NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

May 2023

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 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 were reviewed by Trust Board in May and will be implemented from July 2023.

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
- Strategic Objectives & Priorities
- Quality
- People
- National metrics
- Care groups
- Finance
- Systemwide monitoring

The Strategic Objectives & Priorities section has been updated to reflect the Trust's priorities and associated metrics for 2023/24. 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.

Strategic Objectives & Priorities

• 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 May 2023, disability 43.5%, sexual orientation 43.4% and postcode 99.8% of service users have had their equality data recorded. 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, the Trusts Equality, Inclusion and Involvement Committee monitor this work.

• Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.

• Timely completion of equality impact assessments (EIA) for service and policy remains a key metric and currently 53.7% of service EIAs have been reviewed within 12 months. 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale.

• Referral to assessment within 2 weeks for mental health single point of access continues to be impacted by demand and capacity. 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 Single point of access (SPA) together with some progress in recruitment should contribute to an improved performance in the coming month.

Quality

NHS England Indicators (national)

The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted:

• Inappropriate out of area bed days continue to be above trajectory with 574 days in May. 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 17 people placed in out of area beds at the end of May. 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 within 6 weeks decreased to 53.3% in May from 60.7% 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 80% (target 95%). In May 4 out of 5 urgent cases were seen within one week. The case that breached was due to patient declining an appointment that was offered within timescale.

• The percentage of children and young people with an eating disorder designated as routine cases who require access to NICE concordant treatment within four weeks remained below target at 89.5% (target 95%) - In May 17 out of 19 urgent cases were seen within four weeks. Appointments within timescale were offered to both cases that breached and were either declined or cancelled by the patient.

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 May data is showing an improved position of 85.7% and remains above threshold. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

May data shows a slight decline in performance from the previous month within inpatient services (87.7%), however community services (94.6%) have shown a marked improvement. All areas are working to improve performance and quality of risk assessments. Issues with data capture, service pressures and data quality continue to be addressed. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A new trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.

Waiting Lists

• Childrens 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 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 84.3% (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

95% of patient incidents reported in May 2023 resulted in no or low harm or did not occur whilst under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents has decreased slightly to 186 from 192 in April. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month is stable, not showing any cause for cause concern and is within expected range. This is described as common cause variation within the report.

• 86.6% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there was one incident over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service user and staff involved in the incident.

• There was one pressure ulcers due to a lapse in the Trust's care during May. 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 May was 53, which is an increase from last month. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

• Our substantive staff in post position continues to remain stable and has increased slightly in May. The number of people joining the Trust outnumbered leavers in May. Year to date, we have had 97 new starters and 74.8 leavers during the first two months of the year and focus remains on recruitment and retention.

• Overall turnover rate in May was 12.2% which is the lowest level it has been over the last 12 months. This is monitored against a revised target of between 12 to 13%.

• Sickness absence in May was 4.6%, which is the lowest it has been in the last 12 months with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for May saw a small increase, from 74.4% to 74.9%. The Executive Management Team (EMT) have agreed an improvement trajectory of 78% for May, the improvement trajectory will be reviewed monthly in EMT to be clear on how the Trust will achieve the 90% target in year. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Overall mandatory training is at 90.9% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.5% reported in April. However, 2 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to EMT with hot spot reports reviewed by the Operational Management Group (OMG).

• The refreshed Trust position for information governance data security training achieved 95.9% at the end of May which is above the 95% threshold. Food safety performance also achieved the 80% threshold during May, reporting at 83.4%.

Care Groups

Staffing vacancies and absence 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 May, these are as follows:

• All care groups, with the exception of inpatients (94.3%) and LD, ADHD, ASD (94.2%) are now achieving the compliance rate for information governance mandatory training. Focus still remains on compliance. Managers are receiving weekly lists of non-compliant staff so that progress can be monitored, and actions can be taken to address compliance. This is monitored at operational management group and executive management team.

• Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

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

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

• During May, there was a slight decrease in the overall number of cases that were clinically ready for discharge, reducing from 2.4% to 2.1%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the '100 Day Discharge Challenge' and working at Integrated Care Board level to share improvements and collaborative approaches.

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

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

Finance

• Although April 2023 continued the positive run rate, the May 2023 position has been significantly impacted by the gap associated with the national Agenda for Change pay award. This will be paid in June 2023. Agency spend in May was £908k.

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

• The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.

• Pay costs were £20.46m in May, compared to last month which was £19.14m.

• Out of area bed costs - Despite acute bed day usage being higher than plan, out of area bed costs for April and May are both below plan at £1609k. This is due to less additional nursing being used than planned and a reduction in bed day rates.

• Performance against the Better Payment Practice Code increased to 97%.

