**NHS**
South West
Yorkshire Partnership
**NHS Foundation Trust**

# Integrated Performance Report
# Strategic Overview

With **all of us** in mind.

# March 2023

# Table of Contents

Click on each section heading to navigate to that section

# Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2023. The development of the IPR will continue to evolve to reflect any changes in the operational environment.

The Trust has developed care group summary reports for inclusion in the IPR. This is to provide an overview of performance against key indicators by care group in order to give assurance regarding the quality and safety of the care we provide. These have been added to the start of the care groups section.

Many of the agreed metrics identified to monitor performance against our strategic objectives have been populated, whilst others are in development with indicative timescales provided. Executive directors have reviewed all priority programmes and how they should be reported in the 2023/23 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval.

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided, as opposed to the March month-end data. This will ensure that Trust Board can have a discussion on the most current position available. Given the fact different staff provide different sections of the report, there may be some references to data from slightly differing dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:
• Improving health
• Improving care
• Improving resources
• Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Executive summary
• Priority programmes
• Covid-19 response
• Emergency preparedness, resilience and response (EPRR)
• Quality
• People
• National metrics
• Care groups
• Finance & contracting
• Systemwide monitoring

The priority programmes section has been updated to reflect the Trust's priorities and associated metrics for 2022/23. The national metrics section has also been updated to reflect changes in the NHS oversight framework, long-term planning metrics and NHS standard contract metrics. We also need to consider how Trust Board monitors performance against the reset and recovery programme. The Trust is also keen to include performance data related to the West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) – this is an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Our Integrated Performance Strategic Overview Report is publicly available on the internet.

This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics. More detail is included in the relevant sections of the Integrated Performance Report.

**Priority programmes**
• The Trust demonstrates good progress against the majority of its priority programmes. With the majority of key milestones reporting delivery of actions within agreed timescales.
• A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.3% against a target of 90%. For the Trust derived indicators, as at March 2023, 70.2% of service users have had their equality data recorded (disability 41.9%, sexual orientation 42.2% and postcode 99.8%). Whist recording postcode is not technically part of equality data it does help identify referrals from areas with higher levels of deprivation, which could indicate inequalities in relation to healthcare access, experience and outcomes. Work continues to ensure data capture will be extended to all services, this work is monitored by the Trust's Equality, Inclusion and Involvement Committee.
• Work continues to ensure data capture will be extended to all services, this work is monitored by the Trust's Equality, Inclusion and Involvement Committee.
• Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.
• A series of metrics and measurements for the Great Place to Work programme have been devised and the data collated to show the impact of the work that has taken place during 2022/23 on this programme.
• Community Learning disability services have commenced work on creation of a management tool for reporting, measuring, and managing waiting lists and undertaken a pathway mapping exercise which has identified areas for improvement to flow of patients to reduce numbers waiting.

**Quality**
**NHS England Indicators (national)**
The Trust continues to perform well against the majority of national metrics. The following performance should be noted:
• Inappropriate out of area bed days continue to be above trajectory with 511 days in March. This remains high and mainly relates to increased acuity, Covid-19 outbreaks and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 15 people placed in out of area beds at the end of March (a reduction of 2, February 2023). The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.
• The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 79.8% in March from 91.6% reported in the previous month, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service which is a small service and there have been a number of staffing issues that have impacted on clinic availability. Performance is not expected to reach 99% until October 23 with additional pressures related to increased number of referrals also impacting.
• The percentage of children and young people with an eating disorder designated as urgent cases who require access to NICE concordant treatment within one week remained below target to 87.5% (target 95%) - In March 7 out of 8 urgent cases were seen within 1 week. The case that breached was due to patent cancellation.

**Quality continued**

**Local Quality Indicators**

The Trust continues to perform well against the majority of quality indicators; however, the following improving/exceptions and actions being taken should be noted:

**Care Planning**

Work continues in front line services to adopt collaborative approaches to care planning.  The March data is provisional however, this is showing an improved position of 75.1% compared to 58.6% in February. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

**Risk Assessments**

March data is provisional however, an improvement across both inpatient (89.9%) and community (83.2%) areas can be seen against a target of 95%. All areas continue to work to improve performance. Issues with data capture, service pressures and data quality are being addressed but have proved to be more complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

**Waiting Lists**

• CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.

• Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs.

• Waiting list times continue to be an issue due to staffing/operational pressures in community learning disability services, with 76.2% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.

• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels higher than pre-pandemic – cases are triaged and prioritised according to need.

**Patient Safety Indicators**

96% of patient incidents reported in March 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents has decreased slightly to 203 compared to 223 in February. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month is stable, not showing any cause for cause concern and is within expected range. This is described as common cause variation within the report.

• 100% of prone restraint incidents were for a duration of three minutes or less which is an improved position from 87% reported in February.

• There was one pressure ulcers that related to a lapse in the Trust's care during March. Further details on the cases are within the main report. The Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Clinical Governance Clinical Safety Committee as part of the Chief Nurse report.

• The number of inpatient falls in March was 39, which is a further decrease compared to 49 in February and 51 in January and is the lowest number of reported falls since June 22. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

**Our People**

• Our substantive staff in post position continues to remain stable and has increased slightly in March. The number of people joining the Trust outnumbered leavers in March.

• Overall turnover rate in March was 13.5% which is the lowest level it has been at throughout the financial year. This is monitored against a target of between 10 to 12%.

• Last year we had 561.3 new starters compared to 658 (10% increase) this year and conversely 612.8 leavers last year compared to 559.2 this year, demonstrating an improvement in recruitment and retention of existing staff. It should be noted that this is the overall Trust figure and some services have not seen the same trend.

• Sickness absence in March was 5.1%, which is a slight decrease from the February position. The year-to-date sickness absence position is 5.3%.

• Rolling appraisal compliance rate for March increased marginally from 71.5% to 71.8%. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Overall mandatory training is at 90.2% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.1% reported in February. However, 4 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation, food safety, information governance and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

## Care Groups

Staffing vacancies and absence and ongoing industrial action continue to impact on the Trust and our partners resulting in significant challenges across our local places and integrated care systems.

The care group summary section describes the "hotspot" performance areas and mitigating actions for the month of March, these are as follows:

• No care group is meeting the compliance rate for information governance mandatory training. The IG manager is providing additional face to face training sessions. Managers are receiving weekly lists of non-compliant staff so that progress can be monitored and actions can be taken to address compliance. This is monitored at operational management group and executive management team.

• Mental health acute wards have continued to manage high levels of acuity and have been impacted by covid outbreaks.

• High occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

• Workforce challenges have continued, with staff absences due to sickness and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Workforce challenges are being supported through Trust wide recruitment and retention programme.

• Challenges with demand outstripping capacity in the Single Point of Access (SPA) services remains high with referrals being risk screened to ensure that urgent demand is met. This increases the risk of routine triage and assessment being delated. Work to maintain patient flow continues, with the use of out of area beds being closely managed, however usage continued to be high and remained at a high level in March.

• During March, there was a slight decrease in the overall number of delayed transfers of care, reducing from 4.5% to 3.5%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the 100 Day Discharge Challenge and working at Integrated Care Board level to share improvements and collaborative approaches.

• The children's eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within a current provider. Work is taking place across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

## Finance

• At year end, the Trust reported a surplus of £3.2m which was achieved in line with the plan.

• Agency spend in March was £1.1m, with a full year spend of £10m which is £2.2m more than cap.

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

• The capital forecast was revised during 2022/23 to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM&T. The full year capital spend was £7m.

• Cash in the bank remains positive. As is traditional this has reduced in March with the payment of Public Dividend Capital (PDC) made in month. The final cash position was £74.6m.

• Pay costs were £37.6m in March, compared to last month which was £19.7m. March figures includes notional pension contributions and proposed pay award for 22/23.

• Out of area bed costs were £573k in March, an increase compared to £508k in February.

• Performance against the Better Payment Practice Code remains at 95%.

The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical process control charts in each section as relevant to identify improvement or areas that require further work or investigation.
Key agreed milestones have also been identified and reporting against these will be provided at the identified date or by exception.

We have added a column which will identify variation and assurance where we are monitoring against a threshold. See appendix 2 for key to the icons used.

**Improving health**

| Priority programme | Metrics | Threshold | Jan-23 | Feb-23 | Mar-23 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|---|
| Ensure that equality, involvement and inclusion is central to everything we do to reduce inequalities, tackle stigma & eliminate discrimination | Percentage of service users who have had their equality data recorded (ethnicity, disability, sexual orientation, deprivation, carers) | 90% (ethnicity only) | 70.2% | 70.2% | 70.0% | | Figures shown are the combined percentage for completion of ethnicity (96.3%), disability (41.9%), sexual orientation (42.2%) and from July 2022 postcode (99.8%). The threshold is currently based on the national target for ethnicity recording only, which is already in place and being achieved. This is subject to review by the Chief Operating Officer. We are looking at developing a phased target to monitor our progress against this metric. |
| | Referrals and admissions by ethnicity, disability, sexual orientation, deprivation, carers | N/A | See reducing inequalities section of the report for detail | | | | |
| | Timely completion of equality impact assessments (EIAs) in services and for policies (Quarterly) | 100% | 47.5% Service 92.9% Policy | 49.7% Service 92.9% Policy | 77.6% Service 95.3% Policy | | EIAs for services are reviewed annually. This means all services have an EIA in place. The data describes the EIAs that require an annual update. Due to winter pressures and the holiday periods, we know that some services have an outstanding review date and work is being undertaken to support services with the updates. |
| | Completion of equality mandatory training (Quarterly) | >=80% | 94.6% | 95.1% | 95.1% | | |
| Support social responsibility & sustainability in the Trust & our communities | Carbon Impact (tonnes CO2e) - business miles | 76 | 68 | 60 | 56 | (icon) | Data showing the carbon impact of staff travel / business miles. In March staff travel contributed 56 tonnes of carbon to the atmosphere. |
| Work in partnerships at System & Place to improve the health of our communities | Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation | 55% | Due May 2023 | | | (icon) | Q3 - 64.3% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different places. |
| | Forensic lead provider: % of patients in service with a physical health check and % with a care improvement and maintenance plan in place | 100% | Medium Secure - 100% & 100% Low Secure - 100% & 100% | | | | Q3 - England position for Medium Secure is 95% and 97% respectively and for Low Secure is 92% and 99% respectively. Q4 information will be published in May 2023. |

**What the data is telling us.** Statistical process control charts will be inserted here to alert the reader to charts which identify improvement or that require further work or investigation
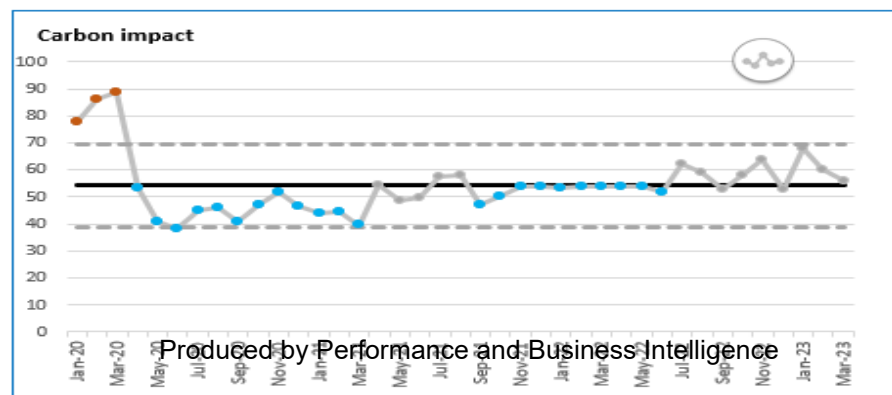


The SPC chart shows that as at March 2023 we remain in a period of common cause variation. The drop in mileage figures are a direct consequence of Covid-19 and now that restrictions are being lifted and face to face activity is increasing we should anticipate that this will rise. Levels are not expected to return to those seen pre-Covid-19 as there should be a more blended approach to working going forward. The performance against this measure will continue to be monitored and if required, the upper and lower control limits re-calculated to include post-Covid-19 levels only.

| | Variation Icons The icon which represents the last data point on an SPC chart is displayed. | | | | | | Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range. | | |
|---|---|---|---|---|---|---|---|---|---|
| ICON | (icon) | (icon) | (icon) | (icon) | (icon) | (icon) | (icon) | (icon) | (icon) |
| SIMPLE ICON | ●●● | ●?HL● | ●H● | ●L● | ●H● | ●L● | ? | F | P |
| DEFINITION | Common Cause Variation | Special Cause Variation where neither High nor Low is good | Special Cause Concern where Low is good | Special Cause Concern where High is good | Special Cause Improvement where High is good | Special Cause Improvement where Low is good | Target Indicator – Pass/Fail | Target Indicator – Fail | Target Indicator – Pass |

Below we have set out progress against the key agreed milestones. Reporting against these milestones is provided at the identified date or by exception.

**Improve health**

**Key Milestones** - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)

**Implementation deliverables**

| | |
|---|---|
| 🟢 | On Target to deliver within agreed timescales |
| 🟡 | On Trajectory but concerns on ability/confident to deliver within agreed timescales |
| 🟠 | Off Trajectory and concerns on ability/capacity to deliver within agreed timescales |
| 🔴 | Action will not be delivered within agreed timescales |
| 🔵 | Action Complete |

| | | | |
|---|---|---|---|
| Support social responsibility & sustainability in the Trust & our communities | Phase 1, developing the social responsibility and sustainability action plan, to be completed by July 2023 | 🟢 | The draft metrics for measurement of delivery against the strategy were presented to the April EMT where they were well received. This is on track to enable compilation of the opening quarterly report to cover the first quarter of 2023/24, which is in line with the plan.<br><br>The eBikes for staff pilot has been delivered to our partner Barnsley Cycle hub, protocols and user agreement documents have been drafted and launch is scheduled for early Summer as soon as the garage on the Kendray site has finished refurbishment.<br><br>We are confident that the successful social responsibility and sustainability (SRS) session and guest speaker at the March extended EMT, will stimulate discussion and even more activity across all areas, and plans are well underway for the launch of the SWYPFT Green Team and a co-ordinating SRS oversight group. |
| Work in partnerships at System & Place to improve the health of our communities | Forensic lead provider, West Yorkshire:<br> • Progress the repatriation plan for West Yorkshire residents, achievement of annual targets against strategic repatriation ambition (quarterly update) | 🟢 | Review of those out of area and repatriations is included in weekly meetings of the Single Point of Access. |
| | Forensic lead provider, West Yorkshire:<br> • Achieve annual financial plan (quarterly update) | 🟢 | The provider collaborative is operating with financial surplus. Oversight is via the Trust collaborative committee. |
| | Forensic lead provider, South Yorkshire:<br> • Achieve annual financial plan (quarterly update) | 🟢 | For the 12 months to March 2023, the provider collaborative operated at breakeven. However there is financial risk associated with the agreement of contract with one independent sector provider. Oversight is via the Trust collaborative committee. |
| | Community Mental Health transformation:<br>Identify actions for SWYPFT to support implementation of next phase. April 2023 | 🟢 | Work continues on developing an understanding of the requirement of SWYPFT in the next phase of transformation and internal coordination of this activity to support implementation. |
| | Community Mental Health transformation:<br>Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation. May 2023 | 🟢 | Work has commenced in February following alignment work. |

| Summary | Priority Programmes | Covid-19 | Emergency Preparedness | Quality | People | National Metrics | Care Groups | Finance/Contracts | System-wide Monitoring |

## Improve Care

| Priority programme | Metrics | Threshold | Jan-23 | Feb-23 | Mar-23 | Variation/Assurance | Notes |
|---|---|---|---|---|---|---|---|
| Deliver safe care including our quality priorities to improve coproduction of care plans and risk management | The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient | 95% | 83.6% | 87.8% | *89.9%* | | March data is provisional and will be refreshed next month, though initial figures show a continued improvement moving into special cause improving variation.. All areas are working to improve performance. Issues with data capture, service pressures and data quality are being addressed but have proved to be more complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. Trajectory to achieve full performance not been achieved but shows continued improvement throughout the year. |
| | The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community | 95% | 68.2% | 67.0% | *83.2%* | | |
| | % Service users on CPA offered a copy of their care plan | *Jan - 60% Feb - 70% Mar - 80%* | 50.5% | 58.6% | 75.1% | | All areas continue working to improve performance and the impact of this can be seen through the data improvements. It is recognised that we continue to be below the targeted threshold, however improvement has been complex due to issues with data capture, service pressures and data quality. The actions in place at each care group plus the change ideas being tested through the improvement group are supporting continued improvements, further improvements are expected in the next reporting period. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. |
| Continually improve the care we provide, ensuring it is responsive, inclusive & timely | Number of staff in post on adult acute mental health inpatient wards | 323.2 | 244.5 | 248.2 | 244.5 | | April 22 to March 23 we have gained 18.3 whole time equivalents on substantive or fixed term contracts. 80% of those were nursing and midwifery registered |
| | Average length of stay in adult acute mental health inpatient wards | *32 (national benchmark)* | 47 | 29 | 49 | | Data based on adult acute discharges only. Individuals are being admitted at a higher level of acuity, taking longer to reach recovery as well as the challenge with delayed transfers of care. Length of stay is continuously monitored through the patient flow team. |
| | Number of violence and aggression incidents against staff on mental health wards involving race | Trend monitor | 12 | 23 | 20 | | These were spread across all mental health inpatient areas, with more incidents reported across this time period in Wakefield's mental health wards. In forensic services the majority of race related incidents against staff were reported in medium secure in the time period, with the highest number of incidents reported on Hepworth ward. |
| | Inappropriate out of area bed placements (days) | Q4 - 630 | 482 | 511 | 511 | | See statistical process chart below for further detail. |
| | Percentage of video consultations | Trend monitor | 1.6% | 1.6% | 1.7% | | |
| | Percentage of telephone consultations | Trend monitor | 28.8% | 28.2% | 29.8% | | Performance has plateaued reflecting new ways of working post-Covid |
| | Percentage of face to face consultations | Trend monitor | 69.6% | 70.2% | 68.5% | | |
| | CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale | 126 | 416 | 645 | 607 | | Clients are seen in order of need and not according to how long they have waited. The longest wait for those seen in the month was 989 days, the shortest was 41 days both of these were appropriate given the needs of the clients. The number on the waiting list at the end of March was 295. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24. Please see locality section for further detail on neurological waiting times. |
| | CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees | 126 | 478 | 493 | 495 | | Clients are seen in order of need and not according to how long they have waited. The longest wait for those seen in the month was 657 day, the shortest was 107 day, both of these were appropriate given the needs of the clients. The number on the waiting list at the end of March was 1483. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24 |
| | Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks | 90% | 80.0% 44/55 | 78.7% 37/47 | 76.2% 64/84 | | Barnsley achieved target. Calderdale – 2 breaches of 10 referrals (OT – staff sickness; SALT/Nursing – problems making contact with patient). Kirklees 14 of 30 breached (2 Dietetics cases to have welfare calls this week (no dieticians – out to recruitment); rest have had welfare calls as there are vacancies include nursing, physio & psychology – some posts have been recruited to and awaiting start dates. Wakefield - 3 cases in Psychology – all on waiting lists; two had Welfare Calls, one to be done. |

## Improve Care Continued

| Priority programme | Metrics | Threshold | Jan-23 | Feb-23 | Mar-23 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|---|
| Continually improve the care we provide, ensuring it is responsive, inclusive & timely | Referral to assessment within 2 weeks (external referrals) | 75% | 88.9% | 82.6% | 67.7% | | Demand into the single point of access (SPA) and capacity issues has lead to ongoing pressures in the service which have impacted on previous months performance. Workforce challenges are continuing to compound these problems and have been increasing. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas, with particular pressures across Calderdale, Kirklees and Barnsley. The situation is being kept under close review by general managers and teams and all possible mitigations are in place. |
| | Assessment to treatment within 6 weeks (external referrals) | 70% | 98.8% | 99.1% | 88.9% | | |

### Glossary

| | |
|---|---|
| CAMHS | Child and adolescent mental health services |
| CPA | Care Programme Approach |
| WTE | Whole time equivalent |

**What the data is telling us.** Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)
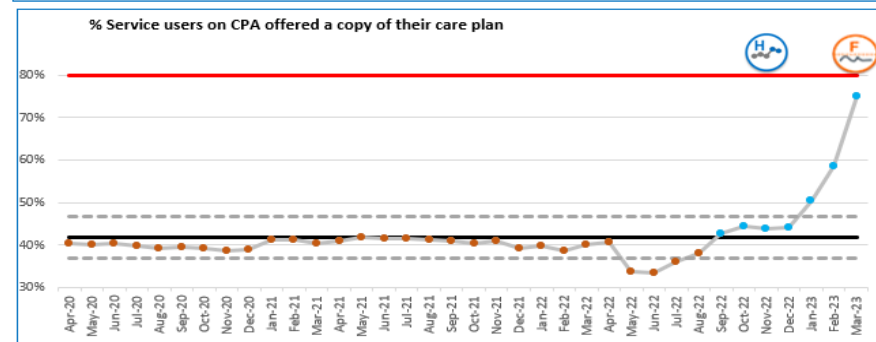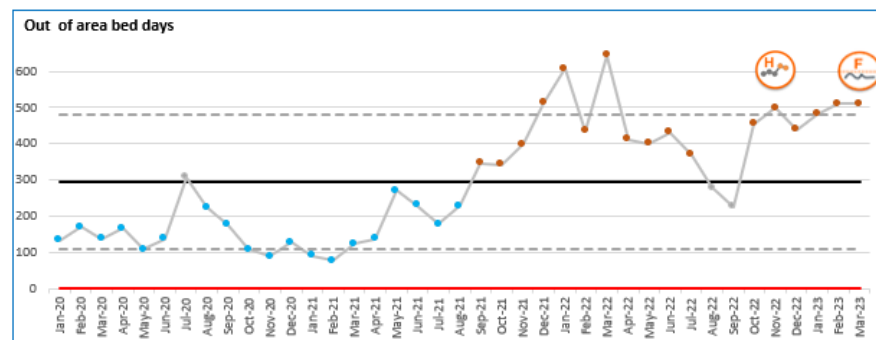


There has been a step change increase in out of area bed usage from summer 2021 onwards. There are several reasons for the increase including staffing pressures across the wards, increased acuity, covid outbreaks and challenges to discharging people in a timely way.

The inpatient improvement programme is aiming to address many of the workforce challenges. Systems are being put in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible. Many of these challenges are happening across other providers nationally. NHSE have recognised this, and provider Trusts have submitted trajectories to zero out of area placements by the end of the 2023/24 financial year. The Trust had 15 people placed in out of area beds at the end of March 2023.



Performance against the percentage of service users offered a copy of their care plan remains in special cause improving variation. Work continues in front line services to adopt collaborative approaches to care planning. A new person-centred metric has been identified and work is being undertaken to implement this in the coming months which will improve performance. The SPC chart shows that we have entered a period of special cause improving variation which is indicative of the changes to the process that have been made.

| | Variation Icons The icon which represents the last data point on an SPC chart is displayed. | | | | | | Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range. | | |
|---|---|---|---|---|---|---|---|---|---|
| **ICON** | | | | | | | | | |
| **SIMPLE ICON** | ● ● ● | ● ? H L ● | ● H ● | ● L ● | ● H ● | ● L ● | ? | F | P |
| **DEFINITION** | Common Cause Variation | Special Cause Variation where neither High nor Low is good | Special Cause Concern where Low is good | Special Cause Concern where High is good | Special Cause Improvement where High is good | Special Cause Improvement where Low is good | Target Indicator – Pass/Fail | Target Indicator – Fail | Target Indicator – Pass |

**Improve Care**

| **Key Milestones** - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales) | | | |
|---|---|---|---|
| Deliver safe care including our quality priorities to improve coproduction of care plans and risk management | Use the Patient Safety Incident Response Framework (PSIRF) to analyse our data and intelligence to identify the Trust's patient safety priority areas. Phase one: orientation by 30/11/2022 completed<br>Phase two: diagnostic and discovery by 31/5/2023<br>Phase three: governance and quality monitoring by 31/5/2023<br>Phase four: patient safety response planning by 30/06/2023<br>Phase five: curate and agree patient safety policy and plan by 31/8/2023<br>Go Live: develop comprehensive improvement plans by Autumn 2023 (NHS England have revised the go live date) | | PSIRF Phase two: Diagnostic and discovery is well under way and will be complete by the end of May.<br>All other phases have commenced.<br>It should be noted although dates are given, these are estimates as the phases are not linear and aspects are expected to continue throughout our journey. |
| | Six stage QI process to be used as part of the care planning and risk assessment improvement programme to March 2023 | | Completed |
| Continually improve the care we provide, ensuring it is responsive, inclusive & timely | Improving Access to Care (IATC): Update on improvement work to reduce waits delivered to EMT March 2023. | | On behalf of Trustwide community learning disability services, Calderdale local delivery group has commenced work on creation of a management tool for reporting, measuring, and managing waiting lists. A pathway mapping exercise has been completed and areas for improvement identified to improve flow of patients to reduce numbers waiting. They have also commenced development of a standardised welfare check process including checklist for completion to support measurement and assurance reporting and commenced configuration of SystmOne waiting list functionality.<br><br>In children's mental health neurodevelopmental services in Kirklees and Calderdale, quality improvement focused work on transition pathway has commenced with adult Attention Deficit Hyperactivity Disorder/Autistic Spectrum Disorder services. Workshops have been planned and scheduled. The first workshop to be held in April will focus on development of standardised SystmOne transition form.<br>In adult community services, core psychology improvement action plan is in development.<br>SystmOne waiting list project continues to support services in using the functionality correctly and preparing other services such as learning disability community for setup. Working with integrated change team and health intelligence, a data framework is in development to support improvements in data capture |
| | Out to public consultation on Older People inpatient services by Summer 2023 | | First draft business case complete and shared with steering group, EMT and programme board in late February, for feedback in mid March.<br>Timeline for governance in development.<br>Briefing for overview and scrutiny committee being updated in March<br>Work to agree capital and review information for the business case to take place – March<br>Presentation to Trust Board – 28 March<br>Further edit and finalisation of business case Mar-May<br>Integrated care board governance and NHS England assurance processes – Spring 23<br>Resourcing for consultation process to be agreed Apr 2023<br>Draft consultation document developed during Spring 2023 |

**Improve resources**

| Priority programme | Metrics | Threshold | Jan-23 | Feb-23 | Mar-23 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|---|
| Spend money wisely & increase value | Surplus/(deficit) against plan | £3,178k | £294k | (£554k) | (£546k) | | The unaudited financial position for 2022/23 is a surplus of £3.2m in line with plan |
| | Capital spend against plan | £13.1m | £836k | £840k | £2721k | | Total capital spend for 2022/23 is £7.0m. The main variance to plan is the pause agreed for the Bretton Centre scheme. This pause has enabled additional IM&T investment to be made in year. |
| | Agency spend managed within the overall workforce (Monthly) | 3.5% | 5.5% | 4.2% | 5.7% | | Total agency spend is £10.0m. Continued usage of agency staffing as part of the overall workforce solution. Monthly performance higher than target. Additional focus and scrutiny being placed on agency spend. |
| | Overhead costs | TBC | 15% | 15% | 15% | | Threshold to be confirmed |
| | Financial sustainability and efficiencies delivered over time | £6,350k | £469k | £469k | £471k | | Savings in line with plan although majority are non-recurrent. Key elements are lower than previous out of area placements and the impact of workforce numbers. |
| Use our estates to enable effective ways of working to support staff & deliver best care | Please see below table for performance against a number of estates metrics. | | | | | | |
| Use digital approaches to deliver best care and support to service users, carers, staff and the wider community | Communication preferences of service users captured/recorded on SystmOne | | Questionnaire to collect this information is live on SystmOne | | | | |
| | Percentage of wards live with EPMA over time | 96.5% by March 2023 | 86% | 90% | 100% | | All wards now live. |

**Glossary**

| EMPA | electronic prescribing and medicines administration |
|---|---|

**What the data is telling us.** Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

**Improve resources**

**Key Milestones** - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)

| | | | |
|---|---|---|---|
| Spend money wisely and increase value | Final 2023/24 plan, including financials, delivered to the Trust Board March 2023 | | Completed. Submitted to Trust Board in March. |
| | Patient Level Costing Implementation (PLICS): Engagement process (clinical and finance) by January 2023 | | On track |
| | Patient Level Costing Implementation (PLICS): Data quality review by February 2023 | | On track |
| Use our estates to enable effective ways of working to support staff & deliver best care | Estates strategy to be approved at Trust Board by Early 2023 | | Initial draft has been circulated for review and comments. |
| Use digital approaches to deliver best care and support to service users, carers, staff and the wider community | To oversee and facilitate the introduction, configuration, and development of digital access to personal health records for service users by mid-June 2023 | | The 'Patient Knows Best' project board in March agreed to revise the go live timescale to a realistic timeframe accounting for numerous bank holidays and staff availability. This has been revised to Mid-June 2023 to ensure appropriate time for user testing and pre-go live engagement activities. |
| | Implementation of a Trust wide approach to digital dictation submission for Board approval July 2023. | | On track. Currently out to tender with supplier evaluations due to commence in May. Phase 2 implementation procurement is underway. |

