs, and a plan to test out within a specific area of the Trust before rolling out across the Trust.

Subsequent actions and monitoring after the Trust response to the Regulation 28 report

9.91 In March 2023 there was a workshop described as an initial engagement session to scope out practice in the Trust. This workshop identified the need for more involvement from unregistered staff and those with lived experience. A subsequent workshop took place on 19 April 2023.

9.92 In April 2023 the Quality Improvement Committee received an action plan appended to a relevant paper stating:

"*The actions arising from the Regulation 28 completed in January 2023 was for observation audits to be reviewed and any themes identified to address concerns raised by the coroner. This piece of work is currently being led by the associate directors of quality in specialist and Adult Forensic Services and will drive the review of observations policy and practice trust wide.*"

9.93 In May 2023 there was a meeting of the Therapeutic Observation Group (established sometime in 2023). This group was working to harmonise policies between the Trust and another recently acquired organisation (Wigan services) and to change the focus of observations practice. It described this work leading to a training package, competency framework and assessment and audit process. This makes no reference to the audits that were said to have been completed by January 2023, nor any themes that might have been identified.

9.94 In July 2023 the Quality Improvement Committee - Learning from Deaths Report, described actions taken in response to this Regulation 28. This was described as Service User Observation within inpatient areas. A description of actions taken included: a workshop, a thorough review of the observation policy and practice, considering best practice standards and guidance, setting out a legal and best practice framework and undertaking a training needs analysis and agreeing a competency assessment framework. After this work was completed, there were plans for a pilot to be undertaken within a division and then for this work to be rolled out across the Trust. This makes no reference to the audits that were said to have been completed by January 2023, nor any themes that might have already been identified.

9.95 In September 2023 (35 months after the event) our review team requested and received two documents describing the procedure to manage abnormal blood results. These were undated and so we do not know when they came into action. However, in light of the evidence given to the coroner, it must be assumed that this was between the coroner's court (November 2022) and the date of request (31 August 2023). Both documents describe the change in action as described by senior clinicians in November 2021 after a safety alert issued that same month, i.e., that the form must include information that ensures a clinician with authority to act receives any abnormal blood results.

9.96 The current observation policy available on the GMMH website does not have evidence of any updates associated with these actions and has a review date of June 2023. We were advised by the Trust that regular observation audits were taking place in CAMHS. We requested the audits from July 2023 and received those from one week of July (week commencing 27 July 2023) and the audits from weeks commencing 3, 10, 17 and 31 August. Initially, the Trust told us that the audits were not available for the whole of July as they had been sent to a member of staff who was not in work. The Trust told us they were exploring whether they could access the audits another way.

9.97 We then asked for the month of June as we wanted to review a complete month. Following this request, we were told that the missing audits for July had not been completed and that "*you were misinformed.*" We asked the Trust to send us the process for completing the audit and what dates

the audits were available for us to review. We were then told that "*It has come to our attention there was no formal system and process in the form of governance and the application of this audit at ward level. Furthermore, Quality Risk and Assurance Group had been advised that this audit had continued to be implemented."*

9.98 The dates that the audit was available for showed that it was not always being completed. In 2021, the audit was completed 17 times out of a possible 28 (61%); in 2022 it was completed 25 times out of 52 (48%); and in 2023 it was completed 9 times out of 36 (25%).

9.99 We reviewed the audits that were supplied from July and August. These were described on the form as an 'Observation Ward Managers Spot Check Assurance Audit'. This appeared to be a weekly audit, specifically looking at whether:

- level 3 observations and planning had been completed;
- enhanced observations had been completed;
- an MDT review had taken place;
- seclusions procedure had been followed; and
- a spot check to ask staff if they understood what they were checking for in relation to observations and how to raise concerns. These would not pick up falsification of records.

Conclusion

9.100 This review concentrated on how the Trust's systems and processes functioned in response to the opportunity to learn from the death of an individual using their inpatient services. In particular, how improvements could be made about the management of abnormal blood test results in-house and the management of observations.

9.101 It is not clear what happened between the tragic event and November 2021, when a safety alert was issued after the serious incident review in October 2021. Concerns were immediately raised about the safety alert, by senior clinicians working within these services, regarding the content of that alert and its impact on the problem it was designed to solve. Evidence suggests that actions to resolve these concerns were not taken for many months later. The documentation received by the review team describes these issues of concern being addressed, but no date as to when this happened. There seems to have been a missed opportunity for the clinicians working on the unit to be involved in workable remediation of the safety issues identified.

9.102 The actions taken around observations are difficult to follow. An initial management review was taken promptly, but a recommendation to look for similar poor practice elsewhere in the Trust was not taken forward. This review did make recommendations for a change in practice on the unit and some new assurance processes were introduced. There were no other changes. The serious incident review adds no other substantial recommendation for change.

9.103 The improvements suggested from then on lack continuity and clarity and do not address the initial finding that a number of staff who were deemed competent to carry out observations on the unit were not always doing so in the correct manner and were on occasions falsifying records. There was a missed opportunity to be curious as to why staff were behaving in this way. It is noteworthy that there were issues with observations in other similar cases and within the issues identified at Edenfield. The improvement plans appear to change and lack clarity. The focus is on changing and developing new policy and practice and training. The Trust reviewed and ratified their Therapeutic Engagement and Observations Policy in September 2023. However, it is noteworthy that it doesn't address the original problem. There was no issue with the policy and the Trust was able to demonstrate that a number of staff working on that ward understood the policy and its implementation, but for reasons that are still not fully understood, they failed to follow its guidance.

Case study 4: Review of the improvement plan

Background to the improvement plan

9.104 The level and type of oversight which NHS trusts and ICBs will have is determined by the NHS System Oversight Framework. Organisations are placed in one of four 'segments' with four being the lowest performing, and defined as 'Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support' (NHS England).

9.105 In November 2022, NHS England placed the Trust in segment 4, and it entered the Recovery Support Programme, which is designed to ensure that trusts have the intensive support needed to make improvements. The Trust has since produced an improvement plan which sets out how it will make the changes needed to exit segment 4, improve the quality of care, and start to move forward from what was exposed through Panorama.

Improvement plan: structure and governance

9.106 The improvement plan is divided into five workstreams with 139 actions in total. Each workstream has component actions and an executive sponsor. These are:

- *Patient safety*: This has 67 actions and its executive sponsor is the Chief Nurse.
- *Clinical strategy and professional standards*: This has 15 actions and its executive sponsor is the Medical Director.
- *An empowered and thriving workforce:* This has 23 actions and its executive sponsor is the Director of HR.
- *An open and listening organisation*: This has eight actions and its executive sponsor is the Director of HR.
- *Well governed and well led Trust*: This has 26 actions and its executive sponsor is the Deputy CEO.

9.107 The plan is clearly ambitious and broad ranging in its focus. In understanding the scale of change required, many people we spoke with felt that the plan is unwieldy, and it is difficult to understand what the organisation's key change priorities are. A notable comment in this area was:

"*We would have been better clearly stating what the four or five things we really want to achieve are, and putting our efforts behind these.*"

9.108 Many people we spoke to, both internally and externally, expressed a concern that the scale of what the Trust is trying to deliver could be unachievable, especially with its current leadership constraints. Four of the five workstreams now have a substantive executive lead and one workstream has an interim lead.

9.109 The NHS England-led System Improvement Board has overseen the progress of the improvement plan to date. The Trust's internal governance and oversight of the plan are still being agreed, and it is important that this is clear so that the Board can be assured of delivery and any risks. The Trust has told us that the Board has received a report which outlines the governance structure of the improvement plan through five workstreams reporting to an Improvement Steering Group. The Board also receives regular progress updates, including on risks. We have not reviewed these documents. The Trust should also consider its arrangements for having separate processes for monitoring compliance with CQC notices, as this adds further complexity to its improvement oversight.

Development of the improvement plan

9.110 The organisation consulted widely in the development of the plan and many stakeholders provided views on what should be included. We heard that significant resource and effort were put into ensuring that people were able to contribute to its content.

9.111 Nonetheless, we saw and heard concerns that the importance of working collaboratively with patients, carers and all partners has not been sufficiently reflected in the content of the plan. It is important that the Trust addresses this in light of the findings of this review regarding the strength of the patient's voice in the organisation. This is, in our view, a cultural change which needs to take place.

9.112 The Directors of Adult Social Services (DASS) wrote to the CEO and Chair on 18 April 2023 to express their disappointment in the improvement plan around the lack of acknowledgement of the partnership arrangements surrounding social care.

"*As a DASS group we have raised significant concerns on an ongoing basis regarding assurance and the safe delivery of services mainly in the integrated services within the community. As DASS we are concerned that the new duties for CQC inspection for Local authorities of Care Act duties cannot adequately be demonstrated within the integrated partnership arrangements for community Mental Health services, this risk needs to be addressed collectively.*"

9.113 The letter continued to outline areas where the improvement plan needed strengthening.

9.114 The CQC also wrote to the Trust to share concerns about the size and complexity of the improvement plan and the capacity of the Trust to deliver it.

9.115 Patient groups also shared their disappointment about the lack of patient involvement in the plan.

Content

9.116 The breadth of scope of the improvement plan is commendable and suggests the Trust's ambition for change. The plan presents a real opportunity for the new executive team to reset the Trust and signal clearly that they want to do something different. To some extent, its content has been driven by exiting System Oversight Framework segment 4 and this has put an emphasis on short-term and more transactional matters. These are essential to address, including some of the hugely important safety measures such as ligature management. This has led, in our view, to a disproportionate focus on processes and inputs, with insufficient weight given to the cultural work needed to embed sustainable improvements for patients and staff. Without this cultural work, there is a risk that actions taken will not embed, as staff and managers will not have sufficiently 'bought into' the need to do things differently in the long term. We set out the key areas for development in the improvement plan below.

- **Success measures** – These have been defined in most cases, but not all, with some items listed in this column being outputs (such as policy changes) rather than outcomes which will be felt by patients. Those overseeing the plan should consistently ask themselves "What improvement are we trying to achieve? What changes can we make that might result in this improvement? How will we know that this change will result in this improvement?" (NHS England and Improvement,2022). For actions linked to seclusion and long-term segregation, for example, there is currently no intention to measure patient experience linked to this restrictive practice. Changing seclusion practice is a complex problem and changing a policy on its own has not been shown to lead to sustained change of practice[33].

- **Realistic goals and timelines** – As of late August 2023, 24 of the 139 identified actions are overdue for completion. This is likely reflective of the scale of the plan and a need to rationalise and prioritise its ambitions. For example, the plan has an action for working with NHS Professionals to ensure all staff hired by them are PMVA trained by March 2023. This date has long since passed and the action remains open.

- **Impact** – Some actions are marked as completed but not yet tested: one of these is the Trust's new Seclusion and Long-Term Segregation policy. Policies and processes are an important part

[33] In the national Mental Health Safety Improvement Programme (Health Innovation Network, 2022) (42) to reduce restrictive practice, the biggest finding was that interventions that improve the relationships between staff and patients made the biggest difference (changing the policy was not associated on its own with any improvement). In order to make an improvement in seclusion there needs to be clarity around what the Trust are trying to achieve. If the aim, as it should be, is to reduce episodes of seclusion/segregation, then there needs to a statement of how much by and when.

of delivering safe care; it is essential that the plan and actions recognise that policies are 'work as imagined' and recognise the importance of training, skills, competence and culture in effective and safe care. There is a risk that if actions are marked as completed before their impact is understood (such as staff awareness and training on the new policy and implementation), they lose focus and oversight before changes have been made. In the case of seclusion, this is particularly important given what was exposed by the BBC.

- **Level of detail and interdependencies** – There are examples in the plan where the existing problem may not have been fully explored and understood before defining the action required. For example, an action has been recorded relating to the training of staff in PMVA. We have heard from many groups of staff across the Trust that temporary staff are reluctant to get involved in restraint, as in case of injury, they do not get sick pay and therefore will lose their livelihood. The action to address the shortfall of PMVA-trained staff does not identify what a safe number is. This action illustrates the need for the problem to be understood more fully, with the support of direct care staff, to identify the right action to address the issue.
- **Extent to which issues have been considered systemic rather than localised** – There are examples of the improvement plan treating issues in a very localised way. For example, the racism concerns raised at Park House are not explored across the Trust but are worded as a 'Park House' matter in the improvement plan, even though the Trust has acknowledged publicly that this is an issue across the organisation. There is no reference in the plan to how patients are affected by racism in the organisation. There is no mention or exploration of the impact of racism on patients.

9.117 In summary, the plan should ensure that it is prioritised, realistic, fully thought through (with the right expertise), and with appropriate outcome measures to assess its impact. Its core focus must be on delivering excellent care to patients; improved relationships with regulators, and consequently less regulatory scrutiny, should be a by-product of this and not the primary goal. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic timescale for implementing identified actions with the support of their system partners.

Conclusion

9.118 It is critical that the Trust is able to evidence learning and improvements when things go wrong. This is particularly important in the case studies we have looked at, where patients have died, and families are grieving. Families who were impacted by BBC Panorama are also experiencing their own trauma. Our analysis found that while the Trust is increasingly seeking to learn and make improvements when things go wrong, there remain long-standing cultural issues, as well as weaknesses in its governance processes which are stopping this from happening effectively. We make further commentary about these areas in Chapter 6.

9.119 Changing culture takes time and commitment, and it is important that this is fully understood by the Trust and its partners. The focus of the new Trust leadership should be on creating a learning culture, in which staff feel safe in speaking up and improving their services. We note that the Trust has made a considerable investment in developing its capability in a systematic approach to quality improvement. There is an opportunity to continue to build the governance and improvement infrastructure supporting this approach to enable delivery of some of the quality improvements that the Trust needs to make.

9.120 Alongside this, the structures and processes put in place to respond to adverse events need to enable leaders to have a clear understanding of what has happened, giving them the information they need to measure improvements and a culture in which they are able to report this safely.

9.121 In this chapter we have described how the organisation seeks to learn and improve. In the next chapter we describe what we found when we looked at other areas of the Trust.

Chapter 10 Elsewhere in the organisation

Introduction

10.1 The scope of our work included forming an opinion on whether what was identified at Edenfield could be happening elsewhere in the Trust. To do this, we assessed the main contributory factors which enabled what happened at Edenfield to unfold. We did this by reviewing the BBC journalist's dossier of evidence ('*Annex A*'), reviewing key documents relating to Edenfield, and visiting the site to understand the care environment and its challenges for ourselves.

10.2 The main conditions we identified as contributing to the failings at Edenfield were:

- Patients, their families and/or carers not being listened to and taken seriously
- A weak and fragmented clinical voice
- Unsafe levels of staffing and high use of temporary staff, leading to inadequate skills, knowledge and experience required to care for their patients
- A poor physical environment
- Poor culture, including a lack of psychological safety and low morale, including unsupportive leadership behaviours, unsound HR practices including perceived unfair recruitment and promotion and a lack of transparency about formal investigations
- Conditions leading staff to not adhere to clinical policies such as record keeping and observations
- Some staff described being treated unfairly because of a protected characteristic
- Some staff reported not being supported to acquire the skills, training and knowledge to carry out their role
- Poor governance practices

Method

10.3 We then looked for signs that these issues might be presenting elsewhere in the organisation. We called this a 'sample test'. It is important to note that we were constrained in the time we had available to apply this test, and as such we have had to limit ourselves to identifying any major risks presenting in each area. We believe there is risk in other services which should be of concern to the Board, and more detailed responsive reviews of certain services should be commissioned independently of this work.

10.4 In order to identify which areas we wanted to sample test:

- we looked for potential 'hotspots' which were evident from key documents such as the National Staff Survey, the Safe Staffing report and CQC activity reports;
- we reviewed patient safety incident investigation reports;
- we spoke with staff working in central departments; and
- we spoke to external stakeholders to seek their views.

This resulted in us visiting the following places:

1. **Park House** which provides a number of services including acute care for adults of working age, wards for older people with mental health needs and a long stay rehabilitation ward.
2. **Woodlands Hospital** which provides care for older people with mental health needs.

3. **Junction 17 and the Gardener Unit**, which provide CAMHS in both acute and a medium secure setting.

10.5 Our review involved us visiting each service to speak to staff and patients, and to form our own view of the care setting.

Conclusion

10.6 It was clear from this part of our work that these services face some significant challenges, many of which are reflective of those we found at Edenfield and could potentially lead to similar outcomes for patients. In some of these services we found indicators of closed culture environments. Staffing is low at all of these sites; at some sites we found low morale and we found evidence of staff being discriminated against based on race and ethnicity. We also found that there had been improvements in some areas, including changes to environments, some staff feeling more able to speak up, the clinical voice becoming stronger, and more visible, empowered leadership.

10.7 In this part of the review, we have not been able to fully assess the scale of the risks in these services, nor have we reviewed all the services which we identified as potential areas of concern. Had we had more time, we would have also liked to have visited:

- community mental health teams in Manchester;
- prison health services; and
- Laureate House in South Manchester which has acute wards, a psychiatric intensive care and a ward for older people.

10.8 The impact of the challenges faced by services named in this chapter needs to be understood more fully to determine the effect on quality and safety. There needs to be a second stage review which can more fully explore services potentially in distress at GMMH to understand the current state of safety, any immediate actions required, and longer-term actions to ensure that the culture and clinical model of these areas are set up to provide high-quality care.

Findings

10.9 In this section, we describe what we found when we visited the sites mentioned above.

Park House

Service overview

Park House is a 142-bed site, providing care for:

- working age adults in acute wards
- those in psychiatric intensive care
- older people
- people needing rehabilitation.

It is located in Crumpsall, North Manchester. Management of the site transferred to GMMH services in January 2017.

CQC rate mental health services by service type and not location, therefore the ratings here are for all wards which provide the service, not just Park House. Current CQC ratings are as follows:

- Acute wards for adults of working age and psychiatric intensive care units: rated inadequate overall (July 2023)
- Wards for older people with mental health problems: rated requires improvement overall. (February 2023)

- Long stay or rehabilitation mental health wards for working age adults: rated good overall. (February 2018)

Why we visited this service

Culture

For staff in North Manchester, 96 of 104 questions on the 2022 NHS staff survey had responses which were worse than the Trust average, which itself benchmarked very poorly compared to other mental health trusts in England.

Concerns had been raised by some staff that they were not being treated fairly because of their race. The Trust had commissioned an internal review into this.

CQC concerns

In 2022, the CQC had issued warning notices relating to:

- poor management of fire risks, including patients smoking on wards and staff training;
- ligature risks not being effectively managed.

A warning notice is issued when there are significant improvements needed to the quality of care. In April 2023, the CQC issued a further warning notice as the Trust had not made progress against the requirements of the July 2022 warning notice. This suggested a lack of learning and recognition of the changes required.

Physical environment

The building is old with maintenance issues, which could have been impacting on patient safety and quality of care. It has what is known as dormitory accommodation, which is where patients share their sleeping space. This has inherent issues and risks to personal safety, privacy and dignity, disturbed sleep and can present problems such as a risk of theft of personal belongings.

Staffing

There was a high vacancy rate among nursing and allied health professionals, and high use of temporary staff.

Historical concerns

In December 2020, the CQC visited Elm Ward at Park House and raised concerns regarding whether some of the wards were large enough for the number of patients being cared for in them.

In September 2021, the CQC raised various concerns regarding the environment and cleanliness of Poplar Ward. It also identified concerns regarding staff having access to up-to-date ligature risk assessments to help them reduce the risks for patients.

The Trust is aware that Park House is an old building with a number of issues which impact the safety and quality of care. The Trust's Estate Strategy 2022–2027 sets out that all but one of the Trust's high priority estates risks have been identified and located at Park House. It also states that "*it is considered unfeasible to address these in the interim period*" as a new unit has been commissioned and should be ready for patients in 2024. These risks were to be mitigated locally.

What we heard and saw

We assessed Park House against the issues we identified at the Edenfield Centre, described in the method statement above, and found that:

- The clinical voice was becoming stronger. An example of this clinical leadership was the service was moving to a system where the people with the most clinical need and greatest risk were admitted first rather than those who were impacting acute hospital Emergency Department targets.
- The medical team had a full consultant complement (including a long-term locum). They had implemented some rules about civility and worked together cohesively.

- Staff had felt able to raise their concerns with a colleague about their experience of unfair treatment because of their ethnicity.
- Some improvements had been made in response to quality concerns, such as reduction in bed numbers on the largest ward and the use of surge beds had stopped.
- Patients now had lockable storage to keep their possessions safe.
- Patient feedback was generally positive, and we observed positive interactions between staff and patients.

We also heard:

Discrimination: Some staff we spoke with told us that they experienced racial abuse from patients, and we were given examples of physical violence. This was confirmed by the findings of the internal review about the concerns raised by staff. Park House Responsive Review Report went to Board in July 2023. A media statement by the Chair of the Trust apologised and shared the findings:

The review found that the structures and culture at Park House have meant that:

- Ethnically diverse staff who engaged in discussions felt they have experienced fewer opportunities in relation to career progression, resulting in a lack of representation in senior leadership roles.
- They felt unsafe due to racial abuse from patients and that abuse has not been dealt with effectively resulting in loss of faith in the system.
- They experienced disproportionate disciplinary action at higher rates compared to their white counterparts.
- They felt unable to raise concerns for fear of no action being taken or fear of retribution.
- They felt generally excluded and unwelcome which has led to a perception of divisions between wards.

There was a pledge to address the issues identified, which included:

- the establishment of an Anti-Racism Steering Group;
- co-production of an anti-racism action plan that will set out the actions required to roll out the Patient Carers Race Equity Framework (PCREF).

Staffing: Some people told us that the lack of staff impacted the quality of care they were able to deliver. Staff were often asked to move to other wards which meant they did not know their patients as well as they might otherwise. There was a high use of temporary staff, who are not all trained in PMVA. This means that there are fewer staff available to safely manage patients when they need to be restrained, and this creates extra pressure on the staff who are trained in PMVA.

There were not enough psychologists or occupational therapists, which meant that patients could not easily access the required support for their recovery, and the multidisciplinary teams did not always include input from all professional groups.

Culture: Some staff told us that they felt that operational leaders still have the most powerful voice in the senior leadership team, and that they did not have sufficient control locally to improve the quality of care. For example, staff were told to admit patients even if they had said it was unsafe. Some staff told us they felt bullied when they raised challenges in Trust operational meetings.

Some staff did not feel empowered to make the changes needed to improve the quality of care. Some staff told us that after raising concerns about racial abuse, they had not been involved in the review, and the action plan had been developed centrally without input from those who were experiencing the issue. In the 2022 NHS Staff Survey 38.6% of staff felt involved in changes that affect their work. This was the fourth lowest score in the Trust's 24 divisions.

We were told that a small number of people had raised issues with the FTSU guardian and only one had received a response. Mostly staff we spoke with felt able to raise concerns, and that they would be listened to.

The NHS Staff Survey 2022 data was divided into 24 divisions. Park House results were in Manchester North Services which included the whole division, not just inpatient staff. Manchester North had the third lowest score of the 24 divisions with 14.5% of staff feeling there were sufficient staff to do their job (only Manchester South and Adult Forensic Services scored lower). This score was significantly lower than the whole Trust result of 24.6%.

Environment:

In terms of the environment:

- Patients told us that being cared for in dormitories impacted their recovery as there was a lack of privacy. One patient with autism said they found it very stressful being in a shared space. Caring for highly distressed patients in dormitory accommodation where they do not have their own safe space is very difficult for both the patient and staff.
- Staff described challenges with the gender mix of staff on wards which meant that they were not always able to provide gender-sensitive care or to do so they had to not follow Trust policy and best practice. One example was that there was a female patient being cared for in seclusion and female staff were required to provide observations.[34] As there was only one female member of staff on duty, they had to provide continuous observations for seven hours of their shift. This is not in line with Trust policy and NICE guideline [NG10] (NICE, 2015) which states that staff should not carry out observations for more than two hours at a time and should have regular breaks.
- Patients openly smoked in the gardens and, when we visited the site in July, nearly all acute wards had many cigarette ends in them, as did the garden. Patients told us that some people smoked in the wards.
- Senior clinicians' and administrators' offices sometimes flooded.
- Wards all had different fittings and fixtures which makes it more difficult for staff to recognise ligature risks when they move wards.

Woodlands Hospital

Service overview

Woodlands Hospital is a 50-bed unit providing care for older people with mental health needs. It is located in Little Hulton, Salford. Its CQC rating falls under that of 'Wards for older people with mental health problems'. This is rated requires improvement overall (February 2023).

Why we visited this service

Staffing

The service was short-staffed, with nurses covering more than one ward reported by the CQC in February 2023. There was a lack of medical staff.

Enforcement action

The CQC had issued a s29A Warning Notice in November 2022, specifically to this hospital. This related to staffing levels and medicines management. They had also identified issues with blanket restrictions (MHA Code of Practice, 2015) and care planning for patients.

Environment

There were concerns around poorly maintained and damp estate. Ligature risks had not been identified and acted on appropriately.

[34] Observation is a minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a patient to ensure the patient's safety and the safety of others.

Historical concerns

There was a CQC inspection of the hospital in November 2022. This found that there were not enough nursing and medical staff who knew the patients and had received basic training to keep people safe.

Staff turnover and sickness rates were high. There had been frequent occasions where one nurse was allocated to more than one ward and registered nurse associates allocated as the nurse in charge; these roles should always work under the direct supervision of a registered nurse.

What we heard and saw

We assessed Woodlands Hospital against the issues we identified at the Edenfield Centre and found that:

- Nursing staff were passionate about their patients and keen to do their best for them. They were proud that feedback had been more positive following a recent CQC revisit. It was clear that staff supported each other.
- The nurse staffing picture had improved somewhat. The introduction of a 'floater' qualified nurse meant that even if someone was off sick there, would still be enough qualified staff.
- There had been improvements made to the environment and the hospital looked clean and well maintained.
- Staff told us that the new leadership team was visible and supportive. It was commented on positively that they sat and had lunch with staff. Staff reported as feeling more listened to.

We were also told:

- The service had been particularly impacted by the pandemic, and sadly some of its patients died from COVID-19. Staff described that other areas in the Trust had been supportive during the pandemic, but they did not feel that the impact of the pandemic on the unit, and their hard work, had been acknowledged by the Board and senior leaders at the time.
- While staffing had improved to some extent, there was still high usage of temporary staff. Historically, staff told us that the service had regularly not had enough staff, with nurses often holding keys for more than one ward. This was usually at night when there was no medical cover on site. Staff told us that when they refused to hold two sets of keys, they had been made to feel selfish. One example was shared when there had been one qualified nurse for all three wards.
- Medical staffing was precarious with only one substantive consultant. The Trust had identified this as a risk and were managing it through the business continuity process. Staff described it as challenging with the number of temporary medical staff impacting on patients and them.
- Since the CQC inspection in November 2022, staffing has improved, but there remained a reliance on temporary staff who did not know the patients as well as permanent staff. Before the CQC inspection, staff had regularly had to work through a shift without breaks, they were often moved between wards and there had been lots of changes at ward manager level which had been destabilising for staff.
- There had been a lack of senior leadership visibility, which was perceived as having become worse since the pandemic. Staff had not felt listened to previously about their concerns regarding staffing and felt that managers only became visible 'when something goes wrong'. Staff did not know who senior managers in the Trust were.
- When things went wrong, such as safety incidents, there had been a lack of debrief, reflection and learning. This was now changing.

Inpatient CAMHS: Junction 17 and the Gardener Unit

Service overview

Inpatient child and mental health services are delivered through two units in Prestwich. Junction 17 is a 15-bed unit providing specialist mental health care for young people aged 13 to 17. The Gardener Unit provides care to children and young people in a forensic setting and is one of only four nationally commissioned forensic services for children and young people. At the time of our visit, there was also a five-bed ward for people aged 18 to 25 (Griffin Ward) which has since been closed.

The CQC rating for child and adolescent mental health wards is currently Good overall, with the caring domain rated as Outstanding.

Why we visited this service

Staff turnover in CAMHS overall is exceptionally high. In the National Staff Survey results for 2022, 86 of 104 questions were below the Trust average, which itself benchmarked very poorly compared to other mental health trusts in England. (See Chapter 6 Culture, about historical whistleblowing relating to this service.)

The CAMHS service had been in the same care group (Specialist Services) as Edenfield, and therefore had come under the responsibility of the same senior leadership team.

A number of people had raised concerns about the service via the FTSUG.

Historical concerns

There had been three deaths of young people between 2020 and 2021.

What we heard and saw

We assessed these units against the issues we identified at the Edenfield Centre and found that:

- Staff were passionate about providing good quality care to their patients.
- Staff delivering care felt well supported by local ward leaders.
- The senior leaders had recognised the high turnover of staff and were working to improve retention.

Some groups of staff reported that the multidisciplinary teams worked effectively together and described a supportive cohesive leadership team.

We were also told:

Staffing: In the NHS Staff Survey 2022, only 19.8% staff who worked in CAMHS (this includes inpatient and community staff) felt there were enough staff to do their job, compared with the Trust average of 24.6%.

People told us that there were not sufficient staff, especially at night. There was a recognition of a skills gap, notably with insufficiently experienced nurses. This led to challenges about supporting newly qualified staff, including how they should provide care in the least restrictive way. We heard from some junior staff that there was a lack of clarity as to how best to support young people who were tying ligatures.

Understaffing was leading to there being insufficient time to build therapeutic relationships with young people. It also means an over-reliance on temporary staff who:

- do not know the patients well;
- are not all trained in PMVA and so cannot restrain patients. This places a further pressure on the permanent staff who are trained in PMVA.

Support: Lack of staffing meant that the Preceptorship Framework could not always be followed, and examples were shared where learners had struggled to progress with their preceptorship. Nurses who were on preceptorship were not sufficiently supported and preceptees often worked

alone without another qualified nurse. This is not compliant with Trust policy and the Multi-Professional Preceptorship policy.

Culture: In the National Staff Survey results in 2022:

- 36.8% of CAMHS staff felt relationships at work were unstrained compared with a Trust score of 49.6%.
- 37.9% of CAMHS staff felt that staff involved in an error/near miss/incident were treated fairly compared to a Trust score of 47.7%.
- 64.6% of CAMHS staff would feel secure raising concerns about unsafe clinical practice compared to a Trust score of 69.7%.

The culture of the service was described as hierarchical by more junior staff, who felt criticised particularly for how they managed restrictive practice, without being given appropriate support. Staff described a fear of having their judgements undermined and talked about in safety huddles. A key comment in this area was "*Those who are doing the doing don't feel safe*". Staff described that those above deputy ward manager level felt very separate from the service.

Cultural issues were leading to burnout and resignations. Some staff did not feel listened to and had chosen to leave the service. We were told that some of this was due to staff feeling unsafe in their working environment. Some told us that they had taken their concerns to FTSU but that nothing had changed.

We heard about a number of concerns that impacted on consultant recruitment and retention across a range of areas. These included operational management overruling a clinical safety decision, and external influence attempting to overrule consultant decision-making.

While we visited inpatient CAMHS services, concerns were also raised with the review team about the community CAMHS service, where similar issues were presenting. We were told of a culture of:

- patients and staff not being listened to and patient safety concerns being disregarded
- long waiting lists
- people being discriminated against because of protected characteristics
- an inability to challenge management
- incivility from some senior managers
- failure to manage and resolve consultant group dysfunction
- 'in' groups and cliques
- a lack of senior level support.

10.10 This chapter has described what we found when we looked at other areas of the Trust. Next, we will look at how the other organisations in the system responded.

Chapter 11 System oversight

Changes in healthcare systems

11.1 Partnership working has seen an increasing focus in NHS policy in recent years, as described in previous chapters of this report. This is partly in recognition of the fact that NHS providers do not (and cannot) work effectively in isolation.

11.2 The last three years have seen enormous challenges and changes across every part of the health and care system which have altered how care is commissioned and planned. These changes were happening alongside a global pandemic which health and social care systems were at the forefront of responding to.

Impact of the Health and Care Act 2022

11.3 Until July 2022, clinical commissioning groups (CCGs) commissioned health services in set geographical locations and monitored the delivery of those services. To promote collaborative working among health and social care organisations, the Health and Care Act 2022 introduced integrated care systems (ICSs). These are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services.

11.4 ICSs operate across larger geographical footprints than CCGs did previously. This means that their oversight role of providers has effectively grown much larger. Until April 2022, there was a lead CCG identified for monitoring quality of care at GMMH, except in Health and Justice where NHS England Specialised Commissioning had this role. Meetings were held every quarter. With the move to ICS', the governance processes changed, and we heard that some of these are still in their maturing stages.

11.5 The Health and Care Act 2022 also brought significant changes to the structure of national bodies charged with oversight and support to NHS trusts. Of note, NHS Improvement, Health Education England, NHSX and NHS Digital were incorporated into NHS England, who took on responsibility for workforce planning, training and development, setting standards for use of technology in the NHS, and providing data. These mergers created significant change within these bodies, and also led to reductions in staff across national and regional NHS England teams.

Local provider collaboratives

11.6 At the same time, the ways in which specialised services[35] are overseen in England has changed, through the formation of provider collaboratives. This has involved the transfer of responsibilities from NHS England Specialised Commissioning to local provider collaboratives[36] (LPCs) to commission and oversee specialist services.

11.7 GMMH is the lead provider of the LPC for adult secure services in Greater Manchester. This means that this is the organisation which is accountable to NHS England for the commissioning and oversight of specialist services. This includes Adult Forensic Services for Greater Manchester.

11.8 It is important to note that these arrangements represent a shift in how services have historically been commissioned in the NHS, in which there was traditionally a clear distinction between the commissioner (the planner and buyer of services) and the provider (being the organisation providing care to patients). LPCs nationally are still developing the governance structures and processes to manage this shift.

[35] Specialised services support people with a range of rare and complex conditions. https://www.england.nhs.uk/commissioning/spec-services/

[36] NHS-led provider collaboratives are local partnerships of organisations which provide specialised mental health services, and they are being established across England.

COVID-19 recovery

11.9 Key staff in the Trust and system partners told us that the oversight and governance of services, internally within GMMH and also by the system, were reduced during the pandemic. This is not specific to GMMH, and nationally, a whole range of oversight meetings were stood down during the pandemic so that trusts could focus as much of their resource as possible on providing care. However, some interviewees also told us that the combination of all the structural changes outlined above, alongside the pandemic, has meant that system oversight has lost its former rigour.

11.10 Some partners described how the local and national system's approach to recovery from the pandemic had been mostly focused on acute care, with central targets set for elective surgery, Emergency Department and ambulance waiting times, and cancer referrals for example, but with no equivalent focus on mental health services, other than the Long Term Plan and the continuation of the mental health investment standard. Some system partners we spoke to reflected on the time it has taken to re-establish robust oversight of mental health providers. We were told, for example, that commissioners had expressed concerns regarding the Trust's high levels of open serious incident action plans. While this was acknowledged by its commissioners, it is unclear what action is being taken to improve this.

11.11 The pandemic led to in-person visits being stopped by a number of stakeholders including NHS England Specialised Commissioning case managers, Healthwatch[37] and CQC Mental Health Act reviewers. More generally, the CQC stopped routine visits to the NHS at the start of the pandemic and then re-started these on a risk basis, with those rated higher risk being inspected again first.

11.12 When restrictions eased following the pandemic, we heard of various stakeholders who were held at reception and unable to enter the unit. This included families and carers of patients, the Trust's Quality team staff and case managers. Healthwatch told us that they received varying degrees of engagement from the Trust, depending on which borough they were working with.

System mapping

11.13 GMMH is overseen and regulated by various bodies. When we talk about "the system" in this chapter, we are generally referring to all or some of the bodies below. We summarise the role of each of these in overseeing the quality of care provided by trusts below.

NHS England Regional Team	NHS England has seven regional teams who support local systems. GMMH and Edenfield are under the North West Regional team. The NHS England website states these teams "*are responsible for the quality, financial and operational performance of all NHS organisations in their region… They also support the identity and development of integrated care systems*."
NHS England Specialised Commissioning	Most NHS services are now commissioned by ICBs, although NHS England remains the accountable commissioner for very specialised services. "*Specialised services are accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. They are provided in relatively few hospitals.*" (NHS England[38])
Care Quality Commission	The CQC is the "*independent regulator of health and social care in England*" (CQC[39])
Integrated care board	The majority of NHS England's budget is allocated to ICBs which commission services for their populations. ICBs have taken over most commissioning

[37] Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

[38] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/our-services/specialised-commissioning/

[39] https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are

	responsibilities previously held by CCGs. They are accountable to NHS England for how they spend their funding and the performance of the system.
Provider collaborative	An NHS-led provider collaborative is a group of specialised mental health services who have agreed to work together to improve the care pathway for their local population.[40] (NHS Data Dictionary). Provider collaboratives have a lead provider. This is "*a single trust [which] takes the responsibility, and contract, to deliver a set of services on behalf of the provider collaborative*[41]". (Kings Fund 2023). As stated above, this blurring of role between provider and commissioner represents a different way of working in the NHS.
General Medical Council	The GMC manages the UK medical register, sets professional standards for doctors and doctors in training, ensures that doctors have an annual appraisal (known as revalidation) and investigates doctors when serious concerns are raised.[42] (GMC)
Nursing and Midwifery Council	The NMC is the independent regulator of nurses and midwifery professionals across the UK. It also creates resources to support nurses and midwives in their careers and influences policy in health and social care.
Local authority	Local authorities have a range of statutory functions that can extend to the commissioning and provision of aspects of healthcare. This can be achieved through Section 75 agreements that can include arrangements for pooling resources and delegating certain NHS and local authority functions to partners.

GMMH's standing in the system

11.14 The Trust was generally held in high regard in the system, with its Chair and CEO described to us as active and outward facing. The Trust had a reputation for its strong performance and ability to deliver. The award of Manchester community services to the Trust in 2017 was seen as confirmation of this, and indeed, the Trust has had a reputation as a growing organisation. The Greater Manchester ICS has two of the largest acute trusts in the country. We heard that some system partners wanted there to be a single mental health trust formed to deliver services across the whole of the Greater Manchester footprint, to mirror these enlarged organisations. These views were not necessarily supported by patient and advocacy groups.

11.15 Our review of Board minutes confirmed this external focus. Various interviews with Board members underlined that there was an appetite for further growth and business opportunities. Some people told us that they felt that this emphasis impacted on the time and capacity given to looking at the quality of the services the Trust already had.

11.16 Key interview comments in this area included:

- "*There was a view and conversation in Board that there should be a single trust for GM.*"
- "*We celebrated the chance to get Manchester. We thought if we didn't agree to this growth we would go… it was a survival tactic.*"
- "*The care group structure would help us build on developing further growth and scale.*"
- "*Culturally Manchester [community services] was a massive challenge. We probably hugely underestimated what was needed including "hearts and minds". We just spoke about delivery.*"

[40] https://www.datadictionary.nhs.uk/nhs_business_definitions/nhs-led_provider_collaborative.html

[41] https://www.kingsfund.org.uk/publications/provider-collaboratives

[42] https://www.gmc-uk.org/about

11.17 The Trust's reputation had been strengthened by the overall CQC rating of Good in 2019. This was taken as confirmation across the system that there were no significant quality concerns, although its Safe domain had been rated as Requires Improvement. We have heard that generally NHS England, previous CCGs, the CQC and Healthwatch felt that the Trust delivered well. Examples given to us included the Trust's response to the system during the pandemic, which was described as helpful and proactive, and the Trust's contribution to its acute partners' emergency departments. Conversely, the neighbouring mental health trust had had a series of reported concerns, including lower CQC ratings. We heard from some system partners that they felt that oversight of this (neighbouring) organisation had taken priority in the system.

What oversight occurred?

Introduction

11.18 This section sets out the roles that the various oversight bodies above played in monitoring the performance of Edenfield and/or the Trust more widely.

CQC

11.19 The responsibility of providing safe care sits with the Trust, while the CQC's main objective is to *"protect and promote the health, safety and welfare of people who use health and social care services*".' (Health and Social Care Act, 2008). Following the recommendations of the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust and Sir Bruce Keogh's Mortality Review, the CQC completed comprehensive inspections of all NHS trusts. Since then, it has adapted its approach and now inspects service providers according to risk, and to check whether improvements have been made. It also monitors the quality of services based on data available to it, including hard and soft intelligence which is gathered from people making complaints directly to the CQC, those who work in services raising concerns, and from system partners. Further changes are being made to how the CQC delivers its objectives. This has led to changes in roles and how inspection teams are set up.

11.20 Key CQC activity at Edenfield can be summarised as follows:[43]

- **July 2019 – inspection of Adult Forensic Services**. The CQC told us that this was prompted partly in response to concerns raised to them anonymously by staff. These related to staffing levels, burnout, staff not feeling safe to raise concerns with managers, or that the local management response was inadequate. The service was rated as Good overall and Requires Improvement in the Safe domain.
- **December 2020** – There were also concerns regarding the quality of care on Buttermere and Ferndale wards which led to the CQC raising a safeguarding alert and a meeting with the Trust to discuss the concerns.
- **July 2021** – Ongoing whistleblowing from Edenfield staff to the CQC. The CQC shared their increasing and continued concerns about this with the Trust. It is noteworthy that staff from Edenfield were raising concerns directly to the CQC and not through the Trust's internal FTSU routes.
- **September 2021** – The CQC held a meeting with the Chief Nurse and Service Manager from Edenfield. GMMH gave updates regarding Edenfield and actions that were being taken on the unit, including quality improvement projects that were due to be starting. The CQC agreed to receive updates as part of the regular engagement meetings with the Trust.
- **13 to 17 June 2022 – Inspection of Adult Forensic Services**. The CQC did feed back to the Trust its concerns about the management of ligatures at Edenfield on 17 June 2022. The CQC used its enforcement powers to issue a s29A Warning Notice which included issues about staffing and management of ligatures in acute inpatient wards but did not include any action for

[43] This information is taken from our review of CQC reports, as well as a summary timeline provided to us by the CQC.

Edenfield. It did not identify a breach of regulation in how the Trust was managing restrictive practices. It told the Trust in the report that was published on 24 November 2022, five months after the inspection of the forensic wards, that it should:

  - ensure that they have complete oversight and regular reviews of all restrictions placed on patients;
  - ensure that they have an accurate and complete picture of all long-term segregation used in the service.

- **25 July 2022** – The CQC issued its high-level feedback letter to the Trust following the well-led inspection. This did not make any specific reference to Edenfield.
- **23 September 2022** – The CQC issued a s29A Warning Notice served at provider level, which included concerns about staffing and oversight of the forensic service. At this time, the CQC suspended all the forensic core service ratings.
- **22 October 2022** – The CQC suspended all the well-led ratings for the Trust.

11.21 We understand that information used by the CQC in its ongoing monitoring of providers and in preparation for inspections varies. Our documentation review found a number of sources of evidence which pointed to clear concerns in Adult Forensic Services over time. These included:

- FTSU cases from Edenfield (since 2018);
- NHS Staff Survey data, which showed the Trust to have some of the lowest scores nationally, and Adult Forensic Services to have some of the lowest scores in the Trust (and therefore the country);
- whistleblowing cases to CQC from Edenfield;
- restrictive practice and seclusion data from Edenfield that were indicators of poor practice;
- exceptionally high turnover of some staff groups in Edenfield;
- the Impact cultural review in specialist services (2019) also showed concerns, although regulators would not be aware of this work unless it were explicitly mentioned to them by the Trust. It is unlikely that this was shared by the Trust with the CQC, given its low profile in the organisation;
- ongoing action from the CQC across the Trust, and the Trust's failure to make the improvements required.

It is unclear how much, if any, of this intelligence the CQC was provided with, although we know that several concerns were raised to the CQC directly by staff from Edenfield.

11.22 The concerns contained in these sources point to various warning signs of a closed culture, as defined in CQC guidance (CQC, updated 12 May 2022). The CQC were aware of some concerns which pointed to a closed culture, including concerns raised directly to them in relation to staffing levels, burnout, care quality and poor leadership. It is also noteworthy that the abuse shown on BBC Panorama was recorded at the same time as the CQC was inspecting the service. However, we are not suggesting that the CQC were on the relevant wards at the time of the covert filming. It would appear that the CQC's approach for assessing closed cultures was not sensitive enough to pick this up and make the necessary impact at Edenfield.

11.23 We note the CQC's different approaches to inspecting various Trust services during the pandemic and shortly after. As stated above, Forensic Services had been rated as Good in July 2019. A planned re-inspection of the service was postponed from January 2022 to June 2022 because of COVID-19. However, in CAMHS inpatient wards, a focused inspection of the Safe domain took place in January 2022, based on intelligence available to the CQC and 'reduced COVID-19 risks'. This inspection was extended to a comprehensive inspection at a time when inspections were risk-

based and no concerns were identified in the Safe domain. This approach was not taken for Adult Forensic Services, where there had been repeated concerns raised regarding staffing, culture and safeguarding of patients since before the meeting the CQC held with the Trust in December 2020. Equally, when concerns were raised about staffing in Adult Community Services, a focused inspection by the CQC took place in April 2022. This resulted in enforcement action.

11.24 We were also curious about the CQC's method for selecting which GMMH inpatient wards to visit; while only seven of 19 forensic inpatient wards were inspected, we understand that all PICU and acute inpatient wards were visited onsite by the CQC. The CQC told us that this was as a result of their sampling method, which they said targeted inspection activity to the wards where there were most concerns.

11.25 The Trust as a whole is now rated Inadequate, following the inspection of three core services in June and July 2022 and a well-led inspection, as well as a series of warning notices. Some stakeholders, and Trust staff, voiced surprise at the perceived change in how the CQC viewed and regulated the Trust after the screening of Panorama, with the feeling that the CQC is now taking higher level enforcement than pre-Panorama. The Trust and stakeholders were under the impression that the CQC inspection had gone well and the high-level feedback letter to the Trust following the well-led review dated 25 July 2022 was generally positive about leadership and culture overall.

11.26 The CQC has finite resources, and we understand that these need to be deployed appropriately. Within this, it has identified various and important observations about where the Trust must improve, including for example, in relation to fire and ligature risks. We would also suggest that there is an opportunity for the CQC to review the information it uses in its ongoing monitoring of providers, and how it uses information to prepare for inspections. This is particularly the case where it is inspecting a service at high risk of developing a closed culture. It should also reflect on how it monitored, shared and responded to the continued and sustained concerns being raised about Adult Forensic Services by staff, alongside the signs that the Trust more widely was struggling to make the necessary improvements.

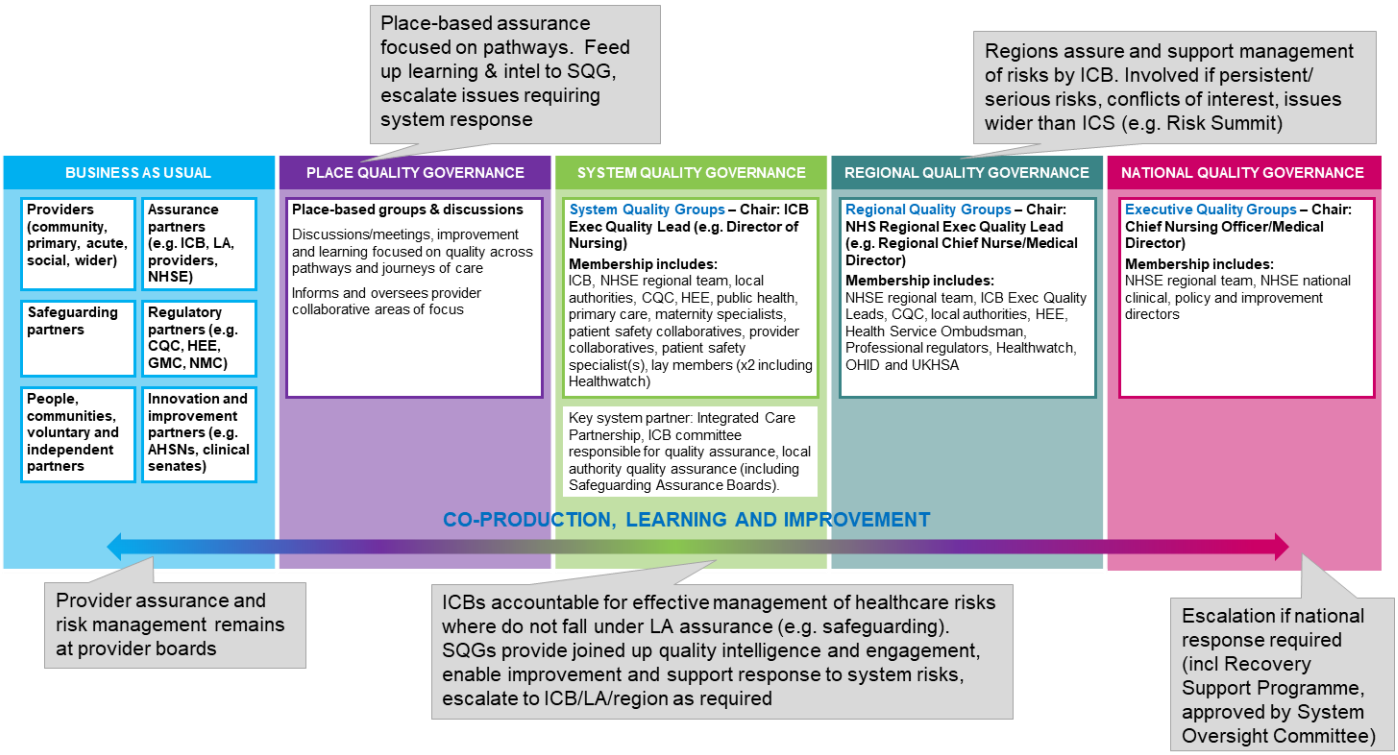
NHS England and North West Regional Team

11.27 Guidance on national bodies' expected involvement in quality governance is defined in 'Quality Risk Response and Escalation in Integrated Care Systems' (National Quality Board, 2022). It sets out the approach that must be considered by system leaders as they manage quality risks within ICSs. It also confirms the key principles:

- having a clear line of sight, including concerns and risks;
- investing in building an improvement culture;
- having streamlined, agile and lean quality structures which are standardised where possible and support partnership working and intelligence sharing;
- working closely with staff and people using services to support effective quality management.

11.28 The emphasis is on the risk being managed as close to the point of care as possible, and where successful mitigation is not possible describes the process and responsibilities for escalation and management. This is a shift from the previous approach where NHS England was the decision maker for escalating to a single item risk summit. This meeting, where stakeholders discussed emerging risks, has been replaced by a Rapid Quality Review Meeting to rapidly share intelligence, diagnose, profile risks and develop action/improvement plans and may be set up at short notice by ICBs or wider partners (e.g. local authority, NHS England, other regulators), where there is deemed to be a significant or immediate risk to quality, including safety, which is not being addressed in wider discussions.

Figure 21: National Quality Board guidance on quality governance



11.29 Due to emerging concerns, NHS England explored with the ICB whether there should be a 'single item risk meeting' to discuss these with the Trust in July 2022. This meeting did not happen, as the system already had an imminent planned meeting, known as the Quality Surveillance Group. In addition, it was highlighted that the CQC was, at that time, inspecting GMMH. It was also underlined that where concerns had previously been raised by the system in relation to GMMH CAMHS, some partner agencies in the system had taken assurance from the positive published CQC report.

11.30 This is further indicative of how CQC inspections have been used in the system, sometimes as a substitute for local, routine and agreed quality oversight processes. It is of concern that more weight was ascribed to the view of the CQC than to other partner agencies, and that the system was prepared to wait for the outcome of the inspection and report. This was a missed opportunity to consider the issues in the prison service, the warning notice for community services and to hear from all involved parties about the Trust's services.

11.31 Finally, we found that NHS England had produced a report (2021) into a mental health trust which was well regarded by the system and had been rated Good by the CQC and was subsequently downgraded to Inadequate. This report made a number of recommendations, including in relation to the importance of information-sharing within the healthcare system, and warning against an over-reliance on the view of the CQC. We found many parallels between the findings in this report and our work at GMMH. We could not see what actions NHS England had taken following this report, to ensure that its learning was shared. This, in our view, amounted to a missed opportunity to improve care at an earlier stage for patients in GMMH.

Specialised Commissioning and provider collaborative

11.32 Until April 2022, NHS England Specialised Commissioning had been responsible for quality oversight of Adult Forensic Services and CAMHS. For Adult Forensic Services, this oversight then transferred to GMMH as the lead provider in the provider collaborative, at which point the Quality and Commissioning Hub, including case managers transferred to the employment of GMMH. This is a new structure, nationally, and most lead providers are still establishing how to enact this role, which involves both a commissioning and a provision function.

11.33 We found, however, various ways in which the provider collaborative could have functioned more effectively. See also Chapter 9 in which we discuss how the Commissioning Committee handled concerns raised to it relating to an independent care and treatment review of an Edenfield patient.

- GMMH entered into a lead provider role without having a permanent Quality Lead in post. We also saw minimal clinical involvement at the Commissioning Committee. This may be indicative that the Trust did not recognise the scale of the quality assurance role it was assuming.
- Some stakeholders told us that the Trust was cautious about its reporting of serious incidents to the provider collaborative. As lead provider, it is important that the Trust sets a tone of openness and transparency. It is not clear whether this view was reported to Specialised Commissioning or the NHS England Regional Team.
- NHS England undertook due diligence before making GMMH lead provider, though the process did not identify that there had been quality and staffing concerns in its specialist services which are outlined throughout this report, and it remains unclear how explicitly case managers had been escalating this, to either Specialised Commissioning or the provider collaborative.
- As outlined in Chapter 8, potential conflicts of interest in the Commissioning Committee do not appear to have been managed robustly. Various meetings of the committee were cancelled.

11.34 The GMMH Lead for Commissioning raised the concerns from the IC(E)TR, described in Chapter 9, with NHS England North West Specialised Commissioning, Health and Justice on 30 June 2022. Specialised Commissioning personnel also shared the concerns with NHS England nationally which led to a memo being sent to Directors of Learning Disability and Autism and Mental Health about the bullying from staff, explicitly mentioned a closed culture in the unit, and that the unit had been identified "*as an area of good practice by NHS England as part of the blended model pilot*". This flagged the possibility that the Trust needed closer scrutiny, as these concerns had emerged unexpectedly. However, the NHS England North West quality team and the Regional Director with responsibility for Mental Health and Learning Disability were not informed directly of the detailed concerns from the IC(E)TR until September 2022.

11.35 In February 2023, NHS England Specialised Commissioning issued a contract performance notice to the Trust as they were concerned about the lack of a detailed improvement plan for Edenfield. NHS England Specialised Commissioning told us that they sent copies of this letter to NHS England colleagues, the CQC and the ICB.

Integrated Care Board

11.36 Until April 2022, there was a lead CCG identified for monitoring quality of care. Meetings were held every quarter where key quality metrics were analysed, such as complaints, performance and GP feedback. We heard that the Trust always performed well on quality and would have a clear recovery plan if performance was off-track. We note, however, the high degree of open serious incident cases held by the Trust. We were told that this was likely due to the Trust having low thresholds for declaring a serious incident, which is incompatible with the feedback we heard from staff.

11.37 Following Panorama, the ICB undertook a desktop review of key quality metrics to understand if it had missed any important 'red flags' at GMMH. We were told that two key findings emerged from this exercise:

- Having looked at quality metrics they had historically reviewed at GMMH, the ICB found that there were no sources of intelligence that had been 'missed', including safeguarding referrals, CQC activity, and FTSU cases.
- The complexity of commissioning of GMMH services became apparent, with various different bodies overseeing different GMMH services, all in receipt of different sources of intelligence. We were told that commissioners were not sharing information effectively with each other in any routine or structured way.

11.38 This last point underlines that the ICB is monitoring quality at a very high level and would not routinely receive some of the more worrying sources of information we identify earlier in this chapter. We understand that some of the performance oversight arrangements sat with a committee known as the Greater Manchester Provider Federation Board. This was composed of all providers from Greater Manchester, who monitored and evaluated their own performance. We believe that this model has now been amended and recognised as ineffective.

11.39 We were also struck by the lack of senior mental health expertise in the CCG's (now ICB's) quality oversight team. It is important that this is brought into the new quality oversight structure so that there is the necessary expertise to clearly understand what the data from the Trust is telling commissioners. A good example of this is restrictive practice and seclusion data, which does not seem to have featured in the ICB's retrospective desktop review.

11.40 We set out earlier in our report the significant financial challenges that the ICB is facing across Greater Manchester. The ICB has a clear role in the oversight and performance of NHS providers, and we were interested in how this was developing across Greater Manchester. Recently the ICB has been made aware of several improvements that it could make to improve some of its core functions. These include:

- developing a more cohesive set of data and performance measures for provider organisations;
- improving the quality of information and data for mental health services;
- improving how different parts of the system both understand and relate to each other including aspects of the governance structures; and
- developing a more structured approach to performance monitoring.

11.41 We were told that the ICB is still in the process of developing its quality oversight structures at the time of our review. In our view, three important points emerge from this which the ICB should take forward in the development of its governance structures:

- It is important that all commissioners of GMMH services share their intelligence with each other.
- The lack of information from safeguarding and FTSU should have been cause for further investigation, rather than taken as signs of positive assurance.
- The patient voice was missing in the oversight of the Trust. Patient groups, advocates and complaints processes had all highlighted issues which later came to light in Panorama.

Local authorities

11.42 Greater Manchester is made up of ten local authority areas, each one of which has its own place-led priorities which collectively support the city region. Five of these local authorities have a direct relationship with GMMH. Local authorities have a range of statutory functions that can extend to the commissioning and provision of aspects of healthcare. This can be achieved through Section 75 agreements that can include arrangements for pooling resources and delegating certain NHS and local authority functions to partners.

11.43 We heard that the current arrangements for working with the Trust have been difficult, with variable engagement at executive and care group level. We were told these arrangements have proved more challenging since the Trust expanded. More recently, the Directors of Adult Social Services (DASS) have sought to develop a more cohesive strategic relationship with the Trust, aligned to a more collaborative approach at service level. We were told that this was, in part, influenced by difficulties in the current governance arrangements and a view that some staff feel disconnected from their Council as their employer.

11.44 The DASS recognise the difficulties for the Trust in working across five local authorities and have asked for greater ownership from GMMH at executive level regarding the Section 75 agreements in place. They have expressed concerns regarding the delivery of community services and are

working with the Trust to develop more effective oversight and governance arrangements in relation to the delegated duties from the councils to the Trust.

Nursing and Midwifery Council (NMC)

11.45 The NMC is the independent regulator for nurses and midwives in the UK, and nursing associates in England. It receives referrals where there are concerns about a nurse's practice. We asked the Trust for details on how many nurses it had referred to NMC between April 2020 and March 2023. The Trust told us it was 89. We asked the NMC for the same data and it told us they had received 63 referrals between April 2020 and March 2023. Some of these referrals came from routes other than the Trust, which means there is a discrepancy in the data. The NMC told us that there are many variables which make it difficult to comment on or compare the number of referrals received and it is also difficult to compare trusts against one another as they will offer a variety of services, use different models of employment for staff and have distinct workforce sizes. We believe this seems a relatively high number of referrals for one organisation in a three-year period.

General Medical Council (GMC)

11.46 The GMC is the independent regulator for doctors in the UK. The GMC had not received any referrals (and so there are no open cases) recorded against Edenfield. Between April 2020 and March 2023, the GMC received 31 complaints recorded against GMMH, of which one remains in progress.

Conclusion

11.47 Our review found clear indications that there had been long-standing quality and cultural issues at Edenfield. These were happening in the context of a Trust which was struggling to make and sustain improvements across various services. National and legislative changes to the way that health services are monitored, as well as the pandemic, had led to the oversight of the Trust being reduced.

11.48 Different bodies were in possession of different sources of information about the Trust, and it appears that these could have been shared in a more purposeful and systematic way to ensure a clear picture of service quality.

11.49 Actions taken by other stakeholders have followed action taken by the CQC and do not appear to have been taken independently, based on their own findings and monitoring.

11.50 In effect, there were several warning signs at Edenfield which could have been picked up and acted on sooner, not least by the Trust's internal quality governance structures. These include:

- patient concerns and complaints being raised;
- potentially high levels of restrictive practice and potentially very long seclusion and segregation rates;
- some of the lowest staff survey scores in the country, including around psychological safety;
- high turnover of staff;
- a dearth of FTSU cases (yet reporting of these to the CQC); and
- a lack of safeguarding referrals.

11.51 All of these indicators are suggestive of a closed culture, as defined by the CQC. The methods used by the CQC in its oversight of the service do not appear to have been sensitive enough to pick these up in a timely way nor to inform their initial ratings or enforcement activity.

11.52 Similarly, there were signals that the Trust more broadly was facing challenges which do not appear to have impacted on stakeholders' views. These included:

- CQC warning notices, that were not being closed on a timely basis;

- high numbers of open serious incidents, with action plans not being closed on a timely basis;
- inpatient deaths, including of three young people on CAMHS wards;
- concerns that learning was not taking place, which were flagged by the coroner in Prevention of Future Death Notices. As referenced earlier in this report, between January 2020 and February 2023 GMMH received 17 Regulation 28 reports;
- some of the lowest NHS staff survey results for mental health trusts nationally;
- exceptionally high nursing vacancies; and
- all of these issues occurring after the Trust's rapid growth.

11.53 In writing this chapter, we acknowledge that, since March 2020, the NHS has faced its biggest challenge, in dealing with the pandemic and its aftermath. The recovery of services post-pandemic has had to happen during a period of enormous change in the health and care landscape. This was echoed by a system leader we interviewed who said that "*whilst we have a great deal to do, the system lacks compassion. The Trust needs to organise itself to support the five place areas, but system partners need to be more sensitive to the pressures we are under.*"

11.54 However, it is difficult to see how the system identified, joined up and responded to warning signals about the Trust and Edenfield specifically, prior to Panorama. Restructures made since the Health and Care Act 2022 provide an opportunity to reset quality oversight processes, so that partners can ensure that they are assessing care quality through the lens of patient experience.

11.55 This report has set out how connected the issues are that led to the failures of care. The next chapter sets out our recommendations for the Trust so that it can make the changes needed to create sustained improvements.

Chapter 12 Recommendations

Overview

12.1 We have used a systems-based approach in completing this review. We wanted to show that the issues we identified are not independent of each other but interconnect and influence each other. In order to achieve the improvement needed to provide high-quality care, the recovery plan must consider these recommendations in combination and not as stand-alone actions. This is why we have placed all the recommendations together in one chapter and not isolated them at the end of each chapter. Within this review, 'quality' is taken to encompass safety, effectiveness, and a positive patient experience.

12.2 Each recommendation refers to areas for improvement identified during this review; they are blended to allow the Trust flexibility in their practical implementation and are described to encourage a system-based approach to make many of the changes needed. Their design also allows for some local determination by the Trust. However, it also recognises that GMMH is in a period of transition and will require ongoing support to ensure it understands the scale of the changes required. Assurance will be based on an assessment of the evolution of these systems against their aims.

12.3 Each planned improvement must have clear aims, a set of actions to be taken to achieve them, and an evaluation to show progress towards the aims. The Trust has previously used the mantra: "*clinically led, managerially partnered and academically informed*", which was well recognised by staff we spoke to. It seems pertinent to many of the improvements required, and the Trust may wish to reignite the use of this strapline in its continued journey.

12.4 In implementing our recommendations, a fundamental component will be supporting GMMH in continuing to create a culture of improvement. This will not happen overnight, and stakeholders and partners will need to work alongside each other in enabling GMMH to thrive and safely manage risk.

12.5 The Board and system partners must assure themselves that GMMH has the capacity and capabilities to deliver these recommendations. We would strongly recommend that the Board encourage the Trust to look to organisations external to themselves to find best practice that they might take and adapt into their services.

12.6 Due to the complexity and scale of work the Trust knows it must do, in conjunction with an already significant improvement plan, the recommendations we make in this chapter focus on actions the Trust must commence over the next 12 months to build solid foundations for a sustained improvement journey. The review team will undertake an assurance visit in approximately 12 months' time to determine the progress made.

Patients, families and carers

12.7 **Area for improvement:** The Trust has not kept patients, families and carers at the centre of their service delivery. It missed opportunities to hear the voices of patients, families and carers when services failed to meet expectations and, in the case of Edenfield, care has sometimes been abusive, unkind and unsafe. The Trust's previous strategies in relation to engagement with patients, families and carers have not been fully effective.

Recommendation 1: The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services. They have developed a strategy in this area, which now needs to be implemented and evaluated to understand its impact.

12.8 The Trust must continue to work on these areas in the first year:

- Carry out a full appraisal of the Service User Engagement Strategy with all relevant stakeholders to ensure that its aims are being delivered and that it meets the needs of the

Trust's communities. This evaluation must assess the degree of cultural sensitivity and responsiveness enabled by the strategy.

- Systems to represent and respond to patients' expertise at every level of the organisation.
- Systems to represent and respond to family and carers' voices at every level of the organisation.

Clinical leadership

12.9 **Area for improvement:** The voice of clinicians is undervalued and weak in the Trust. We heard this from all professional groups, and especially from direct care nursing staff. It has been further muffled by a more dominant operational voice. The organisation needs to develop and nurture a strong clinical voice that is present at every level and in every forum across the organisation, so that clinical quality is at the centre of every decision made.

Recommendation 2: A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

12.10 The Trust must continue to work on these areas in the first year:

- Systems for developing robust clinical leadership, which includes a clear understanding of roles and responsibilities and expectations.
- System of high-quality supervision, mentoring and coaching to support clinicians undertaking clinical leadership roles.
- Evaluate the effectiveness of the care group triumvirate model.

Culture

12.11 **Area for improvement:** The culture of an NHS organisation is determined by the Trust Board. This Board allowed a dysfunctional executive team with a culture that valued operational performance above clinical quality. The Board did not balance its responsibilities to its external environment with its responsibilities to its internal quality of services. Furthermore, the Trust has had a poor patient safety culture, and we heard consistent reports of management behaviours at every level across a number of services that have discouraged and suppressed staff speaking up about quality concerns. This has had a major impact on the Trust's ability to deliver safe care. The Trust has not always provided an equitable experience and opportunity for their staff with protected characteristics.

Recommendation 3: The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor. This culture must ensure that no staff experience discrimination.

12.12 The Trust must work on these areas in the first year:

- The Board must reflect on the findings of this report and what happened at Edenfield in order to develop a clear set of expectations about the values and behaviours expected from all staff working within the organisation.
- Develop systems that deliver and measure key aspects of culture so that staff and leaders can be held to account for demonstrating values and behaviours that support the development of a new and healthy organisational culture which encourages and listens to people.
- The organisation must work with staff to develop systems which support a culture of inclusion and engagement that addresses concerns in relation to equality and racism.
- Review the current leadership programme and ensure that its content covers these key areas. Prioritise this programme's delivery.

Workforce

12.13 **Area for improvement:** The Trust is failing to provide an environment that supports staff to provide high-quality care and maintain their health and wellbeing. The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements that the Trust can make in its workforce planning. Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff, as well as permanent staff.

Recommendation 4: The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the stability of nursing staff. The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.

12.14 The Trust must continue to work on these areas in the first year:

- Develop a strategy for the recruitment and retention of staff and an associated delivery plan; with systems to support the Trust to understand the potential impact that unstable staffing (particularly among nurses) has on the quality of their care and to adapt to these challenges.
- The systems to ensure that staff are encouraged to speak freely and that they are listened to when they raise areas of concern or areas for improvement.
- The systems to ensure that staff have the right knowledge, skills, supervision and mentoring to perform their roles.
- The systems to ensure that staff health and wellbeing are supported.

12.15 We know that the quality of the environment impacts on patients, their families and the workforce; a number of the buildings within the Trust estate are no longer fit for the purpose of providing modern mental health care. The Trust is undertaking some rebuilding to improve their estate. However, buildings are not always maintained to a standard that allows services to be delivered safely, and issues with the fabric of buildings are not always reported and if reported not always maintained in a timely way. Where safety critical maintenance is not being undertaken, mitigation should always be considered to manage risks that this creates. Ward environments are not always clean and uncluttered.

Recommendation 5: The Trust needs to have a better understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe environment. It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

12.16 Within the first year the Trust must continue to:

- The Trust Board must assure itself about the quality of its estate and safety within it.

Governance

12.17 **Area of concern:** The current (and historical) governance structure has not been effective in escalating information in ways that are sufficiently timely, clear or useful. The reasons for this are twofold. Firstly, that the structures and processes in place are unclear, including a poor use of data and intelligence to understand the current quality of services. Secondly, the organisational culture has inhibited the raising of concerns at every level. This has had a significant detrimental impact on the Trust's ability to learn and improve in its services.

Recommendation 6: The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right

level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

12.18 The Trust must continue to work on these areas in the first year:

- Ensure that governance functions (including, but not limited to, safeguarding and complaints) are adequately resourced to meet the needs of the size of the Trust.
- Ensure that the governance framework supports the necessary information flows for staff at all levels to manage and improve quality (from Board to floor).
- Develop systems that proactively scan for safety concerns across its services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.
- Design a quality management system to enable the systematic planning for, maintaining and improving quality.

Edenfield

12.19 **Area for improvement:** Edenfield has not been able to consistently provide the forensic services that its patients need and deserve. At times, services there have been unsafe, unkind and abusive to those using them. Management behaviours have actively discouraged and suppressed concerns being raised and there has been long standing dysfunction in the consultant group, which has impacted adversely on relationships and consultants' leadership.

12.20 The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements this service must make. Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff alongside permanent staff.

12.21 The journey to developing the high-quality service patients, families and staff want it to be will take time. The improvements required will need to be sequenced to ensure that they can be sustained over time. We encourage the service to look outside itself to find best practice within other organisations.

Recommendation 7: The Trust must ensure that Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve this.

12.22 The enhanced leadership team have made a good start on Edenfield's recovery and need to continue to build in the following areas over the next year:

- The clinical model to deliver best forensic practice.
- The systems that deliver and measure key aspects of culture with particular emphasis on compassionate, high-quality care and a positive patient safety culture.
- The systems to ensure that the lived experience and expertise of patients and families are central to the work of the service.
- The use of data and intelligence that gives leaders meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.
- The systems that encourage staff to report quality concerns and improvement ideas.
- A review of advocacy services in Edenfield to ensure that they are delivering the intended benefits for patients there which includes how leaders value advocacy.

- The systems that support all staff, including those who are temporary, to work effectively in multi-professional teams. This should include consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing.
- The systems that ensure that the internal environment is clean, safe and fit for purpose.

Improvement plan

12.23 **Area for improvement:** The current improvement plan is large and ambitious. The problems the plan is trying to solve are not clearly defined, and actions often lack appropriate consideration of how their impact will be evaluated. Prioritisation is not focused on what would make the most difference to the quality of care for people using services, or the experience of people working in these services. Already, some actions have not been completed in the timeline described. The safe and sustainable delivery of this plan is fundamental to rebuilding the trust of stakeholders (including patients and staff) in the organisation.

Recommendation 8: The Trust should review the improvement plan again following receipt of this report's findings to develop further clarity about the problems that they are trying to solve and the actions that need to be taken to achieve better outcomes. It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan should be prioritised to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from GMMH. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic timescale for implementing identified actions with the support of their system partners.