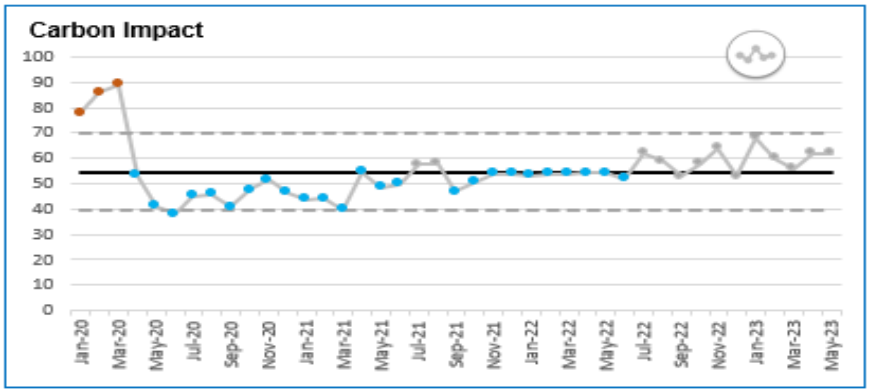
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical 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	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	*90%*	96.3%	96.6%	96.6%		
Percentage of service users who have had their equality data recorded disability	To be determined for 23/24	41.9%	43.2%	43.5%		The threshold for 23/24 is being developed by the equality inclusion and involvement committee and it is expected to be included in the July report.
Percentage of service users who have had their equality data recorded - sexual orientation		42.2%	43.3%	43.4%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)		99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies (Quarterly)	95%	77.6% Service 95.3% Policy	53.3% Service 94.6% Policy	53.7% Service 96.1% Policy		EIAs for services are reviewed annually. This means all services have an EIA in place. Work is being undertaken to support services with the reviews within the year.
Completion of equality mandatory training (Quarterly)	>=80%	95.1%	96.0%	96.2%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	-	0	1		2023/24 to be used as a baseline
Carbon Impact (tonnes CO2e) - business miles	76	56	62	62		Data showing the carbon impact of staff travel / business miles. In May 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%	63.3%	Due August 2023			Q4 - 63.3% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different places.

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 May 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.

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 in the Trust & our communities	Phase 1, developing the social responsibility and sustainability action plan, completed by July 2023		The first quarterly update of the strategy was presented into the Equality, Involvement and Inclusion committee in June. This included the metrics for measurement of delivery against the strategy which were agreed. Plans are in place to launch the green team to establish a network of people who can champion this agenda. The eBikes for the staff pilot have been delivered to our partner Barnsley Cycle hub, protocols and user agreement documents have been agreed. Work has commenced on the refurbishment of a garage on the Kendray site. The Social Responsibility and Sustainability Steering group has been established and held its first meeting. EMT supported the proposal for social responsibility and sustainability to become a 'golden thread' throughout all strategic change priority programmes in 2023/24.
Work in partnerships at System & Place to improve the health of our communities	Community Mental Health transformation: Identify actions for SWYPFT to support implementation of next phase. April 2023		EMT supported next steps proposal. Internal steering group for Community Transformation (mental health (MH)) is in process of being established to take forward this work under the improving mental health portfolio of priority programmes for 2023/24
	Community Mental Health transformation: Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation.		This work is being aligned to Place based and ICS messaging via weekly meetings and is a workstream of the newly formed internal Community Transformation (MH) steering group.
	Address inequalities involvement and equality in each of our places with our partners		It has been agreed by EMT that in 23/24 there will be a priority programme of improvement work with the focus on ensure equality, involvement & inclusion are central to all that we do so we reduce inequalities. This programme is currently under rescoping, building on the existing work that has been undertaken and setting an improvement plan for 2023/24. EMT supported the proposal for equality, involvement and addressing inequalities to be a 'golden thread' throughout all strategic change priority programmes in 2023/24.

