NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

April 2023

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for April 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 2023/24 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval. Metrics for 2023/24 have been identified and will be reviewed by Trust Board in May with a view to implementing from July 2023.

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided, as opposed to the April 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 96.6% against a target of 90%. For the Trust derived indicators, as at April 2023, 70.7% of service users have had their equality data recorded (disability 43.2%, sexual orientation 43.3% 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.

• Specific actions the Trust is taking to address inequalities include codesigning 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.

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 447 days in April. 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 18 people placed in out of area beds at the end of April. 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 60.7% in April from 79.8% 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 at 33.3% (target 95%) - In April 1 out of 3 urgent cases were seen within 1 week. One case that breached was due to patient cancellation and the other was due to difficulties making contact with the client which delayed our appointment offer.

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 April data is showing an improved position of 85.0% and is now above threshold. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

April data is provisional however, an improvement across both inpatient (90.6%) and community (82.5%) 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

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

• 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 72.9% (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

97% of patient incidents reported in April 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 192 compared to 203 in March. 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 acceptable range. This is described as common cause variation within the report.

• 90% of prone restraint incidents were for a duration of three minutes or less which is a decrease from 100% reported in March.

• There was one pressure ulcer that related to a lapse in the Trust's care during April. 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 April was 34, which is a further decrease compared to 39 in March 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 again in April, despite a high level of recruitment activity. The number of people joining the Trust continues to outnumber leavers.

• Overall turnover rate in April was 13%.This is monitored against a target of between 10 to 12%.

• Sickness absence in April was 5.0%, which has reduced by 0.1% since March. The rolling 12 months sickness absence position has remained the same at 5.3%. Sickness continues to cause pressure within services and staff wellbeing remains a key focus for managers. Covid absence has decreased to 6.9%

• Rolling appraisal compliance rate for April has increased by 2.6% to 74.4%. 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 reports 90.5% which is above Trust target. However,.3 subjects out 17 reported are below the Trust 80% target, which are Resuscitation, Food Safety, and RRPI. Actions being taken to address these areas.

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 although this has increased from last month. The information governance manager is providing additional face to face training sessions. Continued focus is being placed on ensuring all staff are up to date with this training. 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.

• 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.

• 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 with a significant number of vacancies despite active recruitment.

• 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, and is below target performance in Barnsley and Calderdale and Kirklees.

• During April, there was a slight decrease in the overall proportion of clients who were clinically ready for discharge and remaining in an inpatient bed (delayed transfers of care), reducing from 3.5% to 2.4%, 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 continues to take place across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

• Pressures continue within the neighbourhood nursing service with 14% vacancies across the services creating capacity issues.

Finance

• For April, the Trust continues to report a surplus which is £22k better than plan.

• Agency spend in April was £939k which is slightly better than £1.1m reported in March but still exceeds the capped rate.

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

• Capital spend is profiled to increase across the year. Spend in April is £282k which is more than planned.

• Cash in the bank remains positive and with continued levels of interest rates will be maximised. This helps to support the value for money agenda.

• Pay costs were £19m in April.

• Out of area bed costs were £384k in April, a decrease compared to £573k in March.

• Performance against the Better Payment Practice Code increased slightly to 96%.

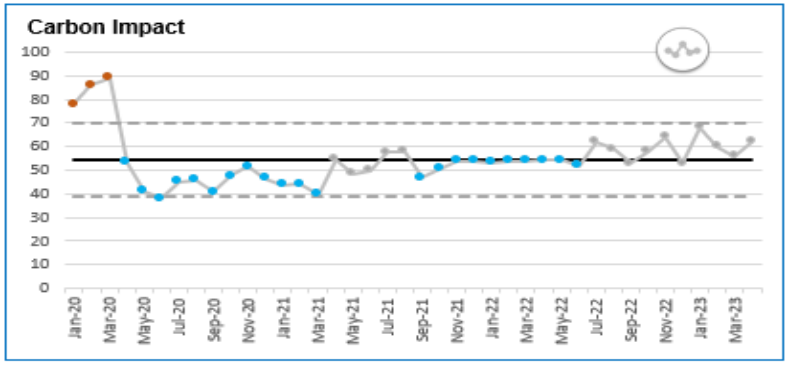
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical 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.

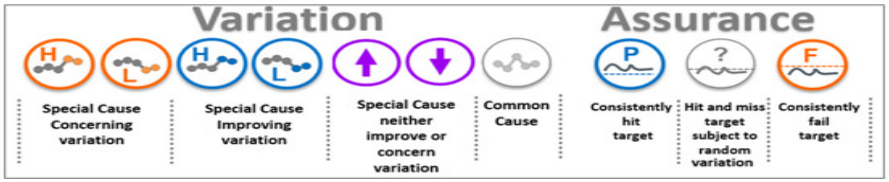
Improving health

Metrics	Threshold	Feb-23	Mar-23	Apr-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded (ethnicity, disability, sexual orientation, deprivation, carers)	*90% (ethnicity only)*	70.2%	70.0%	70.7%		Figures shown are the combined percentage for completion of ethnicity (96.6%), disability (43.2%), sexual orientation (43.3%) 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%	49.7% Service 92.9% Policy	77.6% Service 95.3% Policy	53.3% Service 94.6% 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%	95.1%	95.1%	95.7%		
Carbon Impact (tonnes CO2e) - business miles	76	60	56	62		Data showing the carbon impact of staff travel / business miles. In April staff travel contributed 62 tonnes of carbon to the atmosphere.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	*63.1%*		Due July 2023		Q4 - 63.1% Reported 6 weeks in arrears. Q4 data is provisional and will be refreshed next month. 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%		Due July 2023		Q4 - England position for Medium Secure is 94% and 98% respectively and for Low Secure is 93% and 98% respectively.

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 April 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 have been removed 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 a more blended approach to working is expected 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.



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

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

Improve health

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

Support social responsibility & sustainability (SRS) in the Trust & our communities	Phase 1, developing the social responsibility and sustainability action plan, completed by July 2023		The draft metrics for measurement of delivery against the strategy were presented to the April executive management team (EMT) where they were well received. We are 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. The eBikes for the staff pilot have been delivered to our partner Barnsley cycle hub, protocols and user agreement documents have been drafted Launch is scheduled for early summer as soon as the garage on the Kendray site has finished refurbishment. We are confident that the successful 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 coordinating SRS oversight group.
Work in partnerships at System & Place to improve the health of our communities	Forensic lead provider, West Yorkshire: • 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: • 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: • Achieve annual financial plan (quarterly update)		The provider collaborative is operating with financial surplus. Oversight is via the Trust collaborative committee.
	Community Mental Health transformation: 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: 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.

Improve Care

Metrics	Threshold	Feb-23	Mar-23	Apr-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	87.8%	*89.9%*	*90.6%*		April 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 sustained 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%	67.0%	*79.4%*	*82.5%*		
% Service users on CPA offered a copy of their care plan	80%	58.6%	75.1%	85.0%		All areas continue working to improve performance and the impact of this can be seen through the data improvements. The April position is now above threshold. The actions in place at each care group plus the change ideas being tested through the improvement group are supporting continued improvements. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.
Number of staff in post on adult acute mental health inpatient wards	323.2	248.2	244.5	265.4		April 23 we had increase of 20.9 WTE, of those 8 WTE were starters from our international nurse recruitment.
Average length of stay in adult acute mental health inpatient wards	*32 (national benchmark)*	29	49	33		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	23	20	23		In April the majority of race related incidents against staff were reported in Forensics and reported equally over low and medium secure. In mental health inpatient areas the majority of incidents were recorded in Barnsley, with all incidents in Barnsley reported on Melton PICU.
Inappropriate out of area bed placements (days)	Q1 - 455	511	511	447		See statistical process chart below for further detail.
Percentage of video consultations	Trend monitor	1.6%	1.7%	1.4%		Performance has plateaued reflecting new ways of working post-Covid
Percentage of telephone consultations	Trend monitor	28.2%	29.8%	27.2%		
Percentage of face to face consultations	Trend monitor	70.2%	68.5%	71.4%		
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	645	607	694		Average wait in days. Clients are seen in order of need and not by how long they have waited. Number on waiting list at end of April - 279. The longest waiter on the waiting list had waited 780 days. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	493	495	492		Average wait in days. Clients are seen in order of need and not by how long they have waited. Number on waiting list at end of April - 1560. The longest waiter on the waiting list had waited 776 days. 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%	78.7% 37/47	76.2% 64/84	72.9% 43/59		Barnsley: Three of 17 breached - all speech and language therapy; no permanent clinician and locum focus on dysphagia and urgent communication patients. Calderdale: Two of eight breached – both psychology – on waiting list and welfare calls made. Kirklees: Six of 20 breached – two nursing – on waiting list, had welfare calls; two Psychology both on waiting lists and had welfare calls and one physiotherapy and occupational therapy respectively – on waiting lists but no welfare calls. Wakefield: Five of 14 breached – four psychology due to waiting list – all had welfare calls; one physiotherapy – seen but after the target date.

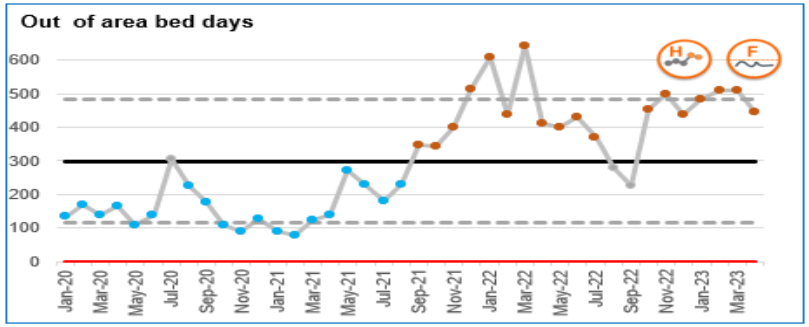
Improve Care Continued

Metrics	Threshold	Feb-23	Mar-23	Apr-23	Variation/ Assurance	Notes
Referral to assessment within 2 weeks (external referrals)	75%	82.6%	67.7%	60.4%		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 with a significant number of vacancies despite active recruitment. 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, and is below target performance in Barnsley and Calderdale and Kirklees. Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming month.
Assessment to treatment within 6 weeks (external referrals)	70%	99.1%	88.9%	97.6%		

Glossary

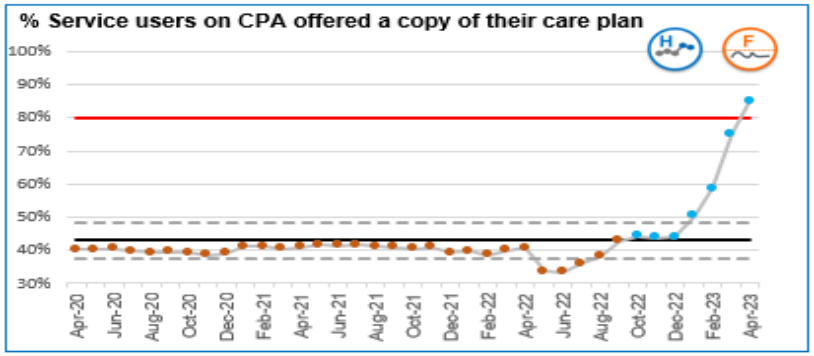
CAMHS	Child and adolescent mental health services
CPA	Care Programme Approach
WTE	Whole time equivalent

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)

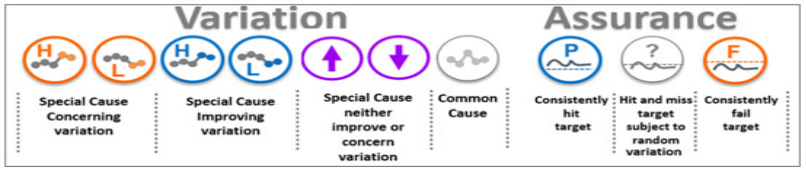


There has been a step change increase in out of area bed usage from summer 2021 onwards. There are several reasons for the increase including staffing pressures across the wards, increased acuity, covid outbreaks and challenges to discharging people in a timely way.

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 18 people placed in out of area beds at the end of April 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, though at this point we are still not estimated to meet the target.



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 Phase two: Diagnostic and discovery by 31/5/2023 Phase three: governance and quality monitoring by 31/5/2023 Complete/ Under Review Phase four: patient safety response planning by 30/06/2023 Phase five: Curate and agree patient safety policy and plan by 31/8/2023 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. All other phases have commenced. 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 executive management team (EMT) March 2023.		On behalf of Trust wide community learning disabilities services, Calderdale local delivery group has commenced work on creation of a management tool for reporting, measuring, and managing waiting lists. Completed a pathway mapping exercise and areas for improvement identified to improve flow of patients to reduce numbers waiting. Commenced development of a standardised welfare check process including checklist for completion to support measurement and assurance reporting. Commenced configuration of SystmOne waiting list functionality. In CAMHS Neurodevelopmental Services in Kirklees and Calderdale, QI focused work on transition pathway has commenced with Adult ADHD/ASD services. Workshops have been planned and scheduled. The first workshop to be held in April will focus on development of standardised SystmOne transition form. In adult community services, core psychology improvement action plan is in development. SystmOne waiting list project continues to support services in using the functionality correctly and preparing other services such as learning disabilities services in community for setup. Working with IT department 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. Timeline for governance in development. Briefing for OSCs being updated in March Work to agree Capital and Review information for the business case to take place – March Presentation to Trust Board – 28 March Further edit and finalisation of business case Mar-May Integrated care board governance and NHSEI assurance processes – Spring 23 Resourcing for consultation process to be agreed Apr 2023 Draft consultation document developed through Spring 2023

Improve resources

Metrics	Threshold	Feb-23	Mar-23	Apr-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan	Breakeven	(£554k)	(£546k)	(£222k)		The positive run rate from 2022/23 has continued into April 2023 with a surplus reported. This is £22k better than plan.
Capital spend against plan	£8.8m	£840k	£2721k	£282k		Capital spend is profiled to increase across the year. Spend in April is £282k which is more than planned.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	4.2%	5.7%	£939k		Agency run rate continues higher than planned and exceeds the capped rate with spend of £939k in month.
Financial sustainability and efficiencies delivered over time	£12m	£469k	£471k	£568k		Savings in line with plan.
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	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	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	-	3		8			7			7			Due July 2023
Estates Urgent Response Times - SLA 1 & 2	Improving Resources	Effective	95%	Reporting commenced November 2022						97.1%	98.1%	97.6%	97.6%	95.6%	93.8%
Premise Assurance Model (PAM)	Improving Resources	Effective	Good							Good	Good	Good	Good	Good	Good
Statutory Compliance 3	Improving Resources	Effective	100%							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

Metrics	Threshold	Feb-23	Mar-23	Apr-23	Variation/ Assurance	Notes
Vacancy rate (Overall)	<10%	18.0%	17.6%	15.9%		Vacancies have decreased to 15.9% in April from 17.6% in March
Turnover external (12 month rolling)	>10-12<	13.7%	13.5%	13.0%		Rolling turnover continues to decrease and has dropped by 0.5% to 13.0%
Sickness absence - Month	<=4.4%	5.3%	5.1%	5.0%		Rolling absence is 5.3% to date, absence rate in month decreased by 0.1% to 5.0%.Long term sickness (any absence over 3 weeks) has reduced from 3.8% to 3.7%.
Workpal appraisals - rolling 12 months	>=90%	71.5%	71.8%	74.4%		For the month of April, the % rate increased by 2.6% to 74.4%.
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 with action plans received. 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 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 to be presented to EMT 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:

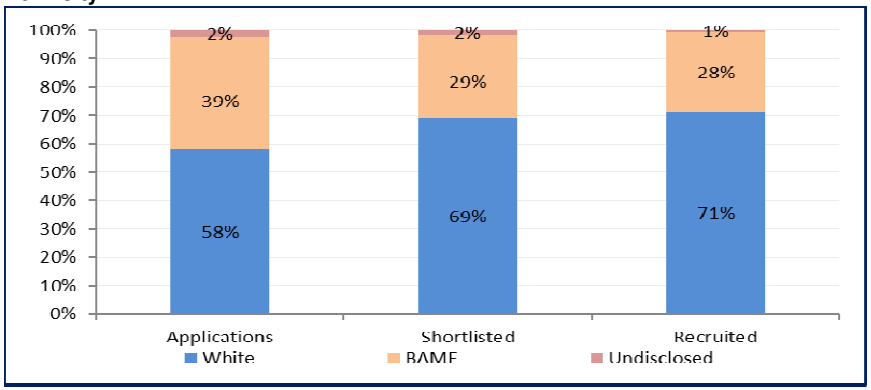
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and 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.