12.24 The Trust must continue to work on these areas in the first year:

- Articulate clearly the problems the Trust is trying to resolve. This process needs to involve clinicians and service users.
- Ensure that impact measures are clearly defined and that the Trust knows how it will measure them.
- Ensure the plan is prioritised, sequenced, and the first 18 months of work are described clearly.

Elsewhere in the organisation

12.25 **Area for improvement:** In each area we were struck again by the commitment of staff and their desire to improve their services. We found evidence of concerns in all of the services we visited. Some of these reminded us of the culture and working practices at Edenfield, which precipitated the abuse and poor treatment of patients which Panorama uncovered (such as low levels of staffing and psychological safety).

Recommendation 9: We identified some common concerns across services we visited at the Trust, which were also prevalent within Edenfield. The Trust and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below.

12.26 Within the first year:

- The Trust should urgently review how it identifies safety concerns and initiates sustainable learning when people die unexpectedly while using their inpatient services.
- The GMMH Board needs to immediately ensure that it has an up-to-date and accurate view of the current levels of safety within each of the services referenced, and controls in place to address any immediate risks. This should include a re-assessment of the effectiveness of their ligature reduction plan.

- NHS England should consider whether they, and GMMH, require a more detailed review of deaths across both inpatient and community services to ensure that safe care is being provided and to maximise every opportunity to learn, in line with contemporary practice.
- As a second stage review, the Trust and its partners should identify together where and in which services further independent assurance is needed. We recommend that Community Mental Health Services are independently reviewed.

System oversight

12.27 **Area for improvement:** The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting providers did not identify and respond to the failings happening within GMMH prior to BBC Panorama airing. We consistently heard that the Trust had a reputation for strong performance and its ability to deliver, despite there being signals of significant quality concerns across several of the Trust's services. The regulator did not identify some of the key safety issues in relation to closed cultures and poor patient care.

Recommendation 10: The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation.

12.28 There are a number of areas that must be implemented in the first year:

- Within each organisation discussed in this report, review the assurance architecture for the oversight of GMMH and consider why this failed to identify workforce, culture, and quality concerns at an earlier stage.
- The ICB should review the level of mental health expertise it has in its oversight of mental health organisations, ensuring that its staff have the relevant experience and seniority to be able to identify leading quality concerns in providers.
- The CQC must define why their oversight of the Adult Forensic Service did not identify a closed culture or that the service was at risk of developing one, as per their definition.
- Redesign systems to support better partnership-working between external agencies, so that information is shared and understood in a timely way to identify potential services in distress.
- Review how the system supports the Trust to ensure that their approach is focused on enabling the Trust to identify priorities, make the improvements needed, and model, at a system level, the compassionate leadership that is required to achieve sustainable change.

12.29 **Area for improvement:** The Greater Manchester Adult Secure (Northwest) provider collaborative, in its present format, is not effectively fulfilling its quality oversight responsibilities, and lacks the necessary clinical input to support this role. There appears to be an overall lack of clarity about the purpose of the collaborative and the subsequent governance structures required to support the delivery of this role. GMMH acts as the lead provider within this collaborative.

Recommendation 11: NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this report in relation to Adult Forensic Services (and wider issues in the Trust's Specialist Services), the role of GMMH as lead provider needs to be reviewed by NHS England. If this arrangement is to continue, support should be provided to GMMH to stabilise the current situation and to develop it to deliver the role effectively in the future.

12.30 There are a number of areas that must be reviewed in the first year:

- NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role.
- Review GMMH's position as lead provider in the provider collaborative.
- NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

Chapter 13 Conclusion

13.1 We hope that this review will support GMMH to provide high-quality services to the people and communities they serve. We know from listening to so many people, that this is what their staff want, it is what their patients, families and carers want, and it is what their communities deserve.

13.2 A fundamental change in emphasis is required to achieve this. The priority must be on people, on quality, and it must be on listening to those who use and work in their services. The Trust has many positive attributes, not least its many talented staff. It must focus on enabling those staff to thrive. This will require a significant cultural shift if the required changes are to happen successfully. The scale of this should not be underestimated. We have seen some signs that the changes are starting to happen and, if sustained, this is a positive step forward.

13.3 We heard from some that staffing at the Trust is too constrained to meaningfully change culture. Our view is that culture starts with the Board which dictates the tone of the organisation, what is important, the extent to which staff feel listened to, and the priority given to continuously improving services.

13.4 The partner organisations that work alongside the Trust must also focus on supporting GMMH to make improvements and model the compassionate leadership that is required to achieve sustainable change. These will not be achieved by ticking a box in an action plan; the change will be made by creating a vision and a future for the Trust that people believe in.

13.5 Finally, we were drawn to the words of Dr Bill Kirkup: "*The first step in the process of restoration is to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings.*" (Kirkup, 2015). GMMH must adopt a similar philosophy and with this, positive change will come. We hope the Trust will use this review to reflect on what has happened and to now focus on the future and the changes that need to be made.

Appendix 1 – Review terms of reference

Background

The following terms of reference are for an independent review regarding failings of care and treatment provided to patients at Greater Manchester Mental Health NHS Foundation Trust, with the Edenfield Centre being the primary focus of the review.

While the Edenfield Centre is the focus, the review will also determine if, in identifying any issues regarding patient care or the oversight of quality, this indicates concerns in other areas of the Trust. This will be informed by evidence and information obtained from key parties including patients, families and staff.

Professor Oliver Shanley OBE ('the Chair') is appointed by NHS England to chair the independent review. The Chair will appoint those with appropriate experience to help deliver these terms of reference, including:

- An expert panel and specialist advisers
- Secretariat functions to be delivered by Niche Health and Social Care Consulting

The review findings will be informed by hearing directly from patients, families, and staff to understand their concerns, and how Greater Manchester Mental Health NHS Foundation Trust has responded to these.

Purpose and scope of the independent review

To undertake an overarching independent review that will deduce, scrutinise and assess areas of concern. It will focus on how these incidents were able to happen and why the failings were not picked up. Crucially, the review will provide:

1. An independent assessment of what has happened within the Trust's secure services and identify conclusions and lessons. This assessment will ensure it identifies the actual reality of care for patients and staff.
2. An assessment of the culture, leadership, workforce planning and governance that may have impacted on the ability of the Trust to improve patient safety, treatment, and care, including how the Trust involved patients and families. This will include observations on culture that may have led to failures in professional standards.
3. An assessment of the adequacy of the actions taken by the Trust since the concerns were raised. This will include whether the Trust can demonstrate broader organisational learning to improve the quality of its services.
4. The review will consider whether the processes, actions, and responses of regulators, local commissioners, NHS England's Specialised Commissioning function, and other stakeholders relevant to the provision of secure services were satisfactory in responding to and predicting concerns about the quality of care.
5. Whether the Trust's current systems, processes and controls would give rise to the identification of similar issues now (and going forward) in all areas of care delivery.
6. Whether the issues identified in 1 to 5 above indicate concerns in other areas of the Trust.

The review period will consider any concerns that have been raised from April 2021 to March 2023, including, but not limited to, HM Coroner. The review will aim to provide assurance to patients, families, staff and the broader public regarding the quality and safety of services provided by Greater Manchester Mental Health NHS Foundation Trust.

Methods and approach

The independent review will focus on the experience of the people and families affected and the response of the Trust. This will have reference to clinical standards for mental health care during the period including, but not limited to, areas such as the use of restraint, seclusion, record keeping, and restrictive practices. The independent review will listen to the concerns of the affected patients and families, use their experience to inform the key lines of enquiry, and provide an opportunity for them to be heard.

The review will consider both quantitative and qualitative information, notably the lived experience of patients, families, and staff. The review team will use a range of recognised patient safety approaches to learning from incidents in line with best practice. Importantly, this will be underpinned by a commitment to compassionate engagement and involvement of those affected.

The independent review will also consider and report upon any good and notable practice observed.

Outcome of the review

Taking account of improvements and changes made, the review will aim to provide lessons helpful to Greater Manchester Mental Health NHS Foundation Trust, but also more widely where there are broader opportunities for improvement.

The review will submit a report to NHS England by September 30, 2023, which will include:

1. A full assessment against all aspects of these terms of reference
2. A description of the evidence used to underpin those findings
3. The identification of any areas of good practice
4. The identification of any care or service delivery problems
5. A full suite of agreed actionable recommendations, where deficits have been identified
6. A proposal to conduct an assurance follow up visit with key stakeholders 12 months after publication of the report, to assess implementation and monitoring of associated action plans.

Appendix 2 – National Staff Survey – analysis and benchmarking

We analysed the GMMH results from the National Staff Survey from both 2022 and 2021. The latter was to understand if there had been a significant deterioration of staff responses following the BBC Panorama broadcast.

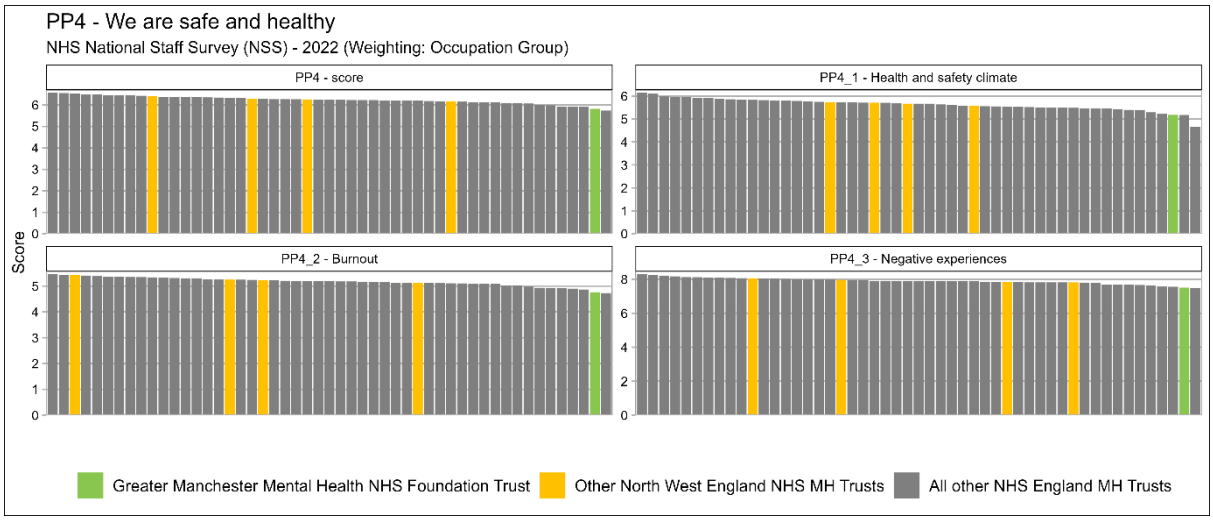
In one exercise, we compared GMMH's scores against all other English mental health trusts' scores. In a following exercise, we compared the scores of GMMH Forensic Services with those of the Trust's other inpatient services.

In this appendix, we have shown some key findings arising from this analysis.

1. People Promise 4 – We are safe and healthy.

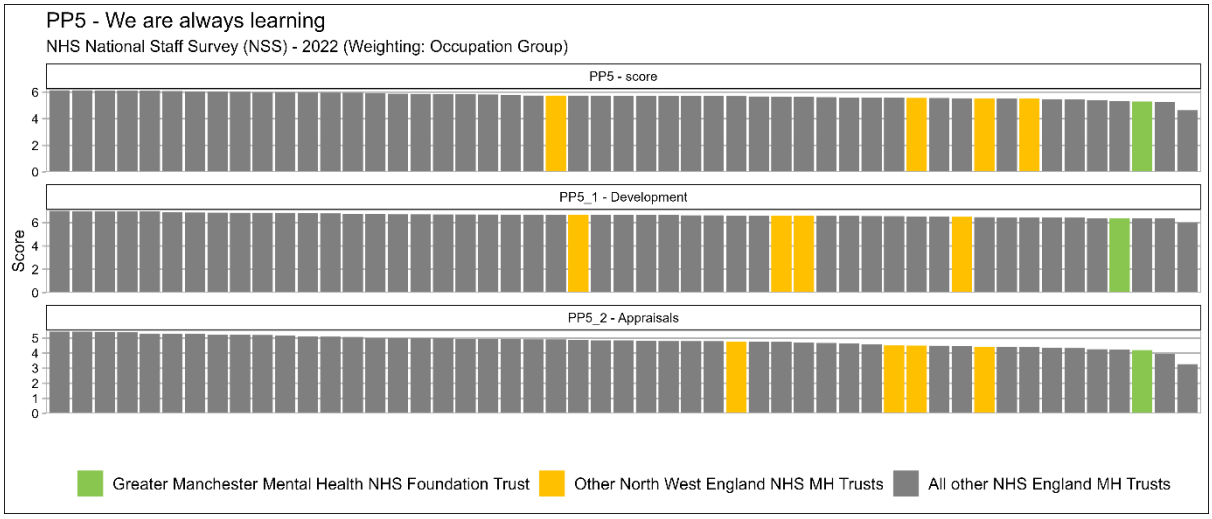
In 2022, GMMH scored 5.8 on People Promise 4. This is the second lowest score of all NHS England mental health trusts. The 2022 GMMH score for People Promise 4 has decreased by 0.2 since 2021, when it obtained the sixth lowest score of all NHS England mental health trusts.

In 2022, GMMH scored 0.4 lower than the Northwest average and 0.5 lower than the National average.



2. People Promise 5 – We are always learning.

In 2022, GMMH scored 5.3 on People Promise 5. This is the third lowest score out of all NHS England mental health trusts. The 2022 GMMH score for People Promise 5 has decreased by 0.2 since 2021, where it obtained the 14th lowest score of all NHS England mental health trusts.



In 2022, GMMH scored 0.2 lower than the Northwest average and 0.4 lower than the National average.

3. Staff engagement

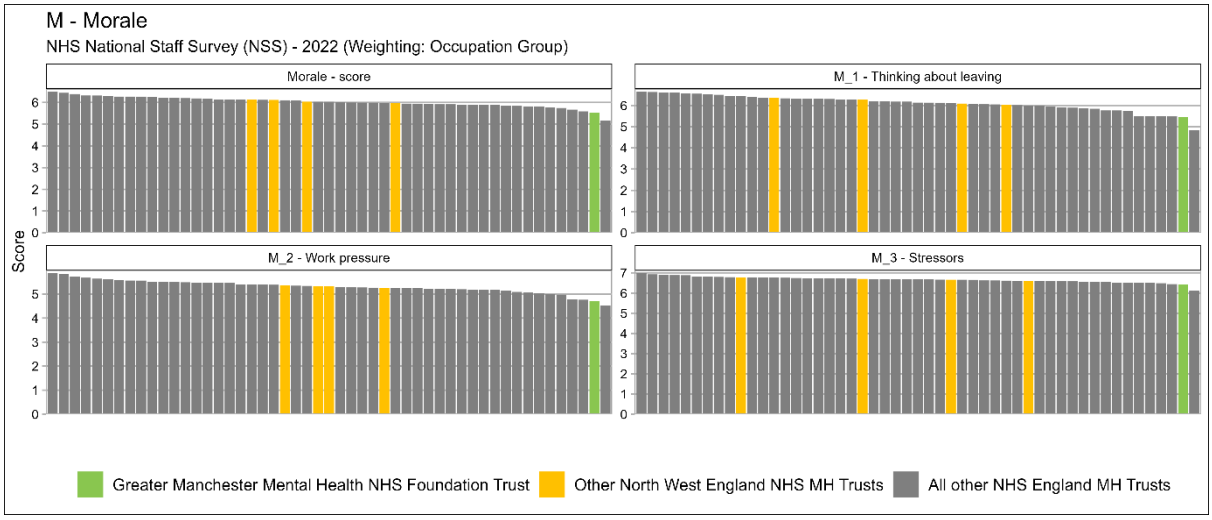
In 2022, GMMH scored 6.5 on Staff Engagement. This is the second lowest score out of all NHS England mental health trusts. The 2022 GMMH score for Staff Engagement has decreased by 0.4 since 2021, where it obtained the fifth lowest score out of all NHS England mental health trusts.

In 2022, GMMH scored 0.5 lower than the Northwest average and 0.6 lower than the National average.

4. Morale

In 2022, GMMH scored 5.5 on Morale. This is the second lowest score out of all NHS England mental health trusts. The 2022 GMMH score for Morale has decreased by 0.3 since 2021, when it obtained the seventh lowest score out of all NHS England mental health Trusts.

In 2022, GMMH scored 0.4 lower than the Northwest average and 0.5 lower than the National average.

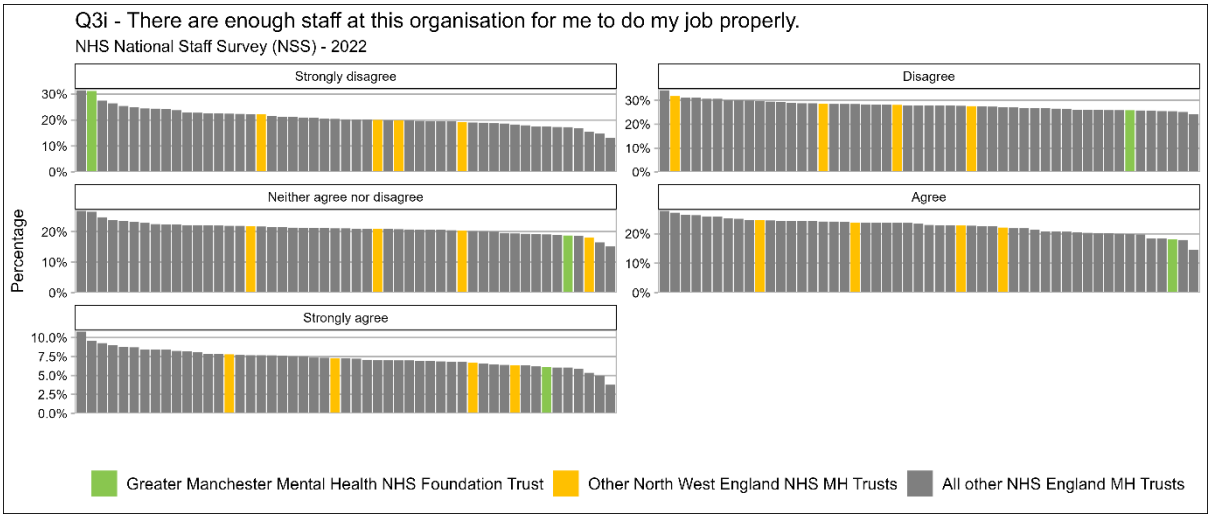


5. There are enough staff at this organisation for me to do my job properly. (Trust response)

In 2022, 57% of staff disagree or strongly disagree that there are enough staff at GMMH to do their job properly. This is the fourth highest percentage when compared with all other NHS England mental health trusts and is 4% higher than in 2021 (when GMMH had the seventh highest percentage).

In 2022, GMMH had 7% more than the Northwest average and 6% more than the national average either disagree or strongly disagree that there are enough staff at GMMH to do their job properly.

In 2022, GMMH had 24% of staff agree or strongly agree that there are enough staff at GMMH to do their job properly and 19% neither agree nor disagree.

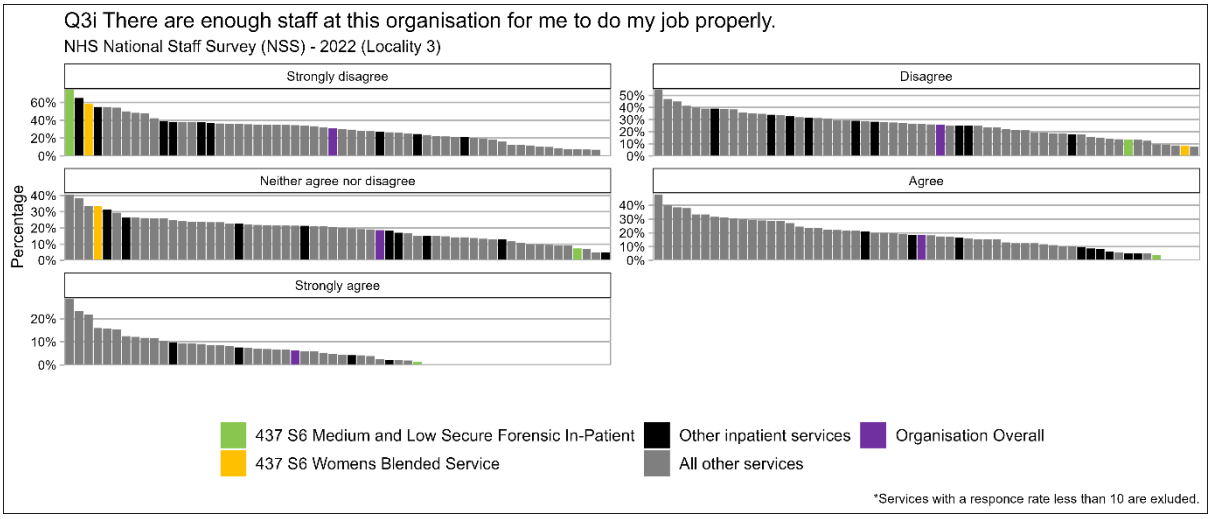


6. There are enough staff at this organisation for me to do my job properly. (Internal benchmarking)

In 2022, Forensic Services averaged 85% of staff disagreeing or strongly disagreeing that their organisation has enough staff. Compared with all other GMMH services, Forensic Services had the fourth highest percentage (out of 60 services), with the percentage significantly higher in 2021 by 28%.

In 2022, Forensic Services had 16% more than the inpatient services average and 28% more than the GMMH average either disagree or strongly disagree that the organisation has enough staff.

The Medium and Low Secure services had 88% of staff disagree with the statement, whereas the Women's Blended Service had 67% disagree.

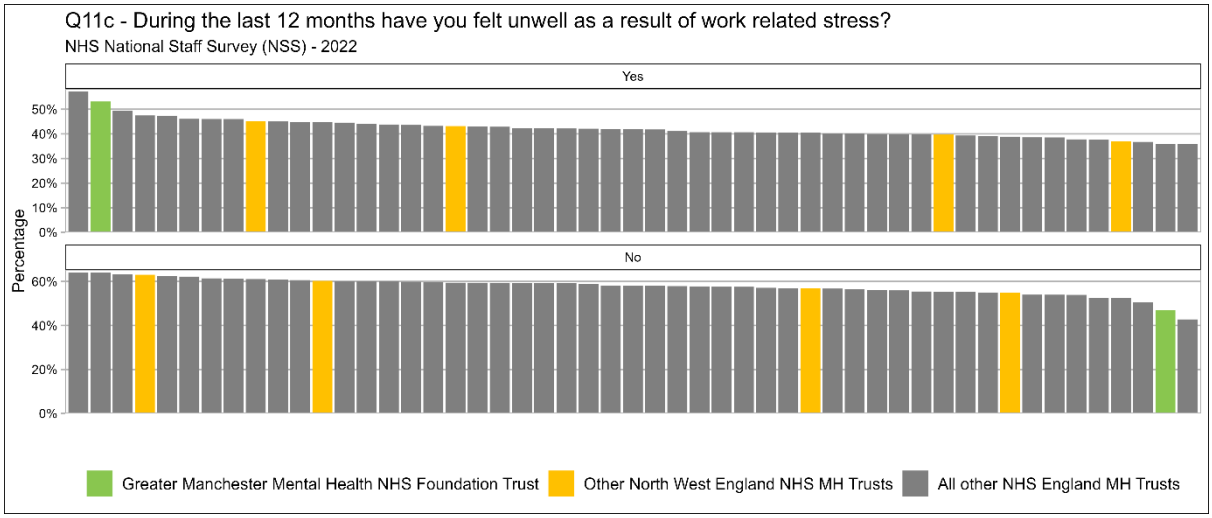


7. During the last 12 months have you felt unwell as a result of work-related stress? (Trust level)

In 2022, 53% of staff answered yes when asked if they have felt unwell as a result of work-related stress in the last 12 months. This is the second highest percentage when compared with all other NHS England mental health trusts and is 4% higher than in 2021 (where GMMH had the sixth highest percentage).

In 2022, GMMH had 10% more than the Northwest average and 11% more than the national average answer yes when asked if they have felt unwell as a result of work-related stress in the last 12 months.

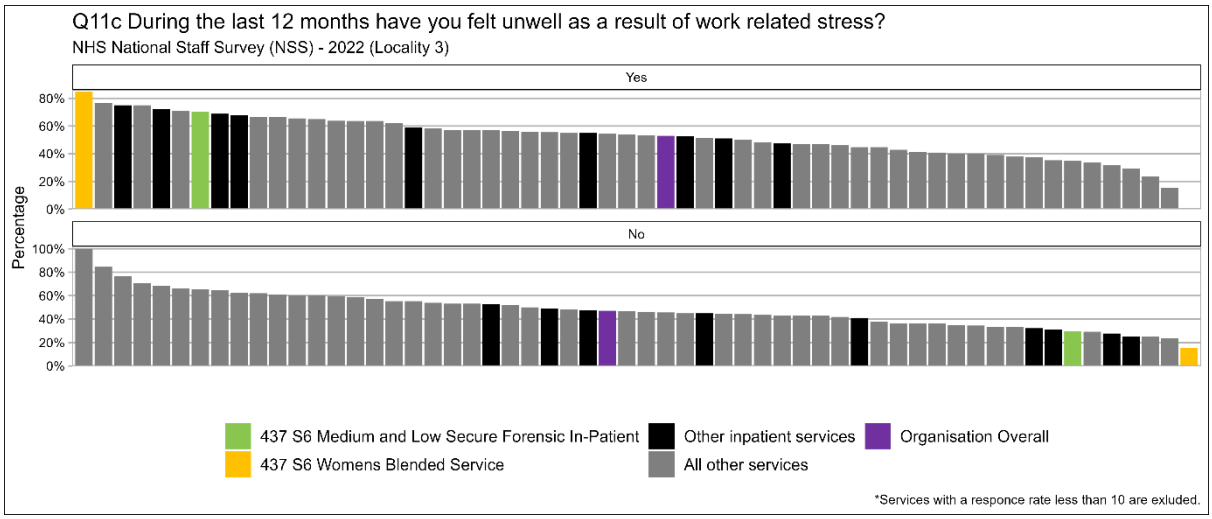
In 2022, 47% of GMMH staff answered not when asked if they have felt unwell as a result of work-related stress in the last 12 months.



8. During the last 12 months have you felt unwell as a result of work-related stress? (Internal benchmarking)

In 2022, Forensic Services averaged 72% of staff answering yes when asked if they have felt unwell as a result of work-related stress in the last 12 months. Compared with all other GMMH services, Forensic Services would have the fifth highest percentage (out of 60 services), with the percentage being 22% higher than in 2021.

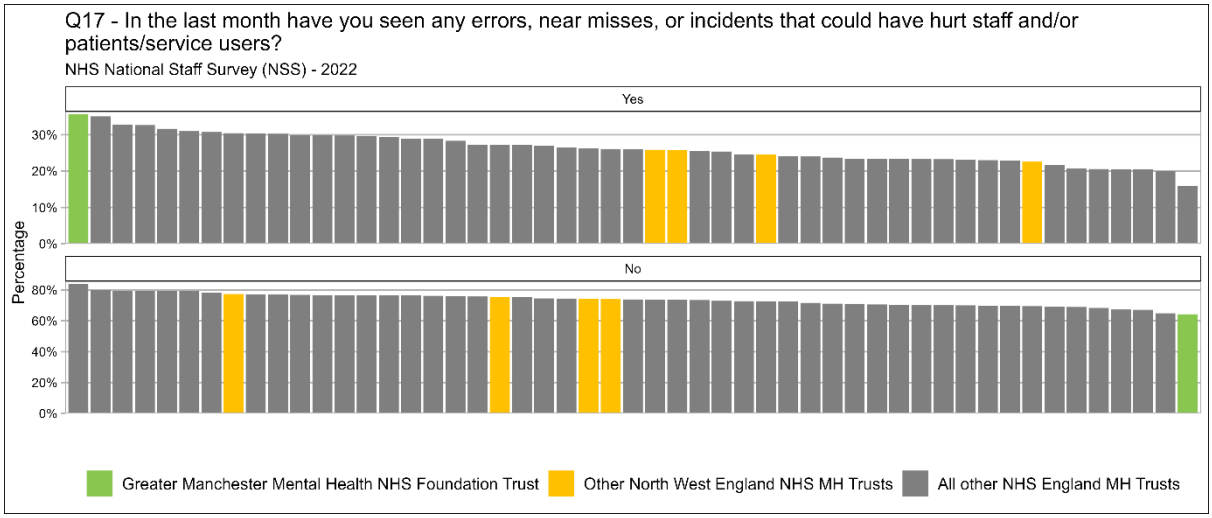
In 2022, Forensic Services had 9% more than the inpatient services average and 19% more than the GMMH average who answered yes to this question. Women's Blended Service had a large 85% of staff answer yes, as opposed to Medium and Low Secure services, where 70% of staff answered yes.



9. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users? (Trust level)

In 2022, GMMH had 36% of staff say that they have seen errors, near misses or harmful incidents which could have harmed staff or service users over the last month. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

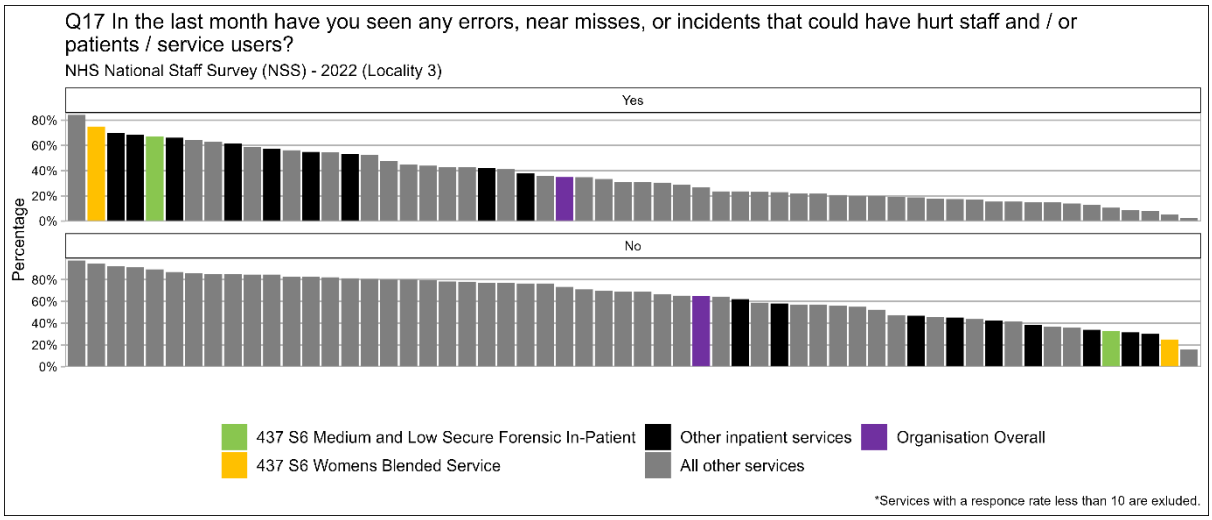
In 2022, GMMH had 10% more than the Northwest average and 10% more than the national average saying they have seen errors, near misses or harmful incidents which could have harmed staff or service users over the last month.



10. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users? (Internal benchmarking)

In 2022, Forensic Services averaged a high percentage of 68% of staff answering yes when asked if they have seen any errors, near misses, or potentially harmful incidents in the last month. Compared with all other GMMH services, Forensic services had the fourth highest percentage (out of 60 services).

In 2022, Forensic Services had 12% more than the inpatient services average and 33% more than the GMMH average answer yes to the question. In Women's Blended Service 75% of the staff answered yes to the question, whereas for Medium and Low Secure services 67% of the staff answered yes.

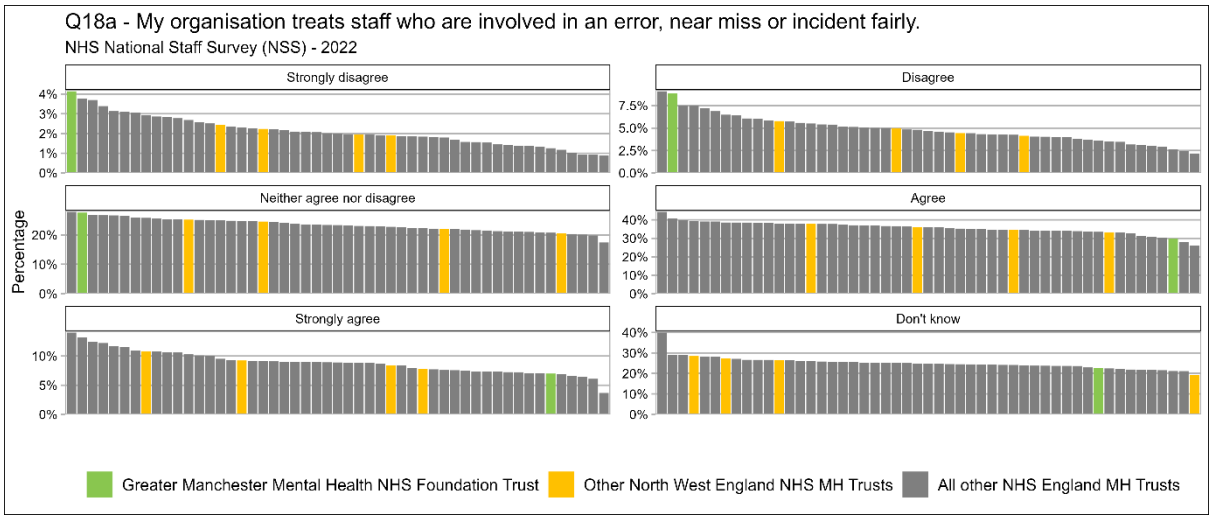


11. My organisation treats staff who are involved in an error, near miss or incident fairly. (Trust level)

In 2022, 13% of staff disagree or strongly disagree that GMMH treats staff who are involved in an error, near miss or incident fairly. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 5% more than the Northwest average and 6% more than the national average either disagree or strongly disagree that GMMH treats staff who are involved in an error, near miss or incident fairly.

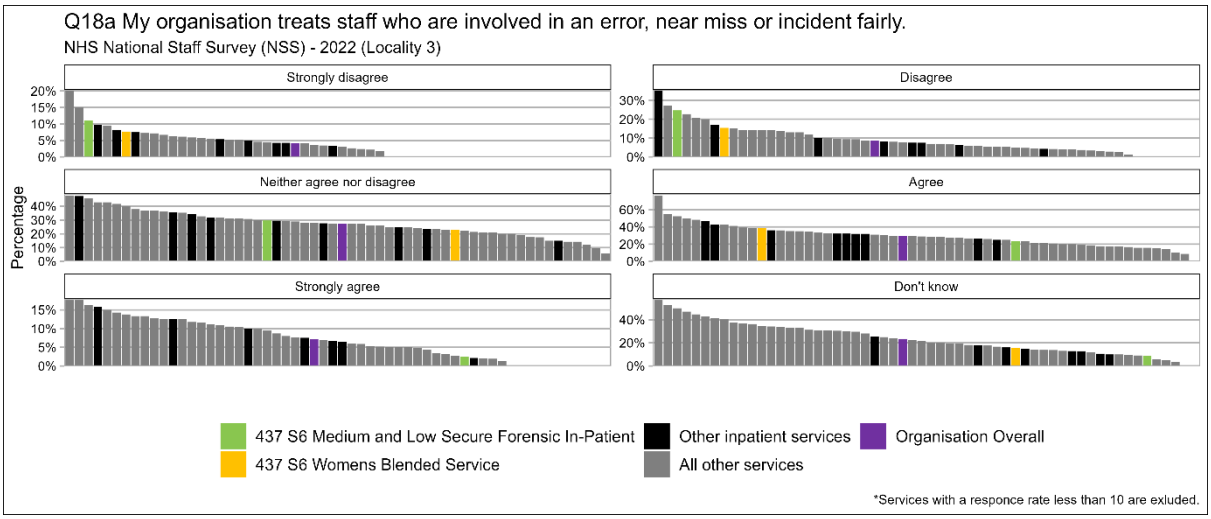
In 2022, GMMH had 37% of staff agree or strongly agree that GMMH treats staff who are involved in an error, near miss or incident fairly (the third lowest when compared to all other NHS England mental health trusts) and 50% remained neutral (answered either “neither agree nor disagree” or “don’t know”).



12. My organisation treats staff who are involved in an error, near miss or incident fairly. (internal benchmarking)

In 2022, Forensic Services had a high average of 34% of staff disagreeing that their organisation treats staff fairly who are involved in an error, near miss or incident. Compared with all other GMMH services, Forensic Services had the third highest percentage (out of 60 services).

In 2022, Forensic Services had 15% more than the inpatient services average and 21% more than the GMMH average disagree with the statement. Medium and Low Secure services had 36% of staff disagree with the statement, as opposed to 23% of staff in the Women’s Blended Service disagreeing.

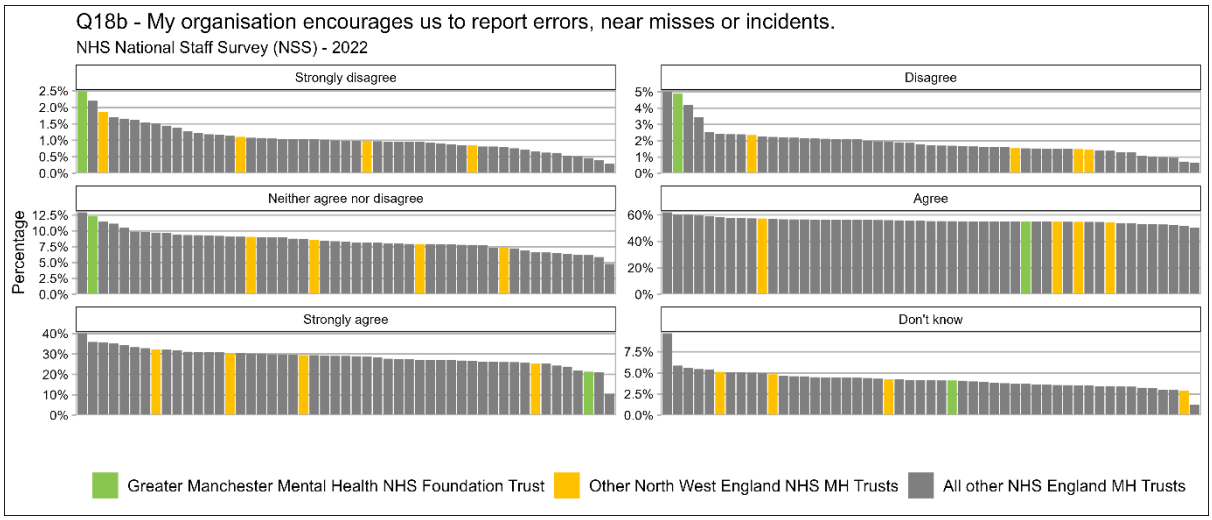


13. My organisation encourages us to report errors, near misses or incidents.

In 2022, 7% of staff disagree or strongly disagree that GMMH encourages staff to report errors, near misses or incidents. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 3% more than the Northwest average and 4% more than the national average either disagree or strongly disagree that GMMH encourages staff to report errors, near misses or incidents.

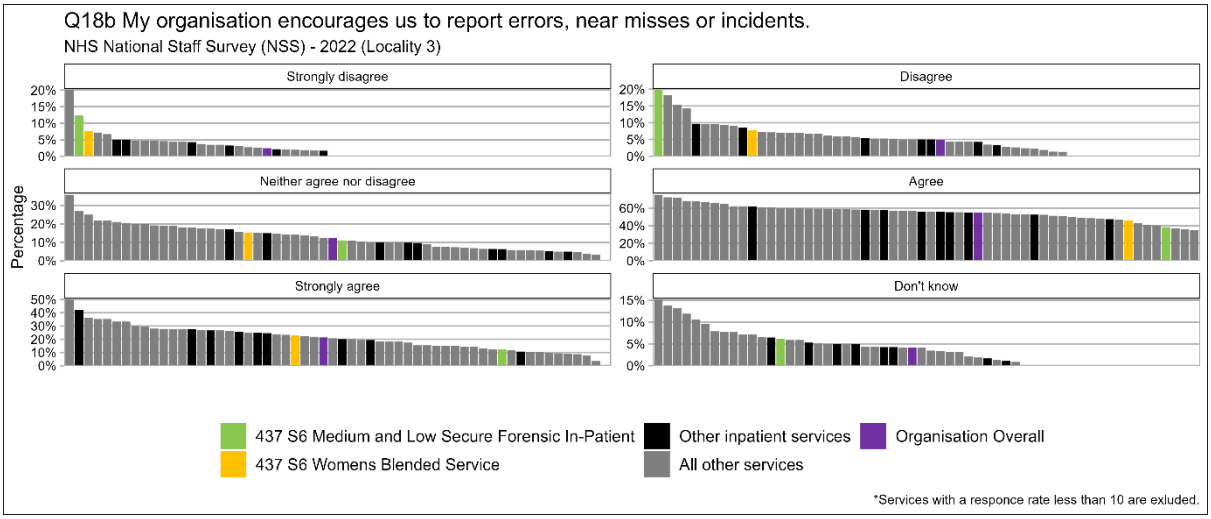
In 2022, GMMH had 76% of staff agree or strongly agree that GMMH encourages staff to report errors, near misses or incidents (second lowest when compared to all other NHS England mental health trusts) and 16% remained neutral (answered either “neither agree nor disagree” or “don’t know”).



14. My organisation encourages us to report errors, near misses or incidents. (Internal benchmarking)

In 2022, Forensic Services had a high average of 30% of staff disagreeing that their organisation encourages them to report errors, near misses or incidents. Compared with all other GMMH services, Forensic Services had the highest percentage (out of 60 services).

In 2022, Forensic Services had 19% more than the inpatient services average and 23% more than the GMMH average disagree with the statement. Medium and Low Secure services had 32% of staff disagree with the statement, as opposed to 15% of staff in the Women’s Blended Service disagreeing.

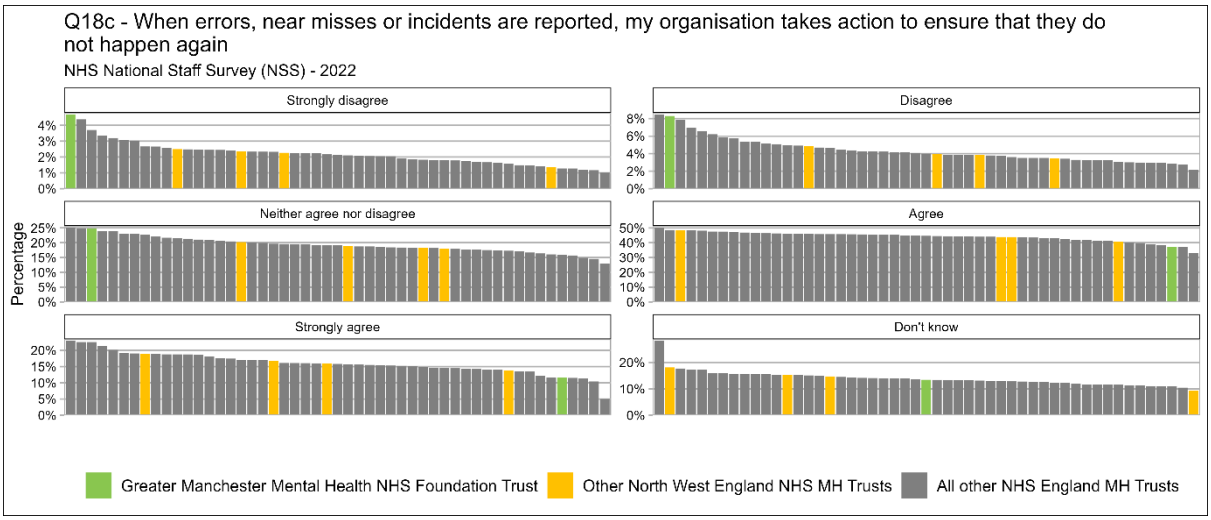


15. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.

In 2022, 13% of staff disagree or strongly disagree that GMMH takes action to ensure errors, near misses or incidents do not reoccur. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 6% more than the Northwest average and 7% more than the national average either disagree or strongly disagree that GMMH takes action to ensure errors, near misses or incidents do not reoccur.

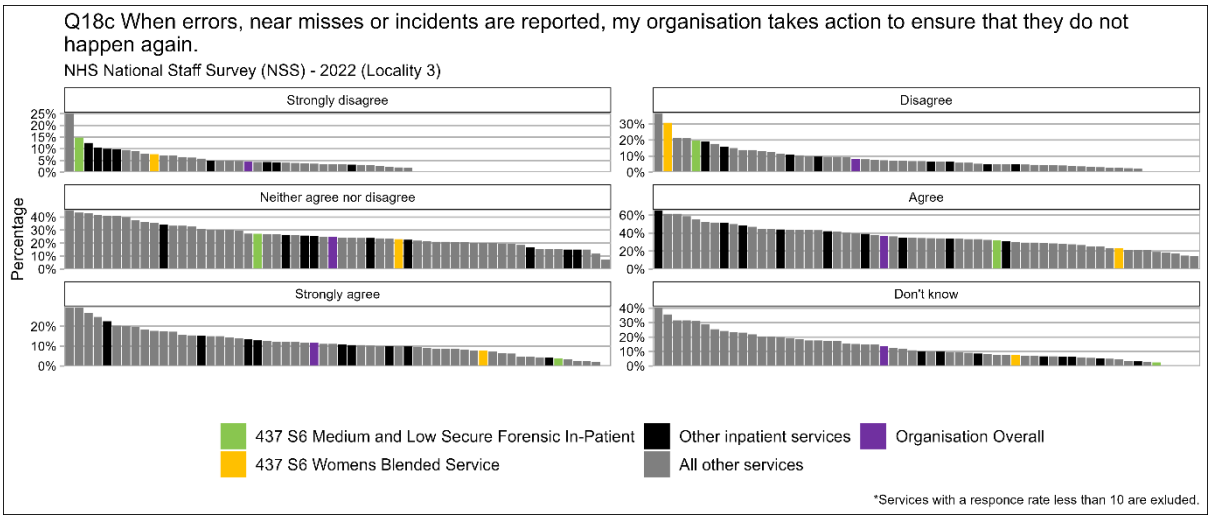
In 2022, GMMH had 49% of staff agree or strongly agree that GMMH takes action to ensure errors, near misses or incidents do not reoccur (third lowest when compared to all other NHS England mental health trusts) and 38% remained neutral (answered either “neither agree nor disagree” or “don’t know”).



16. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again. (Internal benchmarking)

In 2022, Forensic Services had a high average of 35% of staff disagreeing that their organisation takes action to ensure errors, near misses and incidents aren’t repeated. Compared with all other GMMH services, Forensic Services had the second highest percentage (out of 60 services).

In 2022, Forensic Services had 16% more than the inpatient services average and 22% more than the GMMH average disagree with the statement. There was no notable difference between Medium and Low Secure and Women’s Blended services.

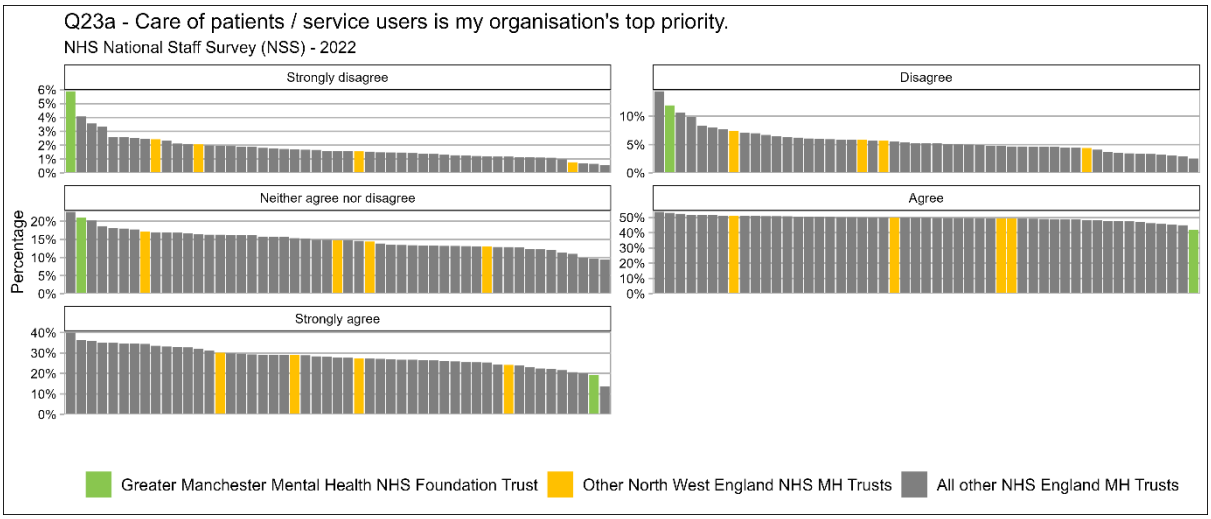


17. Care of patients/service users is my organisation's top priority.

In 2022, 18% of staff disagree or strongly disagree that the care of service users is GMMH's top priority. This is the second highest percentage when compared with all other NHS England mental health trusts and is 6% higher than in 2021 (where GMMH had the fourth highest percentage).

In 2022, GMMH had 8% more than the Northwest average and 11% more than the national average either disagree or strongly disagree that the care of service users is GMMH's top priority.

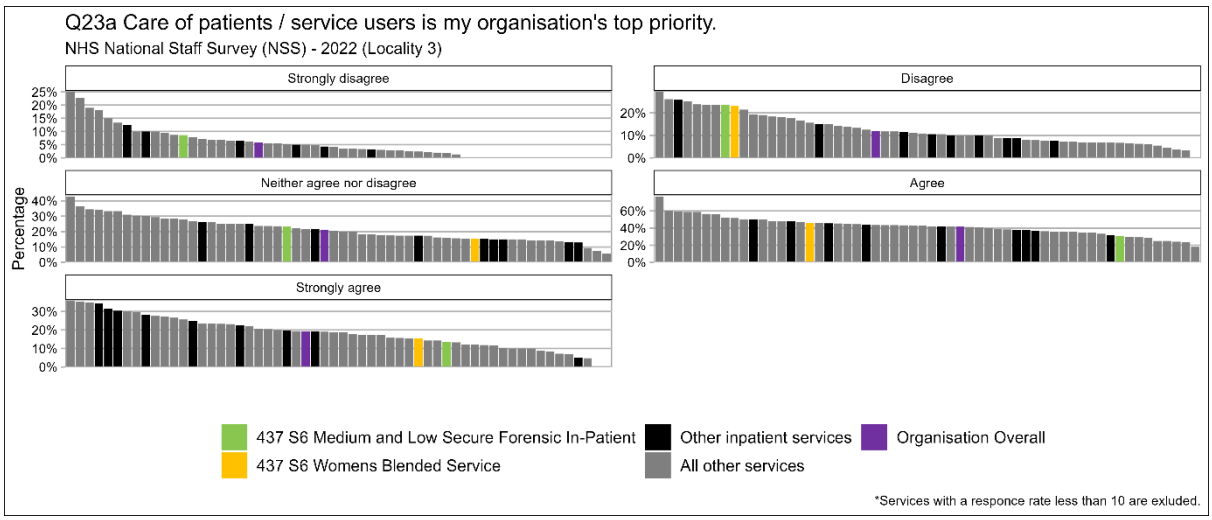
In 2022, GMMH had 61% of staff agree or strongly agree that the care of service users is GMMH's top priority and 21% neither agree nor disagree.



18. Care of patients/service users is my organisation's top priority. (Internal benchmarking)

In 2022, Forensic Services had a high 31% of staff disagreeing that the care of service users is the organisation's top priority. Compared with all other GMMH services, Forensic Services had the fifth highest percentage (out of 60 services), with the percentage being 18% higher than in 2021.

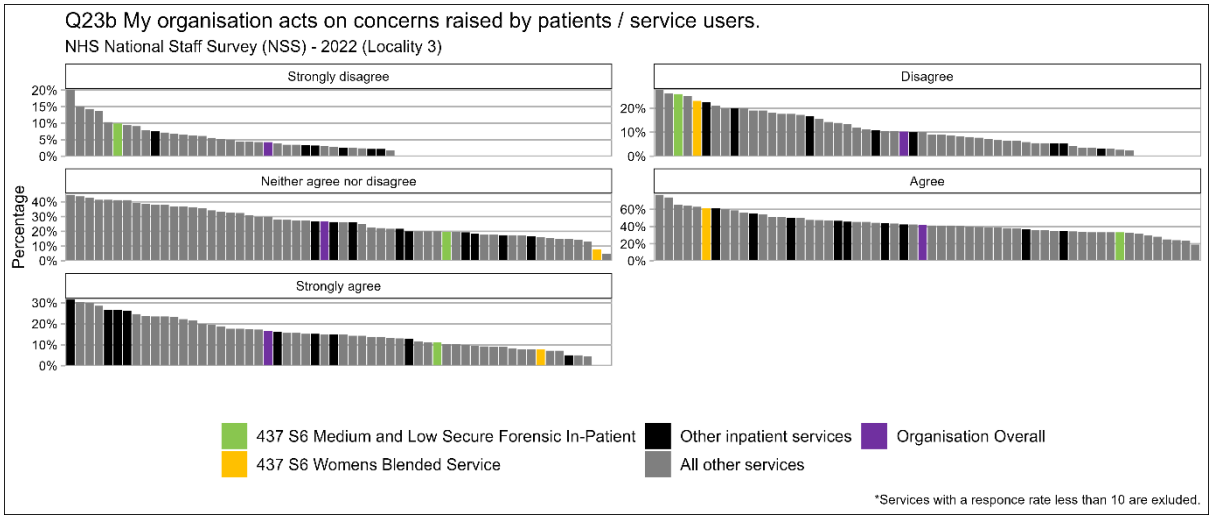
In 2022, Forensic Services had 12% more than the inpatient services average and 13% more than the GMMH average disagree with the statement. Medium and Low Secure services had 32% of staff disagree with the statement, as opposed to 23% of staff in the Women's Blended Service disagreeing.



19. My organisation acts on concerns raised by patients/service users. (Internal benchmarking)

In 2022, Forensic Services had a high 34% of staff disagreeing that their organisation acts on service user concerns. Compared with all other GMMH services, Forensic Services had the third highest percentage (out of 60 services), with the percentage being 27% higher than in 2021.

In 2022, Forensic Services had 17% more than the inpatient services average and 19% more than the GMMH average disagree with the statement. Medium and Low Secure services had 36% of staff disagree with the statement, as opposed to 23% of staff in the Women's Blended Service disagreeing.



Appendix 3 – Case note audit: key analysis

Introduction

In July 2023, the review team undertook a case note audit using a randomised sample of 20 patient records on the Edenfield site. The following wards were in scope: Borrowdale, Derwent, Hayeswater, Dovedale, Eskdale, Ferndale, Newland/Fast, Silverdale and Ullswater.

Method

The audit focused on the last six months of care. The balance of male/female patients included in the audit was 50/50. The proforma was piloted with two sets of case notes at the outset of the audit, with minor revisions required subsequently made by the auditors. The auditors were supported to navigate the electronic patient record system throughout their work by a clinician from Edenfield.

For each patient we reviewed their relevant care plans (mental health, physical health, relationships, risk (and problem behaviours), and others as needed), their progress notes, and other parts of the Patient Record Information System as required to find specific information. If we could not find something after 15 minutes of looking, we stopped.

Case notes were scored as follows, but with comments added to explain these scores where necessary.

0 – no omissions

1 – occasional omissions

2 – several omissions/deviations from good practice

3 – regular omissions/deviations from good practice

4 – significant omissions/deviations from good practice

5 – must be referred as a significant cause of concern

Audit proforma

This proforma was designed by the review team, using their collective knowledge and experience, and with reference to the findings made by BBC Panorama.

The audit areas and questions were:

1) Quality of the record

a. Entries are legible and chronological.
b. Key decisions are documented by suitably qualified staff as per the Trust policy.
c. Entries are all signed and dated. The person making the entry is clearly identifiable.
d. There is no evidence of retrospective or ‘bulk’ entries being made.
e. The patient is described in a professional way which is free of opinion.

2) Individualised care

a. There is a clear and up-to-date trauma-informed, asset-based care plan.
b. The care plan is based upon a thorough and co-produced assessment of need.
c. There is a clear primary diagnosis and a clear indication of secondary and co-morbid factors (including any physical health needs).
d. There is an up-to-date and good summary of the main points that need to be considered when supporting the patient.
e. It is clear in the case notes who in the family is to be contacted and how they would like to be contacted (assuming that individuals have consented to this).
f. There is an up-to-date approved visitors list in the notes.

g. There is clear evidence of family engagement/views of family (and this is noted as 'third-party').
h. There is evidence of families being kept informed when significant changes to care happen (assuming that individuals have consented to this), i.e., move to seclusion, assaults, ligatures, etc.
i. There is evidence that a carer's assessment has been offered.
j. Where a carer's assessment was accepted, there is evidence that one was completed.

3) Risk assessment

a. An up-to-date risk assessment is in place.
b. The risk plan is regularly reviewed and reviewed in line with the Trust policy.
c. There is an up-to-date crisis plan in place.

4) Least restrictive practice

a. Where restrictive practice is used (including seclusion, enhanced observations), there is evidence that this has been regularly reviewed as per Trust policy.
b. Individuals have frequent access to outside space and activities.
c. There is an intervention/ positive behaviour support (PBS) plan in place.
d. Is there evidence of staff following the PBS plan?

5) Law

a. The legal status of the individual is clearly reported, and their capacity is documented in line with the Mental Capacity Act (MCA).
b. There is evidence that the patient has been informed of any changes to their status under the Mental Health Act (MHA). as per Trust policy.
c. Treatment is given in line with the MHA.
d. There is clear evidence of referral to a second opinion appointed doctor (SOAD).
e. There is evidence of regular mental capacity tests being undertaken.
f. The leave status is recorded and understandable as per Trust policy.
g. There is identification of clear escalations to other agents around the patient, where needs are identified, for example, safeguarding, an independent mental health advocate.

Summary findings

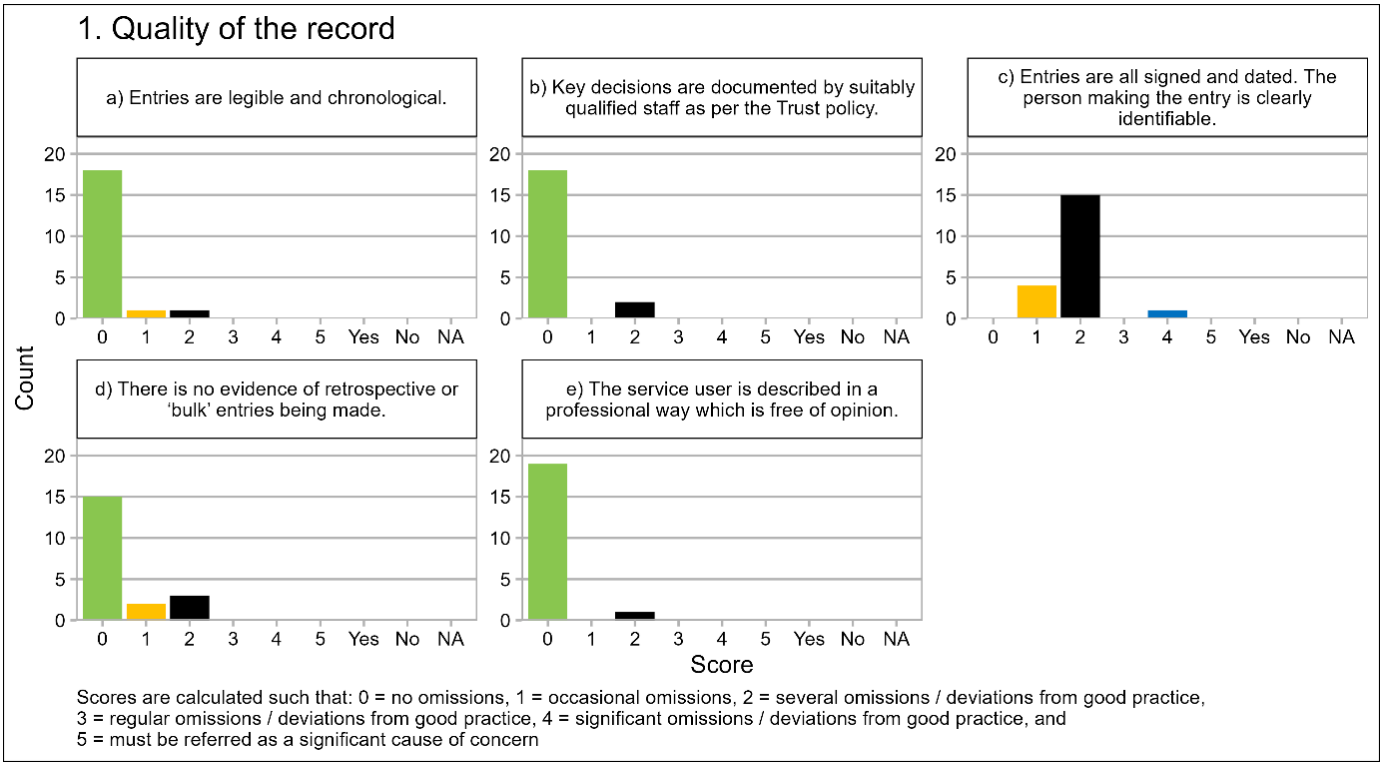
1. Quality of the record	
a) Entries are legible and chronological.	No major concerns identified.
b) Key decisions are documented by suitably qualified staff as per the Trust policy.	Standard typically met; there were more entries by qualified staff than anticipated. Patients were frequently described as "*settled*" without any attempt to describe this.
c) Entries are all signed and dated. The person making the entry is clearly identifiable.	A significant minority were not signed.
d) There is no evidence of retrospective or 'bulk' entries being made.	We only found one clearly retrospective entry. No evidence of bulk entries although some care plan entries were very generic.
e) The patient is described in a professional way which is free of opinion.	We found no evidence of unprofessional or judgemental descriptions of patients.

2. Individualised care	
a) There is a clear and up-to-date trauma-informed, asset-based care plan.	Care plans were very variable in nature; however, very few were in any way trauma-informed. There are no prompts within the care plan documented used for trauma-informed information. Where trauma history information was captured (within risk assessments for example) this was not picked up within the mental health care plan. Two segregation plans we saw were trauma informed.
b) The care plan is based upon a thorough and co-produced assessment of need.	Variable: there were good and poor examples found. Most appeared to be co-produced with lots of "I" statements although some of these were written in professional language which most patients would not normally use such as "*I hope to engage in more therapeutic relationships with my peers*". Some plans were individualised and gave a clear picture of the patient as a person, whereas others were so general they could have applied to any patients on the ward. Where patients had declined to be involved in developing the plan or having a copy this was generally stated in the notes.
c) There is a clear primary diagnosis and a clear indication of secondary and co-morbid factors (including any physical health needs).	Primary diagnosis usually clear and confirmed within current period. Very few had secondary diagnosis recorded. The physical health care plan prompted information capture on this, although input was variable. Some physical care plans seemed to include information which should have been stored elsewhere, e.g., one patient's diabetes care plan included a ligature plan.
d) There is an up-to-date and good summary of the main points that need to be considered when supporting the patient.	Variable and stored inconsistently in different parts of the record.
e) It is clear in the case notes who in the family is to be contacted and how they would like to be contacted (assuming that individuals have consented to this).	We could not find this quickly, or at all in some cases.
f) There is an up-to-date approved visitors list in the notes.	All patients had a list with contact details, although some were very dated and may not have been recently reviewed.
g) There is clear evidence of family engagement/views of family (and this is noted as 'third-party').	This was poorly collected. The family's voice was often not there at all. The family voice was weak in most plans. For example, in one record a patient had assaulted a family member, and the plan was for the patient to return to live with other members of the family. This was stated several times in the notes, but without indication of what the family members' views were of this expectation.
h) There is evidence of families being kept informed when significant changes to care happen (assuming that individuals have consented to this), i.e., move to seclusion, assaults, ligatures, etc.	This was difficult to find. We did not find any good examples of this being undertaken.

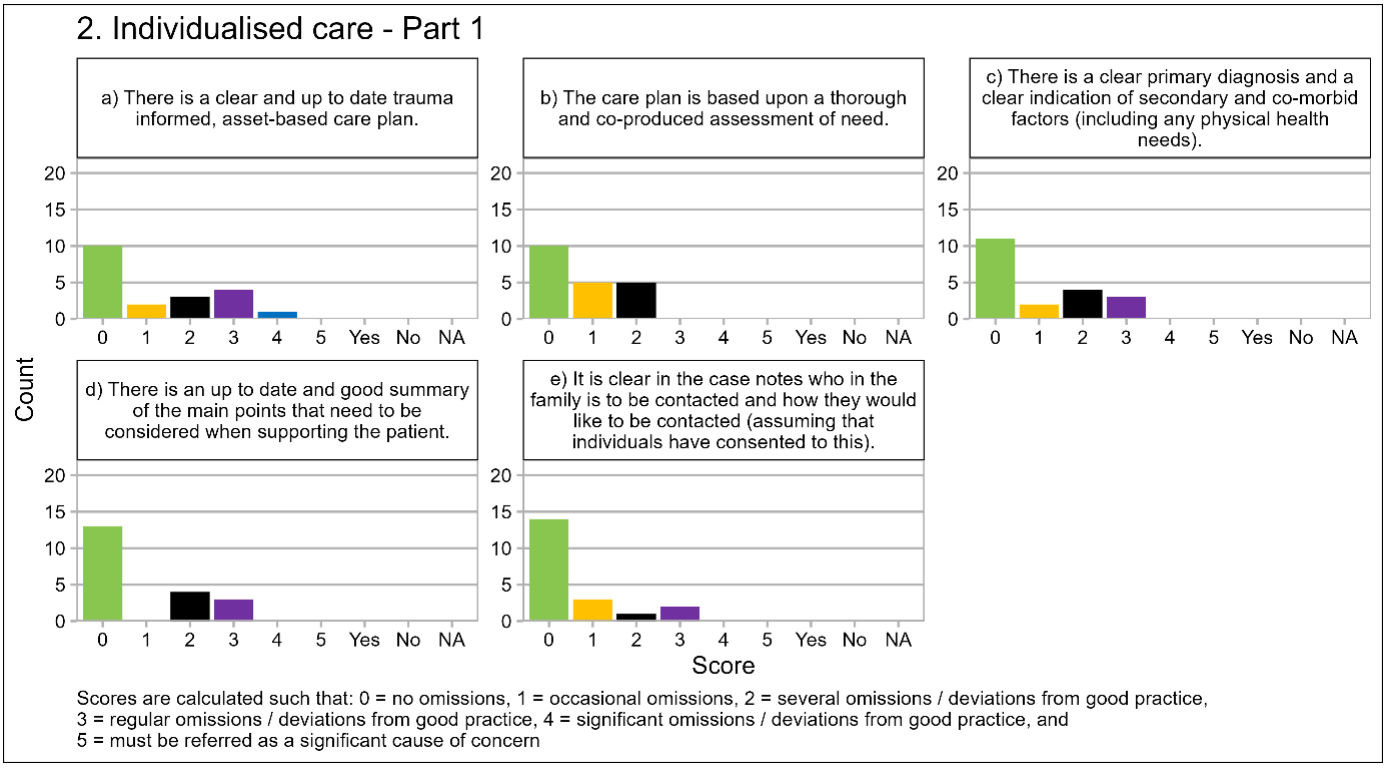
i) There is evidence that a carer's assessment has been offered.	This section was often not completed.
j) Where a carer's assessment was accepted, there is evidence that one was completed.	Few examples found.
3. Risk assessment	
a) An up-to-date risk assessment is in place.	All had an up-to-date plan, but the content and quality were variable. Few were trauma informed. Many contained generic statements rather than ones which appeared to be specific to the individual patient.
b) The risk plan is regularly reviewed and reviewed in line with the Trust policy.	On first review, risk assessments appeared to be in date. However, on closer inspection, risk assessments frequently contained information, which was likely to be out of date, for example, referring to wards which the patient was no longer on.
c) There is an up-to-date crisis plan in place.	We did not find any evidence of individual crisis plans labelled on the system. The ward manager working with us confirmed that they did not have such documents. Some elements of what you might expect to find in a crisis plan were contained within a number of documents such as the risk plan or segregation plan.
4. Least restrictive practice	
a) Where restrictive practice is used (including seclusion, enhanced observations), there is evidence that this has been regularly reviewed as per Trust policy.	Yes – generally, evidence of review found.
b) Individuals have frequent access to outside space and activities.	This was apparent in the progress notes. There were several entries documenting that patients had attended activities, but with little reference to the impact of these activities on the patient's recovery and wellbeing.
c) There is an intervention/PBS plan in place	We only found one PBS plan within the notes reviewed, although some elements of this were included within other parts of the record.
d) Is there evidence of staff following the PBS plan?	N/A
5. Law	
a) The legal status of the individual is clearly reported, and their capacity is documented in line with the MCA.	Yes for legal status; less clearly for MCA status. The location of this information was inconsistent, such that it was hard to find and sometimes unclear.
b) There is evidence that the patient has been informed of any changes to their status under the MHA, as per Trust policy.	There was evidence that the vast majority of patients had had their rights and status under the MHA read to them within the period under review, and with signed documents on the system.

c) Treatment is given in line with the MHA.	Yes, as far as we could tell given the time available. There may be elements of this which require more specific audit.
d) There is clear evidence of referral to a SOAD.	Yes, as far as we could tell, although the location of relevant information was inconsistent in the record and required significant effort to find.
e) There is evidence of regular mental capacity tests being undertaken.	See above.
f) The leave status is recorded and understandable as per Trust policy.	This was typically done well.
g) There is identification of clear escalations to other agents around the patient, where needs are identified, for example, safeguarding, an independent mental health advocate.	Information was frequently difficult to locate, particularly safeguarding information which required some searching around the system.