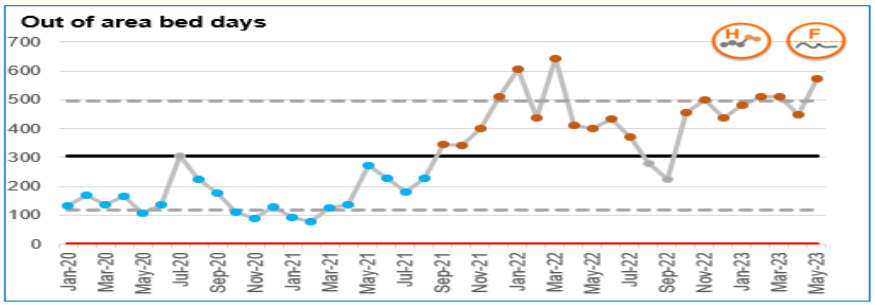
Improve Care

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	89.9%	90.6%	*87.7%*		May data shows a slight decline in performance from the previous month within inpatient services, however community services have shown a marked improvement. All areas are working to improve performance and quality of risk assessments. Issues with data capture, service pressures and data quality continue to be addressed but are 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. A new trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		79.4%	80.7%	*94.6%*		
% Service users on CPA offered a copy of their care plan	80%	75.1%	85.0%	85.7%		All areas continue working to improve performance and the impact of this can be seen through the data improvements. The May position remains above threshold for the second month. 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.
Registered substantive staff in post mental health and learning disabilities services	Establishment	Due July 23 (August report)				
Staff in neighbourhood teams	Establishment					
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	20	23	37		In May the majority of race related incidents against staff were reported in Forensics, 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. Any increases are monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	511	457	574		See statistical process chart below for further detail.
% service users clinically ready for discharge	<=3.5%	3.5%	2.4%	2.1%		
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	607	694	296		Average wait in days. Clients are seen in order of need and not by how long they have waited. The longest wait for those seen in the month was 775 days, the shortest was 20 days. Number on waiting list at end of May - 270. The longest waiter on the waiting list had waited 797 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	495	492	479		Average wait in days. Clients are seen in order of need and not by how long they have waited. The longest wait for those seen in the month was 583 days, the shortest was 44 days. Number on waiting list at end of May - 1573. The longest waiter on the waiting list had waited 807 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%	76.2% 64/84	72.9% 43/59	84.3% 59/70		Barnsley is above target (One speech and language case due to locum focus on dysphagia and urgent communication cases). Calderdale below target but there only one out of six cases in breach (psychology case on waiting list - no welfare call). Wakefield was below target with three of 17 cases in breach (two psychology on waiting list and had welfare calls; one psychiatry case – service offered but patient cancelled/DNA appointments – opt-in being sent). Kirklees – there are a six breaches (four physio cases on waiting lists; 2 psychology, one of which DNA – patient not brought).
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	86.6%	90.3%	88.2%		There has been a slight decrease in May however this is still within acceptable range and this metric remain in special cause improving variation
Community health services two hour urgent response standard	70%	83.8%	87.3%	86.6%		
Referral to assessment within 2 weeks (external referrals)	75%	67.7%	60.4%	68.6%		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 months.

Glossary

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

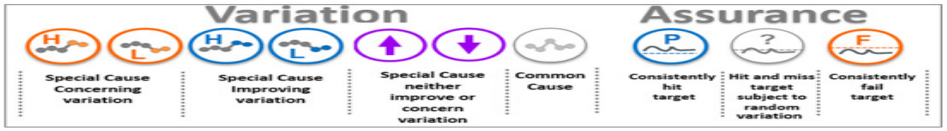
What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)



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 17 people placed in out of area beds at the end of May 2023.



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 completed 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 four: patient safety response planning by 30/06/2023 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.
	Care Planning and Risk Assessment		It has been agreed by the executive management team (EMT) that in 23/24 there will be a priority programme of improvement work with the focus on Care Planning and Risk Assessments. This programme is currently under rescoping, building on the existing work that has been undertaken and setting an improvement plan for 2023/24.
	Personalised Care (Moving on from CPA)		It has been agreed by EMT that in 23/24 there will be a priority programme of improvement work with the focus on Personalised Care (moving on from CPA). This programme is currently under rescoping, building on the existing work that has been undertaken, alignment to community mental health transformation, and setting an improvement plan for 2023/24.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Improving Access to Care (IATC): Update on improvement work to reduce waits		- Community LD services (LD): The design of SystmOne waiting list functionality with the Calderdale team has been approved. Configuration team and training team are aiming to complete build and have this rolled out to wider localities in a collaborative approach and teams using the System by end of July. - The Equality and Involvement and Business Intelligence teams provided an awareness session with Calderdale team to support in data recording and understanding of importance of data capture of protected characteristics to improve data collection. - CAMHS neurodevelopmental services in Kirklees and Calderdale: In the last month, configuration of the agreed standardised referral form on SystmOne to support the transition between children's and adult ADHD service was completed. A workshop has been scheduled to create a set of shared transition principles and expectations. This work links in with the wider work being undertaken by West Yorkshire Mental Health, Learning Disabilities and Autism (MHLDA) Partnership Board transition project group. - Adult community services – Core psychology: SystmOne waiting lists have gone live in all core psychology localities. Service level data analysis work has begun as this will help identify potential areas of improvement. A rescoped project plan and driver diagram have been developed. - SystmOne waiting list project: The project continues to support services in using the functionality correctly, supporting solving of data quality issues, and concentrating on the remaining services trained/setup to begin feeding data from the high-level reporting tool/become "live". - Review of waiting times report: This is a collaborative piece and work continues to develop the report to the agreed plan, in line with the scheduled Clinical Governance and Clinical Safety Committee (CGCSC) meetings. Work has commenced on scoping the programme of work for 2023/24 aligned to other priority programmes under the Improving mental health portfolio.
	Improving Mental Health portfolio		It has been agreed by EMT that in 23/24 there will be four priority programmes of improvement work covering Care Closer to Home, Inpatient Improvement, Community Transformation (Mental Health) and Improving Access to Care. These programmes are currently under rescoping, building on the existing work that has been undertaken and setting improvement plans for 2023/24.
	Out to public consultation on older people inpatient services by Summer 2023		Work continues on finalising the business case and draft consultation documents