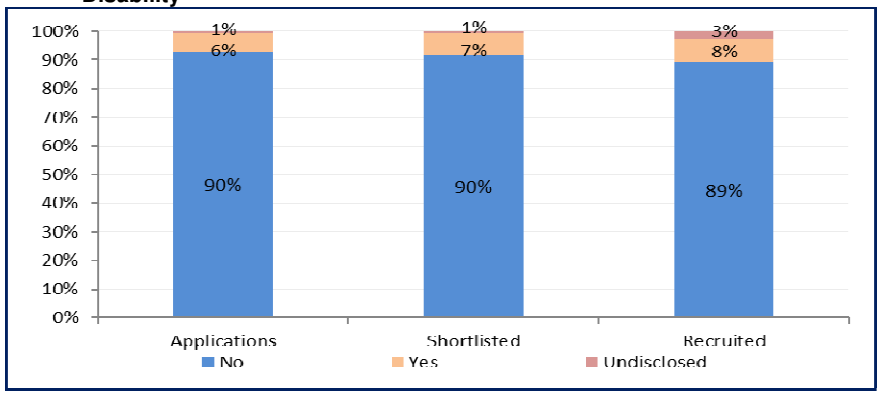
Reducing Inequalities

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

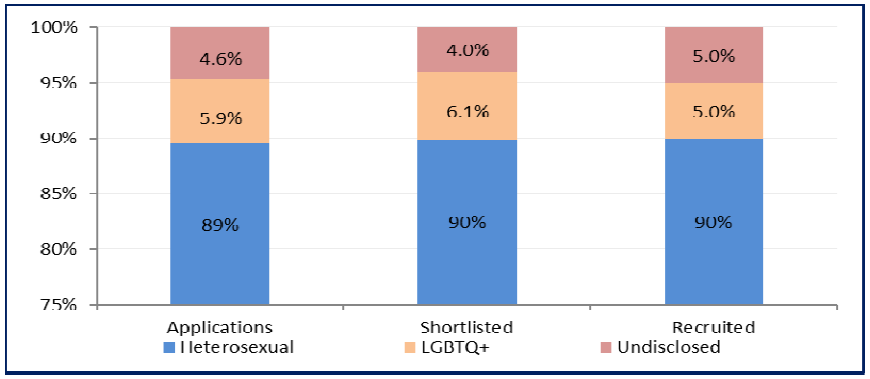
Ethnicity



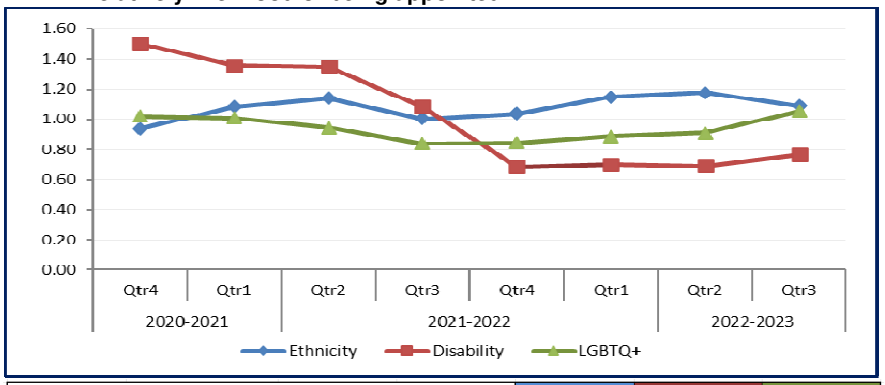
Disability



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.

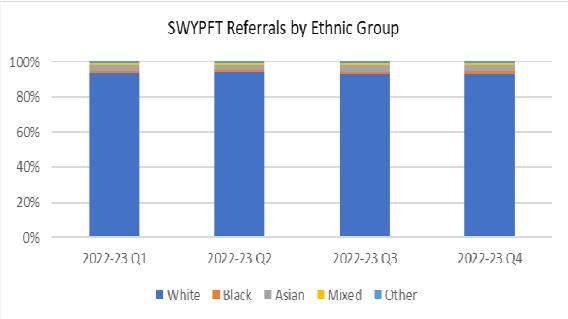
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.08
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.92
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter =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

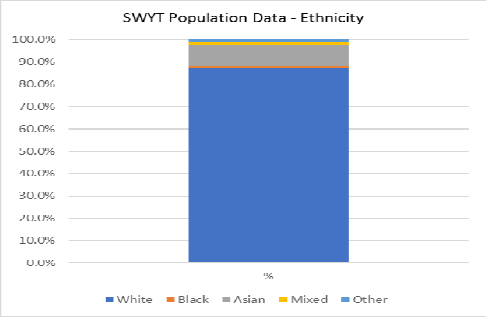
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

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

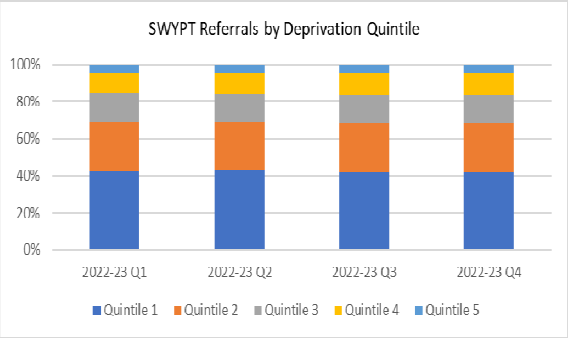
Reducing Inequalities

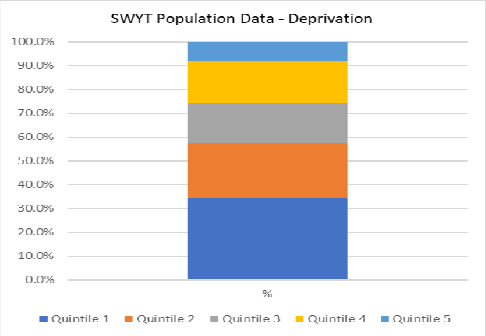
Referrals - (Includes physical health, mental heath, learning disability and forensics)





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%





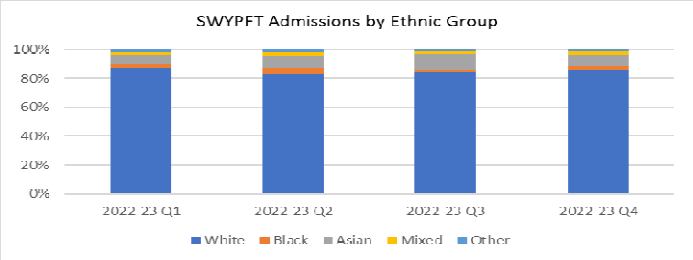
Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	42.3%	42.7%	41.7%	41.8%	34.1%
Quintile 2	26.9%	26.4%	26.5%	26.6%	23.4%
Quintile 3	15.5%	15.2%	15.6%	15.2%	17.0%
Quintile 4	10.9%	11.0%	11.5%	11.6%	17.8%
Quintile 5	4.4%	4.7%	4.7%	4.8%	7.8%

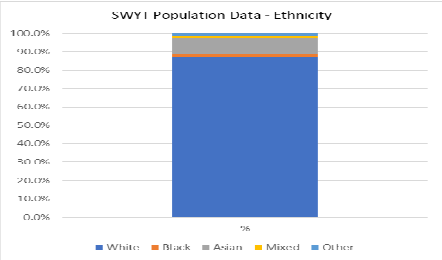
Notes:

- 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.

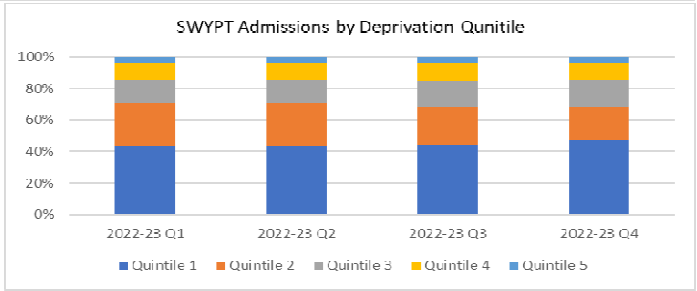
Reducing Inequalities

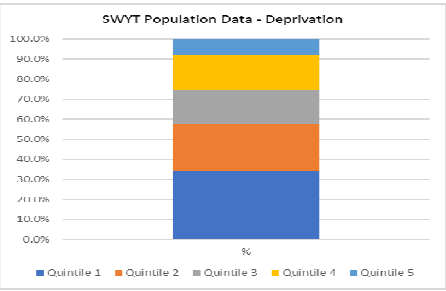
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
White	87.6%	83.6%	84.4%	86.1%	87.1%
Black	2.2%	3.2%	1.7%	2.5%	1.4%
Asian	6.2%	8.6%	11.1%	7.6%	8.9%
Mixed	1.8%	2.7%	1.5%	2.7%	1.6%
Other	2.2%	1.8%	1.3%	1.1%	1.1%





Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	43.6%	43.6%	44.4%	47.8%	34.1%
Quintile 2	27.4%	27.4%	23.8%	20.5%	23.4%
Quintile 3	14.5%	14.5%	16.1%	17.3%	17.0%
Quintile 4	10.7%	10.7%	12.1%	10.5%	17.8%
Quintile 5	3.8%	3.8%	3.5%	3.9%	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
- 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	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
No of Service users Covid-19 positive and now recovered	7	21	23	17	21	6	16	17	18	57	7
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	3
No of Service users Covid-19 positive and deceased within 28 days of positive test	0	1*	3*	0	1	0	1*	1*	1	0	0
No of wards with outbreaks	1	1	2	2	3	1	2	3	4	8	1

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 April 2023 there was one ward with an outbreak of Covid-19.

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 continues 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.

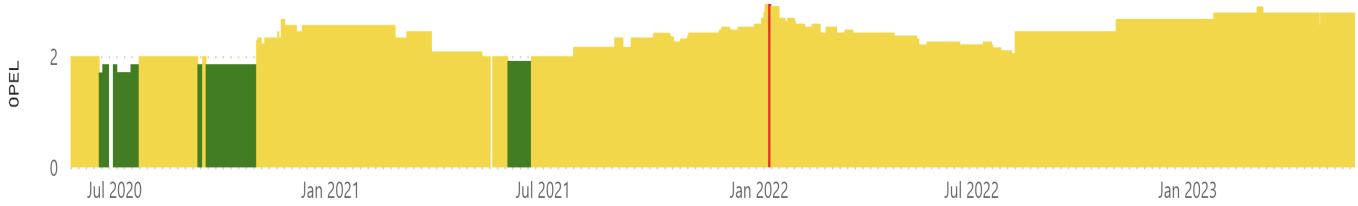
• The Trust is supporting and engaged with partners across our places in the event a spike/wave of Covid re-emerges to allow suitable and effective response.

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 remain at OPEL 3.



Current average OPEL level

2.78

Key
OPEL Level 1
OPEL Level 2
OPEL Level 3
OPEL Level 4

Quality Headlines

Section	KPI	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	66.0%	61.3%	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	4% 1/25	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	17% 4/23	1
Service User Experience	Friends and Family Test - Mental Health	84%	85%	85%	88%	85%	85%	84%	86%	85%	83%	85%	83%	82%	1
	Friends and Family Test - Community	95%	92%	93%	93%	92%	93%	93%	93%	94%	93%	95%	97%	94%	1
Quality	Number of compliments received	N/A	25	25	31	10	13	5	28	39	83	22	26	50	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	trend monitor	38	26	31	19	35	32	33	31	40	30	37	23	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	trend monitor	0	3	0	0	0	2	2	2	3	2	1	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	0	0	1	2	1	0	0	0	2	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	33.6%	33.5%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	4
	Number of Information Governance breaches 3	<12	9	19	10	9	13	11	13	8	12	8	13	12	2
	Clinically Ready for Discharge (Previously Delayed Transfers of Care) 10	3.5%	2.4%	2.1%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	77.2%	72.1%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	*90.6%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	95%	62.4%	72.2%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	*82.5%*	4
	Total number of reported incidents	trend monitor	1192	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) 9	trend monitor	31	24	27	11	32	26	30	24	34	26	35	18	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	trend monitor	3	1	4	3	3	3	7	7	3	3	2	2	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	trend monitor	4	1	0	5	2	3	0	3	3	1	2	3	
	Safer staff fill rates	90%	115.1%	116.6%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	87.0%	85.0%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	trend monitor	59	44	50	26	43	49	48	39	55	46	37	26	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	0	0	3	0	1	1	1	4	0	2	1	1	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	90%	100.0%	87.5%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	1
	Number of Falls (inpatients)	trend monitor	37	37	70	63	58	68	63	59	51	49	39	34	
	Number of restraint incidents	trend monitor	148	152	171	161	160	169	223	189	212	223	203	192	
	% people dying in a place of their choosing 14	80%	74.1%	85.7%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Improving Resource	NHSEI Oversight Framework metric 13	2	2	2	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	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

Quality Headlines

• Number of restraint incidents - during April decreased to 192 from 203 reported in the previous month. Further detail is provided in the relevant section of this report.
• 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 April. Lapses in care identified. There were lapses in care as risk assessments and prevention of pressure ulcers were not in place. There is ongoing supervision and training in place within the team to ensure high standards of care are delivered. Learning is disseminated team wide.
• 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 is now above threshold. See Priority Programmes section for further details.
• Clinically ready for discharge (previously delayed transfers of care) - This remains below threshold in April 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.