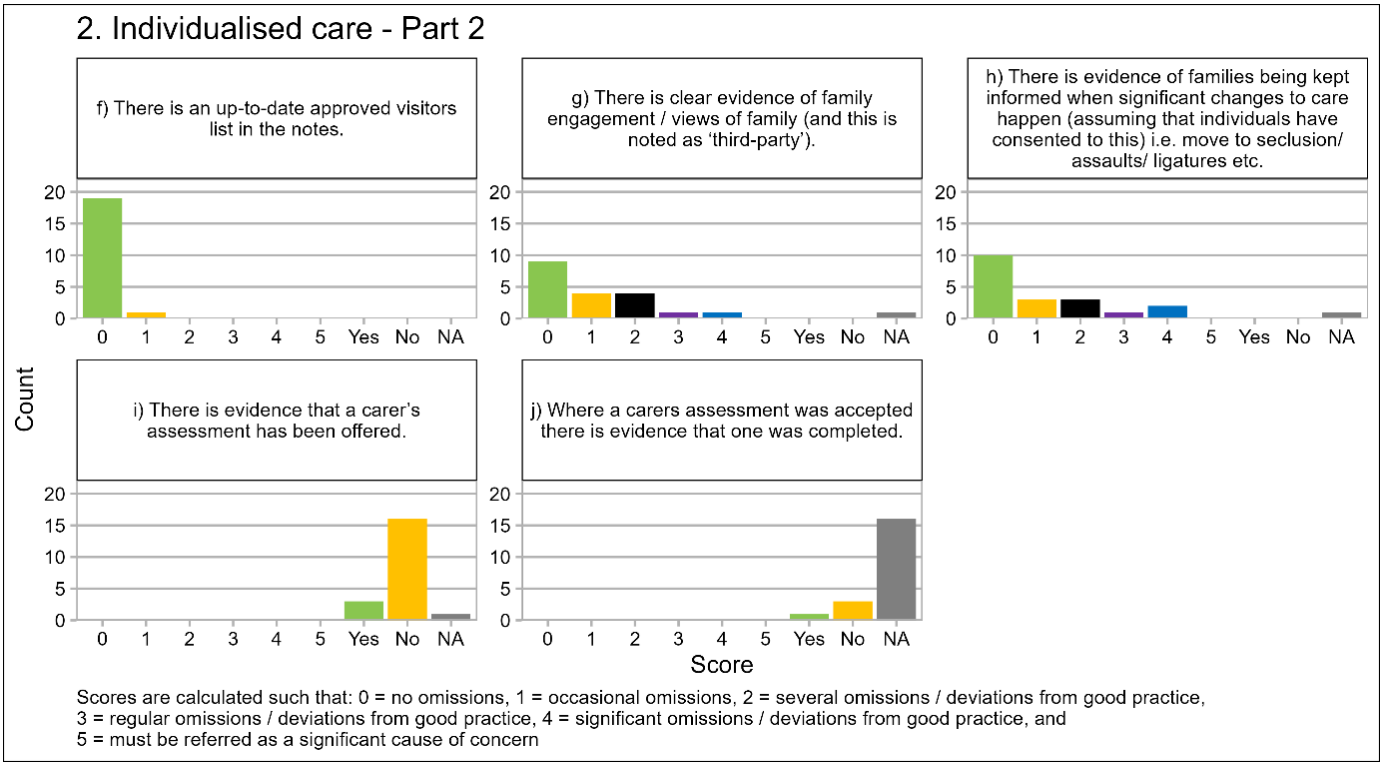
1 – Quality of the record



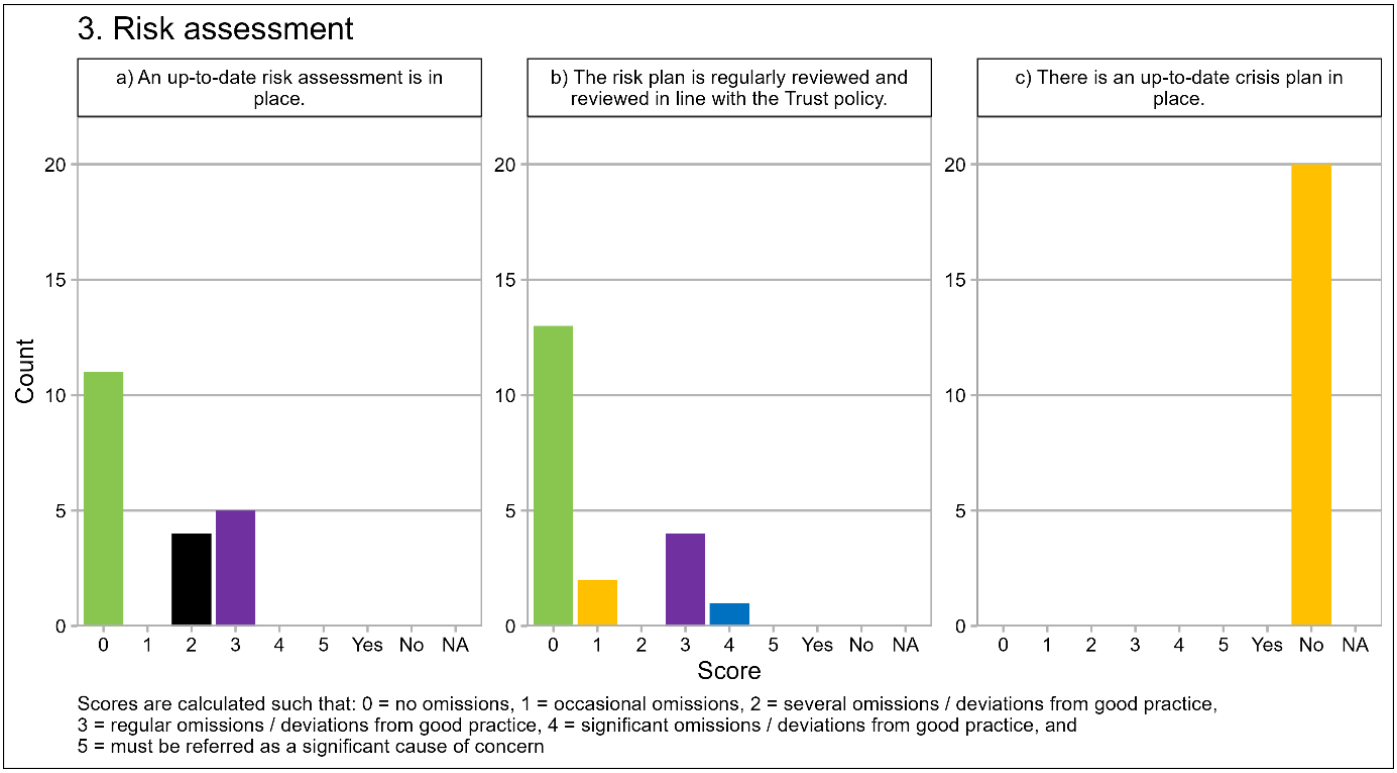
2 – Individualised care (a)



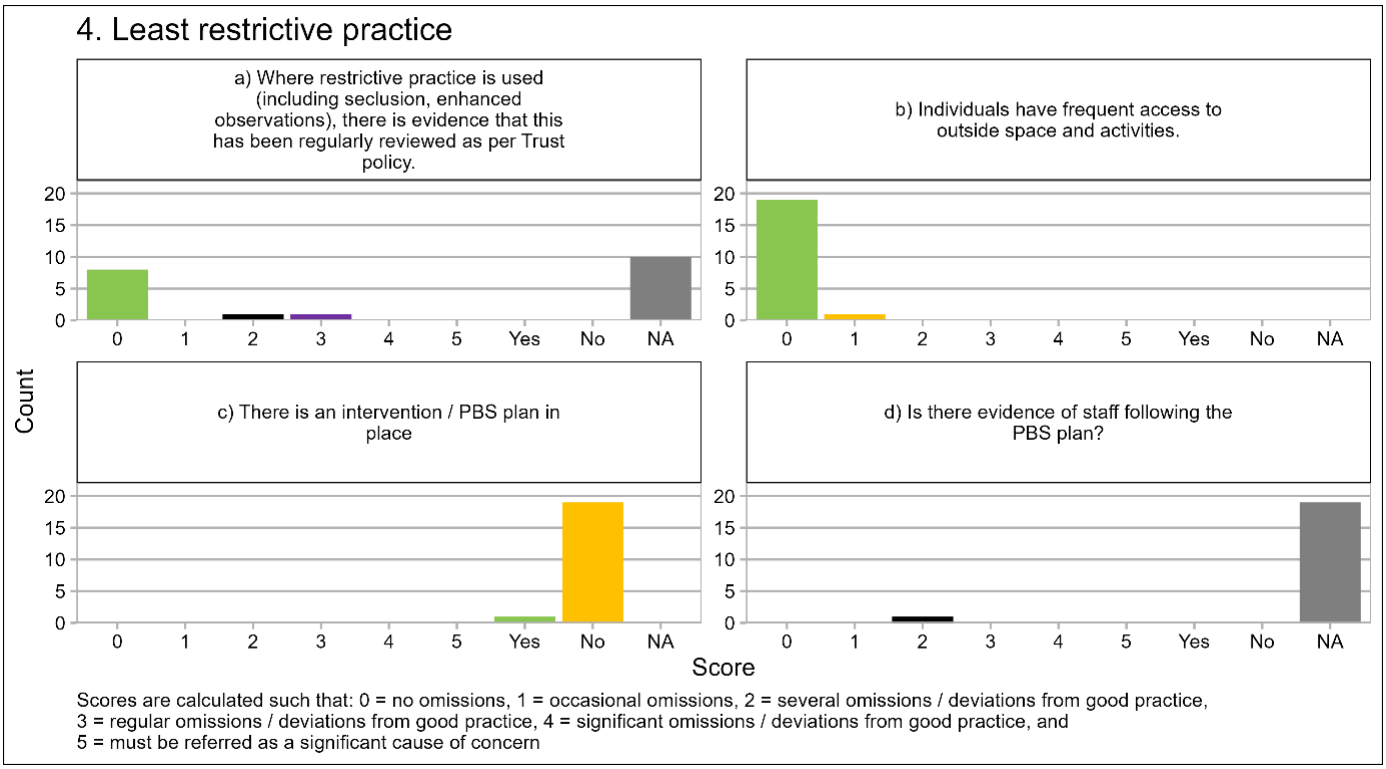
2 – Individualised care (b)



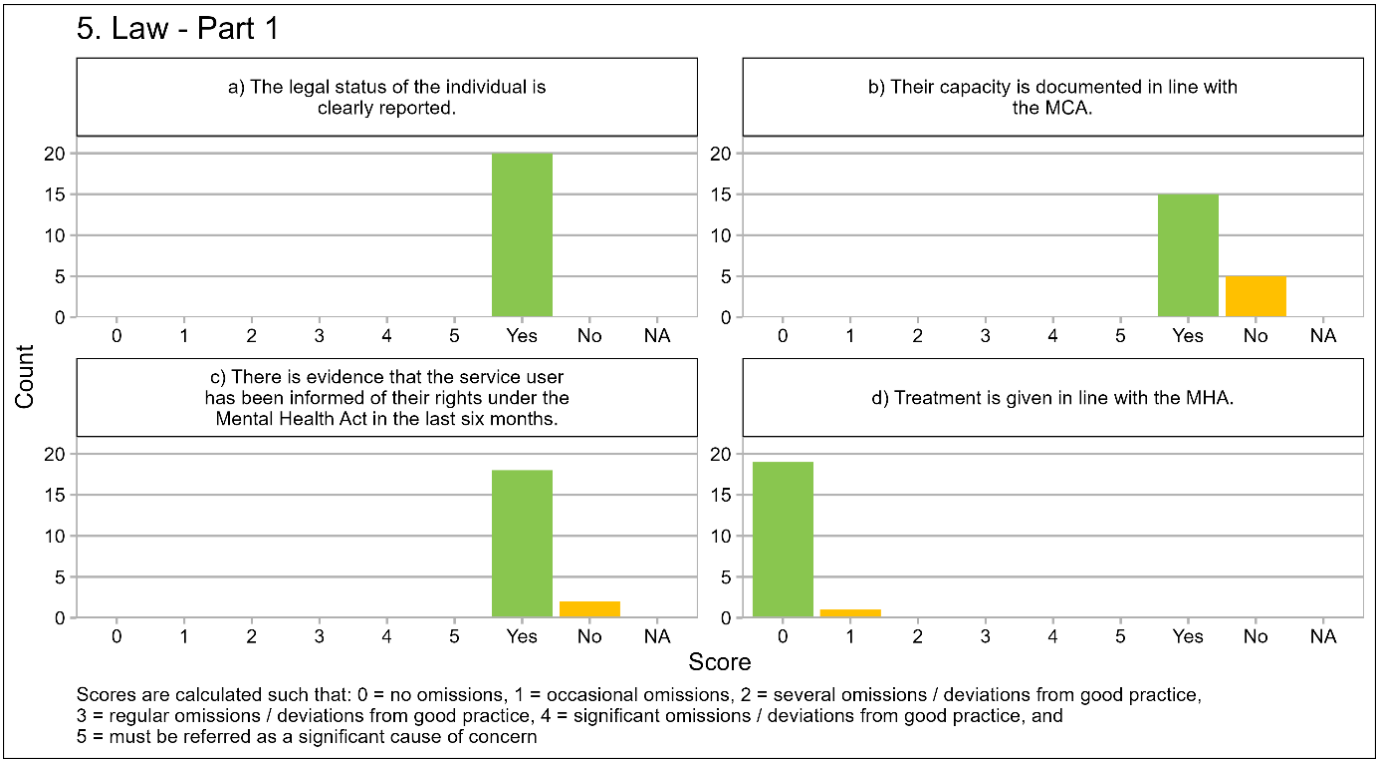
3 – Risk assessment



4 – Least restrictive practice

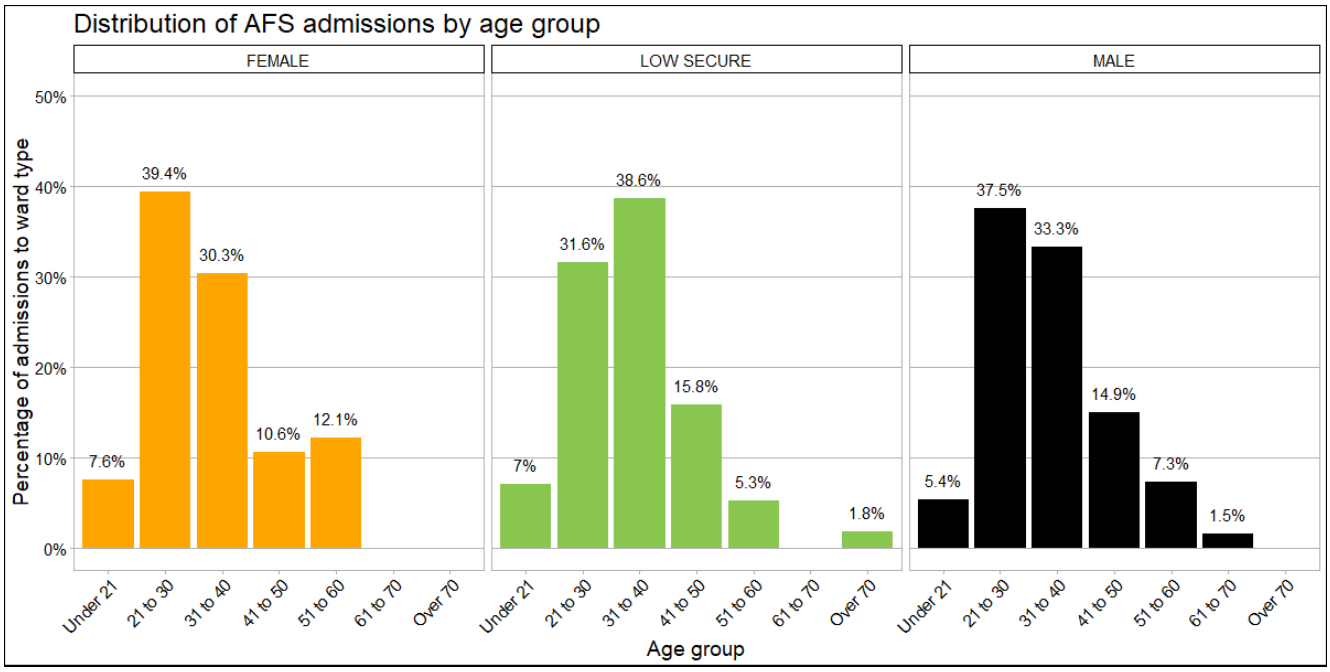


5 – Law

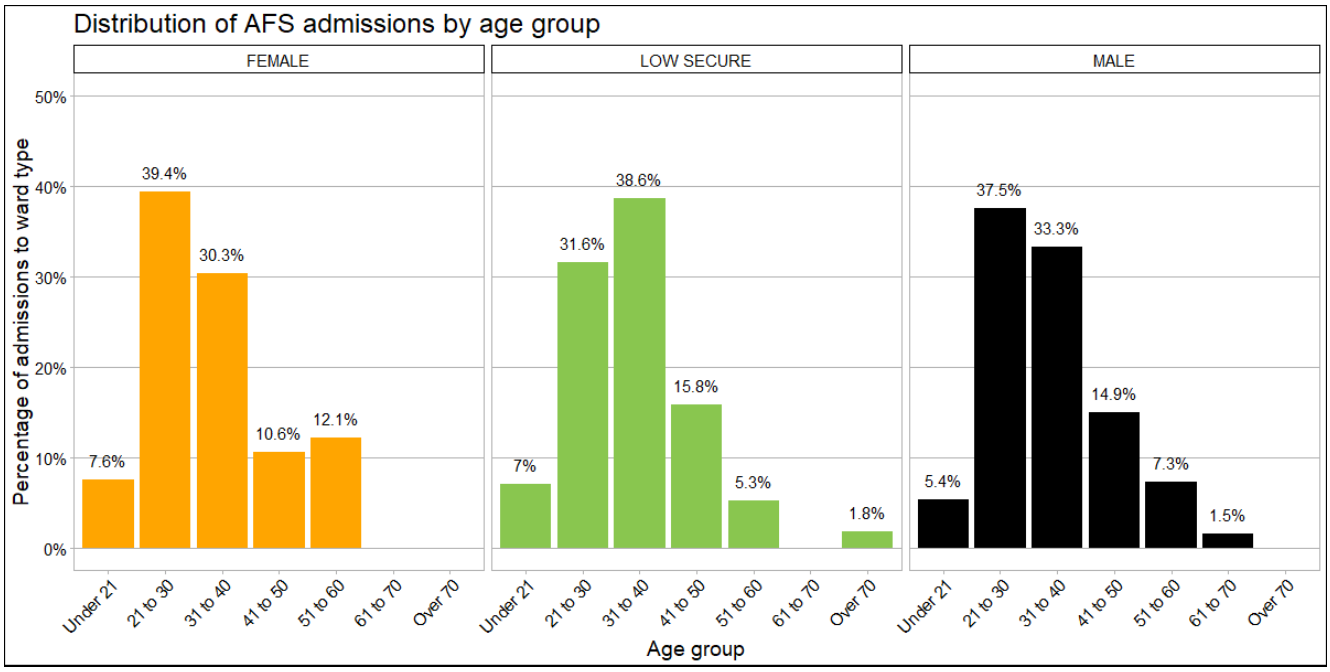

5. Law - Part 1
a) The legal status of the individual is clearly reported.
b) Their capacity is documented in line with the MCA.
c) There is evidence that the service user has been informed of their rights under the Mental Health Act in the last six months.
d) Treatment is given in line with the MHA.
Count
Score
0 1 2 3 4 5 Yes No NA
0 5 10 15 20
Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice, 3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and 5 = must be referred as a significant cause of concern

Appendix 4 – Contextual analysis

The population of Edenfield

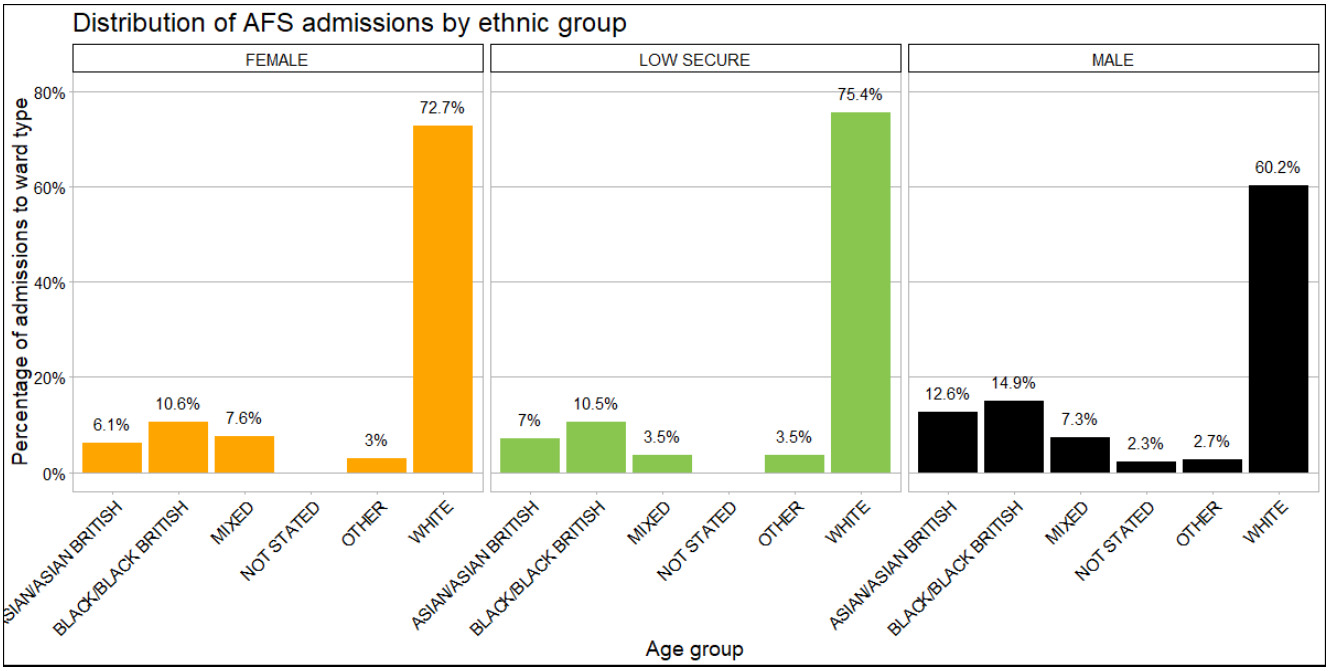


The age distributions are relatively similar for each service, with around 70% of all admissions aged between 21 and 40. The average age on admission was 33.3 for female wards, 34.2 for male wards and 34.5 for low secure wards.


Distribution of AFS admissions by age group
FEMALE
LOW SECURE
MALE
Percentage of admissions to ward type
50%
40%
30%
20%
10%
0%
39.4%
30.3%
10.6%
12.1%
7.6%
38.6%
31.6%
15.8%
7%
5.3%
1.8%
37.5%
33.3%
14.9%
7.3%
5.4%
1.5%
Under 21
21 to 30
31 to 40
41 to 50
51 to 60
61 to 70
Over 70
Age group

The age distributions are relatively similar for each service, with around 70% of all admissions aged between 21 and 40. The average age on admission was 33.3 for female wards, 34.2 for male wards and 34.5 for low secure wards.

Ethnicity distribution at Edenfield by AFS service, for patients occupying a bed between April 2020 to March 2023



Source of admission to Edenfield AFS services, for patients occupying a bed between April 2020 to March 2023

Source of admission	FEMALE (n = 66)	LOW SECURE (n= 57)	MALE (n = 261)
Local authority residential accommodation i.e. where care is provided	2%	2%	1%
NHS other hospital provider: ward for general patients or A&E department	6%	12%	4%
NHS other hospital provider: ward for patients who are mentally ill or have learning disabilities	27%	21%	13%
NHS other Hospital Provider - high security psychiatric	6%	2%	10%
Non-NHS (other than local authority) run care home	2%	2%	1%
Non-NHS run hospital	26%	11%	3%
Not applicable	0%	0%	1%
Not known	2%	0%	2%
Penal establishment, court or police station / police custody suite	23%	37%	56%
Temporary place of residence	0%	2%	2%
Usual place of residence	8%	12%	7%

Discharge destination from Edenfield AFS services, for patients occupying a bed between April 2020 to March 2023

Discharge Destination	FEMALE (n = 51)	LOW SECURE (n= 44)	MALE (n = 172)
Local Authority residential accommodation i.e. where care is provided	4%	0%	0%
NHS other hospital provider - high security psychiatric	2%	0%	9%
NHS other hospital provider - medium secure unit	14%	0%	4%
NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities	16%	23%	10%
NHS other hospital provider: ward for general patients or A&E department	0%	2%	1%
Non-NHS (other than Local Authority) run Care Home	16%	7%	3%
Non-NHS run hospital	16%	39%	17%
Non-NHS run hospital - medium secure unit	4%	2%	3%
Not Known	8%	2%	2%
Penal establishment, court or police station / police custody suite	10%	9%	28%
Temporary place of residence	2%	2%	6%
Usual place of residence	10%	14%	16%

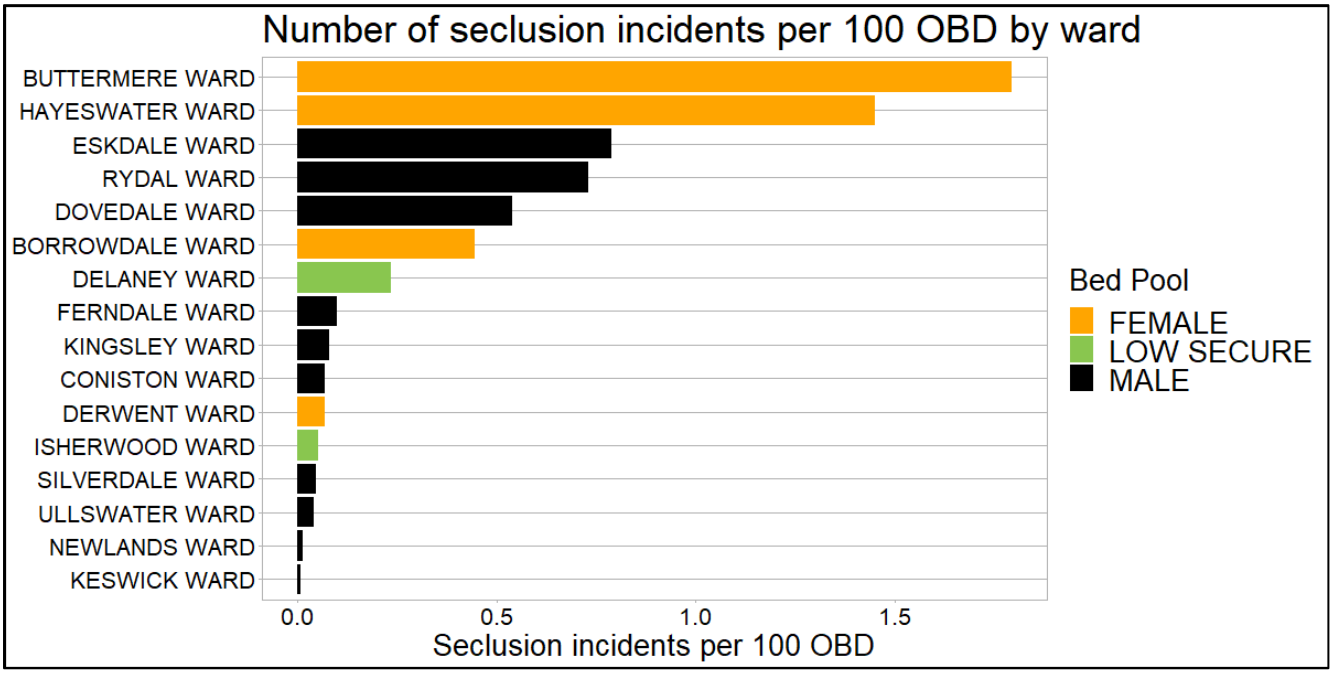
Mental Health Act Status on admission to AFS services, for patients occupying a bed between April 2020 to March 2023

Mental Health Act Status on admission	FEMALE (n = 66)	LOW SECURE (n= 57)	MALE (n = 261)
1983 MHA 47/49 LIFE LICENCE	0%	2%	2%
1983 MHA SECT 37/41 COND DISCH	2%	5%	0%
1983 MHA SECTION 2	9%	16%	14%
1983 MHA SECTION 3	38%	26%	13%
1983 MHA SECTION 36	0%	0%	0%
1983 MHA SECTION 37	8%	2%	0%
1983 MHA SECTION 37 NOTIONAL	3%	4%	2%
1983 MHA SECTION 37/41	6%	5%	7%
1983 MHA SECTION 37/41 RECALL	8%	0%	6%
1983 MHA SECTION 38	2%	4%	3%
1983 MHA SECTION 47	0%	2%	1%
1983 MHA SECTION 47/49	6%	16%	26%
1983 MHA SECTION 48/49	11%	7%	14%
1983 MHA SECTION 5(2)	0%	0%	1%
COMMUNITY TREATMENT ORDER	5%	5%	2%
CRIM PROCEDURE INSANITY ACT	2%	0%	0%
INFORMAL	2%	7%	6%
ON LEAVE TO GMMH	0%	0%	1%
UNKNOWN	2%	0%	0%

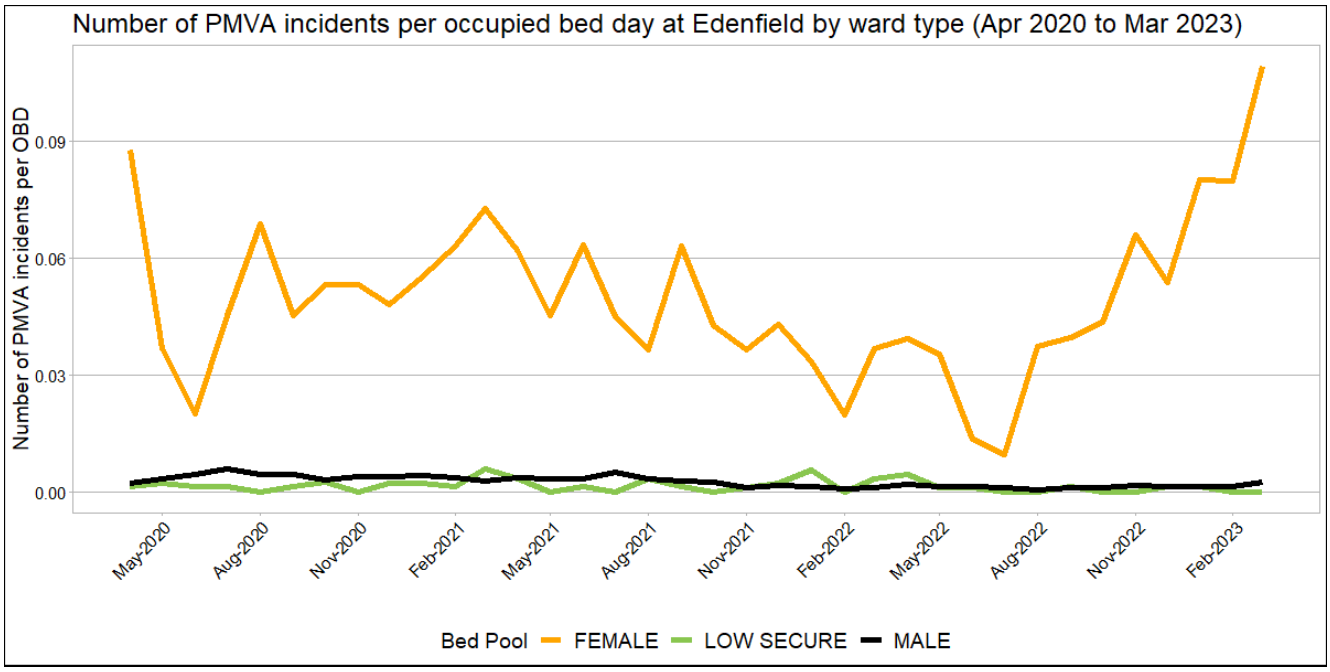
Restrictive practice

Positive and Proactive Care (Department of Health and Social Care, 2014) places an increasing focus on the use of preventive approaches and de-escalation for managing behaviour when patients are distressed. All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need. The Mental Health Act Code of Practice 2015 states that "*Any restrictive interventions (e.g., restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights.*"

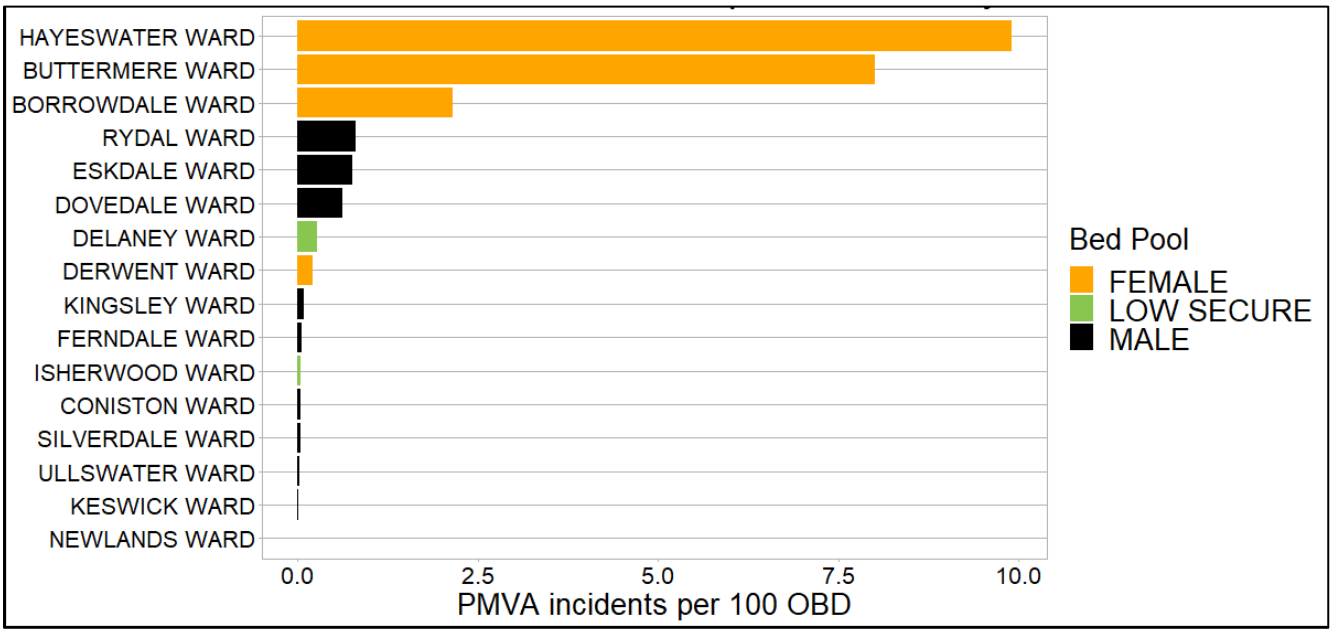
Seclusion incidents per 100 occupied bed days, by ward, at Edenfield, April 2020 to March 2023



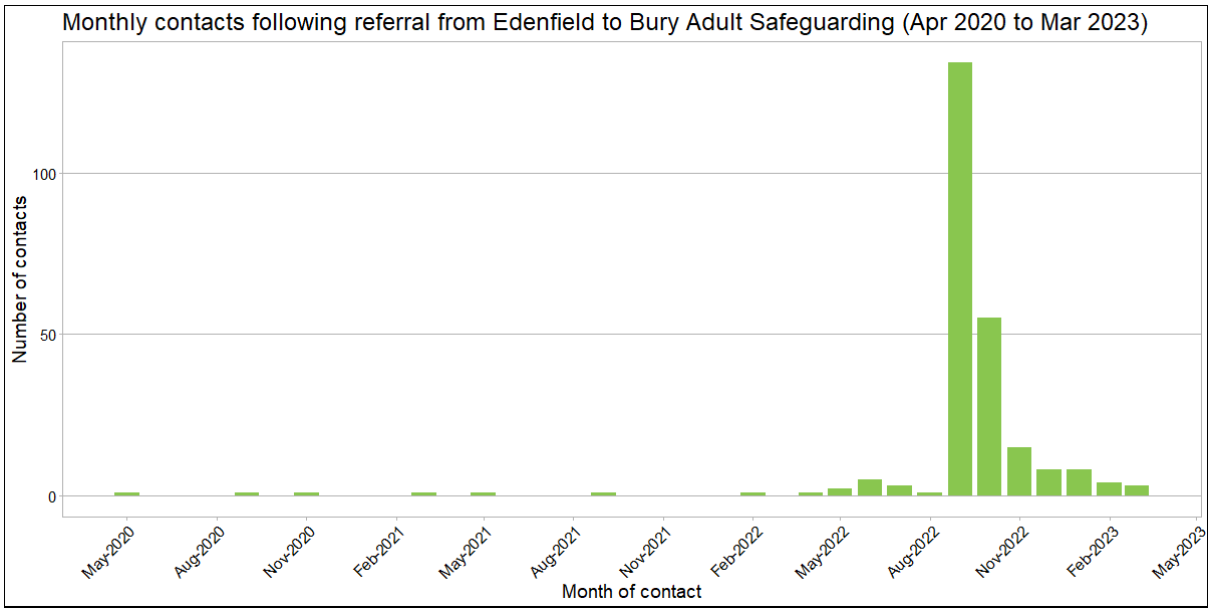
PMVA incidents per occupied bed day over time at Edenfield, April 2020 to March 2023



PMVA incidents per 100 occupied bed days, by ward, at Edenfield, April 2020 to March 2023



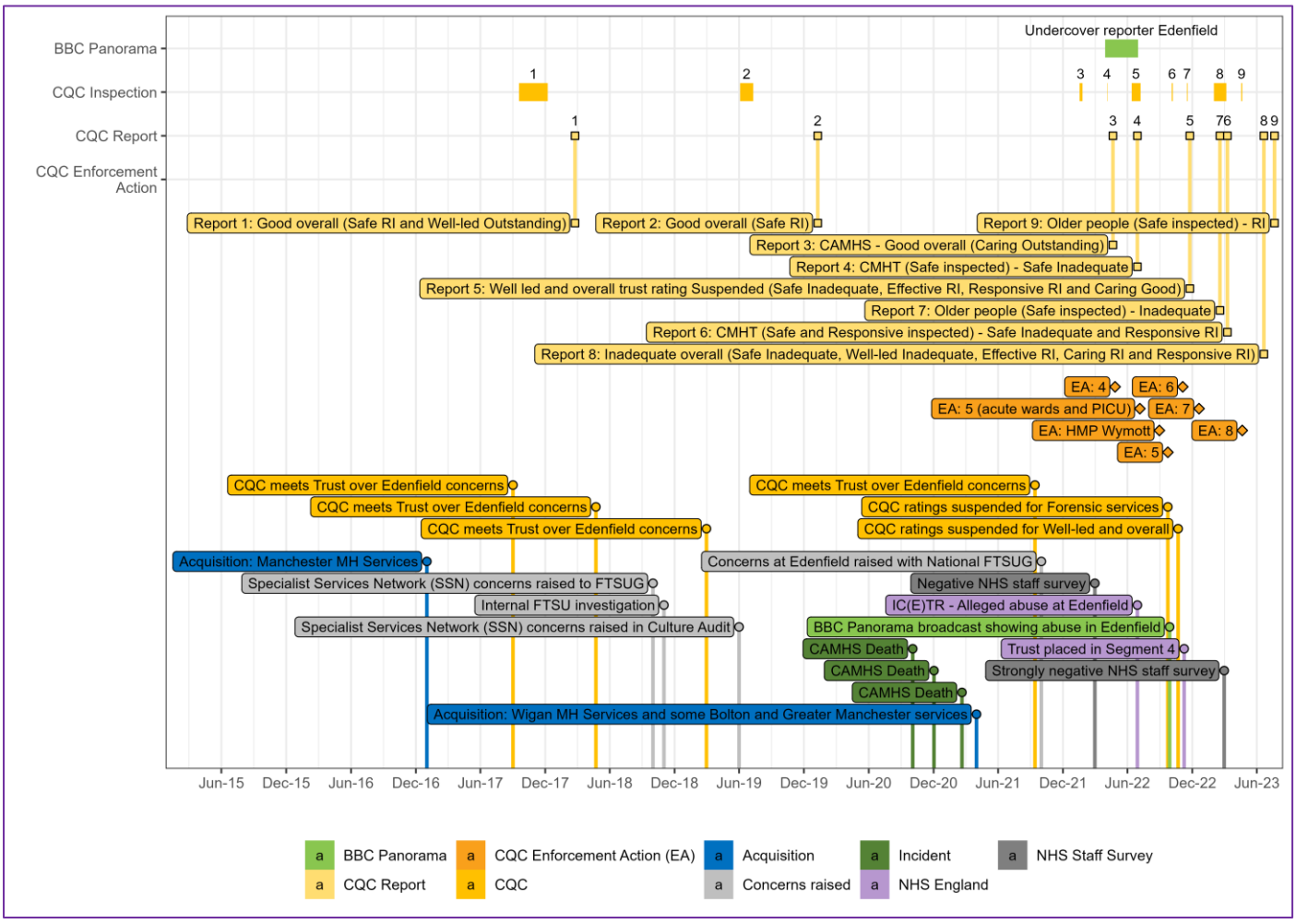
Monthly referral contacts from Edenfield to Bury Adult Safeguarding



77% of all contacts appeared to take place in September and October 2022, with small volumes of activity prior to this. 54% of all contacts resulted in an outcome of proceeding the safeguarding enquiry, 37% were resolved at contact, while 9% had a blank outcome recorded.

Appendix 5 – Timeline of key events

Summary timeline



Detailed chronology

Date	Event
January 2017	Greater Manchester Mental Health NHS Foundation Trust was formed with the acquisition of Manchester Mental Health and Social Care Trust.
1 September 2017	Following an on-site Mental Health Act review visit of Keswick ward (Edenfield) concerns were raised by CQC with the trust about staffing levels on the ward in August 2017. Concerns were followed up with information requests to the Trust. The Inspector and Inspection Manager (IM) at that time attended an onsite meeting with managers from Edenfield on 01 September 2017.
September-December 2017	CQC inspection. Core services inspected were acute admission wards for working-age adults and psychiatric intensive care units (PICU), child and adolescent mental health wards, wards for older people, long-stay rehabilitation wards, substance misuse services and a well-led inspection of the Trust overall.

February 2018	CQC report published for the Trust: The Trust rating is Good overall. The Safe domain is rated Requires Improvement, Effective, Caring and Responsive domains are rated Good and Well-led domain was rated Outstanding.
April 2018	A new CEO is appointed.
23 April 2018	The CQC met with senior managers from the Edenfield Centre prior to a Trust engagement meeting with the Trust to discuss Edenfield regarding recent whistleblowing and patient complaints.
October 2018	Concern raised to FTSUG at the Trust regarding Specialist Services Network (SSN). This includes the Edenfield Centre. Concerns were that there were often not enough staff at Edenfield: staff covering multiple wards, there was a ban on using agency staff, a culture of not speaking up, staff were not reporting incidents and there was poor quality data.
November 2018	The Trust commissioned an internal FTSU investigation into concerns raised in October. A draft report was produced: '*In summary, the root cause of the staffing challenges within SSN is a significant shortfall in Registered Nurses. This needs to be quantified and a strategy put in place to ensure the wards can be staffed safely and with minimum Registered Nurse cover at all times. The root cause of why the concern was raised is lack of confidence in the current management team to address safety issues within the network. This requires a cultural shift and transparency in order that the extent of the challenges can be specified and addressed*.'
March 2019	CQC undertook enhanced engagement activities at Edenfield. This included a walk-round of some of the wards and two staff focus groups (ward managers and open staff group). This was in response to concerns being raised with CQC about staffing levels and the impact of these in early 2019. CQC gave feedback to the Trust about themes identified from the focus groups and areas the Trust might need to consider.
June 2019	Report completed of an external Organisational Behaviour Audit which was piloted in the Specialist Service Care Group, which included Forensic Services among others. It identified concerns in Forensic Services.
4 June – 10 July 2019	CQC inspection: Core services inspected: Acute admission wards for adults of working age and psychiatric intensive care units, forensic inpatients/secure wards, community-based mental health services for adults of working age and specialist community mental health services for children and young people. CQC also completed a well-led inspection of the overall Trust.
9 January 2020	CQC report published from June 2019 inspection: The Trust is rated as Good overall. The Safe domain is rated Requires improvement; Effective, Caring, Responsive and Well-led domains are rated as Good. Forensic services were rated Good overall: Safe domain was rated as Requires Improvement, Effective, Caring, Responsive and Well-led domains were rated Good. The CQC inspection was prompted partly in response to concerns raised to them anonymously by staff. These related to staffing levels, burnout, staff not feeling safe to raise concerns with managers, and that the local management response was inadequate. Inspectors visited 12 wards out of 18 wards in total. The report for forensic services notes that *'staff did not always make requests for cover through the on-call management system.*' The report also notes that the *'decisions to deploy staff to cover duties on different wards should be agreed through the on-call management system in place and take account of those staff who have disability passports and are not meant to be moved to cover other ward areas.*

Q4 2019/2020	The Trust undertook a review of staffing levels at Edenfield using the Mental Health Optimal Staffing Tool (MHOST). The results of this exercise were not available. Management told the review team that it showed a clear staffing deficit on some wards. Consultants told the review team that they had been told by management that the service was overstaffed according to the tool.
3 October 2020	Death of a young person who was an inpatient on the Gardener Unit, a secure CAMHS service.
2 December 2020	Death of a young person who was an inpatient at Junction 17, a CAMHS service.
7 December 2020	CQC inspection: Acute wards for adults of working age and psychiatric intensive care units. Focused inspection at Park House.
December 2020	There were concerns raised with the CQC regarding the quality of care on Buttermere and Ferndale wards. This led to the CQC raising a safeguarding alert and arranging a meeting with the Trust to discuss the concerns.
11 February 2021	CQC inspection report published from December inspection: Safe rated Requires improvement, well-led not rated.
19 February 2021	Death of an inpatient on Griffin Ward at Junction 17, a CAMHS service.
1 April 2021	The Trust acquired Wigan mental health services, and a small number of Bolton and Greater Manchester-wide services.
July 2021	Ongoing whistleblowing from Edenfield staff to the CQC. The CQC shared their increasing and continued concerns about this with the Trust.
6 September 2021	CQC inspection: Acute wards for adults of working age and psychiatric intensive care units. Focused inspection of 8 wards.
13 September 2021	A virtual meeting took place between the CQC and the Trust to discuss concerns received by the CQC over the summer in respect of Edenfield. The Trust gave updates regarding Edenfield and actions that were being taken on the unit, including Quality Improvement projects that were due to start. The CQC agreed to receive updates as part of the regular engagement meetings with the Trust.
1 October 2021	Concerns were raised with NHS England national FTSUG about the Edenfield Centre. The concerns related to low levels of staff at the Edenfield Centre and staff being moved to provide cover. The NHS England guardian signposted the person to the Trust FTSUG and concerns were shared with the CQC.
November 2021	CQC agreed an inspection plan for the Trust. Four core services were selected for inspection between 17 and 28 January 2022 which were the forensic inpatients/secure wards, (including the Edenfield Centre), acute admission wards for adults of working age and psychiatric intensive care units (PICU), child & adolescent mental health wards (CAMHS) and crisis and health-based places of safety services. A Trust well-led inspection was planned for February 2022.
26 November 2021	CQC report published from September 2021. Safe not rated: issues identified with management of ligatures and the environment.
29 December 2021	The CQC inspection planned for January 2022 was suspended due to national COVID-19 concerns and changing guidance about the impact of inspections on NHS at that time.

17 – 24 January 2022	A focused inspection by CQC of the child and adolescent mental health wards took place. CQC initially limited this to the safe domain based on an assessment of intelligence and reduced COVID-19 risks due to team size and patient group. This inspection was extended to comprehensive (although no concerns were found and therefore no risks identified).
March 2022	NHS Staff survey for 2021 published: the Trust scores are lower than the national average for morale, people promise and staff engagement.
Late March – late June 2022	Covert filming takes place at the Edenfield Centre by a reporter.
1 April 2022	An external well-led developmental review of the Trust started.
5 April 2022	CQC complete a focused inspection of community-based mental health services of adults of working age in response to whistleblowing concerns about staffing levels. This is limited to the safe key question.
6 April 2022	A routine 'safe and wellbeing review' was completed for a patient at the Edenfield Centre. This was part of a national programme which checked the well-being of all people with a learning disability or autism diagnosis held in a mental health hospital. This identified that the patient was being nursed separately from their peers in what amounted to long-term segregation, which had not been recognised by the Trust. This led to an Independent Care Education Treatment Review (IC(E)TR) being arranged.
21 April 2022	The CQC published the CAMHS inspection report. The service was rated as Outstanding in the caring domain and Good across all other key questions.
27 April 2022	CQC issued a s29A Warning Notice to the Trust following the focused inspection in April 2022 of community mental health teams in Manchester. There were significant concerns including in relation to managing risk and staffing.
23 June 2022	An 'Independent review of the use of long-term segregation' was carried out for a patient in response to the findings of the safe and wellbeing review in April.
29 June 2022	An Independent Care Education Treatment Review (IC(E)TR) was undertaken with a patient at the Edenfield Centre. The patient made several allegations relating broadly to 'bullying and mimicking/taunting' by staff. The list of allegations was long and detailed, including individual named members of staff taunting the patient; for example, saying that they were in seclusion because they are a baby, making a gun like gesture to their head through the seclusion room window and many more. They also highlighted some of the general restrictions and disruption on the ward, such as a lack of continuity in psychology staff, the ward environment being noisy, and a general lack of care.
29 June 2022	CQC published the report following the community mental health services inspection in April 2022. The CQC rating of Safe went down from Requires improvement to Inadequate.
13 June – 7 July 2022	CQC completed an inspection at the Trust. There were three core services inspected, acute admission wards for adults of working age and psychiatric intensive care units, forensic inpatients/secure wards and mental health crisis services and health-based places of safety, an overall well-led inspection was completed.
1 – 6 July 2022	Following the IC(E)TR findings, a quality review of the service where the patient was cared for was undertaken by Case Managers.

6 July 2022	CQC issues a s29A Warning Notice to the trust relating to the inspection of acute admission wards. This highlighted urgent safety concerns including management of fire risks and management of ligature risks.
18 July 2022	The Commissioning Committee meets for the first time since the IC (E) TR. There is no specific item on the agenda regarding the allegations made by the patient, but within a presentation on 'Management of Failure/Quality Concern Scenarios', one bullet point notes *'Concerns raised by an Independent IC(E)TR chair regarding the care of an individual patient placed with the lead provider which led to wider quality issues being identified.'*
20 July 2022	The report from the Case Manager review of service is received and an action plan is requested from the Trust.
25 July 2022	The Chair of the Commissioning Committee reports to the private part of the Trust Board that a safeguarding referral had been made following an IC(E)TR in the service.
3 August 2022	A formal response to the concerns raised by the Case Manager Review was sent to the Quality and Commissioning Hub from the service. Many of the issues raised are noted as already completed (such as environmental issues, advocacy, PMVA training).
14 August 2022	The Quality Improvement Committee (QIC) met and a paper broadly outlining the concerns raised by the Case Manager review of the service is presented.
30 August 2022	CQC issued a s29A Warning Notice following an inspection of HMP Wymott for concerns relating to medicines management.
8 September 2022	The BBC alerts the Trust regarding the upcoming broadcast. The Trust then informed stakeholders including NHS England and the CQC.
23 September 2022	CQC suspended the ratings for forensic services.
23 September 2022	CQC issued a s29A Warning Notice to the Trust relating to the inspections which took place in June and July 2022. The Warning Notice did include concerns at the Edenfield Centre. The Trust did not have sufficient numbers of suitably qualified, competent and skilled staff to ensure that patients received the care and treatment they needed and to keep them safe within the acute, psychiatric intensive care and forensic wards. The Trust did not have effective governance systems and processes in place to ensure that the acute, psychiatric intensive care and forensic wards operated safely and that risks to patients were assessed, monitored and mitigated. The Trust had not ensured that patients' privacy, safety and dignity within the acute wards were respected and maintained. Patients were provided with beds on mixed sex wards and in dormitory accommodation. There had been 26 sexual safety incidents on the mixed-sex wards.
23 September 2022	The CQC draft report was issued to the Trust which had a rating of Requires Improvement for well led.
28 September 2022	The BBC Panorama programme was broadcast depicting examples of bullying and abusive behaviour by staff which were similar to the concerns raised during the IC(E)TR.
29 September 2022	The Equality and Human Rights Commission write to the Trust Chief Executive setting out their concerns regarding the abuse that was shown in the BBC Panorama programme.
4 – 6 October 2022	The CQC inspect community-based mental health services for adults of working age. The safe and responsive domains are inspected.

22 October 2022	The CQC remove the ratings of well led and the overall rating from the CQC public website with the following message – "*We have suspended the ratings for this provider while we investigate concerns*."
01 November 2022	The coroner issued a Prevention of Future Death notice relating to the death of a young person on the Gardener Unit, the forensic CAMHS service. This relates to issues with observations not being undertaken and signed as completed, blood results not being available and a lack of suitably experienced nursing staff on the ward.
4 November 2022	CQC issue a further s29A Warning Notice for community-based mental health services for adults of working age relating to oversight and governance and case load management.
8 November 2022	The Trust were placed into Segment 4 of the NHS Oversight Framework. This meant it entered the National Recovery Support Programme and would receive mandated intensive support.
16 – 17 November 2022	The CQC carried out a focused inspection of wards for older people with mental health problems at Woodlands Hospital. This was in response to concerns raised by a whistle-blower and following an MHA monitoring visit. A Letter of Intent was issued to the Trust following the inspection.
24 November 2022	The CQC report is published following the June/July 2022 inspection. The overall trust ratings are Inadequate for Safe, Requires improvement for Effective and Responsive and Good for Caring. The well led and overall trust rating would remain suspended pending a further inspection of the trust to be completed in early 2023. Both the Forensic core service and Acute wards and/PICUs core service were rated inadequate overall. Both services were rated as inadequate for the safe and well led domains and the remaining three key questions were rated as requires improvement. The Crisis & Health Based Place of Safety core service was rated Good overall and in all key questions.
20 December 2022	The CQC issued a s29A Warning Notice relating to the inspection at Woodlands Hospital. This centred on concerns relating to the management of ligature risks, environmental risks, medicines management, risk management/patient records and handover between staff, access to records and oversight of quality.
1 January 2023	An interim Chair joins the Trust.
31 January – 6 March 2023	CQC undertook an inspection of acute admission and PICU wards, forensic/secure wards and community mental health teams for adults. An overall well-led inspection of the Trust was also completed.
7 February 2023	The coroner issued a Prevention of Future Death report relating to the death of a patient on Griffin Ward, a ward for young adults at Junction 17. Issues relating to clinical risk assessment are highlighted.
17 February 2023	The CQC inspection report for wards for older people with mental health problems at Woodlands Hospital following inspection in November 2022 was published with the safe domain rated Inadequate.
21 February 2023	A contract performance notice was issued to GMMH's provider function (secure services) by NHS England specialised commissioning.
March 2023	The NHS Staff survey results were published. The Trust results for 2022 are among the lowest for all mental health trusts in England across many measures.

10 March 2023	The CQC inspection report is published following the inspection of community-based mental health services for adults of working age in October 2022. The safe key question remains rated as Inadequate, and the responsive key question is rated as Requires Improvement.
17 March 2023	The CQC issued a letter of intent to the Trust requiring urgent assurances relating to fire safety/smoking and ligature risks/audit.
18 – 20 April 2023	The CQC complete a focused inspection of Woodlands Hospital and identified improvements following the Warning Notice issued in December 2022.
21 April 2023	The CQC issued a Section 29A Warning Notice to the Trust. It noted that the Trust had failed to improve in response to a previous Warning Notice relating to management of ligature risks and fire safety.
21 June 2023	The CQC published inspection reports from the inspection in early 2023. The forensic/secure core service rating improved to Requires Improvement in all domains, the acute admission wards and PICU core service were rated Inadequate for safe and well led and remained rated as Inadequate overall. Community mental health teams had improved to being rated as Requires Improvement overall, with the safe and responsive domains rated Requires Improvement. The overall Trust Well-led rating remained Inadequate.
1 July 2023	The CEO steps down and an interim CEO starts at the Trust.
21 July 2023	The CQC published an inspection report for Woodlands Hospital following the inspection in April 2023. The safe domain is now rated as requires improvement; the other domains were not fully inspected. The report states *'At this inspection, the trust had developed action plans to address all of these areas. We were able to see all the areas of concern had improved and there were ongoing plans to ensure that progress was built on and improvement sustained. We also saw areas of good practice at Greenway ward including comprehensive care plans, risk assessments which were complete and updated daily and good medicines management.'*

Appendix 6 – Glossary of terms used

Term used	Definition
ADO	Associate Director of Operations
AFS	Adult Forensic Services
CAMHS	child and adolescent mental health services
CC	Commissioning Committee: a sub-board committee
CCG	clinical commissioning group
CCTV	closed circuit television
CEO	Chief Executive Officer: the role provides strategic leadership and management to the whole organisation
CHARM	Community for Holistic, Accessible, Rights Based Mental Health
CHPPD	Care Hours per Patient Day
COO	Chief Operating Officer: this is a member of the executive team and sits on the Board
CQC	Care Quality Commission
DASS	Director of Adult Social Services
EPR	electronic patient record
FAST	Forensic Advice and Support Service
FT	Foundation Trust
FTE	full-time equivalent
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GM	Greater Manchester
GMC	General Medical Council
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GMW	Greater Manchester West NHS Foundation Trust
HR	Human Resources
ICB	integrated care board: they replaced care commissioning groups in April 2022
ICS	integrated care system: these are partnerships between organisations that meet health and care needs across an area
IC(E)TR	independent care (education) and treatment reviews
IMHA	independent mental health advocate: a specialist advocate
LP	lead provider
LPC	local provider collaborative: a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population
MAPPA	multi-agency public protection arrangements
MCA	Mental Capacity Act
MDT	multidisciplinary team

MFT	Manchester University NHS Foundation Trust
MH	mental health
MHA	Mental Health Act
MHOST	Mental Health Optimal Staffing Tool: a tool used to measure patient acuity and dependency to help plan staff numbers
MHSIP	National Mental Health Safety Improvement Programme
MMHSCT	Manchester Mental Health and Social Care Trust
MS Teams	Microsoft Teams
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NED	non-executive director
NG10	Violence and aggression: short-term management in mental health, health and community settings (NG10)
NHS	National Health Service
NHS Long Term Plan	The NHS has written a Long Term Plan so it can be fit for the future; the plan is based on the experiences of patients and staff
NHS Professionals	NHS Professionals provides temporary clinical and non-clinical staff to the NHS
NHS England	NHS England
NICE	National Institute for Health and Care Excellence: an organisation which produces evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders
NMC	Nursing and Midwifery Council
NSS	National Staff Survey
OT	occupational therapist
PALS	Patient Advice and Liaison Service
PARIS	Patient Record Information System (PaRIS)
PBS	positive behaviour support: a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge
PCDC	People, Culture and Development Committee
PCREF	Patient Carers Race Equity Framework
PDG	People Delivery Group: a sub board committee
PICU	psychiatric intensive care unit
PMVA	Prevention and Management of Violence and Aggression: training in how to manage situations safely for patients and staff when patients become distressed
PP	People Promise
PRN	pro re nata: a term used for medicines which are prescribed for when they are needed rather than at set times
PSIRF	Patient Safety Incident Response Framework
Q&C Hub	Quality and Commissioning Hub

QI	Quality Improvement
QIC	Quality Improvement Committee: a sub board committee
QIODG	Quality Improvement Operational Delivery Group: a subcommittee of the QIC
RC	responsible clinician
RCA	root cause analysis
Regulation 28 PFD	Regulation 28 Prevention of Future Death report: The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths
RRN	Restraint Reduction Network
Safeguarding	Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality healthcare. Safeguarding children, young people and adults is a collective responsibility.
Section 17 leave	Section 17 of the Mental Health Act 1983 allows for certain patients who are detained under the Mental Health Act to be granted 'leave of absence' from the hospital in which they are detained for a specified or indefinite period subject to particular conditions specified in their leave care plan.
Secure services	Secure services provide care and treatment for individuals with mental and/or neurodevelopment disorders who are liable to be detained under the Mental Health Act (MHA) 1983, and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings.
SEIPS	System Engineering Initiative for Patient Safety
SLT	senior leadership team: the tier of leadership below the executive team
SOAD	second opinion appointed doctor: they safeguard people who do not agree to their treatment under the Mental Health Act or are too unwell to agree
SPA	supporting professional activities
Specialised Commissioning	Specialised Commissioning: the part of NHS England which commissions and oversees quality of services in secure services
ToR	terms of reference
VCSE	voluntary, community and social enterprise
WRES	Workforce Race Equality Standard
WTE	whole-time equivalent

Appendix 7 – References

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3.5. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.5

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational from January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns. The enclosed Public Log reflects discussions from the BFS Full Board meeting on the 18th June 2024.

Key items for information:

- Review of Picker Staff survey actions
- Strong financial start to the year
- Recruitment Open Day delivers great results
- New drinks and food offering for A&E

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors notes the attached report and takes assurance that the Operated Healthcare Facility is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS: BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 24/08/01/3.5

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** JUNE 2024	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	BFS is supporting Nursing as they engage with the national uniform project which will standardise the uniforms of our nursing staff within NHS England. The board was updated on consultations with end-users and designers to review the proposed refurbishment of the Education Centre which has been approved by the Executive Team. Costings are also being looked at for a proposed new extension to the rear of the building to increase lecture theatre capacity and operational flexibility, to reduce further costs of these facilities being presently provided at off-site venues. Reinforced Autoclaved Aerated Concrete (RAAC) – Works are nearing completion. The Stores and Workshop areas are due for handover at the end of June, with only some snagging, and a builder clean is required. The new roof covering is installed, and the air source heat pump has been reinstalled on the roof. Work is ongoing with the estates team to redesign the interior to best suit their needs and to reflect the changes in practice and operations since the building was originally fitted out. The board was advised that a new and improved hot drinks dispensing offering for the Emergency Department waiting area was signed with Nestle. Several suppliers were looked at but this was felt to be the best value for money offering. Investigations are underway for a new food vending option as well.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.	**Finance**	BFS has started the financial year well and, at this early stage, is on target to deliver its top line financial objectives for the year including their Efficiency and Productivity savings targets. Focus has already begun on developing efficiency and savings opportunities for the 25/26 financial year.	Trust Board	For Information and Assurance
3.	**People**	The BFS recruitment 'Open-Day' held on the 13th June in Colliers Restaurant was a resounding success with 36 applicants registering on the day and 21 people being offered positions. The Open Day was widely promoted through social media and The Chronicle. The HR team presented to the board an update on activity and progress from the Picker Staff Survey from 2023. The update demonstrated that the HR & Organisational Development Plan appears to be providing positive effects on our people, as evidenced through the follow-on activities such as Pulse Checks, Focus Groups and general feedback. The Board acknowledged that these are encouraging signs, but we recognised that more work is required. Lee Rogers was the esteemed recipient of this year's BFS Heart Award, and the Procurement team also featured with a joint award with Paediatrics for the Chair and Quality & Innovation Awards. The whole event was a resounding success and provided a wonderful opportunity to celebrate and acknowledge the achievements and recognition of all nominees and winners across the trust, not just at BFS.	Trust Board	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/3.5i

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational in January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns. The enclosed Public Log reflects discussions from the BFS Full Board meeting on the 15th July 2024.

Key items for information:

- Continued support for Project Search
- Transition from paper base to Web Requisitions

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors notes the attached report and takes assurance that the Operated Healthcare Facility is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS: BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 24/08/01/3.5i

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** July 2024	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	The RAAC identified to the Estates Building has been fully removed and the refurbishment and decorating completed. The estates team who occupy the site are now moving back in. The Outpatients Pharmacy performance continues to improve but is still below expected levels of performance and customer satisfaction. New operating protocols are being reviewed and implemented to improve performance. The BFS procurement team have successfully completed the transition away from a paper based procurement requisition system to a web based E-Requisitioning system across the entire trust.	Trust Board	For Information and Assurance
2.	**Finance**	BFS has started the year well and, at this early stage, is on target to deliver its financial objectives for the year. The BFS Efficiency and Productivity programme is also progressing well and in line with expectations year to date and for full year.	Trust Board	For Information and Assurance
3.	**People**	BFS continues to support the Project SEARCH scheme, providing internship programmes for 18-24-year-olds with learning disabilities and autism, in collaboration with partners Barnsley College and Barnsley Council. We look forward to welcoming further interns on the 2024 /2025 scheme into Portering and Waste, Domestic Services and Catering for the forthcoming year.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		We continue to work with South Yorkshire and Bassetlaw and the Princes Trust on two recruitment schemes, (SWAP and Bespoke) for Domestic Services recruitment, which are aimed at encouraging individuals back into work. One of the two-week training schemes, for 18 – 30-year olds is currently active with interviews having taken place on 4th July for Domestic Operatives. We were delighted to make 5 offers of employment. We are actively encouraging staff members to take support from the Princes Trust if appropriate, and communicating that they are on site on Fridays. The Princes Trust have thanked BFS and said this will be a life changing opportunity for these people. Following the decision of COG, after reviewing their constitution to invite BFS to be a Partner Governor, we are pleased to say that Matt Hall, our commissioning / Space Utilisation Officer has volunteered. Matt is very much looking forward to joining the COG, he is very familiar with BFS and its services as a whole and we think an ideal partner.		

3.6. Executive Team Report and Chair's Log

For Assurance

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/08/01/3.6

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Managing Director/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

Our mission is to provide the best possible care for the people of Barnsley and beyond at all stages of their life. The Executive Team meets on a weekly basis to ensure the smooth day to day running of the Trust and ensure the Trust is delivering on the vision through its oversight and decision making.

EXECUTIVE SUMMARY

This chairs log covers the ET meetings held in June & July 2024 including key decisions/points to note.

RECOMMENDATION

The Board of Directors is asked to receive and review the attached log.

CHAIR'S LOG: Chair's Key Issues and Assurance Model - Public

Committee/Group	Date	Chair
Executive Team	June 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
5 June 2024	24/477	Guardian of Safe Working Biannual Report on Safe Working Hours for Doctors in Training July – December 2023	The bi-annual report showed an increase in exception reporting, there have been 4 breaches/fines during the period and historical breaches/fines are disclosed within the report. ET noted the report and the requirement for an annual report.
5 June 2024	24/478	Chief Pharmacist Recruitment Options	ET approved that Barnsley and Rotherham will begin the process of recruitment of two Chief Pharmacist's, one for each organisation as soon as possible.
5 June 2024	24/481	CBU1 Medical Staffing Business Case - June 24	The paper requesting substantive recruitment of junior doctor's (Monday to Friday 9am to 5pm). ET acknowledged the good work and supported the investment to align budgets and the recruitment to substantive Medical Staff to affect the change and in turn realise a run-rate reduction in spend. The recruitment should be advertised in a flexible way to enable staffing of out of hours. A short review paper in the next month describing benefits; improving patient care, flow, length of stay, criteria to reside compliance, discharge (D1's), outliers and including winter escalation costing. In order to address this, this paper is requesting an investment of approximately £1.9m offset versus extra contractual pay.

12 June 2024	24/507	Health on the Highstreet Project Update	The paper provided an update on progress to delivery of the full business case for the Health on the High Street. BK timescales have been challenging and it was noted the hard work that colleagues have undertaken. ET accepted the report and approved/endorsed the appointment of the health care planners and revised timetable.
12 June 2024	24/509	Deep Cleaning of Wards - Phase 2	Phase 2 deep clean of wards paper, proposing that the Trust continues to adopt a deep cleaning programme using HPV and that Ward 37 will be used as a decant facility to enable full environmental decontamination of the ward area. It is proposed that: • June – no planned decant deep cleans, although Ward 36 will be deep cleaned on a bay-by-bay basis. • July – Ward 19. • August – Ward 23. • September – Ward 17. This will leave Wards 21, 30, and 32, which have been identified as having increased infection risk, without a deep clean, while Wards 17, 19, 20, 23, 27, 28, and 37 will have received a full decant clean. ET supports the second phase of a deep cleaning programme.

CHAIR'S LOG: Chair's Key Issues and Assurance Model - Public

Committee/Group	Date	Chair
Executive Team	July 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
3 July 2024	24/264	ED Nurse Staffing Rota	The paper has been through check and challenge with professional advice to support the recommendations, the workforce within ED which has expanded to support ongoing patient care within the department, resulting in a significant overspend. The proposal is to align the budget to the correct staffing levels required, to provide assurance that safe and effective staffing models are in place to provide a sustainable 365 24/7 service to patients. Discussions took place regarding the need to improve performance against 4 hours and the safety of the department with a flex change in staff. It was confirmed this would be monitored with the safe nursing tool data and will be reviewed week by week and other CBUs are overstaffed with the ability to utilise staff in ED and was approved by ET.
3 July 2024	24/266	Occupational Health Service Onsite Counsel Team Outline Proposal Paper	The main cause of sickness absence at BHNFT is attributed to mental health issues. In July 2022, South Yorkshire ICB provided temporary funding for a Lead Specialist Staff Counsellor to support the workforce and their mental health & wellbeing at the Trust. The funding is no longer viable to support the demand for the counselling service. SG queried about the low uptake of VIVUP asking do we need to revisit the offer and cost, MS confirmed that VIVUP is funded by ICB and staff have been encouraged to use the service, following the backlog of referrals and the demand for the service continues to rise. The paper was approved by ET.

3 July 2024	24/270	CBU Performance Meeting	Following changes which have been made in light of increased external expectations and an internal requirement to drive improvement in key performance areas were summarised. It was agreed that the chairs logs would be presented at ETM to escalate any concerns.
10 July 2024	24/291	Outpatient Pharmacy Changes	The paper suggested changes to improve outpatient patient turnaround times. ET supported the implementation of the recommended changes. Common themes for prescriptions/medications not collected will be reviewed and it was confirmed that the pharmacy staffing model will be reviewed following the changes.
10 July 2024	24/292	MMBRACE Neonatal Mortality Review (ID2573)	The paper on the 5% higher than average for similar Trusts and Health Boards for MMBRACE report on neonatal mortality and the undertaken deep dive. Temperature control changes, preterm clinics and BAPAM 7 have provided improvements. ET thanked colleagues for their proactive response and noted the assurance provided and accepted the findings of the review.
10 July 2024	24/295	Permanent Employee of Cancer Navigator Roles	The paper recommended the substantive recruitment of the Cancer Navigator roles which are a key function to meet the national single point of contact for all patients referred on a pathway and meet the NHSE Core principle around highlighting health inequalities and providing tailored support to these patients. ET acknowledged the work that these roles have completed over the past 2 year and formally approved to continue the 3 navigator roles therefore placing on a permanent contract.
10 July 2024	24/296	Acorn Unit (Intermediate Care) Update and Costings	The paper summaries intermediate care services provided by Barnsley Hospital NHS Foundation Trust. ET reviewed the paper and supported presentation of costs to Barnsley ICB, with the expectation of full payment for the costs identified. Plus, the list of actions to deliver better value for the service as listed in the paper.
10 July 2024	24/297	GP Non-Statutory Ballot: GP Practice Survival Toolkit	The paper was included for information relating to the suggested ballot inviting GP contractors/partner BMA members to determine the actions they will be willing to take should they proceed with industrial action. The increase risk to the Trust of more ED activity was highlighted if the GPs decide to proceed due to them being

			prescriptive about the numbers of patients seen per GP.
17 July 2024	24/308	Barnsley NHS Foundation Trust - Drivers of the Deficit Review – Emerging Analysis	Deloitte colleagues attended via Microsoft Team to present on the work commissioned by the ICB to identify key financial deficit drivers. Following discussions, it was commented that the final report should be peer group relevant/appropriate.
17 July 2024	24/320	Additional Consultant Arthroplasty Surgeons (Hip and Knee Arthroplasty) x2	The paper was written to enable the delivery of activity at Mexborough Orthopaedic Elective Centre (MEOC). ET supported the recruitment of an additional 2.0 wte Consultants for lower limb arthroplasty and 2 Registrars. Discussions highlighted the need to fill MEOC lists between now and January 2025, when the new positions will be in place and the future opportunities to downsize consultant numbers once the backlog is cleared.
17 July 2024	24/324	EPR Convergence - Strategic Outline Case including Legal Requirements	An external company has been commissioned to produce a report with a broader perspective on choices on convergence and it has been recommended that an outline business case is developed. Convergence will be a challenge and will be unaffordable without external funding. It was highlighted that the case should be scored objectively. Legal advice confirms it is possible to use the Sheffield contract, but there may be a risk.