Improve resources

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan	Breakeven	(£546k)	£222k	(£326k)		Although April 2023 continued the positive run rate, the May 2023 position has been significantly impacted by the gap associated with the national Agenda For Change pay award. This will be paid in June 2023.
Capital spend against plan	£8.8m	£2721k	£282k	£537k		Capital spend is ahead of plan due to schemes brought forward. These were existing schemes within the plan but an opportunity was taken to complete them earlier than planned. The overall forecast remains that the £8.8m allocation will be fully utilised in year.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£1073k	£939k	£908k		Agency run rate continues higher than planned and exceeds the capped rate with spend of £908k in month.
Financial sustainability and efficiencies delivered over time	£12m	£471k	£568k	£1,497k		Savings in ahead of plan for the year to May 2023. Risks remain in overall deliverability and schemes, with mitigations, are being progressed.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	7	Due July 23			
Estates Urgent Response Times - SLA	95%	95.6%	93.8%	96.8%		SLA 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time
Premise Assurance Model (PAM)	Good	Good	Good	Good		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency &
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe	100%	-	50.0%	76.0%		All jobs that pertain to a ligature risk

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	Financial Improvement plan		Financial improvement plan established and scope of plan, including non-recurrent funding for project management resource, agreed by executive management team (EMT).
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 go-live for launch of Patient Knows Best has been postponed by a few weeks as NHS England work through some technical details with the NHS App which are also impacting existing users of Patient Knows Best in other areas of the country.
	Implementation of a Trustwide approach to digital dictation submission for Board approval July 2023.		Tender submissions evaluated and decision making in progress.

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.

Make SWYPFT a great place to work

Metrics	Threshold	Mar-23	Apr-23	May-23	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	13.5%	13.0%	12.2%		Rolling turnover continues to decrease and has dropped by 0.8% to 12.2%
Registered workforce growth	3% (by March 23)		0.6%			
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month decreased by 0.4% to 4.6%.
Workpal appraisals - rolling 12 months	>=78%	71.8%	74.4%	74.9%		For the month of May, the % rate increased by 0.5.% to 74.9%.
% staff recommending the Trust as a place to work	65%	Due Aug 23				Quarterly reported, next survey July '23.
% staff recommending the Trust as a place to receive care and treatment	65%	Due Aug 23				Quarterly reported, next survey July '23.
Staff supervision rate	80%					Supervision data is currently excluded due to a review of the supervision policy, recording and reporting. An improvement approach is being taken to this work. The supervision database will be live from end June and it is anticipated reporting will be available from August with planned trajectory for improvements.
Complaints - Number of responses provided within six months of the date a complaint received	100%	29% (4/14)	27% (4/15)	38% (3/8)		
Mandatory training - Cardiopulmonary resuscitation	80%	75.0%	75.5%	79.2%		
Mandatory training - Reducing restrictive practice interventions	80%	74.6%	73.8%	73.8%		
Mandatory training - Fire	80%	89.4%	90.2%	91.2%		
Mandatory training - Information governance	95%	86.5%	90.6%	95.9%		

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 and will be used as a baseline and developed further to provide an ongoing mechanism for reporting impact during 2023/24. Inclusive recruitment, retention and wellbeing and living our values programmes of work have been agreed and the improvement work plans for these is currently being scoped. EMT supported the proposal for recovery focused and becoming a trauma informed organisation to be a 'golden thread' throughout all strategic change priority programmes in 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 NHS Talking Therapies (formerly Improving Access to Psychological Therapy (IAPT)) services received training on delivering 'Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
- NHS Talking Therapies 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:

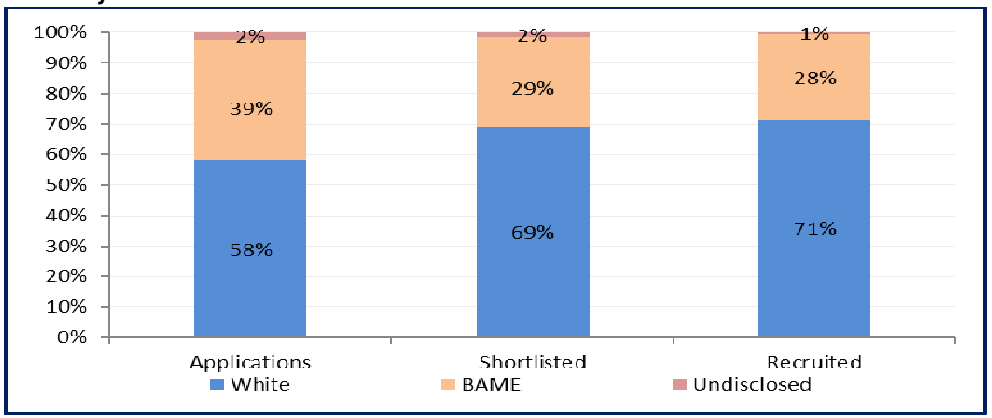
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and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