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. We are progressing through various phases of work, including discussions with our ICB 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' 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 we report Serious Incidents)
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.
As with all NHS Trusts using Datix, we are now awaiting an upgrade to Datix around June/July to activate further system enhancements before further work can continue and promote changes 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 executive management team, and arrangements for training are underway.

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).

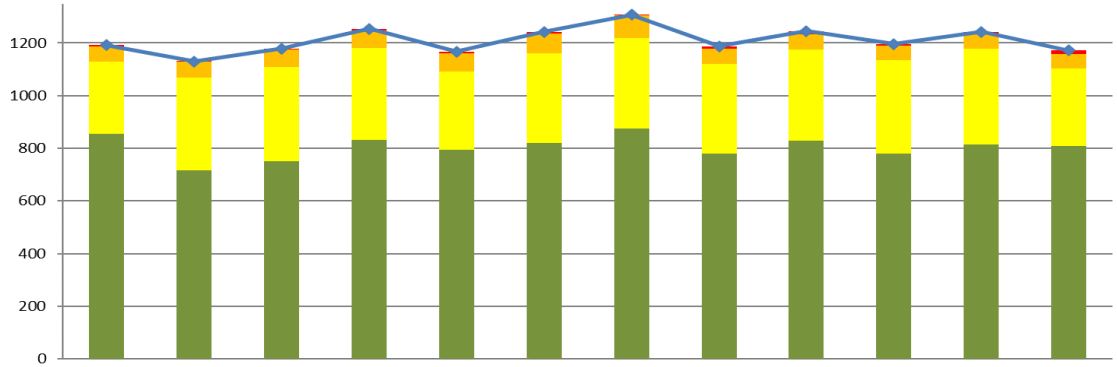
A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).

97% of incidents reported in April 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 statistical process control (SPC) and remain within the acceptable range, any areas with higher or lower rates than acceptable 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



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Red (should not be compared with SIs)	5	2	5	6	8	6	3	8	11	6	9	14
Amber	58	60	65	66	68	76	85	58	59	56	57	55
Yellow	274	351	358	350	299	339	345	340	347	353	363	295
Green	855	717	751	832	793	821	874	781	828	781	814	808
Total	1192	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172

The Trusts 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 are regularly reviewed.

No never events reported in April 2023

Safety First cont…

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

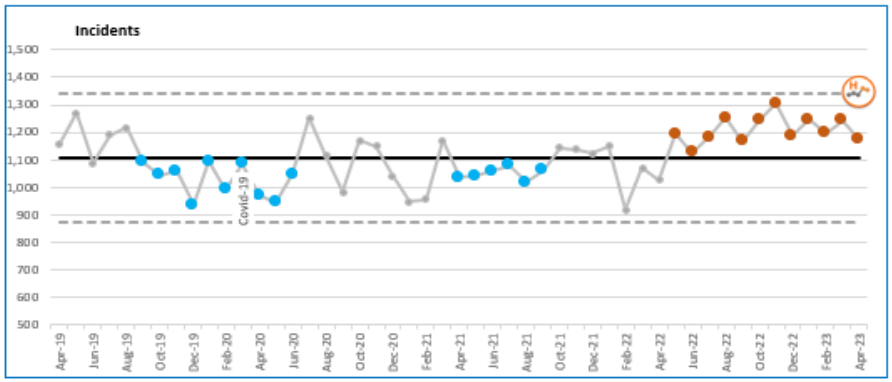
This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death. Please note this is different to severity as described above.

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 expected range, any areas with higher or lower rates than normal are explored further.

Breakdown of incidents in April 2023:
18 moderate harm incidents
2 severe harm incidents
3 patient safety related deaths

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 3 May 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.

Content, including presentations, is available on the intranet.

The next event is on Wednesday 9th August at 1:30pm - 3:30pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

Bluelight alerts

Bluelight alert 67 - 9 May 2023 - Identification of incorrect hypodermic needles for drawing from glass ampules

Bluelight alert 66 - 3 May 2023 - Tampering of seclusion, bedroom and bathroom environments

Bluelight alert 65 - 6 April 2023 - UK emergency alert

Bluelight alert 64 - 5 April 2023 - concealed blades in pens

Bluelight alert 63 - 21 March 2023 - suspended ligature from door closure within a corridor area

Bluelight alert 62 - 27 February 2023 - F-size oxygen safety incidents

Bluelight alert 61 - 27 February 2023 - Oxygen concentrators and emergency cylinders

Bluelight alert 60 - 17 February 2023 - Countersigning of medicines administration on the electronic prescribing and medication administration (EPMA) system

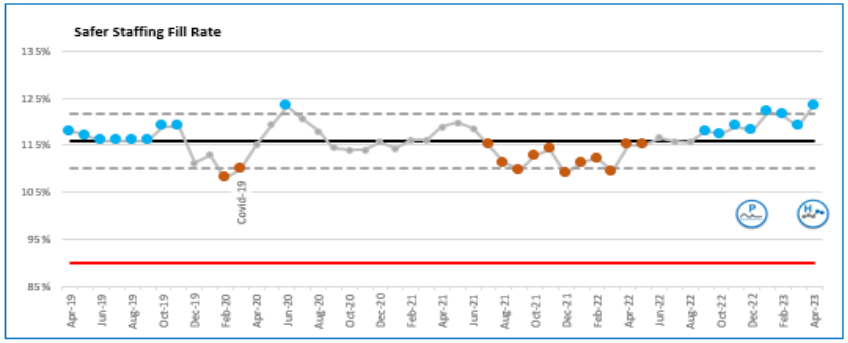
Patient Safety Alerts

Patient safety alerts issued in April 2023

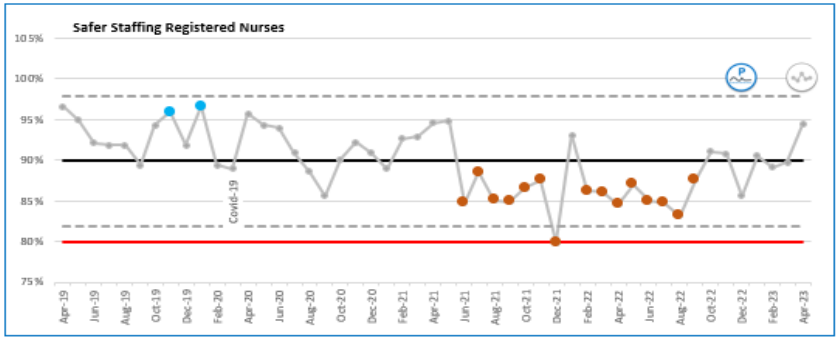
Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing Patient Safety Alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for reviewing safety alerts 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.

There were no patient safety alerts not completed by the deadline of April 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 April 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 April 2023 we have entered a period of common cause variation. Further information about staffing levels can be found on the previous page.

There has been an overall decrease in demand in April on the flexible staffing pool with a total of 665 less shifts requested. The number of shifts filled remained consistent and fill rates increased in all inpatient care groups. This is as a result of support mechanisms and management strategies in place on the wards to deal with acuity and challenging situations, a decrease in the number of staff being unavailable primarily due to a decrease in annual leave being taken in April and robust roster planning in place, all of which have contributed to a decrease in the number of flexible staff required. The cancellation of shifts that have not been filled by wards has had a negligible impact on the number of unfilled shifts. A reduction in requests does not equate to a reduction in acuity. This should not be seen as achieving our requirements as this describes our fill rate compared to our budgeted figures (capacity) and not our acuity (demand). Historically March has shown an increase in annual leave due to staff trying to use up their entitlement and there is less pressure in April. We continue to monitor staffing related Datix to identify hotspots and undertake trend analysis of staffing deficits.

Both bespoke adverts and centralised recruitment continues and there were four assessment centres throughout April which resulted in 15 registered nurses (RN) substantive, 15 health care assistant (HCA) substantive, 68 health care assistant bank band 2 and 4 alongside bank band 5 job offers being made. We are also looking at flattening the recruitment process for students both on bank and external.

We continue with bespoke adverts for band 5 RN's as well as with our international recruitment. To date we have had 54 international recruited band 5 nurses with 54 being on the wards throughout the Trust, including on the Neuro Rehab Unit. We have received financial support from NHSE through to Q3 and hope to realise another 40 candidates before December 2023 from this funding and have also had discussions, and submitted, a funding request for another 30 band 5s following the success of the face-to-face recruitment campaign. We were also visited by Duncan Burton, Deputy CNO NHSE, who heard from one of our recruits.

Escalation and continuity plans are followed 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 work, 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 use through being innovative and bold in sourcing our own staff, reducing processes for 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 and understanding the reasons why this has happened.
Project plans for the continued roll out of SafeCare and getting all teams onto the health roster system have been agreed by the executive management team and are ongoing.

Safer Staffing Inpatients cont…

Although there has been an overall improvement, we continue to fall short of the RN fill rate for day shifts 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 high quality care, as well maintaining safety, and 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). For the third month running one ward fell below the 90% overall fill rate threshold which was Enfield Down in Calderdale and Kirklees. Inpatient areas continue to experience high acuity. 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. Consistent with the previous month, there were 26 (83.2%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 26 wards, 15 (an increase of five on the previous month) 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, and the systems wide increase of acuity, the focus for the flexible staffing resources has been Horizon Centre in Wakefield and the Dales in Halifax. 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 5.1% to 88.5% in April compared with the previous month.
Registered Nurses Nights: Overall registered Night fill rates have decreased by 4.2% in April to 100.2% compared with the previous month.
Overall Registered Rate: 94.35% (increased by 4.65% on the previous month)
Overall Fill Rate: 123.5% (increased by 4.2% on the previous month). Health care assistants showed an increase in the day fill rate of 8.2% to 143.2% and the night fill rate decreased by 1.5% to 151.0%.

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	362 (-174)	3,948.00	30.53% (-7.36%)	853 (-41)
Unregistered	338 (-292)	3,722.08	7.98% (-4.86%)	4,057 (-158)
Grand Total	700 (-466)	7,670.08	12.67% (-5.61%)	

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.

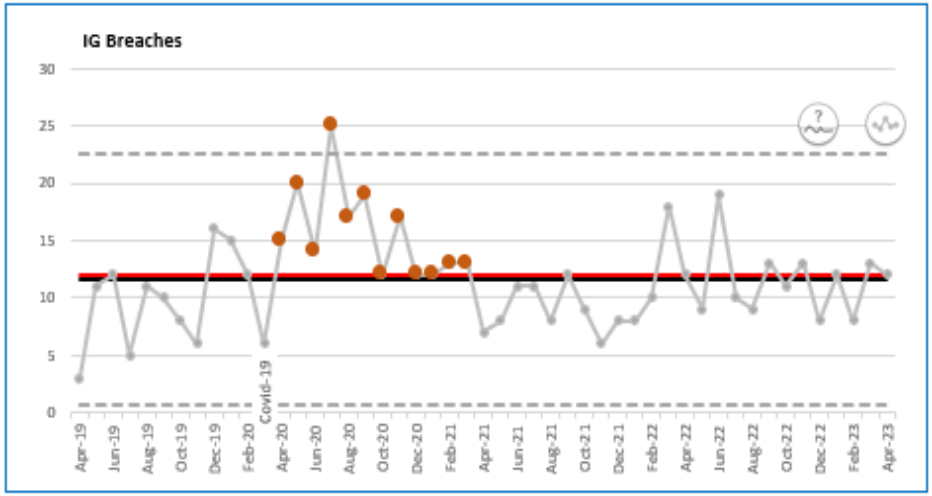
Information Governance (IG)

12 personal data breaches were reported during April. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity.

10 breaches involved information being disclosed in error. They were largely due to another patient's details being included on a letter, correspondence sent to the wrong recipient, letters sent to the wrong address, information shared without patient consent and confidential information attached to emails in error.

A further incident involved a notebook containing patient names and addresses being lost: this has not been found to date and duty of candour has been undertaken. Another incident involved paper health records being held in an unsecure cabinet: these have now been located to a locking cabinet.

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



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

Commissioning for Quality and Innovation (CQUIN)

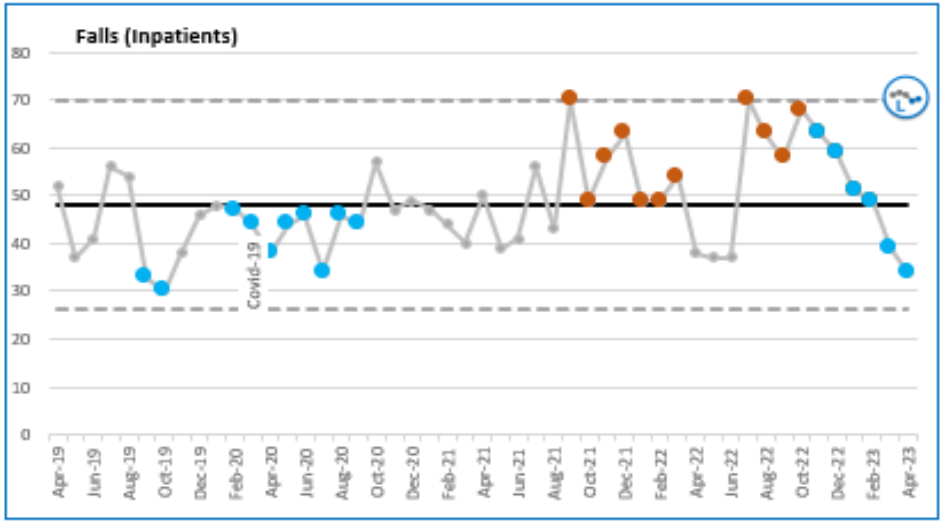
CQUIN schemes are in place for 2022/23 contracts. These mainly relate to the Trust's contracts with our place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN is 1.25% of total contract value.
Performance for the first three quarters has been achieved against 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 (submissions due early June) 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 early June 23.