4. Performance

4.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/4.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Shaun Garside, Corporate ADO				
SPONSORED BY:	Lorraine Burnett, Chief Operating Officer				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT

The monthly Integrated Performance report is aligned to the Trust objectives and informs the Board of Directors on key delivery indicators against local and national standards.

The report is currently being developed to reflect 3 of the 6 'P's' as per the Trust strategic objectives. The report does not currently contain metrics directly related to Place & Planet as these are reported separately, with all objectives reported quarterly via the strategy report. The place dashboard is shared as available.

EXECUTIVE SUMMARY

Patients

Overall quality metrics within expected with the exception of C diff where we continue to breached our NHSI mandated target. Patients with C Diff were identified on 5 wards, with ribotyping taking place on one ward. The improvement trajectory for C Diff is still awaited.

Falls and pressure ulcers per 1000 bed days continue to show special cause improvement with below average incidence.

People

Appraisal: below target of 90% at 75.3%.

Turnover: continues to remains within target and benchmarks favourably within South Yorkshire**.**

Sickness: 4.9%, remains above target.

Return to work: below target of 70% at 41%

Mandatory Training: At 90.2% against Trust target of 90%.

Finance: As at month 03 the Trust has a consolidated year to date deficit of £3.100m against a planned deficit of £2.754m giving a adverse variance of £0.304m

Performance

UEC: Performance against 4 hrs for type 1 was 73.2% against the England performance of 60.5% (11/122). Bed occupancy for Jun 24 was 92.6%. The stretch trajectory for ED performance is 80%, with daily attention to focus on evening and overnight waits to seeing clinical decision maker along side flow to wards and AMU.

RTT: 73% performance, England performance for the same period 58.2%. There are 154 patients waiting 52 weeks and above. Clinical business units are working to speciality specific recovery to 92%, including speciality specific stretch to >95% in year to achieve a robust RTT delivery.

Capped Theatre Utilisation: 68.9% as at June 2024.

Diagnostics: 1.8% patients waiting longer than 6 weeks for a diagnostic test against the target of 1% and a recovery target of 5% by March 2025.

Cancer: The trust has achieved the 28-day faster diagnosis standard @ 81 % against a target of 75%, the 31-day treatment standard achieved 91% against a target of 96%. Performance against the 62-day treatment standard of 85% was 75%.

The breakdown of the waiting list by speciality (unvalidated) as at 16/07/24:

Spec	RTT %	<18	18-26	27-51	52-64	65-77
BREAST SURGERY	96.55%	168	5	1		
CARDIOLOGY	95.80%	753	28	5		
CLINICAL HAEMATOLOGY	68.72%	312	85	57		
COLORECTAL SURGERY	66.67%	2	1			
DERMATOLOGY	67.69%	1257	346	253	1	
DIABETIC MEDICINE	89.58%	43	5			
ENDOCRINOLOGY	76.43%	308	68	27		
ENDOSCOPY	50.00%	1	1			
ENT	67.35%	1706	606	214	7	
GASTROENTEROLOGY	94.76%	940	46	6		
GENERAL MEDICINE	100.00%	6				
GENERAL SURGERY	72.17%	1014	203	175	12	1
GERIATRIC MEDICINE	97.35%	147	4			
GYNAECOLOGY	64.62%	1498	470	320	30	
HEPATOLOGY	80.18%	178	42	2		
MAXILLO-FACIAL SURGERY	66.87%	1088	258	271	10	
OPHTHALMOLOGY	83.99%	1595	178	117	9	
ORAL SURGERY	16.03%	50	39	211	11	1
ORTHODONTICS	19.75%	31	21	88	16	1
PAEDIATRIC CARDIOLOGY	90.91%	10	1			
PAEDIATRIC DERMATOLOGY	73.76%	163	41	17		
PAEDIATRIC DIABETIC MEDICINE	33.33%	1	2			
PAEDIATRIC EAR NOSE AND THROAT	74.78%	347	107	10		
PAEDIATRIC EPILEPSY	100.00%	4				
PAEDIATRIC OPHTHALMOLOGY	89.68%	278	21	11		
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	84.57%	159	23	5	1	
PAEDIATRICS	71.93%	592	200	31		
RESPIRATORY MEDICINE (THORACIC MEDICINE)	72.08%	581	151	73	1	
RHEUMATOLOGY	97.96%	192	3	1		
STROKE MEDICINE	92.86%	13		1		
TRAUMA & ORTHOPAEDICS	55.50%	1287	475	514	40	3
UROLOGY	74.70%	815	163	108	4	1
Total	71.28%	15539	3593	2518	142	7

RECOMMENDATION(S)

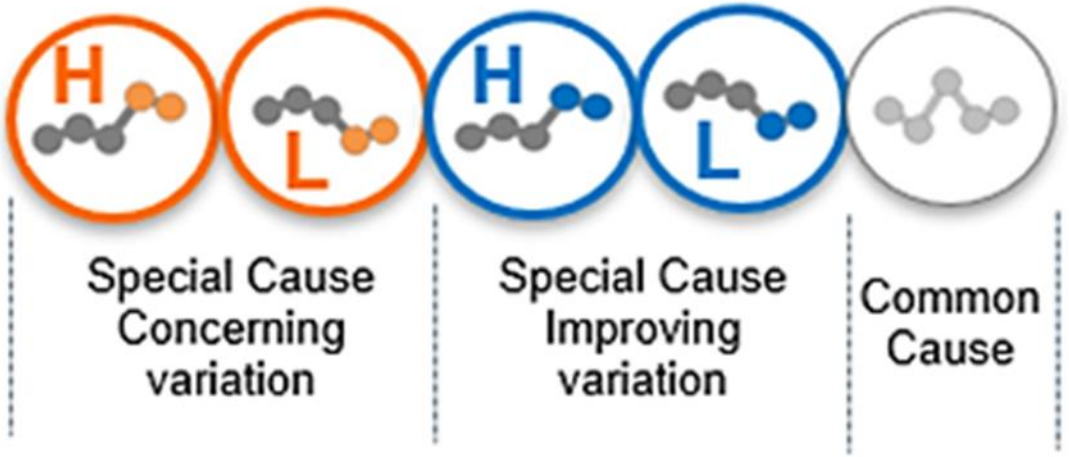
The Board of Directors is asked to note and receive the Integrated Performance Report for June 2024.

Barnsley Hospital Integrated Performance Report

Reporting Period: June 2024

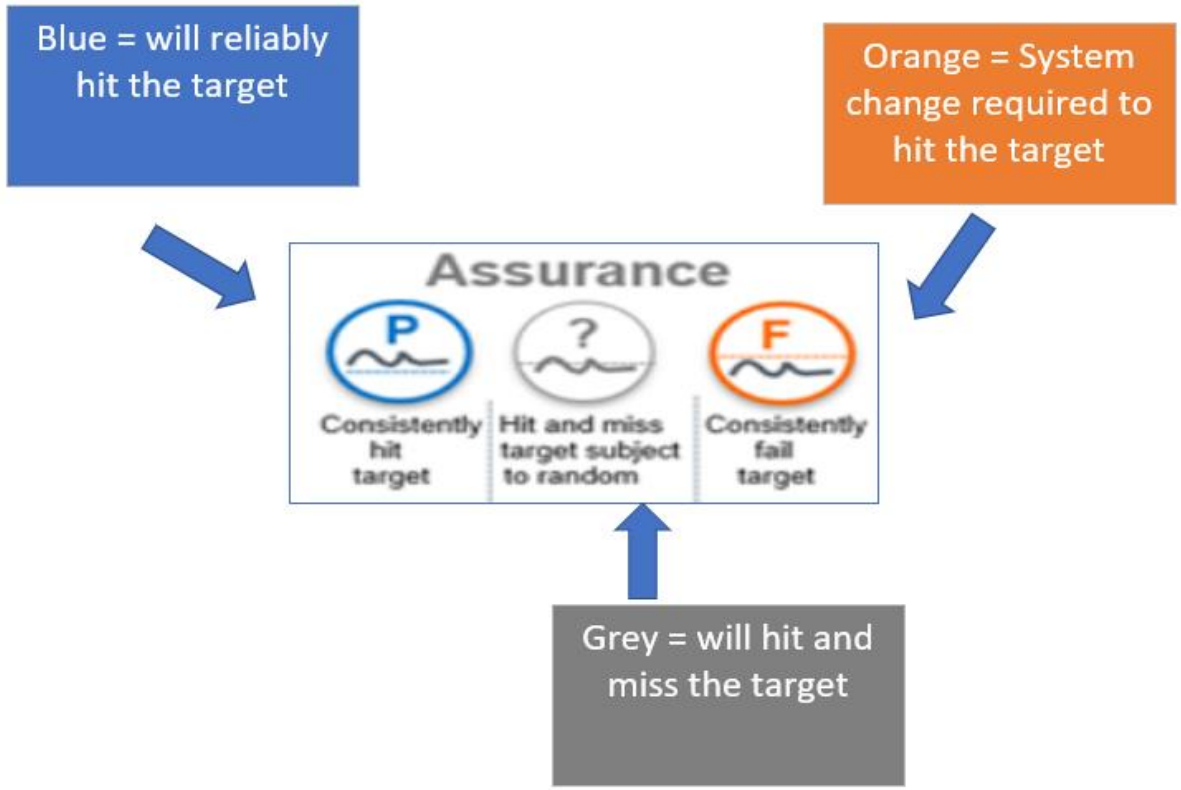
Assurance

Performance



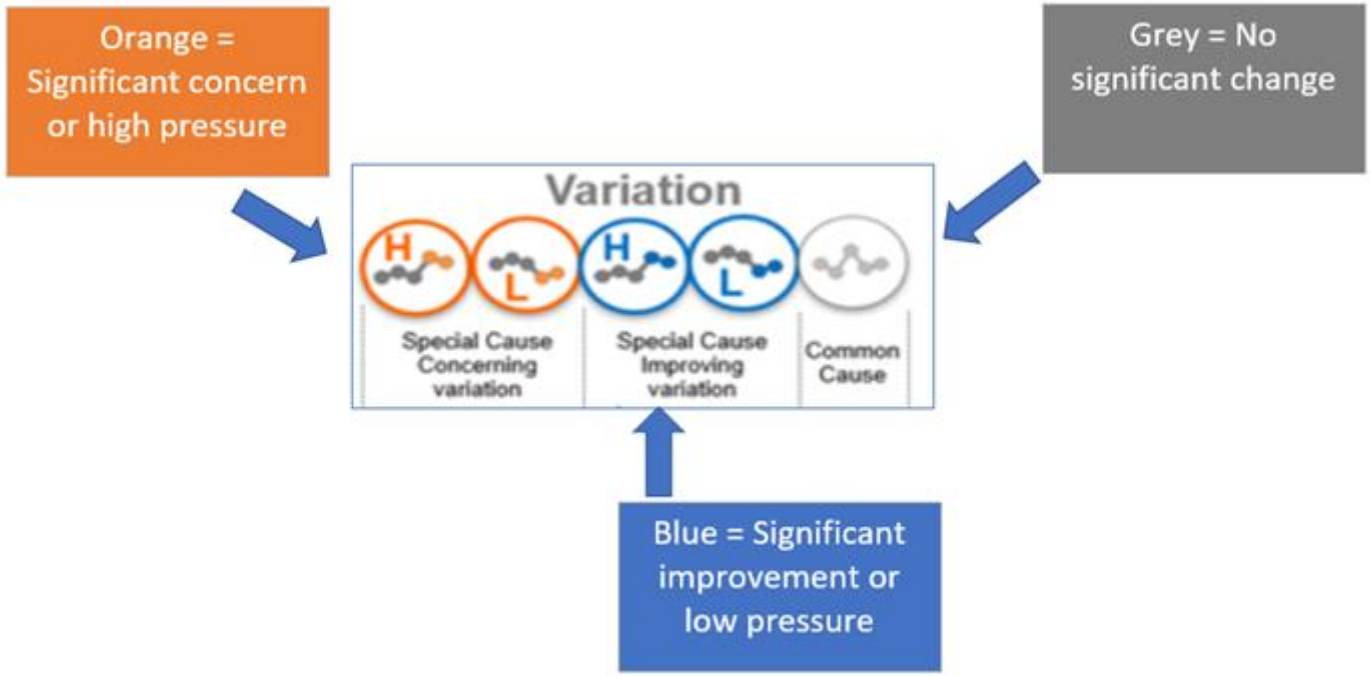
High Level Assurance

Can we reliably hit the target?



High Level Key Performance

Are we improving, declining or staying the same?



Summary icon descriptions

Assure	Perform	Description
		Special cause of an improving nature where the measure is significantly **HIGHER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly **LOWER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.

Summary icon descriptions

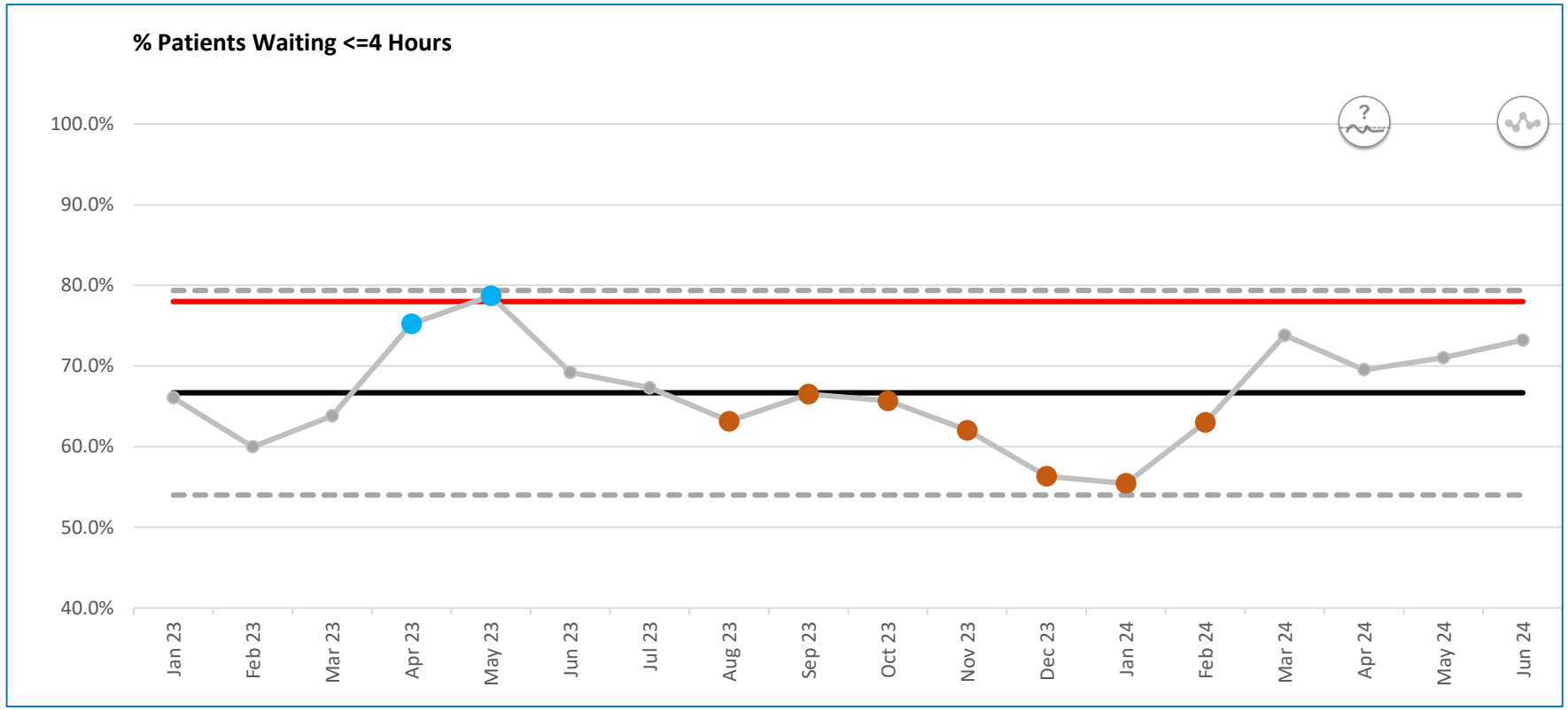
Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
		Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.
		Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Means and process limits are calculated from the most recent data step change.

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Patient Safety Incident Investigations	Jun 24	2	0			2	-3	7
Incidents Involving Death	Jun 24	3	0			1	-2	4
Incidents Involving Severe Harm	Jun 24	0	0			2	-2	6
Never Events	Jun 24	0	0			0	0	0
Falls per 1000 bed days	Jun 24	6.2	6.6			7.8	5.6	10.0
Harmful Falls per 1000 bed days	Jun 24	0.2	0.0			0.2	-0.1	0.5
Pressure Ulcers per 1000 bed days	May 24	2.6	0.0		L	3.4	1.5	5.4
Hand washing	Jun 24	92%	95%			93%	85%	102%
Q - Hospital Acquired Clostridioides difficile	Jun 24	7.0	2.8			4.2	-2.8	11.3
Q - Hospital Acquired MRSA Bacteraemia	Jun 24	0	0			0	0	0
Single Sex Breaches	Jun 24	0	0			1	-1	2
Number of complaints	Jun 24	14				24	5	44
Complaints closed within standard	Jun 24	72.0%	90.0%			69.1%	43.8%	94.4%
Complaints re-opened	Jun 24	2	0		H	1	0	1
FFT Trustwide Positivity	Jun 24	90.1%	95.0%		L	91.3%	84.7%	98.0%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <=4 Hours	Jun 24	73.2%	78.0%	?		66.7%	54.0%	79.4%
RTT Incomplete Pathways	May 24	73.0%	92.0%	F		71.5%	68.7%	74.2%
RTT 52 Week Breaches	May 24	154	0	F		201	132	271
RTT Total Waiting List Size	May 24	22009	21000	?	H	21635	20887	22384
% Diagnostic patients waiting more than 6 weeks (DM01)	Jun 24	1.8%	5.0%	?		4.8%	0.4%	9.2%
% Cancelled Operations	Jun 24	1.9%	0.8%	?		1.1%	-0.4%	2.5%
DNA Rates - Total	Jun 24	7.1%	6.9%	?		7.0%	6.2%	7.8%
Average Length of Stay - Elective - Spell	Jun 24	2.5	3.5	?	L	3.0	1.9	4.1
Average Length of Stay - Non-Elective - Spell	Jun 24	3.5	3.5	?		3.7	3.4	4.1
Bed Occupancy General and Acute % Overnight	Jun 24	92.6%	85.0%	F				
Data Quality - % pathways with metrics on RTT PTL	Jun 24	2.3%	2.0%	?		2.2%	1.5%	2.9%
Care Hours per Patient Day (CHPPD) (excl. maternity)	Jun 24	8.7	n/a	F		8.3	7.7	9.0
28 day - Faster Diagnosis Standard	May 24	81%	75%	?		80%	72%	89%
31 day - Treatment Standard	May 24	91%	96%	?		96%	88%	103%
62 day - Treatment Standard	May 24	75%	85%	?		75%	64%	86%

KPI	Latest data	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Uncapped Theatre Utilisation	02/06/24	73.0%	85.0%			79.3%	70.6%	88.0%
Capped Theatre Utilisation	02/06/24	68.9%	85.0%			74.6%	67.3%	82.0%
Total Number of Ambulances	Jun 24	2279	-			2125		
% Less than 30 mins	Jun 24	79.9%	95.0%			79.2%		
% Greater than 30 mins	Jun 24	15.9%	-			11.9%		
% Over 60 mins	Jun 24	3.1%	-			4.7%		
No time recorded	Jun 24	4.0%	-			4.8%	1.8%	7.8%
Staff Turnover	Jun 24	11.5%	12.0%			10.6%	9.6%	11.5%
Appraisals - Combined	Jun 24	75.3%	90.0%			71.4%	22.6%	120.2%
Mandatory Training	Jun 24	90.2%	90.0%			89.8%	87.8%	91.7%
Sickness Absence	Jun 24	4.9%	4.5%			5.4%	4.8%	6.0%
Return to Work Interviews	Jun 24	41.0%	70.0%			40.8%	30.9%	50.7%
Vacancy Rate	Jun 24	3.6%	0.0%			3.7%	1.9%	5.4%
Bank/Agency Spend £k	Jun 24	2918.0	0.0			2479.6	1472.0	3487.2



June 2024

73.2%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

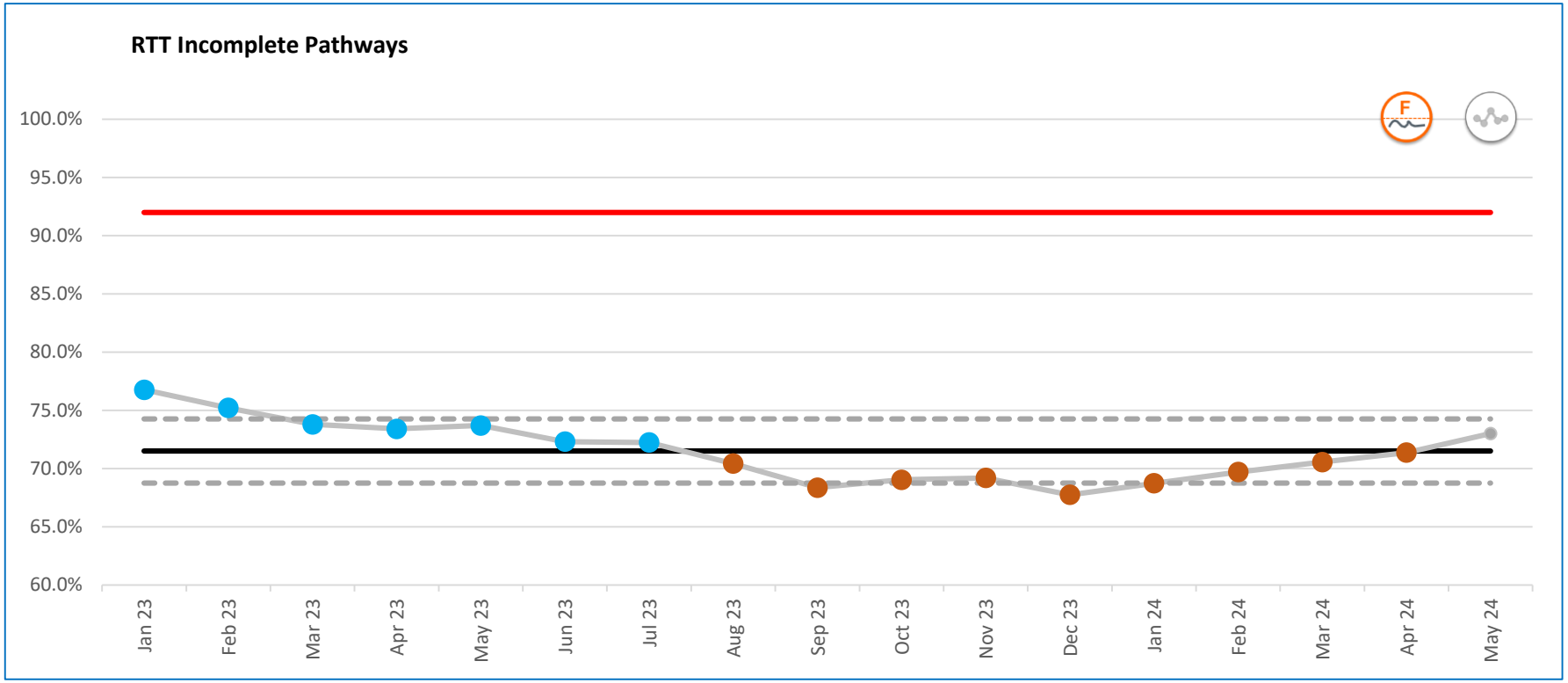
Target

78%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
Emergency Department patients waiting <=4 Hours	Remains below target and will not reach the target without system and/or process change. 2024/25 Operational Guidance requires A&E waiting times a minimum of 78% of patients seen within 4 hours.	Bed occupancy still just above 85% target @ 94%. Demand high and pressured Timely bed availability and high bed occupancy. Infection outbreaks pressuring bed availability	Weekly Executive Oversight Daily oversight, through daily bed and escalation meetings. Daily focused support and presence across the pathway and board rounds. Focus on patients LoS & criteria to reside with an emphasis on discharge. Paediatric pathways continue to have a focus for maintaining flow especially for non-admitted pts	**June 2024** Barnsley 73.2%, England 60.5% **Ranking:** England 11/122 North East & Yorkshire 3/22



May 2024

73.0%

Variance Type

Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.

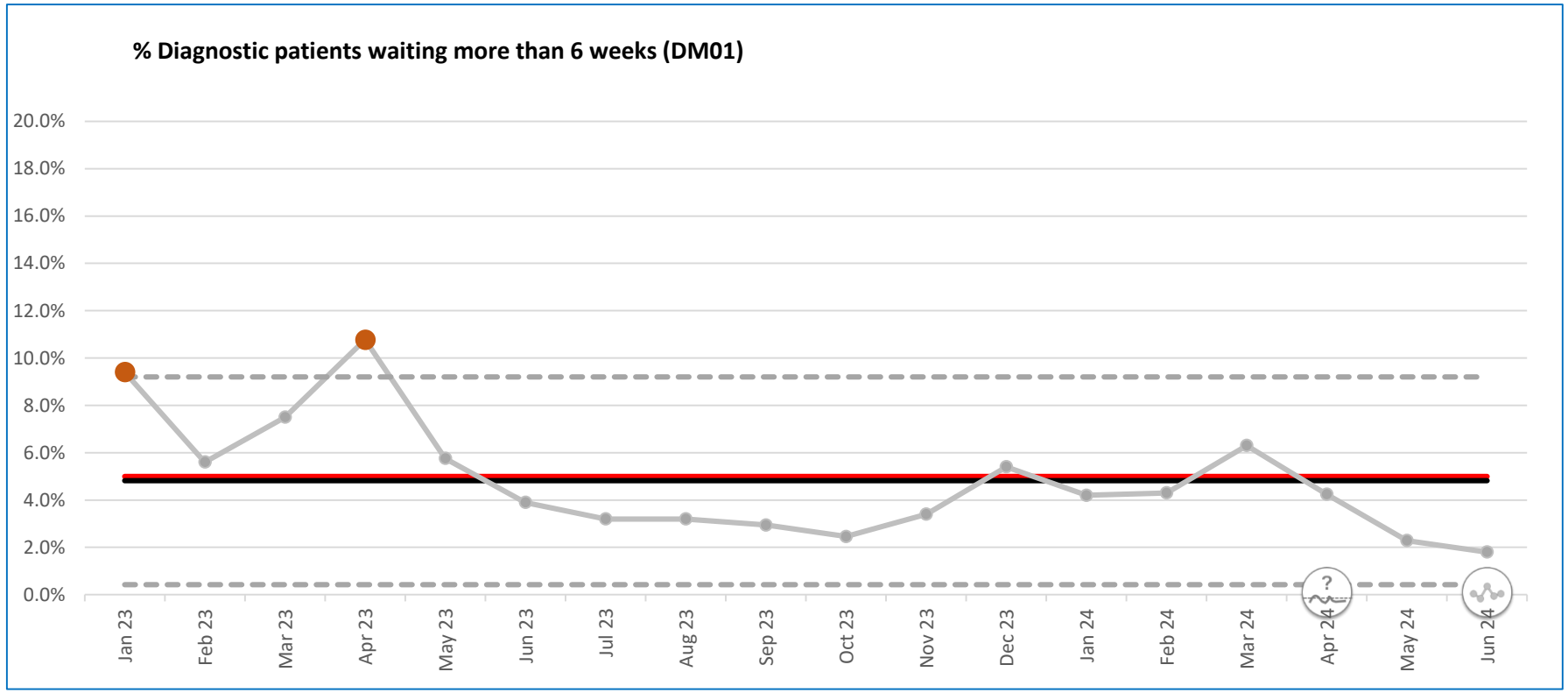
Target

92%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties). Focus on reducing patient cohort at risk of waiting >52 weeks	Forward planning for patients >52 specialty teams working to reduce patient waits below 52 weeks Working with partners across SYB to look at alternative workforce/delivery solutions. Prioritise cancer and urgent patients. The use of independent sector for specific specialties to reduce waits and where required insourcing.	**May 2024** Barnsley 73.0%, England 58.2% **Ranking:** England 25/157 North East & Yorkshire 5/26



June 2024

1.8%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Target

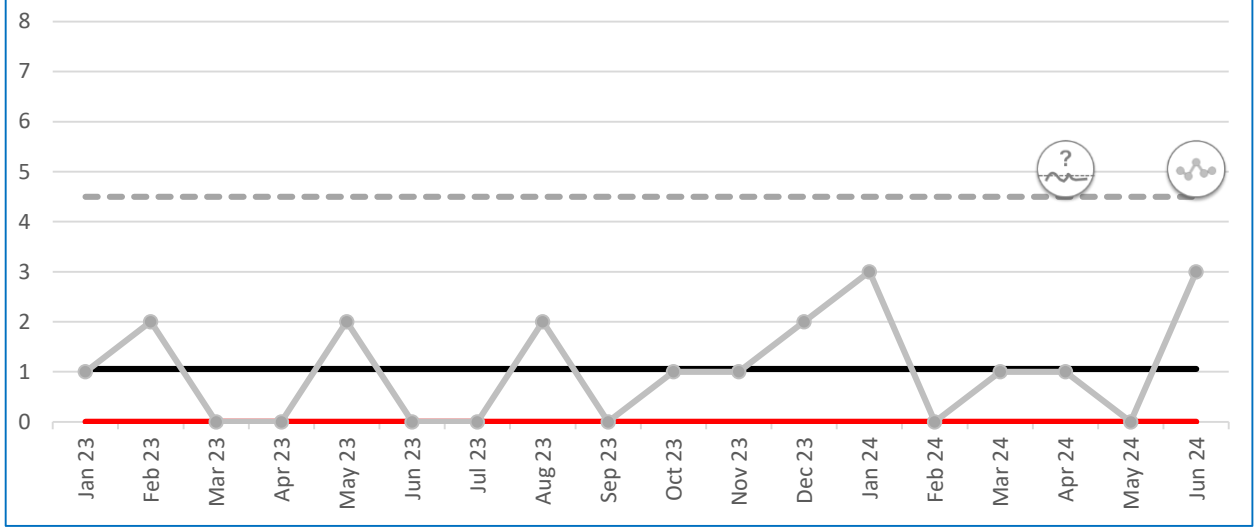
5.0%

Target Achievement

Metric will hit and miss the target

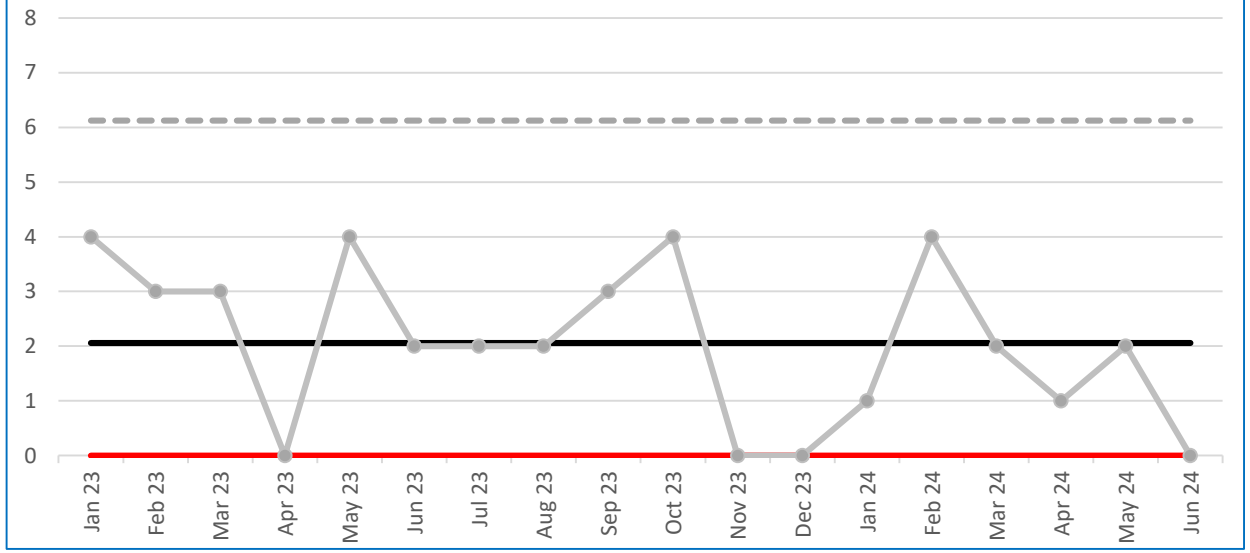
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	Performance remains within control limits but will not hit constitutional target without continued focus. NHS England Operational target for 2023/24 as part of COVID recovery is 5% and is being achieved	Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Validation continues to be a weakness Emergency & inpatient requests impacting on routine wait times.	Cancer and Urgent referrals continue to be prioritised. Pressured specialities working to recover diagnostic position with additional sessions Management of waiting list to allow timely and accurate updating of pathways, helping to support validation and dating of patients. Continued support from data quality team with validation & reporting.	**May 2024** Barnsley 2.3%, England 22.1% **Ranking:** England 174/438 North East & Yorkshire 26/42

Incidents Involving Death



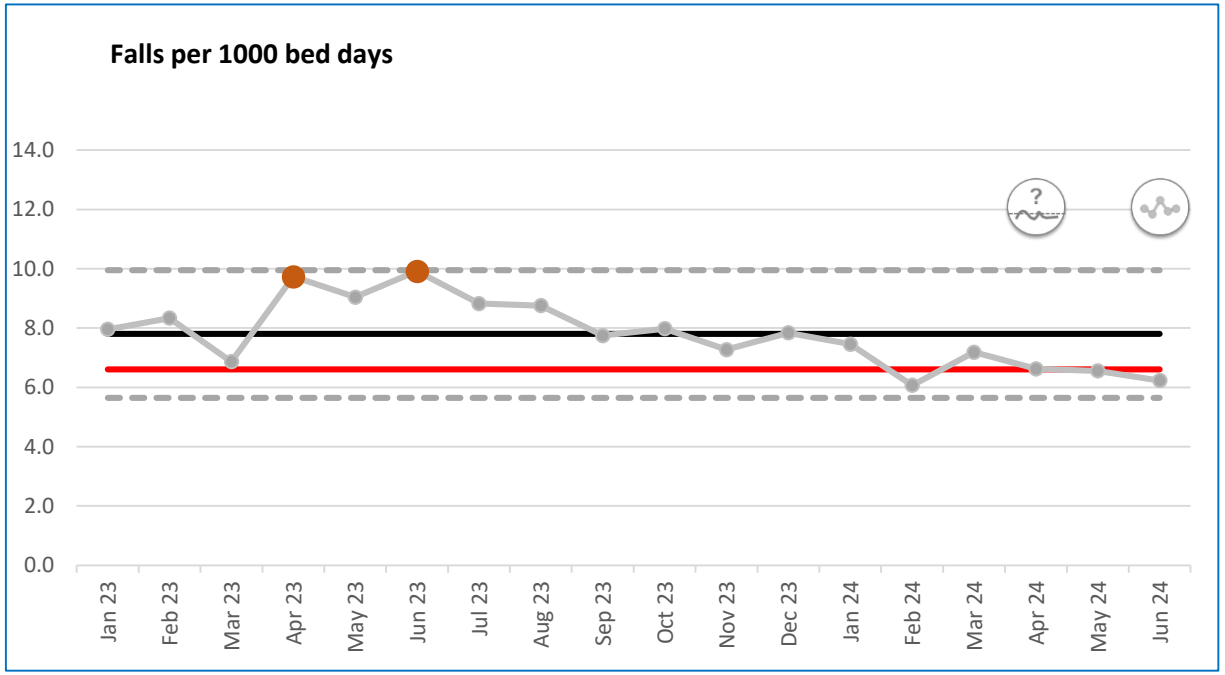
June 2024	Target	Variance Type
3	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

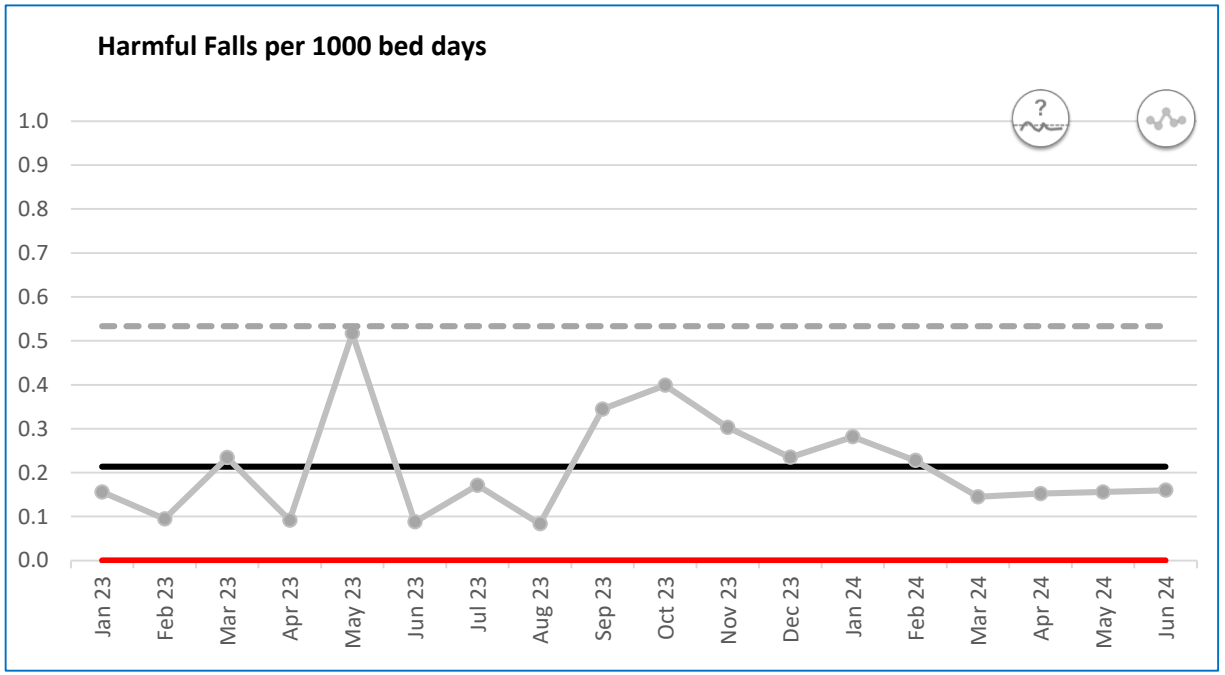
Incidents Involving Severe Harm



June 2024	Target	Variance Type
0	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	Issues
Incidents under investigation involving death of a patient	There were three incidents resulting in a fatal outcome • A cardiac arrest – an investigation is underway and the level of harm related to this incident is under review. • A complication of treatment– an investigation is underway and the level of harm related to this incident is under review. • A diagnosis delay/failure - an investigation is underway and the level of harm related to this incident is under review.
Incidents under investigation involving severe harm	-
Patient Safety Incident Investigations	There were two patient safety incident investigation (PSII) declared in the month • Delay in diagnosis • Sub optimal care of a deteriorating patient

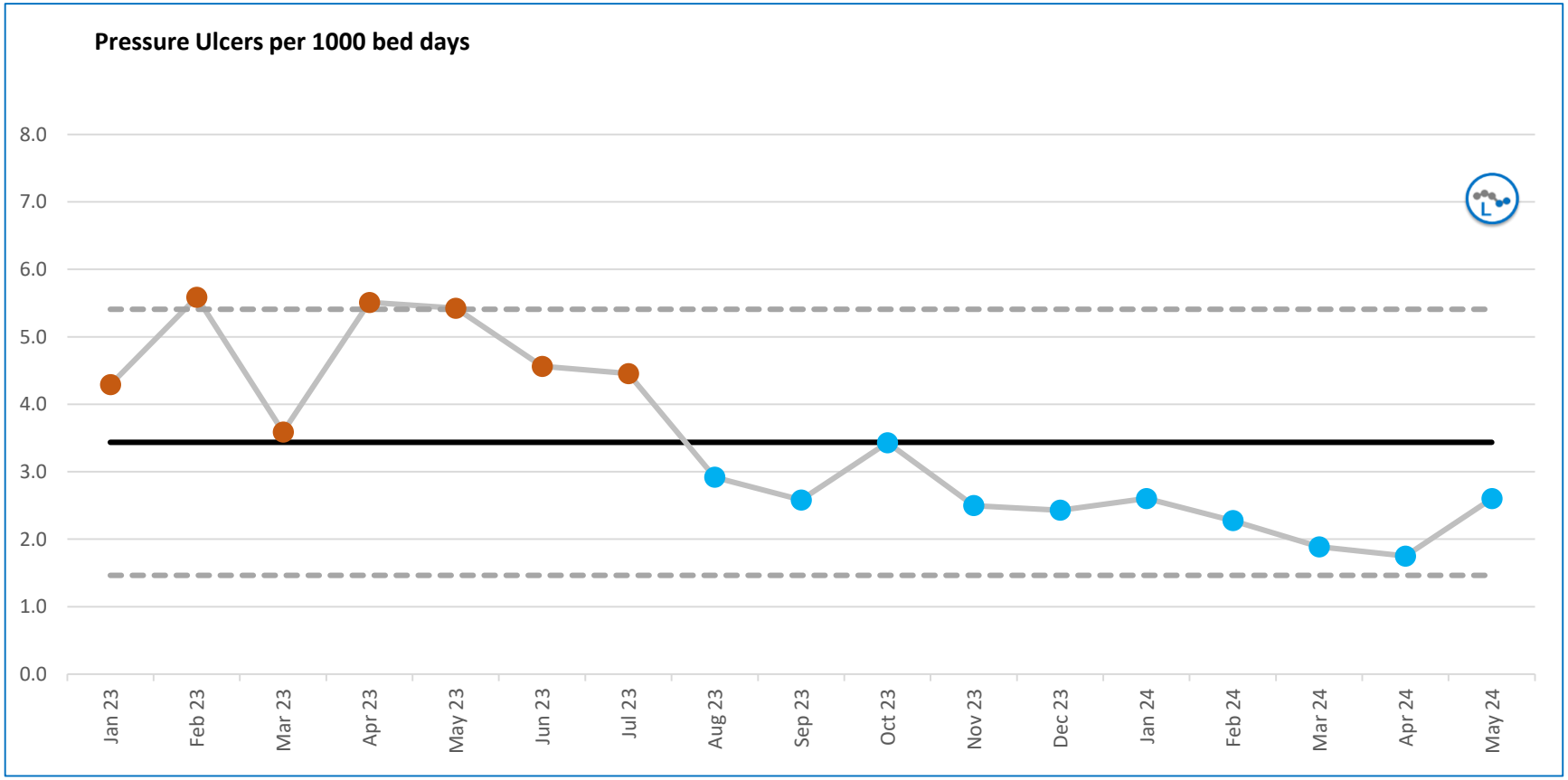




June 2024	Target	Variance Type
6.23	6.6	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

June 2024	Target	Variance Type
0.16	0	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Inpatient Falls	The number of falls are below average and has been for a number of months. The number of inpatient falls is below the agreed target for 24/25.	Increased acuity	Collating actions following MDT Falls review Monthly falls prevention group, individual areas discuss how to reduce falls in their area Individual chart for areas to review the number of falls After action reviews for harmful falls Local interventions in ward areas to reduce falls Three quality target focused around falls Falls trajectories in place for 24/25	-



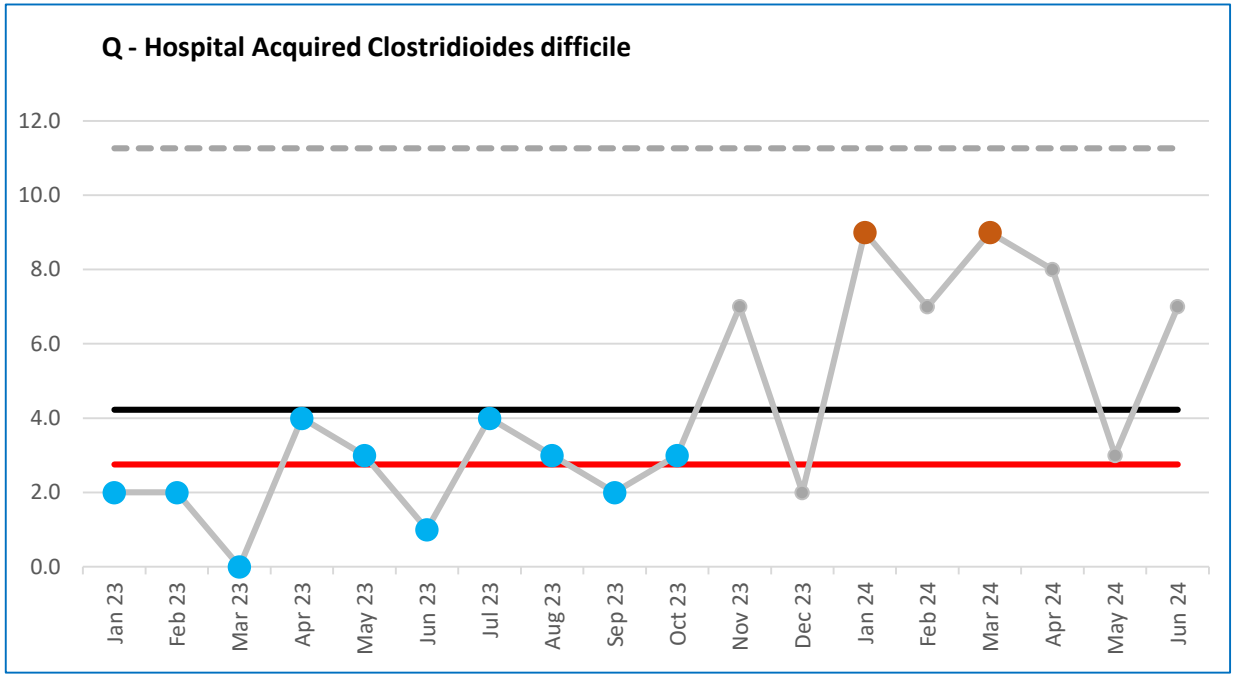
May 2024

2.6

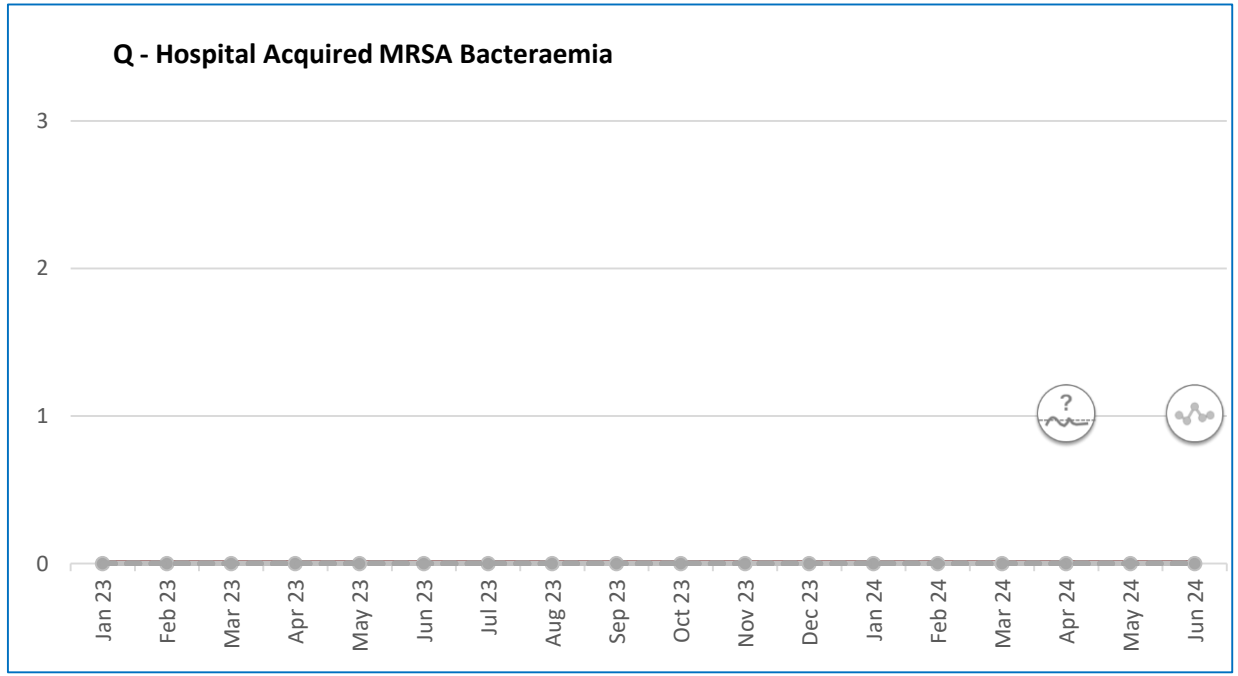
Variance Type

Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Cont ext
Pressure Ulcers	The number of Hospital Acquired Pressure Ulcers (PU) is within normal variation. There has been 9 months where the number of HA PUs has been below average.	Hospital acquired Pressure ulcer are still occurring although decreasing.	Actions - Every Hospital Acquired Pressure Ulcer is investigated through the incident reporting system. Learning outcomes are shared throughout the hospital. Areas continue to trial projects to help reduce Pressure Ulcers, actions are arising from the incidents when investigated. Tissue Viability and practice educators continue to provide tissue viability training. New Tissue Viability study days have commenced and this covers a vast amount of education on the care and management of pressure ulcers including minimising the risk of development of pressure ulcers.	-

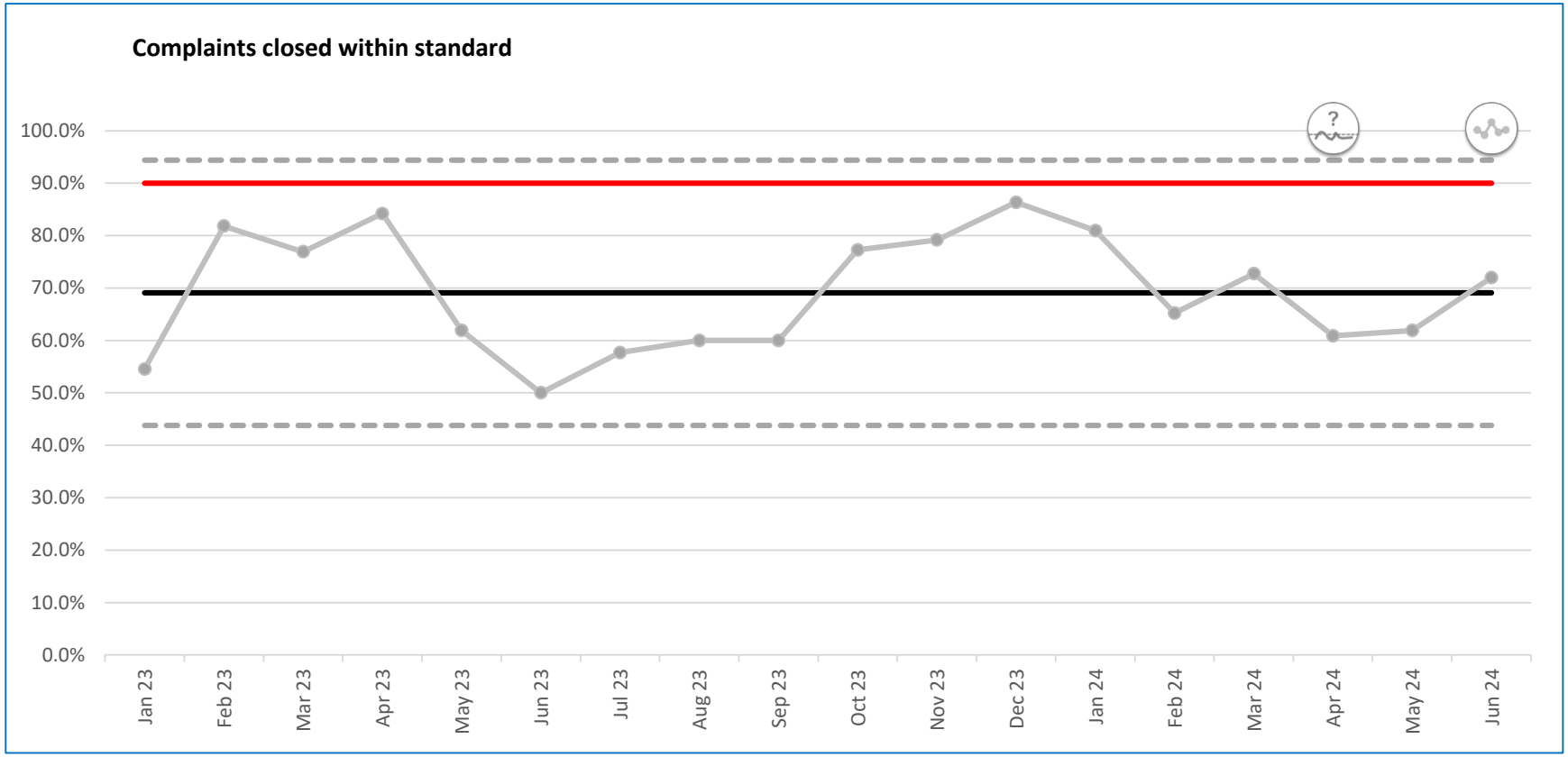


June 2024	Target	Variance Type
7 (18 ytd)	33 per year	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).



June 2024	Target	Variance Type
0	0	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Infections	-	Patients with C difficile infection have System-based reviews that are in progress on all the patients. Patients were identified across 5 wards; ward 22,32,19 and ward 18 with 3 patients on ward 33. Ribotyping results from patient samples on ward 33 have been received from 2 patients; both of which have different ribotypes indicating the possibility of cross infection is unlikely.	-	-



June 2024

72.0%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

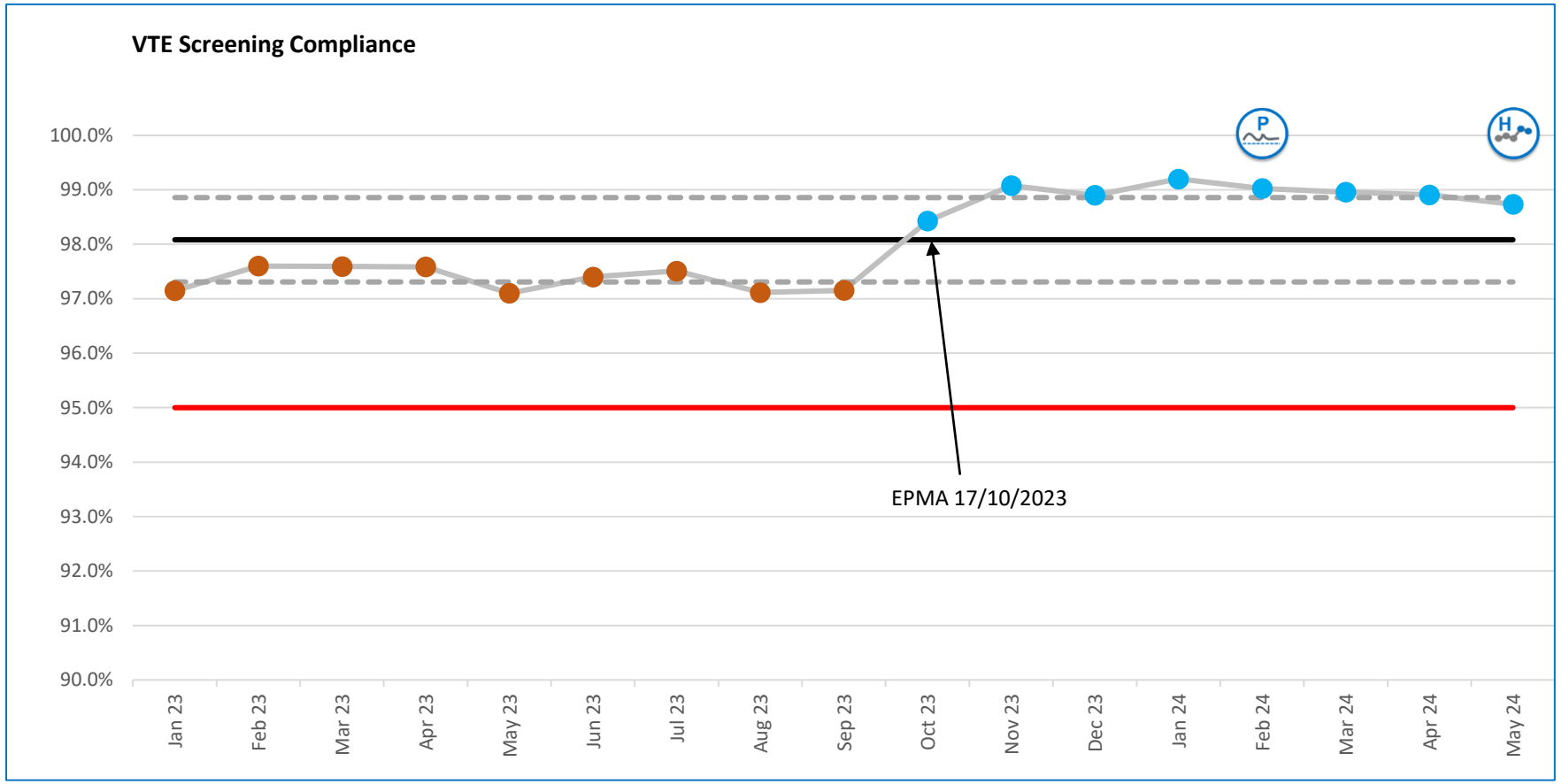
Target

90%

Target Achievement

Measure is failing the target.

Background	What the chart Tells Us	Issues	Actions	Context
Complaints closed within local standard	Consistently failing to achieve the KPI of responding to all formal complaints within 40 working days. 72% of complaints were closed within the KPI initial timeframe target (previously 61%) and an average of 45 days.	New investigator in post from March, previous vacancy caused some workload pressures on cases received through February, March and April. There were seven complaints which failed to achieve the 40 working day KPI: • Four complaint investigations were delayed due to waiting for statements • Two were delayed due to IO workload pressures • One was delayed as it was a complex case	Weekly email escalation processes in place to support the timely access to information and statements required to respond to formal complaints. Weekly updates to CBU triumvirates and Complaints Manager Weekly exception reports to the DoN&Q and MD as required Escalations at CBU performance meetings	All complainants have been kept informed of the progress of their complaint response. New investigator now in post.



May 2024

98.7%

Variance Type

Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.

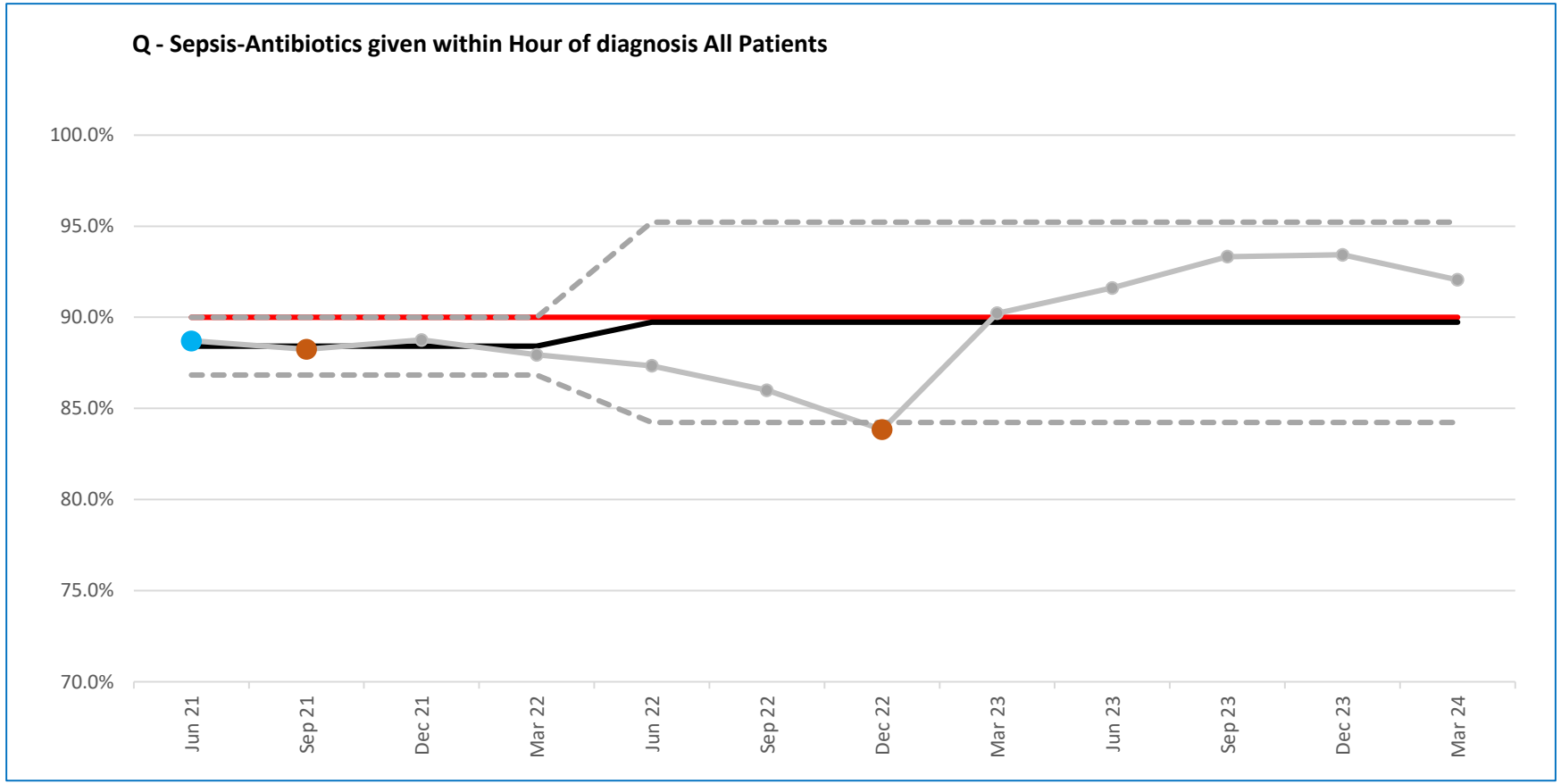
Target

95%

Target Achievement

Consistently passing target.

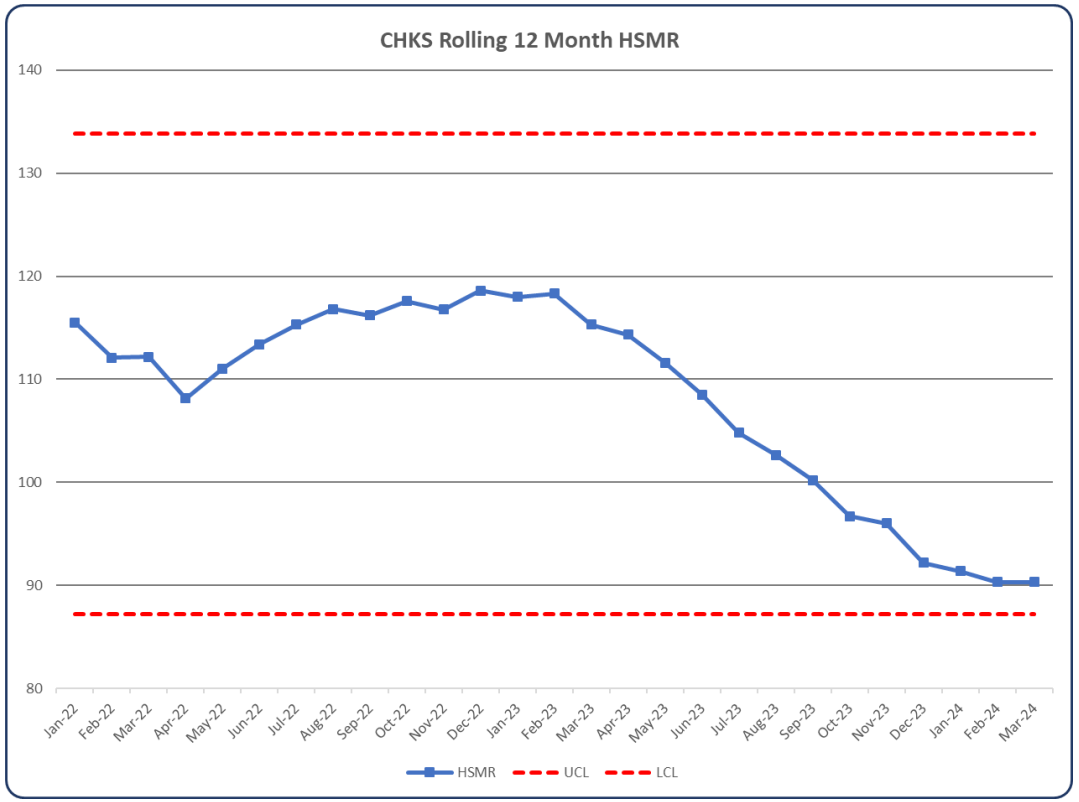
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2023/2024	The target is consistently being achieved.	Ensuring all data sources are included, with the addition of EPMA. Performance can be viewed on IRIS.	The clinical teams that have not achieved the target or are marginally above the target are informed and support is offered.	There continues to be annual review and update on the data specification for reporting. Where necessary manual validation of data is completed to accurately reflect performance.



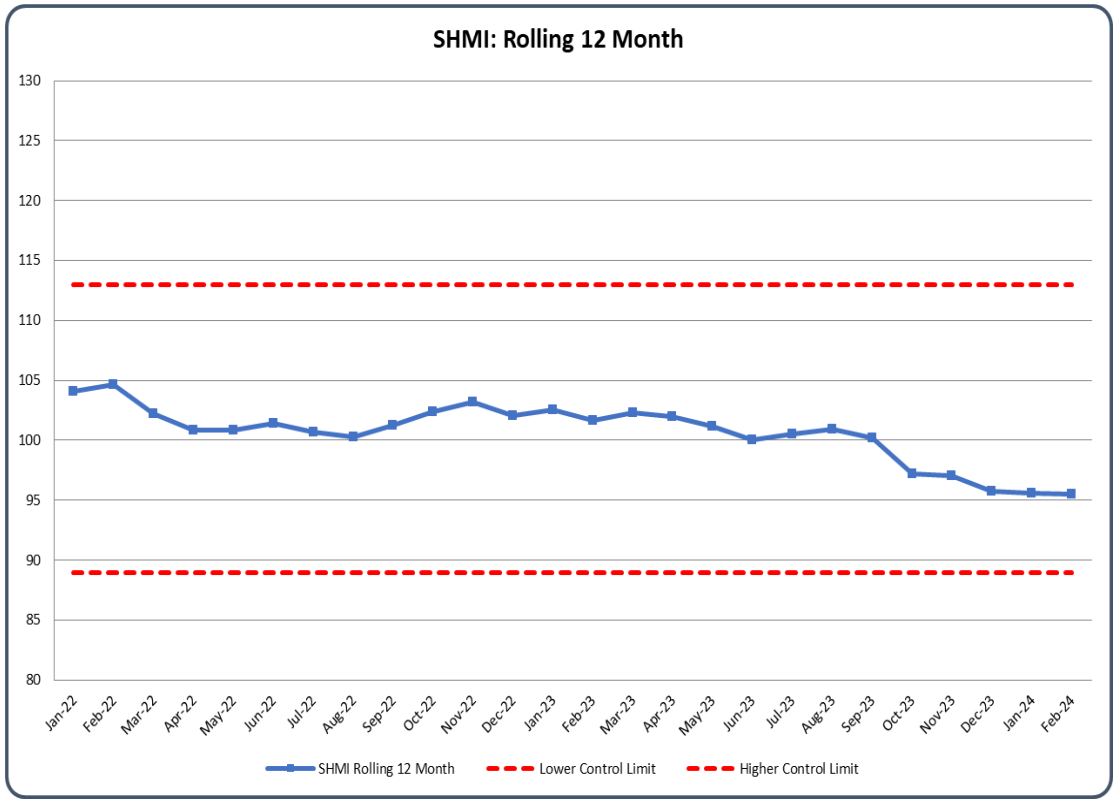
Q4 2023/24
92%
Variance Type
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Actions	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2023/24	The target for inpatients is consistently met ED has met the target for within the hour.	ED sepsis is on the risk register rated at 8 (high risk).	The risk register has been updated by Dr Keep and has been downgraded to a moderate risk. The next review is due Q2 24-25	Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning.