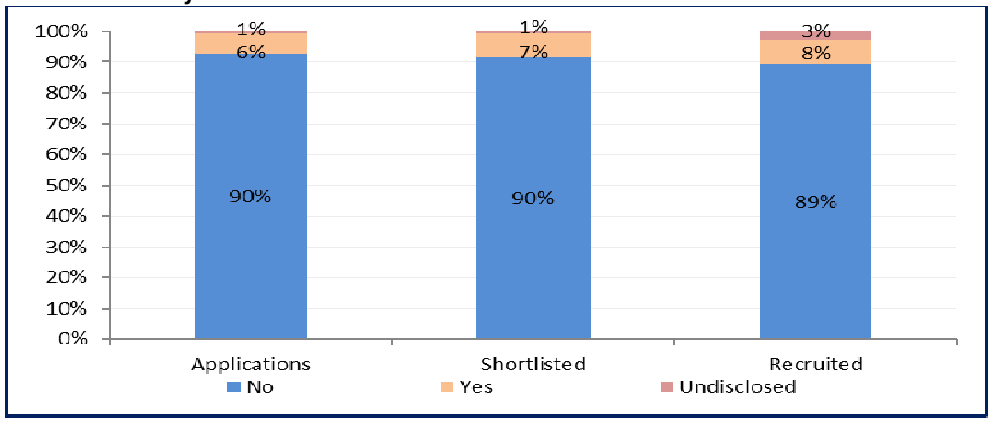
Reducing Inequalities

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

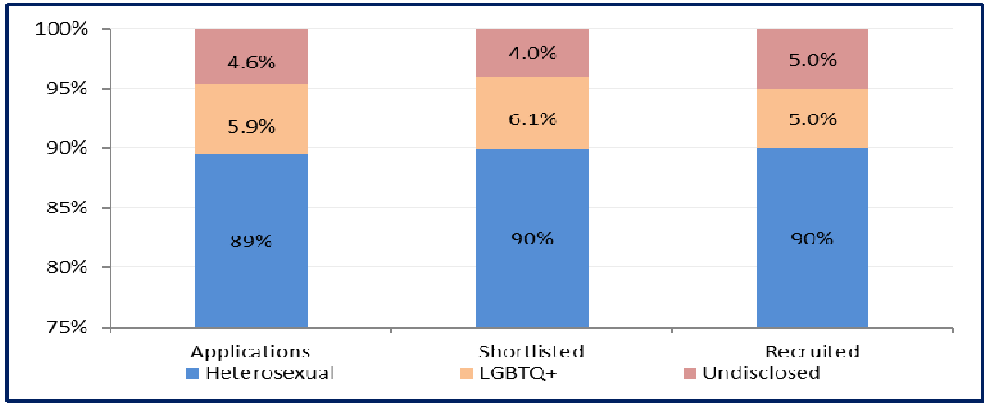
Ethnicity



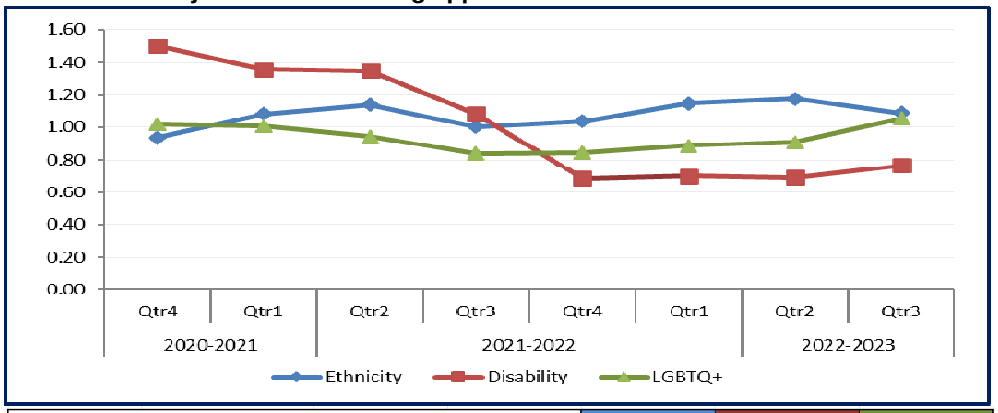
Disability



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.

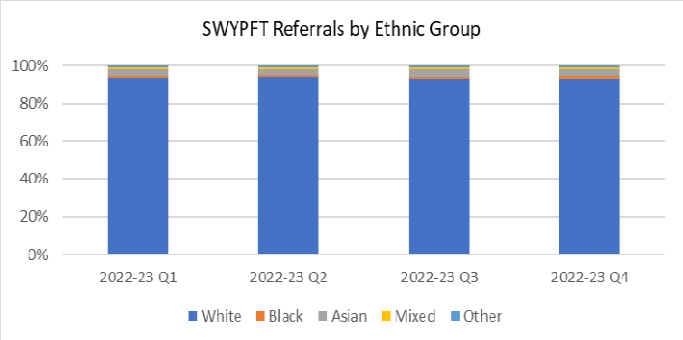
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.08
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.92
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter =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

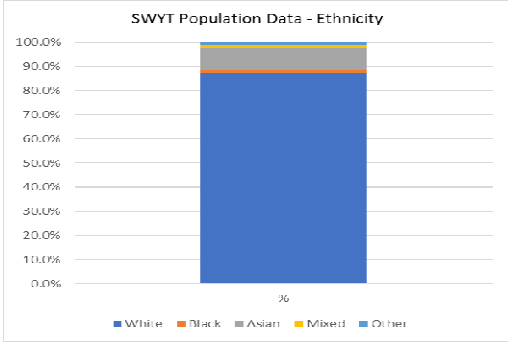
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