Falls (Inpatient)

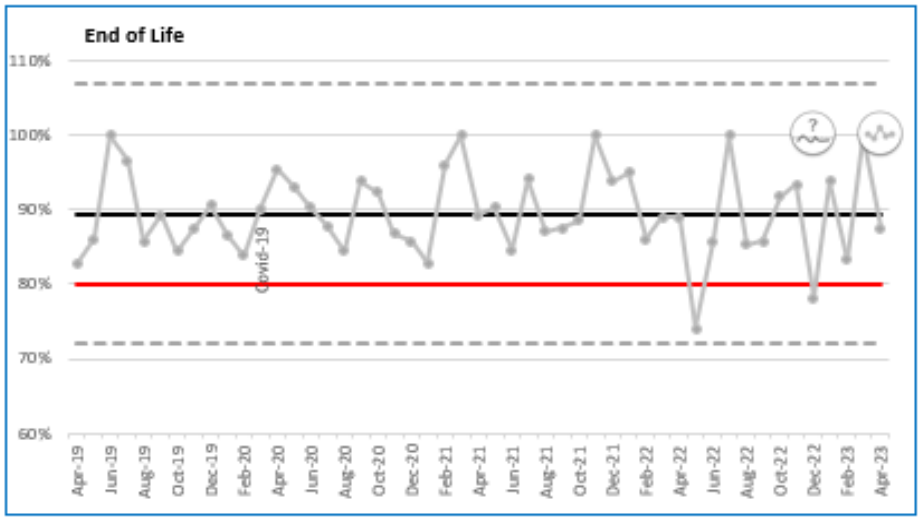
The total number of falls was 34 in April, a decrease from the previous month.
A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams / staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in April 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 87.5% in April.



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

Patient Experience

Friends and family test shows

- 94% would recommend community services
- 82% would recommend mental health services

Mental Health Friends and Family Test Results	Target	Feb-23	Mar-23	Apr-23
Community Services	85%	85%	85%	83%
Acute	85%	100%	86%	93%
Secure & Forensics	60%	80%	71%	100%
Other*	85%	92%	93%	82%
Total	**84%****	**85%**	**83%**	**82%**

**weighted for 23/24

Specialist Services Friends and Family Test Results	Target	Feb-23	Mar-23	Apr-23
ADHD	85%	78%	50%	44%
CAMHS	75%	70%	83%	76%
Learning Disability	85%	91%	100%	100%

Community Services Friends and Family Test Results	Target	Feb-23	Mar-23	Apr-23
Children & Families	95%	94%	98%	93%
Inpatient	95%		100%	100%
Nursing	95%	100%	91%	100%
Other	95%	100%	91%	100%
Rehabilitation & Therapy	95%	95%	98%	94%
Specialist**	95%	95%	94%	95%
Total	**95%**	**95%**	**95%**	**94%**

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

Patient Experience

The satisfaction target figures for each service have been agreed and set by the Trust and these vary depending on the service type. There is a new weighted target figure for mental health services which is 84%. Community services target remains at 95%, with ADHD, CAMHS and learning disability services being 85%, 75% and 85% respectively.

Overall satisfaction across the Trust has declined. A review of the feedback provided and any comments has not identified any trends, themes, or areas of concern related to this decline in satisfaction. Feedback figures have been provided to each service line.

There were only six responses for ADHD services and therefore affects the percentage satisfaction reported above. Work is ongoing to address the response rate and the feedback. This includes how we engage with service users, a project group is being developed to review this.

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

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

Safeguarding Adults:
In April 2023, there were 38 Datix incidents categorised as 'Safeguarding Adults'. No incidents were graded red, five were graded amber, 15 were graded yellow and 18 were graded green.
The incidents were in the following categories: neglect, domestic abuse, emotional/psychological abuse, sexual abuse, financial abuse, physical abuse, self-neglect case, organisational abuse and a failure in the safeguarding process.
Of the five Datix graded amber there was:

- One categorised as ‘neglect’
- Three categorised as ‘emotional/psychological abuse’
- and one was a concern about domestic abuse in which the service user had disclosed high risk concerns

Advice and support was requested as from the safeguarding team as necessary for each incident and in all cases appropriate action was taken.

In addition to the safeguarding adults incidents reported, there were also 13 sexual safety incidents where service users were the affected person. All of these were graded as green or yellow. These are being discussed within the Trust sexual safety project forum.

Safeguarding Children:
In April 2023 there were 22 reported safeguarding children’s incidents, 13 of these were green, low risk and eight were categorised as yellow, moderate risk. There was one amber, high-risk incident reported.
The most common theme was child protection with eight reported incidents, followed by request for services and failure in safeguarding processes both with five incidents each.
The amber incident was in relation to a report to a residential staff team at the care home they were residing. The residential staff team liaised with CAMHS for support however concerns were raised by the clinician that the police or social worker had not been contacted by the residential staff team. Advice was sought from the Trust safeguarding team and a referral was made to the local authority due to the concerns about the residential placement.
As with the adult cases, advice and support was requested from the safeguarding team and in all cases appropriate action was taken.

Infection Prevention Control (IPC)

The National Infection Prevention and Control (IPC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others.

The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. The Trust is complaint with 9 criteria and partial compliance with 1 criteria, of which there are mitigation actions in place. The IPC BAF will be reviewed quarterly.

Surveillance: There have been zero cases of E.coli bacteraemia, C difficile, MRSA bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy:
Hand Hygiene-Trust wide Total – 91%
Infection Prevention and Control- Trust wide Total – 90%
Remain above the Trusts 80% training compliance threshold.

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, which has a target date of March 2024. The current policies and procedures remain compliance, and there is no risk in the system.

Complaints

• Acknowledgement and receipt of the complaint within three working days – 70% for formal complaints.
• Number of responses provided within six months of the date a complaint received – 4 (27%)
• Number of complaints waiting to be allocated to a customer service officer – 24
• 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 – 11 weeks average.
• There were 23 new formal complaints in April 2023
• Of these 2 were closed due to no contact/consent, 8 are awaiting consent, 10 are awaiting allocation and 1 is awaiting questions.
• 17% of new formal complaints (n=4) have staff attitude as a primary subject.
• 50 compliments were received.
• Customer services closed 15 formal complaints in April 2023.
• Number of concerns (informal issues) raised and closed in April 2023 – 20
• Number of enquiries responded to in March 2023 - 137
• Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 0

Reducing Restrictive Physical Intervention (RRPI)

There were 192 reported incidents of Reducing Restrictive Physical Interventions (RRPI) used in April 2023 this is a reduction of 11 (5.4 %) incidents from March 2023.

90% of prone restraints in April 2023 lasted under three minutes.

In April 2023, prone restraint (those remaining in prone position and not rolled immediately) was reported 20 times out of 291 (6.8%) total restraint positions recorded. This is a reduction of six from last month that stood at 26 of 333
Incidents over 3 minutes were reviewed by the RRPI specialist advisors and are satisfied all appropriate actions were taken.

Beamshaw had the most incidents of prone restraint this was due to one service user who attributed for seven (87.5%) of the eight reported incidents of prone restraint. This is a 166.6% increase from March 2023 that stood at three.

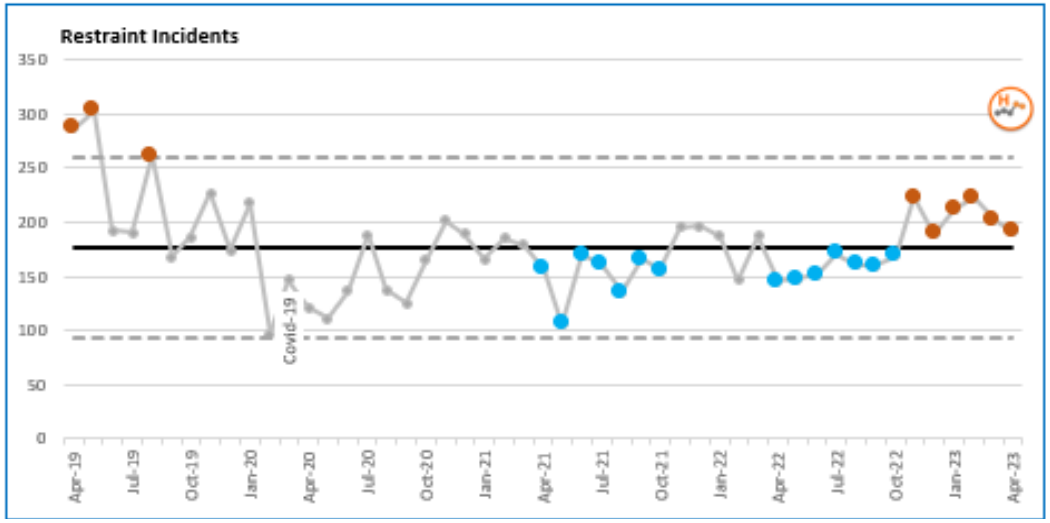
Horizon Centre saw a 50% reduction in prone restraint use. These four incidents involved two service users that attributed one and three incidents respectively.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	98	33.5%
Seated	46	15.7%
Supine	38	13.0%
Safety Pod	36	12.3%
Prone	20	6.8%
Restricted escort	19	6.5%
Side	15	5.1%
Prone then rolled	14	4.7%
Kneeling	5	1.7%

Team Utilising Prone Restraint	Total
Beamshaw Ward - Barnsley	8
Horizon Centre Assessment and Treatment Service	4
Newhaven Forensic Learning Disabilities Unit	2
136 Suite - Unity Centre, Wakefield	1
Ashdale Ward	1
Clark Ward - Barnsley	1
Hepworth Ward, Newton Lodge, Forensic	1
Melton PICU, Barnsley	1
Walton PICU	1
Ward 18, Priestley Unit	1

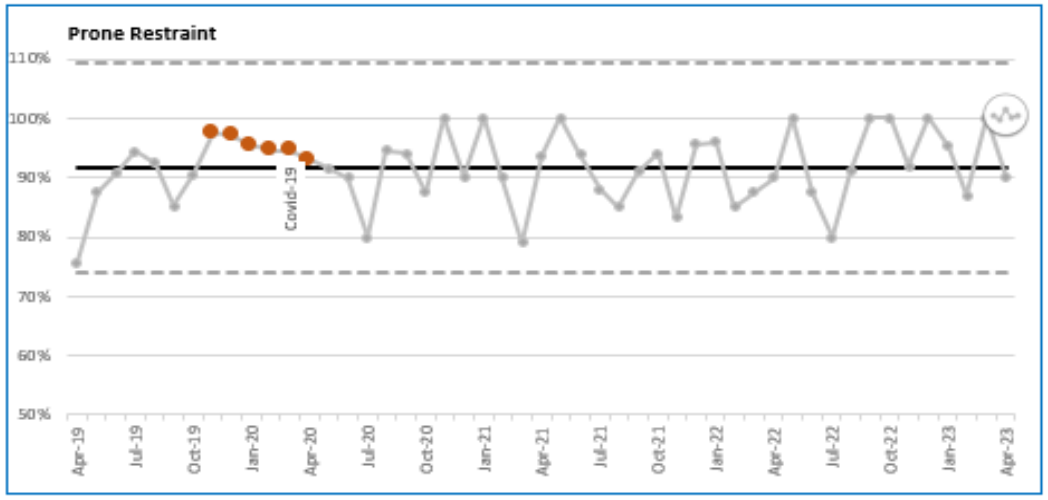
Duration of Prone Restraint	Total
0 - 1 minute	11
1 - 2 minutes	6
2 - 3 minutes	1
3 - 4 minutes	1
7 - 8 minutes	1

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that after a recent period of special cause improving variation (blue markers), in April 2023 we have entered a period of special cause concerning variation (orange markers).

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.



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 April 2023 means that we remain 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	Apr-23
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	5,157.4
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	4,257.0
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	818.9
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%	15.9%
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%	13.0%
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	42.9
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	39.6
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%	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%	5.0%
Employees with long term sickness over 12 months			-	-	-	-	-	0	2	2	2	2	4	2	2	1
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%	74.4%
Employee Relations - Suspensions (over 90 days)			-	0	0	1	1	2	2	2	2	3	3	1	1	0
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%	90.5%
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%	73.8%
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%	75.5%
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%	95.6%
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%	96.5%
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%	96.0%
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%	90.2%
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%	78.0%
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%	93.2%
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%	91.5%
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%	90.6%
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%	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%	92.5%
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%	91.6%
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%	91.6%
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%	95.4%
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%	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%	90.0%

Notes:

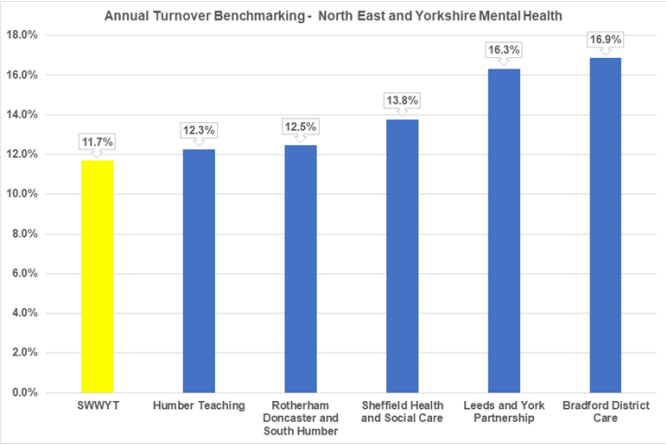
- Employed Staff (Electonic Staff Record - (ESR) last day in the month) - Employed staff in post are staff on temporary or permanent contracts within ESR. This does not include staff on secondments or other recharges such as local authority staff and junior doctors.
- The figures reported here differ 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 Trust's operational management group with reporting and actions from quarterly reports to care groups.
- Employed staff - There has been an increase of 168.8 whole time equivalent staff employed by the Trust since April 22.