We have added some additional metrics from November 2022 to allow the board to review and monitor performance against a number of key estates metrics. These can be seen in the table below.

| Estates | Objective | CQC Domain | Threshold | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations) | Improving Resources | Effective | - | | 3 | | | 8 | | | 7 | | | 7 | |
| Estates Urgent Response Times - SLA 1 & 2 | Improving Resources | Effective | 95% | | | | | | | | 97.1% | 98.1% | 97.6% | 97.6% | 95.6% |
| Premise Assurance Model (PAM) | Improving Resources | Effective | Good | Reporting commenced November 2022 | | | | | | | Good | Good | Good | Good | Good |
| Statutory Compliance 3 | Improving Resources | Effective | 100% | | | | | | | | 100% | 100% | 100% | 100% | 100% |

**Notes:**
1 - SLA 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time
2 - PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency & Effectiveness
3 - Includes Water, Gas, Electricity, Refrigeration, Pressure, LOLER (Lifting Operations and Lifting Equipment Regulations) and Asbestos
Riddor - Four of the seven reported incidents relate to violence and aggression, two following staff slips, trips & falls and one case concerning Injuries/concerns following restraint. The Injuries/concern incident following restraint incident was late being notified to the Health and Safety Executive following delays in passing accurate details to the Datix and Health & Safety Teams from people involved in the incident. In all seven incidents, staff have been supported throughout their recuperation.

| Make SWYPFT a great place to work | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Priority programme** | **Metrics** | **Threshold** | **Jan-23** | **Feb-23** | **Mar-23** | **Variation/ Assurance** | **Notes** |
| Make SWYPFT a great place to work, supporting staff & addressing workforce challenges | Vacancy rate (Overall) | <10% | 17.9% | 18.0% | 17.6% | | Vacancies have decreased by 17.9 whole time equivalent within month to 926.9 whole time equivalent currently open vacancies. |
| | Turnover external (12 month rolling) | >10-12< | 14.3% | 13.7% | 13.5% | | Rolling turnover has dropped by 0.2% to 13.5% |
| | Sickness absence - Month | <=4.4% | 5.3% | 5.3% | 5.1% | | Year to date absence rate is 5.3%, in month decreased by 0.2% to 5.1%.Long term sickness (any absence over 3 weeks) has reduced from 3.8% to 3.7%. |
| | Workpal appraisals - rolling 12 months | >=90% | 69.8% | 71.5% | 71.8% | | For the month of March, the % rate increased by 0.3% to 71.8%. |
| | Quarterly summary from staff survey. This will include response rate from underrepresented staff groups and narrative report on progress made against workforce strategy | N/A | Report to be made available once results analysed | | | | 2022 staff survey results received and under review. Process for wide engagement underway. Some initial feedback has been included in the people section of the report. |

**What the data is telling us.** Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

**Make this a great place to work**

| Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales) | | | |
|---|---|---|---|
| Make SWYPFT a great place to work, supporting staff & addressing workforce challenges | People directorate work plan has been finalised. The Great Place to Work (GP2W) priority programmes are under development. | | A series of metrics and measurements for the great place to work programme have been devised, the data collated, and this is scheduled in April to be presented to the executive management team to show the impact of the work that has taken place during 2022/23 on this programme. It will then be used as a baseline and developed further to provide an ongoing mechanism for reporting impact during 2023/24. |

## Reducing Inequalities

Addressing inequalities and demonstrating we meet the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution is a Trust priority. We know there are differential impacts on protected groups and carers and we use the joint needs assessment (JNA) data in each of our places as a baseline so we can understood the local population and meet the needs of local people:
• Every service in the Trust, and every strategy and policy have an Equality Impact Assessment (EIA)
• We have a Trust dashboard in line with NHSE and CORE20PLUS5 to track out progress for workforce and people in our services
• We are using the King's Fund approach to address inequalities and are testing this model out in service areas
• We continue to co-design services with our communities ensuring representation is reflective of the population and covers all protected groups and carers.
• We work proactively with the voluntary and community sector to reach grass roots communities
• We have started to roll out enhanced equality and diversity training to create the right conditions and culture

**Key actions the Trust are taking to address inequalities are:**
• Data - improving data collection gaps – addressed using the 'All of You' campaign, and staff development.
• Information - literature bank for equality and diversity and community films to support insight and understanding of diverse groups.
• Monitoring – the use of translation services at a service level against patient profile, and ensuring service information is in the right format and accessible
• Improving access - Identifying digital access as part of initial assessment via SystmOne.
• Involving - capturing patient and staff feedback, and equality monitoring responses to highlight specific issues.
• Development – through mandatory and enhanced training and lunch time talks we are developing our staff
• Our People - ensuring reflective and representative workforce and leadership. Removing the requirement for Maths and English qualifications.
• Stories - Using tools to capture patient stories, and approaches such as community reporters and researchers.
• Creative approaches - developed through 'Recovery Colleges' and 'Creative Minds'.
• Faith - spiritual support through 'Spirit in Mind'.

**Specific examples include:**
• Creative Minds worked with 'Lead the Way's Art Group' to develop a piece of work that helped people with learning disabilities share their own experiences of the pandemic
• Staff at Kirklees Improving Access to Psychological Therapy (IAPT) services received training on delivering 'Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
• IAPT are working in partnership with the voluntary organisation 'Solace' in Calderdale to better understand the psychological needs of asylum seekers to ensure we can improve access to services
• Recovery College Kirklees is working with the south Asian community for people with lived experience to become partners and co-facilitators delivering culturally informed groups.

## Reducing Inequalities

**Specific examples continued:**

• Perinatal pathways include peer support workers as key members of staff within the new pathway design

• The Trust has an updated Transgender policy and Accessible Information Policy.  Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and service users, carers, and families.

• The Trust delivered a 'Disability Matters' event in August 2022.

• Wakefield CAMHS Mental Health Support Team have developed leaflets in a variety of languages based on their target audience.

• Young people were involved in the co-creation, design and development of a choose well campaign

• Kirklees carers of people with a learning disability project (funded by SWYPFT) have mapped what support is available to carers of people with a Learning Disability so people can access the support they need to continue their caring role

• In Barnsley mental health services, a gender specific role works specifically with women to focus on physical health in the recovery college and support them to access community services.

• Paediatric SALT has established a Facebook page, You Tube and Twitter feed where parents can send messages via social media, this is proving popular with service users as they can access peers and the support they need.

• The Trust increased the take up of health checks in Calderdale for people with severe mental illness by creating letters that were beautifully illustrated and less formal, so people felt engaged as soon as the letter arrived

• The Trust has developed a consent to care, treatment, and discharge tool within SystmOne to ensure the child's voice is captured in decisions around their care

• A 'Respect Project' was set up to tackle trends in negative language and behaviours relating to ethnicity, sexual orientation, and gender. The project ran an art competition across the wards to promote positive identity and celebrate diversity

This section of the report will continue to be developed as more data becomes available and further analysis is undertaken. Some key metrics have been initially identified, with a focus on recruitment of staff into the Trust and referrals and admissions into Trust services. A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee.  A campaign is being launched related to the collection and recording of protected characteristics and we anticipate this will have a positive effect on the quality of this data.

## Reducing Inequalities

Addressing inequalities and demonstrating we meet the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution is a Trust priority. We know there are differential impacts on protected groups and carers and we use the joint needs assessment (JNA) data in each of our places as a baseline so we can understood the local population and meet the needs of local people:
• Every service in the Trust, and every strategy and policy have an Equality Impact Assessment (EIA)
• We have a Trust dashboard in line with NHSE and CORE20PLUS5 to track out progress for workforce and people in our services
• We are using the King's Fund approach to address inequalities and are testing this model out in service areas
• We continue to co-design services with our communities ensuring representation is reflective of the population and covers all protected groups and carers.
• We work proactively with the voluntary and community sector to reach grass roots communities
• We have started to roll out enhanced equality and diversity training to create the right conditions and culture

**Key actions the Trust are taking to address inequalities are:**
• Data - improving data collection gaps – addressed using the 'All of You' campaign, and staff development.
• Information - literature bank for equality and diversity and community films to support insight and understanding of diverse groups.
• Monitoring – the use of translation services at a service level against patient profile, and ensuring service information is in the right format and accessible
• Improving access - Identifying digital access as part of initial assessment via SystmOne.
• Involving - capturing patient and staff feedback, and equality monitoring responses to highlight specific issues.
• Development – through mandatory and enhanced training and lunch time talks we are developing our staff
• Our People - ensuring reflective and representative workforce and leadership. Removing the requirement for Maths and English qualifications.
• Stories - Using tools to capture patient stories, and approaches such as community reporters and researchers.
• Creative approaches - developed through 'Recovery Colleges' and 'Creative Minds'.
• Faith - spiritual support through 'Spirit in Mind'.

**Specific examples include:**
• Creative Minds worked with 'Lead the Way's Art Group' to develop a piece of work that helped people with learning disabilities share their own experiences of the pandemic
• Staff at Kirklees Improving Access to Psychological Therapy (IAPT) services received training on delivering 'Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
• IAPT are working in partnership with the voluntary organisation 'Solace' in Calderdale to better understand the psychological needs of asylum seekers to ensure we can improve access to services
• Recovery College Kirklees is working with the south Asian community for people with lived experience to become partners and co-facilitators delivering culturally informed groups.

**Reducing Inequalities**

**Specific examples continued:**
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy.  Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and service users, carers, and families.
• The Trust delivered a 'Disability Matters' event in August 2022.
• Wakefield CAMHS Mental Health Support Team have developed leaflets in a variety of languages based on their target audience.
• Young people were involved in the co-creation, design and development of a choose well campaign
• Kirklees carers of people with a learning disability project (funded by SWYPFT) have mapped what support is available to carers of people with a Learning Disability so people can access the support they need to continue their caring role
• In Barnsley mental health services, a gender specific role works specifically with women to focus on physical health in the recovery college and support them to access community services.
• Paediatric SALT has established a Facebook page, You Tube and Twitter feed where parents can send messages via social media, this is proving popular with service users as they can access peers and the support they need.
• The Trust increased the take up of health checks in Calderdale for people with severe mental illness by creating letters that were beautifully illustrated and less formal, so people felt engaged as soon as the letter arrived
• The Trust has developed a consent to care, treatment, and discharge tool within SystmOne to ensure the child's voice is captured in decisions around their care
• A 'Respect Project' was set up to tackle trends in negative language and behaviours relating to ethnicity, sexual orientation, and gender. The project ran an art competition across the wards to promote positive identity and celebrate diversity

This section of the report will continue to be developed as more data becomes available and further analysis is undertaken. Some key metrics have been initially identified, with a focus on recruitment of staff into the Trust and referrals and admissions into Trust services. A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee.  A campaign is being launched related to the collection and recording of protected characteristics and we anticipate this will have a positive effect on the quality of this data.

**NHS South West Yorkshire Partnership NHS Foundation Trust**

**Reducing Inequalities**

**Recruitment - rolling 12 months to end of Quarter 4 2022-2023**

**Ethnicity**
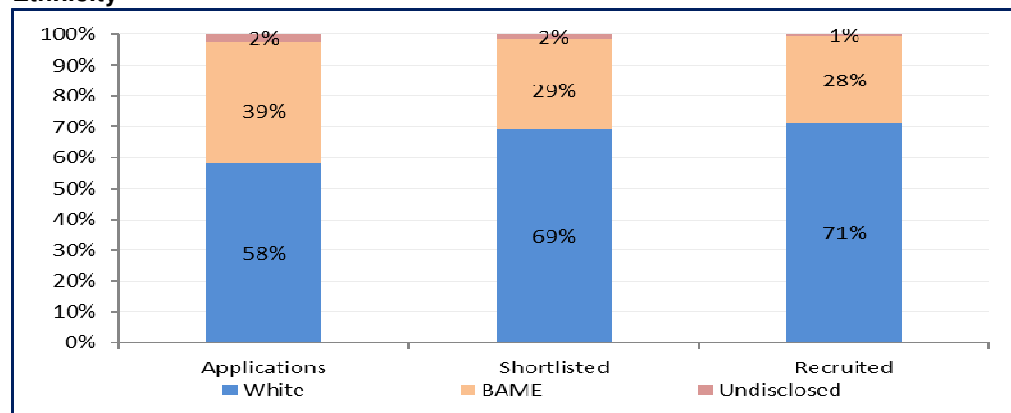


**Disability**
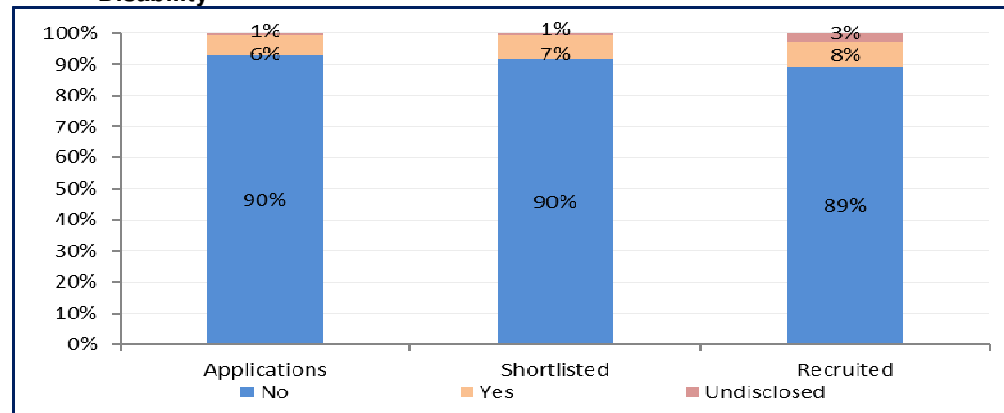


**Sexual Orientation**
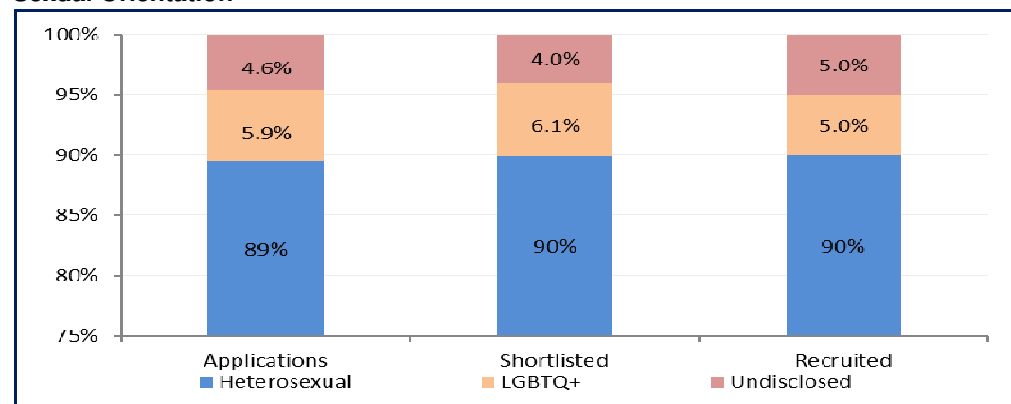


**Relatively likelihood of being appointed**
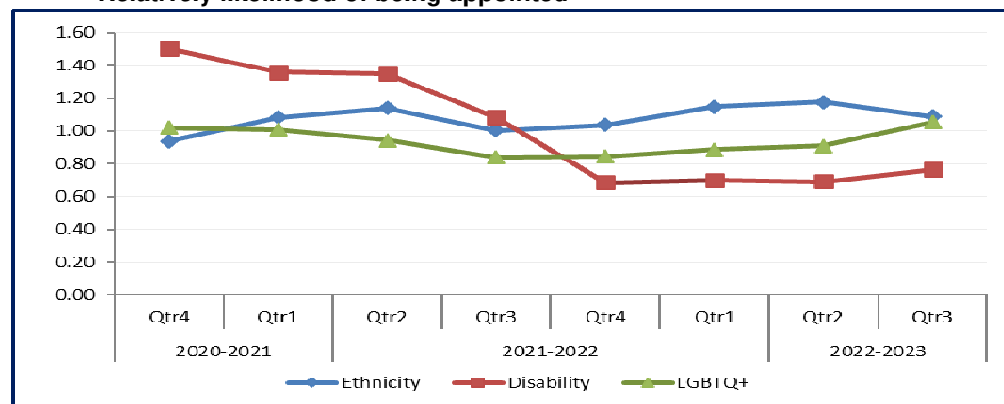


| Relative Likelihood YTD Quarter 4 2022-2023: | BAME: | Disability: | LGBTQ+: |
|---|---|---|---|
| | 1.08 | 0.92 | 1.22 |
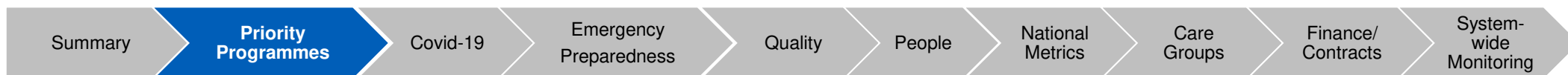
**Reducing Inequalities**

**Recruitment - rolling 12 months to end of Quarter 4 2022-2023 Continued…**

**Notes:**

We are now showing the trend for the relative likelihood.  Including Trust population would not be helpful as we are looking at new staff entering existing population.  Including  local population (census) data will not be helpful as people apply for posts from outside Trust catchment area.

Undisclosed data is not used in the relative likelihood calculation for any of the three categories.

BAME - relative likelihood of being appointed compared to white applicants this quarter =  1.08
Disability  - relative likelihood of being appointed compared to non-disabled applicants this quarter =  0.92
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter =  1.22
NB Relatively large proportions of undisclosed could unintentionally skew the data

Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

Action
Recruitment & Selection policy in the process of being reviewed
Review Recruitment & Selection training
Work with staff networks around action planning

## Reducing Inequalities

### Referrals - (Includes physical health, mental heath, learning disability and forensics)



SWYPFT Referrals by Ethnic Group
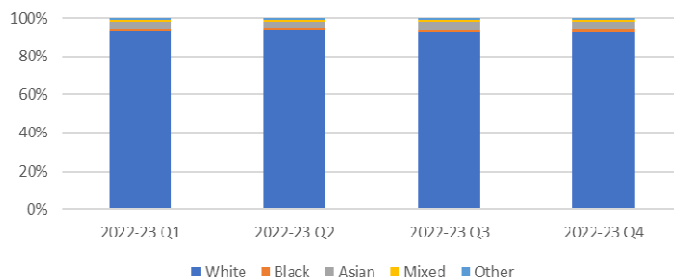


SWYT Population Data - Ethnicity
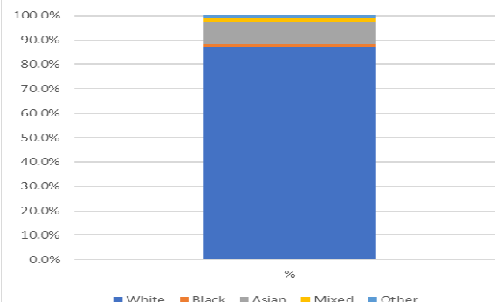
| Ethnic Group | 2022-23 Q1 | 2022-23 Q2 | 2022-23 Q3 | 2022-23 Q4 | Local Population |
|---|---|---|---|---|---|
| White | 97.5% | 97.7% | 93.1% | 93.2% | 87.1% |
| Black | 1.2% | 1.1% | 1.0% | 1.2% | 1.4% |
| Asian | 3.3% | 3.3% | 3.8% | 3.5% | 8.9% |
| Mixed | 1.2% | 1.0% | 1.1% | 1.2% | 1.6% |
| Other | 0.9% | 0.9% | 0.9% | 0.9% | 1.1% |



SWYPT Referrals by Deprivation Quintile
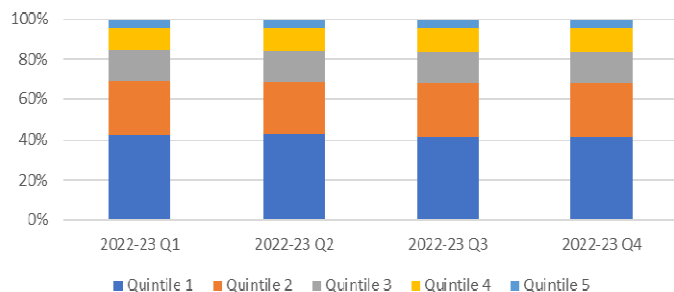


SWYT Population Data - Deprivation
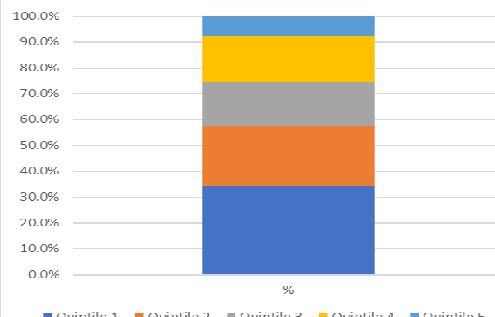
| Quintile | 2022-23 Q1 | 2022-23 Q2 | 2022-23 Q3 | 2022-23 Q4 | Local Population |
|---|---|---|---|---|---|
| Quintile 1 | 42.9% | 42.8% | 41.7% | 41.8% | 34.1% |
| Quintile 2 | 27.2% | 26.4% | 26.5% | 26.6% | 23.4% |
| Quintile 3 | 15.7% | 15.2% | 15.6% | 15.2% | 17.0% |
| Quintile 4 | 11.1% | 11.0% | 11.5% | 11.6% | 17.8% |
| Quintile 5 | 4.5% | 4.7% | 4.7% | 4.8% | 7.8% |

**Notes:**
• Percentage breakdowns for comparison exclude unknown/unrecorded
• Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
• Charts above relate to local population data
• The Trust continues to receive more referrals for people from a white ethnic background.
• When comparing the referrals to the Trust against the ethnic make up of the local population, the proportion of people from a white ethnic background in the local population is lower that the proportion of referrals to the Trust for people from a white ethnic background.

**Reducing Inequalities**

**Admissions - (Includes physical health, mental heath, learning disability and forensics)**
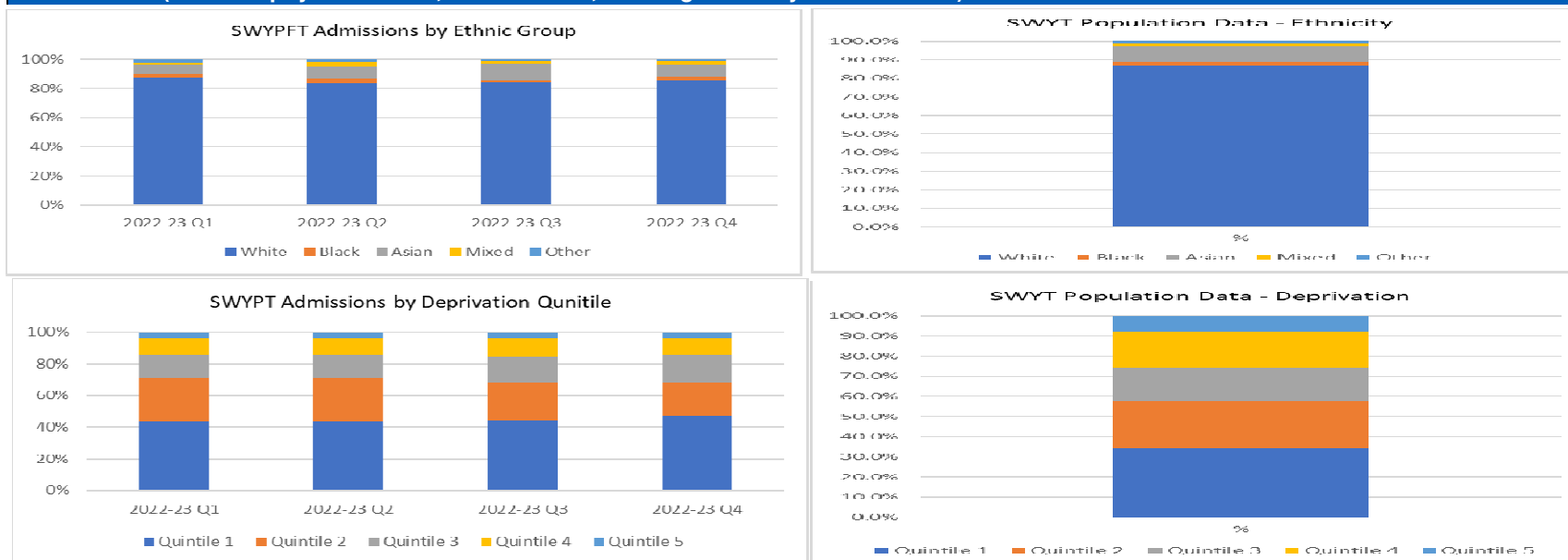


SWYPFT Admissions by Ethnic Group



SWYT Population Data - Ethnicity



SWYPT Admissions by Deprivation Qunitile



SWYT Population Data - Deprivation

**Notes:**
• Percentage breakdowns for comparison exclude unknown/unrecorded
• Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
• Charts above relate to local population data
• Admissions during quarter 3 for people from a white ethnic group were at a lower proportion than that of the population the Trust serves.
• Admissions for people with a mixed ethnic group were slightly lower than the mixed population of the population the Trust serves - these are small numbers and so can impact on the overall percentage.
• There were a significantly greater number of admissions from the quintile 1 (most deprived) compared to the proportion of the Trust's population that are in quintile 1.  44.8% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
• There has been a decrease in the number of admissions from the least deprived areas (quintile 5) compared to the last 2 quarters.

Work is taking place through the Adults and Older People Mental Health Equality, Inclusion and Involvement Care Group to interpret data and identify actions to address any health inequalities using the health inequalities improvement report. The initial focus has been on service users admitted and detained under the Mental Health Act where nationally a disproportionately high number of people from BAME populations are detained.  A framework to support improvements in data capture and reduce health Inequalities has also been developed with the focus initially being placed on the perinatal service - where the UK has one of the highest rate of maternal mortality in Europe - and learning disability services, where the median age of death for people with a learning disability is 20 years younger than the general population and where 49% of deaths were classified as "avoidable" compared with 22% for the general population.  This framework has started to identify areas where there may be gaps in our data such as digital poverty, or where improvements to care could be made such as completion of physical health screenings.

## Covid-19 response

This section of the report focuses on a number of components of the Trust's response to Covid-19 including testing, support to the system and personal protective equipment (PPE).

### Managing the clinical response

**PPE position**

Supplies of and access to PPE remain good, as they have been for the last two years. This report will now only report on PPE levels by exception

### Testing

| KPI | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No of Service users Covid-19 positive and now recovered | 2 | 7 | 21 | 23 | 17 | 21 | 6 | 16 | 17 | 18 | 28 |
| No of Service users Covid-19 positive and still within 28 days, monitoring not completed | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 29 |
| No of Service users Covid-19 positive and deceased within 28 days of positive test | 0 | 0 | 1* | 3* | 0 | 1 | 0 | 1* | 1* | 1 | 0 |
| No of wards with outbreaks | 0 | 1 | 1 | 2 | 2 | 3 | 1 | 2 | 3 | 4 | 8 |

There is a lag in reporting data particularly if service user is discharged from care and/or notification of death awaiting registration.
*relate to community acquired infections
The patient that sadly passed away in February had severe underlying physical health issues.

**Patient testing and pathway/Outbreak response and management**

In March 2023 there has been an increase in ward outbreaks and areas being monitored, which has increased the numbers of inpatient cases (53 out of 57 of inpatient cases, related to outbreaks).

**Testing approach - Current position**

No change to patient or staff testing procedures.

Covid-19 testing for staff and patient changed from 31st August, inline with the Covid-19 testing in periods of low prevalence advice from NHS England.

### Supporting the system

**Care home support offer**

• Significant support to care homes continues to be provided from the general community team in Barnsley.

• Support also includes direct care from community staff including our specialist palliative care teams, district nurses and matrons and our out of hours nurses.

• Mental health and learning disability support has also been provided into care homes across the whole of the Trust footprint to support the residents.

## Emergency Preparedness

This section of the report identifies the Trust's response to the Covid-19 pandemic.

### Supporting the system

Integrated care system (ICS) stress test and outbreak support
• The Trust continue to work closely with partners in outbreak support responses in each of our four places. The Trust has fully engaged with system command structures and other relevant meetings.
• Strong leadership from the infection prevention & control (IPC) team continues so the Trust can ensure appropriate IPC measures are in place.
• The Trust is supporting and engaged with partners across our places in the event a spike/wave of Covid re-emerges to allow suitable and effective response.