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

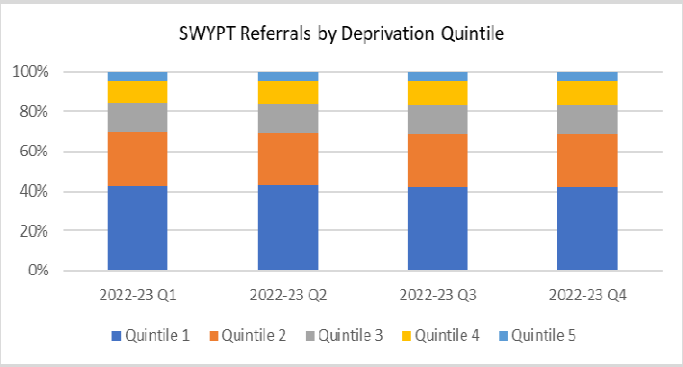
Reducing Inequalities

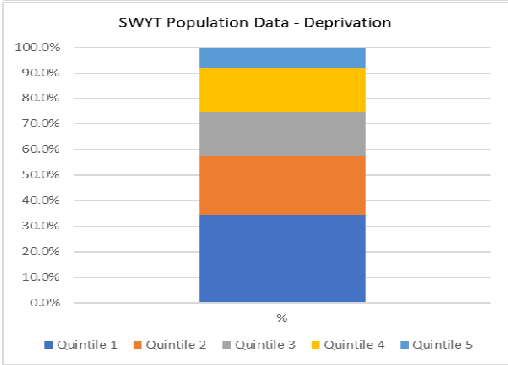
Referrals - (Includes physical health, mental heath, learning disability and forensics)





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%





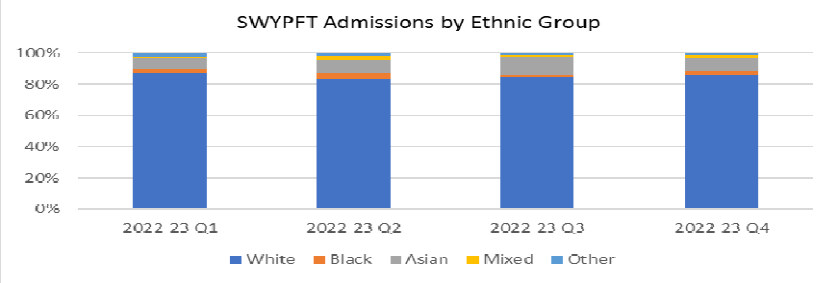
Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	42.3%	42.7%	41.7%	41.8%	34.1%
Quintile 2	26.9%	26.4%	26.5%	26.6%	23.4%
Quintile 3	15.5%	15.2%	15.6%	15.2%	17.0%
Quintile 4	10.9%	11.0%	11.5%	11.6%	17.8%
Quintile 5	4.4%	4.7%	4.7%	4.8%	7.8%

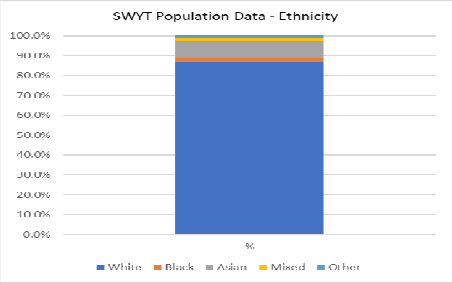
Notes:

- 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.

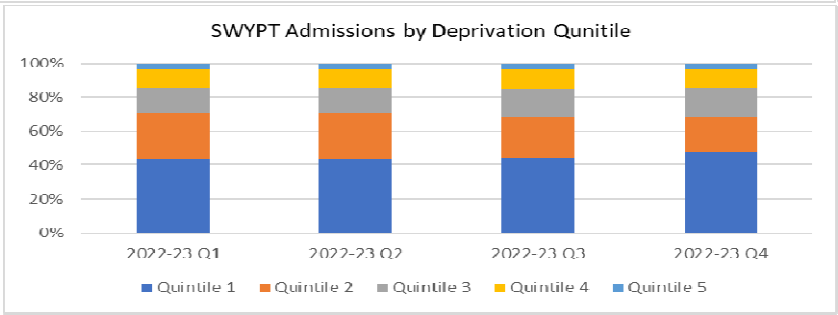
Reducing Inequalities

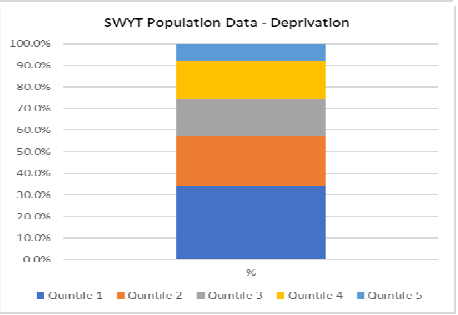
Admissions - (Includes physical health, mental heath, learning disability and forensics)





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.

