

Key Performance Indicators

Best Place to Work: Theme 1: Looking After our People

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend																																				
Staff survey – engagement levels	Strategic	7.03	2023	7.03	7.4 (best)	Staff engagement score remains stable/reduced slightly at 7.03 (-0.05);																																				
Staff survey - % would recommend the Trust as a place to work	Strategic	62.33%	2023	62.33%	63% (sector)	<table border="1"> <thead> <tr> <th></th> <th>2019</th> <th>2020</th> <th>2021</th> <th>2022</th> <th>2023</th> </tr> </thead> <tbody> <tr> <td>Your org</td> <td>58.11%</td> <td>66.35%</td> <td>63.17%</td> <td>64.03%</td> <td>62.33%</td> </tr> <tr> <td>Best result</td> <td>75.13%</td> <td>77.76%</td> <td>73.58%</td> <td>73.01%</td> <td>75.43%</td> </tr> <tr> <td>Average result</td> <td>61.79%</td> <td>67.83%</td> <td>63.17%</td> <td>62.74%</td> <td>65.59%</td> </tr> <tr> <td>Worst result</td> <td>42.82%</td> <td>49.09%</td> <td>43.43%</td> <td>39.56%</td> <td>39.46%</td> </tr> <tr> <td>Responses</td> <td>1297</td> <td>1269</td> <td>1412</td> <td>1329</td> <td>1671</td> </tr> </tbody> </table>		2019	2020	2021	2022	2023	Your org	58.11%	66.35%	63.17%	64.03%	62.33%	Best result	75.13%	77.76%	73.58%	73.01%	75.43%	Average result	61.79%	67.83%	63.17%	62.74%	65.59%	Worst result	42.82%	49.09%	43.43%	39.56%	39.46%	Responses	1297	1269	1412	1329	1671
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Responses	1297	1269	1412	1329	1671																																					
Labour turnover	Strategic	13.68%	Sep 24	12.88%	10%																																					
Number of leavers in 1st 12 months of employment	Supporting	93 (19.3%)	Sep 24	82 / 447 (18.3%)	N/a	The top 3 reasons for leaving (excluding resignation – other/not known) are retirement, VR – Relocation and VR – promotion. 9.62% left due to the end of a FTC, 17.65% through retirement and 4.03% through dismissal.																																				
Sickness absence related to stress / anxiety	Strategic	2.6% of the 6.6% (39.04% of all absence)	Sep 24	2.7% of the 6.95% (38.43% of all absence)	N/a																																					
Sickness absence (Overall)	Supporting	6.6%	Sep 24	6.95% 28	4.0%																																					

Key Performance Indicators

Best Place to Work: Theme 2: Belonging in our organisation

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
WRES data (number areas improved out of 8)	Strategic	5/8 improved	2023/24	5/8 improved	8/8	The WRES/WDES figures are reported Nationally on an annual basis. The figures are closely monitored alongside the Trust's EDI programme.
WDES data (number areas improved out of 12)	Strategic	8/12 improved	2023/24	8/12 improved	12/12	
Gender pay gap (number areas improved out of 2)	Strategic	1/2 improved	2023/24	1/2 improved	2/2	The average (Mean) GPG in favour of males reduced from 2023. The median GPG increased however the increase was in favour of females.
Number of grievances involving discrimination & Proportion disciplinaries involving BAME staff	Strategic	1 Grievance 12 Disciplinaries (15.38% of all ER Casework)	Sep 24	1 Grievances 21 Disciplinaries (31.88% of all ER Casework)	N/a	
Annual Appraisal Rates	Strategic	69.08%	Sep 24	70.9%	80%	

Key Performance Indicators

Best Place to Work: Theme 3: New Ways of Working and Delivering Care

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
Bank and Agency Fill rates	Strategic	91.4% 6.63% Agency 84.81% Bank 8.56% Unfilled	Sep 24	88.37% 6.47% Agency 81.90% Bank 11.63% Unfilled	100%	A reduction in bank and an increase in agency and unfilled duties. Top 3 reasons for bookings are Increased Observations, Vacancy and High Patient Acuity
Bank & Agency Usage (WTE)	Strategic	30.01 Agency 313.70 Bank Ratio: 8.73% Agency 91.27% Bank	Sep 24	32.34 Agency 313.99 Bank Ratio: 9.34% Agency 90.66% Bank	N/a	A reduction in bank and an increase in agency and unfilled duties. Top 3 reasons for bookings are Increased Observations, Vacancy and High Patient Acuity
Vacancy rates	Strategic	7.4%	Sep 24	10.7%	10%	Reduction

Best Place to Work: Theme 4: Growing for the future

Number of apprenticeships	Strategic	116	Sep 24	117	63	Reduction
Number 'new' roles recruited to (inc NAs and ANPs)	Strategic	1	Sep 24	2	N/a	Increase

Strategic Priorities – Assurance Level

Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

<p>Theme 1: Access & Flow – we will</p> <ul style="list-style-type: none"> • Implement ‘right care, right place, right time’ service delivery models to improve choice, access, reduce waiting times and enhance continuity in care, including working with our partners and those in our services, to identify where digitally enabled services will improve accessibility and experience. • Enhance collaboration between mental, physical community health services, and social care and system partners for all services to ‘make every contact count’ and to bring new and innovative ways of working to our communities. • Work collaboratively with partners in a locality-based model to reduce health inequalities by using data and evidence-based practices to maximise the impact and outcomes 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We will have a coherent set of metrics to track performance and safety, highlight inequalities experienced by protected equality groups, identify improvements and consistently benchmark with others. • We can demonstrate equitable access to all of our services. • Use high quality information and analysis to drive predictive health interventions, clinical decision making and service planning to reduce health inequalities. • Service users have the choice to access our services using safe and secure digital tools where appropriate, to stay as healthy as possible. 	<p>Confirmed Current Assurance Level (QSC – quality perspective):</p> <p>2. Limited</p> <hr/> <p>Confirmed Current Assurance Level (Finance and & Performance perspective):</p> <p>1. Low</p>
<p>Theme 2: Learning for improvement – we will</p> <ul style="list-style-type: none"> • Share best practice and learning across integrated multi-disciplinary teams, to improve clinical effectiveness and social impact for service users, carers and families. • Continue to embed the Care Trust Way training and support in service delivery to support continuous quality improvement, adopt innovation and reduce waste. 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We consistently adopt a continuous improvement approach, share learning and creating opportunities for our people to develop their improvement and innovation skills. • We have a vibrant portfolio of research that guides clinical and service decisions 	<p>Confirmed Current Assurance Level:</p> <p>3. Significant</p>

Strategic Priorities – Assurance Level

Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

Theme 3: Improving the experience of people who use our services – we will

- Embrace and apply the principles of trauma informed care in the way we offer services to people and their families consistently, underpinned by training and development for staff.
- Ensure the voices of people in our services help shape our continuous improvement journey.
- Enable better decision-making and choice on care provision and clinical practice through more active involvement of our service users, in particular those disproportionately represented in our services whose voices we don't hear

We will know we have been successful when:

- People who use our services are telling us that they have had a positive experience, including those who are waiting for treatment.
- We have embedded service user involvement throughout the organisation, including developing patient leadership roles.
- We have a coordinated approach to supporting children, young people, carers and their families that improves outcomes and experience.
- We have reduced the reliance on temporary staffing across services.
- We have implemented the Patient and Carer Race Equality Framework requirements.

Confirmed Current Assurance Level (QSC):

2. Limited

Confirmed Current Assurance Level (MHLC – restrictive practices):

2. Limited

Key Performance Indicators

Best Quality Services: Theme 1: Access & Flow

Metric`	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
Reportable Out of Area - Inappropriate (Monthly)	Strategic	Sep 24	363				577	
Number of people with inpatient length of stay <=3 days	Strategic	Sep 24	3	TBC			3	
Number of people with inpatient length of stay > 60 days	Strategic	Sep 24	17	0			14	
Consultant led waiting times (incomplete) referral to treatment	Strategic	Sep 24	63.7%	92%			61.8%	

Key Performance Indicators

Best Quality Services: Theme 2: Learning for Improvement

Metric	Type	Reporting month	Performance	Target	Summary																										
% of staff trained as a CTW Champion	Strategic	Sep 24	43.4%	50%																											
% of staff trained as a CTW Leader	Strategic	Sep 24	22.5%	20%																											
% of staff trained as a CTW Practitioner	Strategic	Sep 24	34.6%	3%																											
% of staff trained as a CTW Sensei	Strategic	Sep 24	76.1%	0.5%																											
No of participants in research studies (YTD)	Strategic	Sep 24	42	380	<table border="1"> <caption>Total Number of Recruits per Month</caption> <thead> <tr> <th>Month</th> <th>Recruits</th> </tr> </thead> <tbody> <tr><td>Oct-23</td><td>2</td></tr> <tr><td>Nov-23</td><td>10</td></tr> <tr><td>Dec-23</td><td>23</td></tr> <tr><td>Jan-24</td><td>27</td></tr> <tr><td>Feb-24</td><td>23</td></tr> <tr><td>Mar-24</td><td>6</td></tr> <tr><td>Apr-24</td><td>88</td></tr> <tr><td>May-24</td><td>10</td></tr> <tr><td>Jun-24</td><td>43</td></tr> <tr><td>Jul-24</td><td>42</td></tr> <tr><td>Aug-24</td><td>13</td></tr> <tr><td>Sep-24</td><td>10</td></tr> </tbody> </table>	Month	Recruits	Oct-23	2	Nov-23	10	Dec-23	23	Jan-24	27	Feb-24	23	Mar-24	6	Apr-24	88	May-24	10	Jun-24	43	Jul-24	42	Aug-24	13	Sep-24	10
Month	Recruits																														
Oct-23	2																														
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Key Performance Indicators

Best Quality Services: Theme 3: Improving the experience of people who use our services

Metric	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
No of patient safety incidents relating to people whilst waiting for services*	Strategic	Sep 24	28	0	N/A	N/A	N/A	
No of complaints relating to people whilst waiting for services**	Strategic	Sep 24	13	0	N/A	N/A	N/A	
FFT / local patient survey – patient experience score	Strategic	Sep 24	93.2	90%	N/A	N/A	N/A	
No of patient safety incidents resulting in moderate or major harm	Strategic	Sep 24	59	0	N/A	N/A	N/A	

Delegated Strategic Priorities – Assurance Levels

Making Best Use of Resources: We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do

<p>Theme 1: Financial Sustainability – we will</p> <ul style="list-style-type: none"> • Ensure that all operational services and corporate functions optimise the use of resources, deliver best value and reduce waste within agreed budgets and with regard to environmental and social impacts 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We are consistently delivering a financially balanced position at Trust and care group level. • We can demonstrate the return on investment and value for money of investments in our physical and digital infrastructure 	<p>PROPOSED Current Assurance Level:</p> <p>1. Low</p>
<p>Theme 2: Our environment and workspaces – we will</p> <ul style="list-style-type: none"> • Ensure that our people have opportunities to shape, test and implement digital solutions to stimulate innovation and creativity in service delivery. • Co-design a revised green plan to embed sustainable healthcare models and to continually drive environmental improvements and innovation. • Co-design spaces that meet the needs of our people and service users, are energy efficient and decarbonising and, where possible, use existing facilities in our neighbourhoods to reduce duplication and deliver care closer to home. • Provide a robust, resilient and secure digital infrastructure that enables our people to do their job from anywhere, anytime 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • Services are co-located in shared health and care delivery spaces across Bradford and Craven, reducing our overall footprint. • Sustainability and efficiency are embedded into all refurbishment and new build projects, using sustainability principles, completing sustainability impact assessments and taking account of NHS England’s targets and guidance. • We will have achieved the targets set out in our Trust’s green plan by focusing on reducing waste, increasing recycling and reducing our carbon emissions. • We have assessed our organisation as being digitally mature, including meeting/ exceeding all 10 standards within the data security protection toolkit 	<p>PROPOSED Current Assurance Level:</p> <p>1. Low</p>
<p>Theme 3: Giving back to our communities – we will</p> <ul style="list-style-type: none"> • Contribute to the social, economic and cultural development of our place through social value led approaches, programmes and procurement 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We can demonstrate that social value is built into all material investment and procurements. • We have delivered the ambitions in our joint climate change adaptation plan, shared with Bradford Teaching Hospitals NHS Trust and Airedale NHS Foundation Trust. 	<p>PROPOSED Current Assurance Level:</p> <p>2. Limited</p>

Strategic Priorities – Assurance Summary



Good governance: Good governance, accountability and effective oversight

<p>We will Have in place good governance arrangements that ensure we make the best decisions</p>	<p>We will know we have been successful when: We have well embedded governance processes that are clear and effective</p>	<p>CONFIRMED Current assurance level: 3. Significant</p>
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Board of Directors – Meeting held in public

21 November 2024

Paper title:	Committee Alert, Advise, Assure + Decision (AAA+D) – strategic risk summary	Agenda Item 10.1
Presented by:	Fran Stead, Trust Secretary	
Prepared by:	Fran Stead, Trust Secretary	
Committees where content has been discussed previously	Mental Health Legislation Committee; Quality & Safety Committee; Finance & Performance Committee, Audit Committee, People & Culture Committee	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report

The purpose of this paper is to highlight the strategic risks identified by each committee to the Board. The detail supporting these risks can be found in each Committee's AAA+D report and associated minutes of each meeting.

Executive Summary

In September and October 2023, the Board moved to new arrangements whereby each Committee is asked to explicitly consider the strategic risks identified as a result of considering all of the information and evidence shared with them. They are then asked to identify how assured they are that appropriate mitigations are in place.

These risks are identified within the AAA+D of each Committee, with the supporting narrative within the AAA+D providing the supporting detail. In order to ensure clarity for Board, these strategic risks are summarised in this over-arching cover paper to the AAA+D reports. This paper should be read in conjunction with the AAA+D of each Committee.

In support of continuous improvement, work is taking place to consider a reporting template which integrates:

- strategy deployment
- strategic risk
- strategic performance
- strategic assurance.

An important factor within this is showing integration & dependency across these areas, & providing a Board Assurance Framework, which is responsive & allows movement.

Linked to this, consideration is also being made to the Audit Committees role in reviewing the establishment & maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust, that supports the achievement of the Trust's strategic objectives. As part of the Audit Committees integrated approach, it will have effective relationships with other key Committees so that it understands processes and linkages.

Work will also take place to ensure we have embedded dynamic reporting arrangements, from Committee, to Audit, to Board, in support of assurance & escalation reporting up, but also seeking further assurances/actions/mitigations back down. Part of this is to review the schedule of meetings to ensure that information is flowing adequately, & reviewing the work plans, & reporting templates as part of the development work. Complementing this work is a review of the strategic measures, which were agreed as part of the Better, Lives Together refresh July 2023.

Included within this report is the Board risk appetite & tolerance. The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take in order to achieve the Trust's strategic aims.

It is good practice to review the Risk Appetite Statement on an annual basis and/or following any significant changes or events.

Board of Directors – Meeting held in public

Committee AAA+D – strategic risk summary

1 Purpose

The purpose of this paper is to highlight the strategic risks identified by each committee to the Board. The detail supporting these risks can be found in each Committee’s AAA+D report and associated minutes of each meeting.

2 Delivering Better Lives Together (BLT)

BLT comprises of four strategic priorities, each of which have strategic measures & supporting measures associated with it. Each priority is broken down into a number of themes, which have been assigned to the relevant Board Committee(s) for monitoring. Underpinning the BLT strategy is a supporting principle of ‘good governance, effective oversight & accountability’, which has been assigned to the Audit Committee for monitoring.

Best Place to Work	Theme 1 – Looking after our people
	Theme 2 – Belonging in our organisation
	Theme 3 – New ways of working and delivering care
	Theme 4 – Growing for the future
Best Use of Resources	Theme 1: Financial sustainability
	Theme 2: Our environment and workspaces
	Theme 3: Giving back to our communities
Best Quality Services	Theme 1 – Access and Flow
	Theme 2 – Learning for improvement
	Theme 3 – Improving the experience of people using our services
Good Governance	Governance, accountability and effective oversight

Our core: Everything we do over the next 3-years will be focused upon making better lives together.

Our purpose: Supporting people to feel as healthy as they can be at every point in their lives& connecting people to the best quality care when & where they need it to make every contact count.

Our vision: To connect people to the best quality care when & where they need it, & be a national role model as an employer

3 Strategic risks and assurance of mitigation

December 2023, the Board received a report on the implementation of the refreshed strategic risk & assurance framework. This included confirmation that whilst the risks being identified by Committee's were different, it was possible to distil the risks to a top 3 overarching risks. They are:

1. There is a risk that the **inability to recruit and retain an appropriately skilled substantive workforce** will continue to negatively impact on the Trust's financial sustainability; the safety and experience of people who use our services & on the morale and experience of colleagues.
2. There is a risk that **continued increase in demand across many of our services** will continue to negatively impact on the quality of services we can offer, including maintaining unacceptable waits for treatment, safety concerns & potential impacts on outcome; that this will continue to negatively impact on the financial sustainability by driving the need for additional staffing related to additional activity & acuity of patients relating to the impact of waiting for treatment, & that this will impact on colleague experience due to increased workload & associated pressures as well as a lack of time to invest in development and support.
3. There is a risk that the **continued lack of available capital to invest across the estate** will lead to patient & colleague safety incidents as well as continued poor experiences for patients & colleague relating to an aging & inappropriate environment.

The following table highlights the most recently identified strategic risks and the current level of confidence in their mitigation.

Committee	Strategic priority	Theme number(s)	Risk Identified	New/Existing	Date added to report	Confidence level in mitigation / Management	Changes since last update
Mental Health Legislation Committee	BPTW BQS	T1 T3	There is a risk that the safety and experience of service users and staff is materially compromised by a limited ability of the trust to respond, in a sufficiently coherent and rapid way, to estates issues and/or innovations.	New pressures on existing situation.	September 2023	Significant.	Improved.

Committee	Strategic priority	Theme number(s)	Risk Identified	New/Existing	Date added to report	Confidence level in mitigation / Management	Changes since last update
	BPTW BQS	T1 T3	There is a risk that the safety and experience of service users and staff is materially compromised by the unjustified or badly-managed use of restraint/intervention on the wards.	New	January 2024	Significant.	Improved.
	BQS	T3	There is a risk of sub-optimal application of “best interests” principles.	New	March 2024	Limited.	Static. Update expected January following audit work taking place.
	GG	-	There is a risk that the Trust may not act in a fully compliant / best practice way in relation to Associate Hospital Managers. This is in relation to recruitment challenges & succession planning.	New	May 2024	Limited.	Static. Update expected January.
Quality & Safety Committee	BPTW BQS	T1 T3	Continued pressure on our workforce impacting on quality of care to patients.	New pressures on existing situation.	September 2023	Limited.	Static.
	BPTW BQS	T1 T3	Continued demand & acuity in a number of services including acute inpatient, community MH, Children & Adults, Podiatry, LAC will have a negative impact on patient experience and outcomes.	New pressures on existing situation.	September 2023	Limited.	Static.