### Standing up services

Emergency preparedness, resilience and response (EPRR) update including OPEL levels
• The Moving Forward Group continues to meet fortnightly, and monitors Covid-19 prevalence, measures and guidance in the Trust. Advising and makes decisions regarding Covid-19 arrangements, risk assessment and staffing. Any decision made by this group are escalated to the Operational Management Group (OMG) and from there to the executive management team (EMT)
• The Trust OPEL level remains at an average of 2.8 with two service areas operating at OPEL 2. Seven service areas are now at OPEL 3.



| Key |  |
| --- | --- |
| OPEL Level 1 | |
| OPEL Level 2 | |
| OPEL Level 3 | |
| OPEL Level 4 | |
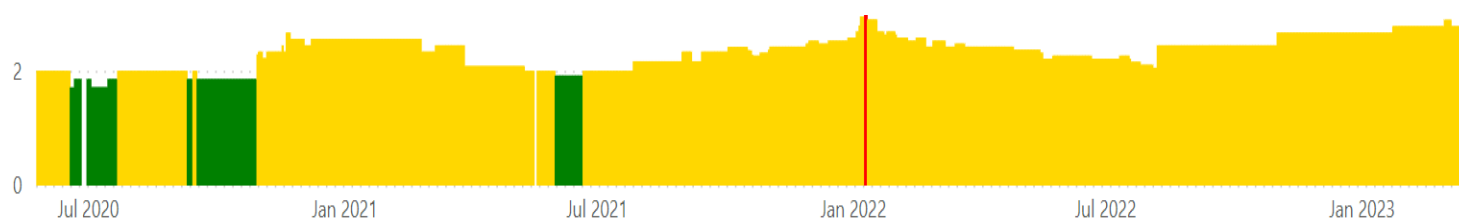
Current average OPEL level

**2.78**

## Quality Headlines

| Section | KPI | Target | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5 | TBC | 61.3% | 57.2% | 60.0% | 53.0% | 66.0% | 68.0% | 70.0% | 72.0% | 74.0% | 78.0% |
| Complaints | % of feedback with staff attitude as an issue 12 | < 20% | 19% 4/21 | 18% 4/22 | 20% 4/20 | 25% 5/20 | 15% 4/26 | 9% 2/22 | 20% 4/20 | 0% 0/16 | 11% 2/18 | 0% 0/21 |
| Service User Experience | Friends and Family Test - Mental Health | 85% | 85% | 88% | 85% | 85% | 84% | 86% | 85% | 83% | 85% | 83% |
| | Friends and Family Test - Community | 95% | 93% | 93% | 92% | 93% | 93% | 93% | 94% | 93% | 95% | 97% |
| Quality | Number of compliments received | N/A | 25 | 31 | 10 | 13 | 5 | 28 | 39 | 83 | 22 | 26 |
| | Notifiable Safety Incidents (where Duty of Candour applies) 4 | trend monitor | 26 | 31 | 19 | 35 | 32 | 33 | 31 | 40 | 31 | 34 |
| | Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4 | trend monitor | 3 | 0 | 0 | 0 | 2 | 2 | 2 | 3 | 2 | 1 |
| | Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4 | 0 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 0 | 2 | 0 |
| | % Service users on CPA offered a copy of their care plan | 80% | 33.5% | 36.1% | 38.2% | 42.8% | 44.3% | 43.8% | 44.1% | 50.5% | 58.6% | 75.1% |
| | Number of Information Governance breaches 3 | <12 | 19 | 10 | 9 | 13 | 11 | 13 | 8 | 12 | 8 | 13 |
| | Delayed Transfers of Care 10 | 3.5% | 2.1% | 2.6% | 3.0% | 2.8% | 3.3% | 2.7% | 3.8% | 4.3% | 4.5% | 3.5% |
| | The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient | 95% | 72.1% | 78.0% | 82.0% | 71.3% | 71.3% | 79.1% | 76.6% | 83.6% | 87.8% | 89.9% |
| | The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community | 95% | 72.2% | 54.2% | 81.7% | 62.9% | 68.0% | 69.5% | 74.3% | 68.2% | 67.0% | 83.2% |
| | Total number of reported incidents | trend monitor | 1129 | 1179 | 1254 | 1168 | 1244 | 1307 | 1187 | 1242 | 1195 | 1233 |
| | Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) 9 | trend monitor | 24 | 27 | 11 | 32 | 26 | 30 | 24 | 34 | 27 | 35 |
| | Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9 | trend monitor | 1 | 4 | 3 | 3 | 3 | 7 | 7 | 3 | 3 | 3 |
| | Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9 | trend monitor | 1 | 0 | 5 | 2 | 3 | 0 | 3 | 3 | 1 | 1 |
| | Safer staff fill rates | 90% | 116.6% | 115.8% | 115.6% | 118.4% | 117.4% | 119.1% | 118.1% | 122.1% | 121.4% | 119.3% |
| | Safer Staffing % Fill Rate Registered Nurses | 80% | 85.0% | 84.7% | 83.1% | 87.5% | 91.0% | 90.8% | 85.6% | 90.5% | 89.1% | 89.7% |
| | Number of pressure ulcers which developed under SWYPFT care (1) | trend monitor | 44 | 50 | 26 | 43 | 49 | 48 | 39 | 55 | 46 | 39 |
| | Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2) | 0 | 0 | 2 | 0 | 1 | 1 | 1 | 3 | 0 | 2 | 1 |
| | Eliminating Mixed Sex Accommodation Breaches | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | % of prone restraint with duration of 3 minutes or less 8 | 90% | 87.5% | 80.0% | 91.0% | 100% | 100% | 92.0% | 100.0% | 95.2% | 87.0% | 100.0% |
| | Number of Falls (inpatients) | trend monitor | 37 | 70 | 63 | 58 | 68 | 63 | 59 | 51 | 49 | 39 |
| | Number of restraint incidents | trend monitor | 152 | 171 | 161 | 160 | 169 | 223 | 189 | 212 | 223 | 203 |
| | % people dying in a place of their choosing 14 | 80% | 85.7% | 100.0% | 85.3% | 85.7% | 91.7% | 93.3% | 78.1% | 93.8% | 83.3% | 100.0% |
| Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | C Diff avoidable cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Improving Resource | NHSEI Oversight Framework metric 13 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | CQC Quality Regulations (compliance breach) | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green |

* See key included in glossary
Figures in italics are not finalised

** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.

1 - Attributable - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

2 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches

4 - Notifiable Safety Incidents are where Duty of Candour is applicable.

5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Work to establish a target for 22/23 is underway which takes into account non-compliance based on individual child and families needs but also ongoing data quality work which is expected to improve performance. Excludes autistic spectrum disorder waits and neurodevelopmental teams.

8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.

9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.

9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.

10 - Trust monitors performance against 3.5% target as set in the mandate to NHS England from the Department of Health in 2017.

11 - Number of records with up to date risk assessment. Up to and including September 2020 the criteria used is - 'Older people and working age adult Inpatients' - we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point. Given the recent implementation of the FIRM risk assessment tool, from October 2020 onwards - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.

12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return.

13 - The NHSEI Oversight Framework was updated in June 22 . Further detail regarding the framework and the metrics monitored can be seen in the national metrics section of the report.

14 - This metric relates to the Macmillan service, end of life pathway

Produced by Performance and Business Intelligence

## Quality Headlines

• Number of restraint incidents - during March decreased to 203 from 223 reported in the previous month. Further detail is provided in the relevant section of this report.

• Duty of Candour - 2 breaches in February 2023 - There was a Duty of Candour breach where a community patient self harmed. The patient was taken to accident and emergency and admitted to intensive care unit. Duty of Candour was delayed as patient was in intensive care and whilst the care coordinator had been in contact with the patient and family it was not felt to be an appropriate time due to mental state. Apology given when patient was more stable. There was a duty of candour breach where a community patient self harmed. The patient was transferred to the acute hospital and was treated in intensive care. The clinical judgement was to deliver the apology at the next appointment with the therapist. However, the patient did not attend the appointment, a letter was therefore sent offering a further appointment with duty of candour being completed within the letter.

• Performance for CAMHS Referral to Treatment - services have highlighted that sustained increases in referrals will negatively impact on the length of wait. A review of support for people on waiting lists is being monitored through the Trustwide Clinical Governance Group.

• Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care - 1 in March. Category 2 ulcer not identified. Learning to review treatment and notification.

• The number of people with a risk assessment/staying safe plan in place within timescale has improved again this month and further improvement is expected to continue. See the Priority Programmes section for further details.

• The percentage of service users on care programme approach offered a copy of their care plan has improved again this month, and further improvement is expected to continue. See Priority Programmes section for further details.

• Delayed transfers of care - This has dropped back within threshold in March 2023.  We are continuing to experience pressures linked to patients being medically fit for discharge but who are subsequently delayed. We are working with systems partners at place to develop crisis provision including safe places to stay away from home, and exploring and optimising all community solutions to get people home as soon as they are ready – utilising roles such as discharge coordinators, and improving links with homeless services and housing providers.

• Patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death tend to fluctuate over time, and data is constantly refreshed as further information is available. This results in some changes to the level of harm, severity and categories of incidents. We encourage staff to report with an upwards bias initially especially when the outcome is unknown. These are adjusted subsequently. Incident data is regularly analysed using SPC to explore any potential higher or lower rates than would usually be considered acceptable. Where there are outlying areas, these will be reported on by exception.

• The percentage of prone restraints with a duration of 3 minutes or less increased to 100% target during March.

**Patient Safety Incident Response Framework (PSIRF)**
As reported in the previous integrated performance report (IPR), NHS England launched the new Patient Safety Incident Response Framework on 16 August 2022.  The transition work commenced in September 2022.  We are in a 12 month transition period working towards going live in Autumn 2023. An internal stakeholder soft launch event was held on 7th October.  The orientation phase of work concluded successfully at the end of November.  We are progressing through various phases of work, including discussions with our integrated care board and provider collaborative colleagues, mapping our services, data analysis and improvement activity. Our intranet page has been updated with an overview of PSIRF https://swyt.sharepoint.com/sites/Intranet/Patientsafetystrategy/Pages/Patient-Safety-Incident-Response-Framework.aspx

**Learn from Patient Safety Events (LFPSE)**
As reported in the previous IPR, learn from patient safety events (LFPSE) will be a new national system that is being introduced to replace:
  • National reporting and learning system (where we send our patient safety incidents)
  • Strategic executive Information system (StEIS -where serious incidents are reported)
NHS England have recently extended the transition timescales as below:
  A) By 31/03/2023 - to have our Datix test system updated with the LFPSE functions - Achieved
  B) By 30/09/2023 - to go live with Datix LFPSE recording - this will be implemented following thorough testing of (A) above.
During March we have had a project manager working on our LFPSE arrangements. We will require a further upgrade to Datix in June/July to activate further system enhancements before promoting with staff.

**Patient Safety Training**
We have developed a proposal to seek agreement and funding for level 3 patient safety training to be essential to job role.
It sets out the national requirement for level 3 patient safety training (levels 1 and 2 are already agreed and underway in the Trust). This supports the NHS patient safety strategy and standards set out in the PSIRF.
The training will include:
  a) investigation training for lead investigators
  b) oversight of investigation training
  c) Engagement and involvement of those affected by patient safety incidents
The paper has been agreed by the Education and Training governance group and will now be presented to our Executive Management Team.

## Safety First

### Summary of Incidents

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

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

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

A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). There continues to be a positive reporting culture and triangulation of incidents with support from specialist advisors. Violence and aggression incidents remain significantly high and the Deputy Director of Operations for Forensics, Learning Disability and ADHD services and the Associate Director of Nursing, Quality and Professions have recently met with the Head of Safety and Resilience to ensure that Health and Safety and Clinical Safety concerns are managed safely and in a timely manner.

96% of incidents reported in March 2023 resulted in no harm or low harm or were not under the care of the Trust. This is based on the degree of actual harm.

Incident reporting levels have been checked using SPC and remain within the acceptable range, any areas with higher or lower rates than normal are explored further.

Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances. All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
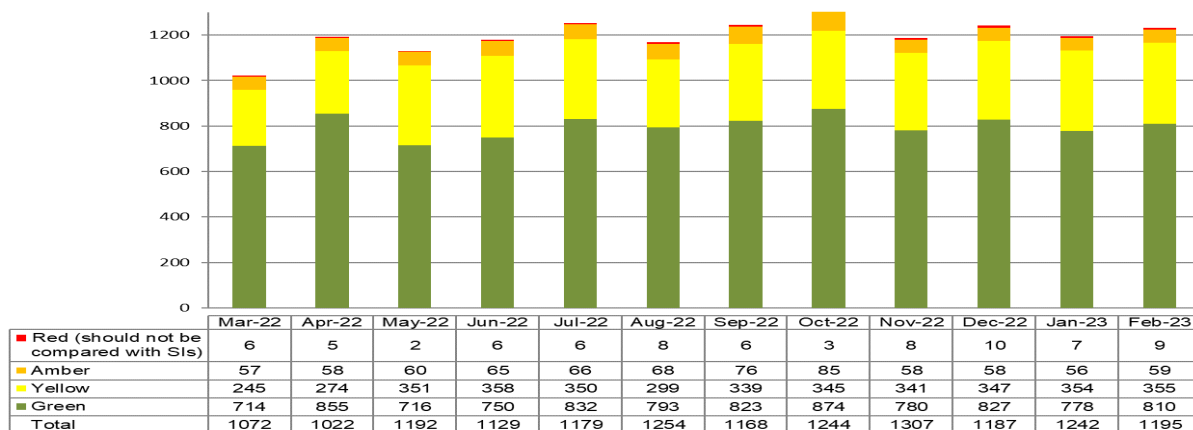
Risk panel meets weekly and scans for themes that require further review or enquiry. The operational management group continues to receive a monthly report, the format and content is regularly reviewed.

No never events reported in March 2023

| | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Red (should not be compared with SIs) | 6 | 5 | 2 | 6 | 6 | 8 | 6 | 3 | 8 | 10 | 7 | 9 |
| Amber | 57 | 58 | 60 | 65 | 66 | 68 | 76 | 85 | 58 | 58 | 56 | 59 |
| Yellow | 245 | 274 | 351 | 358 | 350 | 299 | 339 | 345 | 341 | 347 | 354 | 355 |
| Green | 714 | 855 | 716 | 750 | 832 | 793 | 823 | 874 | 780 | 827 | 778 | 810 |
| Total | 1072 | 1022 | 1192 | 1129 | 1179 | 1254 | 1168 | 1244 | 1307 | 1187 | 1242 | 1195 |

## Safety First cont…

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

This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death.  Please note this is different to severity as described above. Initial incident reporting is upwardly biased and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report.  This is a constantly changing position within the live Datix system. Incident reporting levels have been checked and remain within the acceptable range, any areas with higher or lower rates than normal are explored further.

**Breakdown of incidents in March 2023:**

**35 moderate harm incidents:**
17 Pressure ulcer category 3 incidents
10 self harm incidents
3 Tissue viability
1 Vehicle incident
1 Sexual assault (in supported housing)
1 Slip, trip or fall - patient
1 Administration/supply of medication from a clinical area
1 Assessment, treatment and intervention issues

**3 Severe harm incidents:**
2 pressure ulcer category 4 incidents
1 Self harm (actual harm)

**1 patient safety related deaths:**
1 Suicide (including apparent)

Please note, the total number may decrease once the care group management teams have reviewed the incidents and confirmed the grading.

**Mortality** - No new updates.

**Incidents**
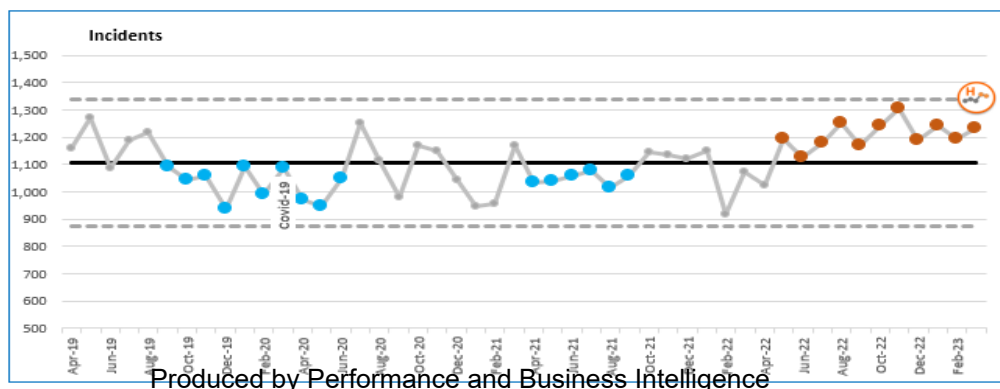


We remain in a period of special cause concerning variation, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern.  We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page.  All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All Amber and Red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly trust wide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

## Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.

Click the following link for further details of the examples which include information around sexual safety, learning from a serious incident/deaths, recording escapes and inappropriate use of 'toaster bags': https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-library.aspx

On 8 February 2023, a Trustwide learning forum was held to share learning between care groups and specialist advisors. The virtual event was very well attended and many positive examples of learning were shared. Presentations are available here https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-Events.aspx

Content, including presentations, is available on the intranet.

The next event is on Wednesday 3rd May 2023 at 2.30pm - 4pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

**Bluelight alerts**

**March 2023**

SBAR Adrenaline accidently injected when training.docx

**February 2023**

SBAR Under 18 Pregnancy Safeguarding Proforma.docx

SBAR Childrens Therapy Jan 2023.docx

SBAR Learning from inpatient ligature death SI 2021.24159.docx

SBAR Safer Discharge From Hospital Final Version.docx

**January 2023**

SBAR Learning Review involving deaths where Clozapine is prescribed.docx

## Patient Safety Alerts

**Patient safety alerts issued in March 2023**

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

Patient safety alerts not completed by deadline of March 2023 - none.

| Reference | Title | Date issued by agency | Alert applicable | Trust final response deadline | Alert closed on CAS |
|---|---|---|---|---|---|
| CHT/2023/002 | Management of National Patient Safety Alerts | 22/03/2023 | Yes - circulated for information | 11/04/2023 | 04/04/2023 |

## Safer Staffing Inpatients
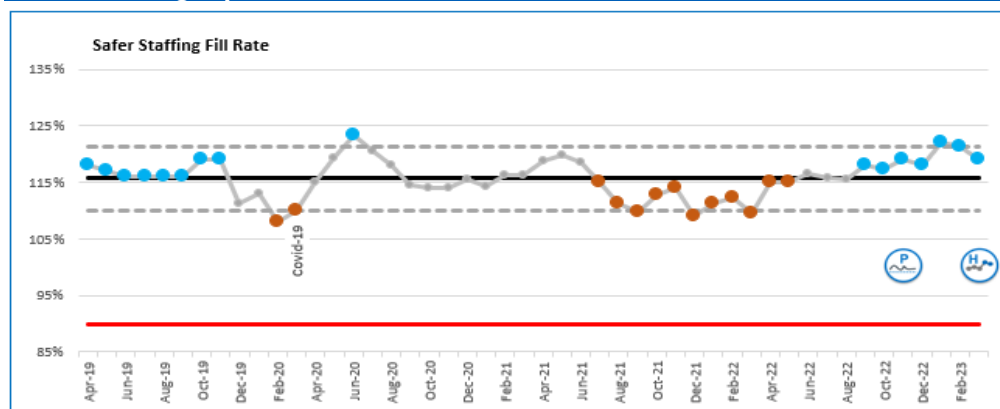


The chart above shows that the staffing fill rate has had a number of periods of special cause concerning variation (orange markers) particularly since the outbreak of Covid-19, though performance has remained consistently above the target. As at March 2023 we remain in a period of special cause improving variation.
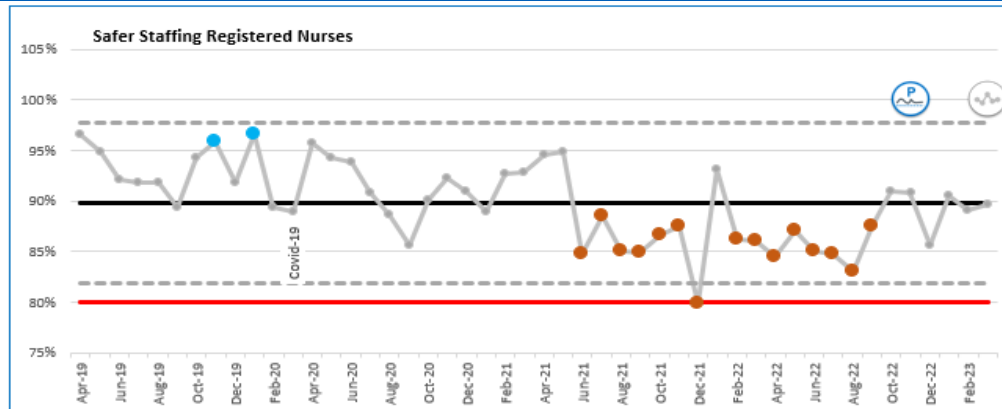


The chart above shows that the staffing rate for registered nurses has also has had a number of periods of special cause concerning variation (orange markers), particularly since the outbreak of Covid-19. In March 2023 we have entered a period of common cause variation. Further information about staffing levels can be found on the previous page.

March has seen a greater demand placed on the flexible staffing resource than in the previous month. This has been for a number of reasons including; ongoing increased acuity on the inpatient areas, substantive staff utilising their annual leave prior to the year end, ongoing sickness and vacancies. There continues to be fluctuations within most wards with an overall decrease in the total fill rate. We continue to monitor staffing related Datix and hotspots and trend analysis of staffing deficits where possible.

Bespoke adverts and centralised recruitment continues, there are four assessment centers planned throughout April for both substantive and bank staff at band 5 and band 2 (over 200 candidates invited) as well as online interviews for direct applicants from overseas. Band 5 Registered Nurse (RN) field continues with bespoke adverts as well as our international recruitment (IR). To date we have had 54 IR band 5 nurses with 52 being on the wards throughout the Trust, including on the neurological rehabilitation unit. We have had a bid for financial support from NHS England through the first three quarters of the new financial year accepted and hope to realise another 40 candidates before December 2023. We have also attended an in-country recruitment drive which resulted in 102 job offers including 12 registered general nurses for the community, as well as establishing links with nursing and doctor's unions and universities. Based on historical patterns we would expect to convert around 70 of these offers into new starters.

Escalation and continuity plans are utilised to ensure the delivery of safe and effective care, and these are supported by the flexible staffing resource. We continue to monitor the hours that staff do, and any working time directive breeches, to support staff wellbeing.

The Trust has established an agency scrutiny group to look at our agency usage and plan for a reduction of requirement through innovation of sourcing our own staff, reducing processes of staff transferring from agency onto our bank or substantive workforce. There will be a second group which will be looking at actual usage and reasons for this to ensure that we have robust processes in place monitoring agency usage.

The continued roll out of SafeCare and moving all teams onto the health roster system have been progressing with engagement events and resource sourcing.

## Safer Staffing Inpatients cont…

Although there has been an overall improvement, we continue to fall short of the registered nurse fill rate for day shift and will continue to look at ways of improving this. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to deliver a high quality of care, and maintain safe services however staffing has impacted on section 17 leave being taken at times as well as other interventions being delayed. We look at various fill rates in the report which gives a definitive picture of staffing compared to our establishment template – the number of staff that are budgeted for - however this must not be looked at in isolation as it is not a true reflection of the requirement of the teams. This is what is meant by capacity (budgeted staffing numbers) v demand (acuity and requirement).

One ward, for the second month, fell below the 90% overall fill rate threshold which was Enfield Down in Kirklees. Inpatient areas continue to experience increased pressure as identified above. There are ongoing interventions, projects and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. There were 26 (83.2%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 26 wards, 10 achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts. Although safe and effective staffing remains a priority in all our teams as well as the systems wide increase of acuity, the focus for the flexible staffing resources has been Wakefield services and the Oakwell Centre in Barnsley. There have been supportive measures put in place including increased block booking, placing bespoke recruitment adverts, and ensuring that additional resources are placed at their disposal.

**Registered Nurses Days:** Overall registered day fill rates have increased by 2.5% to 83.4% in March compared with the previous month.
**Registered Nurses Nights:** Overall registered night fill rates have decreased by 1.4% in March to 96.0% compared with the previous month.
**Overall Registered Rate:** 89.7% (increased by 0.6% on the previous month)
**Overall Fill Rate:** 119.3% (decreased by 2.3% on the previous month). Health care assistants showed a decrease in the day fill rate of 6.0% to 135.0% and the night fill rate decreased by 3.3% to 152.5%.

**Unfilled shifts**
An unfilled shift is a shift that has been requested from the bank office, flexible staffing, and could not be covered by bank staff, agency or overtime. Although not exclusive, there are two main reasons for the creation of these shifts, and they are:
   1 - Shifts that are vacant through short or long-term sickness, annual leave, vacancies, or other reasons that impact on the duty rosters.
   2 - Acuity and demand of the service users within our services including levels of observation and safety concerns.

| Unfilled Shifts | | | | Filled Shifts |
|---|---|---|---|---|
| **Categories** | No. of Shifts | Total Hours | Unfill Percentage | |
| Registered | 536 (+79) | 5,771.83 | 37.89% (+1.50%) | 894 (+92) |
| Unregistered | 630 (+121) | 7,059.50 | 12.84% (+1.55%) | 4,215 (+324) |
| **Grand Total** | 1166 (+200) | 12,831.33 | 18.28% (+1.72%) | |

We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.

## Information Governance (IG)

13 personal data breaches were reported during March, continuing the trend of fluctuating low and high monthly numbers during the current financial year (common cause variation). An improvement plan has been implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality actions.

7 breaches involved information being disclosed in error. They were largely due to information being shared with the wrong recipient. Security breaches occurred when a PC was left unlocked in a public area, an email with a sensitive document attached was sent externally without password protection and three separate paper documents were lost. A further breach occurred when an employee accessed an inappropriate record on the system.

The Trust does not currently have any open cases with the Information Commissioner's Office.
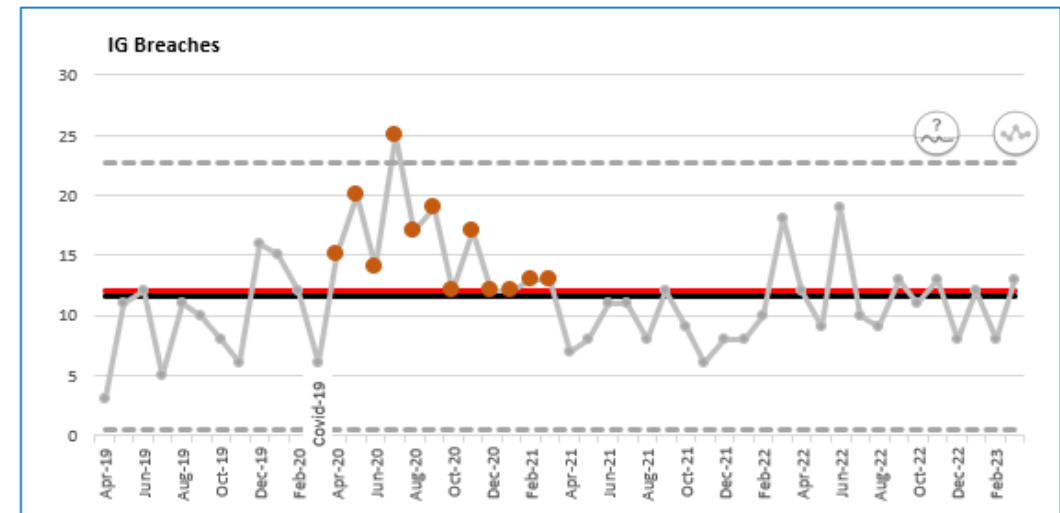


This SPC chart shows that as at March 2023 we remain in a period of common cause variation.

## Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are in place for 2022/23 contracts. These mainly relate to the Trust's contracts with our place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN is 1.25% of total contract value.
Performance for the first three quarters has been achieved against all metrics with the exception of:
  • Assessment and diagnosis of lower leg wounds (Barnsley contract only) and
  • Routine outcome monitoring in children and young people and perinatal mental health services.
Partial achievement has been met for these indicators although improvements have been evidenced in quarter three compared to quarter two, this is expected to continue into quarter 4 and therefore some risk in full achievement remains.
Non achievement for Flu vaccinations for frontline healthcare worker is anticipated and the final figure will be reported in the quarter 4 submission which is due at the end of May 23.