Quality Headlines

Section	KPI	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	61.3%	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	19% 4/21	18% 4/22	20% 4/20	25% 5/20	15% 4/26	9% 2/22	20% 4/20	0% 0/16	11% 2/18	0% 0/21	17% 4/23	11% 2/17	1
Service User Experience	Friends and Family Test - Mental Health	84%	85%	88%	85%	85%	84%	86%	85%	83%	85%	83%	82%	85%	1
	Friends and Family Test - Community	95%	93%	93%	92%	93%	93%	93%	94%	93%	95%	97%	94%	97%	1
Quality	Number of compliments received	N/A	25	31	10	13	5	28	39	83	22	26	50	66	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	26	31	19	35	32	33	31	40	30	37	23	21	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	3	0	0	0	2	2	2	3	2	1	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	0	1	2	1	0	0	0	2	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	33.5%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	4
	Number of Information Governance breaches 3	<12	19	10	9	13	11	13	8	12	8	13	12	9	2
	% of inpatients clinically ready for discharge	3.5%	2.1%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	72.1%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	*87.7%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	95%	72.2%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	*94.6%*	4
	Total number of reported incidents	Trend monitor	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172	1253	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	24	27	11	32	26	30	24	34	26	35	18	26	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	1	4	3	3	3	7	7	3	3	2	2	1	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	1	0	5	2	3	0	3	3	1	2	3	1	
	Safer staff fill rates	90%	116.6%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	85.0%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	44	50	26	43	49	48	39	55	46	37	26	35	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	0	3	0	1	1	1	4	0	2	1	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%	87.5%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	1
	Number of Falls (inpatients)	Trend monitor	37	70	63	58	68	63	59	51	49	39	34	53	
	Number of restraint incidents	Trend monitor	152	171	161	160	169	223	189	212	223	203	192	186	
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	85.7%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	89.4%	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
	E. Coli bloodstream infection rate	0													
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0													
	No of wards with Covid-19 outbreaks	Trend monitor													
	No of Service users Covid-19 positive and now recovered	Trend monitor													
	No of Service users Covid-19 positive and still within 28 days, monitoring not completed	Trend monitor													
	No of Service users Covid-19 positive and deceased within 28 days of positive test	Trend monitor													
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Overall CQC rating														
	CQC well - led rating														

Quality Headlines

Quality Headlines cont…

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. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
11 - Number of records with up to date risk assessment - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.
12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return.
13 - The NHSE 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 186 from 192 reported in the previous month. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less dropped below the 90% threshold for May 23. Further detail can be seen in the following section of the 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 May. Lapse in care identified. There is a lapse in care identified due to appropriate risk assessment and prevention of pressure ulcers not being in place
• The number of people with a risk assessment/staying safe plan in place within timescale has improved again this month for community services but has seen a slight decrease in inpatient services further improvement is expected to continue. See the Strategic Objectives & Priorities 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 remains above threshold. See Strategic Objectives & Priorities 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.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In May, there have been fewer service users who repeatedly fall. However, on one ward there has been a service user with complex physical and mental health needs, this service users accounts for 50% of the falls. 100% of the service user falls were linked with a diagnosis of dementia, which is associated with agitation and wandering, often this is further complicated by postural instability and hypotension, muscle weakness, delirium, urinary frequency or incontinence, effects of medication, and visuospatial impairment, this makes it harder to reduce falls risks. People with dementia are twice more prone to falls than their peers.

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, 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, writing our draft PSIRF policy and plan. 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 Patient Safety Incident Response Framework
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 training is planned between July and December 2023.

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).

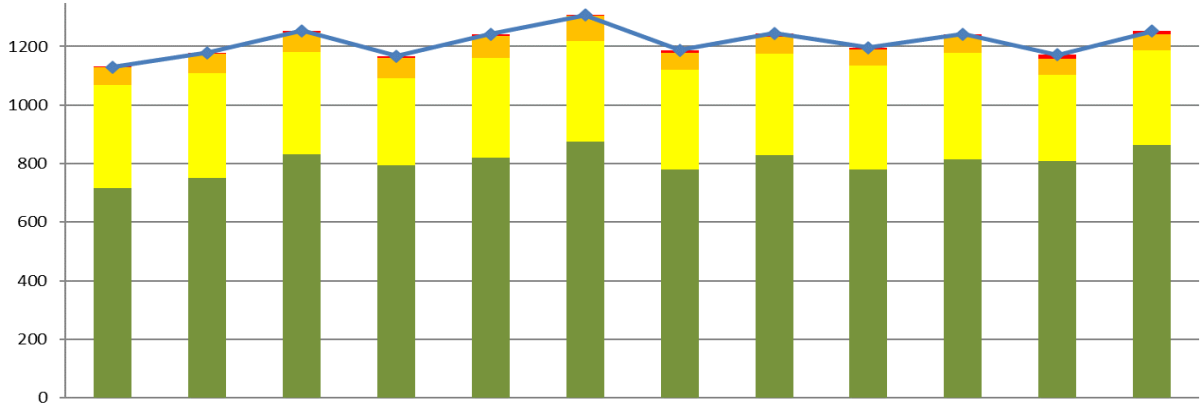
A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).

95% of incidents reported in May 2023 resulted in no harm or low harm or were not under the care of the Trust. This is based on the degree of actual harm.

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

Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.