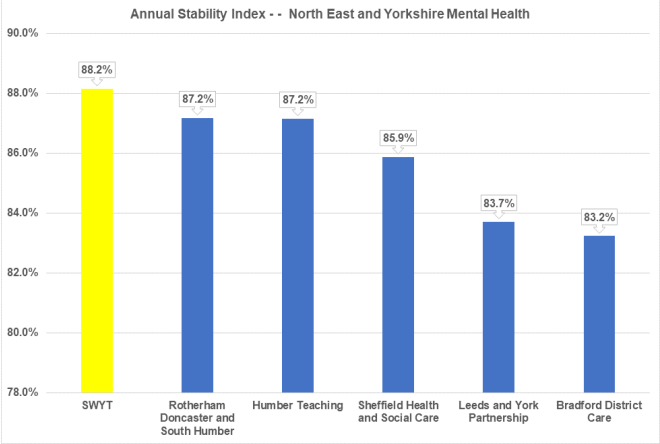
Additional metrics to highlight response to and impact of Covid-19

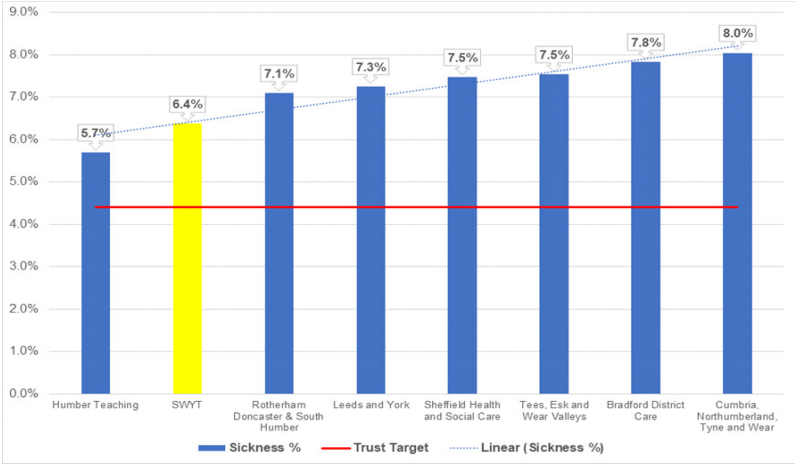
KPI	Target	As at 20th September 2022	As at 20th October 2022	As at 18th November 2022	As at 19th December 2022	As at 25th January 2023	As at 20th February 2023	As at 21st March 2023	As at 17th April 2023	As at 23rd May 2023	Trend
No of staff off sick - Covid-19 not working	N/A	23	53	20	29	9	20	17	21	8	
No of staff working from home - Covid-19 related		9	14	6	16	8	10	16	4	3	

Stability of the Workforce

• Substantive staff in post has risen by 0.4% (15.9 whole time equivalent) in April.
• Following the recruitment event in South Africa & Botswana there were 105 interviews and 75 conditional offers.
• Rolling and year to date turnover is 13%. When benchmarked against the latest Workforce statistic published by NHS England on digital.nhs.uk (Jan 2023) the Trust has one of the lowest rates in our region and the highest for staff stability index (staff in post over 1 year).





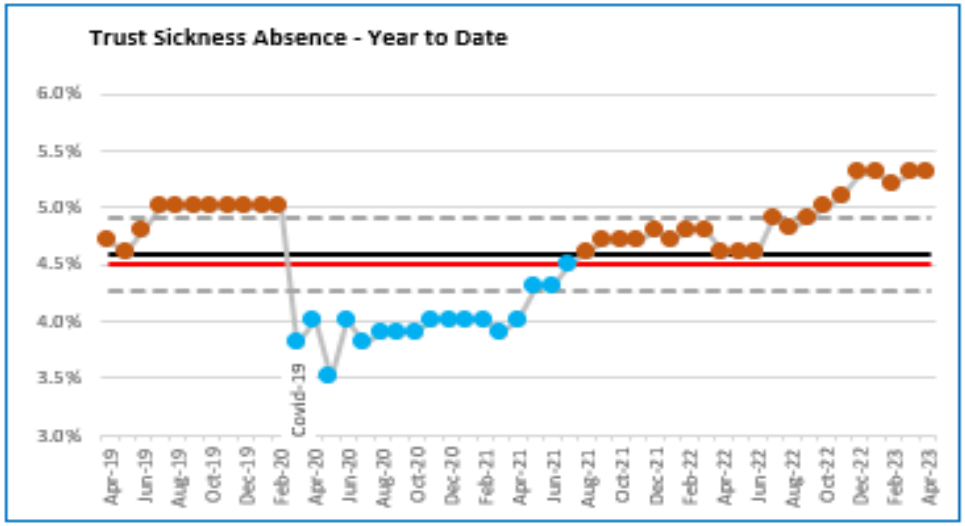


Keep Fit & Well
Absence
• 12 month rolling absence rate is 5.3%, in month decreased by 0.1% to 5.0%.
• Covid-19 absence has decreased to 6.9%
• Forensics absence continues to decrease, this month by 0.3% to 6.5% year to date. Forensic absence has reduced because of focused support with managers on long term sickness, thus resulting in returns to work.
• Estates and Facilities absence has reduced from 6.4% to 5.6 % after a renewed focus of sickness meetings, monthly reports to individual managers and increased personal development support to address this increase.
• Stress related absences still accounts for the largest reason increasing to 38%.
• When compared to the latest figures published by NHS England via digital.nhs.uk (Dec 2022) we have the second lowest percentage in the region.

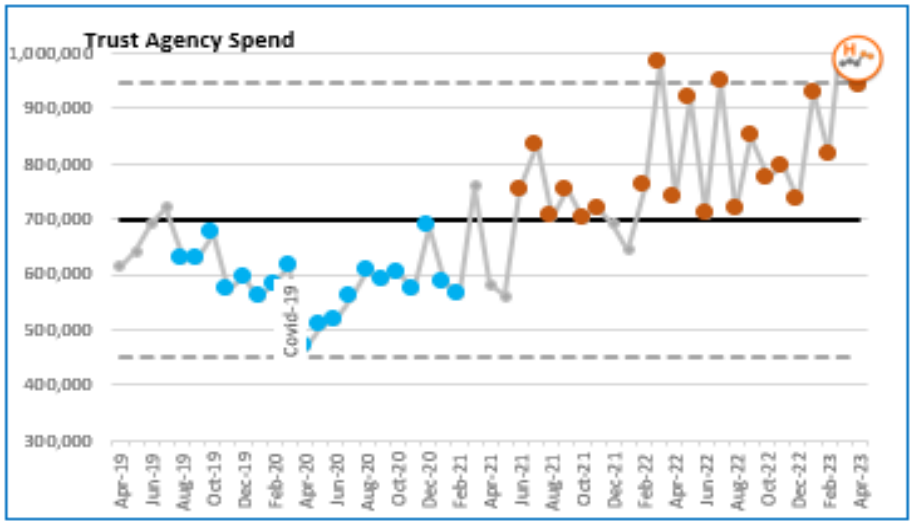
Supportive Teams
Appraisals
• For the month of April, the percentage rate increased by 2.6% to 74.4%.

Mandatory Training
• Overall mandatory training reports 90.5% which is above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by operational management group.
• Three subjects out of 17 reported are below the Trust's 80% target - these are resuscitation, food safety, and reducing restrictive practice interventions. Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, the introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and a project plan being delivered in close partnership with the Nursing, Quality & Professions directorate.
• A continued focus on driving compliance for local induction had resulted in an increase, however following the increase in new starters over the last three months this number dipped to 76.8%. Monthly reminders have now started being sent and we have received a good response.

Analysis



The chart above shows that as at April 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 April 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.

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

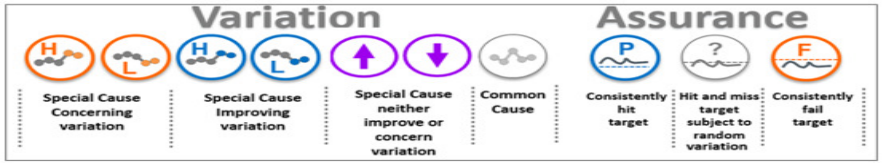
• The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS 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, quality and finance 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 reflect metrics included in the contracts for 22/23 work continues across provider and commissioner to conform contracts for 23/24 and once this process has been completed, metrics may be amended to ensure they reflect current year. 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 - NHS England 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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Data quality rating	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	Q1 - 455	1245	874	1359	1504	483	439	482	511	511	447		
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%	87.3%		
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%	94.6%	84.8%	92.6%	94.4%	81.3%	96.7%		
IAPT - proportion of people completing treatment who move to recovery	Improving Health	Responsive	CH	LTP/SC	50%	53.4%	53.9%	47.1%	54.8%	41.0%	52.6%	57.1%	53.9%	53.6%	*52.7%*		
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	455	377	500	461	480	456		
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	2656	910	698	978	792	886	724		
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%	89.5%	93.5%	95.1%	95.7%	97.5%	97.9%		
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			Due July 2023		
Number of individuals accessing specialist community PMH and MMHS services in the reporting period	Improving Care	Responsive	CH	LTP	Q1 - 316	480	285	225	222	69	84	81	57	84	342		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	Improving Care	Responsive	CH	SC	99%	91.7%	95.9%	86.2%	79.8%	100.0%	86.2%	88.0%	91.6%	79.8%	60.7%		
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care				SC	80%	84.6%	89.0%	88.1%	87.8%	89.6%	88.9%	87.9%	89.6%	86.6%	89.2%		
IAPT - Treatment within 6 Weeks of referral	Improving Health	Responsive	CH	SC	75%	94.7%	97.5%	98.4%	97.8%	98.6%	98.5%	97.7%	97.6%	98.1%	*97.8%*		
IAPT - Treatment within 18 weeks of referral	Improving Health	Responsive	CH	SC	95%	100.0%	100.0%	99.8%	99.9%	99.9%	99.5%	99.8%	100.0%	99.8%	*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%	90.0%	100.0%	87.5%	80.0%	87.5%	33.3%		
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%	79.3%	88.2%	88.6%	100.0%	100.0%	75.0%		
Data Quality Maturity Index	Improving Health	Responsive	CH	SC	95%	98.5%	99.5%	99.4%	*98.6%*	99.6%	99.1%	*99.4%*	*98.2%*	*98.2%*	*99.4%*		

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Data quality rating	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	10	0	8	31	44	15		
Total number of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	1	2	4	3	2	0	2	2	2	3		
Number of detentions under the Mental Health Act (MHA)	Improving Care	Safe	CH	O	Trend Monitor	183	179	161	184	161		184			Due July 2023		
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%	98.7%	100.0%	98.9%	99.0%	98.2%	100.0%		
% 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%	94.9%	96.9%	95.8%	95.4%	97.6%	97.1%		
% clients in settled accommodation	Improving Health	Responsive	CH	O	60%	88.3%	87.2%	85.7%	84.5%	85.8%	85.2%	84.4%	84.4%	84.6%	*84.2%*		
% clients in employment	Improving Health	Responsive	CH	O	10%	11.1%	11.8%	11.7%	11.4%	11.6%	11.4%	11.6%	11.4%	11.2%	*11.2%*		
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%	98.7%	97.4%	98.5%	98.1%	99.1%	98.9%	*98.9%*		
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%*		
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%	99.3%	99.3%	99.4%	99.4%	99.4%	*99.4%*		

Glossary			
SOF	NHSE System Oversight Framework	O	Other National Metric
SC	NHS Standard Contract	SU	Service User
LTP	NHS Long Term Plan	CPA	Care Programme Approach



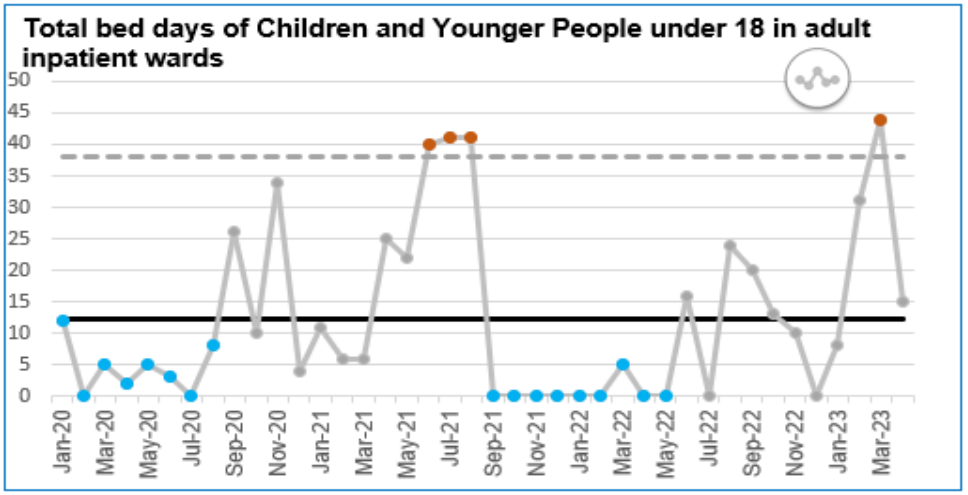
Headlines:

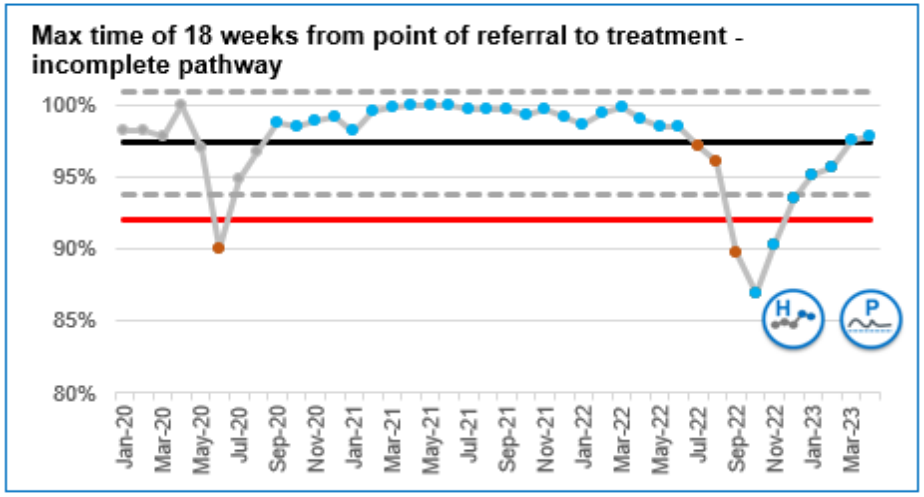
- The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.
- The percentage of service users waiting less than 18 weeks from point of referral to treatment remains above the target threshold at 97.9%
- 72 hour follow up remains above the threshold at 89.2%. 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 60.7% in April and remains below threshold and has reduced from last month. This is a small service and there have been a number of staffing issues that have impacted clinic availability. Due to the continued 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. The service are also reporting a number of appointments being cancelled by their parents/carers, or children not being brought to their appointments. The Was Not Brought (WNB) figures are high and the service are taking steps to try to address this. This includes sending an additional appointment text message reminder closer to the appointment date, and also changing the wording within appointment letters that are sent out to parents/carers. When an appointment is cancelled by a parent/carer or a child is not brought, the service often have to book another appointment that breaches the 6 week wait. 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 April 1 out of 3 urgent cases were seen within 1 week, this has taken the performance below threshold at 33.3%.
- During April 2023, there were three service users aged under 18 years placed in an adult inpatient ward. The combined bed days for these clients during the month was 15 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews.
- The 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 52.7% for April. 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 April. 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 April the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation shows 14.5% of records have an unknown or missing employment and/or accommodation status. This is a decrease from March which showed 15.4% of records have an unknown or missing employment and/or accommodation status. This has been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