## Falls (Inpatient)

The total number of falls was 39 in March, which is a decrease from the previous month.
A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams / staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.
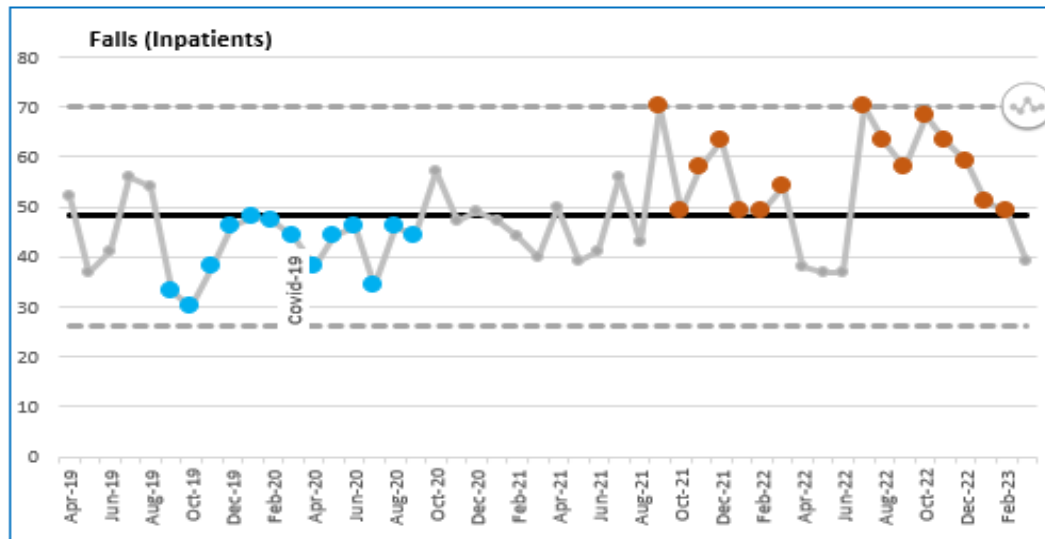


The SPC chart above shows that in March 2023, due to the continued decrease in the number of falls, we have entered a period of common cause variation. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

## End of Life

The total percentage of people dying in a place of their choosing was 100% in March.
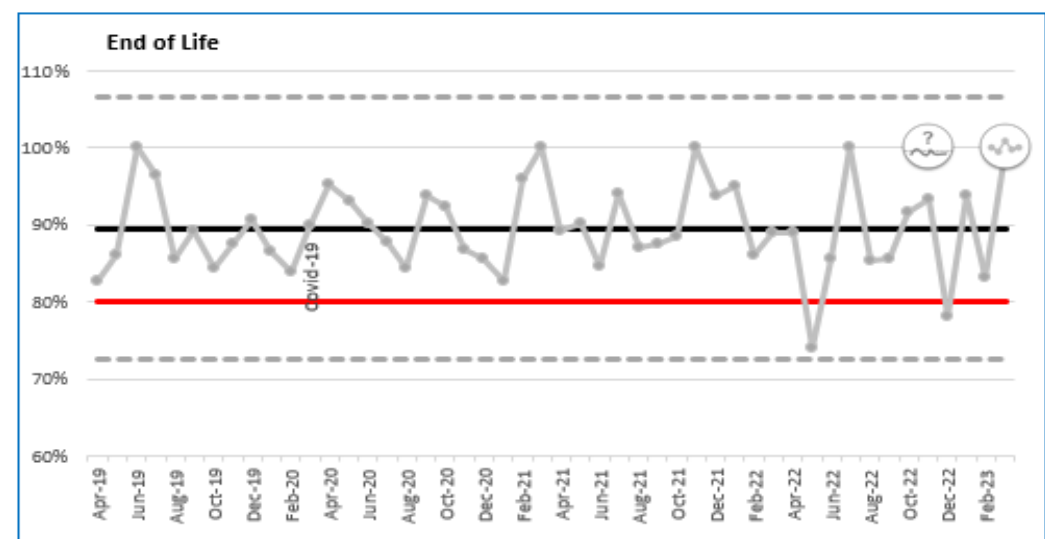


The chart above shows that in March 2023 the performance against the metric remains in common cause variation and therefore within an acceptable range.

## Patient Experience

**Friends and family test shows**
- 97% would recommend community services
- 83% would recommend mental health services

### Mental Health Friends and Family Test Results

| | Target | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|
| Community Services | 85% | 83% | 85% | 85% |
| Acute | 85% | 88% | 100% | 86% |
| Secure & Forensics | 60% | 100% | 80% | 71% |
| Other* | 85% | 84% | 92% | 93% |
| **Total** | **85%** | **82%** | **85%** | **83%** |

### Specialist Services Friends and Family Test Results

| | Target | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|
| ADHD | 85% | 42% | 78% | 50% |
| CAMHS | 75% | 74% | 70% | 83% |
| Learning Disability | 85% | 88% | 91% | 100% |

### Community Services Friends and Family Test Results

| | Target | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|
| Children & Families | 95% | 100% | 94% | 98% |
| Inpatient | 95% | | | 100% |
| Nursing | 95% | 100% | 100% | 91% |
| Other | 95% | | 100% | 91% |
| Rehabilitation & Therapy | 95% | 93% | 95% | 98% |
| Specialist** | 95% | | 95% | 94% |
| **Total** | **95%** | **93%** | **95%** | **97%** |

*includes Insight team, perinatal, friends and family team
**includes equipment and adaptation service, neuro physiotherapy, podiatry

## Patient Experience

There has been an overall improvement in friends and family test results for community services in March and a slight reduction in results for mental health services. A lot of work is underway to improve access, this includes the use of 'CHATPADS' which make it easy for service user to provide real-time feedback. Any results which suggest improvements are needed in services are feedback to the services and support provided by the patient experience team to improve care in that area.

The results for Attention deficit hyperactivity disorder (ADHD) services are from 10 responses received. There is a project group in place and the service are working with the engagement team to review how to encourage further feedback from service users. The team are establishing a service user group to identify how service users wish to give feedback.

| | Top three positive themes | Top three negative themes |
|---|---|---|
| **Trustwide** | 1. Staff | 1. Staff |
| | 2. Communication | 2. Clinical treatment |
| | 3. Patient Care | 3. Admission and discharge |
| **Community** | 1. Staff | 1. Admission and discharge |
| | 2. Communication | 2. Clinical treatment |
| | 3. Access and waiting times | 3. Staff |
| **Mental Health** | 1. Staff | 1. Staff |
| | 2. Communication | 2. Clinical treatment |
| | 3. Patient Care | 3. Communication |

The themes from Friends and Family Test feedback are in the table to the left.

Themes can be both positive and negative in nature.

## Safeguarding

The complex cases discussed through safeguarding advice and supervision are considered by the team, along with the teams continued professional development to ensure that the mandatory training packages and the production of Situation, Background, Assessment, Recommendation (SBAR's) are of high quality to ensure that staff are well informed and knowledgeable.

**Safeguarding Adults:**
In March 2023 there were 40 Datix reported which were categorised as Safeguarding Adults. There were no Datix graded as red, seven were graded as amber, 11 were graded as yellow and 22 were graded as green. The two most common categories of Safeguarding Adult incidents were sexual abuse and physical abuse.

From the seven amber incidents all reasonable actions were taken dependent on and relevant to the issues raised e.g. Domestic Abuse Stalking Harassment and Honour based violence form (DASHH) and Multi Agency Risk Assessment Conference (MARAC) referral completed and a referral was made to the Person in Position of Trust (PiPoT) Lead in the local authority.

**Safeguarding Children:**
In March 2023 there were 23 reported safeguarding children's incidents. There were no Datix graded as red, two were graded as amber, eight were graded as yellow and thirteen of these were green. The most common was physical violence, followed by sexual abuse and request for services.  In most cases advice and support was requested from the Trust safeguarding team and in all cases appropriate actions were taken.

## Infection Prevention Control (IPC)

• Surveillance: There has been zero cases of E.coli bacteraemia, C difficile, Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia and Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia.
• Mandatory training figures are healthy:
    Hand Hygiene -Trust wide Total – 91%
    Infection Prevention and Control - Trustwide Total – 90%
• Policies and procedures, 12 month extension request for policies that are for review in 2023, this is to accommodate implementation of the National IPC Manual.

## Complaints

The Customer Service improvement programme is supporting the team and the Trust in reducing the waiting time associated with providing a response to a complaint. As such we have started to see a reduction in the number of complaints which are waiting to be allocated to a case handler and investigated and a response being provided to the complainant. This will be reflected within the data provided for April.

• There were no complaints in March which were attributed to staff attitude and this reflects a positive and patient-centred culture within our services.
• Acknowledgement and receipt of the complaint within three working days – 100% for formal complaints.
• Number of responses provided within six months of the date a complaint received – 4 out of 14 (29%)
• Number of complaints waiting to be allocated to a customer service officer – 46
• Number of cases who breach the six months target who have not had a conversation to agree a new timeframe for completion 0% – all complainants are updated and have either received the monthly delay/update letter apologising for the delay (for those waiting to be allocated to a case handler), or for those allocated a case handler are updated regarding the progression of their complaint throughout the complaint process/journey.
• Longest waiting complainant to be allocated to a customer service officer – 22 weeks average. Three recently allocated cases have not been in date order due to higher priority to resolve.
• There were 21 new formal complaints in March 2023
• Of these 8 were closed due to no contact/consent, 4 are awaiting consent, 9 are awaiting allocation.
• 0% of new formal complaints (n=0) have staff attitude as a primary subject.
• 26 compliments were received.
• Customer services closed 14 formal complaints in March 2023, as well as 2 reopened complaints.
• Number of concerns (informal issues) raised and closed in March 2023 – 55
• Number of enquiries responded to in March 2023 - 113

## Reducing Restrictive Physical Intervention (RRPI)

There were 203 reported incidents of restrictive physical interventions used in March 2023 this is a reduction of 20 (8.96 %) incidents from February 2023 which stood at 223 incidents.

100% of prone restraints in March 2023 lasted under 3 minutes, see SPC chart below for further information. The measure for monitoring prone restraints under and over 3 minutes is from guidance used by the police and prison service. This was adopted by the Trust and has been reported on for some time. The RRPI team are currently undertaking a review of the current evidence around this figure as within mental health services it may not be relevant to record in this way.

In March 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 26 times of 333 (7.8%) of total restraint positions, this is a slight increase on last month which stood at 23 of 385 (5.9%). Overall these are in line with usual monthly figures, which fluctuate and do not show a consistent increase or decrease.

Minimising the time a person is in a prone restraint is important to minimise the risk of harm to that person. Therefore, monitoring time in prone restraint can help identify when improvements are needed to support teams with restraint interventions. There has been a notable increase in reported RRPI incidents over the winter period (November to February). This is in line with normal variation although further exploration of this will be undertaken to better understand if there are underlying root causes for this. Horizon has reported the highest number of incidents. Again, this is line with normal data and represents the acuity and complexity of the current in-patient population. There has also been an increase in incidents within older people's services, again representative of the acuity of the patient group at the present time. The use of seclusion reduced slightly in February.

The data demonstrates that training around RRPI supports our services to appropriately manage difficult situations. The RRPI team constantly monitor Datix incidents and provide specialist advice and additional training where needed to team and services. Anything reported which is out of the ordinary is acted on immediately with appropriate escalation.

| Restraint Position Used | Number of restraint Positions Used | Percentage of the Type of Restraint Position Used of Total |
|---|---|---|
| Standing | 116 | 34.8% |
| Safety Pod | 54 | 16.2% |
| Seated | 44 | 13.2% |
| Supine | 32 | 9.6% |
| Prone | 26 | 7.8% |
| Restricted escort | 25 | 7.5% |
| Side | 17 | 5.1% |
| Prone then rolled | 13 | 3.9% |
| Kneeling | 6 | 1.8% |

| Team Utilising Prone Restraint | Total |
|---|---|
| Horizon Centre Assessment and Treatment Service | 8 |
| Newhaven Forensic Learning Disabilities Unit | 4 |
| Walton PICU | 4 |
| Beamshaw Ward - Barnsley | 3 |
| Stanley Ward, Wakefield | 2 |
| 136 Suite - Unity Centre, Wakefield | 1 |
| Bronte Ward, Newton Lodge, Forensic | 1 |
| Elmdale Ward | 1 |
| Nostell Ward, Wakefield | 1 |
| Ward 18, Priestley Unit | 1 |

| Duration of Prone Restraint | Total |
|---|---|
| 0 - 1 minute | 16 |
| 1 - 2 minutes | 10 |

## Reducing Restrictive Physical Intervention (RRPI)



**Restraint Incidents**
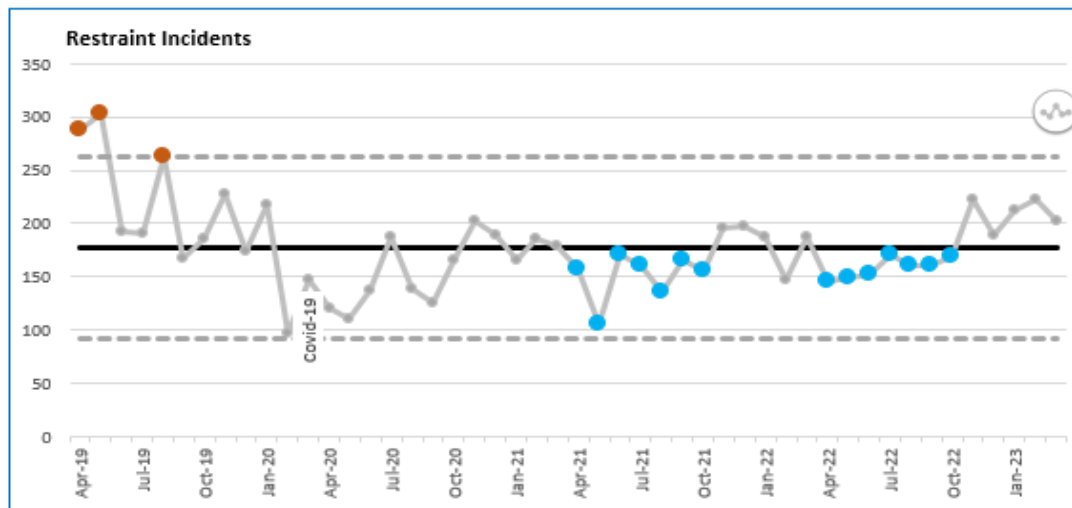
This SPC chart shows that after a recent period of special cause improving variation (blue markers), in March 2023 we remain in a period of common cause variation.

The chart is based on the assumption that an increase in restraint incidents indicates a deterioration in performance however, as described above this is not always the case.
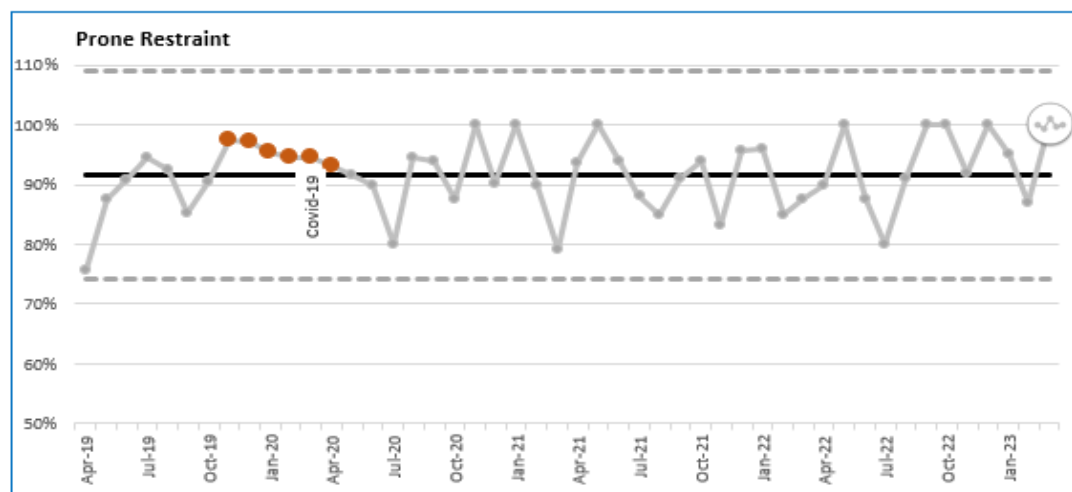


**Prone Restraint**

This SPC chart shows that there was a period of special cause concerning variation in late 2019 and early 2020 (orange markers).

The continued variation in prone restraint incidents in March 2023 means that we are now in a period of common cause variation.

## People - Performance Wall

**Trust Performance Wall**

| | Objective | CQC Domain | Threshold | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Establishment (ledger excluding vacancy factor) | Improving Resources | Well Led | - | 4,918.4 | 4,891.7 | 4,960.2 | 4,933.5 | 5,011.2 | 5,039.4 | 5,145.9 | 5,156.5 | 5,197.9 | 5,237.9 | 5,246.6 | 5,267.2 | |
| Employed Staff (ESR last day in the month) | | | - | 4,088.2 | 4,107.2 | 4,136.2 | 4,134.6 | 4,130.2 | 4,169.2 | 4,174.6 | 4,169.9 | 4,173.4 | 4,186.0 | 4,229.7 | 4,241.0 | |
| Vacancies | | | - | 750.9 | 720.8 | 756.2 | 723.1 | 795.3 | 816.5 | 881.8 | 895.2 | 942.0 | 936.8 | 944.8 | 926.9 | |
| Vacancy rate | | | <10% | 15.3% | 14.7% | 15.2% | 14.7% | 15.9% | 16.2% | 17.1% | 17.4% | 18.1% | 17.9% | 18.0% | 17.6% | ↔ |
| Turnover external (12 month rolling) | | | >10 - <12 | 15.5% | 15.4% | 15.4% | 15.5% | 15.2% | 14.8% | 14.4% | 14.4% | 14.2% | 14.3% | 13.7% | 13.5% | ↔ |
| Starters | | | - | 45.8 | 54.0 | 56.5 | 46.4 | 58.1 | 69.5 | 56.9 | 50.5 | 26.6 | 65.4 | 70.2 | 58.1 | |
| Leavers | | | - | 59.7 | 39.6 | 37.0 | 56.9 | 56.3 | 51.6 | 48.2 | 40.6 | 27.5 | 60.1 | 38.5 | 43.1 | |
| Sickness absence - Year-to-date | | | <=4.4% | 4.6% | 4.6% | 4.6% | 4.9% | 4.8% | 4.9% | 5.0% | 5.1% | 5.3% | 5.3% | 5.2% | 5.3% | ↔ |
| Sickness absence - Month | | | <=4.4% | 4.6% | 4.5% | 4.8% | 5.5% | 4.7% | 4.8% | 5.7% | 5.9% | 6.3% | 5.3% | 5.3% | 5.1% | ↔ |
| Employees with long term sickness over 12 months | | | <=25% | - | - | - | - | 0 | 2 | 2 | 2 | 2 | 4 | 2 | 2 | |
| Appraisals - rolling 12 months | | | >=90% | - | - | 59.7% | 55.8% | 61.3% | 57.3% | 56.0% | 60.7% | 62.9% | 69.8% | 71.5% | 71.8% | ↔ |
| Employee Relations - Suspensions (over 90 days) | | | | 0 | 0 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 3 | 1 | 1 | |
| Mandatory Training - TOTAL | Improving Care | | >=80% | 86.8% | 86.2% | 86.9% | 87.2% | 90.7% | 89.8% | 89.5% | 89.5% | 89.2% | 89.4% | 90.1% | 90.2% | ↔ |
| Mandatory Training - Reducing Restrictive Practice Interventions | | | | 75.5% | 73.7% | 73.6% | 73.8% | 73.8% | 72.0% | 70.3% | 68.4% | 66.4% | 71.9% | 74.5% | 74.6% | ↔ |
| Mandatory Training - Cardiopulmonary Resuscitation | | | | 73.4% | 74.4% | 74.2% | 74.6% | 75.7% | 75.0% | 72.5% | 72.1% | 72.0% | 73.0% | 75.1% | 75.0% | ↔ |
| Mandatory Training - Clinical Risk | | | | 95.9% | 95.6% | 96.2% | 96.2% | 96.4% | 96.6% | 96.3% | 96.2% | 96.0% | 95.7% | 94.9% | 95.9% | ↔ |
| Mandatory Training - Display Screen Equipment | | | | 92.9% | 92.8% | 93.9% | 94.3% | 94.9% | 95.5% | 95.1% | 95.4% | 95.8% | 96.0% | 96.3% | 96.4% | ↔ |
| Mandatory Training - Equality & Diversity | | | | 94.3% | 94.0% | 93.9% | 94.1% | 93.9% | 94.3% | 93.8% | 94.2% | 94.1% | 94.6% | 95.1% | 95.8% | ↔ |
| Mandatory Training - Fire Safety | | | | 90.3% | 88.6% | 87.1% | 87.4% | 87.1% | 86.4% | 87.3% | 87.7% | 87.5% | 88.3% | 88.4% | 89.4% | ↔ |
| Mandatory Training - Food Safety | | | | 77.9% | 76.6% | 79.4% | 79.3% | 79.8% | 79.2% | 78.6% | 79.9% | 79.5% | 79.6% | 79.8% | 79.4% | ↔ |
| Mandatory Training - Freedom To Speak Up (FTSU) | | | | 84.9% | 84.4% | 85.5% | 86.8% | 88.2% | 89.8% | 90.5% | 91.3% | 91.7% | 92.0% | 92.4% | 92.5% | ↔ |
| Mandatory Training - Infection Control & Hand Hygiene | | | | 89.5% | 87.3% | 87.0% | 87.3% | 87.7% | 88.2% | 88.4% | 88.6% | 88.4% | 88.4% | 88.6% | 90.2% | ↔ |
| Mandatory Training - Information Governance (Data Security) | | | >=95% | 92.4% | 93.1% | 92.9% | 92.9% | 92.5% | 92.2% | 91.2% | 89.8% | 87.6% | 87.3% | 84.8% | 86.5% | ↔ |
| Mandatory Training - Moving & Handling | | | >=80% | 96.3% | 95.5% | 95.6% | 95.7% | 95.3% | 95.2% | 95.3% | 95.8% | 95.6% | 93.0% | 93.4% | 95.5% | ↔ |
| Mandatory Training - Nat Early Warning Score 2 (New S2) | | | | 80.6% | 81.3% | 82.6% | 84.3% | 85.6% | 86.3% | 87.4% | 88.1% | 89.6% | 91.1% | 92.0% | 92.4% | ↔ |
| Mandatory Training - Mental Capacity Act/Dols | | | | 93.2% | 92.5% | 93.4% | 93.3% | 93.5% | 93.8% | 93.5% | 93.4% | 93.3% | 95.6% | 95.3% | 94.0% | ↔ |
| Mandatory Training - Mental Health Act | | | | 89.6% | 88.5% | 89.4% | 89.5% | 90.4% | 90.9% | 90.7% | 91.0% | 91.2% | 90.4% | 91.6% | 92.2% | ↔ |
| Mandatory Training - Prevent | | | | 94.1% | 93.9% | 94.4% | 94.6% | 95.1% | 95.3% | 95.0% | 94.6% | 94.4% | 94.7% | 95.2% | 95.6% | ↔ |
| Mandatory Training - Safeguarding Adults | | | | 89.1% | 88.2% | 88.8% | 89.1% | 89.7% | 89.5% | 89.4% | 89.5% | 89.0% | 89.1% | 89.9% | 90.0% | ↔ |
| Mandatory Training - Safeguarding Children | | | | 90.3% | 89.9% | 89.9% | 89.9% | 89.7% | 90.2% | 88.7% | 88.9% | 88.6% | 88.8% | 89.3% | 89.8% | ↔ |

**Notes:**

• Employed Staff (Electonic Staff Record - (ESR) last day in the month) - Employed staff in post are staff on temporary or permanent contracts within ESR. This does not include staff on secondments or other recharges such as local authority staff and junior doctors.

• The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not include overtime, additional hours worked or agency.

• Starters/Leavers - variation in alignment to establishment exists due to a number of factors such as, data taken as a snapshot so will not reflect any changes made on the system after the extraction date as well as changes in contractual hours that cannot be retrospectively applied.

• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trusts operational management group with reporting and actions from quarterly reports to care groups.

• Response rates from leavers giving feedback up to 53% over the last 12 months.

• Employed staff - There has been an increase of 152.8 whole time equivalent staff employed by the Trust since April 22. We are seeing much higher conversion rates of staff moving from bank contracts to substantive than previous years (74.1 WTE since April). We are also seeing much higher health care support worker appointments via our assessment centres and this driving higher starters numbers.

**International nurse recruitment**

• International nurse recruitment joining our inpatient areas with 6 starting in March totalling 42 this financial year (April to March). This is above the target of 40. Our project pipeline for 23/24 is estimating this number will increase to over 100 in general and mental health nursing.

• We have a total of 54 international nurses in the Trust. 52 are now allocated and working in wards. We also have 35 nurses still in recruitment process from direct recruitment/agency feed.

**Additional metrics to highlight response to and impact of Covid-19**

| KPI | Target | As at 23rd August 2022 | As at 20th September 2022 | As at 20th October 2022 | As at 18th November 2022 | As at 19th December 2022 | As at 25th January 2023 | As at 20th February 2023 | As at 21st March 2023 | As at 17th April 2023 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No of staff off sick - Covid-19 not working | N/A | 23 | 23 | 53 | 20 | 29 | 9 | 20 | 17 | 21 | |
| No of staff working from home - Covid-19 related | | 10 | 9 | 14 | 6 | 16 | 8 | 10 | 16 | 4 | |

**Stability of the Workforce**
• Substantive staff in post has risen by 0.2% (11.3 whole time equivalents (WTE)) in March and 3.6% (152.8 WTE) since April 2022.
• Last year we had 561.3 new starters compared to 658.0 (10% increase) this year and conversely 612.8 leavers last year compared to 559 this year, demonstrating an improvement in recruitment and also retention of existing staff.
• Vacancies have decreased by 17.9 WTE within month to 926.9 WTE currently open vacancies, establishment has decreased by 20.6 WTE within month, totalling 5267.2 overall. Establishment increase is due to the monthly phasing in funding from new developments.
• Rolling and year to date (YTD) turnover is 13.5% this is better than our projected rate of 13.7% for the end of year. When compared to the latest figures published by NHS England on digital.nhs.uk  (Dec 2022) the Trust turnover rate is the lowest against the Trusts of our type for both integrated care systems.

**Keep Fit & Well**
**Absence**
• Year to date absence rate is 5.3%, in month decreased by 0.2% to 5.1%.
• Cold and flu numbers continue to reduce, by 1.8% to 4.4% in March. However, Covid-19 has increased again by 1.9% to 9.7%
• Forensics absence continues to decrease this month by 1.1% to 6.8% YTD. Forensic absence has reduced because of focused support with managers on long term sickness, thus resulting in returns to work.
• Estates and facilities absence has reduced from 8.2% to 6.4% YTD after a renewed focus on sickness meetings, monthly reports to individual managers and increased people directorate support. In month sickness dropped by 0.6% to 5.2%.
• Stress related absences still account for the largest absence reason increasing by 1.0% in month to 34.6% YTD.
• Sickness absence benchmarking data from December 2022 shows the Trusts sickness levels to be one of the lowest out of a group of 7 local peer organisations with the highest level being reported as 7.2% and lowest at 5.3%.
**Supportive Teams**
**Appraisals**
• The rolling appraisal compliance rate for March increased again to 71.8%, with the interventions taken starting to show an improving trend.
• Compliance and appraisals due are monitored and reviewed at least monthly at team level.
• The Trust has benchmarked itself against local peers and out of 5 Trusts, the Trust has the second highest rate of appraisal compliance. The highest being 84.4% and lowest being 59.2%.

**Mandatory Training**
• Overall mandatory training reports 90.0% which is above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by the operational management group.
• Four subjects out seventeen reported are below the Trust target - these are resuscitation, food safety, information governance (IG) and reducing restrictive physical interventions (RRPI). Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and project plan being delivered in close partnership with the Nursing, Quality & Professions directorate. Regarding IG training, the IG manager is going out to teams to provide face to face training.  Managers are receiving weekly lists of non-compliant staff.  Progress is being monitored at operational management group and executive management team.
• A continued focus on driving compliance for local induction had resulted in an increase however following the increase in new starters over the last two months this number dipped by 1.9% to 77.2%. As the recording form isn't returned until up to 4 weeks after starting we will follow up to ensure that local inductions are recorded.