Committee	Strategic priority	Theme number(s)	Risk Identified	New/Existing	Date added to report	Confidence level in mitigation / Management	Changes since last update
	BPTW BQS	T1 T3	Recruitment challenges to roles & services having a negative impact on wellbeing & culture.	New pressures on existing situation.	September 2024	Limited.	Static.
Finance & Performance Committee	BUOR	T1	There is a maintained risk that the Trust will be unable to maintain its financial sustainability in the medium to long term.	New pressures on existing situation.	September 2023	Low – there are in year mitigations in place within the Trust, which is also contributed to by wider system pressures.	Static.
	BUOR BPTW BQS	T1 T1 T3	There is a risk that ongoing lack of capital funding will mean we are unable to effectively address the short, medium and long term estates requirements at Lynfield Mount, impacting on the safety, experience and outcomes for patients and staff.	New pressures on existing situation.	September 2023	Significant	Improved.
People & Culture Committee	BUOR BPTW BQS	T1 T1 T3	Continuing medical locum usage, associate quality & financial pressures associated with this strategic risk.	Existing.	September 2023	Limited.	Static.

Committee	Strategic priority	Theme number(s)	Risk Identified	New/Existing	Date added to report	Confidence level in mitigation / Management	Changes since last update
	BUOR BPTW BQS	T1 T1 T3	Workforce utilisation and effective rostering as part of the Model Roster 3 programme.	New pressures on existing situation.	May 2024	Limited.	Static.
	BPTW	T1	Manager capability & competence, in light of new financial pressures/challenges.	New pressures on existing situation.	May 2024	Limited.	Static.
	BPTW	T1	Threat to culture change in light of additional performance/financial pressures as 2024/25 progresses.	New pressures on existing situation.	July 2024	Limited.	Static.

4 Continuous improvement

Part of the deployment of the refreshed BLT strategy included a review of the tools available to the Board to support robust oversight & good decision making. This included moving from a ‘risk based’ Board Assurance Framework (BAF), to an ‘assurance based BAF. The Alert, Advise, Assure & Decision report including confirmation of the top strategic risks identified at each meeting.

Initial review identified the following learning:

- There is a potential mis-alignment in the assurance levels against the strategic priorities where those priorities overlap. More work to do on ensuring corresponding discussion on joint areas is taking place across the Committee’s.
- Not all the Committee’s strategic risks looked to be aligned, raising the question of whether all Board members had a shared view on the strategic risk being experienced.
- A need for an annual review as part of a Board Development Session. Being considered to take place during quarter four each year. Aligned to the effectiveness review, & forward planning for the year ahead.
- The importance of integrated reporting to ensure dynamic governance.
- Further consideration on the role of the Audit Committee.

5 Risk appetite 2024/25

The purpose of a risk appetite statement is to outline what risk the Board of Directors is willing/unwilling to take in order to achieve the Trust's strategic priorities. It is good practice to monitor & review the statement on an annual basis and /or following any significant changes or events. Well Led guidance reference:

- Colleagues & leaders ensure any risks to delivering the strategy, including relevant local factors, are understood & have an action plan to address them. They monitor & review progress against delivery of the strategy & relevant local plans.
- Leaders have the experience, capacity, capability & integrity to ensure that the organisational vision can be delivered & risks are well managed.
- The systems to manage current & future performance & risks to the quality of the service take a proportionate approach to managing risk that allows new & innovative ideas to be tested within the service.

This paper confirms the review for 2024/25, where the Board agreed the current risk appetite, aligned to the Good Governance Institute risk management matrix.

The acceptance of a greater deviation from our risk appetite for some individual areas of decision making and/or acceptance of the need to reprioritise previously agreed risk mitigation actions can be regarded as risk tolerance (the degree of variance from the organisation's Risk Appetite that the organisation is willing to tolerate).

Development work is taking place on the Trust's risk reporting arrangements, aligned to the Board confirming the risk appetite statement. The Compliance & Risk Group, Chaired by the Chief Executive, remains the receiver of this report. The outcome report from the Compliance & Risk Group, is presented to the Audit Committee.

Methods of controlling risks must be balanced. With the Board reminded about the importance of integrated reporting to ensure good decision making is in place as part of dynamic governance arrangements.

The risk appetite, Board effectiveness, & BLT strategy will be reviewed each year in a Board Development Session.

	0 - None Avoidance of risk is a key organisational objective.	1 - Minimal Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 - Cautious Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 - Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 - Seek Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 - Significant Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk <u>as long as</u> appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless <u>absolutely essential</u> .	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge <u>as long as</u> we can be reasonably confident we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo <u>in order to</u> improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless <u>absolutely essential</u> . We will avoid innovation unless established and proven to be effective in a variety of settings.	We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices <u>in order to</u> drive quality improvement.
REPUTATION How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk <u>as long as</u> there is the potential for improved outcomes for our stakeholders. SI Pho ACC	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes SK
PEOPLE How will we be perceived by our current / future workforce?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless <u>absolutely essential</u> . Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation <u>as long as</u> there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We <u>recognize innovation</u> is likely to cause short term disruption with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.



Bradford District Care
NHS Foundation Trust

4. BDCFT Winter Operational Plan

The BDCFT plan outlines the key actions and strategies the Organisation will take to ensure that we are able to maintain service provision throughout the winter period and are in a state of preparedness for the challenges faced during winter. The plan, in line with national and place-based priorities, focuses on ensuring the safety of patients and staff, minimising disruption to services, and ensuring continuity of care across our community and mental health services to provide where possible care in a person's home, or as close to home as possible. The plan is underpinned by collaboration and partnership working.

Winter preparedness and planning commenced in October 2023 and has followed the same process as in previous years taking the following steps:

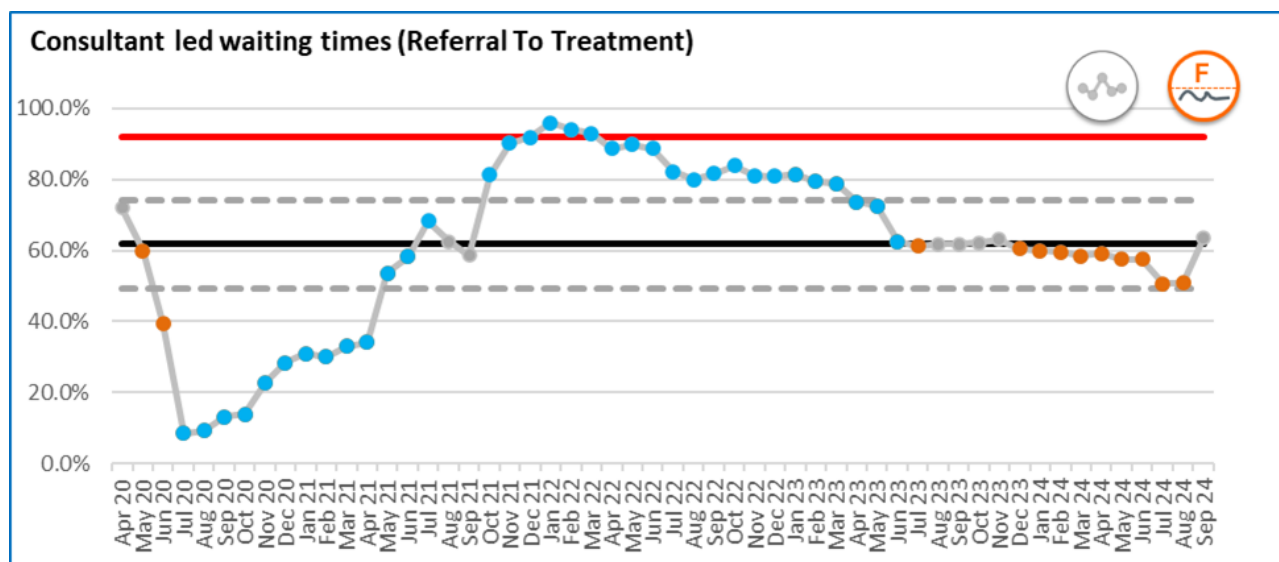
- Learning and reflection from previous winters, responses to unexpected surges in demand and adverse weather events or incidents
- Review of data and intelligence to support demand modelling to include workforce and people metrics
- A review of Business Continuity Plans (BCPs)
- Test modelling assumptions and scenarios against plans
- Identification of risks both internal, external, place & system
- Mitigations and responsive actions

5. Pressures Experienced – Winter 2023

Last winter we identified workforce resilience and availability, increasing seasonal demand and acuity across all pathways exacerbating already stressed pathways and capacity, industrial action and financial challenges across the health and care system.

Throughout 2023/24 the anticipated increases in demand were felt across the partnership. Both Hospital Trusts declared Operational Pressures Escalation Levels (OPEL) level four status (the highest level) over periods of time in relation to high demand and operational challenges. This was managed using the well embedded and tested Health & Care Partnership surge and escalation calls in place across winter, where partners were able to come together and enact BCP and responses to support de-escalation of pressures. This at times meant that non-essential activity had to be temporarily ceased to prioritise critical services having an impact upon some BDCFT services. This has been of significant impact within our Community Dental Service where we require access to theatre sessions at both acute trusts to manage our most complex pathway and RTT.

Graph – Proportion of patients waiting less than 18 weeks to commence treatment – patients who require dental treatment under general anaesthetic

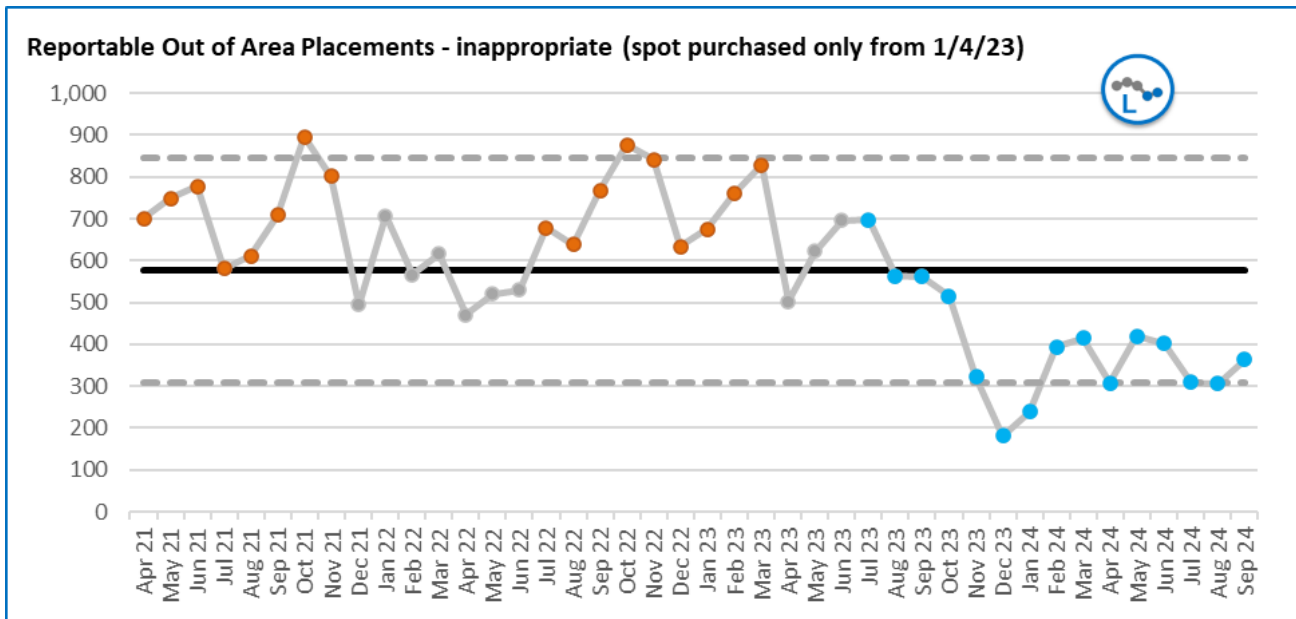


BDCFT community services continued to manage presenting demand in 23/24 as for the previous winter periods, although demand has continued to exceed capacity at a service level, leaving services periodically enacting business continuity arrangements. Community nursing remained overstretched with demand exceeding capacity, demonstrated in graph 2. Daily Lean Management (DLM) was used to flex capacity to where it is needed across the community footprint, and to maintain extended hours of provision across seven days, and to meet UCR requirements as far as possible. This is a daily requirement and monitored/supported via Opel command structures which were enacted within the Trust. The alignment of the service to PCNs in 2022 further impacted on service delivery through increased travel time, as localities had become larger in some instances. In addition, the service experienced other pressures, consistent with the last three years, with increasing requests for community nursing support, including the administration of insulins and anti-coagulant injections in the home, as well as demand for more wound care procedures. The service was also impacted by fluctuations in sickness absence post pandemic.

A transformation programme saw community nurses aligned to the delivery of planned and unplanned/urgent response teams. The next phase of this programme is underway however it is unlikely that this will benefit service capacity this winter but is expected to deliver benefits in 2025.

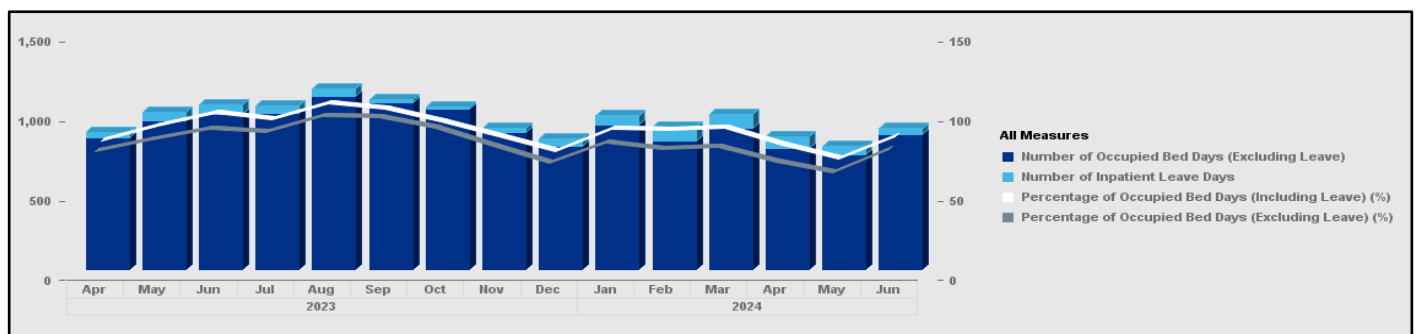
BDCFT mental health services continued to see high levels of demand and acuity across all pathways. Demand within the crisis pathway, and in particular for inpatient admissions, continued at greater than average levels, maintaining a need for independent sector adult acute and Psychiatric Intensive Care Unit (PICU) beds to be utilised. To note however, from October 23 to January 24 out of area bed usage reduced to below statistical trend, but then returned to previous levels as we exited winter months.

Graph – Reportable out of area bed days



Capacity within older people’s mental health, both functional and dementia assessment, was managed within BDCFT commissioned capacity. Monthly occupancy including leave was between 78.1% and 96.8% over the period October 2023 to March 2024.

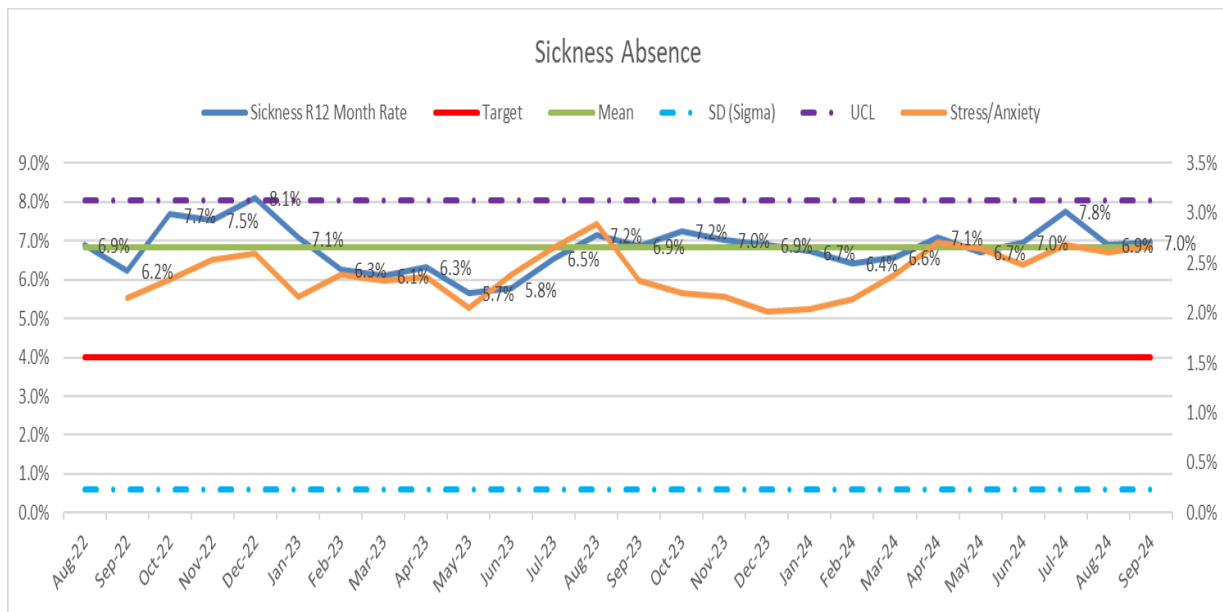
Graph – Older people’s inpatient occupancy



As in previous years the seasonal impacts within Acute Community Mental Health Services were managed through the use of BDCFT bank to increase and flex capacity where needed across the pathway to maintain continuity and responsiveness, in particular to respond to mental health presentations within A&E departments with the Acute Hospital Trusts.

When we look at workforce sickness and absence during winter months of 23/24 (October through to March) sickness and absence overall reduced and in terms of recorded reason stress and anxiety had the most notable reduction.

Graph – Sickness absence



Throughout winter 23/24, the embedded and well tested Daily Lean Management and Communication Cell escalation structures were utilised alongside service level data and intelligence to dynamically assess and test pressures and risks across the services. We were then able to deploy the agreed winter planning actions and mitigations to manage any Trust and/or place based operational challenges.

Services overall showed resilience and an ability to maintain service continuity and patient safety in the face of the already pressured system and the additional pressures winter brings. When considering the factors that contributed to this, we can conclude that the actions put in place to bolster and support delivery and BCP were effective. The Daily Lean Management escalation structures were responsive and able to respond proactively and proportionately to issues as they arose or indeed before they happened so we could proactively prioritise, deploy and respond. Most importantly we were able to support the health and wellbeing of the workforce sufficiently to avoid any escalations in seasonal illness.

BDCFT Assumptions – Winter 2024

Demand and Capacity

We anticipate and predict that we will see a similar trend in terms of additional pressures as a result of winter. Again, this is against a backdrop of services already under pressure with increased demand and complexity.

Across 24/25 all Health & Care organisations have faced significant financial pressures which has seen organisations needing to focus on productivity and cost savings which has resulted in Equality Impact Assessments being undertaken and, in some instances, decisions subsequently made to reduce or cease activity. This is a heightened risk to managing capacity and demand going into Winter 24/25.

An overview of key capacity and demand considerations from areas across the care groups are provided.

Children's Services

The work in Public Health Nursing teams (Health Visiting, School Nursing) continues with regard to evidencing compliance with nationally mandated contacts, and BDCT expects that performance will be challenged by way of seasonal winter sickness, as well as the impact on wellbeing for those staff with long term conditions, as the winter season progresses. The service is also reporting a noticeable increase in strategy discussions for children at risk of imminent harm, again requiring the team to provide a response. The Head of Service will use well embedded Daily Lean Management processes to assess service safety, nurse and leadership coverage, and to escalate concerns.