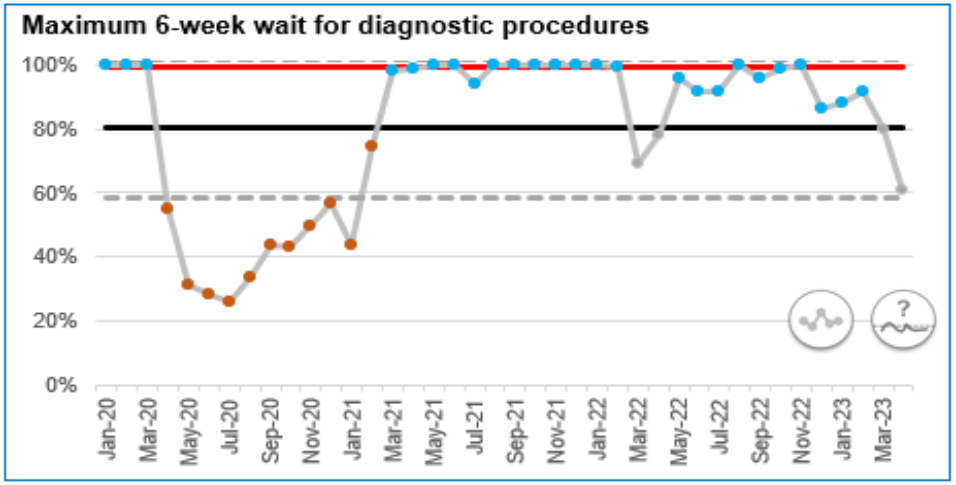
Analysis

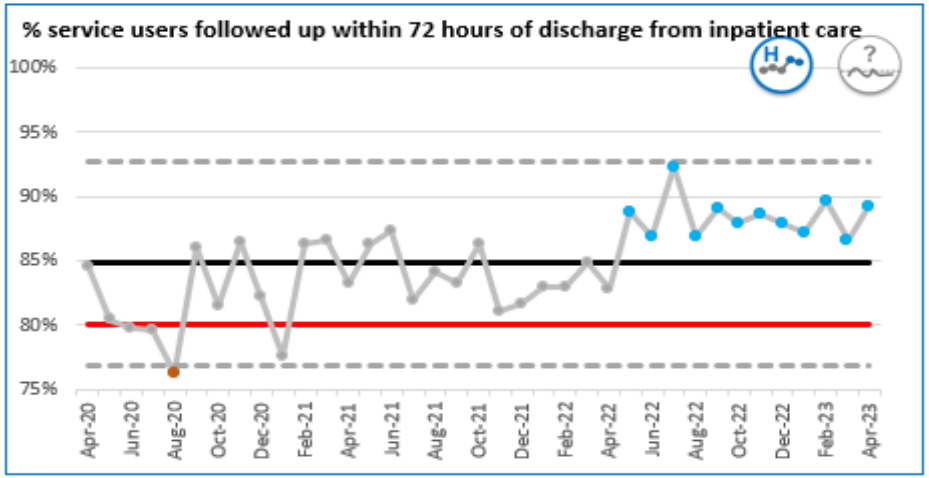




The statistical process control charts (SPC) above show that in April 2023 we have entered a period of common cause variation regarding the number of beds days for children and young people in adult wards. After consecutive periods of improvement against the referral to treatment metric we remain in a period of special cause improving variation in April 2023 and we are expected to meet the target.

Analysis





The SPC charts above show that for April 2023 for clients waiting for a diagnostic procedure we remain in 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.

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	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	72.4%	76.8%	
% Assessed within 14 days of referral (Routine)	75%	67.7%	60.4%	
% Assessed within 4 hours (Crisis)	90%	99.3%	97.4%	
% Complaints upheld with staff attitude as an issue	< 20%	20% (2/10)	9% (1/11)	
% service users followed up within 72 hours of discharge from inpatient care	80%	86.6%	89.2%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.4%	97.4%	
% Treated within 6 weeks of assessment (routine)	70%	88.9%	97.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	72.2%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	79.4%	*82.5%*	
Information Governance training compliance	>=95%	84.4%	86.9%	
No of staff off sick - Covid-19 not working	N/A	3	1	
Reducing restrictive practice interventions training compliance	>=80%	72.0%	69.5%	
Sickness rate (Monthly)	4.5%	5.4%	5.6%	

Barnsley General Community Services

Metrics	Threshold	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	77.9%	77.7%	
% Complaints upheld with staff attitude as an issue	< 20%	50% (1/2)	0% (0/1)	
% people dying in a place of their choosing	80%	100.0%	87.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.4%	77.5%	
Delayed transfers of Care (DTOC)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	89.9%	91.9%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	97.5%	97.9%	
Maximum 6 week wait for diagnostic procedures	99%	79.8%	60.7%	
No of staff off sick - Covid-19 not working	N/A	5	3	
Reducing restrictive practice interventions training compliance	>=80%	33.3%	33.3%	
Safer staffing (inpatient)	90%	108.3%	110.7%	
Sickness rate (Monthly)	4.5%	4.6%	4.6%	

Mental Health Inpatient

Metrics	Threshold	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	39.9%	42.9%	
% Bed occupancy	85%	85.1%	86.3%	
% Complaints upheld with staff attitude as an issue	< 20%	29% (2/7)	40% (2/5)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.4%	72.5%	
Delayed transfers of Care (DTOC)	3.5%	5.0%	3.3%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	89.9%	*90.6%*	
Inappropriate Out of Area Bed days	152	511	447	
Information Governance training compliance	>=95%	87.8%	90.3%	
No of staff off sick - Covid-19 not working	N/A	4	0	
Physical Violence (Patient on Patient)	Trend Monitor	14	18	
Physical Violence (Patient on Staff)	Trend Monitor	51	66	
Reducing restrictive practice interventions training compliance	>=80%	79.5%	79.2%	
Restraint incidents	Trend Monitor	19	***1***	
Safer staffing	90%	122.6%	126.9%	
Sickness rate (Monthly)	4.5%	5.8%	4.6%	

Forensic

Metrics	Threshold	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	65.3%	67.2%	
% Bed occupancy	90%	88.5%	88.5%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/0)	0% (0/1)	
% Service Users on CPA with a formal review within the previous 12 months	95%	83.5%	92.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.8%	80.4%	
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%	86.5%	88.6%	
No of staff off sick - Covid-19 not working	N/A	5	2	
Physical Violence (Patient on Patient)	Trend Monitor	2	0	
Physical Violence (Patient on Staff)	Trend Monitor	8	8	
Reducing restrictive practice interventions training compliance	>=80%	81.9%	83.0%	
Restraint incidents	Trend Monitor	3	***1***	
Safer staffing	90%	111.0%	116.9%	
Sickness rate (Monthly)	5.4%	6.8%	6.5%	

LD, ADHD & ASD

Metrics	Threshold	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	72.7%	69.3%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/1)	100% (1/1)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	51.2%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.9%	80.1%	
Delayed transfers of Care (DTOC)	3.5%	23.3%	25.0%	
Information Governance training compliance	>=95%	83.6%	86.3%	
LD – First face to face contact within 18 weeks	90%	76.2%	72.9%	
No of staff off sick - Covid-19 not working	N/A	0	0	
Physical Violence - Against Patient by Patient	Trend Monitor	1	0	
Physical Violence - Against Staff by Patient	Trend Monitor	27	42	
Reducing restrictive practice interventions training compliance	>=80%	76.6%	75.1%	
Safer staffing	90%	141.5%	140.7%	
Sickness rate (Monthly)	4.5%	5.3%	4.6%	
Restraint incidents	Trend Monitor	10	***3***	

CAMHS

Metrics	Threshold	Mar-23	Apr-23	Variation/ Assurance
% Appraisal rate	>=90%	88.3%	80.4%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/1)	0% (0/3)	
CAMHS - Crisis Response 4 hours	N/A	92.0%	93.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.3%	79.7%	
Eating Disorder - Routine clock stops	95%	100.0%	75.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	87.5%	33.3%	
Information Governance training compliance	>=95%	84.4%	90.4%	
No of staff off sick - Covid-19 not working	N/A	0	0	
Reducing restrictive practice interventions training compliance	>=80%	73.6%	69.8%	
Sickness rate (Monthly)	4.5%	3.0%	3.8%	

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):

Alert/Action

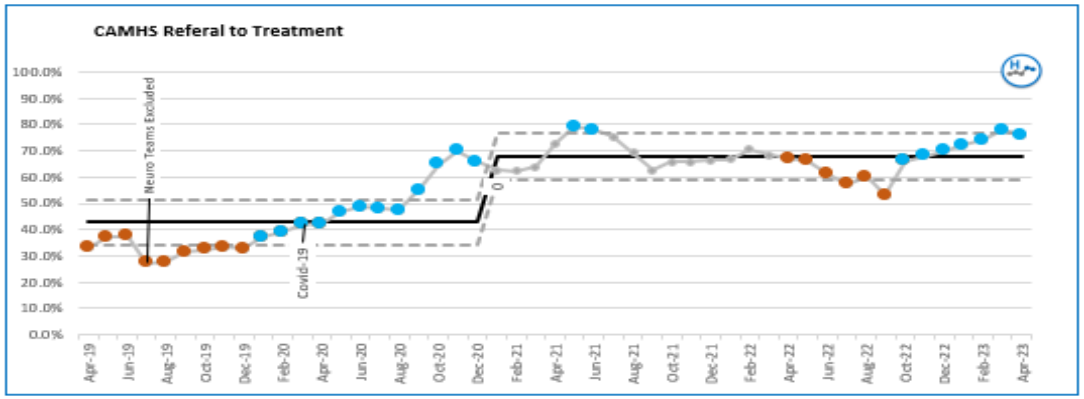
• Waiting numbers for Autistic Spectrum Conditions (ASC)/Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans are in place but a shortfall between commissioned capacity and demand remains. Transition to adult services also remains a focus for improvement work.
• Information governance mandatory training compliance has improved but remains below target. Other training priorities include reducing restrictive practice interventions (69.8% - threshold 80%) and cardio pulmonary rehabilitation (79.7% - threshold 80%).
• Ongoing issue with shortage of specialist residential and Tier 4 places – reduced capacity nationally and ongoing capacity issues at Red Kite View - leading to inappropriate stays for young people on acute hospital wards, Trust inpatient beds and section 136 suites. This is noted on the Trust's risk register and subject of a number of recent MP enquiries. Work continues with the provider collaboratives to improve patient flow.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues. Specific issues in relation to recruitment of band 6 nursing staff.
• Eating disorder pathways remain under demand pressures 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. Proactive within provider collaborative arrangements to optimise capacity.

Advise

• An Any Qualified Provider model implemented by commissioners in Calderdale with regard to ASC/ADHD diagnostic assessment. Work is progressing to ensure a robust CAMHS response.
• No complaints received in reporting period
• 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. Additional mental health support team investment confirmed – enabling further strengthening of schools-based offer.
• Business case being developed in Barnsley with respect to specialist support offer for children with learning disabilities/special educational needs. Recognised gap and supported in principle by commissioners.
• 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.

Assure

• Staff wellbeing remains a focus. Each CAMHS team has an agreed action place in place as a direct response to the staff survey. Staff survey results generally positive across all teams.
• Clinical lead and service manager posts recruited to (and in post) across Wetherby Young Offenders Institute and Adel Beck
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 April 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 – The Team only has one nurse prescriber which creates pressures and risk to the service, particularly for the lead nurse who is prescriber. Since autumn last year we have been unable to recruit through bank/agency on a temporary basis or permanent basis. We continue to work with pharmacy and the walk in centre in Wakefield, to provide cover for the service as necessary.

Barnsley general community services continued:

Advise

• Health Integration Team Urban House review of migrant/asylum seekers provision – The commissioner is reviewing current health provision for the six resettlement programmes in Wakefield and includes Urban House. The care group submitted a discussion paper 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. Further meetings with partner organisations to discuss next steps will take place over the coming weeks.
• Neighbourhood nursing service position paper discussed at the Trust's operational management group in April. This will be escalated to the executive management team for further discussion.
• Barnsley Healthcare Federation and the South Yorkshire Integrated Care Board have made the decision to temporarily close Brierley Medical centre from Monday 24th April and will be operating from the Grimethorpe Lift Building. There will be a patient participant group for Brierley patients on 4th May 5:30pm at Brierley Methodist Church to discuss the relocation further with patients and answer their questions.

Assure

• Deputy director of nursing, quality and professions visited Urban House with an infection prevention and control nurse; this was a very positive visit.
• NHSE visit to Health Integration Team Urban House - The team had a very positive meeting with a team from NHSE this month. The government has tasked them with setting up large accommodation centres (2- 3 thousand people in each centre) and they wanted to understand the potential risks, challenges etc from a health perspective that they would need to consider and how we suggest they could manage them on such a large scale.
• Successful in the tender process for the continued provision of outcome of the School Age Immunisation Service (SAIS) (including flu) for Barnsley. This has been awarded on behalf of NHS England Yorkshire and Humber.
• Yorkshire Smokefree Calderdale (YSFC) - has now gone live with a pilot project in association with Yorkshire Cancer Research (YCR) to enable clients to have access to e-cigs through Totally Wicked (TW). YCR will reimburse TW for the vapes with no cost to SWYPFT.
• The BREATHE service along with secondary care colleagues have been in the process of developing a short term oxygen pathway as part of the virtual ward to support frailty patients in care homes to receive hospital level care in familiar surroundings and a place where they may feel most comfortable. This will be offered to patients who have an acute respiratory infection and frailty condition residing in a care home who are not for escalation above ward level care. The hope is the patients will have less chance of delirium and other hospital acquired harm, and a slower rate of physical and cognitive deconditioning. It improves patient experience and reduces pressure on acute inpatient resources. The patient and carers will receive support from the virtual ward team, community matron's, urgent community response and BREATHE. This will be a quality improvement project.
• Stroke Rehabilitation Unit – Chief Executive of the Stroke Association is aware of all the work and service developments on stroke rehabilitation unit and early supported discharge and plans to visit in September 2023.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

• 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.

Advise

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.

Assure

• 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:

Alert/Action

• Locality trios are being established in each area to provide more clarity of clinical decision making within community teams
• Capacity across the medical structure is being developed
• All four localities are working together on the waiting list project to ensure learning is captured to address needs across the service.
• Pressures in speech and language therapy and psychology services in the community relate to vacancies and sickness, this has an impact on waits. Actions are in place to manage sickness and to recruit to vacancies.

Advise

• Recruitment to the new workforce model in the assessment and treatment unit is showing improvement, although this is slower than preferred.
• The team are reviewing a new learning disability focussed workforce capacity tool used in Cheshire and Wirral and will measure the learning from this against the information provided by the Safecare tool.
• Planning is now underway for learning disability week in June.
• Managers from Horizon visited Greenways assessment and treatment unit, Cheshire and Wirral Partnership NHS Foundation Trust which is currently rated outstanding to learn from their experiences. They have picked up lots of “quick win” ideas to improve the environment as well as some ideas for strengthening the clinical approach.