HSMR



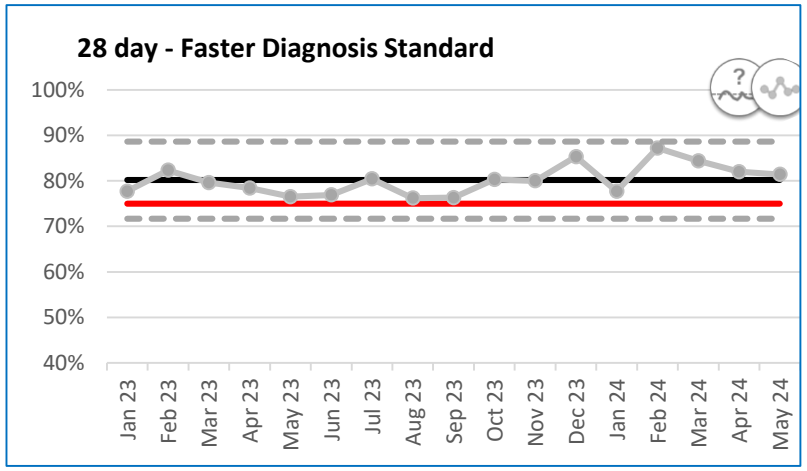
SHMI



Commentary

HSMR Rolling 12 Month: April 2023 – March 2024 **90.35**

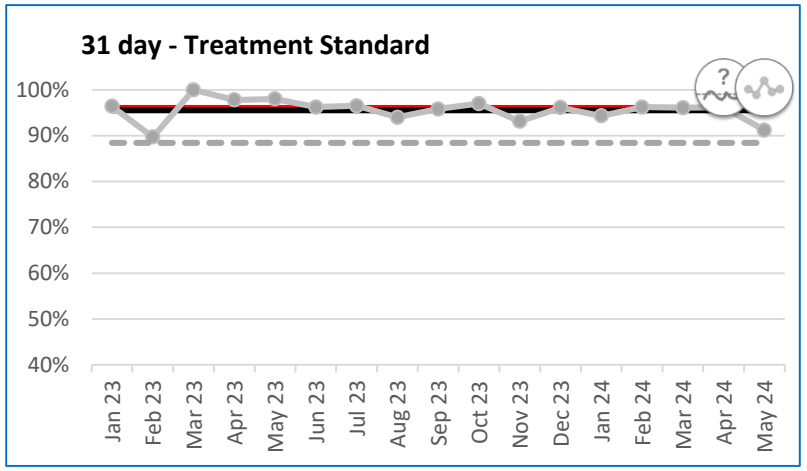
SHMI Latest reporting period: March 2023 – February 2024 **95.50**



May 2024	Target	Variance Type
81%	75%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

28 day - Faster Diagnosis Standard

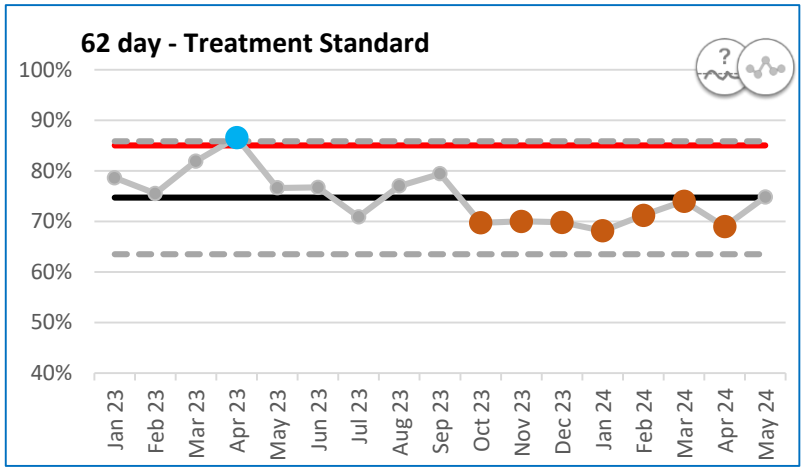
Issues	High Performance continues within this standard.
Actions	Urology LA Transperineal pathway to be implemented



May 2024	Target	Variance Type
91%	96%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

31 day - Treatment Standard

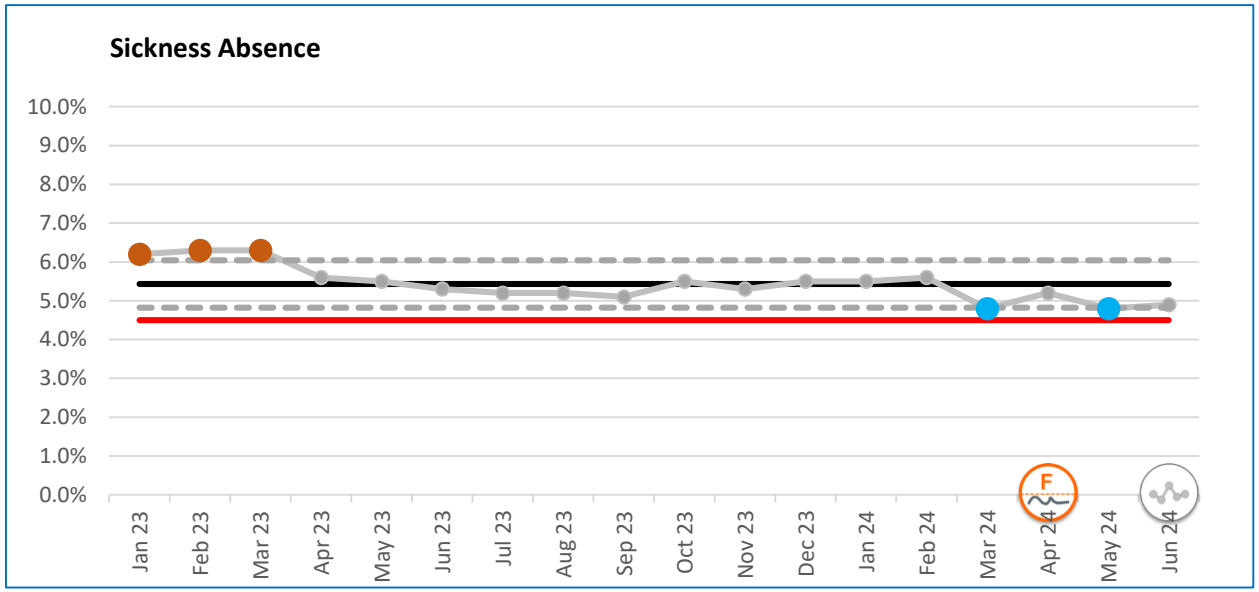
Issues	No Major issues locally. Challenge remains at STH for Oncology and key Surgical Treatment functions in Urology.
Actions	Continue to monitor the Treatment timescales and work closely as a system to support Oncology provision.

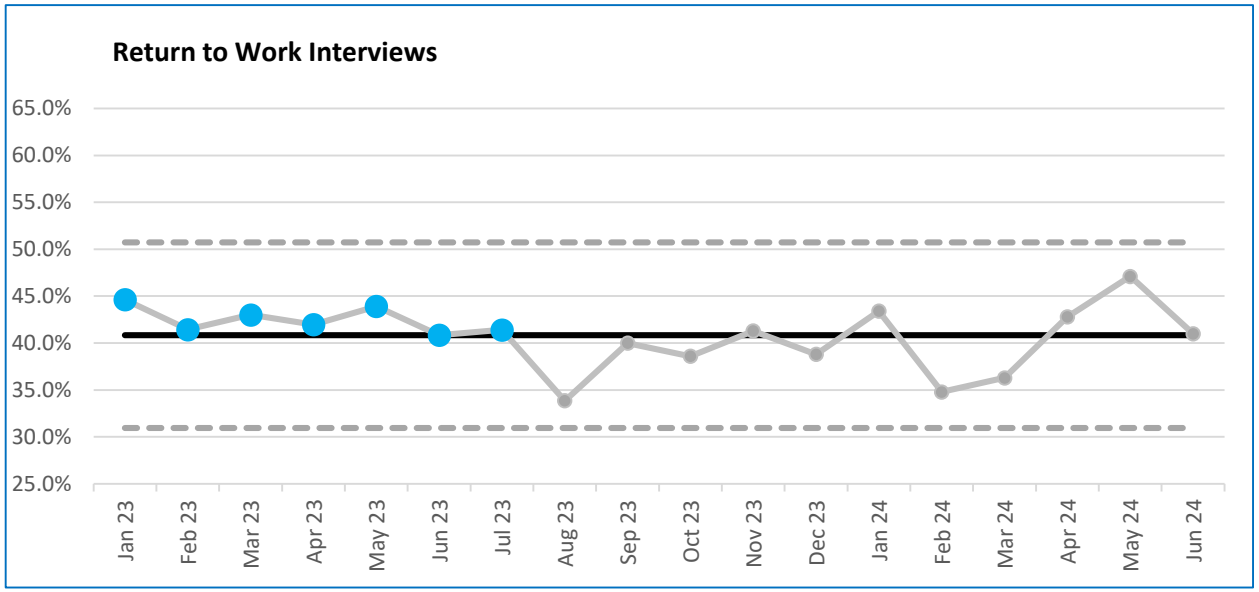


May 2024	Target	Variance Type
75%	85%	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 day - Treatment Standard

Issues	Challenges with Diagnostic pathways to support smoother IPT process for shared care patients
Actions	Focus work in Lung to support.





June 2024	Target	Variance Type
4.9%	**4.5%**	Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.

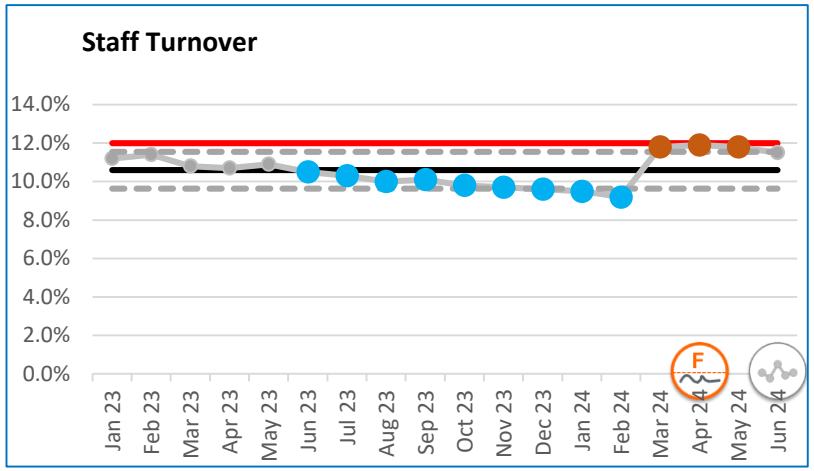
Sickness Absence

Issues	Top high cost absence areas identified, and their sickness management prioritised.
Actions	New focus on CBU sickness absence CIPs at monthly performance review meetings.
Context	This time last year sickness was 5.2%.

June 2024	Target	Variance Type
41%	**70%**	Common cause variation, no significant change..

Return to Work Interviews

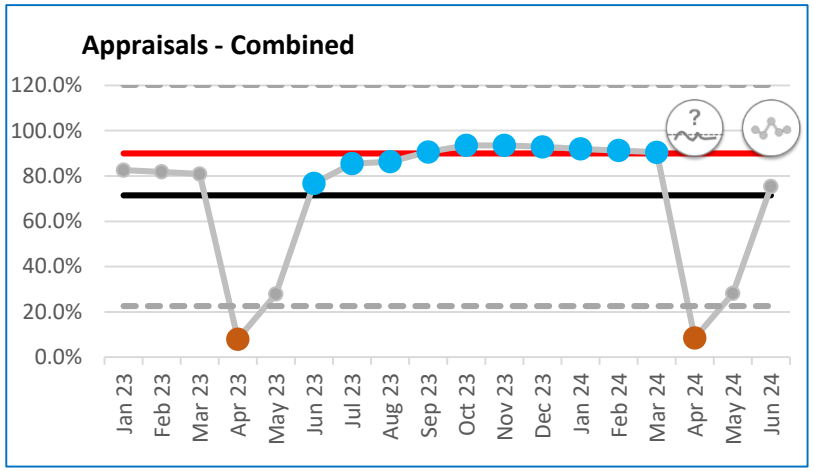
Issues	Missing data entry detected and rectified.
Actions	HRBPs monitoring activity within CBUs to ensure numbers are fully captured in compliance reporting.
Context	Annual cumulative rate remains fairly static.



June 2024	Target	Variance Type
11.5%	**12%**	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Staff Turnover

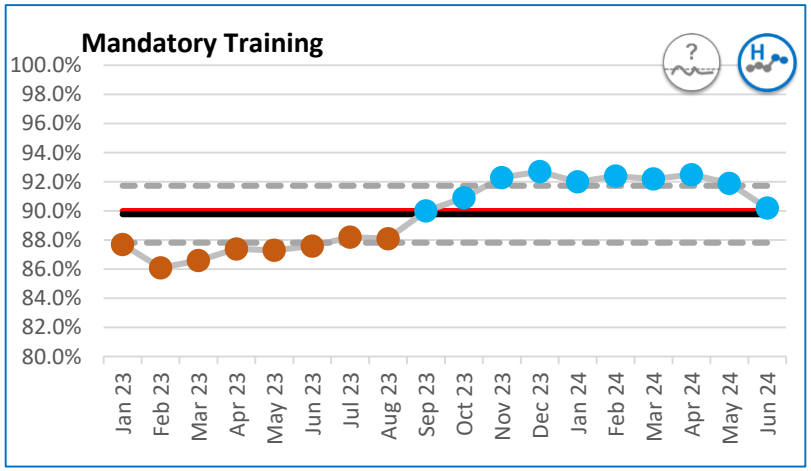
Issues	Improving uptake and quality of exit interview discussions with leavers.
Actions	Focus of Teamwork sub-team of cultural leadership programme. Membership and ToR agreed.
Context	11.5% cumulative staff turnover includes Pathology TUPE leavers in March 24.



June 2024	Target	Variance Type
75.3%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Appraisals – Combined

Issues	Sustaining the target and ensuring quality discussion.
Actions	Re-instating weekly focus on compliance progress.
Context	2024 appraisal cycle opened in April and runs until 30th June 2024.

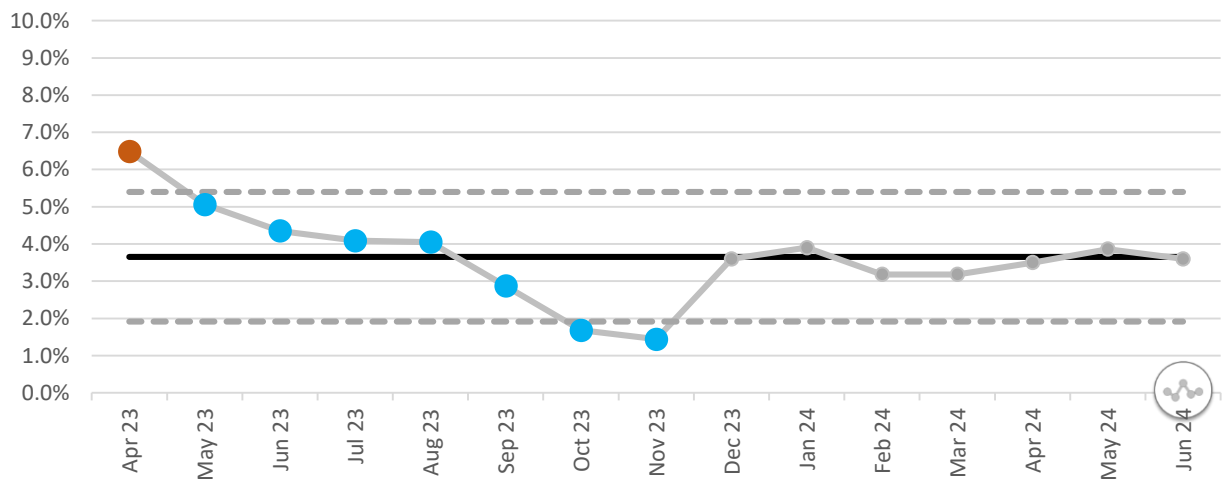


June 2024	Target	Variance Type
90.2%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

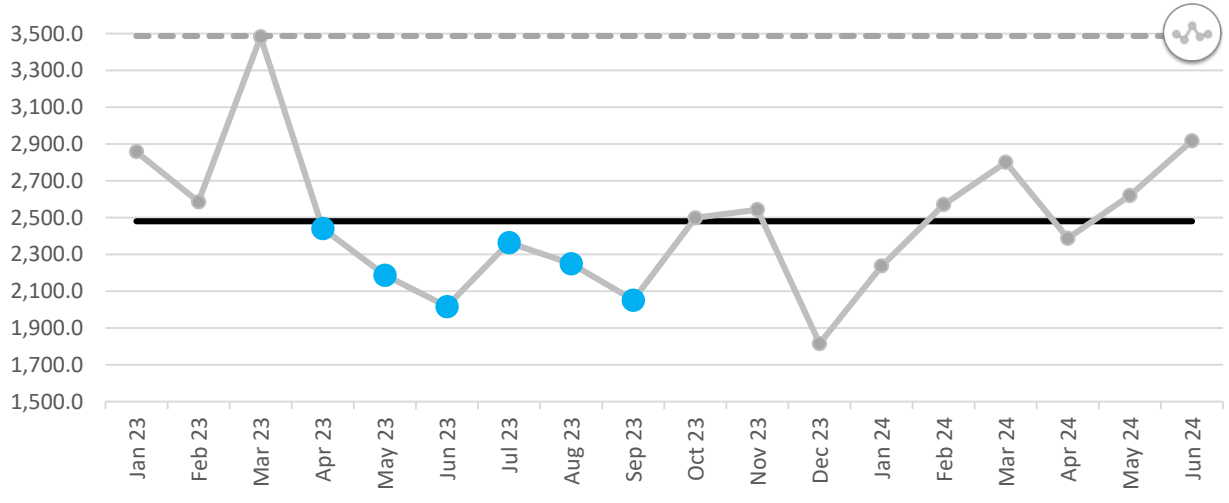
Mandatory Training

Issues	Sustaining the target.
Actions	Re-instating weekly focus on compliance progress, first meeting held of new MAST Approval Group.
Context	Continued improved performance above the target rate.

Vacancy Rate



Bank/Agency Spend £k



June 2024	Target	Variance Type
3.6%		Common cause variation, no significant change.

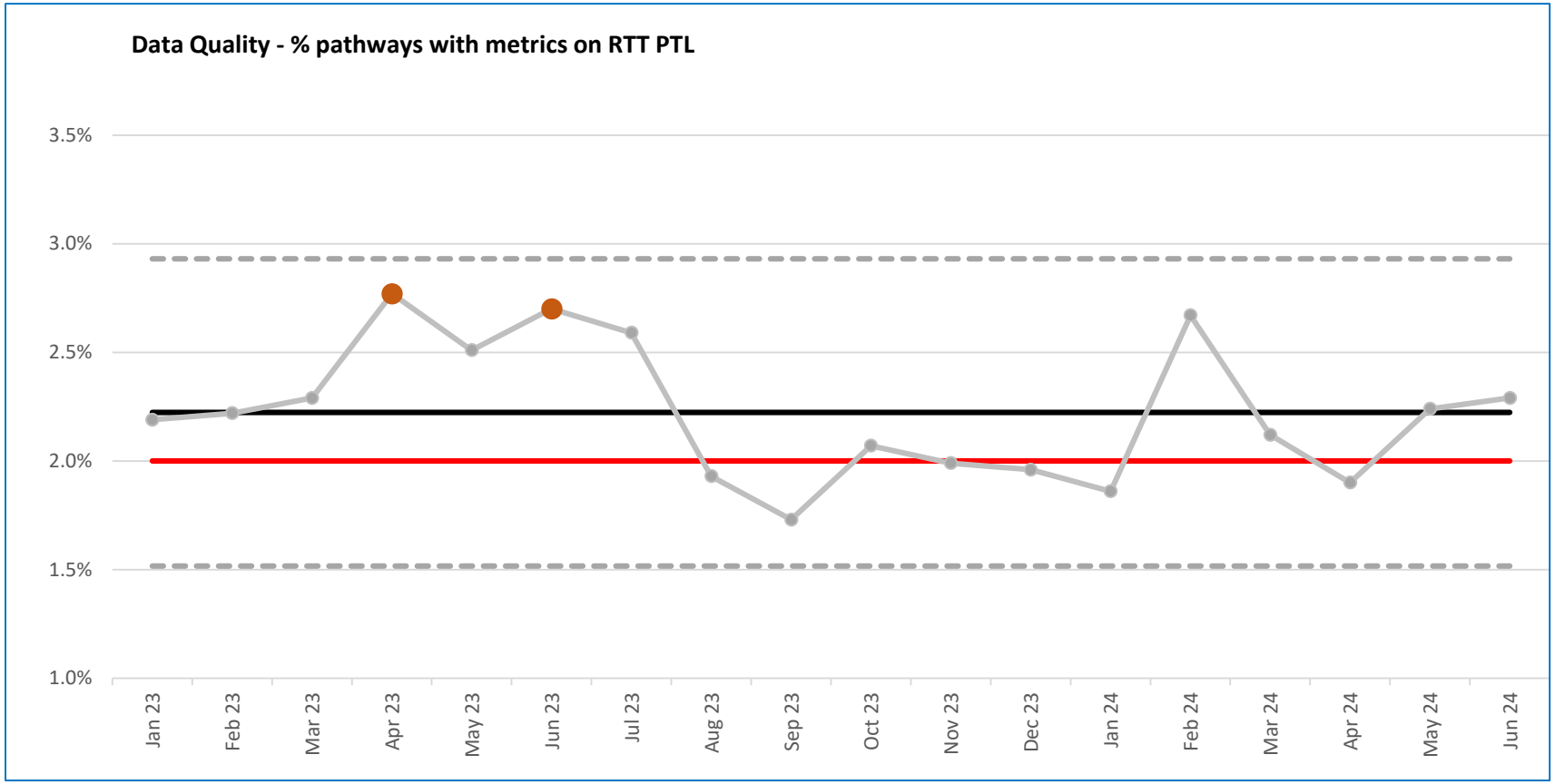
Vacancy Rate

Issues	Certain specialist hard to fill posts.
Actions	Over recruitment to band 5 nursing and midwifery roles. Successful candidates to be placed in areas of high NHSP usage and maternity leave.
Context	over the 12 months period ending March 24, 91% of colleagues were retained.

June 2024	Target	Variance Type
£2918 k		Common cause variation, no significant change.

Bank/Agency Spend £k

Issues	-
Actions	-
Context	-



June 2024

2.29%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Target

2.0%

Target Achievement

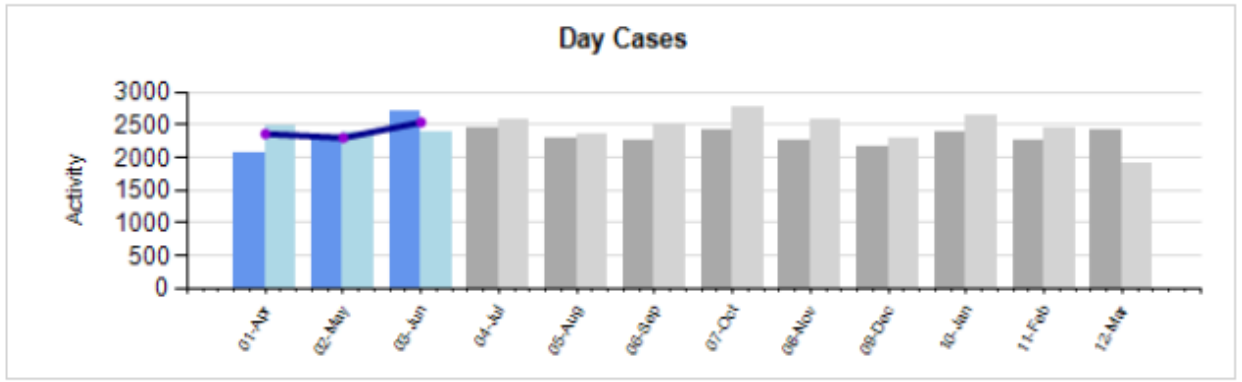
Will hit and miss the target.

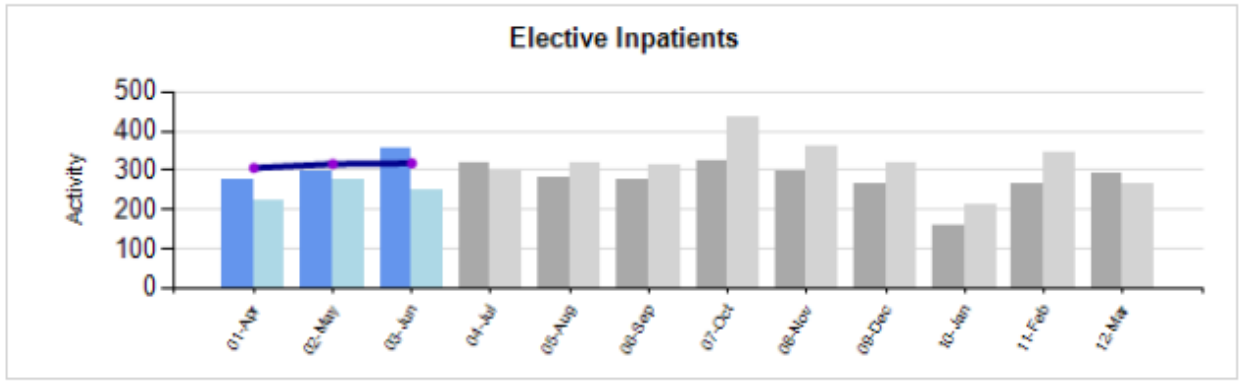
Background	What the chart tells us	Issues	Actions	Context
2% target **Protecting & Expanding Elective Capacity Action on validation**	We are above target by 0.24%.	Patients can have more than one pathway in the same specialty. Pathways continue to be created when they already have a pathway set up in many cases.	Continue to validate any potential duplicate pathways and raise with CBU's for training where necessary.	Validation of RTT pathways. The board receives a report showing current validation rates, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.

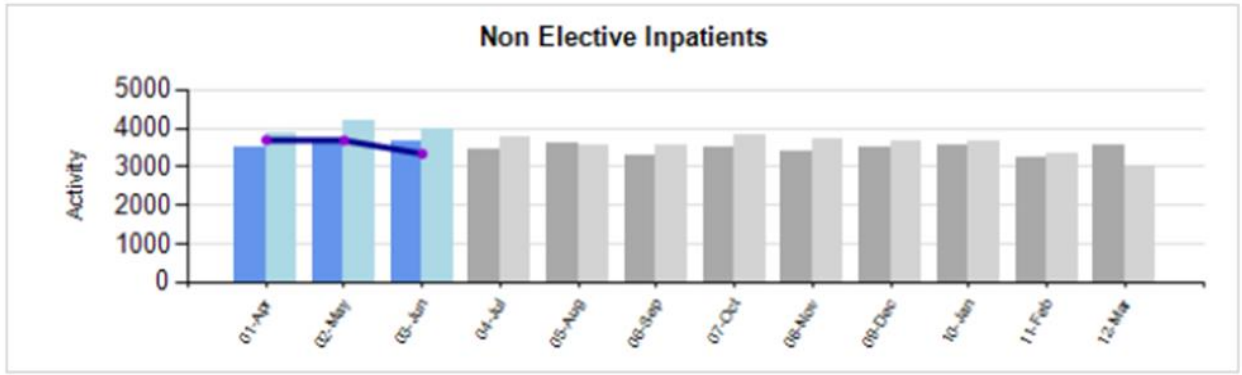
Monthly Activity

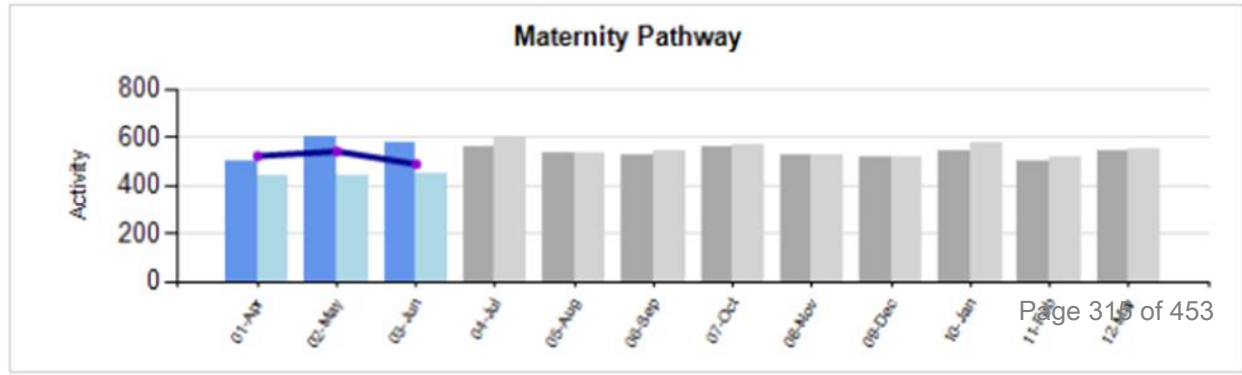
2024/25 Year to Date Activity

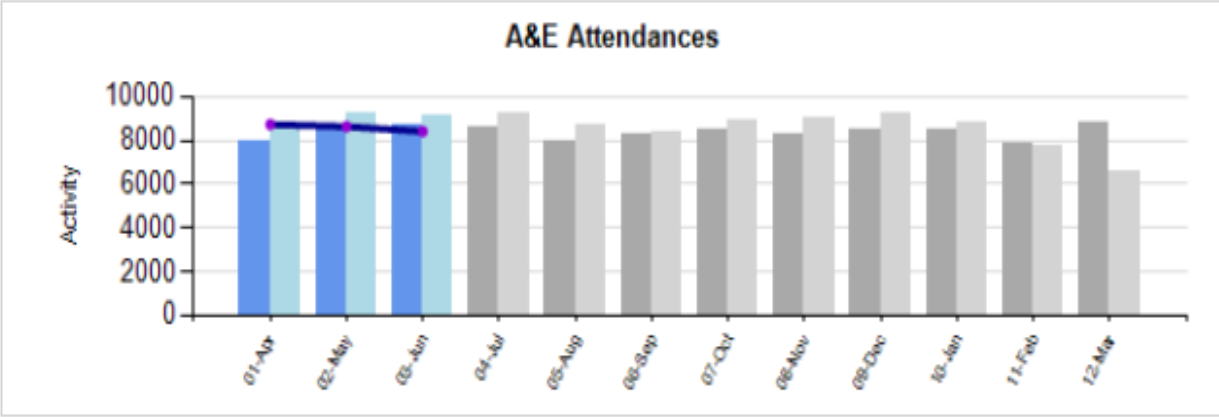
POD Type	2024/25 Plan	2024/25 Actuals	Variance	% variance to plan	19/20 Actuals	% variance to 19/20
A&E Att.	25,349	27,150	1,801	7%	25,760	5%
Elective Daycases	7,011	7,283	272	4%	7,206	1%
Elective Inpatients	926	746	(180)	-19%	940	-21%
Maternity Pathway	1,680	1,332	(348)	-21%	1,554	-14%
Non Elective	10,787	12,002	1,215	11%	10,712	12%
OPPROCs	15,096	15,576	480	3%	15,386	1%
Outpatients_exc_OPPROC	76,305	80,457	4,152	5%	74,524	8%

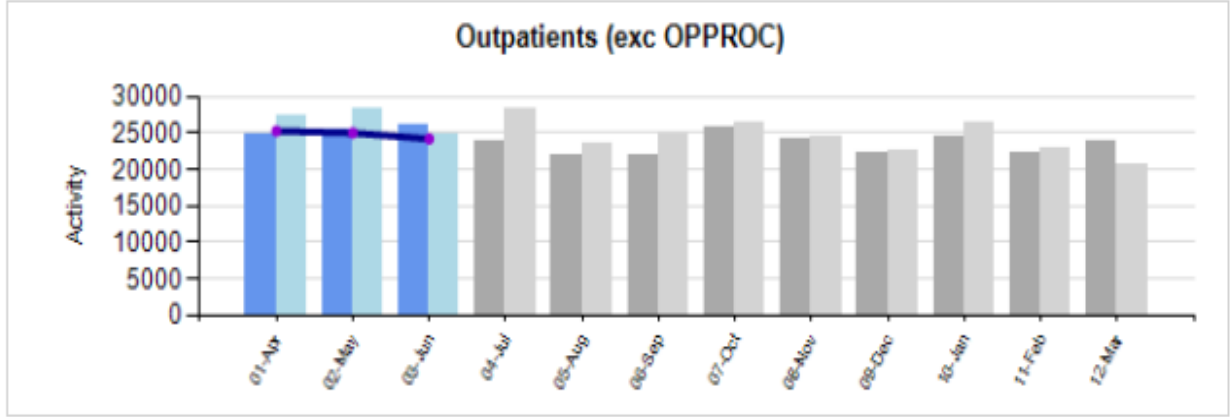


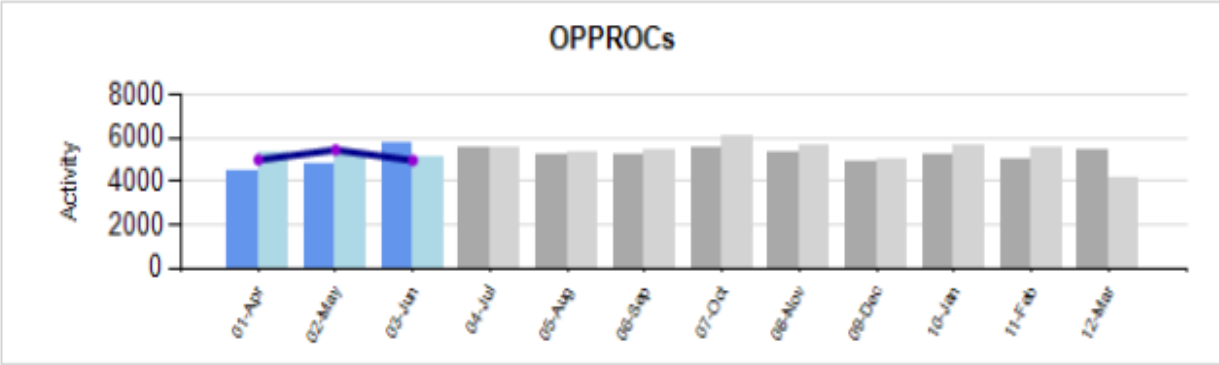


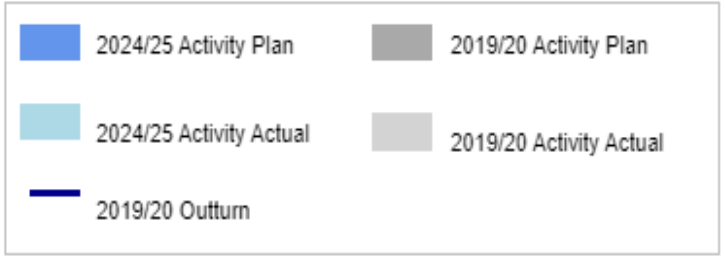












Commentary

Currently 151 patients above 52 weeks
Clinical business units currently producing trajectories and plans to eliminate 65 weeks waits by the end of September 2024.
Trauma & Orthopaedic, Gynaecology, Oral Surgery and Orthodontic patients are currently accounting for the largest proportion of patients waiting over 52-week.
RTT – Clinical business units working to speciality specific recovery to 92%, speciality specific with stretch to >95% in year to achieve a bottom line delivery.
Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% currently 40.9% a 4.3% increase over 19/20, working still ongoing in CBU's to ensure correct recording and maximising the opportunity.
Capped Theatre utilisation further reduced to 68.9% in June.

Finance Performance

Jun 24 Summary

RAG Rating Summary Performance:		
Finance	Planned Financial Position	As at Month 3 the Trust has a consolidated deficit of £3.100m against a planned deficit of £2.796m giving an adverse variance of £0.304m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£16k) and granted assets (£26k), is a deficit of £3.058m against an adjusted planned deficit of £2.754m giving an adverse variance of £0.304m.
	Planned Cash Position	Cash balances have increased from last month by £0.322m, which is £0.107m lower than planned, so are now £0.684m higher than planned for the year-to-date. This is mainly due to the timing of trade creditors payments, partially offset by the timing of receipt of NHS income.
	Capital Plan	Capital expenditure for the year is £0.635m, which is £0.111m below plan.

The RAG rating applied to Variance % is based on the following criteria:

- **Green equating to 0% or greater**
- **Amber behind plan by up to 5%**
- **Red greater than 5% behind plan**

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	355	251	(104)	-29.30%	926	746	(180)	-19.44%
Day cases	2,694	2,396	(298)	-11.06%	7,011	7,283	272	3.88%
Outpatients	29,452	27,950	(1,502)	-5.10%	85,160	89,217	4,057	4.76%
Non-elective inpatients	3,668	3,961	293	7.99%	10,795	12,012	1,217	11.27%
A&E	8,735	9,127	392	4.49%	25,349	27,150	1,801	7.10%
Other (excludes direct access tests)	12,042	10,068	(1,974)	-16.39%	34,963	34,670	(293)	-0.84%
Total activity	**56,946**	**53,753**	**(3,193)**	**-5.61%**	**164,204**	**171,078**	**6,874**	**4.19%**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Elective inpatients	1,364	916	(448)	-32.84%	3,556	2,685	(871)	-24.49%
Day Cases	2,209	1,997	(212)	-9.60%	5,762	5,895	133	2.31%
Outpatients	3,750	3,736	(14)	-0.37%	10,443	11,242	799	7.65%
Non-elective inpatients	9,239	10,108	869	9.41%	27,313	28,291	978	3.58%
A&E	1,610	1,664	54	3.35%	4,672	4,992	320	6.85%
Other Clinical	7,744	6,860	(884)	-11.42%	23,540	21,274	(2,266)	-9.63%
Other	2,130	2,289	159	7.46%	6,394	6,480	86	1.35%
Total income	**28,046**	**27,570**	**(476)**	**-1.70%**	**81,680**	**80,859**	**(821)**	**-1.01%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Pay	(19,893)	(18,934)	959	4.82%	(59,526)	(58,942)	584	0.98%
Drugs	(1,703)	(1,674)	29	1.70%	(5,110)	(5,142)	(32)	-0.63%
Non-Pay	(5,843)	(5,922)	(79)	-1.35%	(17,386)	(17,419)	(33)	-0.19%
Total Costs	**(27,439)**	**(26,530)**	**909**	**3.31%**	**(82,022)**	**(81,503)**	**519**	**0.63%**
EBITDA	**607**	**1,040**	**433**	71.33%	**(342)**	**(644)**	**(302)**	-88.30%
Depreciation	(727)	(725)	2	0.28%	(2,184)	(2,179)	5	0.23%
Non Operating Items	(97)	(103)	(6)	-6.19%	(270)	(277)	(7)	-2.59%
Surplus / (Deficit)	**(217)**	**212**	**429**	-197.70%	**(2,796)**	**(3,100)**	**(304)**	-10.87%
NHSE adjusted financial performance	**(203)**	**226**	429	-211.33%	**(2,754)**	**(3,058)**	(304)	-11.04%

Commentary

The key points derived from this table are as follows:

- The final plan approved by the Board of Directors and submitted in June is a £5.5m deficit, in the context of a South Yorkshire (SY) system £49.0m deficit plan.
- As at Month 3 the Trust has a consolidated deficit of £3.100m against a planned deficit of £2.796m giving an adverse variance of £0.304m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£16k) and granted assets (£26k), is a deficit of £3.058m against an adjusted planned deficit of £2.754m giving an adverse variance of £0.304m. However this is after £1.344m benefit from non-recurrent releases. The impact of the junior doctor strike is c£0.3m.
- The plan was set aligned to the national NHSE planning guidance, which set a planned care recovery target of 103% weighted value of 2019/20 levels of planned care delivery, supported with Elective Recovery Fund (ERF) monies. ERF performance is being monitored against internal profiles until NHSE trajectories are received. ERF income is £0.609m adverse to plan and advice & guidance is £0.056m favourable.
- In-month activity is 7.53% less than last month, and is 5.61% below plan for the month with only non-elective and A&E favourable to plan. The acuity of patients presenting at ED and requiring admission continues to be high, with higher than usual length of stay as a result.
- Total income is £0.821m adverse to plan, mainly due to the underperformance on NHS clinical income which includes the impact of the junior doctor strike.
- Pay costs are £0.584m favourable to plan, substantive staff are £1.968m favourable, bank staff £0.600m adverse and agency staff £0.784m adverse. This includes c£0.120m junior doctor strike cover costs. The remaining adverse variance is a combination of not delivering efficiency due to higher than expected staff sickness levels, a very challenged operational site including ED; which has also seen additional costs incurred as a consequence of covering the sickness, having winter capacity open for a large part of quarter 1 and additional resources deployed in ED.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Commentary
Capital Programme	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		
Capital Spend - internally funded	(94)	(173)	(79)	-84.04%	(361)	(440)	(79)	-21.88%	• The June NHSE plan submission reset the capital year-to-date plan in-line with actual expenditure at month 2. Internally funded spend on Acorn and theatre development ahead of plan. Externally PDC funded IT and Estates scheme slippage expected to recover over the year. Total expected spend for the year is £13.483m.
Capital Spend - externally funded	(289)	(99)	190	65.74%	(384)	(194)	190	49.48%	
Statement of Financial Position (SOFP)									
Inventory					1,802	1,783	19	-1.05%	
Receivables					11,461	11,003	458	-4.00%	• Receivables are below plan due to timing of receipt of NHS income.
Payables (includes accruals)					(43,402)	(44,247)	845	-1.95%	• Payables are above plan due to the timing of trade creditors payments.
Other Net Liabilities					(3,709)	(3,730)	21	-0.57%	
Cash & Loan Funding					**£'000**	**£'000**	**£'000**		
Cash					21,379	22,063	684	3.20%	• Cash balances have increased from last month by £0.322m, which is £0.107m lower than planned, so are now £0.684m higher than planned for the year-to-date. This is mainly due to the timing of trade creditors payments, partially offset by the timing of receipt of NHS income.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)					**£'000**	**£'000**	**£'000**		
Income					325	344	19	5.87%	• Pay schemes are below plan due to not delivering efficiency due to higher than expected staff sickness levels and a very challenged operational site; partially offset by corporate vacancies and digital. Non-pay schemes are above plan mainly due to medicines management, estates and procurement savings.
Pay					573	379	(194)	-33.92%	
Non-Pay					207	296	90	43.31%	
Total EPP					**1,105**	**1,019**	(86)	-7.76%	
KPIs									
EBITDA %	2.16%	3.77%	1.61%	-74.29%	-0.42%	-0.80%	-0.38%	-90.22%	
Surplus / (Deficit) %	-0.77%	0.77%	1.54%	-199.38%	-3.42%	-3.83%	-0.41%	-12.00%	
Better Payment Practice Code (BPPC)									• The BPPC requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Performance has deteriorated from last month, only volume is above the 95% target.
Number of invoices paid within target					95.0%	96.0%	1.02%	1.08%	
Value of invoices paid within target					95.0%	91.2%	-3.83%	-4.03%	

4.2. Trust Objectives 2024/25 Quarter One Report

For Assurance

Presented by Bob Kirton

REPORT TO BOARD OF DIRECTORS – Public	REF:	BoD: 24/01/08/4.2

SUBJECT:	**2024-25 Q1 TRUST OBJECTIVES REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Alice Cannon, Deputy Head of PMO				
SPONSORED BY:	Bob Kirton, Managing Director				
PRESENTED BY:	Bob Kirton, Managing Director				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2024. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2024 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, People Committee, Q&G, F&P and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

This paper presents the 2024/25 Quarter 1 progress update. Operational pressures across the Trust and wider system have impacted delivery of some performance metrics in relation to Urgent and Emergency and Planned Care. Pressures have been evident across the year and have been impacted further by recent industrial action across the medical workforce. Furthermore, growing financial control at a local, system and national level are meaning further restraints to Trust finances. Despite this context, this report provides an update on how the Trust has progressed against the objectives agreed for this year.

Key Highlights Across the strategic "6 Ps"

Best for Patients & the Public

- The Trust has been compliant with all patient safety metrics throughout Q1. All metrics will continue to be monitored in each quarter throughout 2024/25.
- Albeit, the Trust has not achieved all Patient Experience metrics action plans are in place to mitigate these. The Patient Experience team and Complaints team are working together to identify those areas of communication highlighted prevalently within feedback received.
- The Quality Improvement team have successfully achieved their delivery metrics within Q1, seeing 80.34% of staff trained in QI Introduction against a target of 75% and 6.62% of staff training in QI foundations against a target of 5%. Further to this, the 4th Give it a Go Week was held in June 2024 with 49 initiatives registered.
- Links between Research and Innovation functions progress with a Research and Development Project Manager now in post, this has increased innovation hours within the team.
- Digital improvements have advanced with the go-live of digital prescribing (EPMA) within the Emergency Department.

- Successful move within Intermediate Care with the Acorn Unit now back on the Trust site, completed in May 2024.

Best for People

- Positive work within Equality, Diversity and Inclusion as the newly established Armed Forces Forum successfully organised its first promotional event in May 2024, attracting new members and achieving its initial goals. The Trust was successful in achieving a Heart Award and Nomination in May 2024. Further to this success, a further award from the Barnsley Council has been received for the partnership working.
- Work progresses within Recruitment & Retention as the team strengthen links with Barnsley College. A recent 'Get Hired' event was held in June 2024 to promote care careers to students and young people.
- The Trust continues to roll out the new Supporting Staff Attendance Policy and Wellbeing Passport roll-out as part of the Health and Wellbeing and attendance management, phase 1 roll out ends on the 31st July 2024 along with the launch of a toolkit.

Best for Performance

- Operationally it has been a challenging first quarter of the year and this has impacted on the realisation of some of the metrics outlined within the Best for Performance objective including achieving the 85% target for Theatre utilisation. However, there is recognition to the achievement of the 92% bed occupancy rate in Q1.
- Positive work has taken place in Cancer pathways and remains compliant against target metrics.
- The Efficiency and Productivity programme has been developed for the year with a terms of reference in development for a new improvement group to support with the delivery.
- The Trust is currently off financial plan with minimal opportunities identified to support the programme back on plan by year end.

Best for Place and Partner

- Processes strengthened to support our patients with preventative medicine with the support of the Healthy Lives Team. A doctor in training is exploring tobacco dependency treatment opportunities to integrate within the pre-assessment pathway as part of the Waiting Well initiative. A Health and Wellbeing staff awareness event was held in June 2024 to promote 'How's the ticker' campaign. The Early Help Team are now a full complement to enable them to deliver and embed support in key clinical areas.
- In addition, the Anchor Institution continues to progress re-useable items and is progressing well with the pilot of surgical drapes that commenced in June 2024.

Best for Planet

- As part of the Trust's Green Plan the Trust work is progressing with; potential to offer staff long-term loan of EV bikes, implementation and change of waste disposal stream from yellow to tiger to support with sustainable and cost-effective methods, metal recycling is now in place within Theatres, and the launch of the Green Plan video expected Q2.

Key Concerns: There is the potential risk of further industrial strike action for the British Medical Association to take place throughout 2024/25, potentially impacting on the delivery of planned and urgent care objectives.

Progress will continue to be monitored and reported on a quarterly basis for the 2024/25 Trust Objectives.

RECOMMENDATIONS
The Board of Directors is asked to: • to review and approve the report. • accept this report as an assurance of progress against the Trust Objectives.

Subject:	2024-25 TRUST OBJECTIVES Q1 REPORT	Ref:	BoD: 24/01/08/4.2

1. STRATEGIC CONTEXT

1.1 Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2024. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2024 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, People Committee, Q&G, F&P and Trust Board on a quarterly basis.

1.2 Operational pressures across the Trust and wider system have impacted delivery of some performance metrics in relation to Urgent and Emergency and Planned Care. Pressures have been evident across the year and have been impacted further by recent industrial action across the medical workforce. Furthermore, growing financial control at a local, system and national level are meaning further restraints to Trust finances. Despite this context, this report provides an update on how the Trust has progressed against the objectives agreed for this year.

2. INTRODUCTION

2.1 This paper presents the 2024/25 Quarter 1 progress update. The attached report (Appendix 1) outlines progress against the Trust Objectives including the supporting metric dashboard (Appendix 2).

3. KEY HIGHLIGHTS

3.1 Best for Patients & the Public

- The Trust has been compliant with all patient safety metrics throughout Q1. All metrics will continue to be monitored in each quarter throughout 2024/25.
- Albeit, the Trust has not achieved all Patient Experience metrics action plans are in place to mitigate these. The Patient Experience team and Complaints team are working together to identify those areas of communication highlighted prevalently within feedback received.
- The Quality Improvement team have successfully achieved their delivery metrics within Q1, seeing 80.34% of staff trained in QI Introduction against a target of 75% and 6.62% of staff training in QI foundations against a target of 5%. Further to this, the 4th Give it a Go Week was held in June 2024 with 49 initiatives registered.
- Links between Research and Innovation functions progress with a Research and Development Project Manager now in post, this has increased innovation hours within the team.
- Digital improvements have advanced with the go-live of digital prescribing (EPMA) within the Emergency Department.
- Successful move within Intermediate Care with the Acorn Unit now back on the Trust site, completed in May 2024

3.2 **Best for People**

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- Work progresses within Recruitment & Retention as the team strengthen links with Barnsley College. A recent 'Get Hired' event was held in June 2024 to promote care careers to students and young people.
- The Trust continues to roll out the new Supporting Staff Attendance Policy and Wellbeing Passport roll-out as part of the Health and Wellbeing and attendance management, phase 1 roll out ends on the 31st July 2024 along with the launch of a toolkit.

3.3 **Best for Performance**

- Operationally it has been a challenging first quarter of the year and this has impacted on the realisation of some of the metrics outlined within the Best for Performance objective including achieving the 85% target for Theatre utilisation. However, there is recognition to the achievement of the 92% bed occupancy rate in Q1.
- Positive work has taken place in Cancer pathways and remains compliant against target metrics.
- The Efficiency and Productivity programme has been developed for the year with a terms of reference in development for a new improvement group to support with the delivery.
- The Trust is currently off financial plan with minimal opportunities identified to support the programme back on plan by year end.

3.4 **Best for Place and Partner**

- Processes strengthened to support our patients with preventative medicine with the support of the Healthy Lives Team. A doctor in training is exploring tobacco dependency treatment opportunities to integrate within the pre-assessment pathway as part of the Waiting Well initiative. A Health and Wellbeing staff awareness event was held in June 2024 to promote 'How's the ticker' campaign. The Early Help Team are now a full complement to enable them to deliver and embed support in key clinical areas.
- In addition, the Anchor Institution continues to progress re-useable items and is progressing well with the pilot of surgical drapes that commenced in June 2024.

3.5 **Best for Planet**

- As part of the Trust's Green Plan the Trust work is progressing with; potential to offer staff long-term loan of EV bikes, implementation and change of waste disposal stream from yellow to tiger to support with sustainable and cost-effective methods, metal recycling is now in place within Theatres, and the launch of the Green Plan video expected Q2.

4. KEY CONCERNS

4.1 There is the potential risk of further industrial strike action for the British Medical Association to take place throughout 2024/25, potentially impacting on the delivery of planned and urgent care objectives.

5. RECOMMENDATIONS

5.1 The Board of Directors are asked to review and approve the report.

5.2 The Board of Directors accept this report as assurance of progress against the Trust Objectives.

6. CONCLUSION

6.1 Overall the Trust has progressed with the objectives and where there has been challenges and risks, mitigation plans have been implemented where possible to support progression in Q1.

Appendices:

- Appendix 1 - Trust Objectives 24-25 Q1 Report
- Appendix 2 – Trust Objectives 24-25 Q1 Metric Dashboard

Appendix 1

Barnsley Hospital NHS Foundation Trust

BARNSLEY HOSPITAL TRUST OBJECTIVES 2024–2025 – BUILDING ON EMERGING OPPORTUNITIES Q1 REPORT

RAG Key

	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their lives		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

Best for Patients & The Public - We will provide the best possible care for our patients and service users

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Sarah Moppett Simon Enright	We will deliver our defined quality priorities and achieve outstanding care by continuing to learn from exemplary organisations. Delivery measured by: RAG | | Q1 Mortality statistics to remain within confidence limits – Within Limits Scrutiny of Deaths* by the medical examiner service@100% – 100% *Non-coronial	• Achieve the 2024/25 targets aligned to each of the quality priorities with monthly reporting on KPIs/progress via Quality & Governance Committee: **Clinical Effectiveness** ▪ Ensure mortality indicators are within statistically expected confidence limits ▪ Continue to improve and implement systems to provide learning from deaths to prevent avoidable harm, ensuring any reforms to the proposed statutory medical examiner system are implemented in full. ▪ Develop and maintain a Learning from deaths library of structured judgement reviews and learning bulletins ▪ Monitor and embed GIRFT learning to reduce unwarranted variation in outcomes through the GIRFT Oversight and Efficiency and Productivity Groups ▪ Further develop and strengthen our preventive medicine for all patients through our Healthy Lives Programme including QUIT and Alcohol Care Team ▪ Develop and introduce health inequalities reporting across CBU Business and Governance to inform actions to reduce health inequalities, with a focus on preventive care, patient waiting lists, outpatient services and other priority clinical pathways	Mar 2025 Sep 2024	**Green**	**Clinical Effectiveness** • Mortality indicators are within statistically expected confidence limits. • All non-coronial deaths are reviewed by the ME Service. DHSC has published details of the statutory medical examiner system planned from September 9th 2024, including final draft regulations. Processes will be reviewed once the regulations are statutory • Complete: A Learning from Deaths bulletin library and a Structured Judgement Review library is now available on the Trust Intranet page. • The Trust is part of cohort 3 for the GIRFT Further Faster programme. Services are currently completing checklists and following this, themes will be identified with a focus on efficiency and productivity gains. GIRFT Oversight groups continue with services to maintain momentum and to review where appropriate best practice approaches. • An exercise is underway to better understand the holistic needs of people presenting to BHNFT who have drug and alcohol-related problems and to shape more responsive pathways. An optimal model will be proposed to Place Partnership in Autumn for consideration of funding and delivery approaches. The Healthy Lives Team are currently integrating QUIT with the Pre-assessment pathway as part of the Trust and provider alliance waiting fair, waiting well initiative. • CBU2 are piloting a equitable waiting lists imitative using BHNFTs WHaLES to compliment clinical prioritisation with the risk score for health inequalities. Public Health and Population Health analyst are

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Co-create an Advanced Clinical Practitioner (ACP) strategy to explore how to further develop and reflect the full potential of our ACP workforce.

</td>
<td>Dec 2024</td>
<td></td>
<td>supporting the OPD Transformation group to develop approaches for people at high risk at not attending appointments.
• The Trust does not currently have an ACP Lead and we are therefore currently exploring the best way to lead a collaborative approach to developing an ACP strategy. We meet regularly with the SY ACP Faculty and procure training places according to NHS England processes</td>
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<td>Delivery measured by:
• Compliance with patient safety updates (RAG)
• Compliance against deconditioning standards (in development)

Achieve compliance with the following:

<table>
<tr><th>RAG</th><th></th><th>Q1</th></tr>
<tr><td></td><td>VTE related metric as defined by 2024/25 CQUIN released April 2024</td><td>98.73% (May 2024)</td></tr>
<tr><td></td><td>Sepsis related metric as defined by 2024/25 CQUIN released April</td><td>92%</td></tr>
<tr><td></td><td>Reduction in C. diff infection rates in line with NHSE target</td><td>Awaiting NHSE Target to be set</td></tr>
<tr><td></td><td>Reduce falls / 1000 bed days to no more than 6.75/1000</td><td>6.55 (May 24)</td></tr>
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</td>
<td>Patient Safety

Prevent avoidable patient deterioration by implementing any patient CQUINs for 2024/25 and the national standard contract reporting for any patient safety measure

Build on the introduction of the Patient Safety Specialist role within the organisation and delivery of work programmes to support the implementation of the NHS Patient Safety Strategy
Share and implement the learning from the National Patient Safety Team to achieve the strategy’s aims through a series of programmes and areas of work.

Promote prevention of patient deconditioning as a clinical priority:

Design, launch and monitor standards for the prevention of deconditioning

Develop and deliver a multidisciplinary improvement plan to reduce our Clostridium difficile (C. diff) infection rates.

Develop and deliver a multidisciplinary Improvement plan to reduce falls per 1000 bed days

Deliver (year 2) of the national 3-year delivery plan for maternity and neonatal services.

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<td>Mar 2025

Mar 2025

Mar 2025

Aug 2024

Mar 2025

Mar 2025</td>
<td>Green</td>
<td>Patient Safety

In 2023/24 In-patient and the Emergency Department combined within an hour for sepsis achieved >90%. The clinical lead for sepsis reviews all patient records for those coded for sepsis, ensuring any patients who do not receive the administration of antibiotics within an hour receives the appropriate care. Q1 24/25 data is yet to be collated and validated. The VTE clinical lead completes an RCA for all potential hospital acquired VTE, findings are presented monthly at the VTE committee. VTE screening has consistently achieved >95%. AKI alerts for adult inpatient areas are received daily and actioned by the Acute Response Team, ensuring appropriate management.
Patient Safety Specialist (PSS) role is embedded and working well. The national patient training has been added to the MAST TNA for relevant staff groups
Monthly national patient safety updates are actioned and shared by PSS. Wider engagement with the SY ICS is underway. Both PSS participate in local regional and national level PSS workstreams. Any urgent patient safety issues are addressed at the weekly Patient Safety Panel. The PSS provides a monthly report and assurance on the National Patient Safety Updates to the Panel. The PS team will attend this year’s AGM with a stand to showcase the patient safety work they do.
Deconditioning workstreams in progress for the following; Deconditioning Toolkit, Recording of Deconditioning, Ward Level Deconditioning, Patient Experience/ Training and education. AAR's being held. JD completed, and recruitment panned for a 'Deconditioning' practice educator. Working with communications to plan Trust wide launch, aimed for September.
Clostridioides difficile IPC and AMS action plans in place with identified executive and clinical leads. Good progress has been made with both action plans. Both action plans are monitored via the Infection Prevention and Control Group and by exception to the Quality and Governance Committee. NHSE target has not yet been set.
MDT review taken place in May 24 and collating recommendations and actions to take forward. Fall rate in April was 6.62 / 1000 bed days and 6.55 / 1000 bed days in May 24.
We are on track with year 2 of the 3-year delivery plan for maternity and neonatal services. Progress is monitored via the monthly maternity report to Quality and Governance and the transformation work is overseen by the maternity and neonatal transformation group.

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	Delivery measured by: RAG | | Q1 Improve FFT satisfaction score for Inpatients 95% | 85% Improve FFT satisfaction score for ED 85% | 85% Reduction in complaints related to nutrition by 10% (no more than 5 per quarter) | 6 Reduction in complaints related to communication by 10% (no more than 35 per quarter) | 45	**Patient Experience, Engagement & Involvement** ▪ With Barnsley Place partners develop a patient passport for people with Autism and learning disabilities ▪ Identity local improvement initiatives regarding patient communication to reduce number of associated complaints ▪ Improve patient experience through improvement of our standards of assessment and care of individualised nutritional needs of patients. ▪ Communicate and document improvements via a portfolio of "You said, we did" communications ▪ Embed existing patient experience initiatives and implement new innovations to support improved person-centred care ▪ Embed and evaluate the success of the implementation of Care Partners ▪ Co-design and deliver - year 2 delivery plan of the Nursing, Midwifery strategic priorities 2022 – 2025 ▪ Introduce a formal methodology for leadership rounding for lead nurses/midwives and matrons to review and respond to patient experience feedback at ward/department level. ▪ Develop and deliver year one of our next 3-year Dementia strategy	Dec 2024 Mar 2025 Mar 2025 Mar 2025 Mar 2025 Dec 2024 Mar 2025 Sep 2024 Oct 2024	**Amber** Rationale: All actions on track and progressing well. Metric improvement expected by year end.	**Patient Experience, Engagement & Involvement** • The Trust is working with Barnsley Place Partners to support the implementation of a Universal Passport. The passport been co-produced with people with Learning Disabilities and Autistic people at Speak Up, a self-advocacy group. This is in its final stages of development with the SYICB communications team, estimated launch in Q3. • The Patient Experience and Complaints team are working together to identify those areas of communication highlighted prevalently within feedback. There is work ongoing with the Clinical Systems team to inform next of kin, via text message, when their person in hospital is transferred between ward areas. • The Patient Experience team are supporting a number of initiatives throughout the Trust in regard to Nutrition and Hydration. The team have a coordinated approach to Enhanced Support Volunteers supporting at mealtimes. A dataset focussed on Eat, Drink, Dress, Move has been added to the Friends and Family to identify areas of concern and monitor effectiveness of improvements. • Development has started on the revised 'You said -we listened' posters and a process for ward/department leads to display these monthly. Medical Imaging, Ophthalmology and Oral and Maxillofacial have these in place. The communications team have created a 'You said-we listened logo to be included in the feedback display. • This year's Trust objectives for Patient, Engagement and involvement have been included in the wider team's objectives through the appraisal process to ensure we are all working towards and contributing to these aims. • The Care Partner initiative continues to be implemented and embedded which also supports the nutritional needs of patients who require physical and/or emotional support. Care Partners, Welcome Packs and Three things about me continue to be implemented and embedded across the Trust with support from the Quality Improvement team. As part of 'Give it a go' week, Gynaecology are piloting the 'Check In- Check out initiated' aimed at meeting the expectations of patents. • Co-production of the N&M strategic priorities has commenced, with discussion being facilitated at a time out day. Priorities have been agreed by the senior nursing team and the delivery plan is being developed for approval at the N&M professional council in July. • Trial areas for leadership rounding have been agreed by the Nursing and Midwifery professional council. A standard operating procedure is currently being developed. • Dementia strategy objectives discussed at Dementia steering group in June 24, working with communications to design 'strategy on a page' as part of draft.
	Delivery measured by: RAG | | Q1 80% of staff trained in QI Introduction | 80.34 % (as of 30.6.24) Maintain 5% of staff trained in QI Foundations | 6.62% (as of 30.6.24)	**Quality Improvement** ▪ Continue the work to move the transition from a quality improvement trained organisation to a fully demonstrable QI ethos and act on the results of the QI Culture survey results to inform change. ▪ Build on the work in progress to develop improvement capability across the organisation.	Mar 2025 Mar 2025	**Green**	**Quality Improvement** • Demand continues to be high for QI work with 57 active QI projects being undertaken as at 30/06/24. Differing levels of support are provided to projects by the QI team. Q1 saw the Trust's 4th Give It A Go Week (GIAGoW) where 49 GIAGoW initiatives were registered with the team. During preparation for the week the QI team recognised an increased knowledge & engagement from individuals & teams about QI & this translated into further initiatives registered • As at 30 June 2024, 80.34% of staff have completed the QI Introduction training module, along with 6.62% of staff having

		▪ Start to develop deeper engagement with patients and the public ▪ Start to identify the value outcomes of the QI projects undertaken	Mar 2025 Dec 2024	**Green**	completed Foundations training. The objective for QI Introduction training for this year has been increased from 75% to 80% & is expected to reach this target. Additional QI training (3-day Practitioner course) has been developed with colleagues within the ICS. Initial test course has been completed with further dates to be rolled out in the coming months • The importance of patient engagement is covered as part of QI training & when supporting teams with their QI endeavours. The QI team will attend this year's AGM with a stand to showcase improvement work & encourage patients and the public to become involved in future work • Complete: During Q4 of 23/24 the QI team undertook work to understand the dominant themes that reoccurred in closed QI projects. The value outcomes identified were shared with Board by the team during Q1 and these themes are now presented in monthly reporting for all closed projects having a primary and any secondary outcomes associated. Project information is also shared with PMO colleagues on a monthly basis for them to support with the identification of any additional benefits realisation.
Simon Enright	We will build on existing achievements to have research as core business across the Trust and provide staff with expertise, guidance and time to progress research aspirations. Delivery measured by: RAG | Increase number of PIs to 40 by the end of the year | Q1: 34	**Research and Development** • Continue working across all CBUs to engage more principal investigators in more specialty areas especially focussing on areas where there is the greatest health need. • Expand opportunities for clinical staff to become research active e.g. research fellow posts, nurse and allied health professional principal investigator roles • Identify new opportunities for collaborative working through our links with local Integrated Care Systems (ICS), local authorities, primary care and other relevant organisations • Seek commitment for the development of research accommodation that can meet current and future requirements • Build innovative models of engaging nursing and allied health professional staff in research through hybrid roles, training / education, working with lead nursing team	Mar 2025 Oct 2024 Dec 2024 Aug 2024 Jan 2025	**Green**	**Research and Development** • A focussed approach is taken when reviewing new study opportunities. We endeavour to engage those areas with greatest health need and a limited study portfolio. Our current priority is growing the number of respiratory medicine studies and focussing on succession planning for our next Respiratory Clinical Fellow. • Opportunities are discussed at relevant meetings for staff to become more research active and information is provided monthly on on-going research activity to the CBUs. The PI associate scheme is advocated and relevant research training is promoted throughout the Trust. Funding opportunities are being explored to support these roles. • The team attend relevant external meetings to network, understand the wider research agenda and collaboratively work across our local area. Opportunities are being explored for collaborative working and increasing research growth for the population of Barnsley through secondment opportunities • The team are reviewing our accommodation requirements and are working with the estates team to scope out a suitable solution for our ongoing needs. • The Trust Chief Nurse Fellow (CNF) programme is being developed. This programme has been supported by R&D. This will offer an opportunity for nurses, midwives and AHPs to engage in research through protected time and senior support in the organisation.

Simon Enright	We will build on the significant progress made to embed innovation across the Trust and foster a culture whereby day-to-day activities are supported by innovation at the core of our hospital's work.	**Innovation**
		• Continue to develop the innovation function to deliver innovation across the Trust by taking forward the following actions:
		  ○ Identify innovations that meet the needs of the Trust, liaising with clinical and operational teams to pilot and implement
		  ○ Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website
		  ○ Continue to implement systems to promote innovations from external partners in particular Health Innovation Yorkshire & Humber and P4 South Yorkshire
		• Investigate the opportunities for increased capacity in delivering innovation
		• Maintain close working with the Integrated Care Board (ICB) and regional innovation leads to support delivery of Innovation in the Trust, ICB and Region.
		• Foster greater links between Research and Innovation functions with the aim of allowing greater resource for delivering this agenda
			Mar 2025
			
			Mar 2025
			
			Oct 2024
			
			Oct 2024
				Green	**Innovation**
					• The innovation team is currently working on projects to do with:
					  ○ Testing for pre-eclampsia – Further work being undertaken due to challenges with funding. When complete Innovation Team plan to write short case study
					  ○ Considering options for chest drains – Definition of clinical pathway in progress. When this is in place plan to undertake clinical evaluation of both Rocket and Thopaz+ and plan next steps
					  ○ Considering an alternative for nasal surgery -Considerable work going on across the Region. Plan to speak to Susan Douglas in Rotherham and potential for cross sites service.
					  ○ Supporting work around an innovation called Cytosponge – Barnsley have been accepted into a BEST 4 trial for Cytosponge. We will be monitoring progress.
					  ○ Considering potential patient engagement technology – Plan to discuss further with Director of ICT.
					  ○ Heartflow (MedTech) – Meeting planned with key clinical staff for July.
					  ○ APOS (MedTech) – Highlighted by HIN, staying in touch as bigger centres may initially undertake work. Following up with Therapy Lead in Barnsley.
					  ○ Discussions with Comms about website, plan made for initial content.
					  ○ Continued development of innovation processes for innovations identified externally.
					• The innovation team continues to embed our processes for introducing innovation to the hospital.
					• Work continues with our Health Innovation Yorkshire and ICB contacts for the implementation of (applicable) MedTech innovation products. Regular contributions to SY Innovation Newsletter. Innovation presentation delivered to each CBU. Plans to do a further innovation awareness event in September.
					• Research and Development Project Manager now in post and has increased innovation hours.

Tom Davidson	We will continue to use digital transformation to support new ways of working and build on solutions that enable our patients to digitally access information to support their own healthcare needs. Delivery measured by: • 100% Proforma digitalisation for Medical Care. • 50% Proforma Digitisation for Nursing Care • Completion and implementation of the referenced digital.	**Digital** • Implement shared care records into Careflow to enable visibility of ICS patient relevant information from other agencies and providers • Undertake nursing documentation review to digitise 50% of the paper forms used across the Trust • Implementation of digital prescribing and clinical noting in ED in order to digitise from the start of the Urgent Emergency Care patient journey • Complete pilot work to share our appointment and digital letter solution to the NHS app in line with operational planning guidance and priorities • Complete What Good Looks Like digital maturity assessments to insure we are meeting the gap for frontline digitisation by 2025 • Apply for minimum digital foundations funding to facilitate meeting the National NHS Digital targets by 2025 • Finalise our business intelligence strategy to improve the information and insight available, and implement our Power BI plans to support self-service and improve forecasting, planning and intelligence. Support implementation of the Federated Data Platform. • Implement digital solution for pharmacy stock control and patient flow including tracking.	Jun 2024 Mar 2025 Jul 2024 Nov 2024 May 2024 Jan 2025 Apr 2024 Mar 2025	**Green**	**Digital** • Implementation planned for end of July 2024 with training to follow. Awaiting capability from System C supplier. • On track with implementation plan in place. Currently in the initiation stage. • EPMA is live and in use throughout the department. Clinical noting planned for September 2024. • Historical appointments now available via NHS app. Met with Wayfinder team from NHSE July 24 to discuss progress with letters. • Complete: Reviewed in April 2024 with the ICS. • Investment assessment document in draft expected to be presented to Finance and Performance Committee in August 2024. Meeting with procurement team to finalise documents for submission. • Gathering feedback for publishing. Awaiting finalisation by Senior Management Team. • Agreeing timelines with system C for delivery prior to year-end. Currently working on Project Implementation Document

		• Transition of current paper processes to digital including implementation of clinical narrative • Complete delivery of Badgernet and all supporting maternity digital solutions in order to fully digitise maternity healthcare record • Implement our digital inclusion plans to ensure minimal impact to our patients through our digital transformation journey • Use of Robotic Process Automation (RPA) to improve utilisation of capacity across clinical areas and automate repetitive processes in corporate functions.	Aug 2024 Jun 2024 Mar 2025 Mar 2025	**Green**	• Working with system C to secure resource for implementing clinical narrative. Medical Inpatients, Emergency Department and Outpatients expected live September 2024. • Complete: live in June 2024. • New digital inclusion strategy in place. Paper detailing plans expected to be presented to Finance and Performance Committee September 2024. • Robots in use, working with other areas to identify optimisation opportunities. Finance and HR detail workshops scheduled in. Ophthalmology solution for three appointments now in implementation.
Rob McCubbin /Chris Thickett	We will develop our estate to focus on elective recovery, care in the community and intermediate care whilst continuing to deliver our wider capital programme. Delivery measured by: • Capital programme spend against plan	**Estates** • Finalise and approve the new estates strategy 2024/25 • Intermediate care Acorn Unit to be established on ward 12 • Develop the long-term solution for intermediate care estate not based on hospital site • Complete prioritised capital schemes as managed through Capital Monitoring Group, including backlog maintenance and essential fire related works. • Report and contribute to South Yorkshire & Bassetlaw (SYB) ICB Estates Board to understand the role of the estate within the region and agree any appropriate timeframe for actions arising. • Continue to review the efficiency of the estate ensuring optimal use for clinical activities, to be reported monthly through Space Utilisation Group • Review the food and beverage offer across the Trust (inpatient and retail) determining the service and undertake procurement exercise and award	Sep 2024 May 2024 Mar 2025 Mar 2025 Mar 2025 Mar 2025 Oct 2024	**Green**	**Estates** • Works currently being prioritised for Health on the High Street scheme, which will have a significant impact on the Estates strategy. • Complete: back on site and located on ward 12, completed 10 May 2024. • Works are progressing with partners to understand options. • Budgets re-allocation approved by board following the impact of the building safety regulator for Theatres and Ward 19 schemes. • Participation input continues. • Space utilisation group meetings continue monthly with large number of requests accommodated despite ACORN returning to ward 12. • Specification currently being finalised for catering hostess and retail and due to be issued to tender in July. New contract to commence from 1 April 2025. Nescafe coffee machine to be installed within ED during July and further reviews on improved vending are being undertaken.