In addition, Community Children's Services will need to consider its response to the new ways of working regarding Initial Child Protection Case Conferences and Review Conferences and the expectations of partners both during the winter period and beyond. The ability of the staff to service this demand will be monitored via daily comms cells and escalated via winter command processes if required.

Medical capacity across the system for initial health assessments for children in care (CIC) relies on a partnership approach across the three providers/ NHS Trusts and is challenging, given the competing demands on medical advisors. Increased demand in community paediatrics/paediatric departments over the winter period, combined with workforce seasonal illness will impact on compliance rates. This will be monitored via daily comms cells and alternative capacity considered if require. The service will adapt workflow across the CIC service, based on BCP guidance.

The increasing number and complexity of children on roll in Special Schools, places increased pressure and demand on the Special Needs School Nursing team, with caseloads double the

recommended ratio. There is likely to be a further impact on the service as a result of staff seasonal illness, as well as on complex children and young people accessing school due to illness or illness within the family. This will place further demands on the service to support children out of school and to return to school at the earliest opportunity. This will be monitored via daily comms cells and concerns/requirements escalated as part of the system winter escalation processes.

In advance of winter, the service has been working with both Occupational Health and People Matters Directorate colleagues to ensure that staff are supported to be healthy and well at work and we are optimising the vaccination programme as early in winter as possible.

Community Health Services

We expect that pressures on community nursing capacity will continue during the winter of 24/25 and that the service is likely to be impacted further over the winter months as a result of the collective action by GPs, if this is sustained. This leaves community services in a potentially vulnerable position over the coming winter period, with limited capacity to respond to surges in demand. This will be monitored, and demand prioritised using DLM and escalation into OPEL command structures, as required. Community services alongside primary care provide the majority of health care within the system and maintain people in their home environment.

Particular pressures anticipated for winter 2024 are:

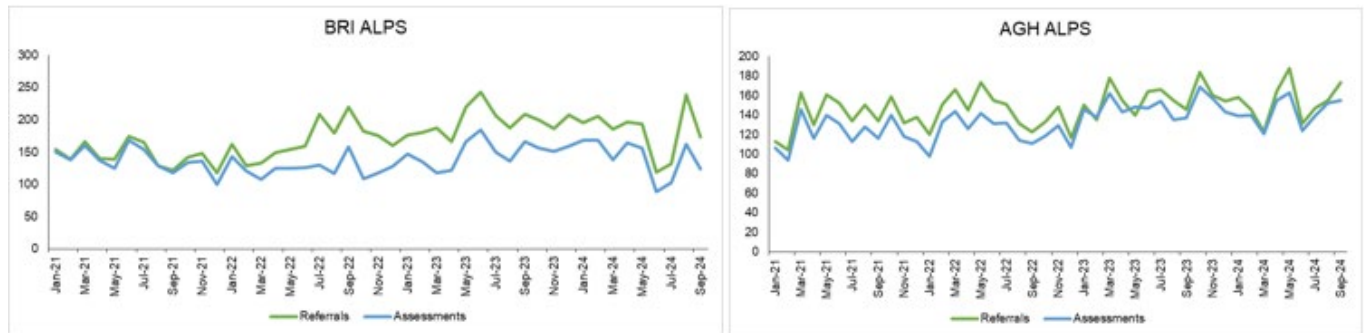
- work shunting when other services are under pressure or stepped down. This has happened during previous winters. This may also be reflected in a 'legitimate' left shift, with earlier discharges from hospital, or prevented admissions increasing demand for community services.
- care home demand – e.g. Norovirus/COVID/influenza outbreaks.
- care home and domiciliary care staffing challenges This may result in people in acute beds waiting for care and increased burden on families and BDCFT services, including community nursing, that may have to deliver care that is outside normal contracted health care.
- operating theatre availability for dental procedures under general anaesthetic, with sessions cancelled by acute trusts due to staff shortages; competing demands for theatre space; and/or increased hospital admissions.
- The consequence of collective action by GPs, meaning some work may shift to community services.

Mental health

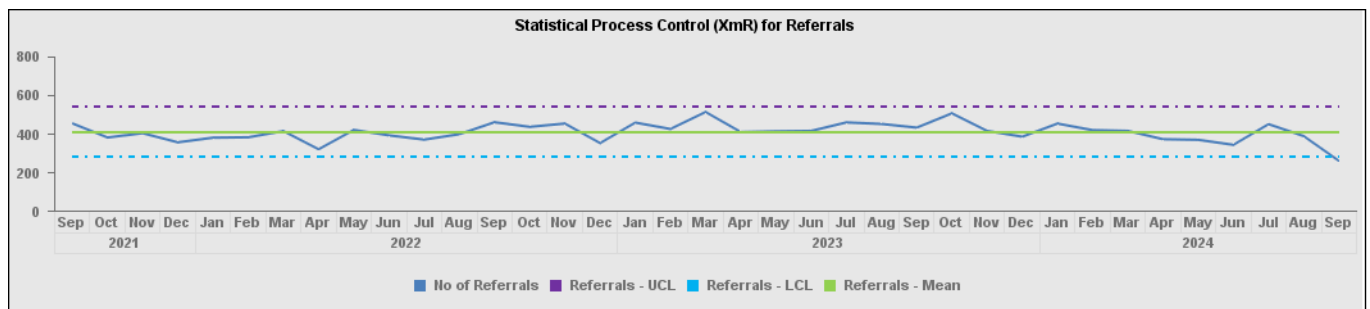
There has overall, been a sustained level of demand for mental health services throughout 2024. There are early indications of demand beginning to stabilise however services continue to manage the backlog and new surge demand that we saw as a result of the pandemic and lockdown. Crisis demand has been increasing during the summer with high levels of assessments being carried out in the Emergency Departments by the Acute Liaison Psychiatry Service. The soft launch of 111 for MH Crisis has resulted in little impact, however it is anticipated that a full press launch in November will trigger an increase in calls into First Response Service with modelling completed around anticipated call increase and additional call handler and responder capacity required to flex and support.

Estates work at the Airedale Centre for Mental Health has resulted in an acute ward moving sites to Lynfield Mount Hospital. This is a 12-month programme of capital works and will have an impact on flow and available beds. This has been modelled into our anticipated bed usage across Winter 24/25 with a mitigation plan for each phase to support and maintain safe access and flow.

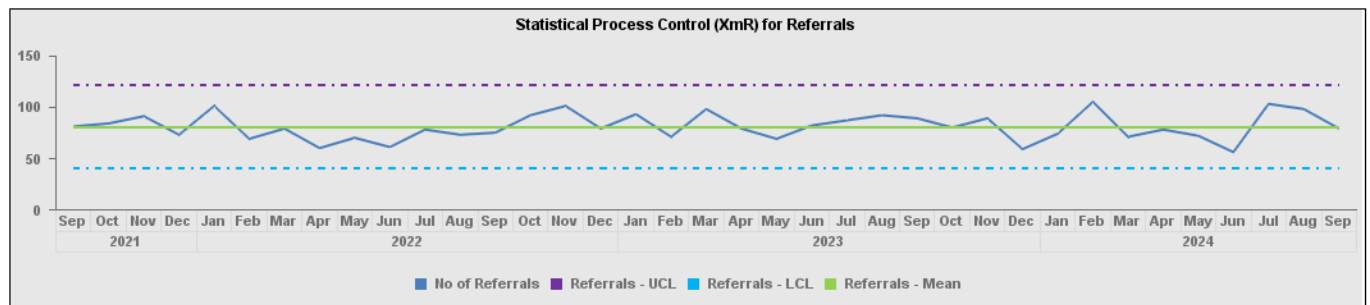
Graph – ALPS Referrals and Assessments at BRI and AGH



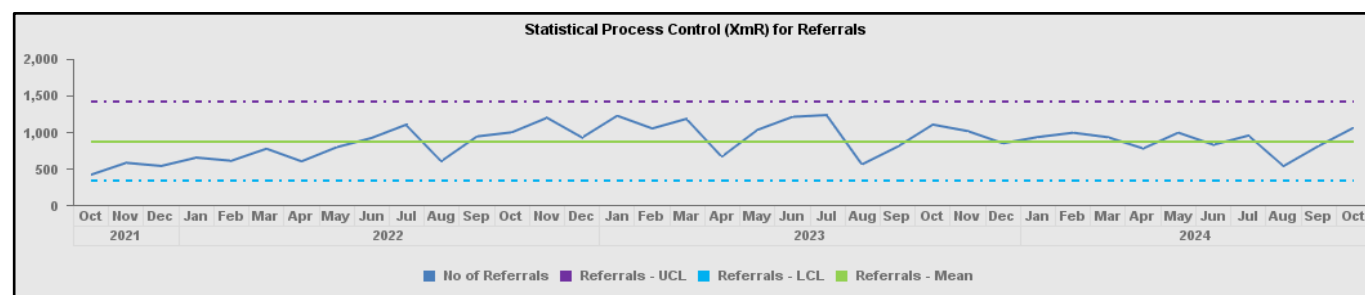
Graph – Referrals of Adult CMHTs



Graph – Referrals of Older Peoples CMHTs



Graph –Referrals for CAMHS



Other factors that may contribute to additional pressures across winter 24/25 are:

- socio-economic impacts as a result of cost of living and fuel increases further impacting and compounding people’s physical & mental health and wellbeing and disproportionately impacting upon our communities living within our most deprived and marginalised communities.
- Potential increase in crisis calls due to the full launch of 111 for Mental Health crisis.
- GP Collective Action
- Ongoing and significant financial challenges across all Health & Care Organisations

Workforce

As identified in the learning from previous winters, we can see that a factor supporting our ability to remain stable across previous winters has been our ability to maintain more stable levels of staff sickness and promote health and wellbeing of our workforce. Potential risks and areas to consider relating to workforce are:

- Workforce uptake of Flu and COVID Vaccination is not optimal
- Workforce are impacted by seasonal illness such as Flu, COVID -19, Norovirus
- Workforce morale and stress and anxiety increases
- LTO and vacancy rates increase
- increased reliance on temporary staffing (quality and financial impacts)

6. BDCFT Supportive Actions

BDCFT have reviewed and assessed the impact of previous winter plan actions and initiatives aligned to the refreshed assessment and assumptions relating to anticipated demand and operational challenges for the coming winter. Some of these actions are actions that are in place throughout the year, others are additional to bolster and support seasonal specific risks and concerns. The high impact actions and interventions are as follows:

- Community services will continue to support Local Authority residential units to enable people to ‘step up’, or ‘step down’ from hospital. Nursing input into these facilities enables people with more complex needs to be supported outside of a hospital setting.
- Community services will continue to work with Yorkshire Ambulance Service (YAS) aside of agreed clinical pathways that support ‘suitable’ patients identified by YAS to be attended by

community nursing services, thereby reducing the likelihood of unnecessary conveyance to hospital. A 'standardised' directory of services (DOS) has just been adopted across West Yorkshire community providers.

- Community services will contribute to the provision of Virtual Ward beds aimed at supporting multiple pathways. These beds will enable patients to receive 'hospital care' in their own homes, thereby reducing pressure on local hospitals.
- Community services continue to work alongside the Urgent Community response standard, attending to conditions likely to be escalated within the two-hour time frame. These pertain to end-of-life care and catheter 'crises'.
- Community services will continue to support timely discharge from acute hospitals thereby supporting flow.
- A trial of the Yorkshire Ambulance Service Mental Health Push Model will commence in November 2024, aiming to divert MH demand from YAS and away from A&E departments
- The YAS Mental Health Response Vehicle is now live in the Bradford District. This vehicle is deployed to MH related ambulance calls and looks to divert away from A&E and support the de-escalation of crisis within a person's home or at scene.
- Daily children and young people mental health huddles within acute hospitals to support multi agency decision making and support for children in crisis presenting to acute hospital.
- Care home liaison and outreach to prevent hospital admissions.
- Ongoing contract with the independent sector to mitigate inpatient bed pressures, potential seasonal bed closures and the current capital estate works and associated lost bed capacity
- Collaborative work with Creative Support to provide crisis beds offering a non-medical approach to supporting a mental health crisis.
- Collaborative work on maximising pathways into Urgent and Emergency Care Delivery Board funded 'Wellbeing Hubs' offering pre crisis support and diversion from ED.
- Ongoing provision of Core 24 across both acute hospital sites through ALP Service.
- Provision of vaccination clinics through the Learning Disability Community Teams as well as targeted activity to vaccinate all eligible inpatients.
- The children's influenza campaign will be delivered to over 200 schools from October to December 2024, for a total of 106,000 children. Inactivated vaccine (injection which is gelatine free) will be offered at the same time as the nasal spray. Additional community clinics will be needed.

Workforce resilience

To address the main workforce challenges anticipated this winter, the Trust will maintain and repeat its targeted approach to supporting the health and wellbeing of our workforce. This includes the promotion of the plethora of staff health and wellbeing offers, bespoke offers to teams and staff groups where we see most need for wrap around support or who are unable to access the usual offers, and dedicated additional People Matters support to target improved management of sickness and absence and proactive employee relations.

Planning structures

Daily lean management structures are embedded across services enable operational challenges to be addressed in a timely manner and escalated as required.

New for winter 24/25 is the NHSE roll out of OPEL for Mental Health Services and also for Community Services. Previously OPEL scoring, escalation and action planning has focused around the operational resilience of Acute Hospital Trusts and in particular the A&E waits and performance. Positively, NHSE have taken a new focus on operational resilience within Mental Health and Community Services. This is a work in progress however through our regional planning leads, provider business intelligence and operational leads, we have been working through and interpreting the NHSE guidance and reporting requirements with a provisional ‘go live’ of the OPEL reporting in mid – December. We will then, alongside our CUTE Colleagues be submitting our OPEL score for both MH and Community into the place and regional strategic command centre which then informs the level of escalation and response required to support continuity of services. We will therefore, as in previous winters continue to:

- Participate in the Bradford and Craven surge and escalation group to respond successfully to seasonal pressures, particularly as some influencing factors are not within the control of BDCFT or system partners.
- work together within the organisation and across the system with regards to the deployment of staff and resource, support for redeployment and stepping down non-essential services if required.

7. Influenza & COVID Vaccination Programmes for Trust Staff

The winter vaccination programme for Trust staff has been reviewed and the action plan updated which includes providing additional education as part of mandatory infection prevention training to improve vaccination uptake. Table 1 outlines vaccination uptake for influenza and COVID-19 within BDCFT during 2023-24.

Occupation	No of HCWs	No vaccinated for influenza	Influenza % uptake	No vaccinated with COVID-19 since 1 st Sept 2023	COVID-19 % uptake
All doctors	123	83	67.5%	57	46.3%
Qualified nurses	1023	578	56.5%	330	32.3%
All other professionally qualified staff	503	235	46.7%	158	31.4%
Support to clinical services	934	399	42.7%	182	19.5%
Total	2583	1295	50.1%	727	28.1%

Vaccinations are an effective defence against infection and this year all trust staff will be offered the influenza vaccine. The COVID-19 booster will be offered to all frontline healthcare workers. The campaign commenced on the 1st October 2024 with the aim of vaccinating as many staff members as possible prior to the expected winter pressures from COVID-19 and influenza.

Operational Services are working with IPC leads to look at dynamic and responsive ways to capture staff out in community. Vaccination uptake is being discussed through DLM structures to support vaccination uptake and look at the barriers and what more we can do to support and improve during winter 24/25.

Conclusion

The BDCFT Winter Plan 2024/2025 has been developed in line with NHSE National winter and Half 2 planning priorities. It focuses on delivering care as close to home as possible, maintaining safe services throughout winter, promoting and keeping people well, especially those facing adversity and inequality. It has taken learning from previous winters and assessed and modelled demand, risks and mitigating actions all designed to mitigate the seasonal pressures ahead, ensuring that safe patient care continues to be delivered to the population. By focusing on workforce resilience, service stability and continuity, and system partnership and collaboration, the Trust aims to manage increased demand and provide timely, safe care to all service users throughout Winter 24/25.

Winter Planning

2024/25

November 2024

Kelly Barker Chief Operating Officer

National Winter Priorities...

NHSE & DHSC have published their winter planning priorities ..



Home First



Maintain safety
and quality care,
Provide safe care,
Support people to
stay well



Involvement of
people
receiving care
& families &
carers



Close
partnership
working & joint
planning

How does this link to us?

Bedford District and Craven Health and Care Partnership

our Vision
By making people where they are, working with them to access the local and opportunities to enable them to be longer in good health...
we Act as One to keep people Happy, Healthy at Home

our Added Value

- Our Population:** Our priority is supporting a better experience of health and care for our people.
- Our Shared Purpose:** All working to the same goal, for our population to have more choices to lead healthier lives.
- Our Partnership:** Greater value through the best use of our collective resources, increasing reputation and trust.

our Purpose

Narrowing the Gap: Reducing the health inequalities in the population through health and wellbeing.

Our Workforce: Empowered people, in partnership, to improve the health and care of our people.

Equality and Justice: Changing health in our area to reduce inequalities between different social, economic, health and wellbeing.

Increasing the Power to Act: Sharing responsibility and power, for people to become active and engaged citizens.

Our Partnership Plan: Tackling the issues in our area of our Partnership plan online, through public consultation.

our Commitments

We will:	We will:	We will:
<ul style="list-style-type: none"> • Maximise our resources to deliver the best care for health and wellbeing. • Understand our local systems to improve care. • Working with people in our system and our community to address their needs. • Empower our people to make choices to improve their health and wellbeing. 	<ul style="list-style-type: none"> • Commit to One in our shared purpose, vision and values. • Plan in One, taking decisions that create a positive impact for our population. • Partner in One in providing the best of health and care. • Invest in One our focus on health and wellbeing through our plan. 	<ul style="list-style-type: none"> • Lead in One in partnership with our population, in our communities. • Maximise the power and responsibility to make the best use of our collective resources. • Grow together through our resources that are our strength, working together. • Deliver in One through our shared skills and mutual ambitions.

our Population **our Place** **our Partnership**

From Ambition to Action 2023-2026 strategy refresh

Best place to work
We will continue to strive to be a smarter working organisation, working together so that everyone is proud to work here, feels they belong and are valued.

We will focus on:

- Looking after our people.
- Belonging in our organisation.
- New ways of working and delivering care.
- Growing for the future.

Deliver best quality services
We will consistently deliver good quality, safe and effective services, making every contact count, meeting the needs of our communities, and focusing on reducing health inequalities.

We will focus on:

- Improving access and flow.
- Learning and improvement.
- Improving the experience of people who use our services.

Making best use of resources
We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do.

We will focus on:

- Financial sustainability.
- Our environment and workspaces.
- Giving back to our communities.

Be the best partner
We will be at the forefront of integration, improvement and innovation, working with partners to deliver services that enable people to live happier, healthier lives.

We will focus on:

- Partnership working.

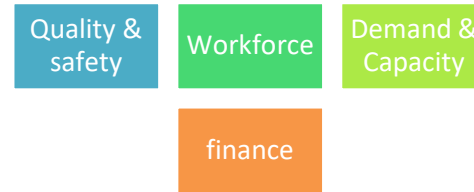


How do we do Winter Planning?