Assure

• The well-being action plan has been completed and rolled out to all teams to further improve the existing well-being approach.
• The assessment and treatment unit now has a psychologist as part of the team.
• Although challenges with substantive recruitment remain, speech and language therapy provision has been identified through an agency worker
• Work has taken place to improve recruitment for occupational therapist in the assessment and treatment unit.

Forensic services:

Alert/Action

• Acuity remains high. All seclusion rooms are now repaired and functional, except Gaskell which is still undergoing significant work. Planning permission for the additional suite on Chippendale ward will be progressed.
• Sickness absence remains above the care group tolerance, but with a small decrease to 7.9%.
• Staff turnover remains high 14.2%. Recruitment and retention remains a priority.
• Care programme approach reviews within 12 months has improved but is still under target at 92.5%. Actions remain in place to address performance.
• Quality network for forensic mental health services (QNFMHS) - The service has received an updated report from the Quality Network for Forensic Mental Health Services. This will be shared with the clinical governance group initially.

Advise

• Work is underway to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative.
• Mandatory training overall compliance is green except the key areas of cardio pulmonary resuscitation – 78.8%, food hygiene – 68%, information governance – 85.5% and targeted work is taking place to address these.
• The roll out of trauma informed care is progressing well and training sessions for staff have commenced with some staff having completed all 4 modules.
• Appraisal and supervision remain a priority.
• The well-being of staff remains a priority and there has been a relaunch of the well-being forum
• Involvement work continues and a new “Connecting with Family and Carers” forum has been planned for 29th June. Wellbeing packs for our carers with useful information and supportive treats have been prepared. The plan will be to hold these meeting quarterly.

Assure

• High levels of data quality across the care group (100%).
• 100% compliance for HCR-20 risk assessments being completed within three 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.
• 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, but the numbers have increased.
• 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 with a significant number of vacancies despite active recruitment.
• 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, and is below target performance in Barnsley and Calderdale and Kirklees.
• Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming month.
• 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 continuing to improve performance for FIRM risk assessments, and performance is showing good progress in all areas for those on CPA 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 7 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 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 CPR 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

• Wakefield memory service has been successful in its re-accreditation with Memory Services National Accreditation Programme which is a quality improvement and accreditation network for services that assess, diagnose and treat dementia in the UK.
• We are performing well in gatekeeping admissions to our inpatient beds.
• We are performing well in 72 hour follow up for all people discharged into the community.

Engagement, Equality and Volunteering Update

• Equality and involvement annual action plans for 2023/2024 now signed off by equality involvement and inclusion committee.
• A Trustwide framework to support staff to review equality data is now being evaluated for use by our performance & business intelligence (P&BI) 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 three month plan to launch has been approved at the first meeting in March
• The Flair survey has now closed. The final response rate was 23%. A paper on how we will review the data and early sight of findings will be shared with the executive management team (EMT) this month.
• The Trustwide approach to involvement is nearly ready to launch. The training modules to deliver three two hour training sessions have been tested this month. A communication 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 the 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, 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 2023/24

Executive Summary / Key Performance Indicators

Performance Indicator		Apr-23	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	(£222k)	Breakeven	In April 2023 the financial position is a surplus of £0.2m which is in line with plan. The forecast position will be assessed by the end of the first quarter. The target is breakeven.
2	Agency Spend	£939k	£8.7m	Agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. This is in line with national, and ICB, reduction targets and caps. Spend in April is £141k (18%) above this trajectory.
3	Financial sustainability and efficiencies	£568k	£12.0m	The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely. Individual performance is provided within the report.
4	Cash	£78.5m		Cash in the bank remains positive and with continued levels of interest rates will be maximised. This helps to support the value for money agenda.
5	Capital	£282k	£8.8m	The capital programme is made up of 2 elements. Key performance is monitored against the ICB capital allocation and excludes the impact of IFRS 16 (leases). The detail is shown within the full report. Capital spend is profiled to increase across the year. Spend in April is £282k which is more than planned.
6	Better Payment Practice Code	96%		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 -

ICB Board meeting and minutes :: South Yorkshire ICB

The Trust is trying to establish a feed of data of applicable key performance indicators for each of the integrated care boards. Progress on this will be provided in next months report.

Publication Summary

This section of the report identifies any national guidance that may be applicable to the Trust or any published data which includes the Trust. This is now reported separately to Trust board.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 1 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0	Executive Summary / Key Performance Indicators			
Key Performance Indicator		**Year to Date**	**Forecast 2023 / 24**	**Narrative**
1	**Surplus / (Deficit)**	£0.2m	£0.0m	In April 2023 the financial position is a surplus of £0.2m which is in line with plan. The forecast position will be assessed by the end of the first quarter. The target is breakeven.
2	**Agency Spend**	£0.9m		Agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. This is in line with national, and ICB, reduction targets and caps. Spend in April is £141k (18%) above this trajectory.
3	**Financial sustainability and efficiencies**	£0.4m		The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely. Individual performance is provided within the report.
4	**Cash**	£78.5m		Cash in the bank remains positive and with continued levels of interest rates will be maximised. This helps to support the value for money agenda.
5	**Capital**	£0.3m	£8.8m	The capital programme is made up of 2 elements. Key performance is monitored against the ICB capital allocation and excludes the impact of IFRS 16 (leases). The detail is shown within the full report. To date expenditure is £0.3m and mainly relates to expenditure on previous year schemes.
6	**Better Payment Practice Code**	96%		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
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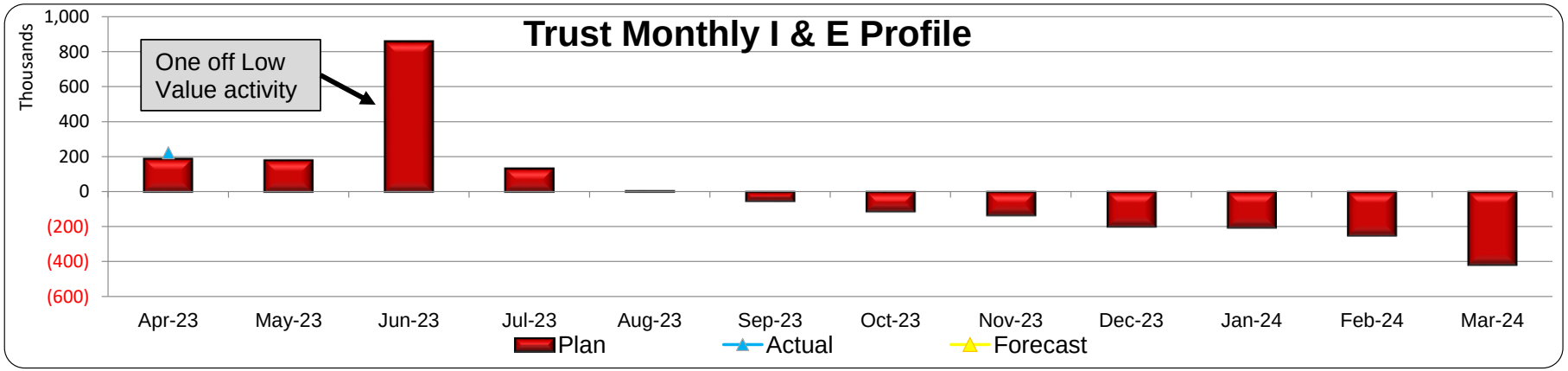
2.0 Income & Expenditure Position 2023 / 24

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust and incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives. The impact of these is reported separately.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k
Healthcare contracts					29,385	29,369	(16)	353,365	353,365	0
Other Operating Revenue					896	1,009	113	10,720	10,720	0
Total Revenue					**30,282**	**30,378**	**97**	**364,085**	**364,085**	**0**
Pay Costs	4,781	4,721	(60)	1.3%	(19,434)	(19,148)	286	(235,676)	(235,676)	0
Non Pay Costs					(10,163)	(10,071)	92	(121,261)	(121,261)	0
Budgets held centrally					(54)	(544)	(490)	(2,121)	(2,121)	0
Gain / (loss) on disposal					0	0	0	0	0	0
Impairment of Assets					0		0	0	0	0
Total Operating Expenses	**4,781**	**4,721**	**(60)**	**1.3%**	**(29,650)**	**(29,762)**	**(112)**	**(359,058)**	**(359,058)**	**0**
EBITDA	**4,781**	**4,721**	**(60)**	**1.3%**	**632**	**616**	**(15)**	**5,027**	**5,027**	**0**
Depreciation					(518)	(517)	1	(5,949)	(5,949)	0
PDC Paid					(179)	(179)	0	(2,148)	(2,148)	0
Interest Received					254	301	47	3,070	3,070	0
Surplus / (Deficit) - ICB performance measure	**4,781**	**4,721**	**(60)**	**1.3%**	**189**	**222**	**33**	**(0)**	**(0)**	**0**
Depn Peppercorn Leases (IFRS16)					0		0	0	0	0
Revaluation of Assets					0		0	0	0	0
Surplus / (Deficit) - Total	**4,781**	**4,721**	**(60)**	**1.3%**	**189**	**222**	**33**	**(0)**	**(0)**	**0**



Income & Expenditure Position 2023 / 24

The Trust has agreed a breakeven plan for 2023 / 24.
This forms part of a consolidated West Yorkshire Integrated Care Board (ICB) financial plan.

The Trust financial plan, resubmitted May 2023, is a breakeven position. This is profiled with a surplus in the first months of the year which reduces in line with Trust workforce recruitment and retention assumptions. Cost reductions are profiled also later in the year which help to reduce the impact of cost increases.

NHS England - monthly submission

No NHS England financial return has been required for April 2023. This will be reinstated for month 2.

Income

The majority of income continues to be received from NHS commissioners. These are block in nature and values have been agreed as part of the planning process and are progressing to formal contract signature. This is mainly income from ICB's, Local Authorities and Specialist Commissioning which includes income for the Provider Collaboratives.

Contracts in month 1 include the full year effect and pre commitments from previous contracting process. Any new investment, including Mental Health Investment Standard (MHIS) income, will be reflected as and when agreed.

Pay

Pay budgets have been refreshed for 2023 / 24 as part of the planning process and include a trajectory of workforce increases through recruitment and retention. Performance against this plan will continue to be monitored. For 2022 / 23 the Trust saw an increase of 254 worked WTE from April 2022 to March 2023. This has reduced to 4,721 Worked WTE in April 2023 although this has seen an increase in substantive staff and a reduction in bank and agency.

In month 1 the pay expenditure value includes a 2% uplift for Agenda For Change staff in line with planning guidance. Subsequent changes will be reflected in month 2 alongside increased income assumptions. This is unlikely to be fully funded and will therefore create a financial pressure for the Trust.

Non Pay

Non Pay spend continues to be predominately Adult Secure Collaborative spend. A small underspend has been reported in April 2023 as inflationary pressures, on areas such as utilities and catering / food costs, continue to be mitigated as far as possible within the overall financial position.

2.2 Pay Information

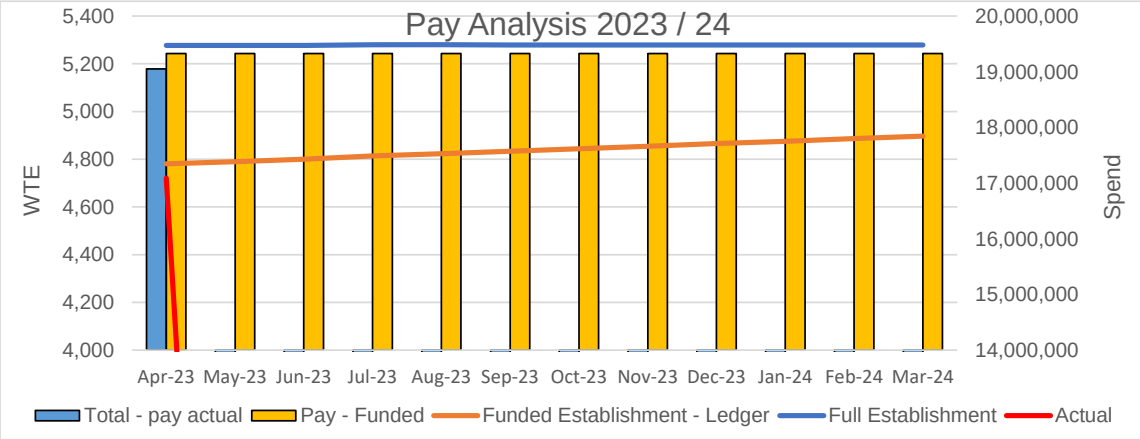
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for in excess of 85% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
Substantive	17,264												**17,264**
Bank & Locum	849												**849**
Agency	939												**939**
Total	**19,052**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19,052**
22/23	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**

Bank as % (in month)	4.5%												4.5%
Agency as % (in month)	4.9%												4.9%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343												**4,343**
Bank & Locum	222												**222**
Agency	157												**157**
Total	**4,721**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,721**
22/23	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**



The workforce plan has been reset for 2023 / 24 as part of the planning process. As such the vacancy factor assumption, as the Trust continues to grow it's workforce to meet service requirements, has been recalculated.

As shown by the graph on the left the full funded established is currently flat across the year (blue line) whilst the funded establishment (orange line) is increasing across the year.

There has been an increase in substantive worked WTE in April, when compared to March 2023, of 37 WTE. Overall, including temporary staff, this is 60 worked WTE less than planned.

2.2 Agency Expenditure Focus

Agency spend is £939k in April. Spend in 2022 / 23 was £10.0m with an average run rate of £834k.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate headline analysis of agency trends, pressure areas and actions are presented below.

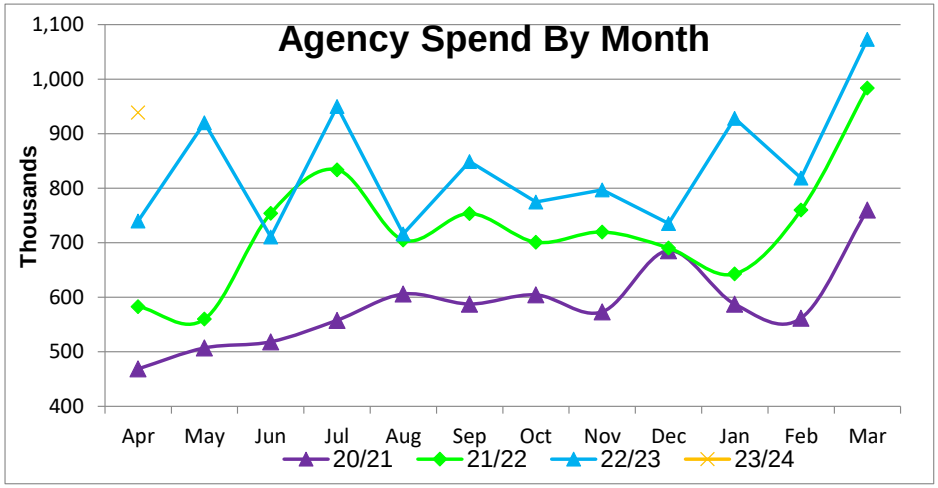
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

Under the NHS Single Oversight Framework, expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23.