## Analysis



**Trust Sickness Absence - Year to Date**
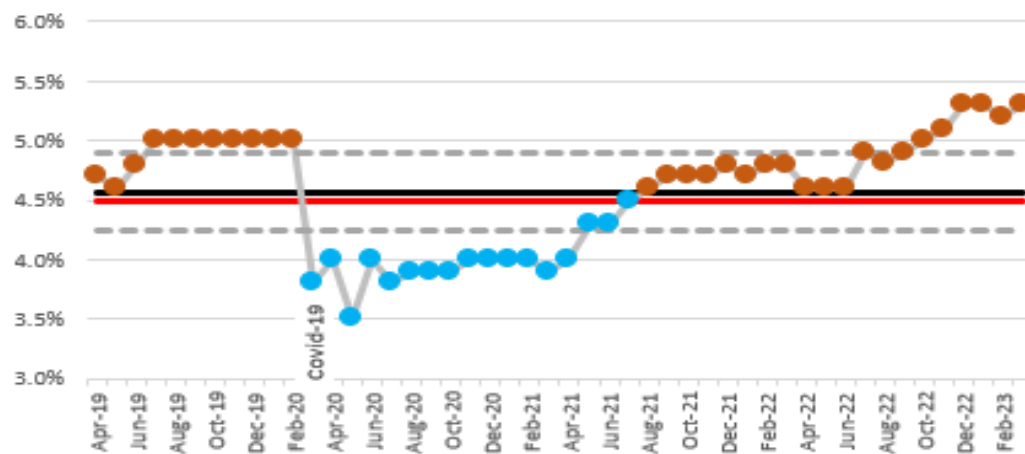


**Trust Agency Spend**

The chart above shows that as at March 2023 we remain in a period of special cause concerning variation (orange markers). From July 2022 this also includes absence due to Covid-19.
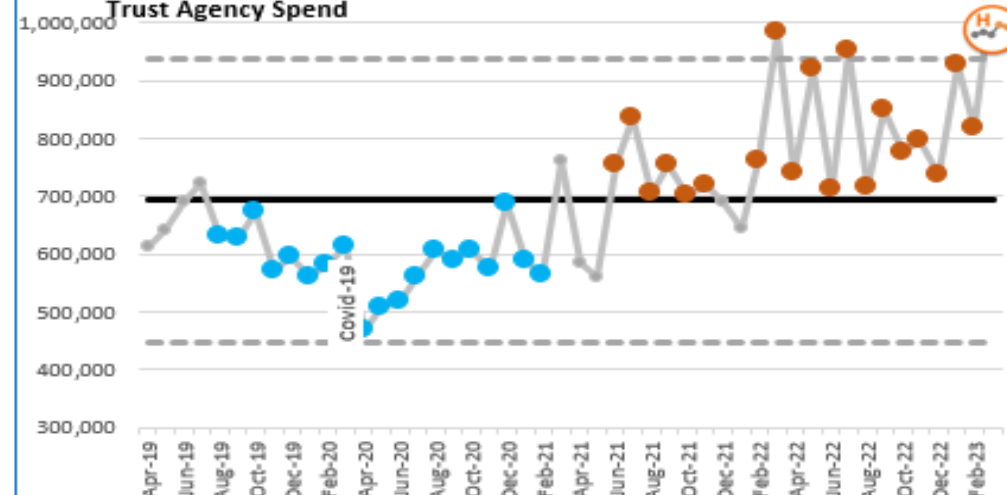
The chart above shows that in March 2023 we remain in a period of special cause concerning variation (orange markers). This is being monitored in workforce/finance. Actions being taken include:
  • the re-introduction of agency scrutiny group who are leading on agency spend reduction plan to meet 23-24 agency cap (£7.8m) – Targeting reduction of high cost individual long term areas of agency spend with bespoke plans to reduce (medical roles).
  • Alternative marketing campaigns to engage wider markets.
  • Review of admin agency usage toward zero tolerance.
  • Significant increase in assessment centre recruitment events – 4 in April (usually 1 per month) over 200 potential candidates into bank and substantive healthcare support worker and nurse posts. This will have a positive impact upon agency provision in future months.

| MEDICAL APPRAISALS | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|---|
| Number expected to be undertaken in period | 31 | 24 | 43 | 37 |
| Number undertaken in period | 29 | 22 | 41 | 34 |
| Number not undertaken for which the RO accepts postponement is reasonable | 2 | 2 | 1 | 1 |
| Percentage of appraisals taken place | 94% | 94% | 95% | 92% |
| Percentage of appraisals signed off in period as satisfactory | 94% | 94% | 95% | 92% |

| MEDICAL REVALIDATIONS | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|---|
| Number of revalidation recommendations due in period | 5 | 5 | 1 | 8 |
| Number of positive recommendations | 5 | 5 | 1 | 8 |
| Number of deferrals | 0 | 0 | 0 | 0 |
| Number of non-engagements | 0 | 0 | 0 | 0 |
| Percentage of revalidation recommendations made | 100% | 100% | 100% | 100% |

| RESPONDING TO CONCERNS | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|---|
| Number of active cases under Maintaining High Professional Standards procedures | 0 | 0 | 0 | 0 |

This section of the report outlines the Trust's performance against a number of national metrics relating to operational performance.

• The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.
• This table only includes operational metrics, there are a number of other workforce and quality metrics that are reported in the relevant section of the IPR.
• NHS Long Term Plan - the Trust fed a number of operational/data lines into the ICS planning programme with associate trajectories. Performance against those metrics will be reported at Trust level in the below dashboard and will be monitored by place in appropriate business delivery performance monitoring.
• NHS Standard Contract against which the Trust is monitored by its commissioners. The below table has been updated to reflect metrics included in the contracts for 22/23. In addition to the national metrics, there are a number of local metrics within each contract that is monitored within the appropriate care group/service. Metrics from these categories may already exist in other sections of the report.

### National Metrics - NHSEI systems oversight framework, NHS long term plan, NHS standard contract

| KPI | Objective | CQC Domain | Owner | Source | Target | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Data quality rating [8] | Variation/ Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period. | Improving Care | Responsive | CH | SC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Inappropriate out of area bed days | Improving Care | Responsive | CH | SOF/LTP | | 1245 | 874 | 1359 | 1504 | 437 | 483 | 439 | 482 | 511 | 511 | | |
| Community health services two hour urgent response standard | Improving Health | Responsive | CH | SOF/LTP | 70% | Reporting to commence January 2023 | | | | | | | 87.5% | 85.0% | 83.8% | | |
| Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops | Improving Care | Responsive | CH | LTP | 60% | 85.5% | 90.1% | 91.5% | 89.5% | 93.6% | 94.6% | 84.8% | 92.6% | 94.4% | 81.3% | | |
| IAPT - proportion of people completing treatment who move to recovery | Improving Health | Responsive | CH | LTP/SC | 50% | 53.4% | 53.9% | 47.1% | 54.9% | 51.4% | 41.0% | 52.6% | 57.1% | 53.9% | 53.7% | | |
| IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period - Barnsley | Improving Health | Responsive | CH | LTP | Per Quarter - 1563 | 1379 | 1202 | 1224 | 1441 | 392 | 455 | 377 | 500 | 461 | 480 | | |
| IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period - Kirklees | Improving Health | Responsive | CH | LTP | No Target Set | 2437 | 2383 | 2457 | 2648 | 849 | 910 | 698 | 978 | 792 | 878 | | |
| Max time of 18 weeks from point of referral to treatment - incomplete pathway | Improving Care | Responsive | CH | LTP | 92% | 98.5% | 88.5% | 93.5% | 97.5% | 86.9% | 89.5% | 93.5% | 95.1% | 95.7% | 97.5% | | |
| Number of people accessing IPS services as a rolling total each quarter | Improving Care | Responsive | CH | LTP | 19 per Qu - Calderdale 15 per qu - Kirklees 5 per qu - Wakefield | Reporting commenced Q1 2022 | | | 18 Calderdale 33 Kirklees 29 Wakefield | | | 40 Calderdale 37 Kirklees 31 Wakefield | | | | | |
| Number of individuals accessing specialist community PMH and MMHS services in the reporting period | Improving Care | Responsive | CH | LTP | Apr-Sep 318 per Qu Oct-Mar 336 per Qu | 480 | 285 | 225 | 221 | 72 | 69 | 84 | 81 | 57 | 83 | | |
| Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only) | Improving Care | Responsive | CH | SC | 99% | 91.7% | 95.9% | 86.2% | 79.8% | 98.7% | 100.0% | 86.2% | 88.0% | 91.6% | 79.8% | | |
| The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care | | | | SC | 80% | 84.6% | 89.0% | 88.1% | 87.8% | 87.8% | 89.6% | 88.9% | 87.9% | 89.6% | 86.6% | | |
| IAPT - Treatment within 6 Weeks of referral | Improving Health | Responsive | CH | SC | 75% | 94.7% | 97.5% | 98.4% | 97.8% | 98.0% | 98.6% | 98.5% | 97.7% | 97.6% | 98.1% | | |
| IAPT - Treatment within 18 weeks of referral | Improving Health | Responsive | CH | SC | 95% | 100.0% | 100.0% | 99.8% | 99.9% | 100.0% | 99.9% | 99.5% | 99.8% | 100.0% | 99.8% | | |
| The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week | Improving Health | Responsive | CH | SC | 95% | 95.5% | 78.6% | 95.2% | 84.6% | 100.0% | 90.0% | 100.0% | 87.5% | 80.0% | 87.5% | | |
| The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks | Improving Health | Responsive | CH | SC | 95% | 90.1% | 77.7% | 80.2% | 95.2% | 78.4% | 79.3% | 88.2% | 88.6% | 100.0% | 100.0% | | |
| Data Quality Maturity Index | Improving Health | Responsive | CH | SC | 95% | 98.5% | 99.5% | 99.4% | 98.7% | 99.5% | 99.6% | 99.1% | 99.4% | 98.2% | 98.5% | | |

| KPI | Objective | CQC Domain | Owner | Source | Target | Q1 22/23 | Q2 22/23 | Q3 22/23 | Q4 22/23 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Data quality rating [8] | Variation/ Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total bed days of children and younger people under 18 in adult inpatient wards | Improving Care | Safe | CH | O | 0 | 16 | 44 | 23 | 52 | 13 | 10 | 0 | 8 | 31 | 44 | | (H) |
| Total number of children and younger people under 18 in adult inpatient wards | Improving Care | Safe | CH | O | 0 | 1 | 2 | 4 | 3 | 2 | 2 | 0 | 2 | 2 | 2 | | (common cause) |
| Number of detentions under the Mental Health Act (MHA) | Improving Care | Safe | CH | O | Trend Monitor | 183 | 179 | 161 | 184 | 161 | | | 184 | | | | |
| Proportion of people detained under the MHA who are BAME | Improving Care | Safe | CH | O | Trend Monitor | 18.0% | 21.2% | 22.4% | 19.6% | 22.4% | | | 19.6% | | | | |
| % Admissions gate kept by crisis resolution teams | Improving Care | Responsive | CH | O | 95% | 96.2% | 99.3% | 99.6% | 98.7% | 100.0% | 98.7% | 100.0% | 98.9% | 99.0% | 98.2% | | (common cause) (P) |
| % Service users on care programme approach (CPA) having formal review within 12 months | Health & Wellbeing | Safe | SR/KT | O | 95% | 96.1% | 94.3% | 96.9% | 96.2% | 95.6% | 94.9% | 96.9% | 95.8% | 95.4% | 97.6% | | |
| % clients in settled accommodation | Improving Health | Responsive | CH | O | 60% | 88.3% | 87.2% | 85.7% | 84.5% | 86.0% | 85.8% | 85.2% | 84.4% | 84.4% | 84.7% | ⚠ | (common cause) (?) |
| % clients in employment | Improving Health | Responsive | CH | O | 10% | 11.1% | 11.8% | 11.7% | 11.4% | 12.0% | 11.6% | 11.4% | 11.6% | 11.4% | 11.3% | ⚠ | (common cause) (P) |
| Completion of improving access to psychological therapies (IAPT) minimum data set outcome data for all appropriate service users, as defined in contract technical guidance 1 | Improving Health | Responsive | CH | O | 90% | 98.2% | 98.1% | 98.1% | 97.7% | 98.8% | 97.4% | 98.5% | 98.1% | 99.1% | 98.9% | | (common cause) (P) |
| Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in contract technical guidance | Improving Health | Responsive | CH | O | 99% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | (H) (P) |
| Completion of mental health services data set ethnicity coding for all service users, as defined in contract technical guidance | Improving Health | Responsive | CH | O | 90% | 99.1% | 99.3% | 99.3% | 99.4% | 99.4% | 99.3% | 99.3% | 99.4% | 99.4% | 99.4% | | (H) (P) |

### Glossary

| | | | |
|---|---|---|---|
| SOF | NHSEI System Oversight Framework | O | Other national metric |
| SC | NHS Standard Contract | SU | Service user |
| LTP | NHS Long Term Plan | CPA | Care programme approach |

| | Variation Icons — The icon which represents the last data point on an SPC chart is displayed. | | | | | | Assurance Icons — If there is a target or expectation set, the icon displays on the chart based on the whole visible data range. | | |
|---|---|---|---|---|---|---|---|---|---|
| ICON | (common) | (?) | (H) | (L) | (H blue) | (L blue) | (grey) | (F) | (P) |
| SIMPLE ICON | ● ● ● | ● ? H L ● | ● H ● | ● L ● | ● H ● | ● L ● | ? | F | P |
| DEFINITION | Common Cause Variation | Special Cause Variation where neither High nor Low is good | Special Cause Concern where Low is good | Special Cause Concern where High is good | Special Cause Improvement where High is good | Special Cause Improvement where Low is good | Target Indicator – Pass/Fail | Target Indicator – Fail | Target Indicator – Pass |

**Headlines:**

• The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

• The percentage of service users waiting less than 18 weeks from point of referral to treatment remains above the target threshold at 97.5%

• 72 hour follow up remains above the threshold at 86.6%.  We are in a period of special cause improving variation due to continued (more than 6 months) performance above the mean.

• The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service has decreased to 79.8% in March and remains below threshold. This is a small service and there have been a number of staffing issues that have impacted clinic availability. Due to the large increase in referrals from January 2023,  it is unlikely we will have any capacity to run additional clinics over spring and summer and therefore we do not anticipate we will hit the 99% target until October 2023.  Please see SPC chart on the next page for more analysis.

• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week - small numbers impact on the achievement of the 95% threshold.  In March 7 out of 8 urgent cases were seen within 1 week, this has taken the performance below threshold at 87.5%. The reason behind the breach related to the service user having to cancel the original appointment that was scheduled to take place within timescale due to being ill.

• During March 2023,  there were two services users aged under 18 years placed in an adult inpatient ward. One of those patients was under 16 years old and admitted and discharged during the month with a length of stay of 13 nights.  The duration of this episode was extended because there was an unclear discharge pathway. The other is under 18 and  was originally admitted in January but remains on the ward. The combined bed days for these two clients during the month was 44 days and is the highest reported in at least the last 3 years and beyond the acceptable range, please see SPC chart on next page.  The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews.

• Percentage of clients in employment and percentage of clients in settled accommodation -  there are some data completeness issues that may be impacting on the reported position of these indicators.

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

• IAPT proportion of people completing treatment who move to recovery is now above the 50% target at 53.7% for March. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

• Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold during the month of March. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

**Data quality:**
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.
For the month of February the following data quality issues have been identified in the reporting:

• The reporting for employment and accommodation for March shows 15.4% of records have an unknown or missing employment and/or accommodation status. This a decrease on February which showed 16.0% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

## Analysis
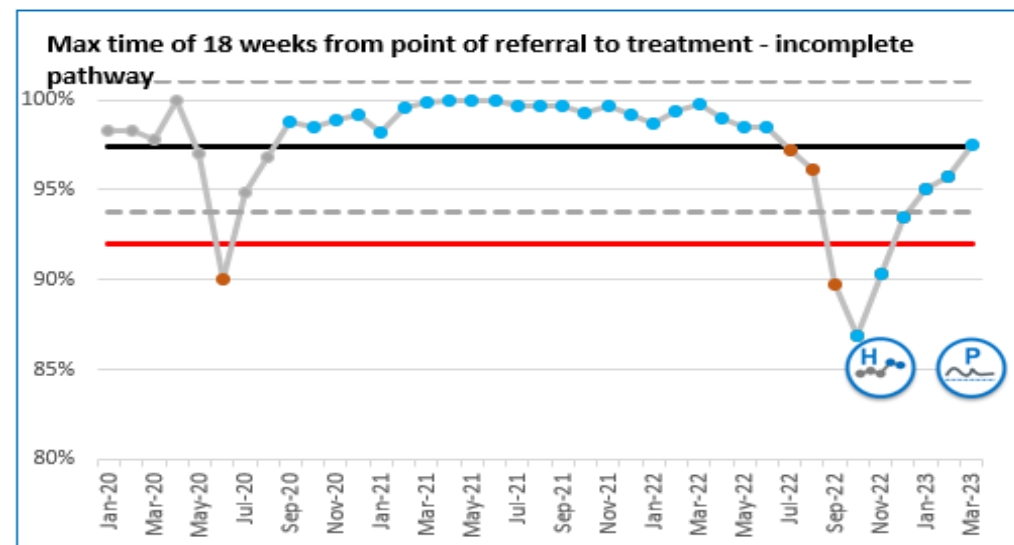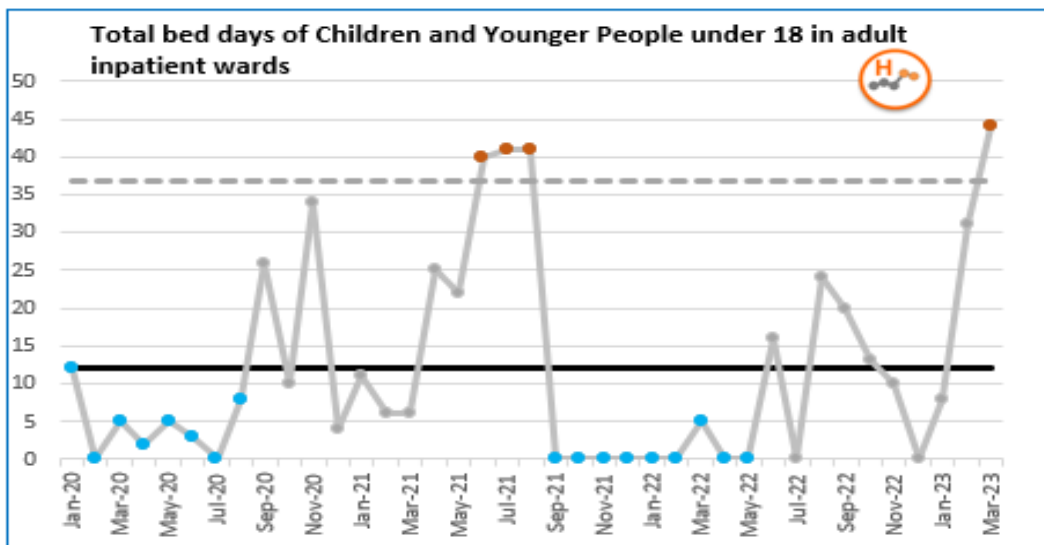


The statistical process control charts (SPC) above show that we have entered a period of concerning variation regarding the number of beds days for children and young people in adult wards. Whilst there were only 2 clients that contributed to this total, the combined bed days (44) is the highest reported in at least the last 3 years and beyond the acceptable range. After three consecutive periods of improvement against the referral to treatment metric we remain in a period of special cause improving variation and we are expected to meet the target.

## Analysis



Maximum 6-week wait for diagnostic procedures



% service users followed up within 72 hours of discharge from inpatient care
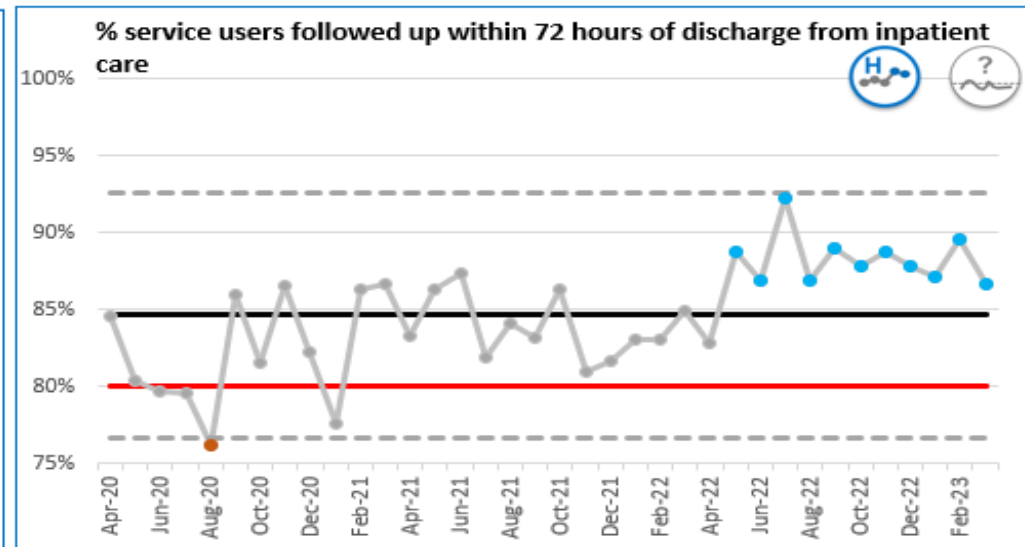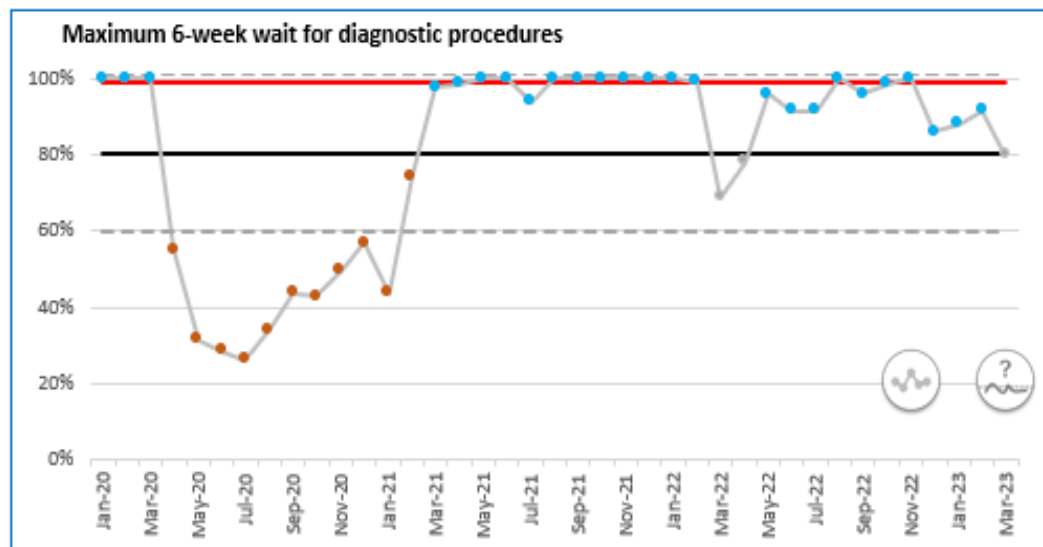
The SPC charts above show that for clients waiting for a diagnostic procedure we have entered a period of common cause variation and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We are currently in a period of improving variation for clients discharged from inpatient care being followed up within appropriate timescales but again due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated.

| Summary | Priority Programmes | Covid-19 | Emergency Preparedness | Quality | People | National Metrics | Care Groups | Finance/Contracts | System-wide Monitoring |

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group and performance for the reporting month is stated along with variation/assurance for each metric where applicable. Figures in bold and italics are provisional and will be refreshed next month.

### Mental Health Community (Including Barnsley Mental Health Services)

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 72.1% | 72.4% | |
| % Assessed within 14 days of referral (Routine) | 75% | 82.6% | 67.7% | |
| % Assessed within 4 hours (Crisis) | 90% | 99.2% | 99.3% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 60% (3/5) | 20% (2/10) | |
| % service users followed up within 72 hours of discharge from inpatient care | 80% | 89.6% | 86.6% | |
| % Service Users on CPA with a formal review within the previous 12 months | 95% | 95.8% | 98.4% | |
| % Treated within 6 weeks of assessment (routine) | 70% | 99.1% | 88.9% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 73.8% | 73.3% | |
| FIRM Risk Assessments - Staying safe care plan in 7 working days | 95% | 67.0% | 82.8% | |
| Information Governance training compliance | >=95% | 85.0% | 84.4% | |
| No of staff off sick - Covid-19 not working | N/A | 5 | 3 | |
| Reducing restrictive practice interventions training compliance | >=80% | 71.9% | 72.0% | |
| Sickness rate (Monthly) | 4.5% | 5.5% | 5.4% | |

### Barnsley General Community Services

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 77.7% | 77.9% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 0% (0/3) | 50% (1/2) | |
| % people dying in a place of their choosing | 80% | 83.3% | 100.0% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 74.7% | 77.4% | |
| Delayed transfers of Care (DTOC) | 3.5% | 0.0% | 0.0% | |
| Information Governance training compliance | >=95% | 87.6% | 89.9% | |
| Max time of 18 weeks from point of referral to treatment - incomplete pathway | 92% | 95.7% | 97.5% | |
| Maximum 6 week wait for diagnostic procedures | 99% | 91.6% | 79.8% | |
| No of staff off sick - Covid-19 not working | N/A | 2 | 5 | |
| Reducing restrictive practice interventions training compliance | >=80% | 50.0% | 33.3% | |
| Safer staffing (inpatient) | 90% | 111.0% | 108.3% | |
| Sickness rate (Monthly) | 4.5% | 4.6% | 4.6% | |

### Mental Health Inpatient

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 27.1% | 39.9% | |
| % Bed occupancy | 85% | 88.1% | 85.1% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 0% (0/3) | 29% (2/7) | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 72.3% | 70.4% | |
| Delayed transfers of Care (DTOC) | 3.5% | 6.7% | 5.0% | |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 87.8% | 89.9% | |
| Inappropriate Out of Area Bed days | 276 | 511 | 511 | |
| Information Governance training compliance | >=95% | 84.6% | 87.8% | |
| No of staff off sick - Covid-19 not working | N/A | 3 | 4 | |
| Physical Violence (Patient on Patient) | Trend Monitor | 16 | 14 | |
| Physical Violence (Patient on Staff) | Trend Monitor | 77 | 51 | |
| Reducing restrictive practice interventions training compliance | >=80% | 79.3% | 79.5% | |
| Restraint incidents | Trend Monitor | 99 | 17 | |
| Safer staffing | 90% | 124.8% | 122.6% | |
| Sickness rate (Monthly) | 4.5% | 6.1% | 5.8% | |

### Forensic

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 67.2% | 65.3% | |
| % Bed occupancy | 90% | 89.7% | 88.5% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 0% (0/0) | 0% (0/0) | |
| % Service Users on CPA with a formal review within the previous 12 months | 95% | 87.1% | 83.5% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 79.6% | 78.8% | |
| Delayed transfers of Care (DTOC) | 3.5% | 0.0% | 0.0% | |
| FIRM Risk Assessments - Staying safe care plan in 7 working days | 95% | N/A | N/A | |
| Information Governance training compliance | >=95% | 84.7% | 86.5% | |
| No of staff off sick - Covid-19 not working | N/A | 3 | 5 | |
| Physical Violence (Patient on Patient) | Trend Monitor | 2 | 2 | |
| Physical Violence (Patient on Staff) | Trend Monitor | 8 | 8 | |
| Reducing restrictive practice interventions training compliance | >=80% | 84.7% | 81.9% | |
| Restraint incidents | Trend Monitor | 12 | 3 | |
| Safer staffing | 90% | 112.0% | 111.0% | |
| Sickness rate (Monthly) | 5.4% | 6.2% | 6.8% | |

### LD, ADHD & ASD

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 68.6% | 72.7% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 0% (0/2) | 0% (0/1) | |
| Bed occupancy (excluding leave) - Commissioned Beds | N/A | 59.8% | 51.2% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 78.4% | 79.9% | |
| Delayed transfers of Care (DTOC) | 3.5% | 18.8% | 23.3% | |
| Information Governance training compliance | >=95% | 87.4% | 83.6% | |
| LD – First face to face contact within 18 weeks | 90% | 78.7% | | |
| No of staff off sick - Covid-19 not working | N/A | 1 | 0 | |
| Physical Violence - Against Patient by Patient | Trend Monitor | 0 | 1 | |
| Physical Violence - Against Staff by Patient | Trend Monitor | 48 | 27 | |
| Reducing restrictive practice interventions training compliance | >=80% | 77.5% | 76.6% | |
| Safer staffing | 90% | 153.4% | 141.5% | |
| Sickness rate (Monthly) | 4.5% | 5.5% | 5.3% | |
| Restraint incidents | Trend Monitor | 51 | 10 | |

### CAMHS

| Metrics | Threshold | Feb-23 | Mar-23 | Variation/Assurance |
|---|---|---|---|---|
| % Appraisal rate | >=90% | 87.9% | 88.3% | |
| % Complaints upheld with staff attitude as an issue | < 20% | 0% (0/4) | 0% (0/1) | |
| CAMHS - Crisis Response 4 hours | N/A | 96.5% | 90.9% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 74.7% | 75.3% | |
| Eating Disorder - Routine clock stops | 95% | 100.0% | 100.0% | |
| Eating Disorder - Urgent/Emergency clock stops | 95% | 80.0% | 87.5% | |
| Information Governance training compliance | >=95% | 82.0% | 84.4% | |
| No of staff off sick - Covid-19 not working | N/A | 0 | 0 | |
| Reducing restrictive practice interventions training compliance | >=80% | 71.3% | 73.6% | |
| Sickness rate (Monthly) | 4.5% | 3.6% | 3.0% | |

This section of the report is populated with key performance issues or highlights as reported by each care group.

**Child and adolescent mental health services (CAMHS):**

<span style="background-color:red">**Alert/Action**</span>

• The senior leadership team recognise that further work is required to improve mandatory training compliance in relation to reducing restrictive practice (73.6% - threshold 80%), cardio pulmonary rehabilitation (75.3% - threshold 80%) and information governance (84.4%- threshold 95%). Specific child focussed training has been requested where access to training is challenging.
• Neurodevelopment diagnostic service waits in Calderdale/Kirklees remain problematic. Robust action plans in place but a shortfall between commissioned capacity and demand remains. Clinical governance clinical safety committee receive further details through the waiting list report.
• Access to specialist residential and Tier 4 inpatient care remains challenging and has been the subject of a number of recent MP enquiries. Work continues with the provider collaborative to improve patient flow.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues with specific challenges in relation to recruitment of band 6 nursing staff.
• Eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets.