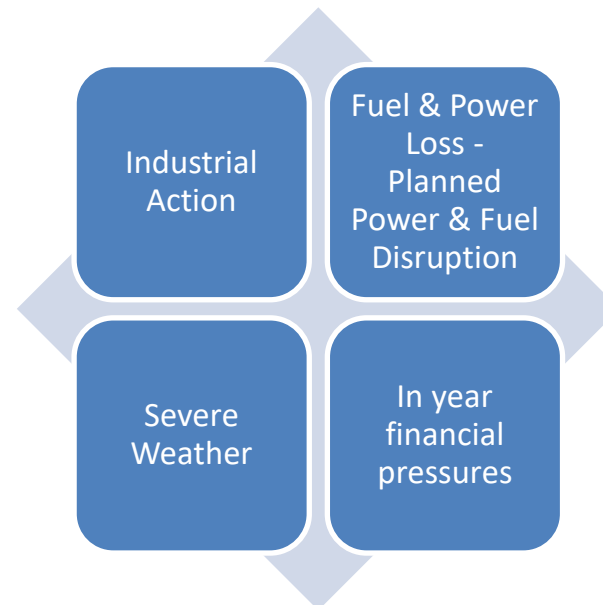
Process



Risks



External & System Factors



Actions & mitigations



Business Continuity

Risk v's benefit

Risk based prioritisation of services & activities

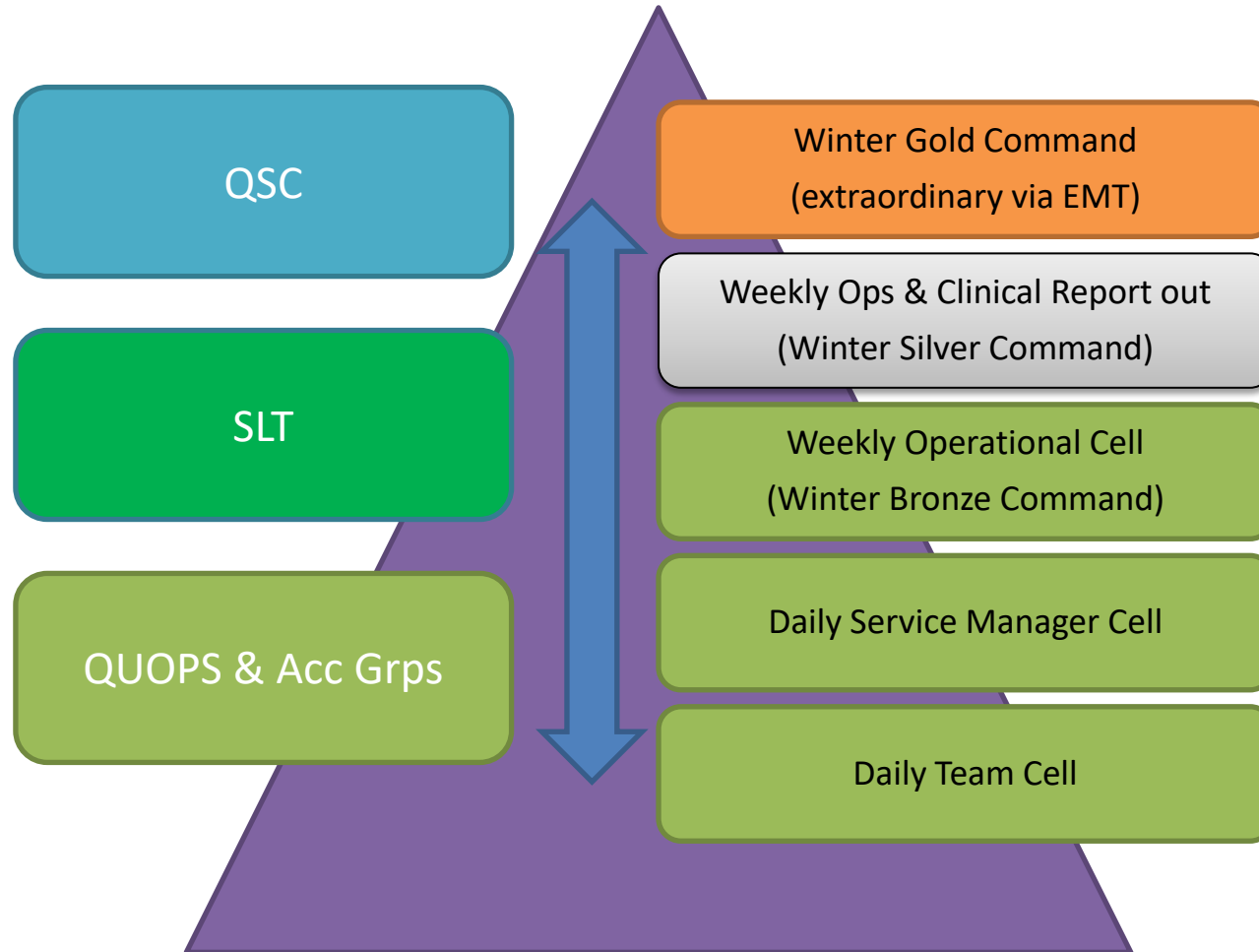
Flexible staffing deployment

System & Integrated working

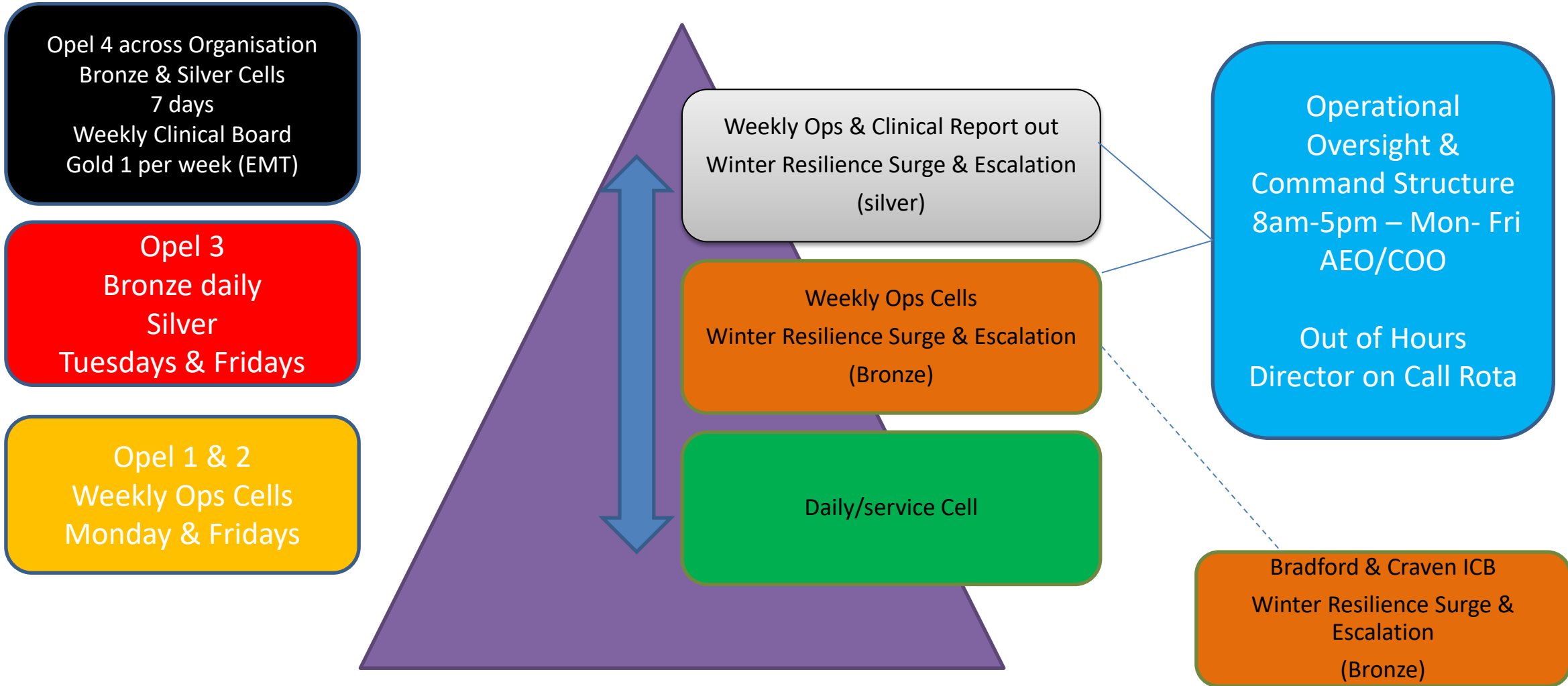
Mutual Aid

Creativity & solution finding – CTW Tools

Daily Lean Management



Winter Resilience Cell Structures



Board of Directors – Meeting Held in Public

Paper title:	Children and Young People Specialist Mental Health Services – Access and Waits Update	Agenda Item 14.0
Presented by:	Kelly Barker, Chief Operating Officer	
Prepared by:	Sadie Booker, Head of Operations Mental Health Supported by Kelly Barker, Chief Operating Officer	
Committees where content has been discussed previously	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input checked="" type="checkbox"/> For information <input type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	X
	New ways of working and delivering care	X
	Growing for the future	X
Delivering Best Quality Services	Improving Access and Flow	X
	Learning for Improvement	X
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	X
	Giving back to our communities	X
Being the Best Partner	Partnership	x
Good governance	Governance, accountability & oversight	x

Purpose of the report

The purpose of the paper is to provide Board with the current position of access and waits within Bradford District Care NHS Foundation Trust Specialist Child and Adolescent Mental Health Service (CAMHS), to describe the context and background to the current position and to provide a high level summary of Quality Improvement work underway to mitigate, stabilize and improve access and waits for our children, young people and families.

Executive Summary

The recent pandemic has brought children and young peoples' (CYP) mental wellbeing into sharp focus, with CYP mental health services receiving their highest ever level of referrals, as well as rising complexity and severity.

National Charity, Young Minds conducted research in 2023 and evidenced that waiting times longer than 18 weeks often resulted in CYP's needs escalating into more impactful mental health needs and difficulties seeing an increase in their acuity and an overall decrease in life their chances, giving us a clear rationale on why we need to work together as a system to improve our overall approach to supporting CYP and their mental health and wellbeing.

In quarter 2 of 24/25 overall waiting times in BDCFT CAMHS have started to show early indications of an improving trajectory in referral activity and waiting times, however still significantly higher than pre pandemic. CAMHS have taken a quality improvement led approach to developing improvement and recovery plans, and during 24/25 have targeted improvement methodology relating to demand, capacity and flow of CYP through the CAMHS pathways. Against a National Institute of Clinical Excellence standard of 18 weeks for routine referral to meaningful interventions commencing, CAMHS are now reporting an average wait of 21.1 weeks, this is an improvement of 12.2 weeks from commencement of the quality improvement plans.

Waiting times for Neurodevelopmental Assessment and Diagnosis remains to be the pathway where children and families wait the longest. This is a national issue and is the focus of place and system strategic programmes to look at how this national issue can be addressed. This area is an area that BDCFT CAMHS are unable to address without WY and place-based support.

Over the next 12 months BDCFT CAMHS will continue its improvement activity and will look to have recovered access and waiting time standards to be within current NICE and NHSE access and waiting time guidance and standards.

Quality & Safety Committee will continue to receive reports relating to access and waits through Care Group updates and via the committee work plan across the year aligned to progress towards the outcomes and measures of the Trust Strategy – Best Quality Services – access and flow.

Board of Directors – Meeting Held in Public

1. Purpose of the Paper

This paper aims to provide the Board with an overview of the current access and waits within Bradford District Care NHS Foundation Trust (BDCFT) specialist Children and Young People's Mental Health Services (CAMHS) and to provide assurance on the implemented recovery plans, to improve waiting times for Children and Young Peoples (CYP) and their families.

2. Executive Summary

The recent pandemic has brought children and young peoples' (CYP) mental wellbeing into sharp focus, with CYP mental health services receiving their highest ever level of referrals, as well as rising complexity and severity.

National Charity, Young Minds conducted research in 2023 and evidenced that waiting times longer than 18 weeks often resulted in CYP's needs escalating into more impactful mental health needs and difficulties seeing an increase in their acuity and an overall decrease in life their chances, giving us a clear rationale on why we need to work together as a system to improve our overall approach to supporting CYP and their mental health and wellbeing.

In quarter 2 of 24/25 waiting times in BDCFT CAMHS have started to show early indications of an improving trajectory in referral activity and waiting times, however still significantly higher than pre pandemic. CAMHS have taken a quality improvement led approach to developing improvement and recovery plans and during 24/25 have targeted improvement methodology relating to demand, capacity and flow of CYP through the CAMHS pathways. Against a National Institute of Clinical Excellence standard of 18 weeks for routine referral to meaningful interventions commencing, CAMHS are now reporting an average wait of 21.1 weeks, this is an improvement of 12.2 weeks from commencement of the quality improvement plans.

Over the next 12 months BDCFT CAMHS will continue its improvement activity and will look to have recovered access and waiting time standards to be within current NICE and NHSE access and waiting time guidance and standards.

Quality & Safety Committee will continue to receive reports relating to access and waits through Care Group updates and via the committee work plan across the year aligned to progress towards the outcomes and measures of the Trust Strategy – Best Quality Services – access and flow.

3. Background and Context

BDCFT CAMHS is one part of a whole system of mental health support for CYP across Bradford & Craven District, delivered by a range of organisations and providers. The THRIVE Framework is an integrated, person centred, and needs led approach to delivering mental

health services for children, young people and families which conceptualises the continuum of need and support in five categories (Image 1).



Image 1 – Thrive Framework.

Emphasis is placed on the promotion of mental health and wellbeing, and for CYP and their families to be empowered to be actively involved in decisions about their care through shared decision making. Youth in Mind (YiM) is the offer of support for CYP who's needs fit into the category of 'Getting Advice' and 'Getting Help' and the support is provided by a selection of VCSE services that link in and interface with providers across the rest of the Thrive Framework providers,

BDCFT CAMHS has within it 13 pathways/teams of support, the majority of which fit into the Thrive categories of 'Getting More Help' and 'Getting Risk Support'. This means those CYP and families receiving support from BDCFT CAMHS are those families that are experiencing moderate to significant mental health needs that cannot be supported or addressed within the YiM offers or within our school based offers such as Mental Health Support Teams in Schools (MHST) .

BDCFT CAMHS receives referrals from healthcare professionals, Local Authority and Children's Trust and schools. Those referrals are supported through a One Trusted Front Door model within the BDCFT CAMHS Duty Team. Referrals are screened and triaged and a first contact appointment is offered. At this first contact the BDCFT CAMHS practitioner will work with the CYP/Parent/Carer to formulate the most appropriate Team/Service to meet the needs of the CYP and family.

Following the first appointment the family are either accepted into CAMHS as their mental health needs require a BDCFT CAMHS level of intervention on the Thrive framework for further formulation assessment, or the family is signposted to a mental health service providing

support in the categories of 'Getting Advice' or 'Getting Help' within the other YiM offers and providers.

If accepted into BDCFT CAMHS following the first appointment the family are then supported within the 13 teams offering specialist intervention and treatment. The Teams/pathways are:

- Primary mental health worker Team (PMHW) – provides consultation support to potential refers, alongside individual CYP support, providing a bridge and conduit to the most appropriate support
- Core Team – provides majority of key worker support to CYP and families and coordinates their care with other agencies and supports access into the right evidence-based pathway for support
- Eating Disorders Team – provides specialist eating disorder support
- Crisis and Enhanced Treatment Team – support CYP in a MH crisis
- Youth Justice Team –
- Be Positive Pathway Team – support those children who are on the edge of care and social care involvement
- Looked After and Adopted Care Team – provides specialist MH support for children in care, foster carers and adopted CYP
- Psychological Therapies Team - provides specialist mental health therapy and provides consultation and advice to the Core Team keyworkers and psychiatrists
- Early Intervention Psychosis (EIP) Team – this is also direct and self-referral pathway to ensure CYP with an emerging first episode psychosis receive help as quickly as possible in line with national Better Access and Waiting Time standards
- Early Years Team, including Specialist Early Attachment and Development Service (SEAD) for under 7's MH support
- Neurodevelopmental Team for Autism and ADHD Assessments
- Mental Health Support Teams (MHST) working in schools supporting CYP
- Little Minds Matters (LMM's) supporting bonding of babies with their families

The above illustrates the broad spectrum of specialist support offered to children and families with the most complex mental health needs. The team is made up of an array of professionally qualified practitioners delivering evidenced based interventions and therapy. The MDT is also supported by health care support workers and assistant psychologists. All the work delivered is reliant upon positive working relationships and pathways into and alongside the agencies that support families both universal and targeted.

4. Demand, capacity and flow challenges

It is nationally recognised that demand for mental health support for Children and Young People has significantly increased, this was noted pre pandemic but post pandemic the rise was sharper and felt across all levels of support.

Listed below are the key figures for BDCFT CAMHS demonstrating those rises in demand:

- CAMHS caseload (includes CYP awaiting Autism and ADHD assessments) was **5,974** in April 2023 compared to current caseload **7,805** Oct 2024.
- New CYP referrals in April 2021 into CAMHS was **432** compared to **1,061** in Oct 2024.

- The number of CYP presenting in A&E and to First Response during a MH crisis is increasing annually. 2022 = **231**, 2023 = **377**, 2024 = **386** (data available until Sept 24).
- The number of CYP waiting for an Autism and ADHD diagnosis in Oct 2024 is **4,072**. Across Bradford District the requests for assessments have increased by **13%** 23/24 and predicted to be a further **14%** increase in request for assessments during 24/25.

The rise in demand at such a pace is the key driver to the increase in waiting times coupled with a growing complexity of need when CYP and families are referred.

Positively in 2022, BDCFT CAMHS received some additional funding to help support the growth in demand however nationally workforce availability in terms of number and expertise has been a challenge and recruitment into those post was slower than the pace of referrals but in the last financial year recruitment has been more positive and vacancies in a healthier position.

Year	WTE Budget ex MHST and LMM's	WTE In Post ex MHST and LMM's	WTE Vacancy Difference
22-23	123.85	115.25	8.6
23-24	138.07	112.6	25.47
24-25	132.36	123.99	8.37

Table – CAMHS WTE (excludes MHST and LMM's)

5. National access and waiting times standards

National Institute of Clinical Excellence (NICE) recommend that routine referrals into secondary services should aim to receive meaningful intervention or start of assessment in no longer than 18 weeks.

Amongst the 13 BDCFT CAMHS pathways there are some that have specific national Better Access & Waiting time standards which differ to the 18-week routine target.

Data aligned to the standards as noted above is reported via the Mental Health Services Data Set (MHSDS) on a monthly basis.

Pathway specific waiting time standards are as follows:

- CYP Eating Disorder Services – Urgent Cases - 1 week or less from referral to start of NICE-approved treatment and intervention
- CYP Eating Disorder Services – Routine Cases 4 weeks or less from referral to start of NICE-approved treatment and intervention
- EIP has an access target of 60% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral

- Mental Health Support Teams in Schools (MHST) have an access target that CYP will wait 4 weeks or less from referral to start of evidence-based treatment.