The Trust agency scrutiny and management group continues to provide oversight ensuring that Trust processes are followed and agency spend is appropriate and minimised.

April 2023 spend, at £939k, is higher than the average run rate for the prior year and therefore corrective action is required if the target is to be met.

The Trust will continue to assess need based upon safety, quality and triangulated with the financial implications.



2.3 Out of Area Beds Expenditure Focus

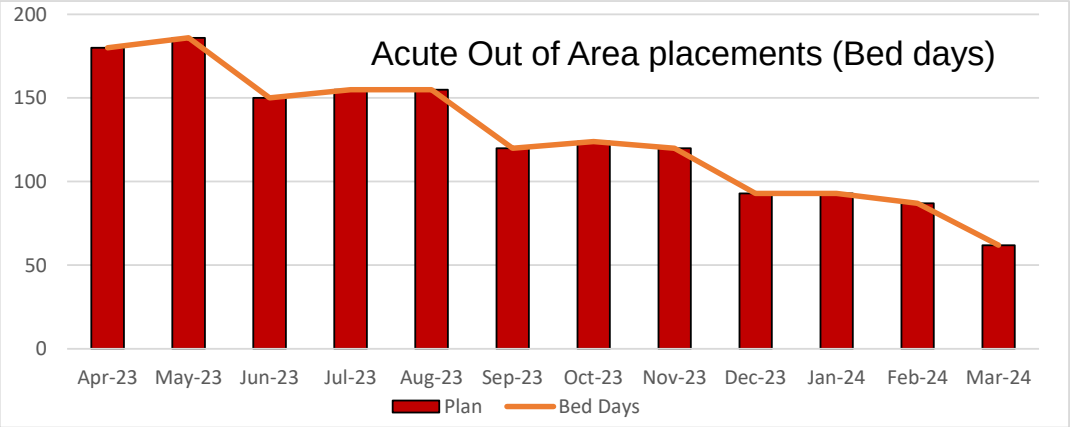
The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provide additional capacity for services which we do. In this analysis this is Trust costs only and therefore excludes provider collaboratives.

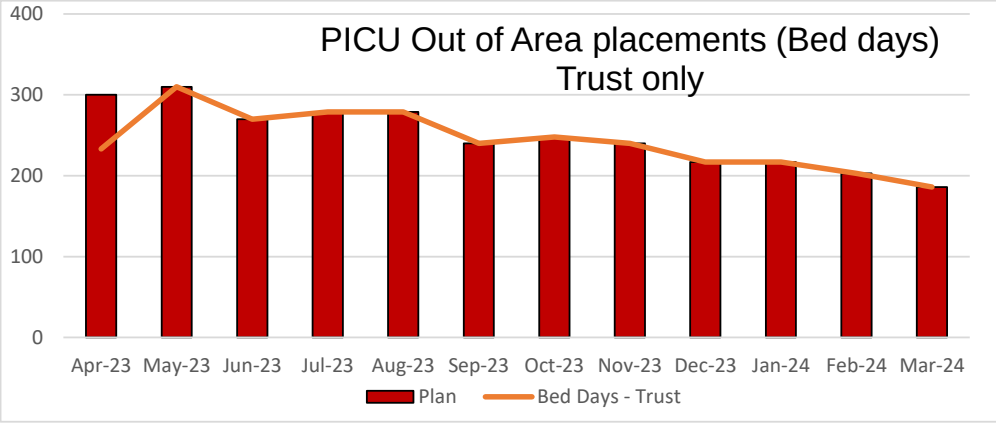
This continues to be an operational, and financial focus of specific reporting, due to it's volatile, and potentially expensive nature. In this context out of area bed placements refers to activity, and spend, incurred in order to provide clinical care to adult and PICU service users in non-Trust facilities.

There are an additional 77 PICU bed days in April 2023 which are paid directly by the commissioner.

Breakdown - Purchase of Healthcare

	Budget	Actual	Variance
	Year to date	Year to date	
Heading	**£k**	**£k**	**£k**
Locked Rehab			0
Out of Area			
Acute			0
PICU			0
Other Services			0
Total	**0**	**0**	**0**

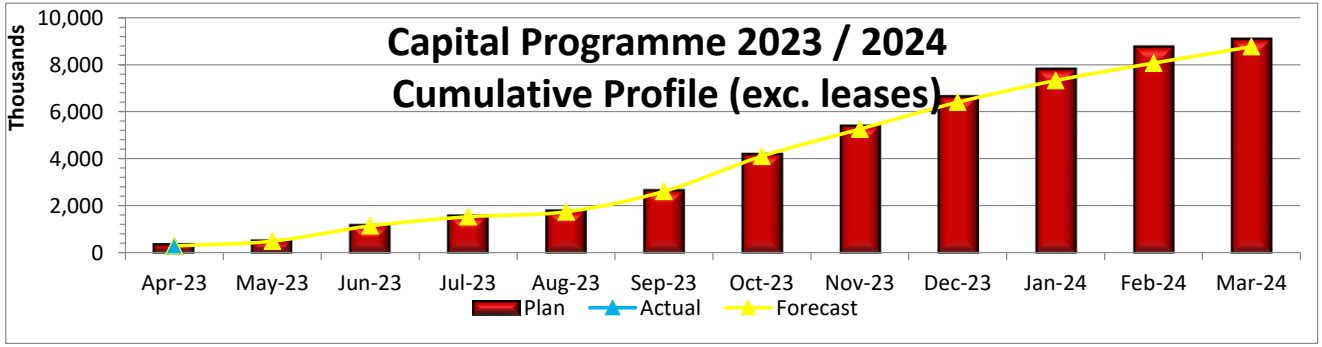




The graphs above present the trajectory of reduction of out of area placements as agreed as part of the 2023 / 24 planning process. This forms part of the overall Trust aspiration to have no inappropriate out of area placements.

3.1 Capital Programme 2023 / 2024

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						
Site Infrastructure	1,475	0	0	0	1,475	0
Seclusion rooms	750	0	0	0	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	0	0	0	735	450
Safety inc. ligature & IPC	990	0	10	10	1,445	455
Compliance	430	50	0	(50)	200	(230)
Backlog maintenance	510	0	0	0	75	(435)
Sustainability	300	0	0	0	225	(75)
Plant & Equipment	40	0	0	0	0	(40)
Other	1,223	0	272	272	1,097	(126)
IM & T						
Digital Infrastructure	1,100	0	0	0	1,200	100
Digital Care Records	180	0	0	0	180	0
Digitally Enabled Workforce	815	35	0	(35)	815	1
Digitally Enabling Service Users & Carers	400	0	0	0	400	0
IM&T Other	270	0	0	0	170	(100)
TOTALS	**8,768**	**85**	**282**	**197**	**8,767**	**(0)**
Lease Impact (IFRS 16)	5,203	5,203	7,097	1,894	7,097	1,894
New lease	303	273	0	(273)	0	(303)
TOTALS	**14,274**	**5,561**	**7,379**	**1,818**	**15,864**	**1,591**



Capital Expenditure 2023 / 24

The Trust has continued to work within the West Yorkshire Integrated Care Board capital allocation in establishing it's capital programme for 2023 / 24. This totals £8,767k.

Changes, implemented under IFRS 16 (leases), mean that these are now included within NHS England Capital Departmental Expenditure Limits (CDEL) but is separate from the ICB capital allocation so is presented below the line here.

The overall programme has been developed from an internal prioritisation process considering safety, the needs of services and improvements required. This programme was subject to a number of reviews and rationalisation both internally and as part of the overall ICB capital allocation process.

At this stage the majority of expenditure is on minor capital and IM & T investment; the ICB allocation methodology does present a risk of being able to agree major schemes even if funded directly by the Trust.

As planned expenditure is minimal in April 2023.

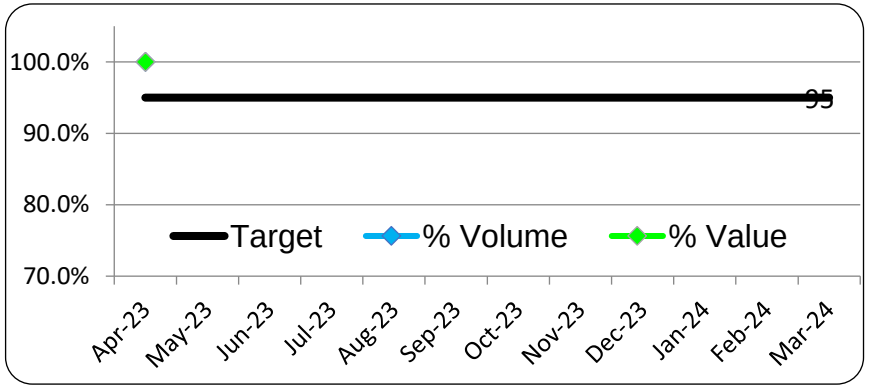
4.0 Better Payment Practice Code

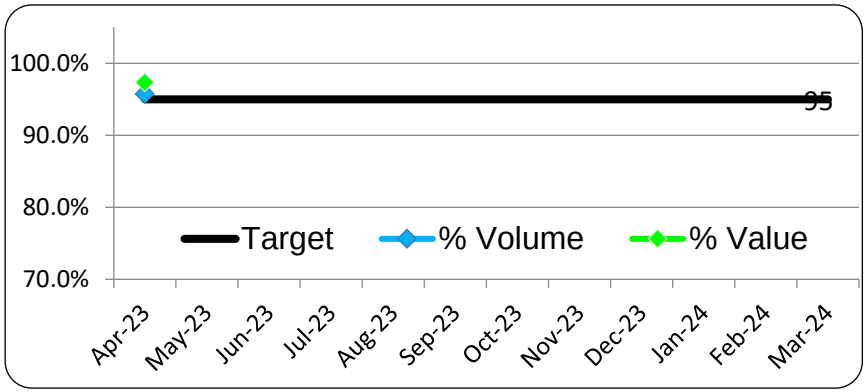
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	100%	100%
Cumulative Year to Date	100%	100%

Non NHS	Number %	Value %
In Month	96%	97%
Cumulative Year to Date	96%	97%





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 post was a new investment was received half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

* 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, reduce expenditure or increase income.

* 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. ICB - Integrated Care Board.

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

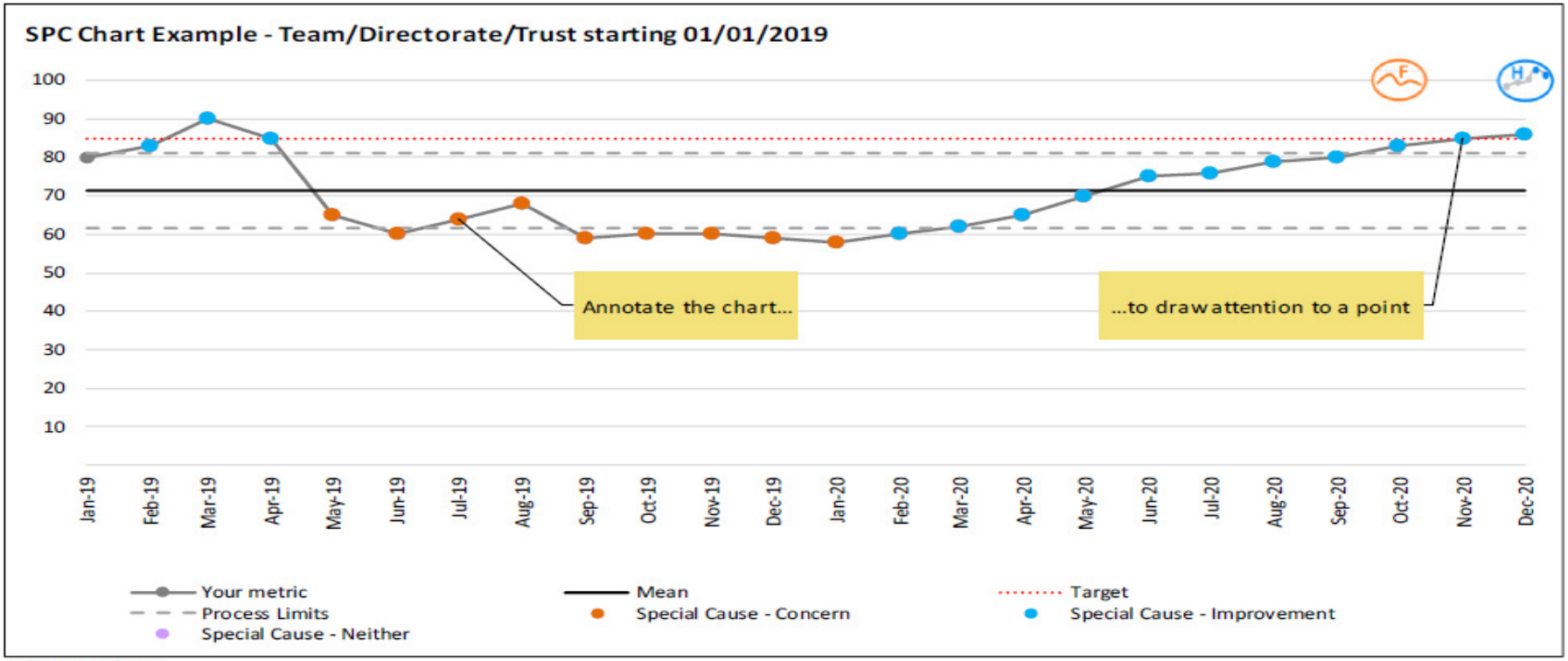
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 **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		?	H	L	H	L	?	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
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

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

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

Glossary

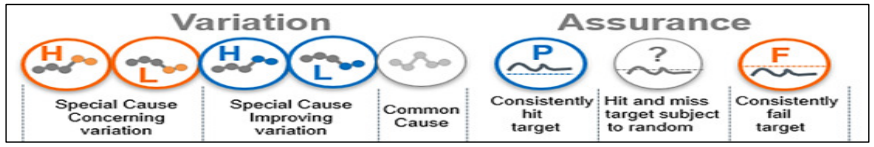
ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SJR	Structured Judgement Review
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
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.