<span style="background-color:orange">**Advise**</span>

• Waiting times from referral to treatment in Wakefield remain an outlier. Referral rates remain a key factor. Brief intervention and group work service offer strengthened and medium term improvement anticipated.
• A number of environmental issues have been escalated with respect to staff working conditions at Wetherby young offenders institute. Progress being made in implementing action plan.
• Work on improving the transition between services for children and the adult attention deficit hyperactivity disorder service is underway. This links in with the work of West Yorkshire mental health and learning disability partnership board transition project group.

## Assure

• Staff wellbeing remains a focus.  Hybrid models of working and flexible working policies are being proactively utilised.
• Proactively engaged with provider collaboratives in South and West Yorkshire to strengthen interface with inpatient providers and improve access to specialist beds.
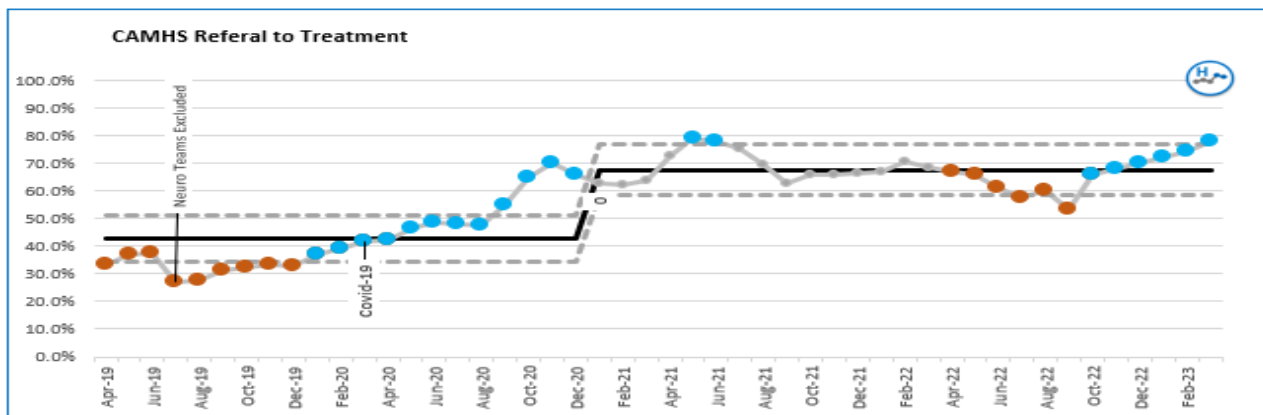


The upper and lower control levels for this measure have been re-calculated from January 2021 following a sustained period of significant improvement, in order to better determine if current performance is within expected variation.

As you can see in March 2023, following a period of special cause concerning variation, we have now entered a period of special cause improving variation. For further information see narrative above.

**Barnsley general community services:**

## Alert/Action

• Health Integration Team (Urban House) – Band 7 Nurse Prescriber left the service in November 2022 leaving only one Nurse Prescriber (lead nurse who is currently working from home due to their clinical vulnerability). This creates pressure and some risk within the service. To date we have been unable to recruit through bank/agency. We are currently working with pharmacy and the walk-in centre in Wakefield, to provide cover for the service as necessary.
• A district nurse was contacted and made aware of a 'bogus' district nurse in the South Yorkshire area. The source came from an email from Yorkshire Ambulance Service (YAS) team member. This information had been shared on social media on a local community group.

**Barnsley general community services continued:**

### Advise

• Live Well Wakefield - a decision tree will be presented to the executive management team regarding the new tender for the service. The bid is to be submitted by the 24th April and awarded 26th June.
• Health Integration Team Urban House (UH) – The commissioner is reviewing current health provision for the six resettlement programmes in Wakefield including UH. Following the meeting with the commissioners in January 2023, a discussion paper was submitted as to how we can work collaboratively with primary care to ensure the delivery of equitable services for all those clients within the resettlement programmes in Wakefield. We have since met with the commissioner and discussed a potential collaborative approach to service delivery with primary care. The commissioner will now arrange further meetings with partner organisations as to next steps.
• Referral rates to children's therapy have remained high.
• Referral rates to paediatric audiology have been particularly high over the past couple of months and this is impacting upon waiting times. Most of these relate to sensory needs and are generated from the local autism assessment pathway, rather than being specific concerns around hearing impairment.
• Integrated Neighbourhood Teams - SystmOne single module rollout continues.

### Assure

• SWYPFT Intermediate Care Engagement event held in Barnsley in March – collaborative working across partners from an AHP perspective.
• Excellence Awards – colleagues shortlisted in both individual and team categories.
• Recognition of our response to the Cost of Living Crisis (More Money in Your Pocket) – Barnsley council hosted event in March in Barnsley. Our colleagues attended in relation to SWYPFT's response and contribution.
• The managers for Live Well Wakefield and Yorkshire Smokefree Doncaster have both been successful in gaining distinctions in Level 5 management and leadership.
• NHSE visit to health integration team UH. The Government has tasked NHS England with setting up large accommodation centres (2000-3000 people in each centre). NHSE wanted to understand the potential risks, challenges etc. that they would need to consider from a health perspective and our suggestions as to how they could manage them on such a large scale.
• Children's Speech and Language Therapy team have been invited to present at the Clinical Governance Clinical Safety Committee, following on from their Excellence award nomination. They will share with the committee examples of good practice and how using digital media has benefited our service users.
• Children's Speech and Language Therapy team are working with learning and development to devise a Trustwide stammering training package. This is aimed at increasing the knowledge and skills of all staff around this neuro difference.
• School Aged Immunisation Service (SAIS) - Childhood flu programme uptake 22/23 – UKHSA (Health Security Agency) reports show that Barnsley is fourth out of 28 Local Authority (LA) areas in North East and Yorkshire for primary school uptake and fifth for secondary school uptake. The team achieved the highest uptake in South Yorkshire. Nationally Barnsley was 17th out of 151 LA areas. SAIS are team finalists in the Trust's Excellence awards.
• Urgent Community Response (UCR) Clinical Lead, Registered General Nurse (RGN) Lead and Neighbourhood Nursing Service (NNS) Clinical Lead all now in post with effect from April 2023.
• The Barnsley Healthcare Federation (BHF) have secured ownership of the Priory Campus property – this will provide opportunities for collaborative working with services including IHeart 365 and Home Visiting Service, and further develop the Alliance partnership with Barnsley council central call and reablement, virtual ward and Right Care Barnsley (RCB).
• New defibrillators have been delivered. There will be a process to remove/replace and train relevant areas across the Trust by our resuscitation team. This resolves the ongoing issues regarding batteries.
• Regional stroke conference to take place in May – SWYPFT team has been successful in submissions to present on Stroke Café, BP@Home (blood pressure) and Life After Stroke Group (6 week programme at Tesco).
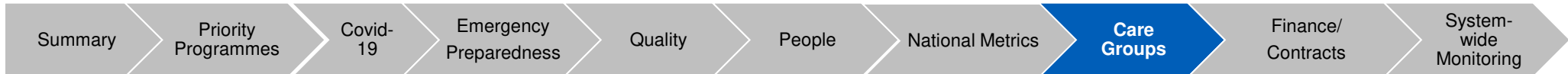
**Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:**

<span style="background-color:red;color:white">**Alert/Action**</span>

• Friend & Family Test – for March, performance is 50% which has reduced compared to previous months. The care group quality and governance lead is undertaking focused improvement activity and this represents the service experienced a significant rise in performance last month but this has not been sustained and further improvement work is being considered currently.
• ADHD Waiting Lists: Remains a high priority for the service with cases being triaged and prioritised using data available. We have 3257 people waiting for an ADHD assessment. The maximum number of people the service can see is 560 per year (when fully staffed).
• Autism (ASD): The screening and triage process (as recommended in the recently published NHS England guidance for integrated care boards) to ensure that only clinically appropriate referrals are accepted for assessment means there is a short waiting list. 24 people are currently waiting for assessment – all have been invited, 14 of these already have an appointment booked. Two have waited longer than 12 weeks due to cancelled appointments.

<span style="background-color:orange">**Advise**</span>

**Bradford Autism Pathway - Collaboration with Bradford District Care Trust (BDCFT)**
• The waiting list project is progressing as planned.
• The new autism electronic referral system has launched across Bradford and Craven.
• Two of the posts required to deliver the sustainable pathway in Bradford have been recruited to.
• Since the approval of the service specification in January mobilisation is being implemented.

<span style="background-color:green">**Assure**</span>

• All key performance targets are being met.
• All training is above the threshold.
• Relationship with Bradford working very well.
• Excellent levels of supervision and appraisal across the team (100%).

**Learning disability services:**

<span style="background-color:red;color:white">**Alert/Action**</span>

**Community Services**
• Work on the reduction of waiting times continues. During this phase of the work Calderdale has been the focus with the intention to role out the improvements across all localities.

**ATU (Assessment & Treatment Unit)**
• Horizon improvement programme continues to make progress.
• Repeat Quality Monitoring Visit (QMV) has now taken place with an improved position noted although there is acknowledgement that further improvements are required.
• Recruitment to posts which were previously shared posts (with Bradford) is underway.
• Delayed Transfers of Care currently 23.3% and reflects system challenges in provision of bespoke packages of care to meet complex needs.

## Advise

**Community & ATU (Assessment & Treatment Unit)**
• Workforce review is now concluded and the focus will now be the mobilisation of the plan.
• Service is working with the executive sponsor (Dr Thyiagesh) with the priority set as collaborative working across the Trust re Green Light Toolkit.
• Community Improvement Programme will commence in the next few weeks.
• Working with Creative Minds to improve sensory environment on Horizon.
• Bid to create a sensory room at the Calderdale hub successful.
• Appraisal currently 63.1%
• No mandatory training in red information governance 79.9% action plan in place to address.
• Training in amber: reducing restrictive intervention practice 77.6%, cardio pulmonary resuscitation 75.7, Food Safety 76.3%.

## Assure

**ATU (Assessment & Treatment Unit)**
• Recruitment continues to progress.
• Robust plans in place to address mandatory training, supervision, and appraisal shortfall and progress is being monitored closely.
• Benchmarking against CQC 'Outstanding' rated services planned.

**Community**
• Waiting List mitigation includes more frequent data cleansing and the establishment of an early alert system which will help teams to potentially avoid delays in appointments.
• Annual health checks across all 4 localities are continuing to improve.
• Although recruitment challenges remain, some further key posts have now been recruited, key posts are the Calderdale nurse lead, Intensive support team nurse lead, dietician, Wakefield out of hours

**Forensic services:**

<span style="background-color:red;color:white">**Alert/Action**</span>

• Acuity remains high – the service has suffered significant patient damage to the estate (seclusion rooms) losing all seclusion rooms in low secure at one point. Estates have supported the service to repair all except Gaskell which will require more extensive work.

• Bed Occupancy – Newton Lodge 87.4↓, Bretton 90.4%↓, Newhaven 91.6%↓.

• Sickness absence/covid absence – remains above the care group target at 8.3%.

• Vacancies & Turnover – Turnover remains high 14%↑. Recruitment & Retention remains a priority.

• Care Programme Approach - under target at 83.5↑ remedial action in place to address this and further work to remove out of area service users from our records will be undertaken with Performance and information colleagues.

• Quality network for Forensic mental health services (QNFMHS) - The service has received an updated report from the Quality Network for Forensic Mental Health Services (QNFMHS (overseen by the Royal College of Psychiatry)). The service had currently challenged the rating from last years reports. It has been amended favourably and the service is currently preparing for this year's visit early May.

<span style="background-color:orange">**Advise**</span>

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative.

• Mandatory training overall compliance:

  Newton Lodge – 89.5%

  Bretton – 87.5%

  Newhaven – 88.2

The above figures represent the overall position for each service. Hotspots across the service are food safety, information governance, local Induction and safeguarding adults (Newhaven only).

• The roll out of trauma informed care is going well and training sessions for staff have commenced with some staff having completed all 4 modules. Phase 2 of the roll out will be discussed in April.

• The West Yorkshire Provider Collaborative held a stakeholder event to discuss the future of forensic community services.

• Appraisal & supervision remain a priority.

• The well-being of staff also remains a priority within the service.

**Assure**

• No delayed discharges recorded across all three services.
• High levels of data quality across the care group (100%).
• 100% compliance for HCR-20 assessment being completed within 3 months of admission.
• Friends and family test is positive at 71%
• All Equality Impact Assessments (EIA) across forensic services have been completed for 23/24.
• Positive feedback received from the commissioning hub relating to our quarterly submissions and presentations at contract meetings.

**Adults and Older People mental health:**

**Alert/Action**

• Acute wards have continued to manage high levels of acuity and several wards have been impacted by Covid-19 outbreaks.
• We have had high occupancy levels across wards and capacity to meet demand for beds remains difficult.
• Workforce challenges have continued.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed, and the actual number placed out of area at the end of March has reduced slightly to 15.
• We are working actively with partners to reduce the length of time people who are clinically ready for discharge spend in hospital and to explore all options for discharge solutions / alternatives to hospital care, underpinned by the work on the 100 Day Discharge Challenge.
• Demand into the Single Point of Access (SPA) and capacity issues have lead to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas, particularly in Barnsley.
• Intensive Home Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing additional workforce challenges and are looking at innovative remedial and improvement approaches as part of a rapid action plan.
• We currently have higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.
• All areas are focussing on improving performance for FIRM risk assessments, and performance is improving in all areas for those on care programme approach who have had a staying-well plan within 7 days and those who have had a formulation within 7 days.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users.
• Care Programme Approach (CPA) review performance is above target in all areas, with Barnsley demonstrating significant improvement across the quarter, action plans and support from quality and governance leads remain in place.
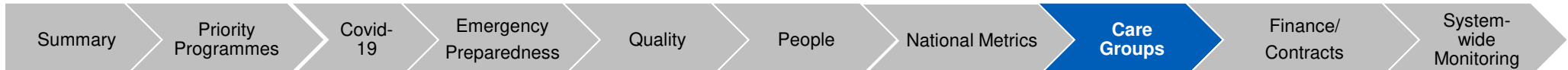
## Advise

• Senior leadership from matrons and general managers remains in place across seven days.
• We are currently reviewing weekend working for senior managers to ensure we can build a sustainable model going forward that offers the required support to front-line 24/7 services.
• Intensive work to consider how we maintain quality and safety on our wards and improve the well-being of staff and service users and encourage recruitment and retention is underway.
• We are actively expanding creative approaches to enhance service user experience and the general ward environments. We are building identified challenges and priorities into the workforce strategy and the inpatient improvement priority programme.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including providing robust gatekeeping, trauma informed care and effective intensive home treatment.
• We are participating in the Trustwide work on how we measure and manage waits in terms of consistent data and performance measurement.
• We continue to work in collaboration with our places to implement the community mental health transformation.
• We recognise the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and that where we need to improve action plans are in place.
• We continue to work towards required concordance levels for cardio pulmonary resuscitation training and aggression management - this has been impacted by some issues relating to access to training and levels of did not attends.
• We are working closely with specialist advisors and we also have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

## Assure

• All acute wards are now live on Electronic Prescribing and Medicines Administration (EPMA) which will contribute towards improving patient safety through reduction in prescribing and administration errors.
• We are performing well in gatekeeping admissions to our inpatient beds.
• We are performing well in 72 hour follow up for people discharged into the community.
• We are looking at specific input into inpatient areas to support rapid improvement with trauma informed approaches, targeting female wards in the first instance.
• Friends and Family Test – remains positive and above threshold for all areas.
• Our lead matron is participating in NHS England's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme, a review in response to the concerns raised around the culture within mental health inpatient services. A series of three national events are being undertaken to develop principles of what quality inpatient care should look like.

## Engagement, Equality and Volunteering Update

• Equality and involvement annual action plans for 2023/2024 now signed off by EII Committee at the March meeting

• A Trust wide framework to support staff to review equality data is now being evaluated for use by our BI/PI teams to build on what is already in place

• Monthly themed lunch box talks –focus on Young carers

• The 'All of You' equality data collection campaign continues to improve data collection for equality

• The Older peoples service transformation is moving towards a formal consultation. Consultation documents, plan, full equality impact assessment and outline business case are now being developed. Formal consultation planned for launch after Purdah in Spring 2023

• All of You: Race forward is now to be delivered through a programme approach, a 3 month plan to launch has been approved at the first meeting in March

• The Flair survey has now closed. The final response rate is 23%. A paper on how we will review the data and early sight of findings will be shared with EMT this month.

• The Trust wide approach to involvement is nearly ready to launch. The training modules to deliver 3 x 2-hour training sessions have been tested this month. A comms plan is now being developed for a full launch in April 2023 and a payment policy is being developed.

• The quarterly insight report was developed this quarter and shared with executive management team to identify a 'you told us we listened' response.

• An 'Electronic Equality impact assessment' is in the final stages of development with the support of information management and technology (IM&T) colleagues. .

• The offer to deliver enhanced training for equality, diversity and inclusion has now been approved and the team are currently looking at resourcing the work so it can be delivered to over 500 senior people across the Trust.

• The volunteer service continues to progress a large-scale piece of work in Barnsley to support community teams with volunteers is underway and 17 new volunteer managers are due to receive training to support these roles.

• Volunteer to career is progressing. Work to understand the befriending role within the Trust will be co-designed and shared with the Trusts operational management group for comment.

## Overall Financial Performance 2022/23

### Executive Summary / Key Performance Indicators

| | Performance Indicator | Out Turn 2022/23 | Narrative |
|---|---|---|---|
| 1 | Surplus / (Deficit) | £3.2m | The position reported here is as per the system financial performance measure. The target of £3.2m surplus has been achieved in line with plan. |
| 2 | Agency Spend | £10m / 4.2% | The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) 2022 / 23 agency cap is £7.8m. Performance is measured against both this and also as a percentage of total pay expenditure. For 2022 / 23 expenditure is £10.0m which is £2.2m more than cap. |
| 3 | Overhead Costs | 15% | This key performance indicator is a measurement of corporate / overhead costs as a percentage of income for the year to date. |
| 4 | Financial sustainability and efficiencies | £6.4m | As per the NHS Operating Framework the Trust revised annual plan submission included a sustainability and efficiency requirement of £6.4m. This is being managed within the overall financial position and as such has been achieved with delivery of the surplus position in line with plan. |
| 5 | Cash | £74.6m | Cash in the bank remains positive. As is traditional this has reduced in March with the payment of Public Dividend Capital (PDC) made in month. |
| 6 | Capital | £7m | The capital forecast was revised during 2022 / 23 (originally set as £13.1m) to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM & T. |
| 7 | Better Payment Practice Code | 95% | This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt. |

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

## System-wide monitoring

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems (ICS) of South Yorkshire and West Yorkshire. Progress against delivery of the ICS five year strategies can be found by following the links below:


West Yorkshire Health and Care Partnership -

https://www.westyorkshire.icb.nhs.uk/meetings/finance-investment-and-performance-committee

South Yorkshire ICS -

https://syics.co.uk/about/integrated-care-partnerships-meetings-and-minutes

# Publication Summary

**This section of the report identifies publications that may be of interest to the board and its members.**

Community services statistics, January 2023

NHS sickness absence rates, November 2022

NHS staff earnings estimates, December 2022, provisional statistics

NHS workforce statistics: December 2022

# Finance Report

## Month 12 (2022 / 23)

**www.southwestyorkshire.nhs.uk**

With **all of us** in mind.

| 1.0 | Executive Summary / Key Performance Indicators | | |
|---|---|---|---|
| **Key Performance Indicator** | | **Out Turn 2022 / 23** | **Narrative** |
| 1 | **Surplus / (Deficit)** | £3.2m | The position reported here is as per the System financial performance measure. The target of £3.2m surplus has been achieved in line with plan. |
| 2 | **Agency Spend** | £10m | The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) 2022 / 23 agency cap is £7.8m. Performance is measured against both this and also as a percentage of total pay expenditure. For 2022 / 23 expenditure is £10.0m which is £2.2m more than cap. |
| | | 4.2% | |
| 3 | **Overhead Costs** | 15% | This key performance indicator is a measurement of corporate / overhead costs as a percentage of income for the year to date. |
| 4 | **Financial sustainability and efficiencies** | £6.4m | As per the NHS Operating Framework the Trust revised annual plan submission included a sustainability and efficiency requirement of £6.4m. This is being managed within the overall financial position and as such has been achieved with delivery of the surplus position in line with plan. |
| 5 | **Cash** | £74.6m | Cash in the bank remains positive. As is traditional this has reduce in March with the payment of Public Dividend Capital (PDC) made in month. |
| 6 | **Capital** | £7m | The capital forecast was revised during 2022 / 23 (originally set as £13.1m) to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM & T. |
| 7 | **Better Payment Practice Code** | 95% | This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt. |

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

# Income & Expenditure Position 2022 / 2023

## Trust Financial Position

| Budget Staff WTE | Actual worked WTE | Variance WTE | Variance % | This Month Budget £k | This Month Actual £k | This Month Variance £k | Description | Year to Date Budget £k | Year to Date Actual £k | Year to Date Variance £k | Budget £k | Forecast £k | Forecast Variance £k |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 22,071 | 32,465 | 10,394 | Healthcare contracts | 246,953 | 252,245 | 5,291 | 246,953 | 252,245 | 5,291 |
| | | | | 9,661 | 19,053 | 9,392 | Other Operating Revenue | 109,959 | 124,156 | 14,196 | 109,959 | 124,156 | 14,196 |
| | | | | 31,732 | 51,518 | 19,787 | Total Revenue | 356,913 | 376,400 | 19,488 | 356,913 | 376,400 | 19,488 |
| 5,172 | 4,784 | (388) | 7.5% | (20,560) | (37,670) | (17,110) | Pay Costs | (233,934) | (239,757) | (5,823) | (233,934) | (239,757) | (5,823) |
| | | | | (10,503) | (14,253) | (3,750) | Non Pay Costs | (112,956) | (127,452) | (14,496) | (112,956) | (127,452) | (14,496) |
| | | | | 0 | 0 | 0 | Gain / (loss) on disposal | 0 | 820 | 820 | 0 | 820 | 820 |
| | | | | 0 | 0 | 0 | Impairment of Assets | 0 | (787) | (787) | 0 | (787) | (787) |
| 5,172 | 4,784 | (388) | 7.5% | (31,063) | (51,923) | (20,860) | Total Operating Expenses | (346,890) | (367,176) | (20,286) | (346,890) | (367,176) | (20,286) |
| 5,172 | 4,784 | (388) | 7.5% | 668 | (405) | (1,073) | EBITDA | 10,022 | 9,224 | (798) | 10,022 | 9,224 | (798) |
| | | | | (482) | (479) | 3 | Depreciation | (5,847) | (5,869) | (23) | (5,847) | (5,869) | (23) |
| | | | | (179) | 64 | 243 | PDC Paid | (2,148) | (1,895) | 253 | (2,148) | (1,895) | 253 |
| | | | | 118 | 274 | 155 | Interest Received | 1,150 | 1,718 | 568 | 1,150 | 1,718 | 568 |
| 5,172 | 4,784 | (388) | 7.5% | 126 | (546) | (672) | Surplus / (Deficit) | 3,178 | 3,178 | 0 | 3,178 | 3,178 | 0 |
| | | | | 0 | (19) | (19) | Depn Peppercorn Leases (IFRS16) | 0 | (229) | (229) | 0 | (229) | (229) |
| | | | | 0 | 0 | 0 | Revaluation of Assets | 0 | 2,225 | 2,225 | 0 | 2,225 | 2,225 |
| 5,172 | 4,784 | (388) | 7.5% | 126 | (566) | (691) | Surplus / (Deficit) | 3,178 | 5,174 | 1,996 | 3,178 | 5,174 | 1,996 |



Trust Monthly I & E Profile



Trust Cumulative I & E Profile
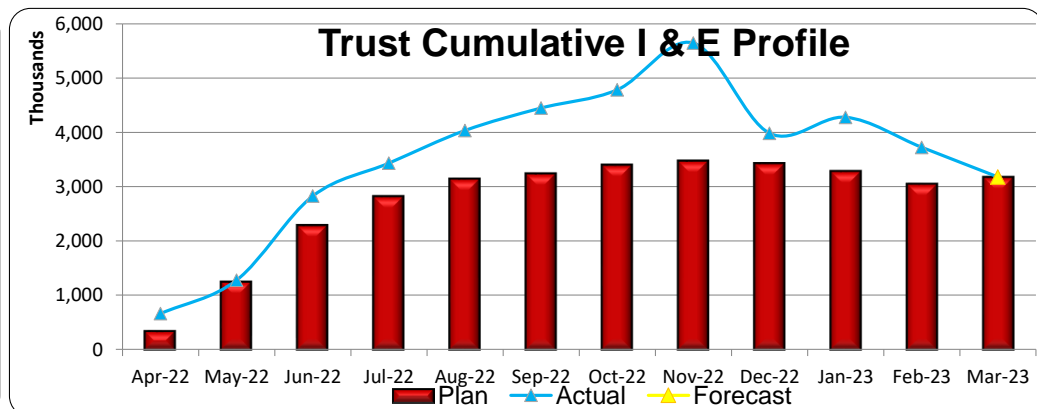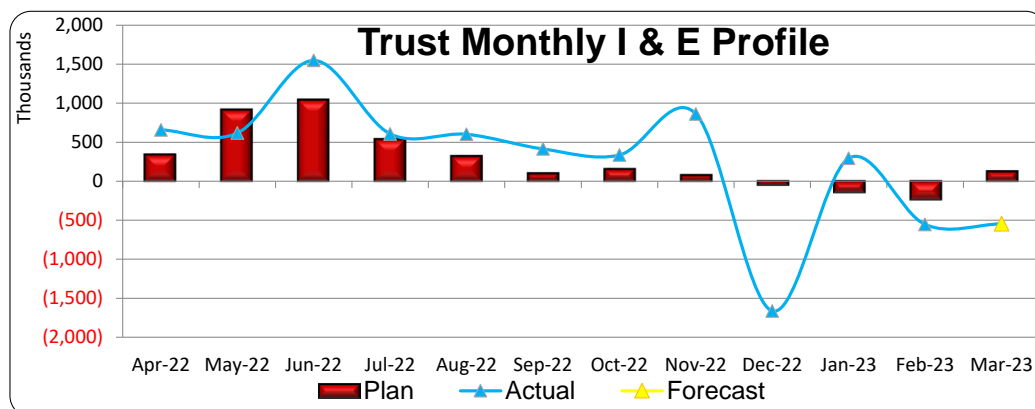
# Income & Expenditure Position 2022 / 23

## The unaudited financial position for 2022 / 23 is £3.2m surplus.
## This is in line with plan.

The Trust revised financial plan, submitted June 2022, is a surplus of £3.2m. This is mainly profiled at the start of the year with workstreams such as recruitment and retention of workforce having an impact on the position in Q3 and Q4.

### NHS England - monthly submission

The actual financial performance as reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care System (ICS). This declaration is also included within the self certification section of the return.

### Income

The majority of income continues to be received through block payment arrangements with any variances to plan agreed by exception. Additional income has been recorded in March. Elements of this relates to additional income agreed with commissioners to reflect investment and agreements during 2022 / 23. Other significant values relate to implementation of national guidance and reporting requirements. For example this includes notional income (and expenditure) relating to centrally paid pension contributions and income for potential 2022 / 23 pay awards as per national

### Pay

As in previous months the pay expenditure run rate has been impacted by one off / non recurrent adjustments such as the pension and pay award adjustments as outlined above. These have been specifically separated out within the additional pay information on page 7. The trend of increasing WTE run rate has continued in March with a stepped change in substantive worked WTE. This includes periodic recruitment into services such as IAPT; recruitment is aligned with training places and timescales.

Recruitment and retention workstreams continue and have been modelled as part of the Trust 2023 / 24 annual plan submission. This will continue to be monitored and reported.

### Non Pay

Non Pay spend continues to be predominately Adult Secure Collaborative spend. Inflationary pressures, on areas such as utilities and catering / food costs, continue to be mitigated as far as possible within the overall financial position.

Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is included as other operating income.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)). For 2022 / 23 a hybrid of the previous year's financial regimes are in place. Formal contracts have resumed and are in place for all of the major commissioners. The financial element remains a block based upon national calculations and tariff changes. The same variation process as 2021 / 22 remains which means that investment in services will be added to contracts as and when agreed.