Current access and waiting times for those pathways not covered by the above national ‘Better access and Waiting Time Standards’, referral to treatment or intervention for routine support is currently 21.1 weeks. This is a significantly improved position when compared to the previous months of 24/25.

The table below shows the improving trend and from work the service has undertaken regarding data quality we know that CYP awaiting neurodevelopmental assessments are captured within the data which impacts on the waiting time figures.

Waiting Times & Access - Monthly								
Measure	Service	Indicator	Target	July	August	September		Reporting Period
Waiting Times (Complete)	CAMHS	Average wait from Referral To 1st Appointment (Assessment)	TBC	147.0 Days 21.0 Weeks	157.3 Days 22.4 Weeks	73.6 Days 10.5 Weeks	↑	Month to date Sept 24
		Average wait from Referral To 2nd Appointment (Treatment)	TBC	237.8 Days 33.9 Weeks	223.1 Days 31.8 Weeks	148.3 Days 21.1 Weeks	↑	

Table – Average wait in CAMHS (including autism and ADHD assessments).

For those services with national Better Access & Waiting Time Standards, their current waiting times are:

- Mental Health Support Teams. The data shows that the average length of wait over Q2 for CYP from referral to treatment from MHST’s is **3.6 Weeks** and the National target is 4 weeks.
- Eating Disorders have a 95% target for urgent referral to be seen in 1 week or less and routine referrals to be seen in 4 weeks or less from referral to a NICE approved treatment. During Q2 **100%** of CYP met the urgent and routine target.
- EIP have a 60% target of people experiencing first episode psychosis will be treated with a NICE approved care package within two weeks of referral. During Q2 **86%** of CYP met the target.

BDCFT CAMHS are currently reviewing their access and waits data to understand any issues relating to equity in access and waits. With support from our Business Intelligence Team, we are creating reports that allow us to review a range of factors with our initial health equity lens being ethnicity and indices of deprivation for those with the longest waits.

Current data is telling us that of the CYP who are currently waiting longest within BDCFT CAMHS (including Neurodevelopmental assessment pathways) neuro) are in the majority White British, and two thirds of those waiting are from the areas in our district that are most deprived.

6. Mitigation and Improvement Activity

The impact of long waits and poor access to services is well documented nationally. BDCFT identified this to be a significant risk to our Children and Families and their outcomes. We also know that the impact of waits is felt across teams and the organisations in terms of team wellbeing and morale, recruitment and retention and to the overall sustainability of the Organisation.

A quality improvement approach was taken to support the teams in identifying and owning their own recovery and improvement plans.

Recovery and improvement plans were created in April 2024, utilising data intelligence to understand the demand, capacity and flow challenges being experienced across the teams with a focus on PMHW Team, Core Team, and the impact that these challenges were having on waiting times, the experience of CYP and their families, alongside the impact of the wellbeing and morale of the staff within CAMHS.

Core Team

The Core Team, with support from BDCFT Improvement and Innovation Team took up the opportunity to work with the Royal College of Psychiatrists Quality Improvement Scheme to look at a national programme that sought to improve waiting times through understanding capacity and flow, to make changes to pathways and processes supporting greater productivity and flow through a pathway. The team designed a new assessment and intervention model, that was strengths and goals based and supports the CYP and the family in structured sessions through a timebound and process mapped pathway.

The Core Team expanded its capacity to triage assess and treat more CYP through changing the hours that they offered support to CYP and families and offered a range of ways for families to connect and be seen.

As a result of the quality improvement work and optimising the workforce available, the number of CYP waiting for Core CAMHS and the length of time waiting has reduced – see table below.

3 Appointment Assessment Model 2024	May	Jun	Jul	Aug	Sep	Oct	Nov 5/11
0-18 weeks	64	77	117	100	111	91	70
18-52	180	157	123	123	108	85	88
52+	33	44	46	28	11	2	0
8 psychological informed sessions 2024	May	Jun	Jul	Aug	Sep	Oct	Nov 5/11
0-18 weeks	20	30	17	19	33	45	78
18-52	37	28	15	15	11	4	2
52+	16	2	3	0	1	0	0

Table – Number of CYP waiting for assessments and treatment in the Core Team

Primary Mental Health Worker Team (PMHW)

A similar approach has been applied to our PMHW pathway and offer. Key to the PMHW pathways is working in partnership with those agencies that support CYP and families. Key recovery and improvement activity has included:

- The reintroduction of school nursing consultations to support the referrer in navigating the right MH support for CYP.
- The introduction of weekend appointments to offer a range of options to support families outside of working hours
- The introduction of working alongside Dance United Yorkshire Group to provide support for CYP while waiting for CAMHS.
- Brathay Trust supporting safe and well phone calls to CYP while waiting for support from PMHW and Core Teams.
- The introduction of a new assessment clinic model to assess the full needs of CYP being referred to CAMHS.

The table below demonstrates the impact that the improvement and recovery plan for PMHW has had on reducing the length of wait for CYP since its introduction.

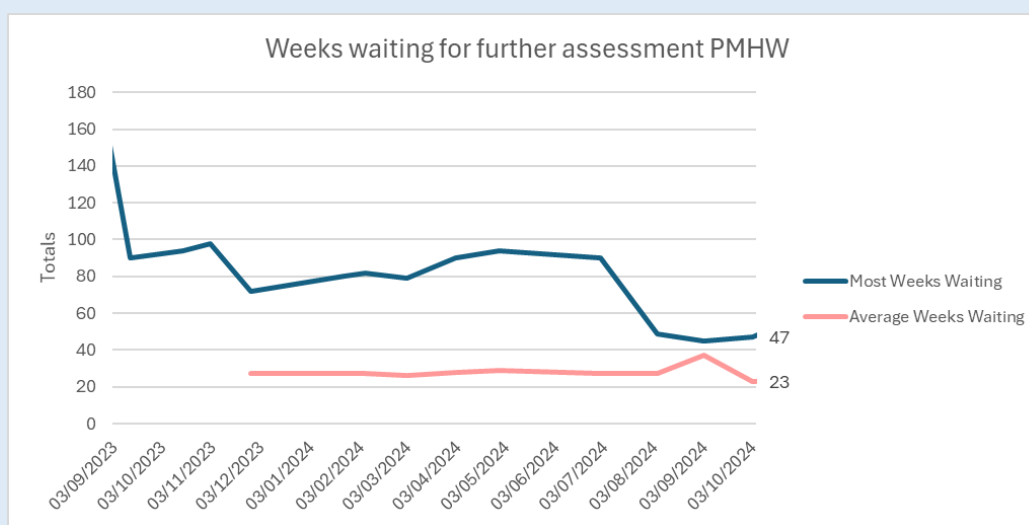


Table – PMHW team length of wait in weeks 2025.

Neurodevelopmental Assessment and Diagnosis Pathway

BDCFT CAMHS assesses Autism and Attention Deficit Hyperactivity Disorder (ADHD) in children and young people (CYP). The team assess CYP referred in before their 18th birthday. For Autism, the Team accept referrals for children over the age of 7. The assessment of autism is carried out not just within BDCFT. The ICB commission BDCFT and the two acute hospital trusts to deliver.

Waiting Times & Access - Monthly				
Indicator	Target	September	October	
Average time waited from referral to first Appointment(days)		237.4	223.6	↑
Average time waited from referral to second Appointment(days)		355.6	412.0	↓
Average time waited from referral to positive ASD diagnosis (Days) (first appointment with an activity code of 'Neuro ASD feedback' recorded)		524.3	1056.6	↓
Average time waited from referral to positive ADHD diagnosis (Days) (first appointment with an activity code of 'Neuro ADHD feedback' recorded)		812.5	916.6	↓
No of people waiting for first Appointment		1305	1346	↑
No of people waiting for Diagnosis		4067	4139	↑

Table – Waiting times for Autism and ADHD diagnostic assessments.

The table above indicates the significant wait families face for assessment and completion of diagnosis. For those with ADHD, once diagnosed and pharmacological treatment is indicated there is a further wait for initiation if treatment.

BDCFT CAMHS have worked with ICB colleagues and have agreed a health equity approach to prioritisation of the waiting list, and this looks to ensure that those children who are most vulnerable, have significant adverse childhood events that further impact their life outcomes are supported.

To note BDCFT CAMHS has an activity-based contract, and the team have achieved its targets in 23/24 and is on track for 24/25 so are assessing and diagnosing the number agreed with ICB. The challenge that BDCFT and all other providers of neurodevelopmental assessments is the exponential rise in referrals for diagnosis and the need for there to be a shift in the model, delivery and commissioning of such services.

There has been significant work undertaken collectively with ICB and the acute hospital trusts to identify pathway improvements, opportunities to maximise the available workforce within the commissioned contracts and there is a team working on a revised model of support that takes a needs led approach to supporting children and families and is a model supported by an innovative workforce model and approach. This requires whole system change and additional financial investment so is subject to ICB equality, quality impact assessment and financial modelling, supported by BDCFT.

7. Waiting Well and Waiting Safely

It is essential that CYP are waiting well and waiting safely. The support available to CYP and families while waiting includes:

- Safe and well checks for CYP while waiting in the Core Team which are conducted by HCSW's with a process to escalate to the Core leadership team in the event of any clinical escalation and/or safeguarding concerns identified.
- Wellbeing safe checks by qualified staff are being completed in PMHW while CYP are waiting for further support.
- Voluntary care sector (VCS) community projects are being utilised to support CYP while waiting for treatment in CAMHS.

Growth of the Waiting Well and Waiting Safe offer

BDCFT CAMHS have developed psychoeducation sessions that CYP, families and Carers can be booked onto at the point of referral to offer information and signposting on how to support each other on some of the key worries and needs that's families face, in particular families that are awaiting neurodevelopmental assessments. These are currently being developed as one-off sessions for families that can be delivered on MS Teams.

8. Performance Monitoring and Assurance Framework

Oversight and assurance of access and waits into BDCFT Specialist CAMHS with a focus on safety is central to BDCFT daily, weekly and monthly governance processes.

Daily Lean Management provides a daily space for teams to come together to report out on their improvement plans and safety of those referrals coming into BDCFT CAMHS. This then triangulates into the Care group and Organisational accountability structures up and back down into committee and board.

Quality Assurance Framework visits have also been undertaken to provide further layers of assurance and support to the teams bolstering our improvement activities and opportunities for any further learning and development.

BDCFT CAMHS continue to develop their improvement plans and their progress feeds into Quality and Safety Committee workplan via biannual waiting time updates and as required should there be a significant change or deviation from the improvement plans.

9. Conclusion

BDCFT CAMHS and the Organisation takes seriously the impact that long waits and access can have upon our Children and families and also the impact that this can have on the teams and the organisation.

A QI approach has been taken to understand how best to find solutions and create realistic and time bound improvement plans to address the significant rise in referrals, support people to wait safely and begin to reduce the length of time people are waiting for support.

We can now see that the actions being taken are starting to show positive improvements in waiting times within our Core and PMHW pathways.

Within the 13 pathways that sit within the BDCFT CAMHS service a number are meeting the national better access and waiting time standard and these are supporting some of our most vulnerable families.

BDCFT CAMHS is focused and committed to continuing to improve the experience and waits for our CYP and families. Not all pathways can be improved by BDCFT alone. The Neurodevelopmental pathway is subject to both a place and WY system wide strategic plan requiring whole system change and investment, but BDCFT is fully committed and involved in this work and maintains its focus on the Organisation and place-based strategy.

10. Recommendations

The Board is asked to note the contents of this report and take assurance in the progress made to address the rise in demand and subsequent impact upon access and waiting times.

Board of Directors – Meeting held in Public

27 November 2024

Paper title:	Mental Health Personal Health Budget	Agenda Item 15.0
Presented by:	Matthew Riley (Involvement Partner) Jacqui Hooley (Principal Social Worker)	
Prepared by:	Matthew Riley (Involvement Partner) Jacqui Hooley (Principal Social Worker)	
Committees where content has been discussed previously	Community Mental Health Transformation Delivery Group, Quality and Safety Committee, Healthy Minds Board	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	X
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	X
	Learning for Improvement	
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	X
	Giving back to our communities	X
Being the Best Partner	Partnership	X
Good governance	Governance, accountability & oversight	

Purpose of the report

Advise and reassure the board around the use of Pilot of One-Off Personal Health Budgets (PHB's) in Mental Health. High lighting some of the key findings of our first six months of the pilot and how we are working to be environmentally and financially sustainable.

Executive Summary

PHB's have supported 110 people (within first six months) either in hospital or at risk of admissions to access support within their own home and/or local communities, this has had an impact of reduced length of stay, reduced delayed transfers of care (DTC), reduced contact with Crisis services, reduced re-admission rates whilst improving engagement and personalising care provision.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

Yes (please set out in your paper what action has been taken to address this)

No

Recommendation(s)

The Board of Directors is asked to:

- Recognise the potential risk of reduced numbers of individuals being transferred home from inpatient settings if PHB's were unavailable due to lack of funding or lack of capacity.
- To support discussions at Bradford District and Craven Health and Care Partnership around longer-term sustainability of PHB's.
- Support wider metric collection (detailed below) to support PHB being sustainable and lean whilst works undertaken to improve data recording as part of wider quality improvement works in inpatients are completed.

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: <ul style="list-style-type: none"> • 						
Care Quality Commission domains Please check <u>ALL</u> that apply	<table border="0"> <tr> <td><input type="checkbox"/> Safe</td> <td><input type="checkbox"/> Caring</td> </tr> <tr> <td><input type="checkbox"/> Effective</td> <td><input type="checkbox"/> Well-Led</td> </tr> <tr> <td><input type="checkbox"/> Responsive</td> <td></td> </tr> </table>	<input type="checkbox"/> Safe	<input type="checkbox"/> Caring	<input type="checkbox"/> Effective	<input type="checkbox"/> Well-Led	<input type="checkbox"/> Responsive	
<input type="checkbox"/> Safe	<input type="checkbox"/> Caring						
<input type="checkbox"/> Effective	<input type="checkbox"/> Well-Led						
<input type="checkbox"/> Responsive							
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report.						

Board of Directors – Meeting held in Public 27 November 2024

Pilot of One-Off Personal Health Budgets (PHB's) in Mental Health

1 Purpose

One off PHB's in Mental Health pilot launched in February 2024, we have supported 200 applications to date within our inpatient settings and those who were at risk of being admitted to inpatient services.

Signposting and a small number of interventions are provided by our delivery partner Bradford District and Craven Mind.

In our first six months we supported 110 applicants (90% inpatients), this reduced length of stay for these individuals, also supported a lower re-admission rate and boosted earlier interventions and help seeking earlier reducing contact with crisis services.

2 Proposed Outcome

- Reduce delayed transfer of care back into community and at home support, supporting transfer back to home when clinically appropriate by reducing socially identified barriers.
- Empower patients and their support network to be involved within their own care design and delivery, support personalisation of care and boost engagement with wider community support increasing the individual's own resilience.
- That we move to offering all inpatients a "What Matters to Me?" conversation, where appropriate a PHB used to provide support (after considering statutory and charity funding available). This is also available to those with a multi-agency care plan who are at risk of being admitted to an inpatient setting (potentially care co-ordinators could support the conversation at the point of referral to Intensive Home Treatment Team (IHTT)).

3 Options

- PHB's for mental health provide the possibility to move towards the NHS long term aim of improving access to personalised care, boosting resilience and supports the aims of community mental health transformation and boosting system working and system resilience.
- We need to have a priority on supporting our inpatients or those at risk of being admitted, with a focus on supporting on the prevention of delayed transfers of care, the PHB pilot has supported conversations with Local Authority partners to joint fund approaches to support individuals returning home in a timely manner once clinically appropriate.

- As an organisation we have a responsibility to provide safe transfers of care from hospital to people returning home, by supporting and addressing socially identified barriers we build up an individual's own resilience in managing their mental wellbeing, building system wraparound support which promotes better outcomes for the individual but also supports our own staff's wellbeing by providing wraparound support to the individual from our wider health, care and VCSE system partners.

4 Risk and Implications

- Funding and resourced to support 20 applications a month, (research shows 75% of patients would benefit from a PHB), if we were to be equitable to all inpatients and those who transition away from hospital, we would need to increase staffing and resources to maintain current service.
- Benefits include reduced length of stay in hospital, reduced re-admission rates, improved access to earlier support from community partners reducing contact with Crisis services. Improves therapeutic relationships with individuals and services. Supports personalised care and improved patient reported outcomes. Supports inpatient staff to support patients to build their own resilience.
- PROMs (Patient Reported Outcome Measures) show 29/31 patients reported overall improvements, improved engagement and trust in community services, support in reduced re-admissions to inpatient services and patient self-reported reduction in contact with Crisis services.
- Increased referrals support the Trust to reduce length of stay and support reducing re-admission (supporting to reduce need for out of area beds), this increases spending at Bradford District and Craven Mind as our delivery partner (funded via Bradford District and Craven Health and Care Partnership), if we wished to support higher referrals to support winter pressures the Trust may need to provide some financial assistance, or recognise the pilot will finish earlier (currently expected to run until July 2025).
- Lack of consistent data recording causes a significant amount of time spent chasing wards for accurate estimated discharge dates (EDD) (this can be due to complexity, point of referral (crisis admission PHB's), staff not knowing where EDD is recorded, we propose tweaking our data reporting, where an EDD is reported we will continue to report bed days saved (and attempt to capture this from the wards when not included), we propose we report as a percentage the number of inpatient applications where a EDD is not provided at point of application (with the aim of highlighting this reducing as improvement works continue to be embedded), we will ask if the PHB will prevent a delay in leaving hospital (reducing and preventing a socially identified barrier), we will then report on the percentage of PHBs which have supported reducing delayed transfers back to community services, additionally for those applicants which are aimed to avoid admission we know when someone is referred to Intensive Home Treatment Team (IHTT) they are most likely to be admitted within 10 days of referral, we would report the percentage of applicants who are not admitted to inpatient services within 10

days of being referred to IHTT. This data is reported and presented in the Community Mental Health Transformation Dashboard.

5 Results

- Presented at Healthy Minds board on 19th November 2024 (postponed until 13th December 2024), awaiting outcome at future meeting around longer-term plan for PHB's in mental health to support prevention of admission and helping people return home and to their communities.
- Await outcome of above, move towards using DIALOG as an outcome measure to support community mental health outcome measures and monitor improvements of patient reported outcomes. Switch to monitoring where it prevents a delayed transfer of care.
- Increase discharge review for 90 days in addition to 28 days, supporting screening with Community Mental Health Rehabilitation team to help maintain longer term recovery and support re-admissions going forward.

Names: Matthew Riley, Jacqui Hooley

Titles: Involvement Partner, Principal Social Worker

Date: 11 November 2024

One-off Personal Health Budgets in Mental Health

Matthew Riley, Involvement Partner
Jacqui Hooley, Principal Social Worker



What is working well?

- ❖ Working closely with the Local Authority, supporting joint funding of PHB's and LA funding working together to support patients to return home.
- ❖ Working together to support Care Act Screening and supporting package reviews to ensure individuals are supported appropriately at home.
- ❖ Working with VCSE (Bradford District and Craven Mind) supporting shared understanding of risks, how to support positive risk management whilst keeping staff and individual safe.
- ❖ Supporting individuals to be empowered in identifying their own recovery goals, working towards the personalised care goals of NHSE to support positive recovery outcomes for individuals.
- ❖ Boosting staff's knowledge of wider community support available.
- ❖ Supporting systemwide staff's understanding of delivering Trauma Sensitive and Trauma Aware approaches and interventions.