Best for People - We will make our Trust the best place to work

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Steve Ned	We will continue to develop and embed a culture which supports being treated fairly and having a chance to succeed, regardless of background. Delivery measured by: RAG | | Q1 EDI mandatory training to maintain a 90% compliance within 3 years | Target date is May 2027 Improve staff survey "we are compassionate & inclusive" score from 7.62 to 7.71 (best) | Data available in Q4	**<u>Equality, Diversity and Inclusion (EDI)</u>** • Work towards reducing the Trust's gender pay gap by increasing access and up take of mentoring and coaching opportunities • Analyse pay data by ethnicity to understand and internally report the Trust's ethnicity pay gap and put in place an improvement plan, to include an analysis and action plan to address Black, Asian and Minority Ethnic (BAME) representation at Band 8a and above. • Pro-actively engage to support and promote the Trust's Armed Forces Covenant bronze award pledges with regards to the employment of veterans and reservists • Implement the Sexual Safety Charter commitments • Continue to strengthen our Barnsley Place Partnership Programmes in developing and delivering education to employment pathways, to support the economically inactive in the labour market get back into active work. • Increase usage of Accessable and Recite-Me, raise awareness and provision of guides to promote in collaboration with Comms, Patient Engagement & Experience teams	Mar 2025 Mar 2025 Dec 2024 Jul 2024 Sep 2024 Mar 2025	**Green**	**<u>Equality, Diversity and Inclusion (EDI)</u>** • Mentoring and career coaching opportunities publicised on the hub, Team Brief and Trust communications. Applications open for third Reciprocal Mentoring programme to commence Sept 2024. • On track to complete by March 2025. • The newly established Armed Forces Forum successfully organised its first promotional event in May 2024, attracting new members and achieving its initial goals. • The charter has been shared and promoted with the staff networks, support groups and inclusion & wellbeing champions to involve them in working towards the commitments. • Third Project Search cohort to commence in Sept 2024, Princes Trust programme and staff success story shared at Trust Board in July 2024. A recent heart award & nomination and a Barnsley Council award has been received for our partnerships working. • Baseline metrics obtained of current usage levels.

		• Review the Trust's Disability Confident Employer status with a view to applying for upgrade to Disability Confident Leader • Review and develop the recruitment and selection process and practices across the Trust to ensure they are fair, objective, reliable, inclusive and free from bias to improve the relative likelihood of people with a disability and Black, Asian and Minority Ethnic (BAME) people of being appointed from shortlisting (WDES and WRES indicator 2). • Develop and deliver bespoke and targeted diverse & inclusive culture awareness training • Develop and deliver additional EDI mandatory training to maintain a 90% compliance trajectory within 3 years when the course is aligned to the core skills training framework frequency • Embed the EDI annual calendar of events by a proactive approach to event planning and increased collaboration with involved teams to deliver key events.	Mar 2025 Mar 2025 Mar 2025 May 2024 Jun 2024	**Green**	• Award criteria analysis and feasibility plan to be discussed with the Ability staff network. • Scoping work of current process and practices completed to inform review. • Bespoke training is being provided to teams on request. • Completed: The virtual training programme is progressing as planned, with training sessions scheduled throughout the year and survey feedback sought for evaluation. • Completed: The calendar of events has been actively promoted across multiple communications channels including the Hub, Team Brief and the engaging "Hello Wednesday" campaign.
Steve Ned	We will continue initiatives to retain our staff and explore all opportunities to recruit to all vacancies across the Trust, including exploring innovative approaches where appropriate, to have a correctly resourced organisation. Delivery measured by: RAG | | Q1 Retention rate – Increase from 90.5% to 92% | 98.32% Vacancy rate – Decrease from 3.18% to 2.5% | 3.48%	**<u>Recruitment & Retention</u>** • Fully automate recruitment and on-boarding processes where possible, to remove duplication, improve efficiency and enhance candidate experience • Launch updated flexible working policy and toolkit, showcase success stories of flexible working in practice, and introduce central reporting and monitoring of flexible working requests and outcomes • Promote NHS careers and Barnsley opportunities, helping to attract talent and provide opportunities and access to the local population and disadvantaged, under-represented groups, e.g. Careers events; Princes Trust; Department for Work and Pensions. • Scope the feasibility of locally ran university education programmes for nurses, midwifes and Allied Health Professionals • Develop roadmap for the care careers in order to have established pipeline of talent in place, including working with schools and education • Embed careers clinics to educate and communicate the career options available in nursing to promote promotion and talent development • Increase opportunities to grow our own future workforce and therefore reduce our reliance on international recruitment	Mar 2025 May 2024 Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Amber** Rationale: Not all metrics achieved in quarter	**<u>Recruitment & Retention</u>** • Work has commenced to map the transactional recruitment process to identify the first phase in the use of Robotics Process Automation (RPA). • Updated policy launched and available on TAD. Accompanying resources & guidance to go on the Intranet is in development. Write up of staff success stories at the design stage. Review underway of current reporting & recording of flexible working outcomes. • Trust's partnering with the Prince's Trust & Barnsley Council has enabled the development of a range of events. Latest activity includes the delivery of a 2- week employability course, including L1 skills gateway qualification and guaranteed interview to support young people facing barriers gaining access into BFS Facilities Operative roles. • A discussion is planned with our local HEIs. Currently apprenticeship opportunities are offered for staff to train to become registered professionals through our local HEIs and the Open University. • We are strengthening links with Barnsley College and attended a 'Get Hired' recruitment event on 27th June to promote care careers to students and young people. Two Health & Care Academy rooms at Barnsley College for employers to access is in development. NHS England have re-launched the Nurse Ambassador role and the team will be reviewing how we roll this out across the Trust. • Nursing Career Clinics delivered as part of the Professional Nurse Advocate offer are proving to be very popular and additional dates have been added across 2024. • We have successfully recruited onto the Student Nursing Associate (NA) programme and are currently recruiting onto the NA to Registered Nurse (RN) and registered nurse degree apprenticeship programmes to commence in Autumn 2024.
Steve Ned	We will continue to enhance health and wellbeing support by evaluating our offer in collaboration with South Yorkshire Integrate Care Board (SY ICB) and providing managers and colleagues with improved tools and expertise. Delivery measured by:	**<u>Health and Wellbeing (H&WB) and attendance management</u>** • Complete phase 1 of new Supporting Staff Attendance Policy and Wellbeing Passport roll-out, disseminate toolkit and start delivery of supporting attendance & wellbeing conversations training for line managers • Continued joint working with the South Yorkshire ICS for the launch of the "Working together for workforce health & wellbeing" roadmap	Jul 2024 Apr 2024	**Amber** Rationale: Not all metrics achieved in quarter	**<u>Health and Wellbeing (H&WB) and attendance management</u>** • Phase 1 roll out ends on the 31st July 2024, managers have been supported with the implementation. New training was launched in March 2024 and incorporates H&WB conversations. Toolkit in development and on track to Launch by the end of July 2024 • Completed: 3-year roadmap launched in April 2024, of which the Partnership group and Proof panel launched in June and the

	<table><tr><td>RAG</td><td></td><td>Q1</td></tr><tr><td></td><td>Overall Sickness absence reduction by 1% to 4.5%</td><td>4.91%</td></tr><tr><td></td><td>'We are Safe and Healthy' theme score from staff survey to improve from 6.44 to 6.55 (best)</td><td>Data available in Q4</td></tr></table>	• Participate in the South Yorkshire ICB health and wellbeing workforce survey to evaluate and benchmark Trust HWB interventions and gather colleagues' health needs assessment baseline data • Refresh the Trust's health and wellbeing needs diagnostic to determine what mental and physical health issues and the biggest causes of sickness absence we need to focus on • Occupational Health & Well Being Teams to work collaboratively to showcase and raise awareness of the wider H&WB offer at the Trust and develop infographics to support managers to navigate it • Develop the preventative approach to staff psychological health & safety and mental wellbeing by implementing a new co-created stress management policy & risk assessment process • Explore an incentive- based approach for sickness absence and evaluation of whether this will be effective • Support more staff through the healthy lives programme and the health inequalities in our workforce.	Jun 2024 Sep 2024 Jun 2024 Sep 2024 Sep 2024 Mar 2025	**Amber** Rationale: Not all metrics achieved in quarter	People Group is launching in July for 6 months. All have BHNFT representation including chairing/deputy chairing. • Completed: Survey closed and results analysed ready for sharing and action planning. • Annual review of organisational diagnostic to take place in Sept 2024. Work in progress to create a dashboard comparing ESR absence data to OH referral data • Completed: Joint annual H&WB report completed and presented at Executive Team and People Committee. Infographics of services available on Occupational Health intranet site. • Policy and risk assessment process in development and on track to be created by Sept 2024. • Scoping work has been undertaken to see what/if other Trusts in the region have an incentive-based approach. Results to be reviewed at the Sickness T&F group in August 2024. • Health and Wellbeing staff awareness event with several providers held in June 2024, including promotion of 'How's the Ticker' campaign. QUIT steering group are looking at supportive smoke-free employment and recruitment policy.
Steve Ned	We will continue to develop our leaders and colleagues trusting our colleagues to care for our patients to a high standard and supporting them to continuously improve their own work and the work of others. Delivery measured by: <table><tr><td>RAG</td><td></td><td>Q1</td></tr><tr><td></td><td>Increase our staff survey response rate from 58% to 65% and improve staff engagement score from 7.14 to 7.32 (best)</td><td>Data available in Q4</td></tr><tr><td></td><td>Staff survey score 'We are always learning' to improve from 5.99 to 6.07 (best)</td><td>Data available in Q4</td></tr></table>	**<u>Learning, Culture and Leadership Development</u>** • Deliver new Corporate Welcome to improve new starter experience, embed Trust Values and aid retention • Roll out Oliver McGowan Training on neurodiversity, learning difficulties and learning disabilities to all colleagues • Set up Proud to Care Cultural Leadership Group to oversee delivery and launch of the Organisational Development and Culture Strategy for Barnsley, in collaboration with the Communications Team • Complete and evaluate key existing senior leadership development programmes e.g. board development and triumvirate • Review and improve Passport to Management programme, aligning to Line Manager Expectations Framework • Introduce Welcome to Leadership induction, aligning to Our Leadership Way – Compassion, Curiosity, Collaboration • Design and deliver Colleague/Leadership Conference • Pilot Scope for Growth career conversations aimed at supporting Black, Asian and Minority Ethnic colleagues • Develop and present business case for new systems to deliver Mandatory learning including a feasibility study on other functionality e.g. Appraisals • Participate in the NHS England People Promise exemplar programme cohort two. Recruit and over-see delivery of the work of a People Promise Manager to co-ordinate and embed all aspects of the NHS People Promise into the Trust to improve colleague experience and retention • Complete maternity cultural development programme • Develop and deliver actions plans to improve those areas identified in the Staff Survey as requiring improvement	Apr 2024 Mar 2025 Apr 2024 Dec 2024 Dec 2024 Jul 2024 Sep 2024 Jun 2024 Jul 2024 Mar 2025 Mar 2025 Jun 2024	**Green**	**<u>Learning, Culture and Leadership Development</u>** • Completed: Launched and now running for 3mths, with positive feedback from delegates. • As of 31/5, 57% completion of Part 1 e learning (2421 staff); 49% Tier 1 completions (590 staff); 30 staff Tier 2 completions (started 15/5) • Completed: Set up in May with a further meeting in June. Comms awareness provided in July Team Brief. The group to report and provide assurance on progress to the People Committee via a Chair's Log. • Triumvirate on track with Shadow Board due in July. Board Development complete with review in July. • On track to complete by Dec 2024. • Due to launch in August following sharing at People & Engagement Group in July. • Design and Planning team meeting weekly to progress. Conference to take place 17/18 Sept. Low take-up so far to be reviewed. Update paper going to Executive Team in July. • Targeted Scope for Growth conversations offer for BAME colleagues made as part of the appraisals data capture which closed end of June 2024. Expressions of interest to be followed up. • Liaising with potential SY Trust partners for confirmed interest in developing collaborative business case/joint procurement. • Up and running with a focus on cultural narrative, Exit Interviews, shared decision-making, and listening strategy. • Session with Champions to be held 8th July to take recommendations forward. • Completed: CBU Leads reported their progress at PEG.

Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Lorraine Burnett	Deliver the expectation on Urgent & Emergency Care (UEC) 4-hour access target with the ambition to perform in the top quartile Delivery measured by: RAG / Q1 Reduce patients with no criteria to reside by 10% – 35.30% Reduce >21-day LoS patients by 10% – 77 (Jun 24) Ambulance handovers (no waits over 1 hour)* – 202 Ambulances 92% bed occupancy – 91.68% Emergency Care Standard at least 78% of patients seen within 4 hours – 71.30% * Total Ambulance Handovers to ED – 6,738 with 12.60% between 30 and 60 mins and 2.99% between 60 and 120 mins.	**Urgent & Emergency Care** • Develop a key metrics daily report to inform UEC performance and required improvement actions • Deliver a winter plan with collaboration from place and South Yorkshire ICB partners • Conclude Barnsley place project on front door model and deliver actions within timescale • Deliver the Discharge and Patient Flow programme to achieve the overall objectives and support early flow throughout the trust to improve patient experience • Deliver discharge pathways within current controls and top quartile against North East & Yorkshire providers	Jun 2024 Sep 2024 Mar 2025 Mar 2025 Mar 2025	**Amber** Rationale: Not all metrics achieved in Q1.	**Urgent & Emergency Care:** • Complete: UEC metrics report exists and is circulated on a daily basis. • Winter Plan in development with system partners, awaiting latest update from UEC board. • A preferred model has been developed and there is ongoing work around data collection, modelling and process mapping. • The Discharge and Patient Flow programme has substantially completed all process maps of the patient journey. Outputs of these have highlighted issues that are the causes for delays, an action plan is in development working collaboratively across clinical and operational team to work on solutions. A focus for Q2 will be on Radiology delays, working with CBUs and ICT teams to support and improve pathways. • Discharge pathways are in place and delivering. The Trust is currently in Quartile 1 for patients discharged with a length of stay of 21+ days (Latest data available on MHS 19/05/24).

Lorraine Burnett	As a minimum we will meet our national operational priorities for Elective, Diagnostics and Cancer care and contribute positively to the South Yorkshire Integrate Care Board (SY ICB) aggregate performance.
	
	Delivery measured by:
	• Model system metrics for Elective, Diagnostics and Cancer reporting weekly to ET
	• Theatre Utilisation at least 85%
	• National planning priority metrics outlined
	  ○ Cancer
	  ○ Diagnostics & Elective Care
		Elective, Cancer & Diagnostics
		• Enact plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities set out in the operational planning priorities across Cancer, Elective Care, and Diagnostics including:
		  ○ Cancer – Improve performance against the headline 62-day standard to 70% by March 2025, improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 and increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
		  ○ Diagnostics - Increase the percentage of patients that receive a diagnostic test within six weeks to 95% by March 2025
		  ○ Elective care – Contribute to system weighted target of 103% and eliminate waits of over 65w waits by September 2024*, increase the
			Mar 2025	**Amber**
				Rationale: Not all metrics achieved in Q1
					Elective, Cancer & Diagnostics
					• Plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities continue as set out in the operational planning guidance across Cancer, Elective Care, and Diagnostics:
					  ○ Cancer (validated May-24) – 28 days FDS sits at 81.4% with a high rate of success in this standard over the past 12 months. One challenge is Bowel Screening as this is a regional service but can impact on our local performance now the standards have been merged. Challenges with 62 Treatment standards in terms of overall recovery. May position had improved to 74.8% (can fluctuate between 65 and 75%). Challenging areas; Local Lung pathways for diagnostics, Complex Radiology biopsy wait times, turnaround time for Histology and speed of decision making at MDT to transfer care of the Tertiary centre for treatment management plans. Staging data collection continues, our Trust currently ranking in the top 20 in the country for data completeness. Early stage diagnosis continues to be monitored with the support of access to community and Primary services to support patients recognising their sign and symptoms sooner to support early diagnosis. Lung Health Checks has seen a considerable shift in this staging metric and has recently been agreed as a national screening program.
					  ○ Diagnostics – percentage of patients that receive a diagnostic test within six weeks in Q1 – 2.28% as at May-24.
					  ○ Elective Care – patients waiting 65 weeks were 16 as at May-24. Outpatient appointments attracting procedure tariff were 40.90% in Q1 against the target of 46%.

		proportion of outpatient appointments attracting procedure tariff to 46% across 2024/25 • Develop a key metrics report to inform delivery and ongoing improvement against Elective, Cancer and Diagnostics care • Agree monitoring of South Yorkshire ICB metrics and measurement of aggregate performance with actions at individual trust level • Improve productivity metrics across theatres, imaging, endoscopy and outpatients in line with operational planning priorities where appropriate • Fully utilise capacity in the Mexborough Elective Orthopaedic Centre of Excellence facility in order to efficiently provide further Orthopaedic capacity • Develop and monitor plans to deliver planned activity levels required to reduce backlogs • Implement use of health inequality metrics into wait list management • Continue service sustainability reviews and develop actions to support at risk services • Explore the integration of health inequalities metrics and activity into statutory reporting processes e.g. Integrated Performance Report (IPR) and Equality Delivery System (EDS) reporting. *except where patients choose to wait longer or in specific specialties	May 2024 Jun 2024 Mar 2025 May 2024 May 2024 Jul 2024 Jun 2024 Jun 2024	**Amber** Rationale: Not all metrics achieved in Q1	• Monthly Integrated Performance Report in place and reporting on diagnostic metrics. • Data and Insights Strategy for South Yorkshire ICS in development, awaiting feedback. • Improvement against productivity metrics continues in quarter – Q1 Theatre Utilisation rate (Capped) was 79.39% and Q1 Day Case rate was 87.80%. • There has been challenges with utilising the full capacity allocated to BHNFT. A business case is to be presented to the Executive Team in July to expand the Orthopaedic Medical workforce to increase our activity levels and utilise the MEOC site. • Clinical Business Units are progressing work, first milestone is to eliminate all over 65-week waiters by end of September 2024. • CBU2 are piloting a equitable waiting lists imitative using BHNFTs WHaLES to compliment clinical prioritisation with the risk score for health inequalities. • Service sustainability reviews have been completed alongside TRFT. A full deep dive review of individual specialities to be completed. • Population Health Analyst continues to work on applying the standardised health inequalities measure across all services and to integrate it into the IPR. EDI & Public Health are working on joint EDS reporting and incorporating Health Inequalities into the Equality and Inclusion assessment process.
Chris Thickett	We will take forward work to further improve how we spend our money and get the best results possible across our services working with place partners to support this. Delivery measured by: • Efficiency & Productivity Programme (EPP) benefits delivered on a recurrent basis.	**Efficiency and Productivity** • Undertake speciality reviews with place partners to identify improvement opportunities collaboratively with a QI approach • Develop and monitor service sustainability development plans to address areas of high spend linked to workforce and demand challenges • Delivery of the objectives set out in the cross cutting workstreams of the EPP programme including Urgent & Emergency Care, Outpatients, Theatres and Workforce • Oversee delivery of the Getting It Right First Time (GIRFT) outputs linking directly to Efficiency and Productivity e.g. Further Faster and High-Volume Low Complexity (HVLC) workstreams. o Review relevant GIRFT checklists against current pathways and processes to understand improvement o Address improvement areas adopting best practice approach where appropriate • Explore and maximise all opportunities afforded via the TRFT and Acute Federation work (to be outlined when determined). • Work towards the efficiency ambitions in the 24/25 national planning priorities including: o Reduce agency spend to 3.2% of total pay bill o Reduce corporate running costs through standardisation, consolidation, collaboration and digitisation at scale o Reduce procurement and supply chain costs o Optimise medicine value.	Sep 2024 Jun 2024 Mar 2025 May 2024 Mar 2025 Mar 2025 Mar 2025	**Red** Rationale: Off financial plan inc. EPP. Lack of opportunities to support the programme to get back on plan by year end.	**Efficiency and Productivity** • To be reviewed in next quarter. • Service sustainability reviews have been completed alongside TRFT. A full deep dive review of individual specialities to be completed. Outputs of these will support the plan to address high spend areas within workforce and demand challenges. • Programme developed with a key focus on identified KLOEs across the four domains of quality, people, finance & performance. The programme includes transformative projects requiring change facilitation across cross-cutting workstreams i.e. UEC, OPD, Theatres and workforce. TOR developed for new improvement group. • The Trust is part of cohort 3 for the GIRFT Further Faster programme. Services are currently completing checklists and following this, themes will be identified with a focus on efficiency and productivity gains. GIRFT Oversight groups continue with services to maintain momentum and to review where appropriate best practice approaches. • Acute federation sessions taking place reviewing corporate services and sustainability reviews, identifying where plans need to be delivered by each individual corporate service. TRFT plans for Haematology service are in development along with a joint catering offer that will be going out shortly. • Work towards the efficiency ambitions in the 24/25 national planning priorities are progressing. Agency spend was 5% in Q1. EPP delivered £1,02m actuals in Q1, £97.5k attributed to Procurement savings & £97k savings through Optimising Medicine values.

Chris Thickett	We will keep to the budget set out for the year ahead. Delivery measured by: • Delivery of agreed financial plan and underlying exit run rate	**Financial Plan Delivery** • Production of robust annual business plans that have direct alignment of the service cost envelope with associated budgetary plans in line ICB system planning • Work with partners to produce a Barnsley Place plan to deliver areas of financial and service improvement not able to tackle solely as a provider e.g. urgent and elective acute care demand. This links to the Barnsley Place priorities outlined in Best for Place • Identify and develop a sufficient Efficiency & Productivity Programme to enable to the Trust to deliver the agreed financial plan • Deliver on the policies set out in NHSE and SYICB in the planning round related to financial control and spend reduction	Jun 2024 Sep 2024 Mar 2025 Mar 2025	**Red** Rationale: Off financial plan inc. EPP. Lack of opportunities to support the programme to get back on plan by year end	**Financial Plan Delivery** • Complete: Business plans and budgets have been completed. • Barnsley Place work ongoing. Currently no efficiency opportunities identified. • Programme in development with a focus on identified KLOEs across the four domains, quality, people, finance & performance. The proposed programme will include transformative projects requiring change facilitation across UEC, OPD, Theatres and workforce. EPP delivered £1,02m actuals in Q1 against a plan of £1.1.5m leaving a negative variance of £84k. YTD deficit of 3.1m against planned deficit of 2.8m, 300k off plan (Includes dropping in non-recurrent benefit of £1m). • Ongoing Work progressing.
Chris Thickett	Develop a plan for our finances over the next few years to get us get back to break even on an on-going basis from April 2026.	**Back to Balance** • Production of a financial recovery plan identifying the actions that are in the Trust's control and those that are dependent upon partners and national funding allocations to deliver a financially balanced position by March 2026. Including the identification of the actions which need to be taken more immediately to support delivery. • Understand ICS system allocations over next 2-3 years and implication for BHNFT • Understand and review Barnsley demand activity over 2-3 years including projected capacity and workforce requirements	Jun 2024 Jun 2024 Jun 2024	**Amber** Rationale: Off financial plan.	**Back to Balance** • Complete: Financial recovery plan completed and identified KLOEs to focus on in order to achieve balanced position by March 2026. • System allocations have not been released for 2 to 3 years. Work ongoing with ICB teams to understand system gap. • Work to be undertaken in Q2 & Q3. This links to Barnsley Place plans that are in development.

Best for Place – We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Bob Kirton	We will continue to play a key role in the delivery of Barnsley Place priorities. Delivery measured by: • High level Barnsley Health & Care plan metrics.	**Barnsley Place** • Support delivery of the priorities agreed by Place board reported quarterly (tbc) • Support development of plans to drive change that delivers efficiency in recognition of the financial pressures across the following priorities: ○ Improving respiratory pathways ○ Integrated and urgent care front door (whole system access/admission avoidance)	Mar 2025 Jul 2024	**Green**	**Barnsley Place** • Delivery against the Barnsley Place priorities continues as reported at May 2024 Board: ○ Ageing well pathways – deep dive analysis completed and initial meetings with key stakeholders completed to review opportunities, further scoping work required. Priorities for the programme have been established ○ Wider Discharge Priorities – utilising existing meetings to complete wider discharge priorities exploration. Four priorities to progress have been chosen, reinforced by data and local intelligence. • Support development of plans to drive change that delivers efficiency in recognition of the financial pressures across the following priorities: ○ Improving respiratory pathways - A Respiratory Partnership Group has been established with a strategic approach across Barnsley Health and Care Partners for COPD & Asthma Management. ○ Integrated and urgent care front door (whole system access/admission avoidance). A preferred model for Urgent Care front door has been developed and requires

		○ Discharge pathways (including virtual ward, intermediate care, step up/down) ○ Frailty pathways • Health on the high street - Following the outline business case sign off, work towards the full business case in year including more detailed analysis and engagement with staff, the public and partners regarding the future model • Improve links with Primary Care working closely with the Provider Collaborative – detailed objectives to be finalised in April and will include further collaboration centred around primary care Barnsley Education Support & Training (BEST) events ensuring strong relationships and integrated pathways between primary and acute care • Continue to work with the Mental Health, Learning Disability, Autism and Dementia Partnership including support with the following: : ○ The Autism Strategy due to be launched in April 2024 ○ Finalised Dementia strategy refresh and roll out of dementia training programme ○ Development of plans to reduce hospital admissions for people with Learning Disabilities ○ Priority areas for investment linked to Barnsley Mental Health Strategy Enabled by the Strategic Workforce, Estates, Digital & Information, Involvement & Inclusion, Health Inequalities & Intelligence and VCSE workstreams	 Mar 2025 Mar 2025 Mar 2025	**Green**	ongoing work around data collection, modelling and process mapping. ○ Discharge pathways (including virtual ward, intermediate care, step up/down). Virtual ward in place for frailty & respiratory. ACORN returned back on site in May 2024. ○ Frailty pathways – scoping out opportunities to pilot a community-based frailty assessment service. • First phase of the project progresses well with the appointment of Healthcare Planners to support with capacity and demand analysis and the development of new patient pathways within the Alhambra. Engagement with staff and partners continues through structured project groups. Communication plan in development to support engagement with the public now that Purdah has ceased. • Reported at May 2024 SY ICB Board, Barnsley Place Committee and Barnsley Place Partnership Board. Ongoing dialogue with regards to national contract for Primary Care with a potential further action in the form of a 'work to rule' within primary care. • Delivery groups are in place to support work with the Mental Health, Learning Disability, Autism and Dementia Partnership which feed into the overarching Partnership Group. The development of a Barnsley Place Strategy has begun. A specific strategy for BHNFT will follow. Dementia strategy has been refreshed and a roll out of dementia training programme will follow. As part of the place Learning Disabilities delivery group, an improved alert system is in development to identify patients that need an annual health check; an information sharing agreement is in draft.
Bob Kirton	We will continue to be an organisation committed to improving population health and reduce health inequalities and deliver our action plan across: 1. Prevention 2. Equity & Fairness 3. Anchor institution Delivery measured by: • Tier one – 85% of admissions screened for priority risk factors under the healthy lives programme • Tier two – Reduce the gap in health inequalities for the priority service area of Cancer. Services measuring and reporting health inequalities. • Tier three – Eliminate plastic waste from surgical gowns and drapes	**<u>Population Health and Health Inequalities</u>** **<u>Prevention</u>** • Develop a sustainable proposal for the Alcohol Care Team and its expansion to support people with drug addiction working with the Combatting Drugs Partnership • Build on the successful embedding of tobacco dependency treatment in acute services, expanding into the next wave of priority clinical areas • Sustain the Early Help Navigator service for children and families and develop a plan for an all-age offer	Jul 2024 Sep 2024 Jul 2024	**Green**	**<u>Population Health and Health Inequalities</u>** **<u>Prevention</u>** • To maximise positive impacts from greater integration with community services across treatment pathways, a partnership approach to quality improvement and sustainability of the Alcohol Care Team has been agreed, supported by the Combatting Drugs Partnership. An exercise is underway to better understand the holistic needs of people presenting to BHNFT who have drug and alcohol-related problems and to shape more responsive pathways. An optimal model will be proposed to Place Partnership in Autumn for consideration of funding and delivery approaches. • A Doctor in Training is exploring tobacco dependency treatment opportunities to integrate within the pre-assessment pathway, in alignment with the Waiting Well initiative and supporting place commitments to offer all smokers support to quit. Work is underway with children's services to embed tobacco dependency support for inpatients +/- parents, including adding screening questions to admission assessments, establishing referrals pathways, and designing age-appropriate interventions. Health and Wellbeing staff awareness event with several providers held in June 2024, including promotion of 'How's the Ticker' campaign. QUIT steering group are looking at supportive smoke-free employment and recruitment policy. • The Early Help team are now at full compliment, enabling them to deliver and embed support in key clinical areas with a sustainable delivery plan. Recent new interventions include the delivery of new classes on site, including teen parenting and "Welcome to the world" classes. Development of an all-age offer is currently on hold until resources become available for expansion.

		Equity & Fairness • Pilot administrative tools to make patient waiting lists fairer with a selection of surgical specialities and develop and implement a plan for a Trust wide approach • Build on the successes of CDC and outpatient service improvement to deliver more accessible diagnostic and outpatient pathways to Core20PLUS5 groups • Sustain improvement in population health analysis and measuring health inequalities/ Core20PLUS5 and give it the same prominence as statutory performance indicators **Anchor institution** • Build on the successful roll out of re-useable surgical gowns by switching to re-useable drapes and other sustainable procedural items • Continue to provide public health support to all departments and plans which support the anchor charter (e.g. for delivery of the People Plan and The Green Plan) • Introduce measurements of health, wellbeing and inequalities in our workforce and develop ways to address them • Continue to use the Barnsley 2030 board to engage with partners for the anchor approach and the 4 goals of healthy, growing, learning and sustainable.	Jun 2024 Mar 2025 Dec 2024 Aug 2024 Mar 2025 Sep 2024 Mar 2025	**Green**	**Equity & Fairness** • CBU2 are piloting a equitable waiting lists imitative using BHNFTs WHaLES to compliment clinical prioritisation with the risk score for health inequalities. • Population Health analyst is supporting the Health Inequalities analyst at the CDC and this plus the partnership approach is informing the expansion of the community services offer into the Alhambra. • Population Health Analyst continues to work on applying the standardised health inequalities measure across all services and to integrate it into the IPR. **Anchor institution** • Re-usable surgical drapes pilot started in June and is currently being evaluated. • Exec Lead and Public Health Consultant continue to convene a regular Anchor network group for the Trust. See relevant progress across Place, Planet and People priorities. • The next anchor network group meeting in July will focus on health and inequalities in the workforce (see reference to smoke-free employment policies as above) • Exec Lead and both Public Health Consultants continue to have prominent roles and provide leadership at place based alliances, including Barnsley 2030 board, inclusive economy board and others

Best Partner – We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Richard Jenkins, Bob Kirton	We will continue to work with and support delivery of the Integrated Care Partnership 5-year strategy and Joint Forward Plan with partners across South Yorkshire. Delivery measured by: • Outcome framework to be developed	**Integrated Care Partnership & Joint Forward Plan** • Support progression of the South Yorkshire Integrated Care Partnership strategy four shared outcomes: o Best start in life for children & young people o Living healthier & longer lives and improved wellbeing for greatest need o Safe strong & vibrant communities o People with the skills & resources they need to thrive. • Support transformation plans across a range of programme areas to support delivery of the objectives set out in the refreshed NHS South Yorkshire 5 Year Joint Forward Plan for 2024/25: o Reducing health inequalities and creating a prevention first NHS e.g. build and embed intelligence and population health management approaches including improvement in women's health o Improving access, quality and transforming care e.g. development of elective hubs and redesign of urgent and emergency care	Mar 2025	**Green**	**Integrated Care Partnership & Joint Forward Plan** • An update was provided to the South Yorkshire Integrated Care Partnership in May 2024. A Health Equity Framework has been developed by the Child Health Equity Collaborative (CHEC). A pilot of this tool is to be completed to test an approach to reducing inequalities and improve health and wellbeing of Children & Young People within South Yorkshire. A 2-year strategy for Data and Insights has been developed and awaiting feedback. Progress with the WorkWell initiative as draft delivery plans have been developed with expected final sign-off in August 2024 with the aim to mobilise the service from 1 October 2024. Work continues with SY Shows Up for Cancer with proposed draft bold ambitions, awaiting feedback. Awaiting publication of July 2024 report and progress. • Progress against the objectives set out in the NHS South Yorkshire 5 Year Joint Forward Plan for 2024/25: o BHNFT led development of a place proposal to invest the Barnsley allocation of the ICS Core20Plus5 monies into a community co development approach to addressing health and social care related health inequalities which was approved by the Place Partnership Committee in June. o Integrated and urgent care front door (whole system access/admission avoidance)A preferred model for Urgent Care front door has been developed and requires ongoing work around data collection, modelling and process mapping.

		○ Maximising the use of digital, data and technology and research and innovation e.g. use of digital communication and NHS app integration ○ Making best use of our collective resources e.g. best use of estate, green plans and joined up system financial plans ○ Working in partnership and collaboration e.g. Mental Health Learning Disability & Autism Provider Collaborative, Acute Hospital Provider Collaborative, Alliances and Networks ○ Supporting and developing our entire workforce e.g. integrated working, health & wellbeing, equality, diversity & inclusion and education.		**Green**	○ NHS app appointment solution is live. Work continues with the Wayfinder team from NHSE to discuss progress with letters. The Research team attend relevant external meetings to network, understand the wider research agenda and collaboratively work across our local area. Innovation work continues with Health Innovation Yorkshire and ICB contacts for the implementation of (applicable) MedTech innovation products. Regular contributions to SY Innovation Newsletter. ○ Space utilisation group meetings continue monthly with large number of requests accommodated ○ The Trust is working with Barnsley Place Partners to support the implementation of a Universal Passport. The passport been co-produced with people with Learning Disabilities and Autistic people at Speak Up, a self-advocacy group. This is in its final stages of development with the SYICB communications team, estimated launch in Q3. ○ South Yorkshire ICB health and wellbeing workforce survey completed, results to be analysed to evaluate and benchmark Trust HWB interventions and gather colleagues' health assessment baseline data. Population Health Analyst continues to work on applying the standardised health inequalities measure across all services and to integrate it into the IPR. EDI & Public Health are working on joint EDS reporting and incorporating Health Inequalities into the Equality and Inclusion assessment process.
Bob Kirton	We will support the delivery of the Acute Federation annual priorities.	**Acute Federation** • Delivery of Acute Federation 2024/25 priorities. • Support delivery of year 2 of the Acute Federation Clinical Strategy • Continue to support the Acute Paediatrics Innovator work to accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute paediatric services • Undertake and share learning for Clinical Service Sustainability Reviews and Non-Clinical/Corporate Function Sustainability Reviews to understand where further collaboration could improve care quality for patients and/or improve productivity and efficiency • Contribute to the development of an Acute Federation Plan for People to understand workforce risks and opportunities across the Acute Federation along with collaborative opportunities to train, retain and reform • Support development of a communications and stakeholder engagement approach which helps us to strengthen communication and relationships across Acute Federation Professional Partnership Groups and with external partners like the ICB, SYB Alliances and Provider Collaborative	Mar 2025 Mar 2025 Mar 2025 Jun 2024 Sep 2024 Mar 2025	**Green**	**Acute Federation** • The Acute Federation priorities have been developed for 2024/25 with the vision to support and reduce unwarranted variation in care for patients, enable safe and sustainable delivery of care and improve productivity and efficiency. • The clinical strategy launched early 2023 with a 5-year vision and framework in place for clinical collaboration. Work continues with the Urology & Rheumatology services with the implementation of a set referral criteria and standardised referral information within Rheumatology to be implemented early 2024/25. A Urology BPH pilot commenced Q1 and will be evaluated within 12 months. • The Acute Paediatrics Innovator programme continues as one of the key priorities in 2024/25. As reported in the annual report Innovator lessons learnt case study will be shared for the benefits of others. Formal evaluations will be completed in partnership with R&D, Higher Education where appropriate. • A key focus for 2024/25 as part of the Elective Recovery Plan will be an informed clinically-led review of service sustainability, in particular specialities with; highest volume of long waiters, rapidly growing waiting lists, benchmarking and improvement opportunities. • Plan for people forms one of the priorities for 2024/25. As part of this work will progressed to develop a single view of workforce challenges and opportunities with coordinated action demand and supply. Joining up the IB People Strategy, Provider Workforce Plans & training pipeline. • To support the Acute Federation priorities a Communication and Stakeholder engagement plan is being developed .

Richard Jenkins	We will continue our work in the Rotherham FT partnership and deliver the joint work programme.	**TRFT Partnership** • Review Clinical Service Sustainably Reviews undertaken across both Trusts and identify areas for collaborative working • Continue to jointly focus on the Haematology programme and produce implementation plans for the target operating model • Undertake external stakeholder survey to seek views on the partnership to assess and identify areas for improvement • Collaboratively review corporate back office functions in order to learn from each other, understand any joint working opportunities and efficiency improvements • Continue to deliver the joint Rotherham and Barnsley Triumvirate Development Programme • Jointly work on our respective Trust's back to balance financial plans identifying opportunities for shared learning, approaches to improvement and further collaboration	Jun 2024 Mar 2025 Jun 2024 May 2024 Mar 2025 Mar 2025	**Green**	**TRFT Partnership** • Service sustainability reviews have been completed alongside TRFT. A full deep dive review of individual specialities to be completed. Outputs of these will support the plan to address high spend areas within workforce and demand challenges. • Work progresses with the joint Haematology programme. Joint Consultant job descriptions have been drafted. A review of lessons learned from the Gastroenterology Programme is underway. • External stakeholder questionnaire in development with Joint Executive Delivery Group members. • A review of corporate areas with each Executive Director pairing underway. Findings and opportunities will be shared at Joint ETM Q2. • A leadership programme has been established and is progressing as planned. Shadow board sessions are planned for July 2024. • Both organisations have shared plans regarding back to balance plans and a financial presentation to engage with clinical leaders has taken place at a Joint Clinical Leads session.

Best for Planet - We will build on our sustainability work to date and reduce our impact on the environment

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Bob Kirton/ Rob Mccubbin	We will continue to work with partners and suppliers to deliver our environmental sustainability goals. Delivery measured by: • Green delivery plan including metrics and deliverables • Waste reduction (KG's) • Anaesthetic gas (volume and CO_2e reduction) • Energy (kWh) and CO_2e reduction • Increase in Ultra Low Emission Vehicles (ULEV) on NHS Fleet Scheme • Reduction in the number of single use PPE in areas where reusable PPE has been rolled-out	**Environmental Sustainability** Green delivery plan monitored by Executive team and Finance & Performance Committee including 10 key areas of focus with an owner for each area across the following: **Travel and Transport** • Develop and implement a new Active Travel Plan to allow staff to make more informed sustainable travel choices • Review the potential to offer Trust green transport for staff to reduce the impact of business travel **Energy & Carbon Reduction** • Develop proposal to install photovoltaic solar panels to generate clean renewable energy in readiness for potential future grant funding • Scan and review opportunities for grant funding of low carbon technologies • Carry out a review with a view to switching from piped Nitrous Oxide to cylinders to minimise waste and reduce greenhouse gases **Waste** • Improve waste segregation across clinical areas to minimise environmental impact of waste disposal **Procurement** • Where possible source products and services locally to support the regional economy. • Identify products which can be switched from single use to reusable	Mar 2025 Mar 2025 Jun 2024 Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Green**	**Environmental Sustainability** Green delivery plan monitored by Executive team and Finance & Performance Committee including 10 key areas of focus with an owner for each area across the following: **Travel and Transport** • Due to prioritising other activities there has been no progress on this action. • Currently having early discussions externally to offer staff long-term loan of EV bikes. **Energy & Carbon Reduction** • Currently awaiting outcome of a bid which will review the potential to install solar. • A grant funding bid was submitted in April to cover the cost of carrying out feasibility studies of installing low carbon technologies. Currently awaiting outcome of bid. • This is in progress and we will be running a trial in Q2. **Waste** • We are implementing a shift in our waste disposal through changing waste disposal stream from yellow to tiger. This is more sustainable and cost effective. We have introduced metal recycling in theatres. **Procurement** • This is ongoing and where local products and services are available we do make the switch in line with Trust procurement rules. • No products switches made in Q1. We are currently in the process to switch two products in ED which will reduce waste and are more sustainable. Further update to be provided in Q2.

		Plans & Partnerships • Develop and implement a new energy policy • Work closely with other public and private sector bodies to contribute to the delivery of carbon reduction strategies and plans including a focus on renewable heat network opportunities • On-going communication with staff and public to engage and involve them in our plans	Aug 2024 Mar 2025 Mar 2025		**Plans & Partnerships** • This is in development through a working Energy Efficiency Group we have established. Further update to be provided in Q2. • We are currently working with external partners and an investment company and reviewing an opportunity to establish and connect to a local heat network. • An event was held to engage with staff in June 2024. Green Plan video is now complete and will be launched Q2.

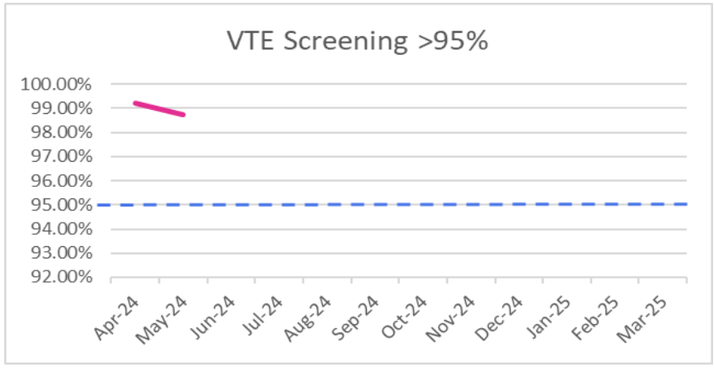
Appendix 2

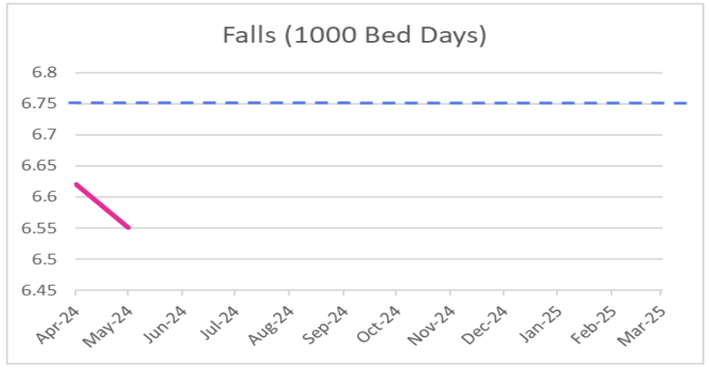
BARNSLEY HOSPITAL TRUST OBJECTIVES 2024-2025 METRICS DASHBOARD (Q1 REPORT)

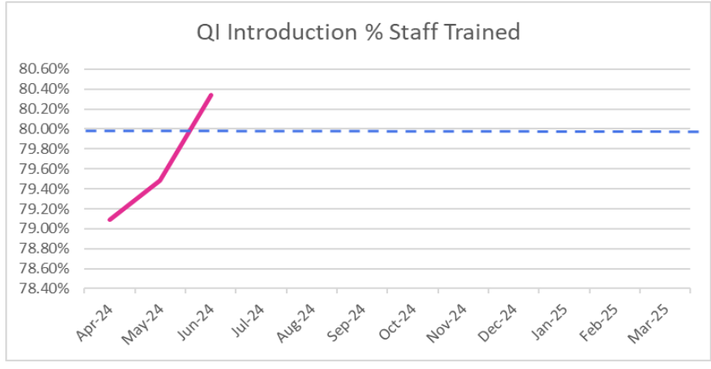
Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

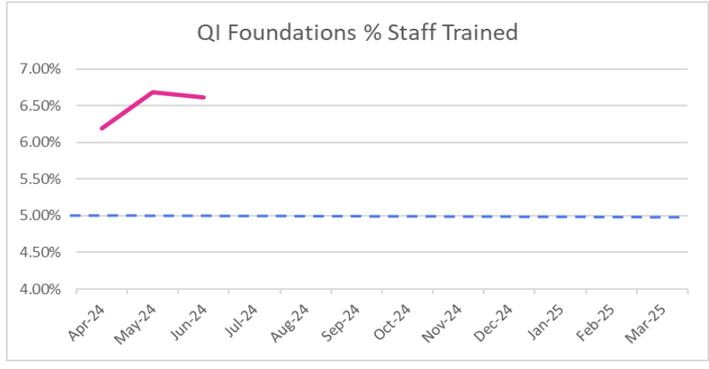
Best for Patients & The Public - We will provide the best possible care for our patients and service users

Clinical Effectiveness, Patient Safety & Quality Improvement Metrics			
KPI	**Measure**	**Target**	**RAG Status**
Scrutiny of deaths by the medical examiner	100%	100%	
VTE Screening metric as defined by 2024/25 CQUIN released April 2024	98.73% (May 2024)	95%	
Antibiotics given within an hour for Sepsis >90%.	92%	90%	
Reduction in C. diff infection rates in line with NHSE target	Awaiting NHSE Target		
Reduce falls / 1000 bed days to no more than 6.75/1000	6.55 (May 2024)	6.75 days	
80% of staff trained in QI Introduction by 2024.	80.34% (June 2024)	80%	
5% of staff trained in QI Foundations	6.62% (June 2024)	5%	







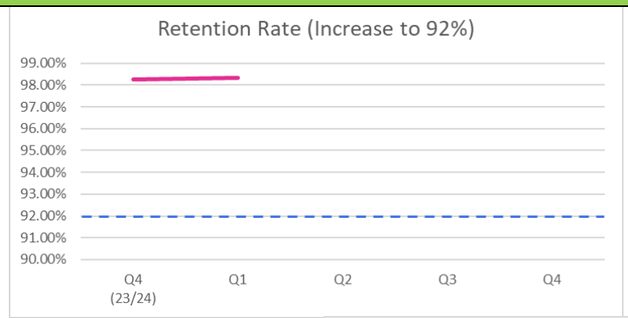


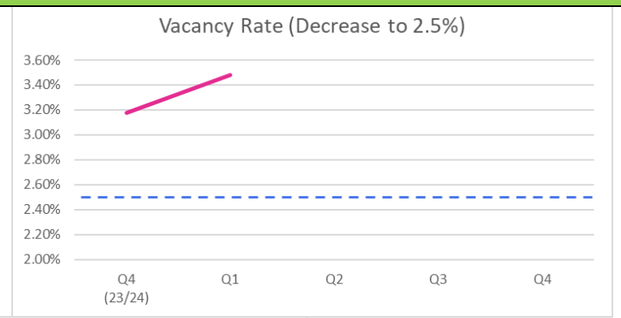
Appendix 2

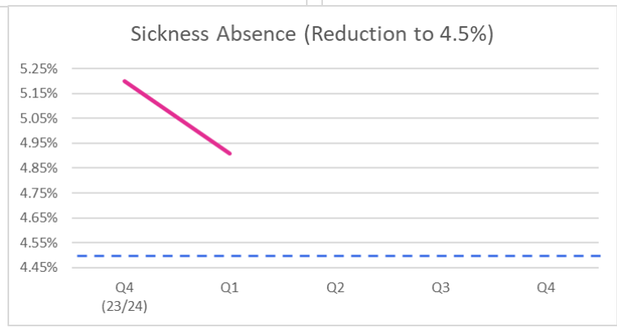
Barnsley Hospital NHS Foundation Trust

Best for People - We will make our Trust the best place to work

KPI	Measure	Target	RAG Status
Retention rate – Increase from 90.5% to 92%	98.32%	92%	
Vacancy rate – Decrease from 3.18% to 2.5%	3.48%	2.5%	
Overall Sickness absence reduction by 1% to 4.5%	4.91%	4.5%	

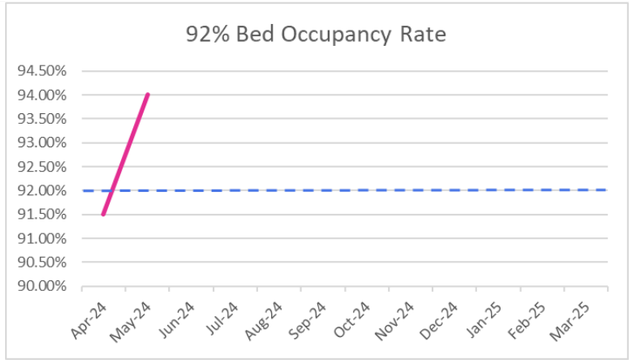


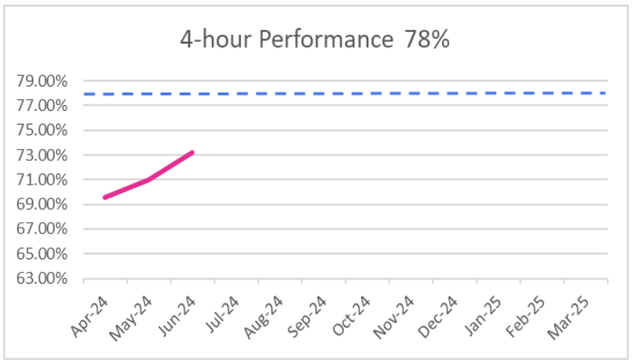




Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

KPI	Measure	Target	RAG Status
Reduce patients with no criteria to reside by 10%	35.30%	10% reduction	
Reduce >21-day LoS patients by 10%	77 (Jun-24)	10% reduction	
92% bed occupancy	91.68%	92%	
Emergency Care Standard at least 78% of patients seen within 4 hours	71.30%	78%	
Theatre Utilisation Rates - Main (Capped)	79.39%	85%	
Day Case Rates	87.80%	85%	



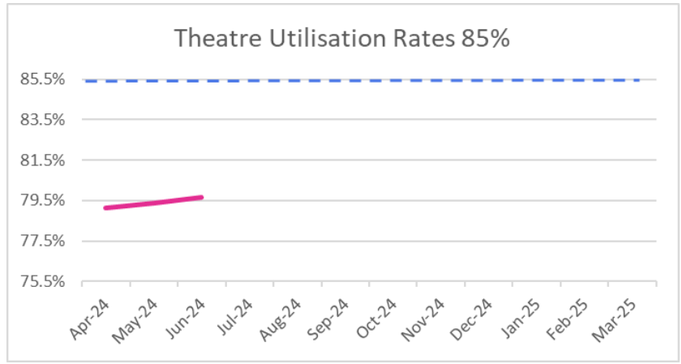


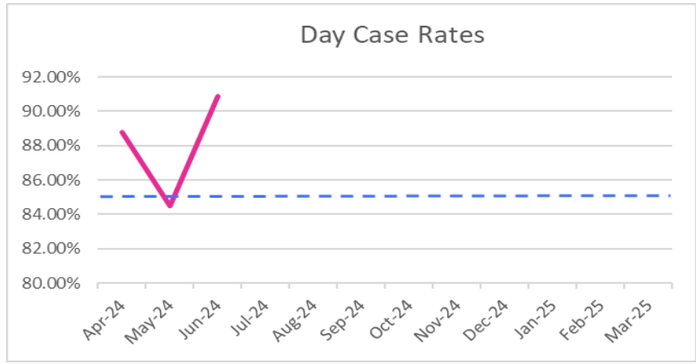
Appendix 2

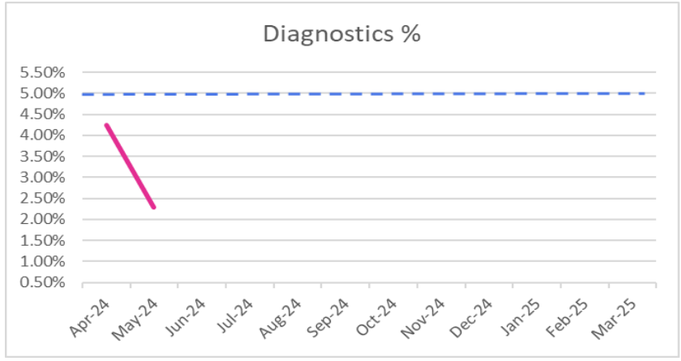
Barnsley Hospital NHS Foundation Trust

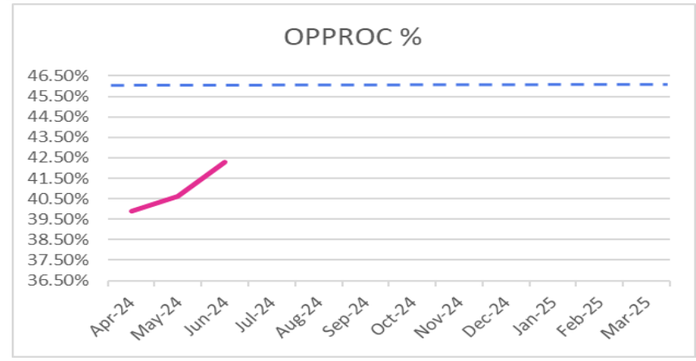
Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

KPI	Measure	Target	RAG Status
Diagnostics - % patients that receive a diagnostic test within 6 weeks	2.28% (May-24)	5%	
Eliminate waits over 65 Weeks by September 2024	16 (May-24)	< 65 weeks	
% of OPPROC Completed	40.90%	46%	
Cancer Performance - Faster Diagnostic Standard (28 Day)	81.4% (May-24)	77%	
Cancer Performance – Treatment Standard (62 day)	74.8% (May-24)	70%	
Ambulance handovers (no waits over 1 hour)*	202	Zero over 1 hour	









Graph Key:

———	Performance figure monthly/quarterly
- - - - - - -	Target Metric

RAG Key		To note:
	On Track	Each of the metrics have their individual RAG rating based on current performance however these contribute to the overall objective RAG status in Appendix 1.
	Issues but Mitigation in Place	
	Significant Issues/Delays	
	Complete	

4.3. Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance

For Assurance

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS – Public	REF:	BoD: 24/08/01/4.3

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sara Collier-Hield, Associate Director of Midwifery				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sara Collier-Hield, Associate Director of Midwifery				

STRATEGIC CONTEXT

This report contains details and assurance relating to the national minimum perinatal clinical quality data set for maternity services.

It is a requirement, as part of the Perinatal Quality Surveillance Model (NHS England, 2020) that this is presented to the Trust Board.

This aligns with all of the Trust's ambitions and strategic objectives.

EXECUTIVE SUMMARY

This report provides the trust board with an analysis of monthly perinatal clinical quality information: The key messages contained within the paper refer to May and June's data and are as follows:

- There were no new PSII's or AAR's declared in May or June. 1 AAR was finalised in June.
- One moderate harm was declared in June regarding a term admission to the neonatal unit.
- Compliance for fetal monitoring training continues to remain at 100% across all staff groups.
- Following an assurance visit from the LMNS on 24th June compliance with SBLv3 has been validated at 83% when all elements are totalled.
- The SCORE culture survey for all staff in maternity and neonates is now completed. Results will be shared with the perinatal quadrumvirate in August 2024.
- BadgerNet EPR was launched on the 4th June, women can now access their own patient record via the App.
- The midwife led tongue tie service has started in May 2024.
- The nationally recommended BSOTS model for triage has been launched in June 2024.
- The Maternity 5-year strategy has now published and disseminated to staff.
- SATOD rates for May 2024 is the lowest to date at 7.2%.

RECOMMENDATION(S)

The Board of Directors is asked to receive the report and acknowledge receipt of the monthly minimum dataset for maternity services.

1. Introduction

This report will provide Board with an overview of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to maternity safety across Barnsley Hospital NHS Foundation Trust.

The information within the report will reflect actions in line with Three Year Delivery Plan for Maternity and Neonatal Services and progress made in response to any identified concerns at provider level.

The Three Year Delivery Plan for Maternity and Neonatal Services was published by NHS England on 31st March 2023 with the aim of making maternity care safer, more personalised and equitable, outlined in four high level themes. The Three Year Delivery Plan provides maternity services with one improvement plan with the Integrated Care Board (ICB) responsible for regional assurance. The expectation is that reporting on the Ockenden Immediate and Essential Actions will be replaced by the Three Year Delivery Plan. A regional assurance tool for delivery of the Three Year Plan is in place and monitored locally.

2. Data measures for Trust Board overview – perinatal quality surveillance tool (Appendix A)

Appendix A provides Board with the minimum dataset required as part of the Perinatal Quality Surveillance model.

- One perinatal death was reviewed in May using the Perinatal Mortality Review Tool. No perinatal deaths were reviewed or reports finalised in June.
- Compliance with MAST training for all staff groups is over 90% for the last eight months
- PROMPT training currently on track
- Fetal monitoring compliance remains at 100% for all staff groups
- There was one moderate harm declared in June regarding a term admission to the neonatal unit (see 4.4)

3. Perinatal Mortality

3.1 Perinatal Mortality Review Tool (PMRT) (Appendix B)

The standard process monitoring data for PMRT's is shared in Appendix B.

There was one report finalised in May 2024 of a 31-week gestation baby following a diagnosis of a fetal abnormality. There were no care concerns identified.

4. Patient Safety Investigations

4.1 Maternity and Neonatal Safety Investigations (MNSI)

There have been no new referrals to MNSI, there remains one ongoing case.

4.2 Patient Safety Incident Investigation (PSIIs), After Action Reviews (AARs) and Swarms

There were no new PSIIs declared in May or June 2024.

There was one ongoing PSII in June 2024. An extension to the timeframe for completion of the investigation was agreed at Patient Safety Panel to allow for the incident to be shared at the LMNS Quality and Safety Forum prior to completion. This was following discussion with the family who wanted to receive the report after it had been to the LMNS rather than before. This PSII is due for completion in July 2024.

There were no new AARs declared in May or June 2024.

One AAR was completed and finalised in June 2024 and the learning has been shared with staff. This related to an IUFD. There were no immediate safety actions identified, however there were four actions that were identified that could improve the service for other patients. As this incident meets the criteria for PMRT in addition to the AAR all learning and findings will be shared together in this paper once the PMRT is finalised.

4.3 Moderate harms and above (Appendix C)

All data reported in appendices A and C refers to the month in which the level of harm was confirmed.

During May there no incidents confirmed as moderate harm or above.

During June, there was one incident confirmed as moderate harm. This incident was a term admission to the Neonatal Unit, which was considered avoidable following review via the ATAIN process. The learning identified was around CTG classification, a delay in obtaining the first blood sugar reading, management of a low temperature in a neonate, and the performing of oxygen saturations with neonatal observations when there are respiratory concerns. This learning has been shared with staff and a drill has taken place in the clinical areas.

5. Training (Appendix D)

<u>Maternity Staff Mandatory Training including Safeguarding level 3</u>

Training compliance for MAST for the maternity establishment has been maintained above the Trust 90% compliance rate. Neonatal unit is at 88.93% this is due to sickness in the team and it is expected this will be above 90% next month.

Obstetric medical staff compliance for MAST has dropped again this month and remains below the Trust 90% compliance rate. The service Manager is liaising with medical staff who are out of date. The aim is to be above 90% by the end of July.

Overall Level 3 Safeguarding training compliance for the maternity establishment remains above the Trust target of 90%. At present the medical staff groups compliance remains below this target but of the 7 Dr's who require training 5 are on the Vocational Training Scheme and commenced post in April. Staff will be allocated on the next available training day which is in August. This compliance is monitored via the CQC oversight meeting. ESR cannot be relied upon for training compliance in this staff group as rotational Dr's not employed by the Trust are not captured on ESR.

PROMPT and fetal monitoring training

Compliance for 5 out of the 7 staff groups for PROMPT remains over 90%.

The two staff groups where compliance is currently less than 90% are:

- 'All other obstetric doctors'; in this group, compliance is now 82.60% which is the same as the previous month. This is due to one of the PROMPT training days being cancelled in May, resulting in a doctor becoming none compliant with training. This doctor is booked to attend in July
- 'All other obstetric anaesthetic doctors' is now at 86.36%, this is steadily increasing month on month. There have been 9 anaesthetists who have started at the Trust since February, only 3 of these haven't attended the PROMPT training day, they are booked to attend in July.

Compliance for the fetal monitoring training remains at 100% for all staff groups.

Mandatory Neonatal Training Compliance

Neonatal level 3 safeguarding is above 90%.
All staff non-compliant with training have been contacted and asked to complete as soon as possible. 10 staff members attended Fire and Health and Safety training in April, May and June, ESR has not yet been updated to reflect this. 7 members of staff have been allocated to Infection Control training between July and September. All Paediatric staff have been allocated to attend PILS training during their mandatory training to improve compliance. Currently PILS compliance is 50% however this is based on 2 neonatal outreach staff of which 1 is attending training in July. 6 staff attended in May and June but ESR has not yet been updated to reflect this.

6. Maternity Dashboard (Appendix E)

Smoking at Time of Delivery (SATOD) is 7.2% in May, this is the lowest this figure has been in 12 months. A more detailed overview of the remit of the smoking team and KPI figures will be provided in the next full board paper.

Dashboard metrics relating to KPI's have been produced in SPC form this month (Appendix F). Further work is being undertaken to enable other key safety metrics to be published in this format.

BadgerNet was implemented in maternity services 4th June 2024, enabling an end to end Maternity EPR. This introduction and migration to BadgerNet has impacted on reporting and data quality. Work is ongoing from the maternity digital team to ensure accurate data cleansing.

In view of moving to the new Maternity EPR, a review of the format of the data contained in the Board paper will be undertaken to review how this could be brought in line with other areas of the trust reporting services.

As from May data has been captured on delayed Induction of Labours (IOL's) and delayed Elective Caesarean sections (EL LSCS). There were no delayed EL LSCS in May or June. In June there were 2 delayed IOL's. The induction process was commenced as planned, both delays occurred once the women were deemed suitable for an artificial rupture of

membranes. This was not possible due to acuity on the BBC. There were no adverse outcomes for either mothers or babies as a result of these delays. This data is captured monthly in the inpatient matron report which is discussed at Women's Business and Governance sub-speciality meeting.

7. Maternity Safety Champion activities

David Plotts has recently been appointed as the new Non-Executive Director (NED) for the Maternity and Neonatal Services. Since his appointment, he has been actively engaging with the services.

During a recent walk round of the neonatal and maternity services, several action items were identified. One key action was the need for larger iPads for BadgerNet on the antenatal and postnatal wards. These iPads have since been ordered.

A detailed log of the walk round and the actions taken has been shared with all staff via email to ensure transparency and keep staff updated on responses to action taken.

8. Workforce: Midwifery, Neonatal and Obstetric Staffing

Midwifery staffing

- The current number of vacancies for midwives, against budgeted establishment is 6.13 wte as of the end of June. The recruitment of newly qualified midwives to start in the Autumn has been positive and will mitigate all current vacancy and the staff on maternity leave.
- There are 8.75 midwives on long term sick at the end of June. All are being supported by their line managers and with HR and occupational health plans in place as appropriate.
- There are 5.32 midwives on maternity leave.
- Community team leader post vacant and soon to be out to advert.
- Maternity support worker vacancies 3.75 wte to be recruited to.

Continuity Of Carer

One of the three continuity teams, 'Amethyst', was stepped down 2nd June 2024 to support vacancies across maternity service. Two continuity of carer teams continue delivering conintuity of carer over a 24 hour period and are part of the maternity escalation policy.

A new continuity of carer SOP is at final draft stage and will go through governance processes by August 2024. This will offer evidence based support and guidance for the multidisciplinary teams.

A review of continuity caseloads will be completed by Quarter 3, 2024 to target Core20PLUS5 care delivery. This supports the national ambition for 75% of women and birthing people from the most deprived backgrounds and those of Black, Asian and Mixed ethnicity to be offered this model, to reduce perinatal mortality rates (MBRRACE UK, 2023: NHS Core20PLUS5: Health Inequalities in Maternity Care, 2022).

The new end to end maternity system (BadgerNet) and improved IT access across community will support Barnsley maternity services ambition to achieve Enhanced Continuity

of Carer by moving from GP attached caseloads, to Geographical caseloads that are digitally allocated onto continuity pathways.

Neonatal staffing

There are no nurse staffing vacancies. New graduate nurses will be commencing in role over the next few months. The Neonatal Network are funding a Governance and Education Lead Nurse role. The job description has been approved and this is progressing through recruitment processes.
The qualified in speciality (QIS) compliance remains on the risk register as it is currently 67% (BAPM standard 70%). This is mitigated with the use of Neonatal outreach staff, the Lead Nurse and Matron should staffing require. The standard of two QIS staff per shift, to care for the service specification of two intensive care cots continues to be maintained.

Obstetric Staffing

Issue	Mitigation	Assurance
1 consultant post vacancy	Long term Locum	Locum to remain for a further 6 months until successful applicant commences October 2024.
2.4 x Registrar level (equating to 3 Registrars for Entrustability)	Entrustable doctors paired with a senior Reg on rota	If Senior Reg is on leave a locum is secured to ensure support for Entrustable Reg . Consultants will remain on site out of hours if a registrar is on the Entrustability matrix and no locum is secured.
Tier 2: 4 current Trainee gap due to Mat Leave Additional 1.0 wte secured for entrustability Tier 1: 0 Gaps	Locums used	Additional Reg secured and commenced February 2024. 2 agency locums covering 2 of the Maternity gaps. Along with recruited Reg this reduces the gap to 1 WTE Interviews taken place July successful recruitment for 1 Permanent Specialty doctor with a potential to recruit 2 if funding allows

Overall vacancy for Obstetrics and Gynaecology – N/A

Additional information

There are currently 4 Tier 2 doctors on Maternity leave. One post is covered by the Registrar appointed in February 2024.
The service had permission to recruit to a permanent Specialty Doctor to support the gaps created from maternity leave and to support entrustability. Successful interviews took place in July, one additional post was recruited to. Two further gaps have been covered by Agency locums

Interviews successfully took place 2nd May 2024 for a Consultant. The successful candidate is due to commence post in October 2025. Prior to this time the vacancy will continue to be covered by a long-term locum who has been in post for the past 6 months.

Awaiting agreement to recruit to a further Consultant post.

9. Insights from service user engagement and MVP

In June maternity services received 39 FFT responses, 100% were good or very good with positive comments across the board. QR code reminders are still being promoted to try to raise response rates further. Response rates have reduced by 11 from 50 in May. Further promotional work continues to see if FFT score can be incorporated into BadgerNet, which launched 3 June 2024, the system was not fully embedded in June which may have affected response rates.

Month 2024	Maternity Response rates	Satisfaction scores	Action
June	39	100% positive	New IT system embedding
May	50	100% positive	Ongoing promotion of FFT
April	14	100% positive	Ongoing promotion of FFT
March	56	100% positive	Ongoing promotion of FFT
February	41	100% positive	Ongoing promotion of FFT
January	42	97.6% positive	There was no narrative to the negative response for ANDU. Ongoing promotion of FFT

MVP feedback

Main themes and workstreams are:

- Not feeling fully informed of the Induction of Labour process – MVP to explore induction of labour workshops where people can ask questions about labour and birth
- Informed consent – working with staff locally to promote this theme
- Having 'risk' of a procedure being explained with data as opposed to 'increased risk' narrative – working on producing local risk data

The Matrons continue to have monthly meetings with the local MVP to discuss feedback and themes to form the action plan. In March the MVP updated their workplan for 2024/2025. They intend to work closely with the neonatal team to become a MNVP.

Neonatal

The neonatal unit has worked with the patient engagement team, and utilises survey monkey and QR codes to gain friends and family feedback

Month 2024	Neonatal Response rates	Satisfaction scores	Action
June	6	97.9%	Promotion of FFT, to complete throughout stay rather than just at discharge given length of stay.
May	4	99.2%	Reminder to staff to offer all families admission pack
April	6	100%	
March	3	100%	

10. Care Quality Commission (CQC) actions

Bi monthly oversight of the maternity CQC action plan takes place in the CQC Aim for Outstanding meeting.

Maternity establishment is now >90% for safeguarding training. The Obstetric staff are still working towards this.
There was a “should do” is in relation to daily checking of all neonatal resuscitaires in all areas. Compliance with this has greatly improved. In Quarter 1, on BBC, there was on day where 100% compliance with this standard was not achieved. There was no adverse outcome on this day.

In Quarter 1, the ANPN ward have achieved 100% compliance with daily resuscitaire checks.

Checking of the resuscitaire in main theatres was 95.4% in April, 100% in May and 95,4% in June.
The Lead Midwives for these areas continue to monitor compliance weekly.

As of the 4th July there are 4 guidelines out of date (4.52%). They have been reviewed and they are on the agenda for the Women’s Business and Governance Meeting in July.

11. Clinical Negligence Scheme for Trusts (CNST) Year 6 including Saving Babies Lives Care Bundle version 3 (SBLv3)

Work continues to achieve full implementation of all six elements of SBLv3. This work stream has now been incorporated into safety action 6 of MIS. The LMNS continue to monitor progress against the safety action, the Q4 position was reviewed in June 2024. Current validated assurance is 83% when all elements are totalled.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	99%	Partially implemented	83%	CNST Met

12. Perinatal Culture and Leadership programme

The SCORE culture survey for all staff in maternity and neonates is now completed. Results will be shared with the perinatal quadrumvirate in August 2024. Four staff have been identified to train as culture coaches.

13. Maternity & Neonatal Transformation – Three Year Delivery plan

On June 4th, BadgerNet was successfully launched across maternity services, providing an end-to-end system accessible to all service users. Concurrently, the Birmingham Symptoms-Specific Obstetric Triage System (BSOTS) was implemented with dedicated staffing to ensure that pregnant individuals receive timely and appropriate care in the correct department.

Additionally, the maternity five strategy was published and communicated to staff in June, outlining the service's vision.

The midwifery-led tongue-tie service also debuted in May with significant success, facilitating quicker assessments and treatments for babies, thereby supporting their feeding journey more effectively.

Glossary

Terminology	Definition
AAR	After Action Review – a structured facilitated discussion on an incident or event to identify strengths, weaknesses and areas for improvement
ANPN	Antenatal and Postnatal Ward
ATAIN	Avoiding Term Admissions Into Neonatal Units
BSOTS	Birmingham Symptoms-Specific Obstetric Triage System
CEO	Chief Executive Officer
CNST	Clinical Negligence Scheme for Trusts
ED	Emergency Department
ESR	Electronic Staff Record
FFT	Family and Friends Test
HLR	High Level Review
ICB	Integrated Care Board
ICU	Intensive Care Unit
IUFD	Intrauterine fetal demise (IUFD) is the medical term for a fetus that dies in the womb at or after the 20th week of pregnancy
LMNS	Local Maternity and Neonatal System
MAST	Mandatory and Statutory Training
MNSI	Maternity and Newborn Safety Investigations
MNISA	Maternity and Neonatal Independent Senior Advocate
MNVP	Maternity and Neonatal Voices Partnership
MVP	Maternity Voices Partnership
NHS	National Health Service
NND	Neonatal death is a baby died within the first 28 days of life.
PMRT	Perinatal Mortality Review Tool
PPH	Postpartum Haemorrhage – blood loss of 500ml or more within 24 hours of the birth
PSII	Patient Safety Incident Investigation
PROMPT	Practical Obstetric Multi-Professional Training
SI	Serious Incident
SWARM	A SWARM huddle is a meeting to explore an incident, a facilitated discussion, which takes place soon after an activity or event.

Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016 (full inspection)	Safe (last inspected 2023)	Caring	Responsive	Effective	Well Led (last inspected 2023)
	Requires Improvement	Good	Good	Good	Good

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Number of perinatal deaths completed using Perinatal Mortality Review Tool	1	1	0	2	0	0	0	2	0	3	0	0	0
Number of cases referred to MNSI	0	0	0	0	0	0	0	0	2	1	0	0	0
Number of finalised reports received from MNSI	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of finalised internal SI/PSII reports	0	1	0	0	0	0	1	0	0	2	1	0	0
Number of incidents confirmed as moderate harm or above	10	14	16	9	12	7	2	3	4	1	2	0	1
Number of Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	81.43	82.14	81.74	85.24	87.48	93.17	92.15	90.58	92.88	92.92	93.52	90.68	90.8
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) ***Reset to zero from December 2023***	43.75	52.25	58.55	58.55	74.20	97.08	0 (new training begins)	12.5	25	33.85	49.60	55.24	64.43
Fetal monitoring training full day attendance (%)	52.09 Dr's strike	52.09 Dr's strike	55.4	55.4 Dr's strike	72.5	90.3	97.5	98.0	100	100	100	100	100
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	3	0	0	0	0	2	0	0	0	0	0	0	0
Midwifery Vacancy rate (WTE)	8.97	9.12	12.76	13.26	5.23	6.34	3.34	3.34	4.14	6.55	5.34	5.34	6.13
Medical Vacancy rate (WTE)	4.4	4.6	5.8	5.8	6.4	2.2	2.2	2.2	1	1	1	1	1
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually – 2022)	**Proportion of midwives who would recommend as a place to work 2022: 60%**									**2023 figure: 68.4%**			
	Proportion of midwives who would recommend as a place to receive treatment 2022: 75.3%									**2023 figure: 81.6%**			
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	**92.3% reported they received good clinical supervision out of hours**												

Appendix B

Perinatal Mortality Review Tool – data to evidence meeting required CNST year six: 8 December 2023 to 30 November 2024

Required standard	Dec 23	Jan 24	Feb 24	March 24	April 24	May 24	June 24
Percentage of eligible perinatal deaths notified to MBRRACE-UK within 7 working days (100%)	100%	100%	100%	100%	100%	100%	100%
Surveillance information completed within one calendar month (100%)	100%	100%	100%	100%	100%	100%	100%
Percentage of parents that have had their perspectives of care and any questions sought following their Baby's death (95%)	100%	100%	100%	100%	100%	100%	100%
Percentage of PMRT reviewed started within two months (95%)	100%	100%	100%	100%	100%	100%	100%
Percentage of eligible perinatal deaths reviewed via PMRT as an MDT and published within six months (60%)	100%	100%	100%	100%	100%	100%	100%

New PMRT Notified cases

Case	Reason PMRT required	Final report due in the month of
x	36+6 IUFD	4th January 2025

PMRT Ongoing cases- BHNFT

Case	Reason PMRT required	Final report due in the month of
x	IUFD 33+2	October 2024
x	Early NND 31+2	October 2024
x	NND at 22+ born at home	November 2024

PMRT Ongoing cases- Assigned to BHNFT

Case	Reason PMRT required	Lead Trust	Final report due in the month of
x	25+4 NND	Bradford	November 2023- no actions for this trust
x	Twins EUT, NND	Bradford	February 2024 –SI completed. No actions for this trust
x	Neonatal death cardiac abnormality	Leeds	April 2024- no actions for this trust
x	Neonatal death cardiac abnormality	Leeds	August 2024
x	Twin 1 cervical teratoma IUFD, Twin 2 IUFD- unknown reasons	Jessops	August 2024- no actions for this trust

Appendix C - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	July 23	Aug 23	Sept 23	Oct 23	Nov 23	New Criteria launched	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	June 24
Uterine rupture	0	0	0	0	0		0	0	0	0	0	0	0
Perineal tear (3rd/4th degree)	0	3	0	3	1		0	0	1	0	0	0	0
Unexpected hysterectomy	0	0	0	0	0		0	0	0	0	0	0	0
ICU Admission	0	0	0	0	0		0	0	0	0	0	0	0
Unexpected return to theatre	0	0	0	0	0		0	0	0	0	0	0	0
Enhanced maternal care >48 hours	0	0	0	0	0		0	0	0	0	0	0	0
Postnatal readmission	1	0	4	2	0		0	0	1	0	1	0	0
Never events	0	0	0	0	0		0	0	0	0	0	0	0
Term admission to neonatal Unit (number)	12	12	5	11	2*								
Avoidable term admissions to neonatal unit							2	3	1	0	0	0	1
Fracture to baby resulting in further care	1	0	1	1	0		0	0	0	0	0	0	0
Perinatal loss	0	0	0	0	0		0	0	0	0	0	0	0
Maternal death	0	0	0	0	0		0	0	0	1	0	0	0
PPH	0	1	0	0	2		2	0	0	0	0	0	0
Other	0	0	1	0	1 (medication)		0	0	1	0	1	0	0

*Automatic grading of moderate harm for ATAIN babies was stopped in November. It is anticipated lower figures for moderate harms will be seen going forward.

Ethnicity for ALL Barnsley Hospital births

Ethnicity	White British	Any other ethnic group	Any other White back ground	Asian - other	Any other mixed back ground	White and Asian	Caribbean	Indian	Pakistani	African	Any other Black back ground	White & Black Caribbean	Irish	Not stated
January	207	3	20	2	1	3	3	3		6	1	1		3
February	209	3	14	1	1	2	1	1	1	4	1	1	1	9
March	196	1	16	2	2			3	3	2			1	12
April	185	3	13	2				1		5	1		3	9
May	189	3	16	1	7	4	2	2		8			4	

- Ethnicity not stated, this may be due to out of area women

Index of Multiple Deprivation (IMD) for ALL Barnsley Hospital births.

Not all postcodes have an IMD allocated, this may be due to there being new housing estates

Month	IMD										
	1 (most deprived)	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (least deprived)**	**unknown**
January	47	42	27	25	22	12	6	14	6	1	6
February	47	46	28	11	18	10	10	9	8	1	6
March	45	43	28	21	15	13	7	18	9	3	41
April	46	43	35	19	22	12	10	15	7	8	5
May	41	36	41	11	25	13	3	14	7	1	46

Index of Deprivation (IMD) patients who have suffered moderate harm and above by Ethnicity & IMD for January, February, March, April and May 2024

- Not all postcodes have an IMD allocated, this may be due to being new housing estates

Ethnicity	IMD										
	1	2	3	4	5	6	7	8	9	10	unknown
White British	1	3		2							
White & Asian	1										
Pakistani		1									

Appendix D - Training compliance

Maternity MAST training compliance (%) June 2024

Department	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Resuscitation Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
163 CBU 3 Management Team	100 →	78.95 ↑	84.21 ↑	94.74 ↓	100 →	87.50 →	100 ↑	100 →	100 →	100 →	100 →	100 ↑	100 →	100 →	95.03 ↑
163 Maternity Establishment	94.74 ↑	92.40 ↑	70.76 ↑	96.49 ↓	100 →	95.73 ↓	92.98 ↑	100 →	33.33 →	95.65 ↓	96.34 ↓	100 ↑	100 →	100 ↑	92.82 ↑
163 Obstetrics & Gynaecology Medical Services	85.00 →	80.00 →	85.00 ↓	82.50 ↓	86.67 ↓	84.00 ↓	95.00 ↓	95.00 →	60.00 ↓	N/A	88.00 ↓	82.76 ↓	90.91↓	57.14 →	84.54 ↓

Neonatal/Paediatric/CAU June 2024

Department	Bus Sec & Emerg Response	Conf Res	Equal & Divers	F, H & S	Inf Cont L1	Inf Cont L2	Info Gov & Data Sec	M&H Back Care Aware	M&H Pract Pt Hand L1	M&H Pract Pt Hand L2	BLS	PILS	SG Adults L1	SG Adults L2	SG Child L1	SG Child L2	Overall
Child Amb Care	100.00%	95.24%	85.71%	95.24%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	75.00%	64.29%	100.00%	100.00%	100.00%	100.00%	93.96%
CAU/ED	80.65%	90.32%	77.42%	77.42%	100.00%	82.14%	87.10%	96.77%	N/A	89.29%	N/A	75.00%	100.00%	80.00%	N/A	100.00%	84.35%
Ward	100.00%	100.00%	84.38%	87.50%	100.00%	93.55%	96.88%	100.00%	100.00%	100.00%	76.92%	83.33%	100.00%	100.00%	100.00%	100.00%	94.25%
NNU	100.00%	100.00%	80.00%	87.50%	N/A	85.00%	85.00%	100.00%	N/A	76.32%	92.11%	50.00%	N/A	82.61%	N/A	75.00%	88.83%
Edu/ANP's	100.00%	100.00%	57.14%	85.71%	N/A	85.71%	85.71%	100.00%	N/A	100.00%	75.00%	100.00%	N/A	100.00%	N/A	N/A	89.55%

Safeguarding Training Compliance

Children's level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)														
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Maternity establishment	161	68.87 ↓	67.72 ↓	73.55 ↑	78.75 ↑	79.27 ↑	80.25 ↑	82.82 ↑	85.00 ↑	86.25 ↑	86.34 ↑	89.02 ↑	92.55 ↑	93.08 ↑	94.87 ↑	94.16 ↓
Neonatal unit	36	89.19 ↓	91.89 ↑	91.89 →	91.89 →	91.67 ↓	91.67 →	86.84 ↓	89.19 ↑	86.84 ↓	88.89 ↑	92.11 ↑	86.84 ↓	91.67 ↑	91.67 →	83.33 ↓
Obstetrics and Gynaecology medical staff	19	28.57 ↓	28.57 →	28.57 →	27.27 ↓	39.13 ↑	47.37 ↑	44.44 ↓	72.22 ↑	73.68 ↑	78.95 ↑	57.14 ↓	66.67 ↑	66.67 →	66.67 →	63.64 ↓
Paediatric medical staff	16	65 →	65 →	65 →	65 →	73.68 ↑	87.50 ↑	82.35 ↓	82.35 ↑	82.35 →	82.35 →	77.78 ↓	77.78 →	77.78 →	83.33 ↑	88.24 ↑
Adult level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)														
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June

Maternity establishment	161	67.53 ↑	65.05 ↓	71.00 ↑	76.00 ↑	69.75 ↓	72.50 ↑	74.85 ↑	80.00 ↑	82.50 ↑	82.61 ↑	87.20 ↑	91.30 ↑	91.82 ↑	94.87 ↑	94.81 ↓
Neonatal Unit	16	62.50 ↑	68.75 ↑	64.71 ↓	76.47 ↑	81.25 ↑	93.75 ↑	93.33 ↑	100 ↑	100 →	100 →	100 →	100 →	100 →	100 →	100 →

PROMPT Rolling annual compliance

Staff Group	PROMPT Rolling annual compliance (%)												
	June 23 (%)	July 23 (%)	Aug 23 (%)	Sept 23 (%)	Oct 23 (%)	Nov 23 (%)	Dec 23 (%)	Jan 24 (%)	Feb 24 (%)	March 24 (%)	April 24 (%)	May 24 (%)	June 24 (%)
Hospital Midwives	64.70↓	61.38↓	71.42↑	60.5↓	77.5↑	99↑	96.96↓	95.09↓	96.2↑	96.15↓	100 ↑	98.01↓	98.98 ↑
Community Midwives	62.85↓	62.85→	61.76↓	56.25↓	80.64↑	100↑	100↑	94.28↓	94.4↑	97.5↑	100 ↑	100→	100→
Support workers	60.60↓	58.06↓	60↑	63.33↑	73.33↑	96.66↑	94.11↓	92.10↓	94.59↑	94.59→	100 ↑	97.22↓	100 ↑
Obstetric consultants	75.00↓	55↓	55→	55→	62.5↑	87.5↑	88.88↑	100↑	100→	100 →	100 →	90↓	90 →
All other obstetric doctors	47.36→	47.36→	* 52.63↑	*19.04↓	47.62↑	95.23↑	95.23→	68.18 ↓	69.56↑	82.60↑	88 ↑	82.60↓	82.60→
Obstetric anaesthetic consultants	66.66↓	52.38↓	* 68.18↑	*66.66↑	85↑	100↑	100→	94.73↓	100↑	95↓	95.23 ↑	95.23 →	95.23→
All other obstetric anaesthetic doctors	66.66↓	44↓	*44→	*21.05↓	47.05↑	82.35↑	82.35→	93.33↑	61.9↓	66.66↑	77.27 ↑	86.36↑	86.36 →

*Dr's rotations in August and September will affect compliance figures.

Community skills and drills compliance and forecast from January 2023

Staff Group	Community skills & drills in year compliance commencing March 2023 and the forecast (%) (reset to 0 in January 2023) Relaunched in July 2023																	
	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 24
Community midwives	0	0→	12.82↑	No training in place			27.59 ↑	27.59 →	45.45↑	61.29 ↑	90.63↑	90.63 →	76.47↓	83.78↑	82.50↑	85.29↑	88.24↑	88.24 →
Support workers	0	0→	0→				16.67 ↑	16.67 →	33.33↑	50 ↑	100 ↑	100 →	100 →	100 →	100 →	83.33↓	83.33 →	83.33 →

Fetal Monitoring Training

Staff Group	Training compliance for fetal monitoring full day face to face training (%) Rolling compliance April 23 to March 24																
	Feb	March	April	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 24	Feb 24	March 24	April 24	May 24	June 24
Midwives	34.32↓	41.9↑	51.09↑	51.09→	Drs strike	Drs strike	55.9↑	Drs strike	75.53↑	95↑	97.8↑	98.4↑	100↑	100→	100→	100→	100→
Obstetric consultants	44→	50↑	55.5↑	55.5→			55.5→		89↑	88↓	100↑	100→	100→	100→	100→	100→	100→
All other obstetric doctors	40→	40→	40→	33.3↓			33.3→		25↓	100↑	92.3↓	92.3→	100↑	100→	100→	100→	100→
Overall percentage	35.29↓	42.2↑	50.95↑	52.09↑			55.4↑		72.5↑	90.3↑	97.5↑	98↑	100↑	100→	100→	100→	100→

Appendix E - Maternity Dashboard

Local Maternity Dashboard 2023/2024	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	Cumulative total
Clinical Activity													
Booked to Birth at BHNFT	243↑	229↓	276↑	223↓	233↑	250↑	207↓	252↑	244↓	219↓	251 ↑	222↓	2849
Number of BHNFT Bookings	216↓	191↓	227↑	201↓	198↓	232↑	184↓	228↑	230↑	207↓	220 ↑	207↓	2541
Booked elsewhere to Birth at BHNFT	38↑	38	57↑	30↓	45↑	30↓	34	36↑	28↓	16↓	37 ↑	22↓	411
Booked by BHNFT to Birth elsewhere	10	6↓	7↑	6↓	9↑	11↑	5↓	9↑	10↑	4↓	4	3↓	84
Booked onto Continuity of Carer pathway	67 ↓	63↓	92↑	76↓	89↑	104↑	69↓	85↑	91↑	77↓	78 ↑	77↓	968
% of Continuity of Care	27.6↓	27.5↓	33.1 ↑	32.9↓	36.6%↑	41.6↑	31.7↓	32.2%↑	37.3%↑	35.4%↓	30.4%↓	34.0% ↑	N/A
% of BAME booked onto Continuity of carer pathway	0↓	28.6↑	37.5↑	36.4↓	46.2%↑	26.6↓	46.2↑	30.0%↓	37.4%↑	35.0%↓	53.9% ↑	25.3%↓	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	16.0↓	22.7↑	42.2↑	32.0↓	42.9%↑	24.5↓	27.3↑	16.4%↓	19.1%↑	29.2%↑	34.7% ↑	38.3% ↑	N/A
Of those booked for CoC, Intrapartum CoC received %	86↑	62.19↓	51.1↓	49.45↓	62.7%	62.1↓	60.2↓	69.9%↓	65.27%↓	64.47%↓	60.75%↓	61.64%↑	N/A
Total Women birthed	250↑	238↓	260↑	252↓	227↓	226↓	252↑	253↑	249↓	237↓	222↓	236 ↑	2942
Sets of Twins	4↑	3↓	2↓	4↑	2↓	1↓	2↑	2	3↑	6↑	3↓	2↓	34
Total Births	254↑	241↓	262 ↑	256↓	229↓	227↓	254↑	256↑	252↓	243↓	225↓	238 ↑	2937
Live Births	251	241↓	261 ↑	255↓	229↓	226↓	253↑	256↑	251↓	243↓	224↓	238 ↑	2874
Live births at term	233↓	223↓	237 ↑	236↓	207	217↑	236↑	242↑	235↓	223↓	208↓	225 ↑	2722
Planned home births - Number	1↓	1 ↑	1	2↓	1↓	1	0↓	1↑	1→	0↓	1↑	1↑	12
Number of times a second emergency theatre required.	1	0↓	0	1↑	0	1	0↓	2↑	1↓	0↓	0	0	6
In-utero Transfers Out	2↓	2	7 ↑	3↓	4↑	4	2↓	4↑	5↑	6↑	5↓	5↓	49
Maternity Unit Closed for Admission	2↓	1↓	0 ↓	0	0	0	2↑	0	2↑	1↓	0	0	8

Local Maternity Dashboard 2023 / 2024		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Cumulative total
Clinical outcomes														
Unassisted Vaginal Birth Rate		53.6%	49.2%	52.7%	52.4%	48.0%	43.8%	38.5%	41.7%	51.4%	41.5%	44.6%	47.0%	N/A
Induction of labour Rate-Ratified		30.8%	30.3%	30.0%	26.6%	29.3%	31.4%	30.2%	27.6%	33.3%	30.1%	35.0%	30.0%	N/A
Ventouse Rate		3.60%	4.6%	6.90%	3.2%	2.60%	3.5%	4.8%	4.3%	5.2%	4.2%	3.15%	6.52%	N/A
Forceps Rate		4.40%	8.8%	6.50%	5.2%	6.10%	10.6%	8.3%	8.7%	6.8%	7.2%	7.65%	13.76%	N/A
Total assisted vaginal births		8%	13.44 %	13.46%	8.40%	9.25%	14.1%	13.1%	13%	11.6%	11.4%	10.81%	11.86%	N/A
Emergency LSCS Rate		22.40 %	27.30 %	20.77%	25.79 %	27.75 %	28.31%	32.14%	30.31%	25.30%	34.59%	29.27%	23.72%	N/A
Elective LSCS Rate		16.00 %	10.08 %	13.07%	13.49 %	15.85 %	14.15%	16.29%	14.96%	11.24%	12.23%	15.31%	17.79%	N/A
Caesarean section														
Group 1	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation in spontaneous labour	4.44 ↓	11.11 ↑	11.11	14.44 ↑	12.22 % ↓	11.11% ↓	17.78% ↑	7.78% ↓	7.78% →	12.22% ↑	9.09% ↓	6.12% ↓	N/A
Group 2a	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation who either had (a) labour induced or were (b) delivered by LSCS before Labour	18.89	24.44 ↑	18.89 ↓	14.44 ↓	22.22 % ↑	16.67% ↓	31.11% ↑	26.67% ↓	17.78% ↓	27.78%↑	20.20%↓	12.24%↓	N/A
Group 2b		20.00 ↑	15.56 ↓	5.56↓	14.44 ↑	13.33 % ↓	13.33%	26.67% ↑	25.56% ↓	16.67% ↓	20.00% ↑	11.11% ↓	16.33% ↑	N/A
Group 5	All multiparous women with at least one previous uterine scar, with single cephalic pregnancy >37 weeks' gestation	23.33 ↓	18.89 ↓	30.0 ↑	25.56 ↓	24.44 % ↓	33.33% ↑	27.78% ↓	37.78% ↑	28.89% ↓	22.22% ↓	27.27% ↑	28.57% ↑	N/A
3rd / 4th Degree tears total		2.59%	0.67%	4.06%	0	2.34%	3.05%	2.30%	2.15%	3.16%	1.60%	0.81%	2.90%	N/A

Local Maternity Dashboard 2023 / 2024		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Cumulative total
3rd / 4th Degree tears - Normal Birth Total	Crude average 2.8%	2.98%	0.85%	3.64%	0	1.6%	1.01%	1.03%	1.86%	2.32%	1.02%	1.01%	3.66%	N/A
		4	1	5	0	2	1	1	2	3	1	1	4	25
3rd / 4th Degree tears - Assisted Birth Total	Crude average 6.05%	0.00%	0.00%	5.71%	0	4.76%	9.37%	6.06%	3.03%	6.89%	3.70%	0%	0%	N/A
	Number	0	0	2	0	1	3	2	1	2	1	0	0	12
PPH ≥1500mls	Percentage (%)	4.80%	1.26%	2.69%	3.17%	0.88%	3.09%	3.57%	2.75%	2.40%	2.53%	2.70%	2.11%	N/A
	Number	12	3	7	8	1	7	7	7	6	6	6	5	N/A
Neonatal Indicators														
Admission to neonatal unit ≥ 37 weeks		5↑	12↑	12→	7↓	10↑	6↓	13↑	13	7↓	16↑	1↓	7↑	109
		2.14%	5.38%	5.06%	2.96%	4.83%	2.74%	5.50%	5.37%	2.97%	7.17%	0.48%	3.11%	
Admission to the NNU ≤ 26+6 weeks		0	0	2	0	0	0	0	0	0	0	0	0	2
Preterm birth rate <37 weeks	National target for less than 6% by 2025	7.9%↑	7.5%↓	9.5%↑	8.1%↓	8.37%↑	3.1%↓	5.9%↑	4.3%↓	6.3%↑	6.8%↑	3.6%	3.4%	N/A
Preterm birth rate <34 weeks		3.9%↑	1.7%↓	2.3%↑	3.9%↑	1.32%↓	0.9%↓	1.2%↑	0.4%↓	0.4%→	1.7%↑	0.9%	0.8%	N/A
Preterm birth rate <28 weeks		0.4%	0.0%↓	0.8%↑	0.4%↓	0.00%↓	0.4%↑	0%↓	0.0%→	0.0%→	0.0%→	0%	0.4%	N/A
Low birthweight rate at term (2.2kg).		0.9%	0.4%	0.8%	0.0%	0.50%	0.5%	0.8%↑	0.4%↓	0.4%→	0.4%→	0%	0.9%	N/A
Right place of Birth	95%	100% →	100% →	99.23% ↓	99% ↓	100% →	100% →	100%	100%	100%	100%	100%	99.57%	N/A
Mortality														
Neonatal deaths		0	1	0	0	1	0	0	0	1	1	1	1	6
Neonatal deaths excluding lethal abnormalities.		0	0	0	0	0	0	0	0	0	0	1	1	2
Stillbirths		3	0	1	1	0	1	1	0	1	0	1	0	9
Stillbirths - Antenatal		3	0	1	1	0	0	1	0	1	0	1	0	8

Local Maternity Dashboard 2023 / 2024	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Cumulative total
Stillbirths - Intrapartum	0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths - excluding those with lethal abnormalities	0	0	0	0	0	0	0	0	1	0	1	0	2
Stillbirths at Term	0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths at Term with a low birth weight	1	0	0	0	0	0	0	0	0	0	0	0	1
MNSI reportable births	0	0	0	0	0	0	0	0	2	1	0	0	3
KPIs													
Women Initiating Breast Feeding at Birth **≥75%**	63.2% ↓	65.9% ↑	56.5% ↓	60.7% ↑	68.7% ↑	64.6% ↓	64.3% ↓	64.2% ↓	65% ↑	58.2% ↓	65.0%	64.0%	N/A
Breastfeeding rate at discharge	58.8% ↓	58.82 %	55.0% ↓	60.70 % ↑	63.9% ↑	57.1% ↓	58.7% ↑	58.7%	59% ↑	54% ↓	55.85%	56%	N/A
Bookings <10 weeks **>90%**	80.6% ↑	73.8% ↓	77.53% ↑	74.1% ↓	80.3% ↑	79.7% ↓	83.2% ↑	75% ↓	69.5% ↓	80.0% ↑	75.0%	76.0%	N/A
Smoking rates at Booking **≤6%**	8.3% ↓	14.7% ↑	13.7% ↓	12.4% ↓	14.7% ↑	11.0% ↓	10.9% ↓	8.77% ↓	10.4% ↑	7.7% ↓	12.27%	16.4%	N/A
Smoking at 36 weeks' gestation **≤6%**	10.71 % ↓	9.75% ↓	14.14% ↑	8.55% ↓	15.25 % ↑	12.43% ↓	9.59%	11.16% ↑	11.94%↑	8.73%↓	6.45%↓	3.92%↓	N/A
Women who receive CO testing at booking	85.2% ↓	94.2% ↑	100% ↑	97% ↓	100% ↑	99.1% ↓	98.9% ↓	98.3% ↓	100%	100%	100%	98.6%	N/A
Smoking Rates at Birth (SATOD) **4-6%** **6-8 %** **>8%**	8.4%↓	8.0%	13.5%	8.0%	7.9%	10.2%	7.9%	9.5%	10.4%	12.7%	8.10%	7.2%	N/A
Carbon Monoxide monitoring at time of booking ≥ 4ppm	13.0% ↑	15.6% ↑	15.0% ↓	9.7% ↓	11.62 % ↑	11.5% ↓	12.6% ↑	12.3% ↓	8.97% ↓	3.76% ↓	10.91%	13.2%	N/A
Carbon Monoxide monitoring at 36 weeks ≥ 4 ppm	10.06 % ↑	5.61% ↓	10.64% ↑	10.34 %↓	10.12 % ↓	12.31% ↑	12.77% ↑	6.32% ↓	17.91% ↑	9.42% ↓	6.90% ↓	3.47% ↓	N/A

Local Maternity Dashboard 2023 / 2024	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Cumulative total
Workforce													
1:1 care in labour	99% ↓	99%	99.60% ↑	99.6%	100%	99%	100%	99%	100%	99%	99.5%	100%	N/A

Appendix F- KPI SPC Charts

Maternity KPI SPC Charts

KPI Description: Bookings before 10 weeks

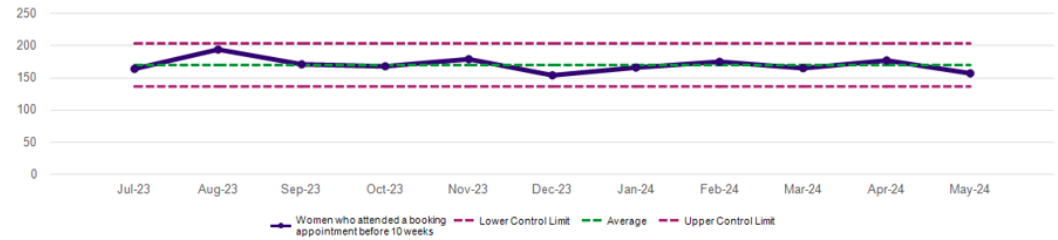
Numerator Description: Women who attended a booking appointment before 10 weeks

Denominator Description: Total bookings

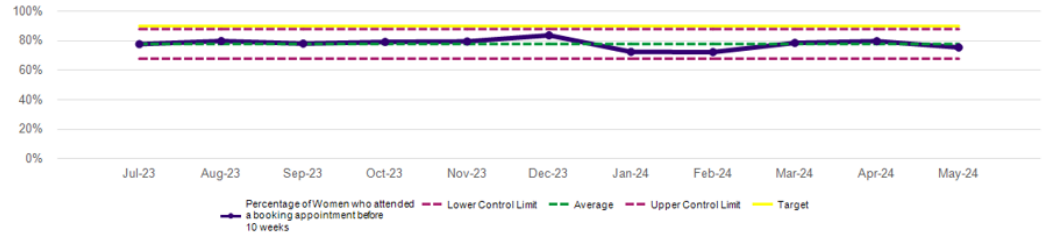
Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Women who attended a booking appointment before 10 weeks	164	194	171	168	179	154	166	175	165	177	157
Total bookings	211	243	219	212	225	184	229	242	210	222	208
Percentage	78%	80%	78%	79%	80%	84%	72%	72%	79%	80%	75%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

SPC Chart: Actual numbers of Women who attended a booking appointment before 10 weeks



SPC Chart: Percentage of Women who attended a booking appointment before 10 weeks



Maternity KPI SPC Charts

KPI Description: Births

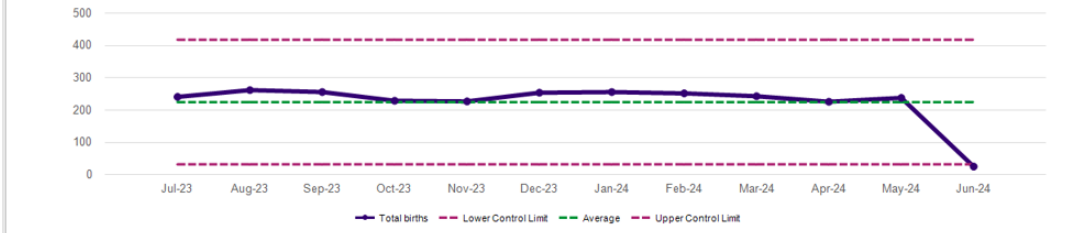
Numerator Description: Total births

Denominator Description:

Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Total births	241	262	256	229	227	254	256	252	243	226	238	25
Percentage												
Target												

SPC Chart: Actual numbers of Total births



Please note no births for June as move to new system.

Maternity KPI SPC Charts

KPI Description: Women initiating breast feeding at birth

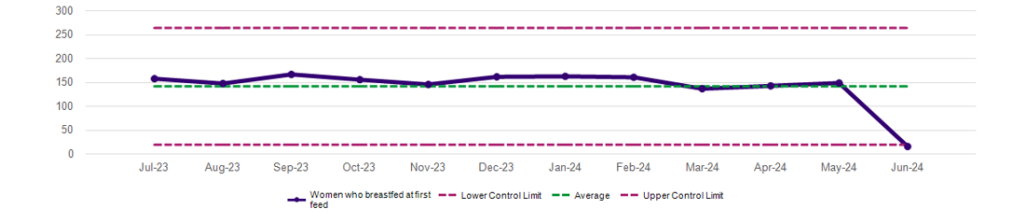
Numerator Description: Women who breastfed at first feed

Denominator Description: Total deliveries

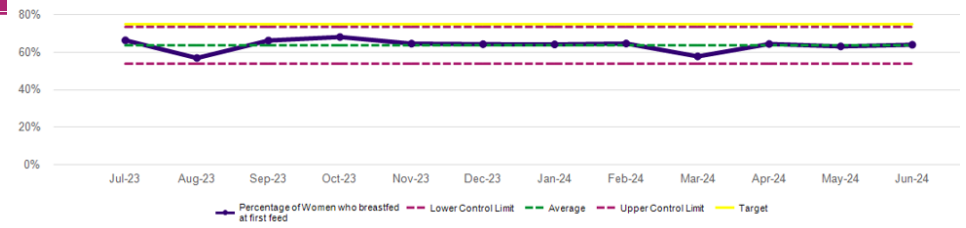
Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Women who breastfed at first feed	158	148	167	156	146	162	163	161	137	143	149	16
Total deliveries	238	260	252	229	226	252	254	249	237	222	236	25
Percentage	66%	57%	66%	68%	65%	64%	64%	65%	58%	64%	63%	64%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

SPC Chart: Actual numbers of Women who breastfed at first feed



SPC Chart: Percentage of Women who breastfed at first feed



Maternity KPI SPC Charts

KPI Description: 3rd & 4th degree tears of all deliveries

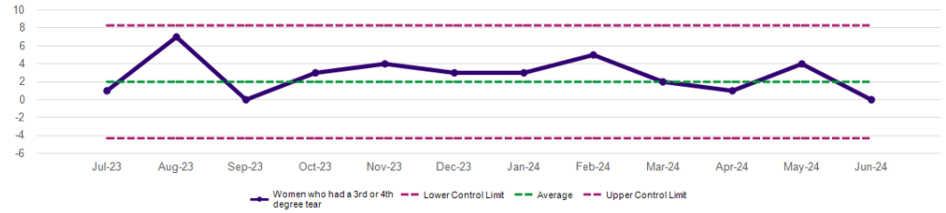
Numerator Description: Women who had a 3rd or 4th degree tear

Denominator Description: Total deliveries

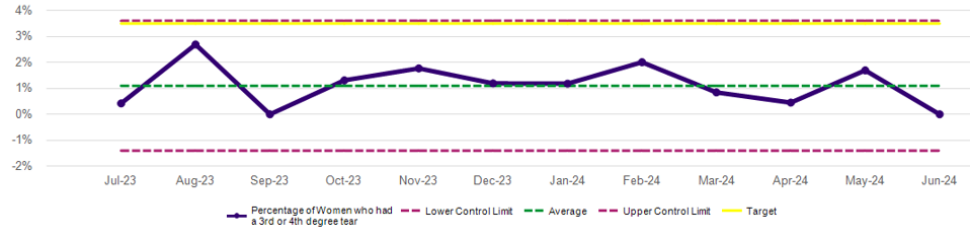
Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Women who had a 3rd or 4th degree tear	1	7	0	3	4	3	3	5	2	1	4	0
Total deliveries	238	260	252	229	226	252	264	249	237	222	236	25
Percentage	0%	3%	0%	1%	2%	1%	1%	2%	1%	0%	2%	0%
Target	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%

SPC Chart: Actual numbers of Women who had a 3rd or 4th degree tear



SPC Chart: Percentage of Women who had a 3rd or 4th degree tear



Maternity KPI SPC Charts

KPI Description: Smoking rates at booking

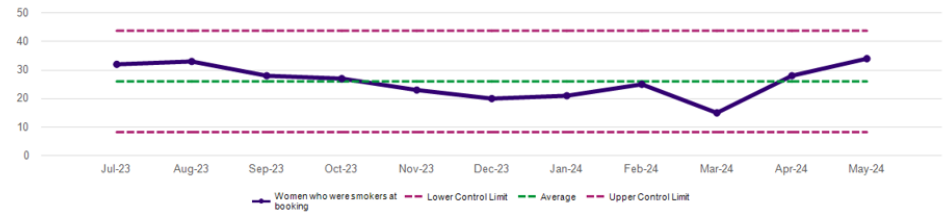
Numerator Description: Women who were smokers at booking

Denominator Description: Total bookings

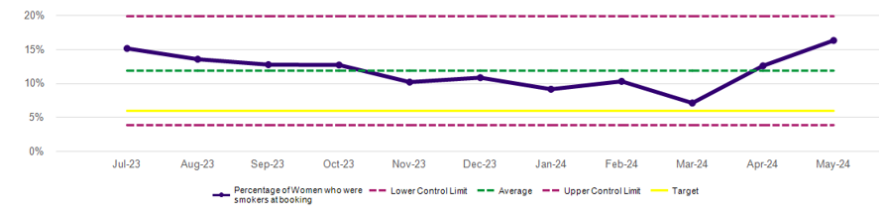
Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Women who were smokers at booking	32	33	28	27	23	20	21	25	15	28	34
Total bookings	211	243	219	212	225	184	229	242	210	222	208
Percentage	15%	14%	13%	13%	10%	11%	9%	10%	7%	13%	16%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chart: Actual numbers of Women who were smokers at booking



SPC Chart: Percentage of Women who were smokers at booking



Maternity KPI SPC Charts

KPI Description: Smoking rates at birth (SATOD)

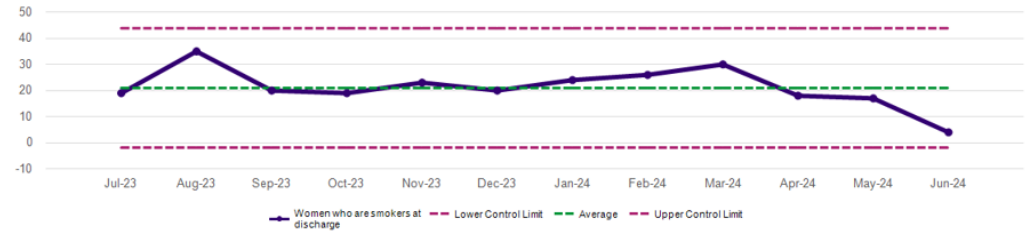
Numerator Description: Women who are smokers at discharge

Denominator Description: Total deliveries

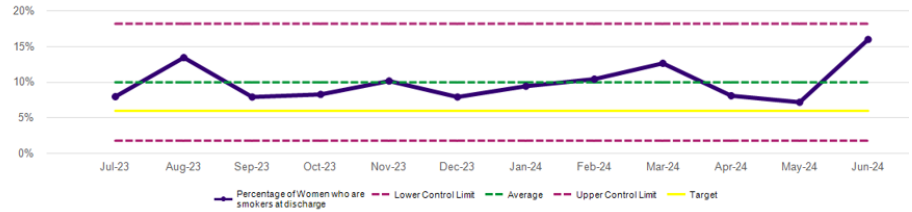
Summary Table

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Women who are smokers at discharge	19	35	20	19	23	20	24	26	30	18	17	4
Total deliveries	238	260	252	229	226	252	254	249	237	222	236	25
Percentage	8%	13%	8%	8%	10%	8%	9%	10%	13%	8%	7%	16%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chart: Actual numbers of Women who are smokers at discharge



SPC Chart: Percentage of Women who are smokers at discharge



Break

5. Governance

5.1. Board Assurance Framework/Corporate Risk Register

To Review/Approve

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/08/01/5.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**				
DATE:	01 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/ approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs				
SPONSORED BY:	Angela Wendzicha, Director of Corporate Affairs				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

The Board of Directors is required to ensure there is in place a sound system of internal control and risk management, including the oversight and approval of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

The report aligns with all Strategic Goals:

- Best for People: We will make our Trust the best place to work.
- Best for Patients and the Public: We will provide the best possible care for our patients and service users.
- Best for Performance: We will meet our performance targets and continuously strive to deliver sustainable services.
- Best for Partners: We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
- Best for Place: We will fulfil our ambition to be the heart of the Barnsley Place partnership to improve inpatient services, support a reduction in health inequalities and improve population health.
- Best for Planet: We will build on our sustainability work to date and reduce our impact on the environment.

EXECUTIVE SUMMARY

The following report provides an update following the reviews of the BAF and CRR during July 2024.

The risks were reviewed in a series of meetings with the Executive Directors/Risk Leads to ensure that they accurately reflect the current position. In addition, the BAF and CRR were discussed at the Executive Team Meeting (ETM), People Committee, Quality and Governance Committee and Finance and Performance Committee at the meetings held in July 2024.

All changes made to both documents since the last presentation are shown in red text for ease of reference.

Board Assurance Framework: There are currently 13 risks aligned to the BAF. All the risks were reviewed in July 2024 followed by discussion at the Executive Team Meeting and the relevant Board Committees.

Following review, there is one recommended amendment to the BAF as follows:

BAF Risk 1713 relating to the risk to our ability to deliver the in-year financial plan. Given the current financial position it is recommended that this risk be increased from 4 to 16.

Corporate Risk Register (CRR): There are currently nine risks on the CRR. The Board will note that two new risks have been added to the CRR as follows:

Risk 3051 relating to the software error relating to the Medical eRoster system graded at 16 and Risk1713 relating to the inability to deliver the in-year financial plan which is also linked to the BAF graded at 16.

RECOMMENDATION

The Board of Directors is asked to:

- Note the reviews of the risks that were completed since the last Board meeting in June 2024;
- Note the two new risks added to the CRR relating to the Medical e-Roster and ability to deliver the in-year financial plan and approve the scores;
- Approve the recommendation to increase the BAF risk relating to ability to deliver the in-year financial plan from 4 to 16; and
- Approve the updated Board Assurance Framework and Corporate Risk Register.

1. Introduction

The following report illustrates the position in relation to the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) for July 2024 both of which have been reviewed in conjunction with the relevant Executive Director/Risk Lead. In addition, the BAF and CRR have been reviewed at the Executive Team Meeting, People Committee, Quality and Governance Committee and the Finance and Performance Committee held during July 2024.

2. Board Assurance Framework (BAF)

2.1 Details of the current BAF risks can be found in Appendix 1, with updates provided in red text for ease of reference. There are a total of 13 BAF risks and the Board will note that there are four BAF risks scored as extreme (one at 15 and three at 16) and two scored as high (12). The Board will note that the remaining BAF risks are scored at 4, 6, 8 and 9.

2.2 The scores for all BAF risks have been reviewed with the relevant Executive Director/Risk Lead, and following discussion at the Executive Team Meeting and relevant Assurance Committees, all scores have been deemed to reflect the current level of strategic risk.

2.3 The Board will note the recommendation from the Executive Team and latterly the Finance and Performance Committee to increase the BAF risk relating to the Trust's ability to deliver the in-year financial plan (BAF Risk 1713) be increased from 4 to 16 (C4xL4). The increase in score is based on the consequence of 4 (major – uncertain delivery of key objectives, loss of 0.5-1.0 per cent of budget based on the risk matrix definitions) and a likelihood of 4 (will probably happen).

2.4 The table below illustrates the high-level summary of the BAF Risks scoring 12 and above.

Risk	Previous Score (June 2024)	Current Score (July 2024)	-/+	Update
2592 regarding the inability to deliver constitutional and other regulatory	15	15	→	No change since June 2024
2845 regarding the inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	→	No change since June 2024
2557 regarding the risk of lack of space and adequate facilities on-site	16	16	→	No change since June 2024
1713 regarding the inability to deliver the in-year financial plan	4	16	↑	Increased score from 4 to 16
2122 regarding the risk of computer systems failing due to a cyber-security incident	12	12	→	No change since June 2024
2605 regarding the risk of the Trust's inability to anticipate the evolving needs of the local population to reduce health inequalities	12	12	→	No change since June 2024

3. Corporate Risk Register (CRR)

3.1 The Trust currently has a total of nine risks on the CRR, details of which can be found in Appendix 2. All risks have been reviewed by the Executive Lead/Risk Owners and by the Executive Team, in addition to the relevant Board Committees.

3.2 The Board will note that since the last review, two new risks have been added to the CRR as follows:

- Risk 3051 relating to the financial and potential people risk as a result of a software error found in the Medical eRoster system. Following initial review, the recommendation from the Executive Team and subsequently the Finance and Performance Committee is for the risk to be graded at 16 (C4xL4).
- Risk 1713 relating to the Trust's ability to deliver the in-year financial plan which is recommended to increase from 4 to 16. This risk is linked to BAF.

The table below illustrates the high-level summary of the CRR.

Corporate Risk (Risk scoring 15+)	Previ-ous Score (June 2024)	Current Score (July 2024)	-/+	Update
2592 regarding the inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	→	No change since June 2024
3014 regarding the lack of clinical leadership and inability to meet service demands within OMFS services	15	15	→	No change since June 2024
2803 risk regarding the delivery of effective haematology services due to a reduction in haematology consultants	16	16	→	No change since June 2024
1199 risk regarding the inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	16	16	→	No change since June 2024
2845 risk regarding the inability to improve the financial stability of the Trust over the next two to five years	16	16	→	No change since June 2024
2976 risk regarding major operational/service disruption due to digital system infrastructure and air conditioning failures	16	16	→	No change since June 2024

2768- Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	16	16	→	No change since June 2024
3051 – Financial and people risk as a result of an error within the Medical e-Roster software		16		NEW RISK
1713 – Risk to the Trust's ability to deliver the in-year financial plan	4	16		Increase from 4 to 16

4. Recommendations

The Board of Directors is invited to:

- Note the reviews of the risks that were completed since the last Board meeting in June 2024;
- Note the two new risks added to the CRR relating to the Medical e-Roster and ability to deliver the in-year financial plan and approve the scores;
- Approve the recommendation to increase the BAF risk relating to ability to deliver the in-year financial plan from 4 to 16; and
- Approve the updated Board Assurance Framework and Corporate Risk Register.

Appendix 1

2605

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
July 2024

Appendix 1

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	We will make our Trust the best place to work	9	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2596	Risk of inadequate support for culture, leadership and organisational development	We will make our Trust the best place to work	8	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2598	Risk of inadequate health and wellbeing support for staff	We will make our Trust the best place to work	4	Workforce / Staff Engagement	Director of Workforce	Current
Best for Patients and The Public	2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time	We will provide the best possible care for our patients and service users	15	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	We will meet our performance targets and continuously strive to deliver sustainable services	16	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2595	Risk regarding the potential disruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	8	Clinical Safety	Director of ICT	Current
Best for Performance	2122	Risk of computer systems failing due to a cyber security incident	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety	Director of ICT	Current
Best for Performance	1713	Risk regarding inability to deliver the in-year financial plan	We will meet our performance targets and continuously strive to deliver sustainable services	16 – proposed increase from 4	Finance / Value for Money	Director of Finance	Current
Best for Performance	2845	Inability to improve the financial stability of the Trust over the next 2 to 5 years	We will meet our performance targets and continuously strive to deliver sustainable services	16	Finance / Value for Money	Director of Finance	Current
Best for Partner	2527	Risk of failure to develop effective partnerships	We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	8	Partnerships	Managing Director of BHNFT	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	12	Clinical Safety / Patient Experience / Partnerships	Managing Director of BHNFT	Current
Best for Planet	2827	Risk of the Trust impact on the environment	We will build on our sustainability work to date and reduce our impact on the environment.	8	Environmental	Managing Director of BHNFT	Current
Best for Place	1693	Risk of inability to maintain a positive reputation for the Trust	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	6	Reputation	Director of Communications and Marketing	Current

Highlighted above are risks scoring 12+
Highlighted above are risks scoring 15+
Proposed for Closure
NEW Proposed

BAF Risk Profile

Risk profile					
Consequence → Likelihood ↓	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain			**2592** - performance & targets		
4 Likely				2845 – long-term financial stability **2557** - lack of space 1713 – in year financial plan	
3 Possible			**1201** - recruitment and retention	**2122** - cyber security **2605** - health inequalities **2827 –** Environmental risk	
2 Unlikely		~~**1713** - in year financial plan~~ **2598** – staff health and wellbeing	**1693** - Trust Reputation	**2596** - staff development **2595** - digital transformation **2527** - effective partnerships **2827 –** Environmental risk	
1 Rare					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 2024/25

	Relative Willingness to Accept Risk					
Category	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
	1	2	3	3	4	5
Commercial						
Clinical safety						
Patient experience						
Clinical effectiveness						
Workforce/staff engagement						
Reputation						
Finance/value for money						
Regulatory/compliance						
Partnerships						
Innovation						
Environmental						

Assessment	Description of Potential Effect
LOWEST THRESHOLD	
Zero Risk Appetite Score – 1 **AVOID**	The Trust Board seeks to **avoid risks under any circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Low Risk Appetite Score – 2 **MINIMAL**	The Trust Board seeks to **avoid risks (expect in very exceptional circumstances)** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Moderate Risk Appetite Score – 3 **CAUTIOUS / OPEN**	The Trust Board is willing to **accept some risks in certain circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
High Risk Appetite Score – 4 **SEEK**	The Trust Board is willing to **accept risks** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
UPPER THRESHOLD	
Very High-Risk Appetite Score – 5 **MATURE**	The Trust Board **accepts risks** that are likely to result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

Appendix 1

Risk Appetite and Tolerance Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

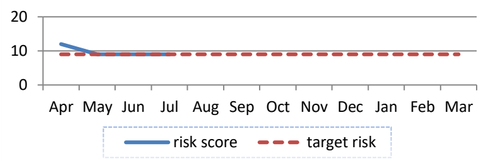
Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	MINIMAL
Partnerships	SEEK
Innovation	SEEK
Environment	OPEN

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	1201	People Committee	Director of People	3x4 (12)	3x3 (9)	3x3 (9)	1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, organisational and talent management due to a lack of financial and human resources this will result in an inability to recruit, retain and motivate staff		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. **Risk Update/Progress Notes** July 2024: Following a review of the risk, no change has been made to the residual risk score of 9. In June 2024, the retention rate was reported at 89.25% with a vacancy rate of 3.6%.

Risk Appetite	**Risk Tolerance**
Open (Workforce / Staff Engagement)	Treat

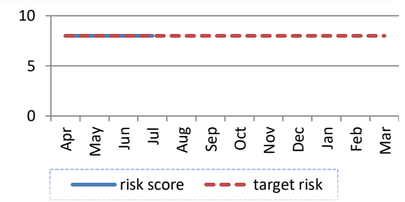
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in control**
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	July 2024	September 2024	E Lavery	None identified
2. Workforce Planning Steering Group with representation from operational areas of the Trust (ADOs, apprenticeships, nursing, medical, etc.) has the CBU workforce planning packs to provide data for decision-making. The group monitors workforce KPIs including recruitment, supply, capacity and demand, etc.	July 2024	September 2024	E Lavery	None identified
3. Staff Redeployment, Staff Recruitment & Retention, Flexible Retirement, Staff Internal Transfer Scheme, Health & Wellbeing, Flexible Working, Rostering, Family Friendly Policies and Procedures	July 2024	September 2024	E Lavery	. None identified
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	July 2024	September 2024	E Lavery	Lack of a recruitment and retention strategy and action plan for hard to fill medics posts
5. Staff nurse recruitment action plan, including recruitment to Trainee Nurse Associate posts and careers pipeline for Nursing Associates to undertake Registered Nurse training through apprenticeship programmes. This action plan is overseen by the Nursing Workforce Group, which oversees nursing workforce numbers, student nurses, nursing vacancy gaps, international recruitment, and standardised newly qualified staff nurse recruitment process across the ICS.	July 2024	September 2024	E Lavery	Continuance of international recruitment reliant on successful pipeline.
6. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5 Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development.	July 2024	September 2024	E Lavery	None identified
7. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention at the Trust.	July 2024	September 2024	E Lavery	None identified
8. The new Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved	July 2024	September 2024	E Lavery	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Received By**		**Assurance Rating**	**Gaps in Assurance**
Control 1: National Operational Workforce Plan submission to ICB (annually)	April 2024	Workforce Planning Steering Group	Full	None identified
Control 2: Annual CBU Workforce Plans	January 2023 – Emma Lavery to provide the date	CBU Performance Review Meetings	Full	None identified
Control 3: Quarterly Recruitment and Retention metrics Report	July 2024	People & Engagement Group	Full	None identified
Control 4 and 5: Nurse Staffing Report	September 2024	People Committee	Full	None identified
Control 6: Workforce Insights Report	July 2024	People Committee	Full	None identified
Control 7: Staff Survey Results 2023	March/April 2024	People Committee Board of Directors	Full	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
Control 8: Culture and OD Strategy	November – December 2023	People Committee Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible e.g. The Trust is part of the ICS approach to international recruitment	N/A	Ongoing	S Ned	2039
Control 4: An Associate Medical Director has been appointed for a 12 months fixed term, and will be responsible for the development of the strategy.		Completed	S Enright	
Control 5: Talent Management and Succession planning framework - see BAF Risk 2596 relating to workforce development. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	March 2027	In progress	T Spackman	March 2027
Control 8: Proud to Care Cultural Leadership delivery group has been formed to oversee the delivery of the strategy	April 2024	Complete	T Spackman	June 2024

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**		Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2596	People Committee	Director of People	4x3 (12)	4x2 (8)	4x2 (8)	1201 - staff recruitment and retention 2598 - staff wellbeing

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate support for culture, leadership and organisational development. There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to succession planning, staff development and leadership development		Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff. **Risk Update/Progress Notes** July 2024: Following a review of the risk, no change has been made to the residual risk score of 8. Mandatory training; MAST training is reported at 90.2% against a target of 90%. The appraisal rate is reported at 75.3% against a target of 90%, noting the new appraisal cycle runs from April – June 2024.

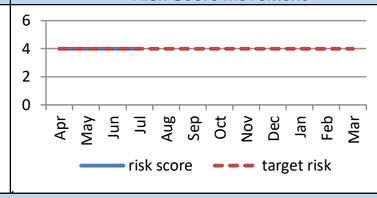
Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Appropriate staff development programmes in place e.g. Apprenticeship Schemes, Advanced Clinical Practitioner Training Programmes, Trainee Nurse Associate Training Programme. This willsupport development and upskilling.	July 2024	September 2024	E Lavery	None identified
2. Nursing Workforce Development Programme. Current key actions on the plan include increased clinical placements and increased numbers of nurses and non-registered clinical support staff accessing apprenticeships and training through Universities and the Open University.	July 2024	September 2024	E Lavery	Local opportunities for non-registered staff continue to be developed through open university/university of Sheffield – degree apprenticeships
3. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing leadership and development. The aim is to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effectivedelivery.	July 2024	September 2024	E Lavery	None identified.
4. Training needs analysis model – annual programme focused on mandatory and statutory essential training, which supports staff development and capability.	July 2024	September 2024	E Lavery	None identified
5. Appraisal and PDPs schedule – there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has been updated and rolled out.	July 2024	September 2024	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	July 2024	September 2024	S Ned	None identified
7. Commissioning and commencement of externally facilitated Board development programme.	July 2024	September 2024	S Ned	None identified
8. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	July 2024	September 2024	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
9. Successfully recruited and appointed a People Promise Manager in April 2024, on a 12 month secondment as part of the People Promise Exemplar National Programme.	July 2024	September 2024	E Lavery	None identified
10.Annual Calendar – diversity events and staff network activity	July 2024	September 2024	E Lavery	None identified
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1 and 2: Annual apprenticeship report – Emma Lavery to confirm the date	March 2023	People Committee	Full	None identified
Control 2: Nurse staffing report	September 2024	People Committee	Full	None identified
Control 3: Workforce Insights Report	July 2024	People Committee	Full	None identified
Control 3 and 8: Staff Survey	March 2024 April 2024	Board of Directors Assurance Committees	Full	None identified
Control 3 and 8: Pulse checks	January 2024	People & Engagement Group	Full	None identified
Control 3 and 8: HHE Training Doctors Quality Assurance Report	September 2023	Board of Directors Assurance Committees	Full	None identified
Control 3: Proud to Care Cultural Leadership Group; commencing in July 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).	November - December 2023	People Committee Board of Directors	Full	None identified
Control 4: Mandatory and statutory training approval panel	March 2024	Executive Team	Full	None identified
Control 5: Weekly Appraisal compliance report	March 2024	Executive Team	Full	None identified
Control 5: Progress and evaluation reports	March 2024	Executive Team	Full	None identified
Control 10: Staff Network Update Report.	March 2024	People & Engagement Group	Full	None identified.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Delivery of the Nursing Workforce Development Programme.	N/A	In progress	B Hoskins	Dec 24
Control 2: Talent Management & Succession planning & leadership development framework. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	March 2027	In progress	T Spackman	March 2027
Control 3: New Proud to Care Cultural Leadership Group has been formed to oversee the delivery of the strategy	April 2024	Complete	T Spackman	June 2024

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2598	People Committee	Director of People	4x3 (12)	4x1 (4)	4x1 (4)	1201 – staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer, due to lack of investment, leading to reduced staff morale, negative impact on health and wellbeing with an adverse impact on staff retention and recruitment.		The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge. **Risk Update/Progress Notes** July 2024: Following a review of the risk, no change has been made to the residual risk score of 4.

Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

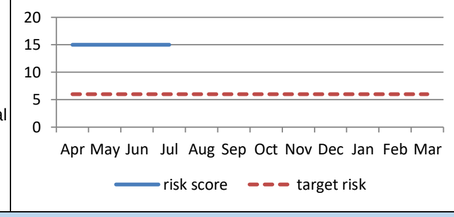
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Occupational Health and EDI services have been re-organised to provide two distinct services(1. Occupational Health and 2. Wellbeing and Inclusion). This will enable a greater focus on the health and wellbeing offer to staff. Staff can access counselling and/or psychological support services, and can self-refer to occupational health where needed. The Trust has also introduced 'Wagestream' – a financial support product for staff to address any financial concerns. Quarterly People Pulse checks have commenced to better measure progress against key metrics from the staff survey, which includes the impact on staff wellness. New Culture metrics dashboard to measure staff experience and wellbeing and organisational culture has been approved at the People Committee in September 2022. A quarterly H&WB activity dashboard is also presented to the People & Engagement Group.	July 2024	September 2024	E Lavery	None identified.
2. People Strategy – a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery.	July 2024	September 2024	E Lavery	None identified.
3.The Trust is also working with the ICS to access wider sources of health and wellbeing support. The SYB ICS Mental Health & Wellbeing hub of online resources, materialsand training courses has been made available to all staff. The Trust has also appointed an Occupational Psychologist post shared with Rotherham Trust in February 2023 for a period of 2 years funded by NHS national charities funds The ICS Occupational Health and Wellbeing Road Map, which is a 3 year plan, was launched in April 2024 to support the delivery of the national Growing Occupational Health and Wellbeing Together Strategy.	July 2024	September 2024	E Lavery	None identified
4. The Trust has approved the adoption of the Standards Framework for Counsellors & CounsellingServices for BHNFT and partners to strengthen the wellbeing support offered. An agreement has also been reached to extend the Schwartz Rounds contract for an additional 3 years. The Schwartz Rounds steering group has been re-instated and the programme of Schwartz Rounds sessions agreed and commenced.	July 2024	September 2024	E Lavery	None identified
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicatedoversight and assurance that the staff health and wellbeing agenda has a Board level champion. A non-executive director has commenced in the role on 01/10/21.	July 2024	September 2024	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	July 2024	September 2024	E Lavery	None identified
7. Commissioning and commencement of externally facilitated Board Development Programme.	July 2024	September 2024	E Lavery	None identified
8. The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff.	July 2024	September 2024	E Lavery	None identified
9. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	July 2024	September 2024	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
10. Annual review and submission of CBU work plans. Work is in progress with the ICB to review the work plans.	July 2024	September 2024	E Lavery	Work in progress
11. Organisational Health and Wellbeing Survey currently being carried out, due to close in May 2024.	July 2024	September 2024	E Lavery	Work in progress
12. Occupational Health User Survey.	July 2024	September 2024	E Lavery	None identified

Assurances Received: L1 Operational, L2 Board Oversight, L3 Independent	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Control 1, 3 and 4: H&WB activity dashboard – Emma Lavery to provide the date	May 2024	People & Engagement Group	Full	None identified
Control 1, 3, 4 and 8: Monthly Occupational Health Activity Dashboard	May 2024	People & Engagement Group	Full	None identified
Control 1: Pulse checks	January 24	People & Engagement Group	Full	None identified
Control 1 and 5: Health and Wellbeing Annual Report	May 2024	People Committee Executive Team	Full	None identified
Control 2 Proud to Care Cultural Leadership Group; commenced in June 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).	July 2024	People & Engagement Group Board of Directors	Full	None identified
Control 2: Workforce Insights Report	July 2024	People Committee	Full	None identified
Control 2, 6 and 7: The new Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved	November – December 2023	People Committee Board of Directors	Full	None identified
Control 9: Staff Survey	March 24 April 24	Board of Directors Assurance Committees	Full	None identified
Control 10: CBU Workforce Plans – Emma Lavery to provide the date	January 23	Clinical Business Unit: Performance Review Meetings	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: New Proud to Care Cultural Leadership Group is being formed to oversee the delivery of the strategy	May 2024	Complete	T Spackman	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Operating Officer	3x5 (15)	3x5 (15)	2x3 (6)	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance, ~~of~~ waiting time standards / targets		Uncertainties surrounding the continuing industrial action alongside seasonal pressures and a backlog from the pandemic is impacting on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2023/24 are aligned to but not reflective of constitutional target delivery. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. There is an inter-dependency regarding the interrelationship between organisational and system-level management **Risk Update/Progress Notes** June 2024: Following review of the risk, no change has been made to the residual risk score of 15.

Risk Appetite	**Risk Tolerance**
Minimal	Treat

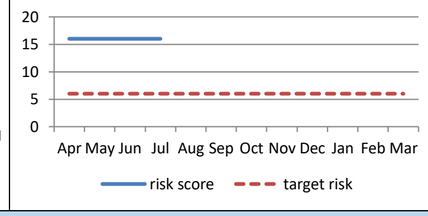
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	June 2024	September 2024	B Kirton/ L Burnett	None identified
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	June 2024	September 2024	B Kirton/ L Burnett	None identified. ~~Business plans are complete, which are aligned to delivery.~~
3. Monitoring of activity, delivery and performance via systems meetings.	June 2024	September 2024	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	June 2024	September 2024	B Kirton/ L Burnett	~~Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS) to reduce health inequalities to improve patient and population health outcomes~~. Work on Health Inequalities was presented to the Finance and Performance Committee in June 2024.
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	June 2024	September 2024	B Kirton/ L Burnett	None identified
6. Attendance at ICS and acute federation meetings and contributions to the development of the system position.	June 2024	September 2024	B Kirton/ L Burnett	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Controls All: IPR report	June 2024	Finance & Performance Committee	Full	None identified
Control 1,2, 3: Reports against trajectories	June 2024	Finance & Performance Committee	Partial	A number of actions to enable recovery require involvement of place & system and are not under the direct control of the Trust
Control 1, 2, 3, 4: Quality Metric Reports	June 2024	Finance & Performance/ Quality & Governance Committees/ Board of Directors	Full	None identified
Control 2: Progress reports - annual business plan	May 2024	Finance & Performance Committee	Partial	None identified
Control 2,3 6: NHSI/E reports	April 2024	Board of Directors	Partial	None identified
Control 3: Report to Trust Board - Activity Recovery Plans 2023/24 and further updates to assurance committees	June 2024	Finance & Performance Committee	Full	None identified
Control 6: Benchmarking reports through ICS	June 2023	Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2 and Assurance 5: Adapt performance reporting so they provide the right assurances on what the Trust has committed to deliver. Started January 21. Incorporate system and place reporting when available	May 2023	Completed	L Burnett/ T Davidson	February 2024
Control 2: Capacity gaps identified in business planning and additional activity requirements discussed with the Finance Director. Report quarterly to the Executive Team and Finance & Performance Committee against recovery trajectory and any mitigation	May 2023	Completed	S Garside	February 2024
Control 2 and Assurance 5 & 7: operational exec to ensure robust plans during periods of industrial action to ensure essential staff cover and report on impact to recovery trajectories	March 2023	Completed	L Burnett/ Dr S Enright	
Control 4: Clinical exec leads to ensure an appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21.	February 2021	Complete – June 2024	Dr S Enright	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	Chief Operating Officer	4x4 (16)	4x4 (16)	1x2 (2)	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.		There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. Thisrisk is also interdependent on capital finance, digital transformation, and may impact on the trusts ability to deliver the services within the trust 5-year strategy. There is an inter-dependency related to estates work with Barnsley 'place **Risk Update/Progress Notes** June 2024: Following review of the risk, no change has been made to the residual risk score of 16.

Risk Appetite	**Risk Tolerance**
Cautious (Patient Experience)	Treat

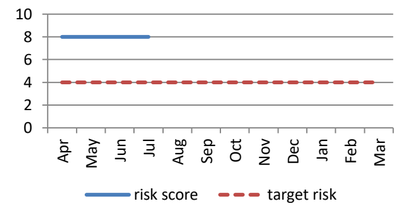
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	June 2024	September 2024	L Burnett	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	June 2024	September 2024	L Burnett	None identified
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	June 2024	September 2024	L Burnett	None identified
4. Space Utilisation Group	June 2024	September 2024	L Burnett	None identified
5. Contracts and SLAs between the Trust and BFS	June 2024	September 2024	L Burnett	Review of outpatient pharmacy SLA.
6. EDMS Project (reduce paper in the Trust and in turn, release space)	June 2024	September 2024	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	June 2024	September 2024	B Kirton	None identified
8. Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce the need for inpatient beds	June 2024	September 2024	L Burnett	Increased demand for urgent and emergency care against previous year.
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	June 2024	September 2024	L Burnett	None identified
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	June 2024	September 2024	L Burnett	None identified
11. Bed reconfiguration programme to increase medical bed capacity	June 2024	September 2024	L Burnett	None identified.
12 Health on the High Street: development off-site facilities for out-patient services	June 2024	September 2024	B Kirton	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Controls All: Regular agenda item on ET	June 2024	Executive Team	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated, business cases expected to include space requirements and plans to provide.
Control 1, 2, 4, 5: BFS performance chairs log	June 2024	Finance & Performance Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
Control 1, 3, 5, 8, 11, 12: Trust Ops regular agenda item	June 2024	Clinical Business Units: Performance Meetings	Full	None identified
Control 7, 8, 12: Item on agendas at Barnsley Place meetings, UECB, planned care & ICP	June 2024	Place Partnership Delivery Group	Full	None identified at PLACE

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: Further review of services that could move off-site or work from home	February 2024	Complete	L Burnett/ S Garside	February 2024
Control 2: Development of the community diagnostic centre	February 2024	Complete	L Burnett/ R McCubbin	February 2024
Control 8: Increase agreed to medical bed base utilizing available ward areas following CCU move	September 2023	In Progress	L Burnett	June 2024
Control 7, 8, 12: Assurance: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	June 23	ongoing	R McCubbin	April 2024
Control 1, 7, 9 and 12: Development of full business case related to Health on the High Street	July 2024	In progress	S Garside	September 2024

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2 (8)	4x2 (8)	4x1 (4)	1693 - adverse reputational damage to the Trust1 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients - risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. **Risk Update/Progress Notes** July 2024: Following review of the risk, no change has been made to the residual score of 8. Learning from EPMA go live in ED on 4 July 2024 with minimal disruption due to this challenging transformation.

Risk Appetite	**Risk Tolerance**
Seek	Treat

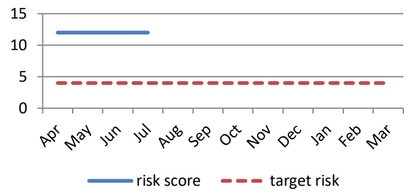
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Effective governance via the Digital Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	July 2024	September 2024	Director of ICT	Clinical Risks associated with a fragmented record split across multiple digital health care record systems.
2. Effective training, project delivery, communications, engagement with all staff in line with an approved project initiation document. Full approval to proceed process with all stakeholders.	July 2024	September 2024	Director of ICT	Potential impacts of external factors such as cyber security impacts on infrastructure ~~COVID-19 on workforce~~ and therefore delivery (outside of the Trust's control)
3. External review of processes and implementations via 360 Assurance. ~~the Trust System Support Model (TSSM)~~	July 2024	September 2024	Director of ICT	None identified
4. Digital Transformation Strategy	July 2024	September 2024	Director of ICT	It is not possible for the Strategy to manage unforeseen disruption and clinical risks.
5. Business Cases for E-prescribing, Electronic Health Care Records and Digital Steering Group ~~Lorenzo replacement~~	July 2024	September 2024	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	July 2024	September 2024	Clinical Reference Group/Director ICT	None identified
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	July 2024	September 2024	Board of Directors Senior Leaders Group	None identified
8. Clinical Digital Safety Group reporting to the Digital Steering Group (which looks at key clinical systems)	July 2024	September 2024	Director of ICT	None identified. Terms of Reference agreed at the Digital Steering Group. TORs presented to F&P in Nov 2023

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1,5 and 8: Digital Steering Group Chairs Log	July 2024	Finance & Performance Committee	Full	None identified
Control 3: Digital Maturity Assessment – To understand potential gaps in our capability	July 2024	Finance & Performance Committee	Full	None identified
Control 3: Submission of the Digital Maturity Assessment as requested by the Central Team	June 2024	Finance & Performance Committee	Full	None identified
Control 4: Significant Assurance Business Continuity 360 Assurance Audit. ~~Patient Letters Communication~~	May 2024	Finance & Performance Committee	Full	None identified
~~Control 4,5 and 8: F&P ICT Strategic Update - Digital Transformations in Delivery~~	~~May 2024~~	~~Finance & Performance Committee~~	~~Full~~	~~None identified~~
Control 4, 5 and 8: Quarterly F&P ICT Strategic Update – Digital Transformations in Delivery	May 2024	Finance & Performance Committee	Full	None identified
Control 8: Terms of Reference for the Clinical Digital Safety Group were agreed at the Digital Steering Group, and presented to the F&P Committee for approval	November 2023	Finance & Performance Committee	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Careful monitoring of the programme of digital transformation via all Trust Board Committees.	On-going	N/A	Director of ICT	N/A
Control 2: Digital Transformation Strategy 5 year plan: 2022 – 2027	2027	N/A	Director of ICT	The completion date will be on the maturity of the strategy.

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	***Initial Risk Score***	***Current Risk Score***	***Target Risk Score***	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x2 (8)	4x3 (12)	4x1 (4)	2416 – cyber-security during the pandemic – risk closed 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients – risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding Cybersecurity and IT systems resilience If we do not protect the information we hold as a result of ineffective information governance and/or cyber security due to lack of resources there is a risk of the Trust's infrastructure being compromised resulting in the inability to deliver services and patient care resulting in poor outcomes and patient experience. The national heightened status of awareness due to recent cyber security breaches has been reflected as part of the risk assessment.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. ***Risk Update/Progress Notes*** July 2024: Following review of the risk, no change has been made to the residual score of 12. Further action and mitigations have been delivered as a result of London Hospital's recent attacks. Increased vigilance and robust security on 3rd party support connectivity mechanisms have been configured/monitored.

Risk Appetite	**Risk Tolerance**
Minimal (Clinical Safety)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally.	July 2024	September 2024	Director of ICT	IT systems and business as usual support continually gets more complex and there are limited resources to ensure mitigation of all risks.
2. A regular review of assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment is completed on minor unsupported solutions. A paper was received at ET to approve this approach.	July 2024	September 2024	Director of ICT	None identified
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, Anti-Malware and Patching strategies in place.	July 2024	September 2024	Director of ICT	There is no protections against a zero-day virus. A brand-new virus that cannot be detected by the various scanning techniques. Careful and consistent monitoring of systems need to be in place through start of the day checks
4. CARECert – Cybersecurity Alerts – for example recent LOG4J alert and remedial actions report to F+P	July 2024	September 2024	Director of ICT	Full assurance from all suppliers has been sought. Some suppliers have provided workarounds but not supplied full patches.
5. Regular briefing and guidance from the South Yorkshire Cyber Security Forum. Relevant actions are implemented.	July 2024	September 2024	Director of ICT	None identified.
6.. Annual Cybersecurity assessment completed by Certified 3rd party to ensure all up to date measures are in place	May 2024	May 2025	Director of ICT	Not all recommendations in the report can be completed; it is a balance of funding/practicality/risk to ensure the most effective cybersecurity controls are implemented.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1: ~~Covid-19~~ Risk assessment of all cybersecurity and IT risks. Significant Assurance provided from 360 Assurance on out Data Protection Toolkit compliance position – Board approved position.	July 2024	Executive Team Finance and Performance Committee	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.
Control 3 and 6: Annual Board Cybersecurity Report including Penetration Testing Results	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified
Control 6: Data Protection Tool Kit 360 Assurance Audit	July 2024	Executive Team Finance & Performance Committee	Partial	Only covers specific areas of cybersecurity.
Control 1 and 4, 5: National Cybersecurity active monitoring and reporting frameworks	July 2024	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-committees.
Control 2: Cyber Security Annual Report	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified
Control 5: Active directory authentication system audit completed by national cyber security commissioned requirement.	July 2024	Executive Team/ Finance & Performance Committee	Full	None identified.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Bolster online defences and complete new penetration test.	May 2025	Ongoing.	ICT Director	The penetration test was completed in April 2024, the next one is due in May 2025.
Control 1 and 4. Strategic update report to the finance and performance committee quarterly to manage resources against priorities	Ongoing	Ongoing	ICT Director	
Control 1: System Vulnerability Test: to be undertaken across the major IT systems within the Trust and ensure the patching regime is fully completed.	May 2024	Complete	ICT Director	Ongoing from April 2024 – May 2024
~~Control 1: South Yorkshire Cyber Security Forum: agreed cyber security assessment across South Yorkshire.~~	~~January 2025~~	~~Ongoing~~	~~ICT Director~~	~~Assessment commenced in January 2024, expected to be completed by January 2025.~~
Control 3: Careful and consistent monitoring of systems need to be in place through start of the day checks and CareCert National Cybersecurity Monitoring	Ongoing	Ongoing	ICT Director	Two major CARECert notifications were received May 2024, both of which have been actioned.
Control 5: Ensure fully risk assessed gaps in cybersecurity action plan delivery.	Ongoing	Ongoing	ICT Director	

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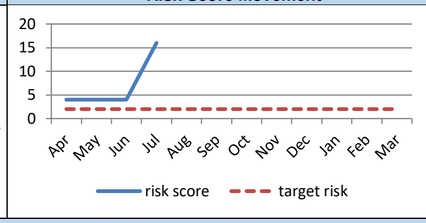
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	4x5 (20)	4 x 4 (16)	2x1 (2)	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures. ***Risk Update/Progress Notes*** July 2024: Following review of the risk, given the Trust is currently off-plan year to date and the recovery plans identified at this stage would not enable balance at this stage, the risk has been increased from a score of 4 to 16 (4 x 4).

Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board owned financial plans	July 2024	September 2024	R Paskell	None identified, Board approved final 2024/25 plan in June
2. Requirements identified through business planning and budget setting processes and prioritised based on current information	July 2024	September 2024	R Paskell	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control
3. Additional requirements must follow business case process	July 2024	September 2024	R Paskell	None identified - well established business case process
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings	July 2024	September 2024	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	July 2024	September 2024	R Paskell	~~Group is now meeting; however,~~ Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities	July 2024	September 2024	R Paskell	Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance
7. Identification of additional efficiency / spend reduction.	July 2024	September 2024	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare	July 2024	September 2024	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management
9. Tight management of costs, with delegated authority limits, including review of agency usage	July 2024	September 2024	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management Industrial action may impact on both costs and income; decisions on central funding support being made in respect of each case of industrial action and are not guaranteed for the future.
10. Continued discussions with SY ICB.	July 2024	September 2024	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
All controls - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	July 2024	Finance & Performance Committee	Partial	Pressures arising from recovery, activity increases and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations, and any increased requirements for the system to break-even in the year.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2, 6 & 10: Gaps in control are outside the Trust's control	N/A	N/A	N/A	N/A
Control 7, 9: Urgent identification of additional opportunities required to reduce spend and increase productivity, as well as reviewing what difficult choices the Trust may need to take to improve the financial position.	September 2024		Chris Thickett	

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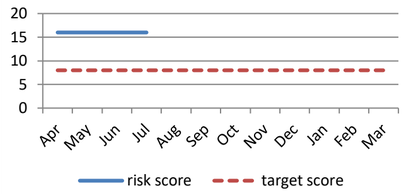
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2845	Finance and Performance Committee	Director of Finance	4x4 (16)	4x4 (16)	4x2 (8)	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability 1791 - Risk regarding insufficient cash funds to meet the operational requirements of the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Inability to improve the financial stability of the Trust over the next two to five years There is a risk that we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit in 2023/24 leading to financial instability.		This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability; It is also inter-dependent with national funding priorities and decisions. ***Risk Update/Progress Notes*** July 2024: Following review of the risk, no change has been made to the residual risk score of 16.

Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board-owned financial plans	July 2024	September 2024	R Paskell	The Board of Directors approved Capital Plan for 2024/25 at the meeting on 6 June 2024. ~~None identified, Board approved final 2022/23 plan in June 2022; 2023/24 draft plan approved in February 2023~~
2. Achievement of the Trust's in-year financial plan and any control total (see risk 1713)	July 2024	September 2024	R Paskell	The Trust is currently off-plan year to date in 2024/25.~~None identified, 2022/23 in-year financial plan and agreed system control total will be delivered~~
3. Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings	July 2024	September 2024	R Paskell	None identified
4. Delivery of the EPP programme recurrently	July 2024	September 2024	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	July 2024	September 2024	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
6. Continued discussions with SY ICB.	July 2024	September 2024	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control
7. Potential additional national and/or system resources become available	July 2024	September 2024	R Paskell	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process. Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control All: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	July 2024	Finance & Performance Committee	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations and potential impact on the Trust.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 6 & 7: Gaps in control are outside the Trust's control	N/A	N/A	N/A	N/A

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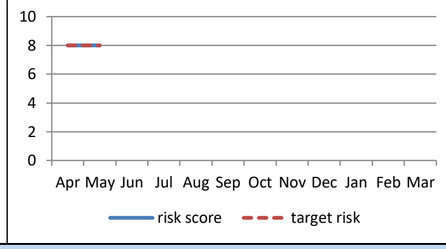
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3 (12)	4x2 (8)	4x2 (8)	1693 - adverse reputational damage to the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.		Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022. **Risk Update/Progress Notes** July 2024: Score remains at 8 which is at target. The main issue relates to long-term model for intermediate care which are alleviated in the short term due to relocation of the Acorn Unit within the Trust.

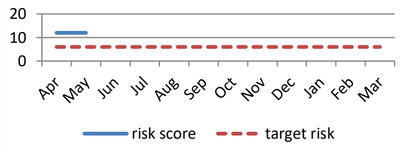
Risk Appetite	**Risk Tolerance**
Seek (Partnerships)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Trust vision, aims and objectives	July 2024	Sept 2024	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration with partners, public, etc.)-	July 2024	Sept 2024	B Kirton	Discuss with Emma Parkes
3. Membership of partnership forums in Barnsley Place and SYB ICS.	July 2024	Sept 2024	B Kirton	None identified
4. Regular meetings with partners, Chair meetings and exec to exec working.	July 2024	Sept 2024	B Kirton	None identified
5. Membership of networks and service level agreements	July 2024	Sept 2024	B Kirton	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance reporting to Finance and Performance Committee in September
6, Review of avoidable attendances in the Emergency Department with partners to agree on alternative models for the front door.	July 2024	Sept 2024	B Kirton	Will require whole system buy in, 3rd party Independent facilitated review due to conclude in August 2024
7. There is an agreement within the SY AF to do a shared sustainable service review and identify priority service areas that need support or review.	July 2024	Sept 2024	B Kirton	Organisations may not agree to shared solutions once the review is completed. Individual Trusts have shared sustainability reviews with the Acute Federation– awaiting a decision July 2024.Trusts coming together in August 2024 to review prioritized opportunities/risks.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Control 1, 3, 4, 6 and 7: regular ET agenda item regarding Barnsley and ICS meetings	July 2024	Executive Team	Partial	There are concerns regarding Intermediate Care (IMC) Services in the short term due to uncertainty about the future location of the Acorn service. The long-term model for IMC is still yet to be agreed. Concerns alleviated due to short term relocation of the Acorn Unit into the main hospital but remains partial assurance due to short term nature of the relocation.
Control 1: Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS	May 2024	Board of Directors	Full	None identified

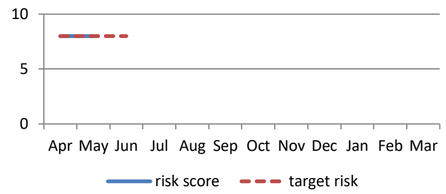
Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: All issues and concerns regarding the Acorn Unit have been escalated to Place Partnership via the Place Board so these issues are understood. The Trust is working as part of a Place Working Group to address these issues, as well as performing an internal Task & Finish Group led by the Managing Director. Regular updates on progress are being to ET and the Board of Directors. All issues and concerns re intermediate care service – agreed model required by end December 2024	1 February 2024	In Progress	B Kirton	1 February 2024
Control 2: Review of unsigned service level agreements and take any necessary actions to address the gap (Control 5). There are no material concerns at the present time Annual review of Service Level Agreement position to F&P	April 2021	In progress	C Thickett	To be added to the workplan for F&P for September 2024
Control 3: Three work streams set up to look at different options as alternatives to the current offer. This work culminates in April 2024 following a clinical workshop and a business case with the final agreed option.	April 2024	In progress	B Kirton	
Control 4: Need to continue to work closely, escalating any issues to the ICB as required.	July 2024	In progress	B Kirton	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)	2527 - ineffective partnership working 2592 - failure to deliver performance/targets
Risk Description	Risk Score Movement						**Interdependencies**
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes There is a risk that we will not take appropriate action to address health inequalities in line with local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities, and improve patient and population health outcomes.							Wider system pressures, partner organisations' capacity and ability to collaborate, and partner's recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners priorities and strategies to improve population health. Developing role of ICS (future ICB) in management of population health and emergent strategy for health inequalities. **Risk Update/Progress Notes** July: Following review of the risk, no change has been made to the residual risk score of 12. There has been progress with support for the specific investment of the Barnsley core20+ allocation into community co-development of services. There is ongoing risk to sustainability of key prevention services at BHNFT including QUIT and ACT. There is ongoing growth of societal drivers to inequalities (e.g. cost of living increases). May 2024: Following review of the risk, no change has been made to the residual risk score of 12. There are ongoing risks around adequate investment to specifically reduce inequalities; ie the Barnsley allocation of core 20 + 5 monies. Progress continues despite financial and demand pressures being experienced.
Risk Appetite							**Risk Tolerance**
Minimal (Clinical Safety)							Treat
Controls	**Last Review Rate**	**Next Review Date**	**Reviewed by**				**Gaps in Control**
1. Continued engagement with commissioners and ICS developments in clinical service strategies to prioritise, resource and facilitate more action on prevention and health inequalities.	July 2024	September 2024	B Kirton Dr S Enright A Snell				Inability to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development. Standard approach to measurement of HI and identifying gaps in service delivery has been established at BHNFT and is being used by other partners (including SWYFT). Financial pressures across the system mean risk to specific investment in reducing inequalities. ~~Financial pressures have increased risk of no dedicated investment in tackling inequalities at Place/ICS level. Proposal submitted in 204/25-Q1 to allocate Health Inequalities monies BHFT piloting an equitable PTL approach in Q1 2024/25. Trust level measure of inequalities improving and actions identified are being taken (PTL and approaches to outpatient transformation).~~
2. Partnership working at a more local level, including active participation in the Health Inequalities workstream, which will feed through the Integrated Care Governance (ICDG andup to the ICPG).	July 2024	September 2024	B Kirton Dr S Enright A Snell				Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across PLACE to ensure those people at the greatest risk of inequalities are able to access services to the same level of those that do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken. ~~Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan which is aligned to the BHNFT plan. This is facilitating alignment across partners but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS. The new proposal for Place health inequalities allocation focuses around community work and engagement the funding is yet to be approved.~~ Understanding the primary care's role and capacity to contribute through the alliance continues to be difficult amidst pressures.
3. All patients on the existing planned care waiting lists and those being booked for new procedures, are regularly assessed against the national clinical prioritisation standards (FSSA) as a minimum, taking into consideration individual patient factors pertaining to healthinequalities where possible.	July 2024	September 2024	B Kirton Dr S Enright A Snell Dr J Bannister				No gaps in clinical prioritisation. Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards – was presented to CEG and approved. Inequalities incorporation in pilot. ~~ADoO (CBU 2) joined the meeting to assure the Group that there is a clinical prioritisation process in place. Defined priority levels are written by the Royal College of Surgeons and the FSSA to help define what priority patients are on the waiting list. The Group was assured with the pathway after the discussion and after seeing the report that was included in the papers. BHNFT, under the leadership of Louise Deakin, is implementing HEARTT (a UHCW initiative), to incorporate IMD and other HI metrics to support clinical decision making for prioritization of the patient waiting list. See control 1 with planned pilot. A local solution is currently being piloted instead of HEARTT to meet local requirements priorities.~~
4. Established population health management team that supports both the Trust, PLACE and is also linked to the ICS lead by a public health consultant.	July 2024	September 2024	B Kirton A Snell				None Identified
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	July 2024	September 2024	B Kirton A Snell				Current lack of clarity on QUIT funding arrangements between the Trust and the ICB being explored for a sustainable solution. National funding for ACT (Alcohol Care team) ends this financial year, sustainable funding arrangement for 2025 onwards currently being developed. Healthy Lives programme continues to deliver effective preventative care but sustainability fragile and expansion plans are being amended to account for the financial pressures, which presents a real risk continuity.
6. 35 key actions to influence health inequalities around 3 key factors: establish new services, enhance existing services & develop as Anchor institution. All within the health Inequalitiesaction plan, including using the vulnerability index to monitor access to care and an information sharing agreement with BMBC	July 2024	September 2024	B Kirton A Snell				Ongoing development and engagement regarding the household level vulnerability index to ensure fuller understanding of information and impact on trust processes across all business units, directors and Board. Integrating inequalities in a way that is not in tension with time based performance measures and funding pressures needs to be managed. Ability to realise BHNFT's full anchor institution potential requires long term work and depends on some partnership approaches which are not always forthcoming, especially with financial pressures across partners. Keeping pace with dynamic context is challenging. ~~Leadership fellow is ending at end of August 2023 returning us back to low capacity for the second key factor. Progress continues to be good and reported into Q&G quarterly. A refresh of the action plan is due in 2024, led by Dr Andy Snell and Dr Ceryl Harwood. Action plan refresh is now taking an annual programme of work cycle aligned with the annual setting of the Trust objectives. The term of the plan has now passed, the Trust has transitioned to incorporating priorities into the Trust objectives (still structured around the three key factors) and running an annual programme of work cycle aligned to these.~~
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**				**Gaps in Assurance**
Control 1: Updates on the strategy and action plan to improve public health and reduce inequalities including measurement of inequalities ~~and supporting clinical prioritisation with clinical health inequalities metrics~~ in BHNFT services, quarterly reports to Q&G and annually to the Board of Directors.	July 2024	Quality & Governance Committee / Board of Directors	Partial				~~Clinical prioritisation process needs to be re-reviewed at the Clinical Effectiveness Group to ensure ongoing evaluation of effectiveness.~~ Progress made across all CBUs but still with specific services and pathways and yet to be Trust-wide. ~~Pop health analyst and new corporate analyst to support this roll out. Pop health analyst now in post and established, focusing on PTL, OPD, cancer services and CDC. To be engaged in the~~ Inequalities not yet integrated with IPR ~~early 2024~~ or given parity with performance reporting.
Control 2: Integrated Care Delivery Group- understanding of priorities for Barnsley regarding health inequalities assessed by the Barnsley Health Intelligence and Equity Group (meet monthly)	July 2024	Integrated Care Delivery Group	Full				While BHFT has established regular reporting of inequalities into Q&G and this goes to BMBC (Barnsley Metropolitan Borough Council) public health management team there is no routine reporting of inequalities at the Place partnership.
Control 3Current working group led by CBU2 and due to report on pilot that will be commencing in April. Currently meeting fortnightly. Group will report to the Executive Team in Q1-2024/25.	July 2024	Clinical Business Unit 2	Full				Feasibility and acceptability of the equitable PTL will need to be reviewed from the findings of the pilot~~s~~ work.
Control 5: ACT and QUIT activity and performance reports submitted at Q & G	July 2024	Quality & Governance					None identified

		Committee		
Control 6: Programme of work for 2024/25 will be presented to Q&G at the next quarterly update from Public Health National conferences and engagement (next one in May 24)	July 2024	National		None identified

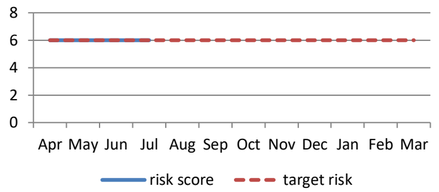
Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
Control 1: The new proposal for Place health inequalities allocation focuses around community work and engagement, the funding submitted and approved.	June 2024	Complete	A Snell	
Control 6: BMBC and BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.	October 24	In progress	A Snell	Dec-23
Control 1 & 2: The new proposal for Place health inequalities allocation focuses around community work and engagement	June 2024	In progress	A Snell	
Control 5: Contract review for QUIT	March/Apr 2024	In progress	A Snell	
Control 5: Funding proposal for ACT	July 24	In progress	A Snell	
Control 6: Programme of work for 2024/25	Marc/Apr 24	Complete	A Snell	
Control 1: Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan which is aligned to the BHNFT plan. This is facilitating alignment across partners but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS.	2023	Complete	A Snell	
Control 3: Piloting a waiting fair initiative for people on BHNFT's PTL (using the locally built WHaLES) across T&O, General Surgery, ENT	Q1 24/25	In progress	A Snell	October 24
Control 3: There is a clinical prioritization process in place which aligns with key waiting time thresholds and is due to be complemented by health inequalities measures (as per update from Louise Deakin, CBU2)	2023	Complete	S Enright	
Control 1: Population health analyst recruited and working across CBUs and with operations to standardize and integrate measurement of inequalities	2023	In progress	A Snell	Ongoing
Control 2. Anna Hartley (DPH) is new SRO for Place inequalities and intelligence priority and reports regularly in the Place Partnership Delivery Group	Q4 23/24	Complete	A Snell	
Control 2: A pilot waiting fair, waiting well initiative is being trialled across the new Provide Alliance looking at how partners can collectively to create more equitable care (with an initial focus on MSK/T&O)	May 24	In progress	A Snell	December
Control 5: Ceryl Harwood (clinical lead for HLP for CBU3 and Corporate) is having regular meetings with Bob Kirton and place partners re sustainable funding model for ACT	July 24	In progress	B Kirton	September
Control 6: Action plan is now entering a new cycle of annual refreshes alongside annual revision of trust objectives and informing an annual programme of work	July 24	Complete	A Snell	
Control 6: Capacity of the BHNFT public health team is nearing full re permanent staff and is regular supported by integration with other key teams and approaches (e.g. QI) PH HSTs and junior docs on PH placement	2023	Complete	A Snell	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will build on our sustainability work to date and reduce our impact on the environment.	2827	Finance and Performance Committee	Managing Director of BHNFT	4x4 (16)	4x2 (8)	4x2 (8)	
Risk Description	**Risk Score Movement**		**Interdependencies**				
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.			Grant Funding Govt directives / legislation **Risk Update/Progress Notes** July 2024: Delivery Plan update to F&P August 2024. Video filmed for communication around sustainability in August 2024. Risk score to remain the same at target.				
Risk Appetite			**Risk Tolerance**				
Open			Treat				

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Green Plan	July 2024	Sept 2024	Sustainability Action Group, BFS Board, Finance & Performance Committee, Board of Directors/ M Sajard	Scope 3 emissions are not currently incorporated. As new methodologies are developed for carbon accounting the Net Zero Targets will be reset. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.
2. Sustainability (Green Delivery) Plan	July 2024	Sept 2024	Finance & Performance Committee	To be presented to the Committee in January 2024. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan. The plan has been presented at ET and F&P.
3. Heat Decarbonisation Plan	July 2024	Sept 2024	Sustainability Action Group, BFS Board, Finance & Performance Committee/ M Sajard	Delivery is linked to grant and capital funding. The first wave of the decarbonisation plan has been delivered in the Trusts outer buildings. The impact of the work is currently being evaluated by the team before applying for more funding and delivery schemes are commenced. Awaiting heat network plan
4. The Trust meets local stakeholders through the Barnsley 2030 Group	July 2024	Sept 2024	Sustainability Group, Chairs Log, Executive Team/ M Sajard	None identified.
5. Trust Sustainability Action Group and ICB Sustainability meetings take place every 6 weeks to co-ordinate the delivery of the Trust's strategic plans, monitor progress, address new and emerging changes.	July 2024	Sept 2024	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None identified
6. Effective engagement with staff and the public	July 2024	Sept 2024	Sustainability Action Group/ M Sajard	Ongoing engagement and communication will be required to achieve the Trust's objectives.
7. Trust has secured funding and continues to seek funding to meet Net Zero targets.	July 2024	Sept 2024	Sustainability Action Group, Chair Log, Finance & Performance Committee / M Sajard	Funding of £3.72m was secured for phase 1 of our decarbonisation project. The Trust will continue to submit bids for further funding as and when they are announced. The target and funding are subject to political pressures
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	
Control 1: Independent sustainability audit gave an opinion of Significant Assurance.	December 22	Executive Team	Significant rating	None identified
Control 1 , 2 & 3: Sustainability Green Plan	Jan 24	Executive Team Finance & Performance Committee		None identified
Control 4: The Trust meets local stakeholders through the Barnsley 2030 Group	March 24	Sustainability Group,		None identified
Control 5: Trust Sustainability Action Group and ICB Sustainability meetings	Jan 24	Executive Team Finance & Performance Committee		None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1, 2 & 3: New communication plan to support and improve understanding of sustainability and the Trusts role with the staff and the public	June 2024	In progress	Emma Parkes	August video
Control 1, 2, 3, 4, 5 & 7: The Trust needs to continue to evaluate all sustainable investments to prove our return on investment, connected to national funding programmes and sustainability networks. Develop innovative schemes with partners and keep well networked.	TBC	Ongoing	B Kirton	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**	
				The risk score is consequence x likelihood				
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	1x3 (3)	3x2 (6)	3x2 (6)	2527 - ineffective partnership working 1865 – zero-day vulnerability	
Risk Description	**Consequence of Risk Occurring**			**Interdependencies**				
Risk regarding adverse reputational damage to the Trust There is a risk of reputational damage through different routes of exposure to the Trust.				Wider system issues resulting in adverse publicity to other NHS service providers may result in increased media scrutiny of this Trust and/or its staff/services. **Risk Update/Progress Notes** July 2024: Following review of the risk, no change has been made to the residual risk score of 6. There have been no high-profile issues to manage proactively, the current controls are working well, social media continues to be monitored and negative coverage has been managed proactively.				
Risk Appetite				**Risk Tolerance**				
Cautious (reputation)				Treat				
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**				
1.Comprehensive communications planner to track and plan for positive and potential adverse publicity	July 2024	September 2024	E Parkes	None identified				
2.Monthly communications planner presented to the Executive Team	July 2024	September 2024	E Parkes	None identified				
3.The Trust has a number of processes in place for the effective management of its overall reputation	July 2024	September 2024	E Parkes	None identified				
4.Reactive statements prepared in advance for high risk matters	July 2024	September 2024	E Parkes	None identified				
5. Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	July 2024	September 2024	E Parkes	None identified				
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**				
Control 1 & 2: Communications Plan presented to the monthly Executive Team Meeting	July 2024	Executive Team	N/A	None identified				
Control 3 & 4: Weekly strategic review of Horizon planner	July 2024	Director of Communications/ Communications Team	N/A	None identified				
Control 5: Internal/External Stakeholder briefings as appropriate	March 2024	Council of Governors	N/A	None identified				
Corrective Actions Required (include start date)					**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1 & 2: Monthly Board of Directors briefing to commence in April 2024					Ongoing	N/A	Director of Communications	ongoing

Risk domain	Risk appetite	Risk level
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	The Trust has a risk-averse appetite for risks relating to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	MINIMAL
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Environment	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	OPEN

Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER
July 2024

Appendix 2

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life

Summary Corporate Risk Register – May 2024

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2022/23	Strategic Goals and Aims	CRR Page No.
Risk domain: Regulation / Compliance								
Performance								
2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	May 2021	Chief Operating Officer	15	July 2024	Best for Patients and the Public - we will provide the best possible care for our patients and service users	Patients and the Public/ Performance	4
Risk domain: Clinical Safety/Clinical Effectiveness/Workforce								
Service Delivery								
3014	Lack of Clinical Leadership and inability to meet service demands within OMFS Services	March 2024	Chief Operating Officer	15	July 2024	Operational Risk	Performance/ Patients and the Public	5
Risk domain: Clinical Safety/ Clinical Effectiveness/ Workforce								
Service Delivery								
2803	Risk to the delivery of effective haematology services due to a reduction in haematology consultants	January 2023	Medical Director	16	July 2024	Operational risk	Patients and the Public / People	7
Risk domain: Finance / Value for Money/ Workforce								
Workforce Costs								
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	November 2021	Director of People/Director of Finance	16	July 2024	Operational risk	Performance / People	9
3051	Payroll/Financial Risk to the Trust as a result of an error with the Medical eRoster system	June 2024	Director of Finance	16	New risk	Operational Risk	Performance / People	8
Risk domain: Finance / Value for Money								
Financial Stability								
2845	Inability to improve the financial stability of the Trust over the next two to five years	January 2023	Director of Finance	16	July 2024	Best for performance – we will meet our performance targets and continuously strive to deliver sustainable services	Patients and the Public / Performance/ Partner/ Place	10
1713	Risk regarding the inability to deliver the in-year financial plan	April 2015	Director of Finance	Proposed to increase from 4 to 16	July 2024	Strategic Objective Best for performance: we will meet our performance targets and continuously strive to deliver sustainable services	Patients and the Public / Performance/ Partner/ Place	11
Risk domain: Clinical Safety / Clinical Effectiveness								
Service Delivery								
2976	Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	November 2023	Director of ICT	16	July 2024	Operational Risk	Performance/ Patients and the Public	12
2768	Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	March 2023	Director of ICT	16	July 2024	Operational Risk	Performance/ Patients and the Public	13

Strategic Objectives:

- Best for Patients and the Public – we will provide the best possible care for our patients and service users.
- Best for People – we will make out Trust the best place to work

- Best for Performance – we will meet our performance targets and continuously strive to deliver sustainable services
- Best for Partner – we will work with our partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways
- Best for Place – we will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
- Best for Planet – we will build on our sustainability work to date and reduce our impact on the environment.

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

Appendix 2

Risk 2592: Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	C = 3 L = 5	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score					*Initial score* *Current score*			

Risk Description:	
There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance or waiting time standards / targets.	**Executive lead:** Chief Operating Officer
	Date added to CRR: May 2021
	Last reviewed date: June 2024
	Committee reviewed at: Finance and Performance Committee

Consequence of risk occurring
The materialisation of this risk will impact patient care potentially resulting in poor outcomes and adverse harm, poor patient experience and breach of standards with associated financial penalties and reputational damage.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	None identified.	
Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET.	None identified. Business plans are complete, which are aligned to delivery.	capacity gap identified in business planning & additional activity requirements discussed with finance director. Operational planning to maintain safety during periods of industrial action.
Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.	None identified.	Development of Acute Federation & Integrated Care Board.
Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes.	Working to include health inequality data alongside waiting list management as per health inequalities action plan.
Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	None identified.	Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes.
Attendance at ICS meetings and contributions to the development of the system position.	None identified	

Risk Update/Progress Notes
June 2024: Following the review of the risk, no change has been made to the residual risk score. Work is ongoing to ensure the delivery of the constitutional standards.

Risk 3014: Risk regarding lack of clinical leadership and inability to meet services demands within Oral Maxillo-facial Services (OMFS)	C = 3 L = 5		**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
					Target score								*Current/ initial score*			

Risk Description:	
The OMFS Department does not have the required capacity to meet the demands of the service, there is no clinical leadership across the Consultant body which subsequently impacts the ability to develop the service, address the capacity issues and support the existing workforce as well as the overall quality of care. The Consultant workforce are not supportive of autonomous practitioner status or recruitment of Oral Consultants to the right size capacity to meet demand. There are backlogs across all waiting lists, and as of 6 March 2024, there are 350 referrals waiting for grading. Five risks have been logged on Datix due to the numerous challenges with the service. The Consultant body will not allow other members of the Clinical Team to grade/support with other areas of the waiting lists, which results in growth and delay. OMFS Consultant recruitment is a national issue.	**Executive lead:** Chief Operating Officer **Date added to CRR:** 12 March 2024 **Last reviewed date:** June 2024 **Committee reviewed at:** Quality & Governance Committee

Consequence of risk occurring
Mismanagement of patient care/ delayed treatment/ loss of finance/poor patient experience/ waiting list backlogs

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Working with STH colleagues to seek sustainable solutions to workforce planning and leadership.	Dependant on the availability of Sheffield Teaching Hospital staff for meetings	
The service Management team works closely with the SAS workforce to manage patient backlogs as much as possible.	SAS Doctors are unable to complete all activity.	
Outsourcing to the private sector for orthodontics	None identified.	
Regular Business and Governance Meetings to be held	Sheffield Teaching Hospital (STH) Consultants are unable to deliver administrative time to attend meetings; Business and Governance meetings require loss of activity.	

Risk Update/Progress Notes
June 2024: Following review of the risk, no change has been made to the residual risk score. Follow-up meeting with STH, Chief Operating Officer and the Medical Director has been delayed until August 2024, due to STH availability. Clinical Business Unit 2 is to deliver an options paper to the Executive Team in July 2024.

Risk 2803: Risk to the delivery of effective haematology services due to a reduction in haematology consultants	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score/ Current score*		

Risk Description:	
There is a risk to the provision of an effective haematology service due to a reduction in consultant cover for Clinical Haematology, ward 24 and the chemotherapy unit. Consultant provision has reduced from 3.4 WTE to 1.6 WTE haematology consultants. There is also a financial implication to the risk; since October 2022 the Trust has spent £850Kon Medical Agency shifts	**Executive lead:** Medical Director
	Date added to CRR: January 2023
	Last reviewed date: July 2024
	Committee reviewed at: Quality and Governance Committee

Consequence of risk occurring
The materialization of this risk could impact on patient safety, result in adverse patient experience and result in significant financial costs.

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Substantive posts out to advert	None identified	The post continues to be advertised
Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.	None identified	1.8 WTE Locum Consultant secured for October
Discussions with Rotherham Hospital regarding support being undertaken at the Clinical Director level.	None identified	
Two WTE agency Locums are in place to ensure service continuity	There is a significant financial implication with using agency locums to cover this service.	Recruitment is in progress to recruit one middle-grade doctor and a Locum Consultant, to reduce the financial burden. Two Consultants recruited and are likely to commence in the next couple of months.

Risk Update/Progress Notes
July 2024: Following review of the risk, no change has been made to the residual risk score of 16.

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		*Initial score*		*Current score*		

Risk Description:	
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.	**Executive lead:** Director of People
	Date added to CRR: November 2021
	Last reviewed date: July 2024
	Committee reviewed at: People Committee/ Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could result in financial over-spend impacting on quality of services and compromising patient care.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Sickness absence reduction plan **(sickness absence target 4.5%)**, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group.	None identified.	
Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend.	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to bedelivered by March 2022 and this has been completed.	Roll out to juniors in General Medicine, Lower Surgery, Women's & Children's complete. Currently working on the build for Anaesthetics, then Emergency Medicine and higher surgery. Once all juniors complete will roll out leave management to SAS and Consultant levels.
National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel.	None identified	ICB provide oversight and approves agency usage
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information.	None identified	
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified	
Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified	
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.	None identified	
Reporting of agency spend/medical staff is provided monthly to the Executive Team and Quality and Governance Committee.	None identified.	
Efficiency and Productivity Programme; regular reporting to the Executive Team, Finance and Performance Committee and Board of Directors.	None identified	
Regular monitoring of workforce costs undertaken through revised performance management meetings.	None identified	

Risk Update/Progress Notes
July 2024: Following review of the risk, no change has been made to the residual risk score of no change to risk score of 16. Regular monitoring of the workforce costs is undertaken through the revised monthly performance management meetings.

Risk: 3051 Payroll/Financial Risk to the Trust as a result of an error with the Medical eRoster system.	C = L =	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score								*Initial/current score*		

Risk Description:	
Payroll/Financial Risk to the Trust as a result of an error with the Medical eRoster system. Following a communication from NHS Employers and the Trusts Medical eRoster provider (Allocate) we have been made aware of a calculation error within the rostering system that has the potential to affect the current and historic pay of junior doctors rotating through the Trust. This error is entirely the fault of the eRoster provider, however the impact on the Trust could be that we have over or underpaid current and historic, junior medical staff. The Executive Team have been updated with the reason and impact of this. This is likely to have significant financial consequences as a result of Doctors requesting back pay, along with the operational costs for rectifying the problem. The solution from NHS Employers and Allocate is push the financial and operational risk back onto the Trust to rectify the problem.	**Executive lead:** Director of Finance **Date added to CRR:** 18 June 2024 **Last reviewed date:** **Committee reviewed at:** Finance and Performance Committee/People Committee

Consequence of risk occurring
Pay records going back three years are inaccurate, leading to significant under or overpayments to Junior Doctors

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Communicating with NHS Employers about the lack of responsibility taken by the supplier (Allocate) in sorting out the financial and operational implications of this issue.	Currently, Allocate is not accepting responsibility for resolving the issue	
Allocate has fixed the issue prospectively.		

Risk Update/Progress Notes
July 2024: Following discussion, the Quality Review Panel agreed with the current residual risk score of 16 and requested an update in 3/12 months or earlier if needed. The risk was discussed and reviewed at the Executive Team Meeting on 10 July 2024.

Appendix 2

Risk 2845: Inability to improve the financial stability of the Trust over the next two to five years	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk Description:	
There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve its financial sustainability and return to a breakeven position.	**Executive lead:** Director of Finance
	Date added to CRR: January 2023
	Last reviewed date: July 2024
	Committee reviewed at: Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back-to-balance position, without external funding.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Board-owned financial plans.	The Board of Directors approved Capital Plan for 2024/25 at the meeting on 6 June 2024. ~~None identified, Board approved final 2022/23 plan in June 2022; 2023/24 draft plan approved in February 2023.~~	The 3 year financial recovery plan was agreed by the Board of Directors.
Achievement of the Trust's in-year financial plan and any control total (see risk 1713).	The Trust is currently off-plan year to date in 2024/25. ~~None identified, 2022/23 in-year financial plan and agreed system control total will be delivered.~~	In-year risk; Risk 1713 regarding the inability to deliver the in-year financial plan.
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.	None identified.	
Delivery of the EPP programme recurrently.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	Efficiency and productivity paper, including reporting and governance arrangements to F&P
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	
Continued discussions with SY ICB.	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.	
Potential additional national and/or system resources become available.	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process.	

Risk Update/Progress Notes
July 2024: Following review of the risk, no change has been made to the residual risk score of 16.

Appendix 2

Risk: 1713 Risk regarding the inability to deliver the in-year financial plan	C = L =	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
				Target score										*Current score*	*Initial*	

Risk Description:	
Risk regarding the inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.	**Executive lead:** Director of Finance **Date added to CRR:** 01 April 2015 **Last reviewed date:** July 2024 **Committee reviewed at:** Finance and Performance Committee
Consequence of risk occurring	
The materialisation of this risk would adversely impact on the financial stability of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage.	

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Board owned financial plans	None identified, Board approved final 2024/25 plan in June	
Requirements identified through business planning and budget setting processes and prioritised based on current information	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control	
Additional requirements must follow business case process	None identified - well established business case process	
Financial performance is reviewed and monitored at monthly CBU performance and Finance & Performance Committee meetings	None identified	
Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management	
Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities	Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance	
Identification of additional efficiency / spend reduction.	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management	
Continued work on opportunities arising from PLICS / Benchmarking and RightCare	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management	
Tight management of costs, with delegated authority limits, including review of agency usage	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management Industrial action may impact on both costs and income; decisions on central funding support being made in respect of each case of industrial action and are not guaranteed for the future.	
Continued discussions with SY ICB.	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control	

Risk Update/Progress Notes
July 2024: Following review of the risk, given the Trust is currently off-plan year to date and the recovery plans identified would not enable balance at this stage, the risk has been increased to 4 to 16 (4 x 2).

Risk 2976: Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score			*Initial Score*					*Current score*		

Risk Description:	
There is a risk that computer systems will fail due to the increase in heat load in the computer room/data centre and this can result in unknown harm to patients. This room hosts all Trust's primary servers, VMware environment and Core network where all the Clinical and Corporate Systems run i.e. Careflow EPR, Careflow Vitals, ICE, PACS, Winpath etc. The heat load has recently been increased due to the new critical care unit build. The two existing air conditioning units repeatedly fail as they are approximately 20 years old. Should this risk occur there would be a failure of major clinical digital solutions impacting on patient care and experience, Trust activity including service disruption and potential for adverse media attention.	**Executive lead:** Director of ICT **Date added to CRR:** November 2023 **Last reviewed date:** July 2024 **Committee reviewed at:** Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could impact on all of the trust Major Clinical Digital Solutions failing to work and will be off line whilst the Disaster recovery room is initiated.

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Two additional small wall mounted units were installed approximately 5 years ago to run if one of the main units failed but these are now unable to cope with the extra heat demands placed upon them.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
Significant repairs have been undergone to overhaul the main aircon units to extend their operational lives and they are now operational.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
Two brand new temporary air conditioning units have been purchased. BFS are responsible for all mitigation controls as well as the air conditioning units.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
New report has been commissioned from SUDLOWS Data Centre specialists to understand the risks and requirements for reduced risk.	The existing Main Aircon units are over 20 years old, so this will remain a significant risk until the SudLows report and recommendations have been implemented.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
There is a secondary data centre for restoring services.	This will result in up to 24 hours of down time to bring it up.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.

Risk Update/Progress Notes
July 2024: Following review of the risk, no change has been made to the residual risk score. The Trust is still awaiting final commissioning of the new air conditioning equipment by the supplier. The expected completion date is the end of July 2024 to mitigate the risk fully.

Risk 2768: Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score								*Current/Initial Score*		

Risk Description:	
Risk of IT service downtime as a result of the Laboratory Information Management System (LIMS) software, CliniSys Enterprise, no longer being supported by the supplier from end of March 2023, resulting in a potential delay to the release of patient results and delays to patient treatment/management affecting 5000 tests per day. If we do not upgrade the system, then the service will not have a supported LIMS.	**Executive lead:** Director of ICT
	Date added to CRR: March 2024
	Last reviewed date: July 2024
	Committee reviewed at: Finance & Performance Committee

Consequence of risk occurring

The Trust has received notification from LIMS supplier, CliniSys, that the current version of Enterprise 7.21 is not supported from 30/03/2023, resulting in:
- Software bugs not being fixed.
- Lack of appropriate security patches to software.
- Software that is more vulnerable to cyber attack.
- Log4j vulnerability being exploited allowing remote code activation and information inappropriately disclosed or allowing remote code activation with the intent to incapacitate the system.

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
1 Business Continuity plans for IT downtime in place		None identified.
2 CliniSys are supporting the software until 30/03/2023	The BRILS will be ready for the 28 April 2024, however the Supplier Clinisys have reported the first available date is 18 May 2024, but will bring it forwards if there are any cancellations following 28 April 2024	Upgrade to go live in June 2024, User Acceptance Testing (UAT)
3 Software sits behind Trust firewalls, so considered less likely to be vulnerable to cybersecurity risks.		
4 Ongoing discussions with Trust IT and CliniSys to upgrade software to supported version including operating systems.		Upgrade to go live in June 2024, User Acceptance Testing (UAT)
5 Weekly meetings with the supplier to progress plan and any technical issues.		

Risk Update/Progress Notes

July 2024: Following review of the risk, no change has been made to the residual risk score. The update is expected to be on 8 July 2024 to fully mitigate this risk.

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care.	OPEN

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Money	Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	CAUTIOUS
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK

6. System & Partnership

To Note

6.1. System and Partnership Report

To Note

Presented by Bob Kirton

Chief Executive Report

Integrated Care Board Meeting

3 July 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive

Purpose of Paper

The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.

Key Issues / Points to Note

Key issues to note are contained within the attached report from the Chief Executive.

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required

The Board is asked to note the content of the report

Board Assurance Framework

This report provides assurance against the following corporate priorities on the Board Assurance Framework (*place ✓ beside all that apply*):

Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any potential Risk Implications? (including reputational, financial etc)?
No
Are there any Resource Implications (including Financial, Staffing etc)?
No
Are there any Procurement Implications?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/A
Have you involved patients, carers and the public in the preparation of the report?
N/A
Appendices
N/A

Chief Executive Report

Integrated Care Board Meeting

3 July 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for May and June 2024. Part of this period is covered by the Pre-election Period ahead of the elections on Thursday 4 July 2024, and the content of the paper reflects that.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board.

The May 2024 Integrated Care Partnership meeting received an update on the Children and Young People Alliance's Health Equity Framework. Ruth Brown, Chief Executive of Sheffield Children's Hospital and CEO of the Children and Young People's (CYP) Alliance, as well as Nicola Ennis CYP Alliance Programme Director, updated on the work being done in partnership with the UCL Institute of Health Equity, Barnardo's and two other partner ICSs (Birmingham and Solihull and Cheshire and Merseyside).

The Health Equity Framework has been developed by the Child Health Equity Collaborative and co-produced with children and young people from each of the three ICSs with the purpose of supporting action for greater equity in children and young people's health and wellbeing. This underpins the development of a pilot intervention. There is an ambition for the framework to also be used more widely with other ICSs and partners.

At the end of May 2024, the Children and Young People Alliance Conference was attended by 210 children, young people and professionals from across health, care and wider local government and voluntary organisations. Dame Rachel De Souza, the children's commissioner for England, opened the event on how she is listening to children and young people and taking that voice to Government. More than half of those that attended were young people.

2.2 Operational and Financial Plan 2024/25

The South Yorkshire Integrated Care System submitted its financial and operational plan to NHS England at the beginning of May. This was in response to the requirements set out in the NHS Planning Guidance published in March 2024. The NHS provider organisations and the ICB have worked closely together to develop an integrated response. The ICB has also sought to ensure wider partners where kept informed regarding progress.

The ICB and representatives from SY NHS provider organisations met with Amanda

Pritchard the CEO of NHS England and her team at the end of May to discuss the plan. The plan describes how the operational requirements set out in the planning guidance will be delivered and an intention to achieve a financial performance, equivalent to the 2023/24 outturn, with a deficit across provider organisations of £49m combined with a requirement for the ICB to achieve breakeven. The plan was accepted by NHSE and support for the financial position is expected to be forthcoming.

2.3 Industrial action

Junior doctors voted in favour of extending their mandate for industrial action for another six months and at the time of writing the next planned action was due to take place from 07:00 Thursday 27 June 2024 to 07:00 Tuesday 2 July 2024. As we have previously, the NHS in South Yorkshire is continuing to maintain its plans for urgent and emergency care, as well as some planned treatment and appointments where possible. The South Yorkshire ICB has continued to provide support through its Incident Co-ordination Centre, which has operated at all times during industrial action as part of our Category 1 Responder duty.

GPs in England are continuing to consider their next steps following the BMA's referendum, where the vast majority of Drs in primary care voted ‘no’ when asked if they accepted the new contract for their service. As independent providers it is unlikely that GPs will take direct strike action, however the BMA is currently balloting its primary care members on proposals to withdraw certain activities which are outside of their contractual responsibilities.

2.4 WorkWell

South Yorkshire has been awarded more than £3.5m to become one of 15 pilot areas across England to help long-term sick and disabled people into work. The region was selected by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC) as part of the Government’s Back to Work Plan.

WorkWell will build on the successes of South Yorkshire Mayoral Combined Authority’s programme, Working Win, that has supported over 6,500 people with a disability or physical and or mental health condition to either start, stay, or succeed in employment since 2018. Each pilot area will help to deliver the new work and health service. The service will offer a tailored early-intervention work and health support and assessment service, and a single, joined-up gateway to other support services.

One of the main focusses of the Integrated Care Partnership Board in South Yorkshire is the relationship between employment and improving population health. WorkWell will offer low-intensity support to people in work who are struggling due to a health condition or disability, to overcome health related barriers to employment.

The scheme will see partners such as NHS South Yorkshire, the South Yorkshire Mayoral Combined Authority, the four Local Authorities and Job Centre Plus working together to create an integrated work and health system with support services that meet the needs of the area’s communities and employers.

2.5 Primary Care Pilot

South Yorkshire has been chosen as one of seven ICBs to test new ways of working within general practice and to understand how General Practice can be supported further. The aim is to identify operational changes and improvements needed to optimise the general practice operating model, and support GPs and wider practice teams to meet increasing demand and complexity across urgent and proactive care. The programme builds on the national Fuller Stocktake and General Practice Access recovery vision.

General practice is the bedrock of the NHS, and its success is critical to patients and the sustainability of the system. It is widely acknowledged however, that Practices face significant challenges in meeting the unprecedented levels of demand. NHS South Yorkshire is currently working with colleagues across General practice to identify two primary care networks (PCNs) to take part. The data and evidence from the programme should bring benefits for GPs, the wider workforce, and patients, and will help inform future decisions about General Practice resourcing and contracting.

2.6 Montagu Hospital

Work continues with the expansion of services at Montagu Hospital in Mexborough. The Elective Orthopaedic Centre is now operational and patients from across South Yorkshire are being seen and treated there, with plans to expand capacity over the course of the year. This is expected to reduce waiting times for planned surgery.

The Community Diagnostic Centre (CDC) being built on site is also progressing with most of the main structure now in place. The new facility, which will include dedicated MRI and CT scanning rooms, two ultrasound suites, changing rooms for patient use, and a waiting area, is the final phase of the CDC's expansion, which began in 2022. The new imaging suite within the CDC aims to perform 68,000 procedures annually, effectively doubling the diagnostic provision for local residents and offering increased access to appointments in a convenient location. This is expected to be completed in early 2025.

2.7 National infected blood inquiry

The final report by Sir Brian Langstaff KC into the Infected Blood Inquiry was published on Monday 20 May 2024. The independent public statutory inquiry was established to examine the circumstances in which patients were given infected blood and infected blood products between the 1970s to early 1990s. The Inquiry has examined why people were given infected blood and/or infected blood products, the impact on their families, how the authorities (including Government) responded and the nature of any support provided following infection.

The Prime Minister subsequently issued an apology on behalf of successive Governments and the British State, and this was followed by an apology from Amanda Pritchard, Chief Executive of NHS England. Communities in South Yorkshire were impacted by infected blood products and our NHS providers have shared information with those affected.

Blood is now distributed to NHS hospitals by NHS Blood and Transplant (NHSBT), which was established in 2005 to provide a national blood and transplantation service to the NHS. Their services follow strict guidelines and testing to protect both donors and patients and are subject to regular inspections by independent regulators.

2.8 Cyber Security in South Yorkshire

Following recent cyber security issues affecting the NHS nationally we are constantly reviewing our security. NHS South Yorkshire supports the system wide South Yorkshire Cyber Forum where partners are working collectively to build a Cyber Strategy to improve security across all organisations. The Forum is working towards the identification and mitigation of security vulnerabilities using best practice, developing system-wide cyber policies and incident response protocols. The forum is also adopting available risk monitoring tools. This work is being completed in line with the Cyber Assessment Framework and working towards the NHS Cyber Security Strategy for health and adult care to 2030, which is a joint strategy between NHS England and Department of Health and Social Care.

3. NHS South Yorkshire

3.1 Change of Estate

NHS South Yorkshire has now fully implemented its change of estate to co-locate with partner organisations across South Yorkshire where possible. The move into South Yorkshire Fire and Rescue Headquarters in Sheffield took place in spring and we have now co-located our offices in Barnsley to Westgate with Barnsley Metropolitan Borough Council, and in Rotherham to Riverside House with Rotherham Metropolitan Borough Council. All three moves will reduce costs and improve partnership working with organisations involved in health, care and incidents that require multi-agency response.

3.2 Covid-19 spring vaccinations.

The booking process for people in South Yorkshire aged 75 or over, and children and adults with a weakened immune system to have their spring Covid-19 vaccine has now been completed. The vaccinations started in late April 2024 and bookings were open until 30 June 2024. Nearly 100,000 people had had their booster at the time of writing. We will continue vaccinating those who have booked an appointment and will start work on planning ahead of any potential autumn vaccination programme.

3.3 Anti-Racism and Race Equality

Sadly, racism remains a feature of our society and public institutions, including the NHS. In NHS South Yorkshire we are committed to prioritising active anti-racism both in terms of how we deliver our services but also as an employer. Our priorities are better understanding the experience of people from minoritized communities, being a stronger ally, and ensuring our own leadership is more inclusive.

3.3.1 North West Race Equality Framework

NHS South Yorkshire has committed to adopting the North West Race Equality Framework, which sets out a systematic approach to becoming an anti-racist NHS organisation, with clear deliverables and external scrutiny of progress. Pearse Butler, our Chair, facilitates the anti-racism group with EDI leads from our provider organisations, all of whom are committed likewise to adopt the framework.

The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. The Framework has five anti-racist principles of prioritising anti-racism, understanding lived experience, growing inclusive leaders, acting to tackle inequalities and reviewing progress regularly. Organisations then measures themselves against a bronze, silver and gold status to track their progress.

3.3.2 South Yorkshire Race Equality Network for Primary Care Staff

NHS South Yorkshire is working with local clinicians and partner organisations to establish a South Yorkshire Race Equality Network for Primary Care staff. The Network is open to all staff working across Primary Care including General Practice, Optometry, Pharmacy and Dentistry. The group will also welcome attendance from allies wanting to improve their understanding of the issues and challenges.

The South Yorkshire Primary Care Race Equality Network can help us do this. The Network will support front-line professionals, promote a culture of wellbeing, and provide a voice to help shape how we work in the future.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

A cancer pre-habilitation and rehabilitation service that helps people prepare for and recover from cancer treatment has now reached 1,000 referrals. The pioneering Active Together service, which is funded by Yorkshire Cancer Research and operated in collaboration with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Hallam University, began accepting referrals in early February 2022 and has since expanded to support to a range of tumour groups including gynaecological, lung and colorectal cancers. There are plans to expand to some breast and prostate patients and offer support at sites in Rotherham, Barnsley, and Doncaster over the coming year.

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals have announced the implementation of advanced computed tomography (CT) perfusion software within their services with an ambition improve stroke care. The technology will enable specialists at the Trust to extend the thrombolysis treatment window from its present standard of four and a half hours to nine hours, and the thrombectomy treatment window from six hours to 24 hours, following a partnership agreement with the Neuro Intervention team at Sheffield Teaching Hospitals.

A new Doncaster Dance on Programme is aiming to raise activity levels and reduce isolation in older adults across the city. The programme, which is being delivered by artists from the local charity Darts, who are one of the largest participatory arts organisations in the UK, has completed a 12-week pilot which has seen many people embed strength and balance into their weekly routine as well as them making a positive lifestyle change and increasing social activity. The pilot has proven to increase strength and balance as well as supporting fall prevention and fall reduction.

4.3 Rotherham

The Rotherham NHS Foundation trust has installed a robotic assistant into the Trust's orthopaedic theatre to improve outcomes for patients. The robot will ensure improved accuracy and reliability of bone resections and soft tissue balancing, leading to enhanced surgical outcomes. The technology reduced the need for CT scans meaning clinical staff can reduce patient exposure to radiation. This not only prioritises patient safety but also streamlines the treatment process.

4.4 Barnsley

NHS South Yorkshire is working with a housing provider to improve the living conditions and health of children with asthma. Asthma is the most common long-term medical condition in children in the UK, with around 1 in 11 children and young people living with asthma. South Yorkshire Children and Young People's Alliance are working in partnership with Berneslai Homes, who manage properties for Barnsley Council, to ensure children and young people with asthma who live in a Berneslai Homes property, have the best possible health outcomes. Respiratory nurses at Barnsley Hospital are working closely with the housing provider to ensure the homes of asthma patients are appropriate for their condition.

5. General Updates

5.1 NHS Confed Expo

NHS South Yorkshire made an important contribution to the NHS Confed Expo in June. Dr Jason Page, Rotherham Place Medical Director, and Hannah Young, Communications and Engagement Officer, presenting their work on targeted lung cancer case finding at the Health Inequalities Improvement Theatre. They were joined by David Fitzgerald of the NHS Cancer Programme. Jason and Hannah talked through the approach by the Cancer Alliance that we'd taken in South Yorkshire and the fact that, through targeting individuals and groups and a comprehensive campaign, more than 120,000 people had been seen. This detected undiagnosed lung cancer in 340 people, but also a further 100 patients who had other cancers present.

Gavin Boyle, NHS SY CEO, led a discussion on the use of digital technology in healthcare along with Prof. Tim Chico, a research active Cardiologist in Sheffield and Director of the SY Digital Health Hub, Dr Susan Thomas, the UK Director of Google Health and Dr David Crichton our Chief Medical Officer. The Digital Health Hub is a new partnership led by our two SY Universities – Sheffield Hallam and University of

Sheffield – along with the NHS, Google, the Mayor, local authorities, and other partners.

It is funded through a £4.5m grant from Engineering and Physical Sciences Research Council. Its aim is to use digital technology to address some of our big challenges here in SY but particularly improving population health and tackling health inequality. The partnership is six months into a three-year programme. One area of exploration is how commonly available wearable tech can be used to provide data which could be interpreted alongside clinical information to help people to manage their health or a particular condition better. In partnership with Google and the South Yorkshire Digital Health Hub we've given out 500 Fitbits for a research study on post-surgical rehabilitation.

5.2 Honours

The Chair of Sheffield Children's NHS Foundation Trust, Professor Laura Serrant OBE and Non-Executive Director, Peter Mucklow, have both received a Commander of the Order of the British Empire (CBE), in the King's birthday honours list. Prof Serrant has received her honour for services to nursing in the North East and Yorkshire, and Peter for services to education. Prof Serrant was appointed to the Chair of Board as Sheffield Children's NHS Foundation Trust Chair in January 2024.

5.3 Awards

South Yorkshire health organisations were recognised for their pioneering digital innovations at this year's HSJ Digital Awards. Sheffield Teaching Hospitals NHS Foundation Trust was highly commended in Improving Back-Office Efficiencies Through Digital with their Stroke Trial Tracker pilot. This is a revolutionary trial tracker developed by research nurses and scientists to rapidly assess if patients are suitable to join research studies. Also shortlisted from South Yorkshire were:

- Digital Innovator of the Year - Rotherham Foundation Trust's Transforming Diagnostic Booking system.
- Empowering Patients Through Digital - Rotherham Doncaster & South Humber NHS Foundation Trust's eClinic
- Generating Impact in Population Health Through Digital - Yorkshire Ambulance Service for their Integrated Urgent Care - Place Based Population Health Management Analytics Tool (Demand and Performance)

Barnsley Council were successful at the Local Government Chronicle Awards. They won the Public Health Award for the 'How's thi ticker?' community blood pressure campaign. The Council also won the Economic Development Award for their Supported employment service.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 3 July 2024

6.2. Barnsley Place Partnership: verbal

To Note

Presented by Bob Kirton

7. For Information

7.1. Chair Report

For Information

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/7.1

SUBJECT:	**CHAIR'S REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Sheena McDonnell, Chair				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

To report events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight several items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

1.1 Long Service Awards Meet & Greet

As Long Service Awards are posted to colleagues, a celebration event is scheduled twice yearly to celebrate long service achievement will colleagues. I attended my first meet and greet on Monday 17 June 2024 where 28 staff were invited to celebrate.

1.2 Brilliant Awards

Since we last met we have delivered several brilliant awards to colleagues and teams as always, they include those people who have been nominated by their peers, their leaders or by members of the public who have contacted the trust to nominate colleagues. We always have lots of nominations to choose from and it's an extremely difficult job to select winners from all the amazing nominations we receive each month.

In the last few months we had Kerry Nippers, Healthcare Assistant in the Emergency Department. Kerry was commented to be a ray of sunshine who cheers up the department. Following the tragic death of a colleague she updated colleagues on funeral arrangements and organised a collection for flowers. Hannah Field, newly qualified Neonatal Nurse was presented an award for supporting her team and implemented a medication of the month, where a medication is named and Hannah puts together a list of questions for colleagues to look up and improve their knowledge.

The plaster room specifically Ramsey and Paul, for helping a child with bilateral talipes treatment and the work and care they provide for each patient. The respiratory department where the nomination stated that nothing was too much for the team, although they were extremely busy and provided explanations and showed love and care.


Patient Feedback Point


Majors 2 Staff Base
hand hygiene station
HAND SANITISING BOARD


Sometimes
the smallest things

1.3 Project Search

As a hospital we support an initiative called project search which provides opportunities for our local young people who may have a learning disability or autistic people to access employment through an internship. I was fortunate enough to attend the graduation of those young people, some of whom had already secured roles and all of whom had benefited from the experience. As a hospital we gain enormously from our interns through project search who bring a different dimension to our teams which has definitely enhanced our working environment.

1.4 Heart Awards

One of the best events of the year for me is going along to the annual Heart awards and hearing about all of the brilliant work that is taking place across the `Trust and with our partners out in the community. I also got the chance to present a special Chairs award which went to a group of colleagues that were focussed on delivering a simple collaborative solution that involved different teams working together to address patient needs, having a mind to the planet and our sustainability and also which was cost effective.

1.5 Internationally Educated Nurses

We have had several nurses join us from Kerala to help us with some of our qualified nurse shortages. I was fortunate enough to join them in a night of celebrations following their completion of conversion courses that are required to maintain their professional registration in the UK. It was a brilliant evening, and I was truly inspired by the efforts and sacrifices many of our nurses educated internationally have made, often leaving their families and children behind, to come and join us here in Barnsley.

Best for Performance 

2.1 Performance

Our focus on recovery continues and our performance particularly in relation to the 4 hour target in the emergency department has been fluctuating over the last month due to continued and sustained levels of demand. We continue to focus on improvements in performance overall and the reduction of our waiting lists, although this is never a standstill position as while we are reducing our wait times, new people are also joining the waiting lists. We were hopeful that the next year may not be hampered by industrial action in quite the same way as this year, although as we stand disruption is likely with the announcement of potential disruption to GP services which may impact on presentations at the emergency department.

2.2 Financially Challenged

The whole of the NHS system is under pressure financially and we are no exception and while we have improved our likely outturn financial position for 23/24 as a South Yorkshire system, we are still under pressure to reduce the deficit we are facing overall. This challenge will continue into the following financial year and we are working hard both internally and with our partners at place and across the system to reduce that deficit further through improved efficiency without an impact on quality as we work towards a balanced position over the coming years. This is not a quick fix but we are focussed on improving effectiveness and efficiency and are developing our plans in relation to this currently.

Best for Patients and the Public 

3.2 Board Development

Board Development Workshop 3 took place on Monday 17 June 2024 at the IBIS Hotel in Dodworth, Board members including Director and Non-Executive Directors were invited to complete the final workshop.

3.3 Governors Lightbox Surgery

The Governors completed a surgery at Lightbox@TheLibrary on Thursday 13 June 2024. They were present to meet and greet members of the public and understand their thoughts on the hospital and to encourage them to become members of the hospital. They were joined by members of the complaints team in case there were any issues that members of the public wanted to raise.

Best for Place

4.1 Place Board

This group continues to meet with partners from across health and care systems including primary care, the Voluntary and Community sectors, and the Local Authority. The meetings are held in public, and questions are invited from members of the public. The most recent meeting considered the strategic approach to involvement and inclusion, as well as the links with the health and wellbeing Board.

4.2 Rotherham Strategic Partnership programme

The strategic partnership we have with Rotherham is working well and is a key part of our strategic goals at both trusts. We have a joint work programme for delivery which includes joint strategic leaders' events exploring opportunities for collaboration and learning as well as a review of clinical service areas. A Board to Board session to review the partnership progress to date and plans for the future was held on the 26th July.

5.1 Integrated Care Partnership (ICP)

The integrated care partnership held its last meeting in July. This is a meeting of partners across South Yorkshire that represent the places in South Yorkshire and the voluntary and community sectors with a focus on health and care across South Yorkshire. The last meeting received an update following the launch of the report from the 'Pathways to Work Commission' from Barnsley. This has been a yearlong commission led by Rt Hon Alan Milburn focussing on how we can support people not in work of working age into good employment. The report outlines a number of calls to action for employers and anchor institutions and is something we are very keen to support here at Barnsley Hospital.

5.2 Acute Federation

We continue to meet as acute providers from South Yorkshire and have a clear delivery plan in place with several areas of focus for us collectively including a clinical strategy. We have held a further for Governors across the system in June. There we considered an update on the work across the ICB including maternity services, services for children and young people and

5.3 Rotherham Strategic Partnership programme

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Sheena McDonnell
Trust Chair
August 2024

7.2. Chief Executive Report: verbal

For Information

Presented by Sheena McDonnell

7.3. NHS Horizon Report

For Information

Presented by Emma Parkes

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 24/08/01/7.3

SUBJECT:	**NHS HORIZON REPORT**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Emma Parkes, Director of Communications & Marketing				
SPONSORED BY:	Dr Richard Jenkins, Chief Executive				
PRESENTED BY:	Emma Parkes, Director of Communications & Marketing				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings for Barnsley Hospital
- New Labour Government
- GP Industrial Action

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	INTELLIGENCE REPORT	Ref:	BoD: 24/08/01/7.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

NHS Feedback for Barnsley Hospital

Emergency Department

Great hospital and staff - ★★★★★

Would just like to say thank you to all the staff who helped me yesterday. The nurses and doctors were great and just wanted to say thank you for making me feel a lot better and helping me, thank you.
Visited Accident and emergency services on July 2024

Midwives - Delivery suite ★★★★★

The delivery midwives who helped bring my son into the world were outstanding.
After spending over 40 hours in labour both sets of midwife's were so patient and friendly, putting my mind at ease every step of the way. A difficult delivery was made extremely comfortable due to their kind nature & assurances. Thank you so much!!
Visited Maternity services on June 2024

Wow couldn't have had better care ★★★★★

Mum aged 92 fell out of bed and had many injuries. Every member of staff on Accident and Emergency were superb, she was treated with great care, dignity and she felt safe.

She was transferred to ward 33 (orthopaedic trauma) and had a hip operation the day after. Sadly she got post-operative pneumonia which we had been told may be the case and 48 hours later was placed on end-of-life care. We were offered 2 'put up beds' to be with her in a side room and spent four days and nights there.

Every single member of staff without exception was kind, caring and professional, not only with Mum but with the rest of the family. We were fed and watered throughout our stay. It made a traumatic experience less so and at the end staff made sure Mum was pain-free, warm and safe. Well done all, you are under so much pressure and are run off your feet but you do an amazing job. You are all fab.

Visited Major Trauma on May 2024

Very poor service ★

I was referred to dermatology under a 2ww referral for a lesion on my face. Upon seeing someone in dermatology I was told it looked like bcc but could be scc. This lady went off to get a second opinion but could not as they were in surgery. I was told it would be quicker to just be put on the list for surgery within 4 weeks and a letter confirmed 4 weeks. All was well until I chased up for an appointment date today. I have now been told that I am under a bcc list, regardless of the doubt on diagnosis and will have to wait a minimum of 4 months for removal. This lesion is growing rapidly and is now affecting nerve sensation on my face, including below my eye.

I'm quite disgusted at being left like this with very poor communication. Being told in person and by letter that surgery was 4 weeks, to then be told it will be at least 4 months is not acceptable practice.
Visited Dermatology on June 2024 – Anonymous

SUBJECT
New Labour Government The Labour Party won the 2024 UK parliamentary general election, which was held on Thursday 4 July 2024. The election followed the dissolution of Parliament on 30 May. Wes Streeting, Secretary of State for Health and Social Care, delivered a comment on the NHS here: The NHS is broken: Health and Social Care Secretary statement - GOV.UK (www.gov.uk)
BMA ballot for collective action for GPs in England The British Medical Association's GP Committee is holding a non-statutory ballot of GP partner members on taking collective action over the 2024-25 GP contract terms. The vote ends Monday, 29 July, and NHSE said the BMA have indicated that they will encourage participating practices to take part at scale from 1 August. If the GPC decides to go ahead, based on the ballot, it's expected to encourage practices to take action from a range of nine options, which include capping daily appointments, instead diverting patients to urgent care; stop "rationing referrals, investigations and admissions"; stop using "e-referral advice & guidance"; and "serve notice on any voluntary services.

7.4. 2024/25 Work Plan

To Note

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/7.4

SUBJECT:	**2024/25 BOARD WORK PLAN**				
DATE:	1 August 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Lindsay Watson, Corporate Governance Manager				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

This report is presented to the Board of Directors to support the Trust Objectives and to ensure that the Board received the right reports at the designated time.

EXECUTIVE SUMMARY

The forward planner sets out the information to be presented to the Board for the current financial year. The forward is an evolving document and will be reviewed and updated on a regular basis and presented at each Board meeting.

RECOMMENDATIONS

The Board is requested note the Public Board Work Plan for the period April 2024 – March 2025 for information.

Board of Directors Public Work Plan: April 2024 - March 2025

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
Introduction									
Apologies & Welcome	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Declarations of Interest	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Approve	✓	✓	✓	✓	✓	✓
Action log	Sheena McDonnell Chair	Sheena McDonnell Chair	Review	✓	✓	✓	✓	✓	✓
Culture									
Patient/Staff Story	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Note	✓ (staff)	✓	✓ (patient)	✓	✓	✓
Freedom to Speak Up Reflection and Planning Tool ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓				
Freedom to Speak Up Update ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak Up Guardian	Assurance		✓				
Freedom to Speak Up Strategy 2022 - 2027 ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak up Guardian	Assurance						
NHS Staff Survey 2023	Steve Ned Director of People	Steve Ned Director of People	Assurance	✓					
Annual Guardian of Safe Working (early time session if possible)	Simon Enright Medical Director	Simon Enright Medical Director/ Jess Phillips Guardian of Safe Working	Assurance				✓		
Assurance									
Chairs log: Quality and Governance Committee (Q&G)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Gary Francis Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
Annual Safeguarding Report (on Q&G Work Plan for March 2024)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Gary Francis Chair of Q&G Non-Executive Director	Assurance	✓					
Analysis/debrief capturing the lessons learned from the recent industrial action ***(date to be confirmed)***	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval		✓ Q&G May 2024				
Annual End-of-Life Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs Sara Andrews Lead Cancer Nurse/ Katie Yockney End of Life Clinical Lead	Assurance					✓ (Q&G October 2024)	
Patient Experience Annual Report 2023/24	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval			✓ Q&G July 2024			
FireCode Statement	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance/ Approval				✓ Q&G August 2024		
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Alison Knowles Chair of F&P/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓ F&P May 2024				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
Chairs Log: People Committee	Steve Ned Director of People	Kevin Clifford Chair of People/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Equality Delivery System (EDS) Report	Steve Ned Director of People	Steve Ned Director of People	Assurance /Approval	✓ People March 2024					
Culture and Occupational Development Strategy	Steve Ned Director of People	Steve Ned Director of People	Information/ Note					✓ People November 2024	
Independent Review Of Greater Manchester Mental Health NHS Foundation Trust – The Shanley Report *(People Committee 26/05/2024)*	Steve Ned Director of People	Steve Ned Director of People	Information			✓			
Premises Assurance Model (PAM)	Bob Kirton Managing Director/ Rob McCubbin Managing Director BFS	Bob Kirton Managing Director/ Rob McCubbin Managing Director BFS	Assurance				✓ Finance August 2024		
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Stephen Radford Chair of Audit/ Non-Executive Director	Assurance		✓	✓		✓	✓
Chairs Log: Barnsley Facilities Services (BFS)	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Performance									
Integrated Performance Report (IPR)	Bob Kirton Managing Director	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
2024/25 Trust Objectives - Building on Emerging Opportunities	Bob Kirton Managing Director	Bob Kirton Managing Director	Review /Endorse	✓					
Trust Objectives 2023/24 End of Year Report	Bob Kirton Managing Director	Bob Kirton Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance		✓				
Trust Objectives 2024/25	Bob Kirton Managing Director	Bob Kirton Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance			✓ Q1		✓ Q2	✓ Q3
Winter Plans	Bob Kirton Managing Director/ Lorraine Burnett Director of Operations	Bob Kirton Managing Director/ Lorraine Burnett Director of Operations	Assurance				✓ F&P Sept 2024		
Mortality Report (6/12)	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Maternity Services Board Measures Minimum Data Set	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Midwifery Workforce Staffing Report: Six Monthly Update	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance		✓ Q&G April 2024			✓ Q&G Dec 24	
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ Approval				✓ People Sept 24		
Annual Workforce Disability Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ approval				✓ People Sept 24		

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
(On People Work Plan for September 2024)									
Annual Fit and Proper Person Test 2023/24	Sheena McDonnell Chair	Steve Ned Director of People Angela Wendzicha Director of Corporate Affairs	Assurance			✓			
Fit and Proper Person Policy (date to be confirmed)	Steve Ned Director of People	Steve Ned Director of People	Approval						
Annual Health and Safety Report	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance					✓ Q&G October 24	
Annual NHSE Emergency Core Preparation Standards	Bob Kirton Managing Director	Mike Lees Head of Resilience & Security	Assurance					✓ Q&G October 24	
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Jeremy Bannister Deputy Medical Director	Assurance				✓ People Sept 24		
Governance									
Constitution Review	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓				
Board Assurance Framework / Corporate Risk Register	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval	✓	✓	✓	✓	✓	✓
Board Code of Conduct	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval		✓				
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓			✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Assurance		✓ Deferred			✓	

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
Terms of Reference for: • Audit • Q&G • F&P • People Committee	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance		✓ (Audit)				✓ ✓ ✓
Risk Management Policy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓				
Risk Management Strategy (date to be confirmed)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve						
NED Champion role (annual)	Sheena McDonnell Chair	Sheena McDonnell Chair	Assurance		✓				
Annual Effectiveness Review	Sheena McDonnell Chair	Sheena McDonnell Chair Angela Wendzicha Director of Corporate Affairs	Assurance				✓		
Benefits Realisation Papers Schedule of Return									
PACS Solution – (Benefits Realisation Paper tbc)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
Electronic Prescribing & Medicines Administration (EPMA) (tbc)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
System Working									
Barnsley Place Partnership	Bob Kirton Managing Director	Bob Kirton Managing Director	Note	✓	✓	✓	✓	✓	✓
System Update (including Integrated Care Board Chief Executive Report)	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Joint Strategy Partnership Update (***date to be confirmed)***	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance						
Quarterly Place Update	Bob Kirton Managing Director	Bob Kirton Managing Director	Information	✓					

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	01.08.24	03.10.24	05.12.24	06.02.25
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
NHS Horizon Report	Emma Parkes Director of Communications & Marketing	Emma Parkes Director of Communications & Marketing	Assurance	✓	✓	✓	✓	✓	✓
Work Plan 2024 - 2025	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Simon Enright	Stephen Radford	Steve Ned	Gary Francis	Sarah Moppett	David Plotts

Strategic Objectives:

Best for Patients and the Public	We will provide the best possible care for our patients and service users. We will treat people with compassion, dignity and respect, listen and engage, focus on quality, invest, support and innovate.
Best for People	We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.
Best for Performance	We will meet our performance targets, and continuously strive to deliver sustainable services.
Best Partner	We will work with partners within South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
Best for Place	We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.
Best for Planet	We will build on our sustainability work to date and reduce our impact on the environment.

Audit Committee Chair: Nick Mapstone 1 April – 31 May 2024/Stephen Radford from 1 June 2024
Quality and Governance Committee: Kevin Clifford 1 April – 30 April 2024/Gary Francis from 1 May 2024
Finance and Performance Committee Chair: Stephen Radford 1 April – 31 May 2024/Alison Knowles from 1 June 2024
People Committee Chair: Sue Ellis 1 April – 31 May 2024/Kevin Clifford from 1 June 2024

8. Any Other Business

8.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

8.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of next meeting: Thursday 3 October 2023, 9.30 am