The block values have been calculated to include all income from NHS commissioners. This includes payment for clinical services, staff recharges and recharges for projects etc. from those organisations although this income is shown as other operating revenue within the Trust income and expenditure position.

| Income source | Apr-22 £k | May-22 £k | Jun-22 £k | Jul-22 £k | Aug-22 £k | Sep-22 £k | Oct-22 £k | Nov-22 £k | Dec-22 £k | Jan-23 £k | Feb-23 £k | Mar-23 £k | Total £k | Total 21/22 £k |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS Commissioners | 17,501 | 18,083 | 17,285 | 17,878 | 18,049 | 19,848 | 18,099 | 18,498 | 18,270 | 18,173 | 18,320 | 20,251 | **220,257** | **199,439** |
| ICS / System / Covid | 854 | 854 | 854 | 854 | 854 | 854 | 854 | 854 | (3,146) | 854 | 854 | 854 | **6,243** | **15,258** |
| Specialist Commissioner | 242 | 324 | 320 | 325 | 319 | 356 | 429 | 331 | 324 | 342 | 343 | 413 | **4,069** | **45,733** |
| Pay Award | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9,058 | **9,058** | **0** |
| Local Authority | 433 | 454 | 484 | 427 | 429 | 460 | 446 | 449 | 463 | 419 | 432 | 414 | **5,311** | **5,172** |
| Partnerships | 422 | 422 | 395 | 413 | 345 | 399 | 309 | 447 | 232 | 496 | 385 | 786 | **5,052** | **7,580** |
| Top Up / ERF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **287** |
| Other Contract Income | 124 | (0) | 555 | 246 | 258 | 470 | 84 | 206 | 146 | (642) | 118 | 689 | **2,256** | **708** |
| **Total** | **19,576** | **20,136** | **19,893** | **20,143** | **20,254** | **22,387** | **20,221** | **20,785** | **16,289** | **19,643** | **20,452** | **32,465** | **252,245** | **274,176** |
| 21/22 | 20,679 | 20,725 | 20,039 | 20,358 | 21,057 | 22,784 | 24,206 | 24,485 | 24,831 | 24,657 | 23,559 | 26,796 | **274,176** | |



**Trust Income Profile (excluding pay award income)**

Plan — Actual — Forecast
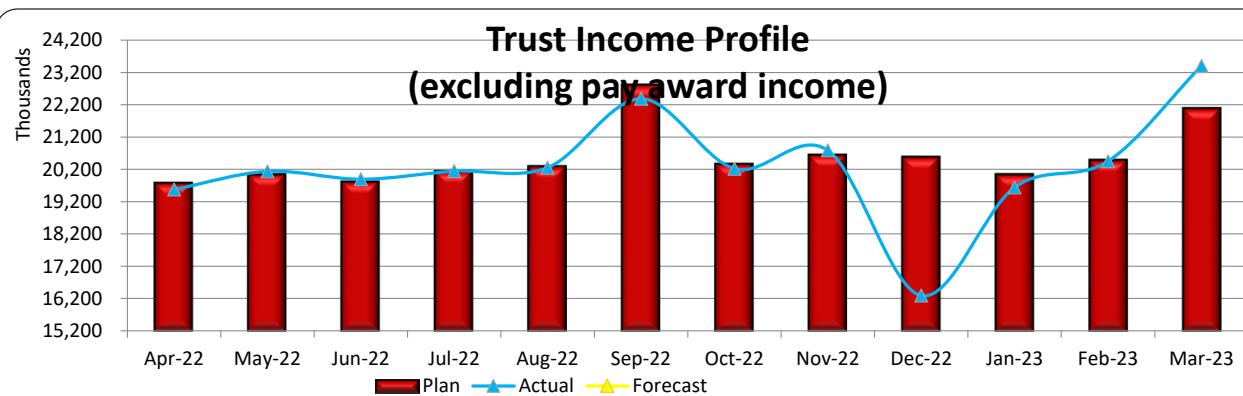
Additional income has been received in March 2023. Some of this was not forecast but has been agreed with commissioners and / or NHS England. For example this includes £9.1m income relating to the potential impact of proposed 2022 / 23 pay awards in March 2023 (excluded from the graph to the left).

Pay expenditure has been included as per Trust calculations which highlights a shortfall against income of c. £0.9m.

Other increased income relates to contract variations now agreed and finalised with commissioners. This, and full year effects, have been reflected in the Trust 2023 / 24 financial plan.

Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for in excess of 85% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.
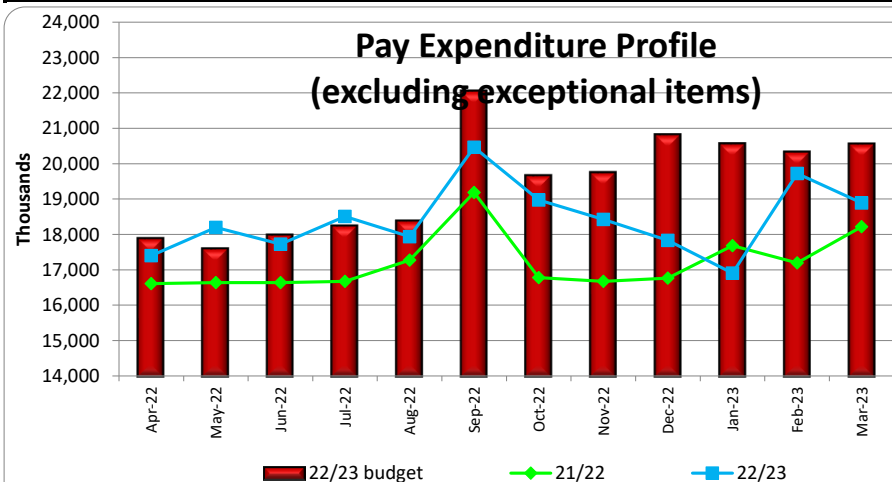
| Staff type | Apr-22 £k | May-22 £k | Jun-22 £k | Jul-22 £k | Aug-22 £k | Sep-22 £k | Oct-22 £k | Nov-22 £k | Dec-22 £k | Jan-23 £k | Feb-23 £k | Mar-23 £k | Total £k |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Substantive | 15,672 | 16,136 | 16,033 | 16,399 | 16,217 | 18,386 | 16,937 | 16,570 | 16,078 | 14,704 | 17,586 | 15,571 | **196,289** |
| Bank & Locum | 986 | 1,145 | 985 | 1,161 | 1,004 | 1,229 | 1,261 | 1,058 | 1,016 | 1,273 | 1,314 | 2,245 | **14,675** |
| Agency | 740 | 920 | 711 | 950 | 716 | 849 | 775 | 797 | 735 | 928 | 818 | 1,073 | **10,013** |
| Exceptional : pay award | | | | | | | | | | | | 9,983 | **9,983** |
| Exceptional : Notional pension contributions | | | | | | | | | | | | 8,798 | **8,798** |
| Total | **17,397** | **18,201** | **17,728** | **18,510** | **17,937** | **20,464** | **18,972** | **18,425** | **17,828** | **16,905** | **19,719** | **37,670** | **239,757** |
| 21/22 | 16,610 | 16,641 | 16,637 | 16,675 | 17,273 | 19,187 | 16,781 | 16,674 | 16,769 | 17,684 | 17,199 | 18,220 | **206,351** |
| | | | | | | | | | | | | | |
| Bank as % (in month) | 5.7% | 6.3% | 5.6% | 6.3% | 5.6% | 6.0% | 6.6% | 5.7% | 5.7% | 7.5% | 6.7% | 11.9% | 6.1% |
| Agency as % (in month) | 4.3% | 5.1% | 4.0% | 5.1% | 4.0% | 4.1% | 4.1% | 4.3% | 4.1% | 5.5% | 4.2% | 5.7% | 4.2% |

| WTE Worked | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | Average |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Substantive | 4,130 | 4,109 | 4,129 | 4,148 | 4,162 | 4,153 | 4,222 | 4,223 | 4,228 | 4,235 | 4,274 | 4,306 | **4,193** |
| Bank & Locum | 251 | 294 | 252 | 307 | 259 | 272 | 313 | 264 | 272 | 329 | 297 | 309 | **285** |
| Agency | 148 | 141 | 149 | 142 | 137 | 175 | 158 | 149 | 170 | 160 | 156 | 169 | **155** |
| Total | **4,530** | **4,545** | **4,530** | **4,597** | **4,559** | **4,600** | **4,693** | **4,636** | **4,670** | **4,724** | **4,727** | **4,784** | **4,633** |
| 20/21 | 4,461 | 4,455 | 4,396 | 4,447 | 4,494 | 4,494 | 4,489 | 4,450 | 4,482 | 4,559 | 4,532 | 4,591 | **4,488** |



Pay Expenditure Profile (excluding exceptional items)

Legend: 22/23 budget — 21/22 — 22/23

As in previous months pay expenditure has been impacted by a number of one off adjustments. Because of the significant financial values involved key adjustments have been separately identified in the table above.

In each case additional income has been received. National pension contributions is a notional adjustment with equal income and expenditure. Pay awards is an estimate of potential costs based upon the current offer. This is currently reported as a cost pressure in 2022 / 23 with nationally calculated income less than expected costs.

Neither of these have a WTE associated with them. Overall there has been another stepped increase reported in March. Substantive staff has increased, supported by continued international recruitment, but also for the timing of new recruitment into IAPT services Trustwide.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below. The Trust has also included an additional key performance indicator for 2022 / 23 linked to agency as a proportion of the overall workforce.

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

**Agency spend is £1,073k in March. Spend in 2022 / 23 is £10.0m.**

Under the NHS Single Oversight Framework, expected maximum agency levels have been set at an Integrated Care Board (ICB) level for 2022 / 23. Within this overall limit an allocation of £7.8m has been set for the Trust. This has been exceeded by £2.2m.

The Trust is already focussed on this as part of the wider workforce strategy as it's often seen as the last resort and the least cost effective but in some cases is the only viable option for ensuring continuity of safe services.

As experienced in previous years there is an increased level of agency expenditure reported in March. Although this increase is across most categories it is highest for unregistered nursing and other clinical staff.

In addition to the £7.8m target, focus has returned to non clinical agency usage. The Trust has spent £372k on admin and clerical staff in order to support service delivery.

**Agency Spend By Month**

Thousands (y-axis: 400 to 1,100)

Months: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar

Legend: 20/21, 21/22, 22/23

**Agency - as a proportion of total pay costs**

(y-axis: 2.0% to 6.0%)

Months: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar

Legend: Target, 2021 / 22, 2022 / 23
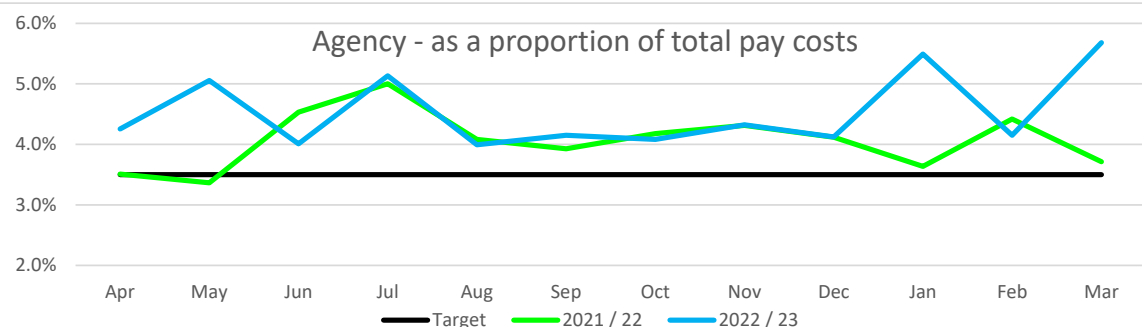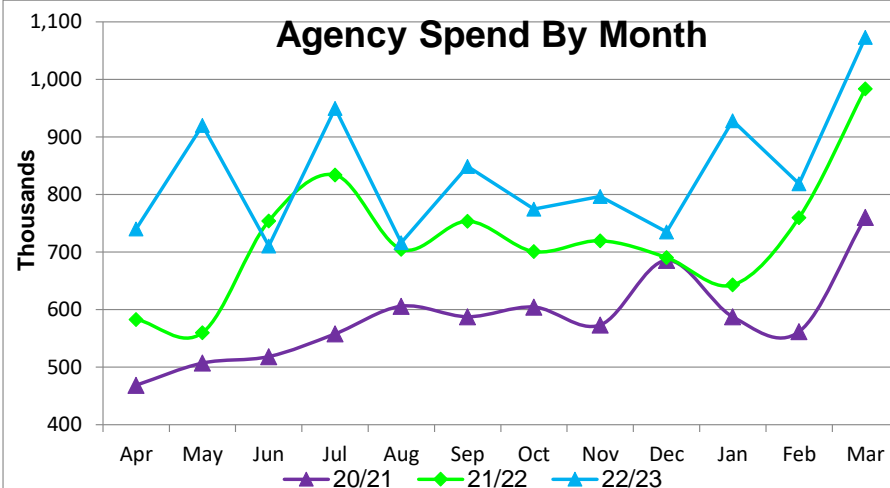
From 1st April 2022 a new key performance indicator has been included within the Trust Integrated Performance Report that highlights the proportion of total Trust pay costs which are agency.

A revised cumulative target, based on the £7.8m target, of 3.5% has been set and monthly performance is shown on the left. Performance in March 2023, excluding exceptional pay items, was 5.5% with cumulative year position of 4.5%. The national target for 2023 / 24 is to be 3.7%.

Whilst pay expenditure is the majority of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

| Non pay spend | Apr-22 £k | May-22 £k | Jun-22 £k | Jul-22 £k | Aug-22 £k | Sep-22 £k | Oct-22 £k | Nov-22 £k | Dec-22 £k | Jan-23 £k | Feb-23 £k | Mar-23 £k | Total £k |
|---------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|----------|
| 2022/23 | 7,025 | 10,112 | 10,148 | 9,568 | 9,952 | 10,655 | 12,511 | 8,729 | 11,253 | 11,795 | 11,450 | 14,253 | 127,452 |
| 2021/22 | 3,834 | 3,783 | 3,712 | 3,729 | 4,246 | 3,949 | 6,512 | 7,107 | 7,556 | 8,140 | 6,961 | 10,478 | 70,008 |

| Non Pay Category | Budget Year to date £k | Actual Year to date £k | Variance £k |
|------------------|------------------------|------------------------|-------------|
| Drugs | 3,459 | 3,374 | (84) |
| Establishment | 7,365 | 10,237 | 2,872 |
| Lease & Property Rental | 7,383 | 7,557 | 174 |
| Premises (inc. rates) | 5,839 | 6,582 | 743 |
| Utilities | 2,233 | 2,382 | 150 |
| Purchase of Healthcare | 9,915 | 12,185 | 2,270 |
| Lead Provider Collaborative | 64,660 | 68,309 | 3,649 |
| Travel & vehicles | 4,371 | 4,278 | (93) |
| Supplies & Services | 6,982 | 7,416 | 434 |
| Training & Education | 2,529 | 2,137 | (392) |
| Clinical Negligence & Insurance | 1,031 | 1,026 | (5) |
| Other non pay | (2,809) | 1,969 | 4,778 |
| Total | 112,956 | 127,452 | 14,496 |
| Total Excl OOA and Drugs | 99,582 | 111,893 | 12,311 |
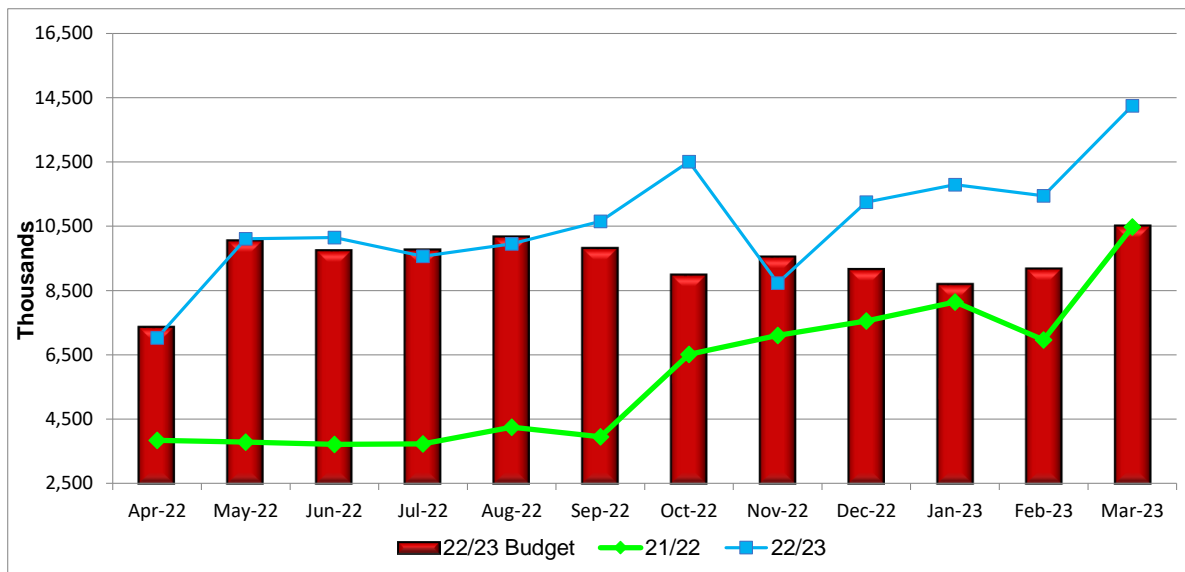


**Key Messages**

As per previous updates the major influence on Trust non-pay expenditure over the past year has been the implementation of the Adult Secure Collaboratives. For West Yorkshire this was in October 2021 and South Yorkshire went live from 1st May 2022. Budgets, and actual expenditure reflect this increase. This will be reported separately in 2023 / 24 for clarify on the impact of collaboratives and also highlight Trust specific non-pay pressures

Other headlines include continued underspends against budget on the travel and training lines. Budgetary requirements have been reassessed as part of the 2023 / 24 planning process.

Other non pay includes all other items not categorised into the above headings. As such this covers a wide range of items and budgets held centrally. Major areas of spend include audit fees, consultancy costs, Trusts costs as part of linked charities including Creative Minds and the Fieldhead Museum.

## 2.3 Out of Area Beds Expenditure Focus

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provide additional capacity for services which we do. From October 2021 this also includes the West Yorkshire Adult Secure Provider Collaborative and South Yorkshire Adult Secure Provider Collaborative from 1st May 2022.

Due to it's volatile, and potentially expensive nature, the non-pay focus has been on out of area bed expenditure. In this context this refers to spend incurred in order to provide clinical care to adult acute and PICU service users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key reasons are highlighted below.

 - Specialist health care requirements of the service user not available directly from the Trust or not specifically commissioned.

 - No current bed capacity to provide appropriate care.

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

This analysis is for the out of area placements relating to adult acute beds including PICU in all areas.  This excludes activity relating to locked rehab in Barnsley or the purchase of other healthcare services.

### Out of Area Expenditure Trend (£)

|  | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| 20/21 | 141 | 55 | 88 | 342 | 253 | 164 | 135 | 68 | 86 | 73 | 119 | 218 | 1,741 |
| 21/22 | 195 | 251 | 199 | 137 | 121 | 88 | 305 | 337 | 382 | 604 | 641 | 720 | 3,981 |
| 22/23 | 644 | 667 | 557 | 378 | 235 | 276 | 474 | 446 | 534 | 474 | 508 | 573 | 5,767 |

### Bed Day Trend Information

|  | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20/21 | 110 | 54 | 120 | 305 | 147 | 76 | 111 | 105 | 148 | 124 | 100 | 126 | 1,526 |
| 21/22 | 221 | 313 | 316 | 223 | 261 | 409 | 422 | 460 | 555 | 653 | 498 | 690 | 5,021 |
| 22/23 | 484 | 512 | 587 | 479 | 355 | 292 | 523 | 606 | 521 | 568 | 548 | 552 | 6,027 |

### Bed Day Information 2022 / 2023 (by category)

|  | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PICU | 427 | 417 | 446 | 379 | 247 | 204 | 235 | 270 | 328 | 348 | 394 | 340 | 4,035 |
| Acute | 57 | 95 | 141 | 100 | 108 | 88 | 288 | 336 | 193 | 220 | 154 | 212 | 1,992 |
| Total | 484 | 512 | 587 | 479 | 355 | 292 | 523 | 606 | 521 | 568 | 548 | 552 | 6,027 |



**Out of Area Expenditure - monthly** (20/21, 21/22, 22/23)
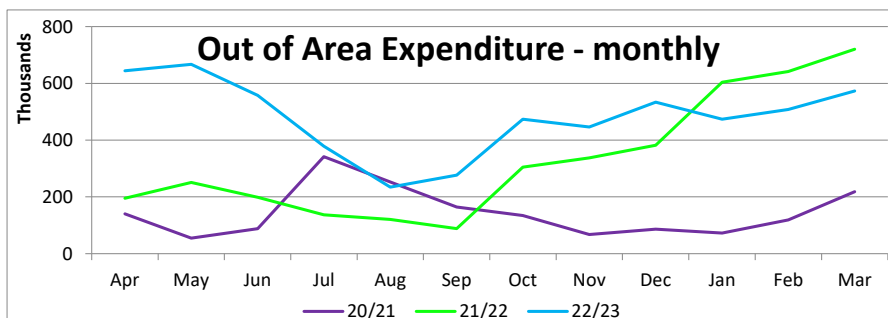
Inpatient services have continued to experience sustained levels of demand and therefore out of area placements have continued at a high level.

Utilisation, in March, is in line with the average since October 2022 at 552 bed days.

Actions continue to minimise the impact, financially and operationally, from out of area placements. Repatriation (or discharge if appropriate) happens at the earliest possible opportunity.

| Balance Sheet / Statement of Financial Position (SOFP) | 2021 / 2022 £k | Actual (YTD) £k | Note |
|---|---|---|---|
| Non-Current (Fixed) Assets | 107,352 | 163,681 | 1 |
| **Current Assets** | | | |
| Inventories & Work in Progress | 189 | 231 | |
| NHS Trade Receivables (Debtors) | 973 | 1,664 | 4 |
| Non NHS Trade Receivables (Debtors) | 921 | 2,443 | 4 |
| Prepayments | 2,174 | 3,482 | 2 |
| Accrued Income | 816 | 9,305 | 3 |
| Asset held of Sale | 1,500 | 1,500 | |
| Cash and Cash Equivalents | 81,368 | 74,585 | Pg 13 |
| **Total Current Assets** | **87,941** | **93,209** | |
| **Current Liabilities** | | | |
| Trade Payables (Creditors) | (39,400) | (46,790) | 5 |
| Capital Payables (Creditors) | (1,790) | (739) | 6 |
| Deferred Income | (6,480) | (4,172) | |
| Other Liabilities (IFRS 16 / leases) | | (51,979) | 1 |
| **Total Current Liabilities** | **(47,670)** | **(103,680)** | |
| **Net Current Assets/Liabilities** | **40,271** | **(10,470)** | |
| **Total Assets less Current Liabilities** | **147,623** | **153,210** | |
| Provisions for Liabilities | (7,716) | (4,319) | 8 |
| **Total Net Assets/(Liabilities)** | **139,907** | **148,891** | |
| **Taxpayers' Equity** | | | |
| Public Dividend Capital | 45,624 | 45,657 | |
| Revaluation Reserve | 13,156 | 14,026 | |
| Other Reserves | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 75,907 | 83,988 | 7 |
| **Total Taxpayers' Equity** | **139,907** | **148,891** | |

The Balance Sheet analysis compares the current month end position to that at 31st March 2022.

1. There has been a stepped change in the value of Trust assets from 1st April 2022 with the value of Trust leases (as per IFRS 16) now included. This is offset, in part, by the other liabilities line now added to this presentation.

2. As per previous years, with payments made as contractually required for the new financial year such as rent and leases, prepayments is higher than previous months.

3. Accrued income is high month although the majority (£9.1m) relates to income to fund the 2022 / 23 proposed pay award. This value is as calculated, and communicated, by NHS England.

4. NHS debtors are higher than plan due to invoices relating to the Adult Secure collaboratives remaining unpaid.

5. Creditors continue to be managed and the Trust continue to pay 95% of valid invoices within 30 days.

6. Capital creditors remain low due to the profile of schemes currently underway in the capital programme.

7. This reserve represents year to date surplus plus reserves brought forward.

8. As planned the value of Trust provisions has reduced during 2022 / 23. This is through redundancy, VAT risk and legal provisions.

| Capital schemes | Annual Budget £k | Year to Date Plan £k | Year to Date Actual £k | Year to Date Variance £k | Forecast Actual £k | Forecast Variance £k |
| --- | --- | --- | --- | --- | --- | --- |
| **Major Capital Schemes** | | | | | | |
| Bretton Centre | 7,500 | 7,500 | 619 | (6,881) | 619 | (6,881) |
| OPS transformation | 500 | 500 | 593 | 93 | 593 | 93 |
| **Maintenance (Minor) Capital** | | | | | | |
| Clinical Improvement | 745 | 745 | 544 | (201) | 544 | (201) |
| Safety inc. ligature & IPC | 1,065 | 1,065 | 490 | (575) | 490 | (575) |
| Compliance | 700 | 700 | 1,397 | 697 | 1,397 | 697 |
| Backlog maintenance | 350 | 350 | 426 | 76 | 426 | 76 |
| Sustainability | 350 | 350 | 19 | (331) | 19 | (331) |
| Plant & Equipment | 550 | 550 | 139 | (411) | 139 | (411) |
| Other | 0 | 0 | 681 | 681 | 681 | 681 |
| **IM & T** | | | | | | |
| Digital Infrastructure | 450 | 450 | 1,503 | 1,053 | 1,503 | 1,053 |
| Digital Care Records | 40 | 40 | 31 | (9) | 31 | (9) |
| Digitally Enabled Workforce | 375 | 375 | 138 | (237) | 138 | (237) |
| Digitally Enabling Service | | | | | | |
| Users & Carers | 65 | 65 | 107 | 42 | 107 | 42 |
| IM&T Contingency | 100 | 100 | 0 | (100) | 0 | (100) |
| Lease Impact (IFRS 16) | 354 | 354 | 358 | 4 | 358 | 4 |
| VAT Refunds | | | | | | |
| **TOTALS** | **13,144** | **13,144** | **7,042** | **(6,102)** | **7,042** | **(6,102)** |
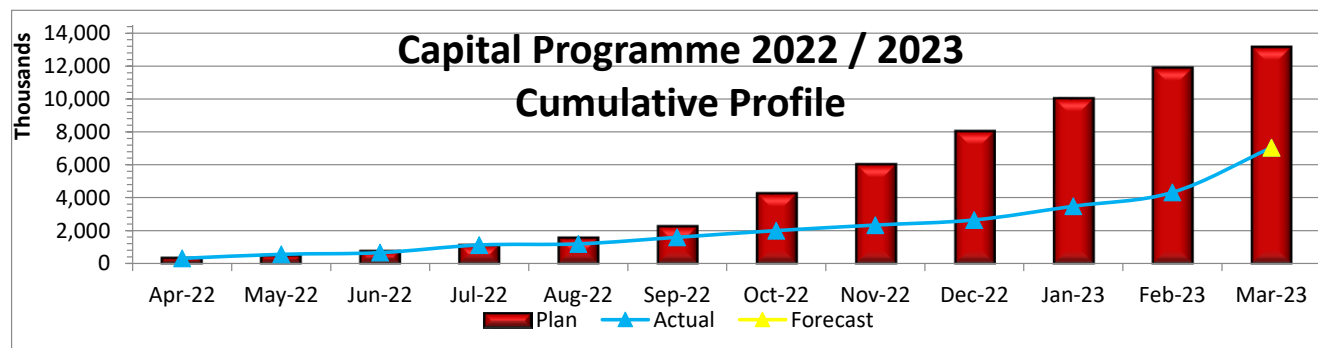
**Capital Expenditure 2022 / 23**

The Trust capital programme forms part of the overall West Yorkshire ICS capital plan. For 2022 / 23 the Trust component is £13.144m.

Forecasts have been updated over the course of the year, reflective of progress and decisions made, and as such a lower year end spend position has been expected for a number of months.

Although the Bretton Centre scheme was paused the Trust has utilised £7.0m of the capital allocation and in doing so delivered schemes, and benefits for:

* Ward enhancements and extra care area on an older peoples ward

* 56 minor capital schemes improving wards and environments, safety and compliance with legisation and best practice and a number of equipment purchases.

* Continued IM & T investment including infrastructure updates and moving forward digital modernisation



Capital Programme 2022 / 2023 Cumulative Profile

# Cash Flow & Cash Flow Forecast 2022 / 2023



## Cash has reduced in month
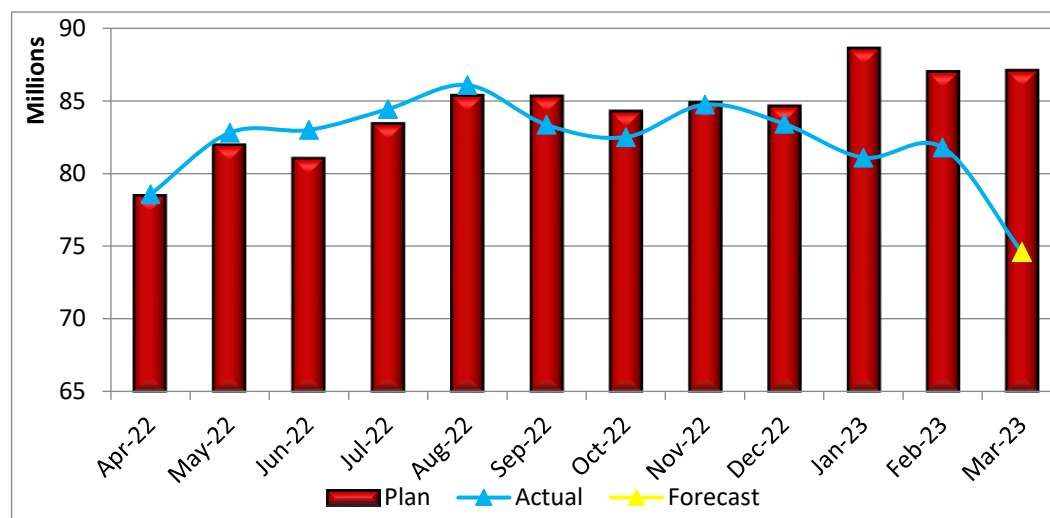
| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 76,454 | 81,368 | |
| Closing Balance | 87,037 | 74,585 | (12,452) |

Cash has reduced in month as discussed on page 14. This includes the payment of Public Dividend Capital (PDC) which is paid bi-annually.