PHB's – The golden thread

One off PHB's in Mental Health have brought many of the principles of Community Mental Health Transformation together.

- ❖ Co-production and involvement – Lived Experience has been involved in designing the approach, promotional materials, training staff and improving knowledge, reviewing applications, signposting and completing warm referrals/handovers, collecting feedback, developing the evaluation report. Each application is completed in partnership between staff and the individual, pulling in what is important to them, what has kept them safe and well in the past and what they would like to achieve in future.
- ❖ Personalised Care – Empowering individuals to recognise what care and support is important to them to creating a recovery pathway in the community, with choice on how this is delivered, so care is designed with their needs at the heart of the conversion.
- ❖ Information sharing/System working – Working in partnership with our delivery partner and joint commissioner we have managed how information is shared, removing silo working and acting as one to provide care and support in a timely and appropriate way.
- ❖ Supporting and empowering people to access care across our wider VCSE system partners, supporting people to access care and support earlier and reducing contact with crisis services.

Personal Health Budget Pilot for Mental Health

Our journey so far...

February to
October
2024

182

Applications supported

415

Personal health budget has contributed to reduction in bed days

2%

Readmission rate compared to 9% for those without a PHB February - July

41500

Reduction in carbon emissions (kg)

327,277

Financial saving from reduction in bed days (£)

One in four

Personal health budgets have supported one in four discharges from hospital (February⁹⁵ July)

Community system support/signposting

841

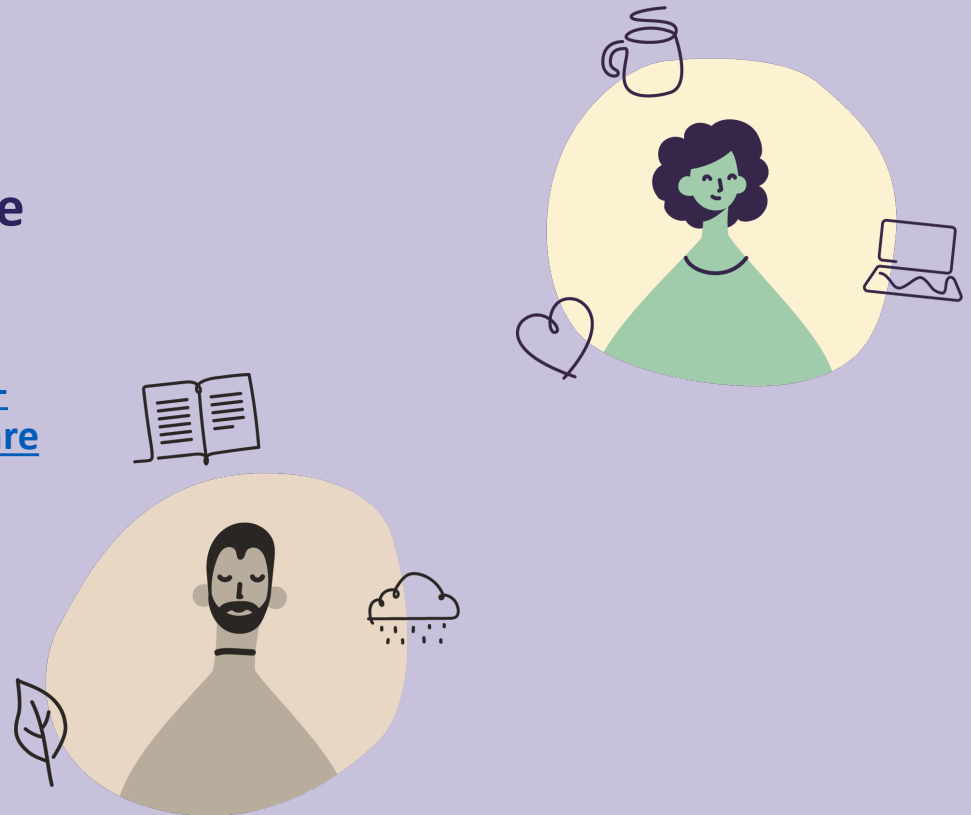


Questions?

Evaluation report will shortly be
on the partnership website

[Community mental health transformation -
Bradford District and Craven Health and Care
Partnership](#)

personalhealthbudgets@bdct.nhs.uk



Trust Board update 27th November 2024

Outline Business Case for the redevelopment of Lynfield Mount Hospital



Executive Summary

- Introduction
- Strategic Case
- Economic Case
- Commercial Case
- Financial Case
- Management Case
- Conclusions
- Recommendation

The Outline Business Case (OBC) has been produced using His Majesty's Treasury (HMT), Department of Health and Social Care (DHSC) and NHS England (NHSE) guidance and seeks Trust Board approval in preparation of the proposed development that requires national capital funding.

The OBC has the following key aims:

- To ensure that this significant capital investment responds to the needs of patients, providing a safe and therapeutic environment that supports transformative adult acute care pathways and the principles of 'Care Closer to Home'.
- To demonstrate that patients, local stakeholders and staff have been engaged from an early stage in articulating the case for change and the Trust's vision.

The Board are to note that The OBC was submitted to regional NHS England finance colleagues on 01/11/24 and has been approved following a check of the fundamental criteria for any OBC submission, reviewing all the elements of the case.

This has now gone to the National Capital and Commercial Team (NCAT) for approval and is estimated to be a 12-week process.

Strategic Case (1)

National and Local Context

- The NHS Mental Health Five Year Forward View made a decisive and unprecedented step towards closing the treatment gap for mental health.
- The incidence of mental health issues within our population is significant.
- In the context of historic underinvestment, the development of services and facilities to support people with a wide range of mental health issues is a pressing national and local concern.
- In January 2019, NHS England published the NHS Long Term Plan. This set out a ten-year vision for mental health services in England, supported by a long-term funding settlement that was agreed by the Government in July 2018. The business case for the redevelopment of Lynfield Mount Hospital represents a significant element of our delivery of the Long-Term Plan.
- Our vision is to make a transformational investment that will dramatically improve the experience of and outcomes for Service Users; promote recovery; inclusion; research and development; and have a beneficial impact on the whole Adult Mental Health pathway.

Strategic Case (2)

Case for Change

- Lynfield Mount Hospital has been redeveloped over time - a main 1960s block and several separate unconnected units, which are no longer functionally suitable to support recovery-focused admissions.
- Many service users who experience acute mental health problems will have experienced significant adversity and trauma that can easily be reactivated by an admission. The current, out-dated and compromised layout and limited access to therapeutic spaces essentially provides containment, despite the best efforts of staff.
- The ward layout and size has led to high staffing costs.
- The Trust faces significant backlog maintenance issues and environments fall far below current standards/ best practice.
- The Trust has relatively high average lengths of inpatient stay, partly fuelled by the poor therapeutic values of our current estate. This leads to high Out of Area placements which is detrimental to patients and to the Trust's financial performance.
- Current accommodation fails to provide sufficient privacy and dignity (e.g. lack of en-suites).
- Carbon net zero by 2030 - Redevelopment affords transformative carbon reduction opportunities by utilising innovative low carbon design and technology.
- Safe Environments - the hospital environment cannot currently support the level of quality or safety of the standard expected for mental health and learning disability services both now and in the future.

Economic Case (1)

Critical success factors – all options evaluated:

- Options 1 to 4 discounted as costs exceed £50m capital allocation/ or cannot be delivered by March 2028
- Options 4a and 5 evaluated against investment objectives (see next slide)

			Do nothing	Option 1	Option 2	Option 3	Option 4	Option 4a	Option 5
			£0	£127,215,648	£91,351,561	£79,396,151	£51,382,897	£49,487,751	£45,432,682
Critical Success Factor category	Critical Success factor	How achieved							
Strategic fit and business needs compliance	* Capacity to meet service need, including reduced reliance on out of area placements * Safe inpatient environment to prevent hazards that have the potential to cause harm	* Increase bed base to meet demand and support care closer to home * Enhanced therapeutic spaces to support recovery and care delivery	Bed base unchanged - service users placed out of area Environment not supportive of therapeutic engagement and care						
Maximises benefits and value for money	* Service pathway improvement * Reduced average length of stay * Supports care closer to home (reduced OAPs) * Improved staff recruitment and retentions * Maximises environmental sustainability * Reduced backlog maintenance	* Improved therapeutic inpatient environment, resulting in: - improved recovery timescales - increased privacy and dignity - reduced patient acuity - staff wellbeing	Inpatient estate remains not fit for purpose						
Option achievability	* Project conforms to required timescale for completion * Must maintain a live hospital site - key considerations of patient distress and alarm response	* Project completion date of March 2028 * Length of time the site is under development		Exceeds March 28 timescales	Exceeds Mar-28 timescales	Exceeds March 28 timescales			
Within our capacity and capabilities to deliver	* What development options allows service continuation and minimise patient disruption, and managing the site safely	Formation of each option to evaluation levels of disruption		Due to the build timescales, disruption to services to extended	Due to the build timescales, disruption to services to extended	Due to the build timescales, disruption to services to extended			
Fits with affordability ceiling	* Options that are not realistically within the capital ceiling will be discounted	* Assessment of total capital costs - inclusive of contingency, optimism bias and fees		Exceeds £50m	Exceeds £50m	Exceeds £50m	Exceeds £50m		
Outcome - Options that will be assessed against investment objectives			Base case	Discount	Discount	Discount	Discount	Proceed to Investment objectives appraisal	Proceed to Investment objectives appraisal

Economic Case (2)

Investment objectives – options evaluated (Do nothing; Option 4a and Option 5)

- Option 5 discounted as benefits derived from the investment are significantly less than option 4a
- Do nothing and Options 4a will be taken forward for a full economic assessment (CIA)

Investment Objective	Weight	Benefits criteria	Benefit summed	Benefit weighting	Un-weighted scores			Weighted scores			
					Do Nothing	Option 4a	Option 5	Do Nothing	Option 4a	Option 5	
SO1 – Therapeutic acute pathway improvement	25%	Maximises staff efficiency and effectiveness within the working environment	100%	15%	1.0	7.0	5.0	0.2	1.1	0.8	
		Reduces the risk of incidents		10%	1.0	7.0	4.0	0.1	0.7	0.4	
		Supports occupancy target – meets national requirements and allows for variation in demand to reduce demand for out of area placements		15%	1.0	9.0	5.0	0.2	1.4	0.8	
		Provides enhanced internal environment leading to improved wellbeing and recovery outcomes		30%	1.0	9.0	5.0	0.3	2.7	1.5	
		Provides access to external recreation facilities leading to improved wellbeing and recovery outcomes		15%	1.0	7.0	5.0	0.2	1.1	0.8	
		Supports 'Care Closer to Home' model of care		15%	1.0	7.0	7.0	0.2	1.1	1.1	
SO2 – Acute discharge facilitation	25%	Supports a reduction in inpatient length of stay by providing a more therapeutic recovery-focused environment	100%	60%	1.0	8.0	6.0	0.6	4.8	3.6	
		Supports (maximises) community/ inpatient staff interaction by providing facilities to enable the in-reach of community staff onto inpatient wards		40%	1.0	8.0	6.0	0.4	3.2	2.4	
SO3 – Recruit and retain the best staff	25%	Provides the best configuration/ greatest capacity for staff training	100%	40%	1.0	8.0	3.0	0.4	3.2	1.2	
		Ward sizes remodelled to optimal 18-bed units		40%	1.0	10.0	10.0	0.4	4.0	4.0	
		Provides better staff welfare facilities/ wellbeing		20%	1.0	8.0	5.0	0.2	1.6	1.0	
SO4 – Comply with best practice and standards	25%	In line with national best practice standards including HSIB	100%	20%	1.0	7.0	7.0	0.2	1.4	1.4	
		In line with Health Building Notes and Health Technical Memoranda requirements		20%	1.0	7.0	7.0	0.2	1.4	1.4	
		Reduced Backlog Maintenance costs		30%	1.0	8.0	4.0	0.3	2.4	1.2	
		Supports enhanced sustainability agenda as the Trust works toward Net Zero 2030		30%	1.0	8.0	6.0	0.3	2.4	1.8	
	100%								4.0	32.3	23.2

Carry forward	Preferred way forward	Discount
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Economic Case (3)

Benefits realisation savings:

The full range of benefits are considered in the Economic Case, whereas only the cash releasing benefits are considered in the Financial Case. The benefits for the economic case of the £49.5m development are as follows:

- Cash releasing savings - £5.794m
- Non cash releasing - £18k
- Societal - £4.175m

Recurrent annual benefits	Annualised benefit value £'000
Reduction in 1:1 observations	£210
Reduction in violence and aggression	£500
Improvement in patient flow	£1,299
Reduction in Out of area placements (10 bed increase @ LMH)	£3,515
Reduction in maintenance and utilities costs	£154
Reduced staff sickness	£116
Total Cash Releasing benefits	£5,794
Reduction in clinical errors	£7
Reduced staff turnover	£11
Improved Mental Health	£4,095
Reduction in CO2	£57
Lifetime and economic benefit of NVQ2 appren	£24
Total recurrent annual benefits	£9,988

Type of Benefit		
Cash releasing £'000	Non-cash releasing £'000	Societal benefit £'000
£210		
£500		
£1,299		
£3,515		
£154		
£116		
£5,794	£0	£0
	£7	
	£11	
		£4,095
		£57
		£24
£5,794	£18	£4,175

Economic Case (4)

The purpose of the economic appraisal within the OBC is to re-appraise and rank the shortlisted options assessed in terms of their relative public value to society. The appraisal tests options using a cost benefit analysis identifies the social value determined by way of a balanced judgement of two measures; net present social value (NPSV) and a benefit to cost ratio (BCR). The test focuses on the incremental change between the BAU and the “preferred way forward” option.

The approach in the CIA model is to calculate the incremental difference (up or down) of both costs and benefits for the preferred way forward against the BAU option, thereby giving a true ‘additional’ economic cost benefit. The tables below shows the results of the economic analysis.

Economic summary

After reflecting the incremental costs and benefits described in section 3.4 of the full OBC, the summary of the economic appraisal is shown in the table below. Option 1 (4a) (£49.5m development) exceeds the required threshold with a benefit cost ratio of 4.59.

Economic Summary (Discounted) - £m		
	Option 0 - Business as Usual	Option 1 - £49.5m development
Incremental costs - total	£0.00	-£49.06
Incremental benefits - total	£0.00	£225.16
Risk-adjusted Net Present Social Value (NPSV)	£0.00	£176.11
Benefit-cost ratio		4.59

Commercial Case (1)

Proposed contract duration and phasing of the redevelopment

Phase 1 (enabling works): January 2025 – March 2025

- Utilising the NHSE Early Fee and Enabling Funding Drawdown Process, form temporary entrance, decant works, demolition of bungalows, preparatory groundworks, stopping up of roads, footpaths etc.

Phase 2: October 2025 - December 2026

- New Entrance, link corridors to existing main building, stair & lift cores including all landscaping works, parking & external spaces. 2x New modular / MMC 18 bed ensuite wards to include all foundations, podium, groundworks and drainage.
- Energy Centre to power new build including services connections.
- Moderate refurb of main building to form: off ward therapy, safe interview rooms, outpatients / doctors' rooms, tribunal/meeting spaces, café, pharmacy, cashier, clozapine clinic, changing place, staff change, toilets, prayer facility, infant feeding, Recreation Hall, off-ward therapy spaces, and storage. Group Rooms & associated server and plant rooms.

Phase 3:-February 2027 – July 2027

- Refurbish Ashbrook ward (18 bed ward; 100% ensuite; address all drainage issues).

Phase 4: September 2027 - March 2028

- Refurbish Oakburn ward (18 bed ward; 100% ensuites; address all drainage issues).

Works complete: March 2028

Commercial Case (2)

The Procurement Strategy

There are a range of high-level procurement options open to the Trust to deliver the project.

Each option has relative and perceived strengths and weaknesses which need to be assessed against the specific project requirements to determine the appropriate procurement strategy.

Recommended Procurement Approach

A procurement assessment has been undertaken to determine the exact procurement route. This process assessed the options available to the Trust, which provided the best value for money solution whilst noting the time and cost implications of the project.

Following a procurement options process the Trust have agreed a preference for a framework procurement approach. Due to the relatively small value of this work, the **NHS SBS Frameworks** will be used to procure the project.

Cabinet Office have completed their Pipeline Assurance Review (PAR) and the status of this workplan is “Assure” status on our proposed commercial and procurement strategy. Cabinet Office do not require any further information on the scheme.

Commercial Case (3)

The New Build element will be delivered via the NHS SBS Modular Buildings Framework Agreement.

-This route has been chosen to **enable us to partner with a suitable contractor early** in the process via a Pre-Construction Services Agreement (PSCA) to ensure the solutions are scalable, adaptable, and cost-effective.

-The Modular Buildings Framework Agreement provides up to **50% faster delivery than onsite construction**. The efficiency gains from modular and offsite manufactured solutions **support the delivery of the government's construction and industry strategy targets**, which include time and cost savings as well as whole life cost benefits and in use savings.

-This route is also preferable as **offsite construction means less disruption** on our live site is highly beneficial to both service users and staff.

-Modular buildings also support the environment, with **reduced carbon emissions, and less dust and noise pollution during the construction process** – ideal for healthcare where the environment should be clean and quiet. This route also supports government strategy by ensuring that **social value, sustainability, MMC and key principles of The Construction Playbook** are incorporated within the framework agreement.

Commercial Case (4)

The Refurbishment element will be delivered via the NHS SBS Public Sector Construction Works Framework Agreement.

-This route was chosen as the Public Sector Construction Works Framework Agreement forms part of a wider solution that **focuses on, 'future-proofing estates and infrastructure', helping to achieve NHSE estates and infrastructure targets.** It is based on eight core principles that **suppliers are required to embrace and commit to, ensuring the delivery of Social Value, Modern Methods of Construction (MMC), collaboration, and an integrated supply chain,** in line with government strategies, to ensure works are completed more cost effectively, while maintaining high build quality.

The form of contract will be the NEC4 form of contract for both elements of the scheme.

-It is anticipated that partnering with a contractor early via the framework in both instances will result in an **earlier construction start date, less exposure to financial risk, reduced risk contingency and a Guaranteed Maximum Price (GMP) and access to the buying power of the listed Preferred Supply Chain Partners (PSCPs).**

Commercial Case (5)

Professional services

A range of services will be required to successfully implement the proposed project. These will differ during the different stages of the project's lifecycle:

- **Specialist advice** – such as financial, tax, legal, technical, healthcare planning and project management, to support the Trust during the business case development and procurement process
- **Design** – to design the redeveloped estate in support of the preferred option
- **Build** – to undertake the proposed construction works
- **Finance** – to fund the proposed works and transition activities.

The Trust has some in-house capabilities for estates, finance, project and service planning, but the scale and complexity require specialist expertise and additional capacity throughout the implementation stages.