A large number of payments have been made in March as per the transparency information starting on page 17.
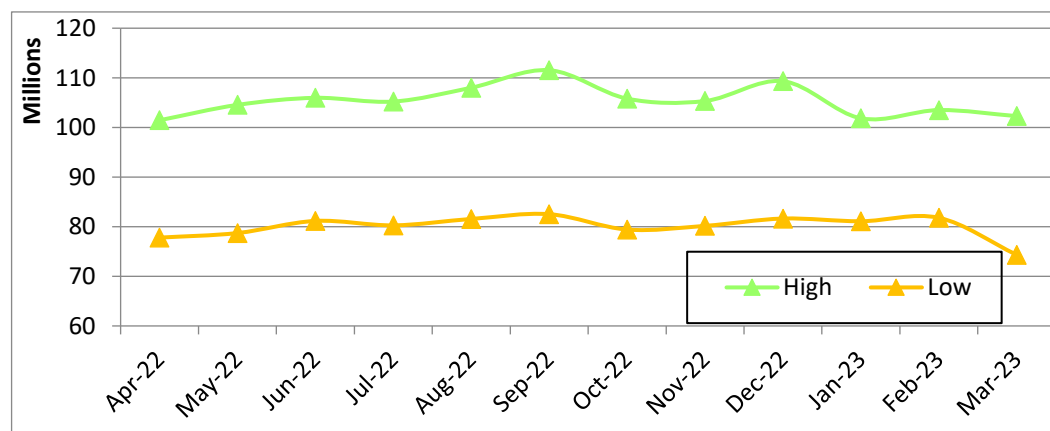


The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £102.3m
The lowest balance is: £74.3m

This reflects cash balances built up from historical surpluses.

| | 3.3 | | | | Reconciliation of Cashflow to Cashflow Plan |
|---|---|---|---|---|---|

| | Plan £k | Actual £k | Variance £k | Note |
|---|---|---|---|---|
| **Opening Balances** | **76,454** | **81,368** | **4,914** | |
| Surplus / Deficit (Exc. non-cash items & revaluation) | 18,562 | 17,065 | (1,497) | |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | (43) | (43) | |
| Receivables (Debtors) | 1,725 | (11,949) | (13,674) | |
| Trade Payables (Creditors) | 3,781 | 6,618 | 2,836 | |
| Other Payables (Creditors) | 0 | | 0 | |
| Accruals & Deferred income | 0 | (2,641) | (2,641) | |
| Provisions & Liabilities | 0 | (3,397) | (3,397) | |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (11,290) | (7,042) | 4,248 | |
| Cash receipts from asset sales | | 2,319 | 2,319 | |
| Leases | (498) | (7,257) | (6,759) | |
| PDC Dividends paid | (2,148) | (2,175) | (27) | |
| PDC Dividends received | | | 0 | |
| Interest (paid)/ received | 450 | 1,718 | 1,268 | |
| **Closing Balances** | **87,037** | **74,585** | **(12,452)** | |

**Cash Bridge 2022 / 2023**
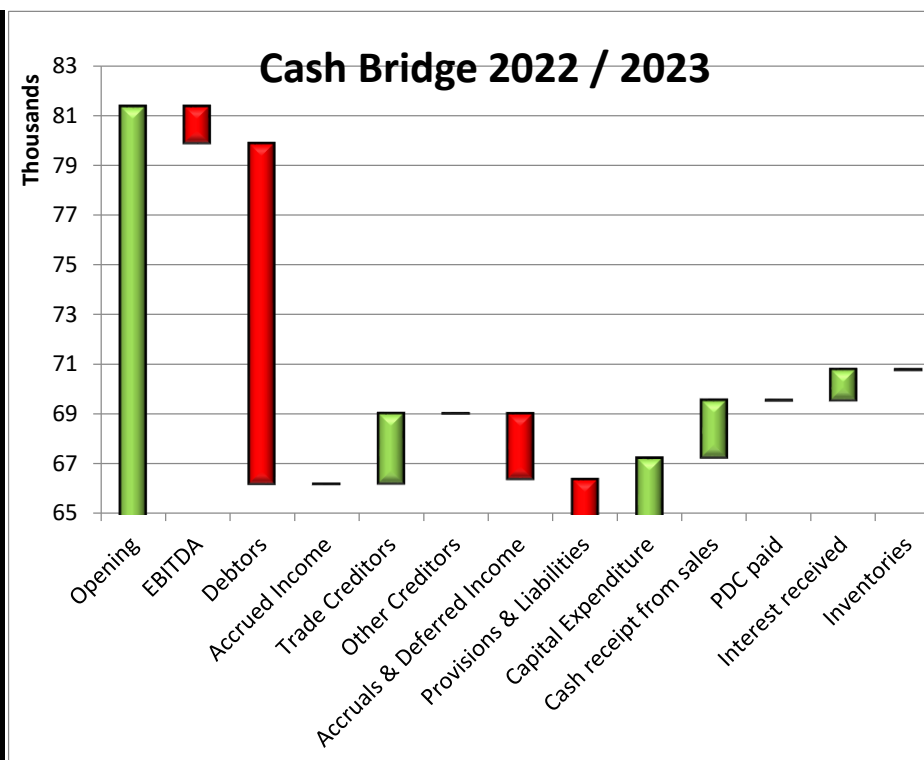


The table above summarises the reasons for the movement in the Trust cash position during 2022 / 2023. This is also presented graphically within the cash bridge.

Cash receipts include both overage on Castleford, Normanton & District Hospital and the sale of the Keresforth site.

| 4.0 | Better Payment Practice Code |
|---|---|

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

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

| NHS | Number % | Value % |
|---|---|---|
| In Month | 97% | 100% |
| Cumulative Year to Date | 97% | 99% |

| Non NHS | Number % | Value % |
|---|---|---|
| In Month | 95% | 96% |
| Cumulative Year to Date | 95% | 96% |
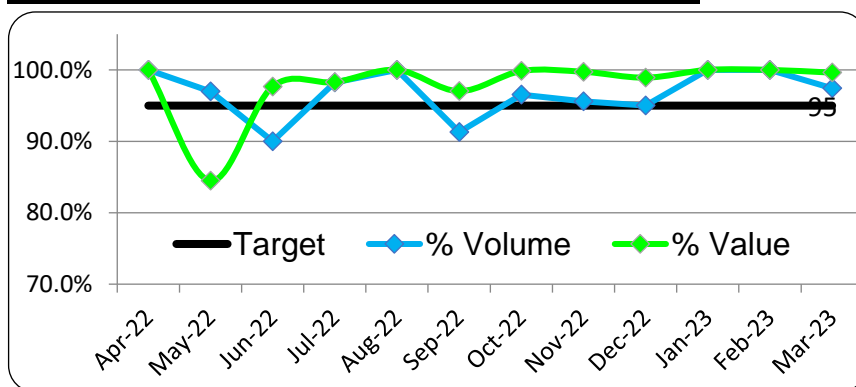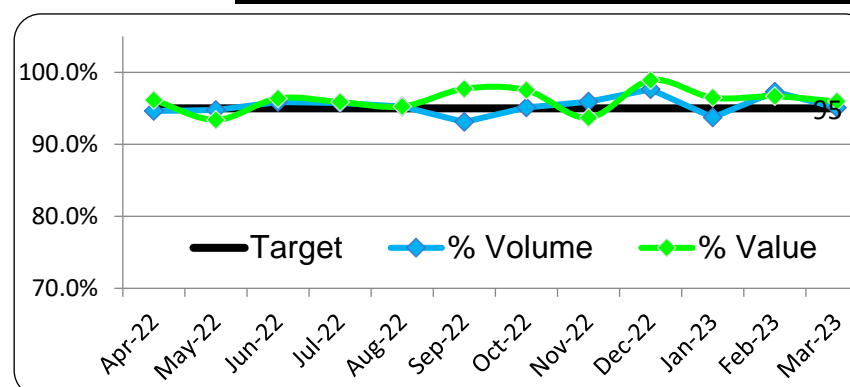
As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

| Invoice Date | Expense Type | Expense Area | Supplier | Transaction Number | Amount (£) |
|---|---|---|---|---|---|
| 21-Mar-23 | Purchase of Healthcare | AS Collaborative | Bradford District Care Nhs Foundation Trust | 203116 | 998,695 |
| 14-Mar-23 | Purchase of Healthcare | AS Collaborative | Cheswold Park Hospital | 4890 | 793,567 |
| 20-Mar-23 | Purchase of Healthcare | AS Collaborative | Nottinghamshire Healthcare Nhs Trust | 1000056805 | 713,730 |
| 10-Mar-23 | Purchase of Healthcare | AS Collaborative | Leeds & York Partnership Nhs Foundation Trust | 999024 | 571,562 |
| 13-Mar-23 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | CYGWYS31 | 544,330 |
| 29-Mar-23 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | CYGWYS32 | 544,330 |
| 21-Mar-23 | Purchase of Healthcare | AS Collaborative | Bradford District Care Nhs Foundation Trust | 203115 | 480,000 |
| 14-Mar-23 | Purchase of Healthcare | AS Collaborative | Leeds & York Partnership Nhs Foundation Trust | 999047 | 393,000 |
| 02-Mar-23 | Purchase of Healthcare | AS Collaborative | Partnerships In Care Ltd | D510007761 | 389,655 |
| 28-Mar-23 | Purchase of Healthcare | AS Collaborative | Rotherham Doncaster & South Humber Mental He | 0000093749 | 325,180 |
| 09-Mar-23 | Purchase of Healthcare | AS Collaborative | Waterloo Manor Ltd | HO NHS LS 270 | 295,636 |
| 07-Mar-23 | Purchase of Healthcare | AS Collaborative | Sheffield Health & Social Care Nhs Foundation Tr | 2100118948 | 293,365 |
| 23-Mar-23 | Purchase of Healthcare | AS Collaborative | Sheffield Health & Social Care Nhs Foundation Tr | 2100119018 | 293,365 |
| 14-Mar-23 | Purchase of Healthcare | AS Collaborative | Leeds & York Partnership Nhs Foundation Trust | 999046 | 288,000 |
| 14-Mar-23 | Purchase of Healthcare | AS Collaborative | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 243,353 |
| 21-Mar-23 | Rates | Barnsley | Barnsley Metropolitan Borough Council | CY56026530102023 | 203,520 |
| 02-Mar-23 | Purchase of Healthcare | AS Collaborative | Cheswold Park Hospital | 4886 | 194,656 |
| 23-Mar-23 | Purchase of Healthcare | AS Collaborative | Sheffield Health & Social Care Nhs Foundation Tr | 2100119019 | 188,824 |
| 30-Mar-23 | Purchase of Healthcare | AS Collaborative | Cheswold Park Hospital | 4926 | 188,377 |
| 29-Mar-23 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | CYGSYS09 | 185,000 |
| 20-Mar-23 | Computer Software | Trustwide | Softcat Plc | INVUK748582 | 170,371 |
| 28-Mar-23 | Consultancy | Trustwide | James Harvard Ltd | 1012856953 | 155,000 |
| 02-Mar-23 | Purchase of Healthcare | AS Collaborative | Rotherham Doncaster & South Humber Mental He | 0000093670 | 134,624 |
| 01-Mar-23 | Purchase of Healthcare | AS Collaborative | Partnerships In Care Ltd | D510007756 | 125,604 |
| 01-Mar-23 | Computer Hardware | Trustwide | Dell Corporation Ltd | 7402891958 | 103,744 |
| 14-Mar-23 | Staff Recharge | Trustwide | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 98,445 |
| 23-Mar-23 | Rates | Kirklees | Kirklees Metropolitan Council | 96916507327022392672 | 92,672 |
| 09-Mar-23 | IT Services | Trustwide | Daisy Corporate Services | 3I505404 | 90,250 |
| 23-Mar-23 | Uniforms | Trustwide | Grahame Gardner Ltd | 923851 | 82,602 |
| 14-Mar-23 | Staff Recharge | Trustwide | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 73,557 |

| | | | | | |
|---|---|---|---|---|---:|
| 11-Mar-23 | Drugs | Trustwide | Bradford Teaching Hospitals Nhs Foundation Trus | 323371 | 71,593 |
| 14-Mar-23 | Staff Recharge | Trustwide | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 71,292 |
| 14-Mar-23 | Staff Recharge | Trustwide | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 66,251 |
| 10-Mar-23 | Purchase of Healthcare | AS Collaborative | Leeds & York Partnership Nhs Foundation Trust | 999023 | 63,771 |
| 21-Mar-23 | Purchase of Healthcare | AS Collaborative | Humber Nhs Foundation Trust | 59892455 | 62,643 |
| 14-Mar-23 | Purchase of Healthcare | AS Collaborative | Humber Nhs Foundation Trust | 59891831 | 61,701 |
| 20-Mar-23 | Purchase of Healthcare | AS Collaborative | Humber Nhs Foundation Trust | 59891828 | 58,515 |
| 21-Mar-23 | Rates | Calderdale | Calderdale Metropolitan Borough Council | 252023909989072023 | 56,832 |
| 24-Mar-23 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 114483 | 56,569 |
| 22-Mar-23 | Community Medical Packs | Trustwide | Corrmed Ltd | INV2847 | 55,380 |
| 31-Mar-23 | Purchase of Healthcare | Trustwide | Northorpe Hall Child & Family Trust | INV0474 | 53,742 |
| 02-Mar-23 | Computer Software | Trustwide | Softcat Plc | INVUK758513 | 48,778 |
| 26-Mar-23 | Staff Recharge | Trustwide | Bradford District Care Nhs Foundation Trust | 203163 | 47,385 |
| 06-Mar-23 | Purchase of Healthcare | AS Collaborative | Mersey Care Nhs Foundation Trust | 72484739 | 46,230 |
| 01-Mar-23 | Furniture & Fittings | Trustwide | Pineapple Contracts | SI83678 | 45,486 |
| 23-Mar-23 | Staff Recharge | Kirklees | Kirklees Council | 8607791934 | 45,250 |
| 10-Mar-23 | Purchase of Healthcare | Trustwide | Sheffield Health & Social Care Nhs Foundation Tr | 2100118950 | 45,091 |
| 14-Mar-23 | Purchase of Healthcare | Trustwide | Invictus Wellbeing Services Cic | 2023022 | 45,000 |
| 24-Mar-23 | Furniture & Fittings | Trustwide | Elysium Healthcare Ltd | 12811203 | 45,000 |
| 11-Mar-23 | Drugs | Trustwide | Nhs Business Services Authority | 1000076207 | 44,752 |
| 16-Mar-23 | Purchase of Healthcare | Trustwide | Elysium Healthcare Ltd | CHA02986 | 44,104 |
| 03-Mar-23 | Mobile Phones | Trustwide | Vodafone Ltd | 103359456 | 43,743 |
| 28-Mar-23 | Furniture & Fittings | Trustwide | Pineapple Contracts | SI84425 | 43,632 |
| 11-Mar-23 | Drugs | Trustwide | Nhs Business Services Authority | 1000075883 | 43,559 |
| 21-Mar-23 | Consultancy | Trustwide | James Harvard Ltd | 1012855317 | 43,050 |
| 27-Mar-23 | Data Lines | Trustwide | Vodafone Ltd | 103528618 | 42,872 |
| 28-Mar-23 | Furniture & Fittings | Trustwide | Pineapple Contracts | SI84423 | 41,928 |
| 28-Mar-23 | Staff Recharge | Trustwide | Leeds & York Partnership Nhs Foundation Trust | 999160 | 41,721 |
| 23-Mar-23 | Purchase of Healthcare | Forensics | Sheffield Childrens Nhs Foundation Trust | 2100224848 | 41,391 |
| 14-Mar-23 | Staff Recharge | Trustwide | Sheffield Childrens Nhs Foundation Trust | 2100224398 | 37,908 |

| 13-Mar-23 | Rates | Kirklees | Kirklees Metropolitan Council | 96921639X2023 | 37,632 |
|---|---|---|---|---|---|
| 22-Mar-23 | Utilities | Trustwide | Edf Energy Customers Ltd | 000014770783 | 36,527 |
| 22-Mar-23 | Audit Fees | Trustwide | Deloitte Llp | 8003347496 | 36,000 |
| 23-Mar-23 | Staff Recharge | Trustwide | Bradford District Care Nhs Foundation Trust | 203149 | 33,955 |
| 02-Mar-23 | Computer Software | Trustwide | Mri Software Emea Ltd | MRIUK1014849 | 33,776 |
| 22-Mar-23 | Protective Clothing | Trustwide | Bitepro Ltd | 105675 | 33,190 |
| 28-Mar-23 | Rates | Wakefield | Wakefield Metropolitan District Council | 8885112606032023 | 33,024 |
| 10-Mar-23 | Staff Recharge | Trustwide | Leeds & York Partnership Nhs Foundation Trust | 999022 | 32,871 |
| 10-Mar-23 | Service Charge | Barnsley | Chapelfield Medical Centre | 316 | 32,630 |
| 23-Mar-23 | Purchase of Healthcare | Trustwide | Elysium Healthcare Ltd | THO03698 | 32,267 |
| 21-Mar-23 | Consultancy | Trustwide | Robertson Cooper Ltd | INV0809 | 32,173 |
| 20-Mar-23 | Staff Recharge | Kirklees | Kirklees Council | 8607815593 | 32,171 |
| 09-Mar-23 | Advocacy | Trustwide | Cloverleaf Advocacy 2000 Ltd | 11863 | 31,397 |
| 24-Mar-23 | Rent | Kirklees | Sjm Developments Ltd | LINV51227 | 30,450 |
| 22-Mar-23 | Security Maintenance | Trustwide | Pinpoint Ltd | 67730 | 29,612 |
| 07-Mar-23 | Purchase of Healthcare | AS Collaborative | Humber Nhs Foundation Trust | 59892411 | 28,712 |
| 07-Mar-23 | Purchase of Healthcare | Trustwide | Cygnet Surrey Ltd | WOK0278020 | 27,860 |
| 13-Mar-23 | Rates | Kirklees | Kirklees Metropolitan Council | 9689426262023 | 27,648 |
| 21-Mar-23 | Rates | Barnsley | Barnsley Metropolitan Borough Council | CY56026542402023 | 27,536 |
| 21-Mar-23 | Rates | Kirklees | Kirklees Metropolitan Council | 9689128942702317136 | 27,136 |
| 07-Mar-23 | Purchase of Healthcare | Trustwide | Cygnet Health Care Ltd | MAS0278055 | 26,684 |
| 20-Mar-23 | Purchase of Healthcare | Trustwide | Cygnet Health Care Ltd | WKE0277781 | 26,684 |
| 13-Mar-23 | Rates | Kirklees | Kirklees Metropolitan Council | 9692164152023 | 26,368 |
| 17-Mar-23 | Purchase of Healthcare | Trustwide | Humber Nhs Foundation Trust | 59892383 | 26,000 |
| 09-Mar-23 | Computer Hardware | Trustwide | Community Links Ltd | 2255 | 25,670 |
| 23-Mar-23 | Purchase of Healthcare | AS Collaborative | Sheffield Childrens Nhs Foundation Trust | 2100224726 | 25,433 |
| 21-Mar-23 | Consultancy | Trustwide | Liaison Financial Services Ltd | 34073 | 25,000 |
| 21-Mar-23 | Purchase of Healthcare | Trustwide | Barnsley Community And Voluntary Services | 77 | 25,000 |
| 22-Mar-23 | Purchase of Healthcare | Trustwide | Nova Wakefield District Ltd | 1271 | 25,000 |
| 22-Mar-23 | Purchase of Healthcare | Trustwide | Third Sector Leaders Kirklees | 1217 | 25,000 |

## 4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

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

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

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

* ICS - Integrated Care System.

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

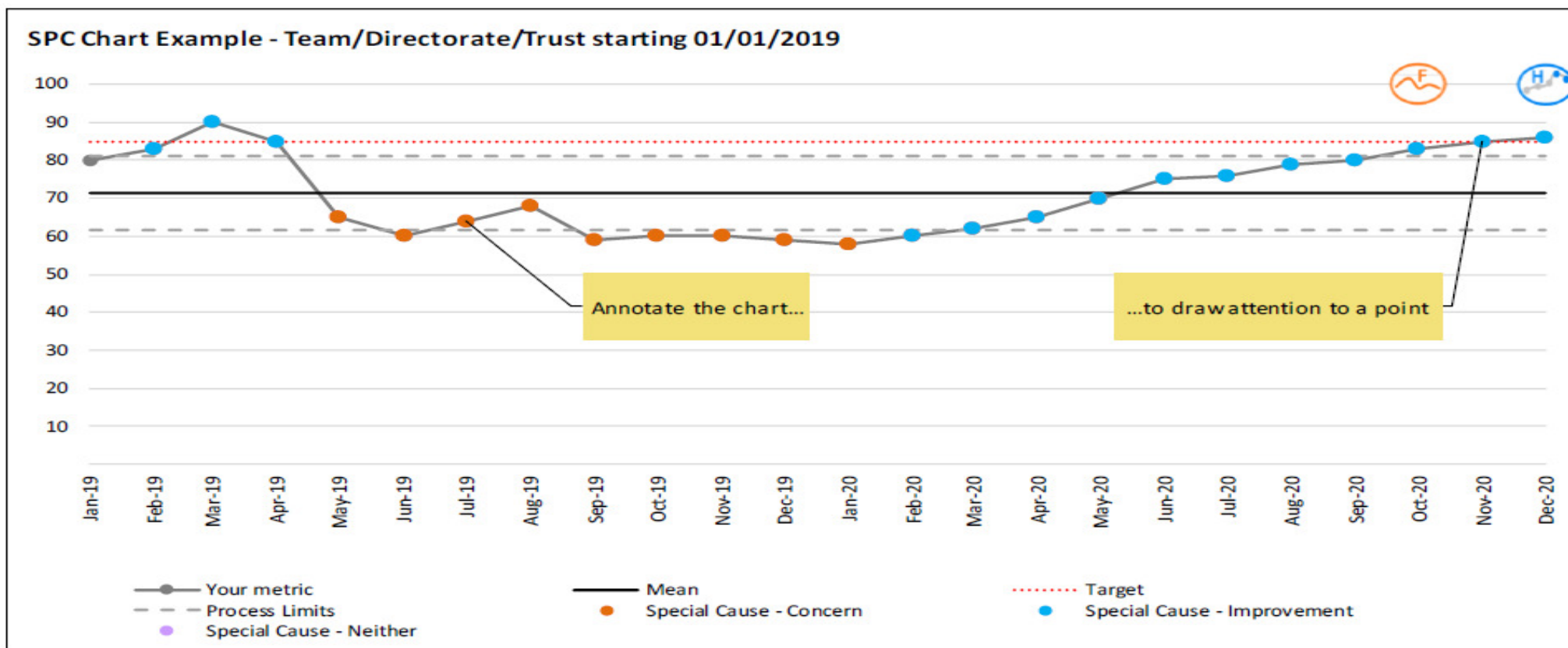# Appendix 2 - Statistical Process Control (SPC) Charts Explained

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

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

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

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

## SPC Chart Example - Team/Directorate/Trust starting 01/01/2019



**Legend:**
- Your metric
- Process Limits
- Special Cause - Neither
- Mean
- Special Cause - Concern
- Target
- Special Cause - Improvement

Annotate the chart...

...to draw attention to a point

## Observations

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

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

| | | | | | | |
|---|---|---|---|---|---|---|
| ACP | Advanced clinical practitioner | HEE | Health Education England | NICE | National Institute for Clinical Excellence |
| ADHD | Attention deficit hyperactivity disorder | HONOS | Health of the Nation Outcome Scales | NK | North Kirklees |
| AQP | Any Qualified Provider | HR | Human Resources | NMoC | New Models of Care |
| ASD | Autism spectrum disorder | HSJ | Health Service Journal | OOA | Out of Area |
| AWA | Adults of Working Age | HSCIC | Health and Social Care Information Centre | OPS | Older People's Services |
| AWOL | Absent Without Leave | HV | Health Visiting | ORCHA | Preparatory website (Organisation for the review of care and health applications) for health related applications |
| B/C/K/W | Barnsley, Calderdale, Kirklees, Wakefield | IAPT | Improving Access to Psychological Therapies | PbR | Payment by Results |
| BDU | Business Delivery Unit | IBCF | Improved Better Care Fund | PCT | Primary Care Trust |
| C&K | Calderdale & Kirklees | ICD10 | International Statistical Classification of Diseases and Related Health Problems | PICU | Psychiatric Intensive Care Unit |
| C. Diff | Clostridium difficile | ICO | Information Commissioner's Office | PREM | Patient Reported Experience Measures |
| CAMHS | Child and Adolescent Mental Health Services | IG | Information Governance | PROM | Patient Reported Outcome Measures |
| CAPA | Choice and Partnership Approach | IHBT | Intensive Home Based Treatment | PSA | Public Service Agreement |
| CCG | Clinical Commissioning Group | IM&T | Information Management & Technology | PTS | Post Traumatic Stress |
| CGCSC | Clinical Governance Clinical Safety Committee | Inf Prevent | Infection Prevention | QIA | Quality Impact Assessment |
| CIP | Cost Improvement Programme | IPC | Infection Prevention Control | QIPP | Quality, Innovation, Productivity and Prevention |
| CPA | Care Programme Approach | IWMS | Integrated Weight Management Service | QTD | Quarter to Date |
| CPPP | Care Packages and Pathways Project | JAPS | Joint academic psychiatric seminar | RAG | Red, Amber, Green |
| CQC | Care Quality Commission | KPIs | Key Performance Indicators | RiO | Trusts Mental Health Clinical Information System |
| CQUIN | Commissioning for Quality and Innovation | LA | Local Authority | SIs | Serious Incidents |
| CROM | Clinician Rated Outcome Measure | LD | Learning Disability | S BDU | Specialist Services Business Delivery Unit |
| CRS | Crisis Resolution Service | MARAC | Multi Agency Risk Assessment Conference | SJR | Structured Judgement Review |
| CTLD | Community Team Learning Disability | Mgt | Management | SK | South Kirklees |
| DoV | Deed of Variation | MAV | Management of Aggression and Violence | SMU | Substance Misuse Unit |
| DoC | Duty of Candour | MBC | Metropolitan Borough Council | SRO | Senior Responsible Officer |
| DQ | Data Quality | MH | Mental Health | STP | Sustainability and Transformation Plans |
| DTOC | Delayed Transfers of Care | MHCT | Mental Health Clustering Tool | SU | Service Users |
| EIA | Equality Impact Assessment | MRSA | Methicillin-resistant Staphylococcus Aureus | SWYFT | South West Yorkshire Foundation Trust |
| EIP/EIS | Early Intervention in Psychosis Service | MSK | Musculoskeletal | SYBAT | South Yorkshire and Bassetlaw local area team |
| EMT | Executive Management Team | MT | Mandatory Training | TB | Tuberculosis |
| FOI | Freedom of Information | NCI | National Confidential Inquiries | TBD | To Be Decided/Determined |
| FOT | Forecast Outturn | NHS TDA | National Health Service Trust Development Authority | WTE | Whole Time Equivalent |
| FT | Foundation Trust | NHSE | National Health Service England | Y&H | Yorkshire & Humber |
| FYFV | Five Year Forward View | NHSI | NHS Improvement | YHAHSN | Yorkshire and Humber Academic Health Science |
| | | | | YTD | Year to Date |

| KEY for dashboard Year End Forecast Position / RAG Ratings | |
|---|---|
| 1 | On-target to deliver actions within agreed timeframes. |
| 2 | Off trajectory but ability/confident can deliver actions within agreed time frames. |
| 3 | Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame |
| 4 | Actions/targets will not be delivered |
| | Action Complete |

**SPC Chart Icon Summary**
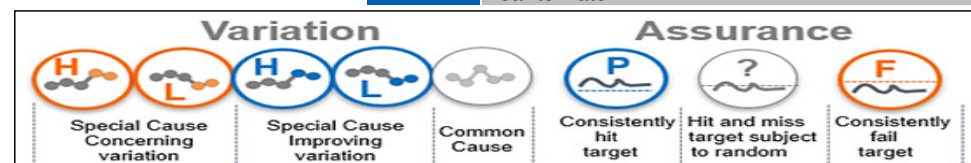
NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.