Commercial Case (6)

BREEAM

- All new build projects for the NHS carry a mandatory assessment BREEAM target criterion of 'excellent'. Refurbishment projects - target reduced to 'very good'.
- The costs associated with achieving a BREEAM target criterion of 'excellent' are not inconsiderable.
- Trust is committed to environmental sustainability, the NHS zero carbon commitment and will employ (and are employing) the most appropriate project approach to minimise adverse environmental impact of the programme of works. Consequently, as a minimum, all the projects relating to the LMH redevelopment project will target a BREEAM rating of 'excellent' for new build elements and 'very good' for refurbishment project elements where clinically appropriate.

Planning Permission

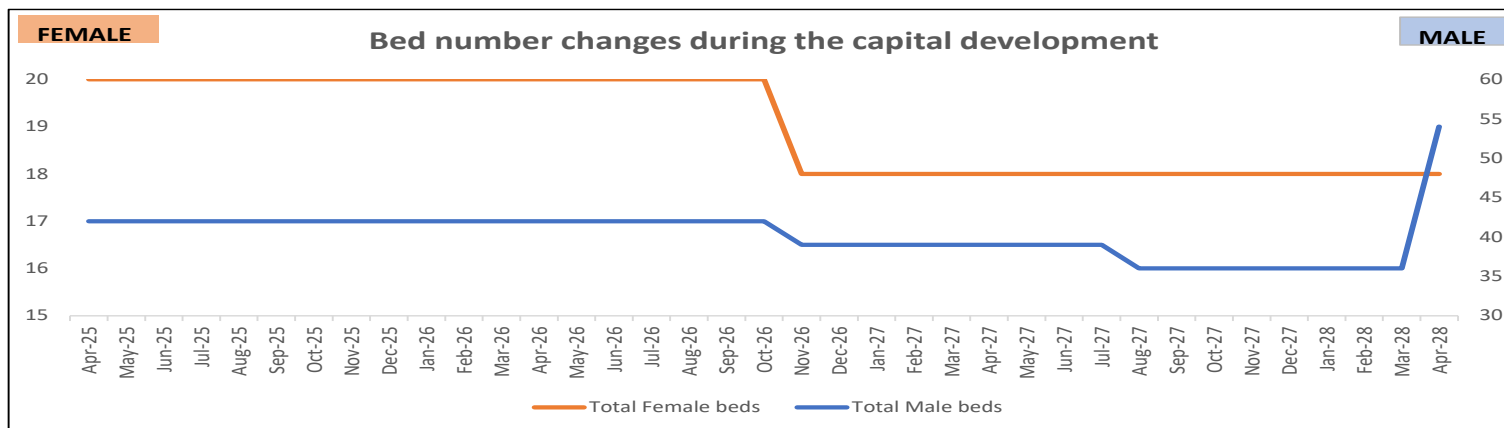
- The Trust are in receipt of full planning approval with reserved matters for the development. All reserved matters will be completed in Q4 2024/25 allowing the new build development to commence in October 2025. The local authority have helpfully indicated that the proposals for this project are not seen as contentious and are fully supporting the Trust to complete the development.

Financial Case (16 - 23) - following slides

Bed modelling

The bed profile below reflects the number of LMH inpatient beds available throughout the various phases of the development.

- Beds will **reduce by 5** from Nov-26 to Jul-27 due to Ashbrook and Maplebeck closing (41 beds) and 2 new modulars opening (36 beds)
- Beds will **reduce by a further 3** from Aug-27 to Mar-28 as Oakburn closes (21 beds) and Ashbrook reopens (18 beds)



	April 25 to Oct 26	Nov 26 to July 27	Aug 27 to Mar 28	Apr-28
Oakburn	21	21	0	18
Maplebeck	21	0	0	0
New Modular 1	0	18	18	18
New Modular 2	0	0	18	18
MALE BEDS	42	39	36	54
Ashbrook	20	0	18	18
New Modular 2	0	18	0	0
FEMALE BEDS	20	18	18	18
Total beds	62	57	54	72

The current bed base for LMH acute inpatient wards is 62 beds and will increase to 72 beds when the build is complete.

- LMH Male beds will **increase** by 12 – from 42 to 54 beds. There are 15 beds @ ACMH - Total Male beds 69
- LMH Female beds will **reduce** by 2 – from 20 to 18 beds. There are 19 beds @ ACMH - Total Female beds 37

Capital Spend Profile

Capital Costs – profiled by project phase and financial year

Phase	Project Description	2024/25	2025/26	2026/27	2027/28	TOTAL
		£000	£000	£000	£000	£000
1	Enabling works; Demolition of Bungalows and new temporary entrance.	673				673
2	New modular two-storey ward building with associated external works. Refurbishment to main building cluster and external works.	602	25,044	17,098		42,744
3	Refurbishment of Ashbrook Ward ensuites.			1,690	1,409	3,099
4	Refurbishment of Oakburn Ward ensuites.				2,972	2,972
	TOTAL	1,275	25,044	18,788	4,381	49,488

Capital Costs – summary of capital cost type in each phase

Initial Capital	Phase 1 (enabling)	Phase 2	Phase 3	Phase 4	TOTAL
	£000	£000	£000	£000	
Works & abnormalities subtotal	439	27,646	2,029	1,960	32,073
Fees	37	2,650	187	175	3,049
Non-work costs	0	271	0	0	271
Equipment	25	866	74	69	1,034
Planning Contingency	25	1,767	125	116	2,033
Sub-total	525	33,200	2,414	2,320	38,460
Optimism bias	43	3,019	212	198	3,473
Total (excluding VAT)	569	36,220	2,626	2,519	41,933
VAT	104	6,525	473	453	7,555
Total Capital Cost (including VAT)	673	42,744	3,099	2,972	49,488

Summary financial overview

Headlines:

- Pay back period 5 years in 2028/29
- Additional **recurrent costs of £3.8m** will be incurred as the number of wards are increasing from 3 to 4 (with an increase in 10 beds), and an additional s136 suite including:
 - Staffing (Nursing and Medical)
 - Estates costs (Utilities, maintenance, house-keeping, food and linen)
 - Non pay costs – Prescribing, ward budget
 - Capital charges
- Net **non-recurrent costs of £2.2m** will be incurred during the build due to the number of beds temporarily reducing during the development.
- Total **cash releasing benefits of £5.8m** will be realised from improvements to the inpatient environment resulting in:
 - Reduction in average length of stay
 - Reduced staff absence and turnover
 - Reduction in violence and aggression
 - Reduction in acuity and special observation needs
 - Reduction in out of area placements reflective of 10 additional beds at LMH
 - Reduction in maintenance and utility costs

	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	TOTAL £'000	Recurrent £'000
Recurrent costs	£159	£824	£38	£2,802	£0	£3,823	£3,823
Non Recurrent incremental change in costs	£0	£516	£1,734	£0	£0	£2,250	£0
Total costs	£159	£1,340	£1,772	£2,802	£0	£6,073	£3,823
Cash releasing benefits	-£10	-£253	-£1,001	-£4,190	-£340	-£5,794	-£5,794
Net incremental annual cost/ (benefit)	£149	£1,087	£771	-£1,388	-£340	£279	-£1,971

Detailed financial overview

Headlines:

- Incremental net cost increases will be funded from MHIS/ SDF over the 4 year period, until benefits are fully realised to cover costs.
- Additional staffing and estates costs will be incurred when all 4 wards are open in April 2028.
- The numbers of beds reduce during the term of the development until all ward are open, so there will be a need to source additional out of area beds at a cost of £3.1m. There will be a reduction in variable costs of £0.9m aligned to bed reductions for costs such as temporary staffing costs, pharmacy, food and linen.

	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	TOTAL £'000
Source of funding						
Mental Health Investment Standard		-£1,049	-£1,772	-£552	£0	-£3,373
Inpatient Quality (SDF)	-£159	-£291	£0	£0	£0	-£450
Total funding cover costs	-£159	-£1,340	-£1,772	-£552	£0	-£3,823
Incremental recurrent costs						
Ward Staffing costs	£0	£0	£0	£1,852	£0	£1,852
Medical/ Clinical Staffing costs	£0	£0	£0	£498	£0	£498
Pay inflationary costs	£0	£0	£0	£399	£0	£399
Estates (House keeping; Food; Linen; Utilities)	£0	£0	£0	£257	£0	£257
Non Pay (incl ward budget & prescribing)	£0	£0	£0	£118	£0	£118
Capital Charges	£159	£824	£38	-£323	£0	£699
Total recurrent incremental costs	£159	£824	£38	£2,802	£0	£3,823
Incremental non recurrent cost changes - phasing of bed base changes						
Out of area placements	£0	£712	£2,391	-£3,103	£0	£0
Variable benefit of temporary bed reductions	£0	-£206	-£693	£899	£0	£0
Total non recurrent incremental costs	£0	£506	£1,699	-£2,204	£0	£0
TOTAL COSTS	£159	£1,330	£1,737	£597	£0	£3,823

Workforce - assumptions

NURSING & AHP

- **Funding in baseline for the 3 wards in scope – 126.07 WTE**
- When 2 new modular wards open, Ashbrook and Maplebeck will close for refurbishment and the staff from these wards will transfer to modulars (3 wards open - 2 modular and Oakburn) – no change in WTE
- When Ashbrook opens, Oakburn will close for refurbishment and staff from Oakburn will transfer to Ashbrook (3 wards open - 2 modular and Ashbrook) – no change in WTE
- Oakburn will open in April 2028, at this point all 4 ward will be open.
- No additional costs will be incurred for OT's. An alternative model is under development to support delivery within current resources.
- S136 suite staffing requires one additional HCSW on shift 24 hours per day – equates to 5.45 WTE

Additional WTE of 43.99 at a cost of £1.85m in 2028/29 (an increase of 5.45 WTE)

MEDICAL STAFF

The following additional posts will be required when all 4 wards are open in April 2028:

- Additional 1 WTE Consultant and 1 WTE SAS Doctor
- Additional 2 WTE training grade doctors – assumed that 40% of the costs are funded from NHS England
- Additional 1 WTE Psychology post

Additional 5 WTE clinical staff at net cost of £0.5m in 2028/29

Workforce Model

Staff Bands	Ashbrook	Maplebeck	Oakburn	Baseline for wards in scope	Ashbrook	Oakburn	New Modular Ward 1	New Modular Ward 2 & new s136 suite	New Staffing for wards in scope	2025/26 3 wards	2026/27 3 wards	2027/28 3 wards	2028/29 increase in establishment	Increase in Costs @ 2024/25 prices	Increase in Costs @ 2024/25 prices £'000
Activities Co-ordinator Band 3	2.73	2.73	2.73	8.19	2.73	2.73	2.73	2.73	10.92	8.19	8.19	8.19	2.73	£88,042	£88
Nurse band 7	2.05	1.05	1.05	4.15	2.05	1.05	1.05	1.05	5.20	4.15	4.15	4.15	1.05	£68,851	£69
Nurse band 6	4.00	4.00	4.00	12.00	4.00	4.00	4.00	4.00	16.00	12.00	12.00	12.00	4.00	£222,815	£223
Nurse band 5	9.62	9.62	9.62	28.86	9.62	9.62	9.62	9.62	38.48	28.86	28.86	28.86	9.62	£459,304	£459
Nurse band 4	2.73	2.73	2.73	8.19	2.73	2.73	2.73	2.73	10.92	8.19	8.19	8.19	2.73	£106,925	£107
Occ Therapist band 6	1.05	1.05	1.05	3.15	1.05	1.05	1.05	0.00	3.15	3.15	3.15	3.15	0.00	£0	£0
Occ Therapist band 5	1.05	1.05	1.05	3.15	1.05	1.05	1.05	0.00	3.15	3.15	3.15	3.15	0.00	£0	£0
Occ Therapist band 3	1.05	1.05	1.05	3.15	1.05	1.05	1.05	0.00	3.15	3.15	3.15	3.15	0.00	£0	£0
Psychologist band 4	1.05	1.05	1.05	3.15	1.05	1.05	1.05	1.05	4.20	3.15	3.15	3.15	1.05	£36,601	£37
Pharmacist Band 5	1.00	1.00	1.00	3.00	1.00	1.00	1.00	1.00	4.00	3.00	3.00	3.00	1.00	£38,446	£38
Healthcare Asst Band 3	5.45	5.45	5.45	16.35	5.45	5.45	5.45	5.45	21.80	16.35	16.35	16.35	5.45	£217,869	£218
Healthcare Asst Band 2 - s136	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.45	5.45	0.00	0.00	0.00	5.45	£213,822	£214
Healthcare Asst Band 2	10.91	10.91	10.91	32.73	10.91	10.91	10.91	10.91	43.64	32.73	32.73	32.73	10.91	£399,676	£400
Ward establishment	42.69	41.69	41.69	126.07	42.69	41.69	41.69	43.99	170.06	126.07	126.07	126.07	43.99	£1,852,350	£1,852
MEDICAL STAFF															
Consultant													1.00	£221,000	£221
SAS doctor													1.00	£155,061	£155
Training grade - CT1 (assumes 40% funding from NHS England)													1.00	£41,254	£41
Training grade - FY1 (assumes 40% funding from NHS England)													1.00	£30,232	£30
Psychology - Band 7													1.00	£50,092	£50
Additional Clinical Staff													5.00	£497,639	£498
Total additional staffing													48.99	£2,349,989	£2,350

Inflated for 4 years pay uplift @ 4%

£2,749,155

£2,749

Benefits realisation

Total annualised recurrent cash releasing benefits realised from the capital investment amount to £5.8m, as shown below.

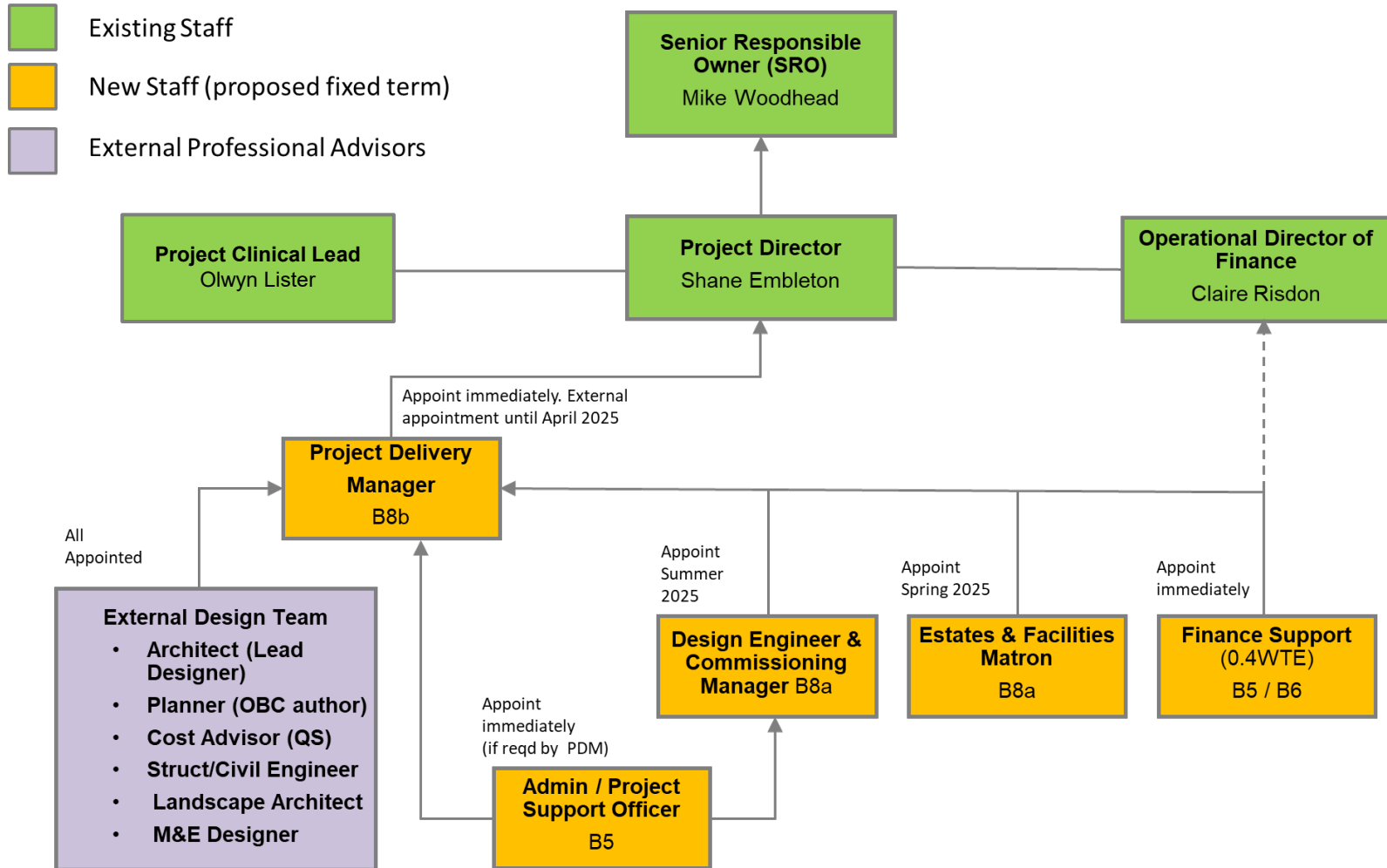
The vast majority of the cash releasing savings will be released from a reduction in reliance on out of area beds from reduced LOS and the additional 10 beds at LMH. Additional savings will be delivered through a reduction in temporary staffing costs from the improved ward environments for both staff and service users, and a reduction in reactive maintenance costs.

Note: Only cash releasing benefits are recognized in the Financial Case

Recurrent annual benefits	Annualised benefit value £'000	PHASING					
		2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	Total £'000
Reduction in 1:1 observations	£210	£0	£70	£70	£70	£0	£210
Reduction in violence and aggression	£500	£0	£125	£208	£167	£0	£500
Improvement in patient flow	£1,299	£0	£0	£629	£330	£340	£1,299
Reduction in Out of area placements (10 bed increase @ LMH)	£3,515	£0	£0	£0	£3,515	£0	£3,515
Reduction in maintenance and utilities costs	£154	£10	£58	£93	£-7	£0	£154
Reduced staff sickness	£116				£116		£116
Total Cash Releasing benefits	£5,794	£10	£253	£1,001	£4,190	£340	£5,794

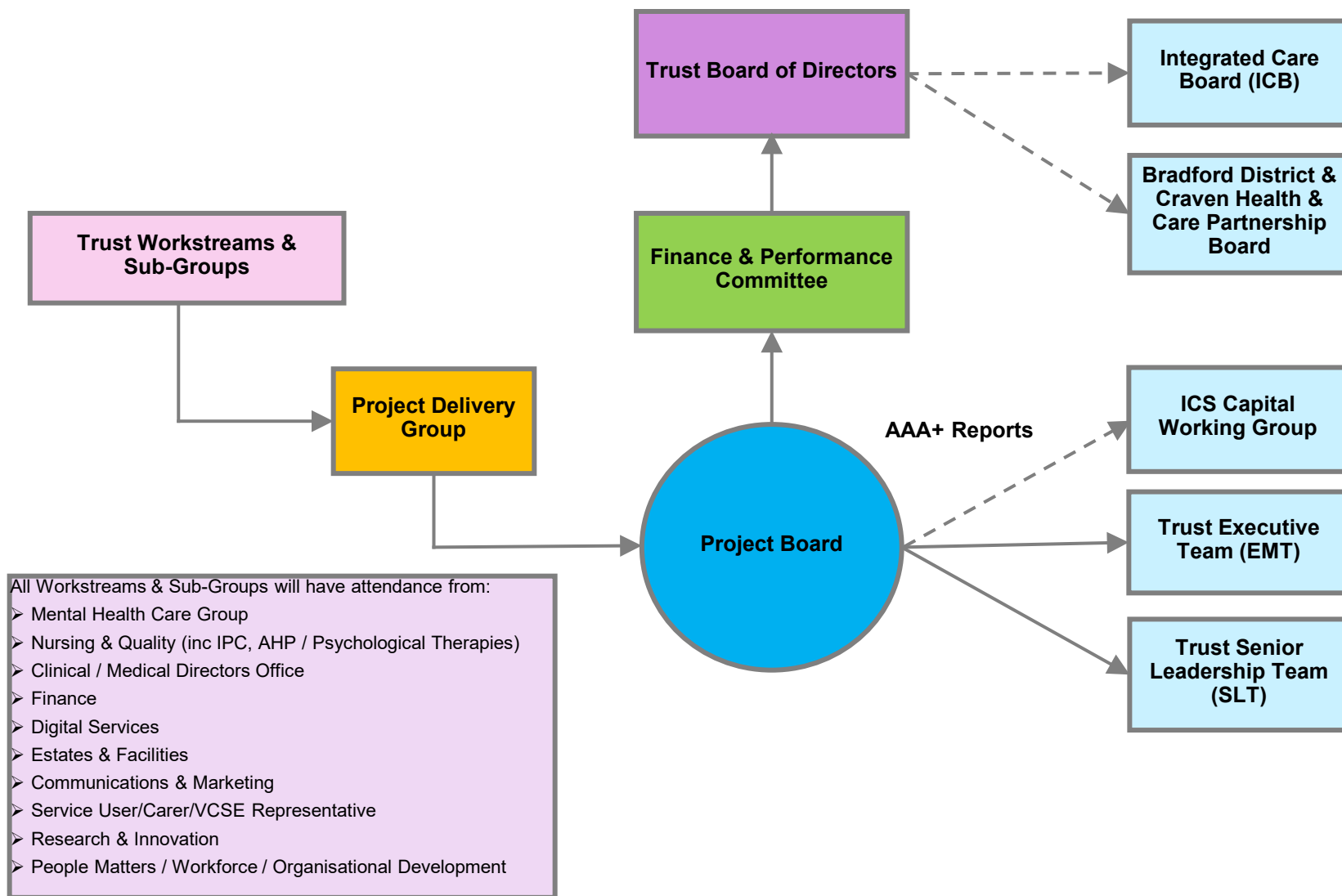
Management Case (1)

Project Management Arrangements



Management Case (2)

Project Reporting Arrangements



Management Case (3)

PROJECT TIMETABLE (GOVERNANCE)

- OBC “Regional Approval” : submitted 1 November 2024 (NOW APPROVED)
- Application for early drawdown of £1.275m capital for enabling works and professional fees: October 2024 – to expend in Q4 2024/25 (NOW APPROVED)
- Cabinet Office submission (all schemes over £20m value) : November 2024 (NOW APPROVED)
- OBC “National Capital and Commercial Team (NCAT) approval” and Joint Investment Sub Committee (JISC) : Q4 (January) 2024/25
- Procurement process: Q1 (April) 2025/26
- Full Business Case (FBC) Approval : Q2 (August) 2025/26
- Start on Site: Q3 2025/26 (October 2025) *noting “enabling works” on site Jan 2025 – March 2025*
- Works Complete: March 2028

The submitted OBC seeks approval to develop a Full Business Case (FBC) to transform part of the Trust's main Inpatient site at Lynfield Mount Hospital.

No contingency plan to meet the strategic and service needs of the Trust exists if this approach is not approved. Therefore:

- The identified business needs will not be met, and the Trust will be unable to provide an acceptable level of therapeutic, safe and high-quality care, or to meet CQC regulatory standards for adult acute inpatient care. Low level refurbishment options have been considered as part of the long list appraisal exercise but have been dismissed as lacking in value as they fail to meet key investment criteria and accommodation standards required.
- The Trust will not be able to provide a best-in-class therapeutic environment which provides a mixture of high specification accommodation and supports therapeutic activities and safe spaces.

At this stage of the project process, it is anticipated that the OBC Business Case capital value (project outturn) will be of £49.5m including VAT, inclusive of Optimism Bias at 13%, a 10% contingency and fees at 15%.

Recommendations

To ensure the Trust Board are full sighted on the OBC process and the project timelines

It is recommended that the Trust Board:

- Note the detail provided in the presentation and endorse the conclusions outlined.
- Approve the full Outline Business Case (OBC) and supporting appendices.
- Note that Cabinet Office have completed their Pipeline Assurance Review (PAR) and the status of this workplan is “Assure”. Cabinet Office do not require any further information on the scheme.
- Receive further updates as the OBC progresses through the approval gateways and into FBC in Q1 2025/26.

Trust Board

27th November 2024

Item 18 - Financial Position as at 31st October 2024 (M07)

Key Messages

In agreeing a breakeven plan for 2024/25, it was recognised that this included significant likely risks in the region of c£6m which would require in year mitigations. The risks largely related to the delivery of the stretching £14.2m CIP Plan.

The CIP Programme is forecasting a shortfall in delivery for the year of £6.8m, which largely relate to the risks identified during planning – Out of area placements and temporary staffing costs. The Trust commissioned 12 high priority programmes which will support delivery of the Trusts breakeven plan, and these continue to be right areas of focus to get us back on track. Four of the Programmes have been delivered, with 8 remaining programmes in focus.

Whilst every effort is being made to identify recurrent plans, more time is needed to secure solutions. It has therefore been necessary to target in year non recurrent measures to provide headroom. These include deploying the planned contingency of £3m; releasing all available flexibilities; fortuitous increase in vacancies; and underspends on wider budgets. After recognising these benefits, we think we can achieve the plan for the year, however we are reporting that we are offtrack from plan by £106k at Month 7.

There are, however, a number of risks that could worsen the financial position, specially associated with the volatility of costs for out of area placements/ temporary staffing, pay award funding and Provider Collaboratives. After modelling the likely risks and mitigations, a net risk of c£1m remains. At this point we are highlighting this as a likely risk, rather than a deterioration in our planned breakeven position. As the year progresses, and the risks and mitigations become clearer a view will be taken on our continued ability to forecast a breakeven plan.

The Trust's rating against the NHS Oversight Framework remains at 'Segment 2' which largely means that the input from regulatory is of a supportive nature. Four of our partner organisations in the West Yorkshire System have moved into 'Segment 3' mainly due to their financial positions, with regulatory involvement increasing. West Yorkshire ICS have commissioned a two Phase external assurance review from PwC which has commenced in September to assess Trusts plans, governance arrangements, productivity and opportunity scoping.

The focus of the new 'Organisational Sustainability Board' will further strengthen the arrangements for oversight and delivery of the remaining 8 high priority programmes, including developing a pipeline of opportunities for medium/ long term sustainability.

Trust Financial Overview

Statement of Comprehensive Income

Financial Position by Care Group/Directorate						
£000's	YTD Budget	YTD Actual	Revised YTD Variance	Annual Budget	FOT Actual	Revised FOT Variance
Mental Health Care Group	54,114	56,211	● 2,097	91,299	96,873	● 5,574
Adults and Children's Comm. Care Group	31,130	31,884	● 754	54,255	55,098	● 843
Medical Directorate	9,964	9,966	● 2	17,013	17,078	● 65
Central Reserves & Developments	8,996	5,112	● (3,884)	12,765	5,551	● (7,214)
Contract Income	(122,616)	(121,398)	● 1,218	(209,463)	(208,248)	● 1,215
Estates & Facilities	6,206	6,168	● (38)	11,006	10,733	● (273)
Finance	1,608	1,651	● 43	2,749	2,784	● 35
Informatics	2,653	2,615	● (38)	4,592	4,581	● (11)
Trust General Management	1,981	1,958	● (23)	3,358	3,273	● (85)
Nursing, Quality and Gov	3,399	3,480	● 81	5,851	5,783	● (68)
Performance, Kaizen and BD	792	799	● 7	1,458	1,389	● (69)
People Matters	2,978	2,865	● (113)	5,117	5,105	● (12)
Grand Total	1,205	1,311	● 106	0	0	● 0

Statement of Financial Position

Statement of Financial Position £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Non-Current Assets	60,763	59,022	(1,741)	60,773	60,773	0
Current Assets	21,780	30,980	9,200	23,690	23,933	243
Current Liabilities	(19,452)	(28,371)	(8,919)	(21,026)	(21,269)	(243)
Non-Current Liabilities	(7,231)	(6,630)	601	(6,168)	(6,168)	0
Total Assets Employed	55,860	55,002	(858)	57,268	57,268	0
Public dividend capital	38,273	38,273	(0)	38,475	38,475	0
Income and expenditure reserve	(1,608)	(223)	1,385	(403)	(403)	0
Revaluation Reserve	9,000	6,757	(2,243)	9,000	9,000	0
Miscellaneous Other Reserves	10,196	10,196	0	10,196	10,196	0
Total Taxpayers' and Others' Equity	55,860	55,002	(858)	57,268	57,268	0

Cost Improvement Programme

The CIP Programme is delivering 58% of the planned savings at Month 7 and forecast to achieve 52% - a shortfall of £6.8m. The main areas of pressure relate to:

- Out of area placements;
- Temporary staffing costs on the acute inpatient wards; and
- Staff wellbeing programme

Strengthened arrangements are being developed to prioritise resources to support delivery of the plans, through a centralised Programme Management Office.

Efficiency Plan	Director Lead	YTD Plan £'000	YTD Actual £'000	Variance from Plan £'000	Full Year Plan £'000	Forecast £'000	Variance from Plan £'000	Risk Rating	BEST	LIKELY	WORST
OOA	Kelly Barker	2,391	876	1,515	5,162	1,547	3,615	High	1,674	1,547	744
Adult Inpatients	Kelly Barker	1,661	0	1,661	2,848	0	2,848	High	0	0	0
Low Secure	Kelly Barker	290	248	42	497	429	68	Low	550	429	395
DAU	Kelly Barker	429	516	(87)	736	866	(130)	Low	866	866	866
Sub Total Inpatients		2,381	764	1,617	4,081	1,295	2,786		1,416	1,295	1,261
Unidentified CIP	Mike Woodhead	162	347	(185)	635	635	0	Low	635	635	525
Stretch Target - Medical Staffing	David Sims	67	10	56	150	11	139	High	180	11	0
Stretch Target - Staff Wellbeing	Phil Hubbard	82	46	37	376	83	293	High	376	83	35
Stretch Target - Estates Maintenance	Mike Woodhead	71	0	71	122	44	78	Medium	122	54	0
Stretch Target - Telephony	Tim Rycroft	13	13	0	30	30	0	Low	30	30	30
Stretch Target - Transformation	Kelly Barker	40	40	0	68	68	0	Low	68	68	68
Sub Total		435	456	(21)	1,380	870	510		1,411	880	658
0-19 Contract funding shortfall	Kelly Barker	131	131	0	225	225	0	Low	225	225	225
Procurement	Mike Woodhead	117	117	0	200	200	0	Low	200	200	200
Digital Telephony	Tim Rycroft	93	182	(88)	160	289	(129)	Low	289	289	289
Overhead Contribution	Mike Woodhead	254	254	0	436	436	0	Low	436	436	436
COVID	Phil Hubbard	404	404	0	692	692	0	Low	692	692	692
Non Recurrent	Mike Woodhead	1,072	1,072	0	1,838	1,838	0	Low	1,838	1,838	1,838
Sub Total		2,072	2,160	(88)	3,551	3,680	(129)		3,680	3,680	3,680
Grand Total CIP		7,279	4,255	3,023	14,175	7,393	6,782		8,181	7,403	6,344
<i>Percentage of CIP plan delivered</i>				58%			52%		58%	52%	45%

Previous Years CIP & Cost Avoidance	Director Lead	YTD Plan	YTD Actual	Variance from Plan	Full Year Plan	Forecast	Variance from Plan	Risk Rating	BEST	LIKELY	WORST
23-24 CIP - Adults & Childrens Non pay	Kelly Barker	167		167	500		500	High	150	0	0
23-24 CIP - Estates rationalisation	Mike Woodhead	104	141	(37)	250	365	(115)	Low	365	365	365
Total		271	141	130	750	365	385		515	365	365
<i>Percentage delivered</i>				52%			49%		69%	49%	49%

Risks & Mitigations

Headlines:

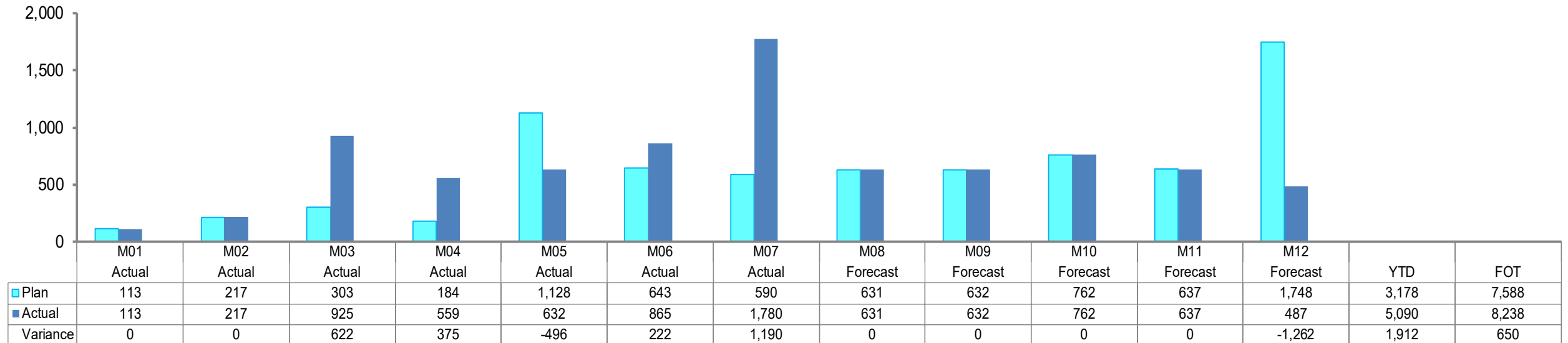
- The areas of greatest variability remains in OAPs costs and temporary staffing spend
- Pay award has been paid in October for the vast majority of staff. New incremental pay points for Band 8a and above and Junior Doctors backpay will be paid in November. A resulting downside risk is expected of c£300k.
- The financial position includes the current forecast risk for Provider Collaboratives of £1.1m. Due to the volatility of costs/ demand the risk could worsen as outlined in the table below.
- Actions from the additional management controls are likely to deliver a likely £787k:
 - £540k reduction in annual leave provision
 - A further £112k from vacancies (above the planned level of £2m for the year)
 - £135k reduction in the redundancy provision

After reflecting all known risks and available mitigations there remains a risk that the Trust will not achieve its breakeven plan by between c£0.9m and c£1.7m. Work continues to focus on opportunities to deliver to plan.

Detail	Planning assumption	Best £'000	Likely £'000	Worse £'000
Breakeven Plan	Breakeven Plan	£0	£0	£0
Downside				
CIP - OAPs	Average OAPS YTD = 30 per day; Forecast assumes average of 29 Assumptions: Best - Commission 7 additional beds from Cygnet from Dec; Likely remain at recent avg of 33; Worse - current OAPs 5.11.24 = 35	£163	(£492)	(£738)
CIP - Low Secure	Risk if run rates continue in line with YTD (80%; 100%; 120%)	(£96)	(£120)	(£144)
CIP - Model Roster 3	Risk if run rates continue in line with YTD (80%; 100%; 120%)	(£98)	(£122)	(£153)
Pay award funding gap	Band 8 and above incremental changes	(£309)	(£309)	(£309)
Provider Collaboratives	Further deterioration in OAPs and Exceptional packages of Care (EPoC) - (10%; 20%; 30%)	(£111)	(£222)	(£334)
PHG Pay award	0-19 Pay Award Funded assumed non recurrently from NHS settlement	(£417)	(£417)	(£417)
ATU - Risk Share	Out of area and EPoC risk (2 placements)	(£20)	(£31)	(£51)
Total Downside Risks		(£888)	(£1,713)	(£2,145)
Upside				
Additional Management Controls	Vacancies/ Annual Leave/ MHIS/ Overtime/ Locums/ FTC risk	£884	£787	£431
Total Upside Mitigations		£884	£787	£431
Risk assessed plan - Surplus/ (Deficit)		(£4)	(£926)	(£1,714)

Capital Expenditure

Capital Expenditure Plan vs Actual/Forecast



The capital position in October is in underspent by £1.9m with a YTD spend of £3.2m.

The Trust capital plan is allocated as follows:

- Operational Capital - £6.7m
- PDC Funding for Year 3 EPR - £0.2m
- IFRS16 Lease Renewals, Additions and Remeasurements - £1.3m

Forecast capital expenditure is £650k under plan at £7.6m, reflecting the Trusts contribution to the Bradford, District and Craven Place (BDC) data cloud investment and £500k IFRS 16 amendment due to review of 24/25 charging schedule from NHSPS and CHP.

In August, the Trust received confirmation that £50m has been allocated over 4 years to support the development of Lynfield Mount Hospital. The Outline Business Case has been developed and submitted to NHS England regional teams, and has passed the gateway. The OBC will now enter the national review process, in advance of the case being considered at January JISC.

Recommendations

Trust Board are asked to:

- Note the challenging financial position, and the actions being taken to deliver the agreed breakeven plan;
- Note the level of risks and actions being taken to mitigate;
- Note that the capital position is largely in line with plan, and the contribution to ICB capital; and
- Highlight any further assurances required.

Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common

Date of the meeting: 23/10/2024

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
<ul style="list-style-type: none"> • There are no alert points to raise.
Advise:
<ul style="list-style-type: none"> • The group had a discussion following a presentation on the progress made with the West Yorkshire Complex Rehabilitation Programme. It noted that a number of Places had suggested that they would not invest in the Complex Rehabilitation Enhance Support Team (CREST) in 2025/26 and recognised that this could potentially be a lost opportunity for improved outcomes for service users and improved productivity and financial savings, as well as a lost opportunity for shared learning. The group acknowledged that Places and providers had agreed on a suitable model and approach for the delivery of care to the complex rehabilitation population and agreed that an assurance framework was required so providers could be assured that they were delivering the same level of outcome for that population cohort across West Yorkshire. The group also agreed that an evaluation on this new way of working should be completed in six to twelve months' time to review whether service users have better outcomes in the places where this model had been adopted compared to places where the model had not been adopted. • The group discussed neurodiversity and noted that the models of practice and the demand for services currently varied across Places. It recognised the need for consistent practice across the ICS and clear roles for Place and the ICB.
Assure:
<ul style="list-style-type: none"> • The group discussed productivity and the work that was being undertaken in each Trust. It noted that there was a lack of benchmarking data for mental health trusts and a lack of guidance on productivity metrics for mental health trusts. It agreed that a shared definition of what 'efficiency' meant would be helpful. It agreed that productivity should be a standing item on future agendas to ensure shared learning and avoid duplication of work. It agreed that the next update should include the outcomes of the PWC review of cost control across the ICB and providers and progress on developing efficiency metrics.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 01/11/2024

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.