All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages. See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx



	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Red (should not be compared with SIs)	2	5	6	8	6	3	8	11	6	9	14	10
Amber	60	65	66	68	76	85	58	59	56	57	55	57
Yellow	351	358	350	299	339	345	340	347	353	363	295	323
Green	717	751	832	793	821	874	781	828	781	814	808	863
Total	1130	1179	1254	1168	1242	1307	1187	1245	1196	1243	1172	1253

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 May 2023

Safety First cont…

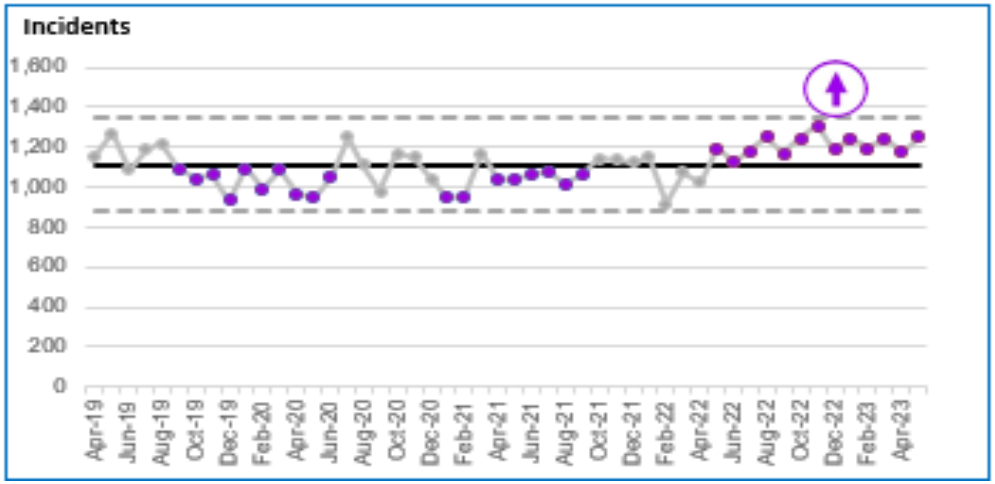
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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 May 2023:
26 moderate harm incidents
1 severe harm incident
1 patient safety related death

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 68 - 16 May 2023 - potential to create an anchor point for a fixed ligature within doorframe

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

Patient Safety Alerts

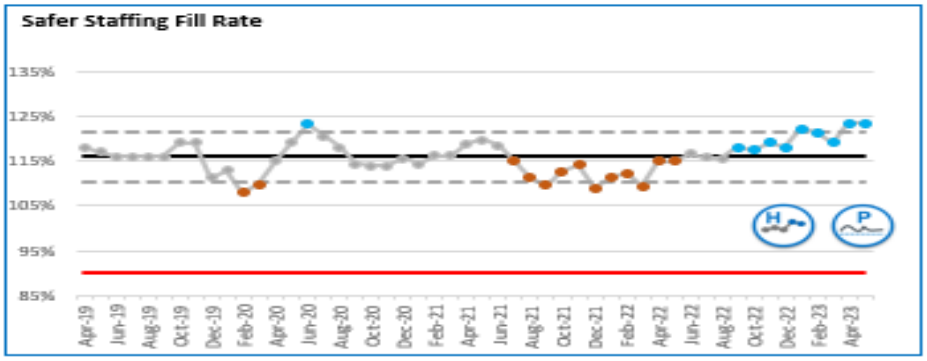
Patient safety alerts issued in May 2023

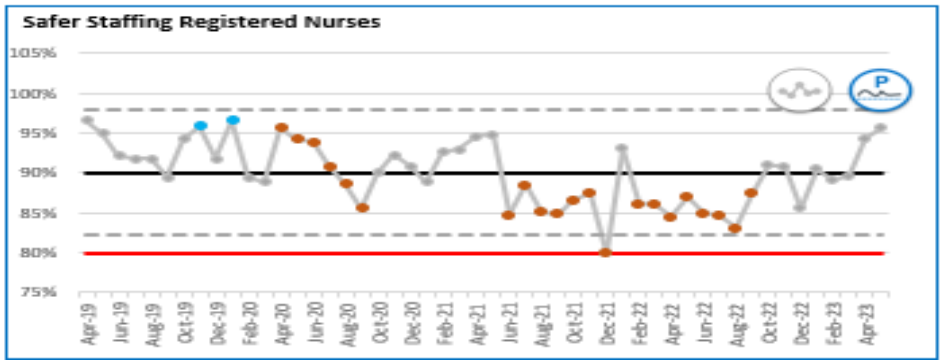
Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for review and for a decision 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 May 2023.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/004/MHRA	Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors, due to the potential for device failure	09/05/2023	Yes - circulated for information	12/05/2023	09/05/2023
NatPSA/2023/005/MHRA	Removal of Philips Health SystemsV60 and V60 Plus ventilators from service – potential unexpected shutdown leading to complete loss of ventilation.	18/05/2023	Yes - circulated for information	02/10/2023	
NatPSA/2023/006/DHSC	Shortage of pyridostigmine 60mg tablets	24/05/2023	Yes - circulated for information	26/05/2023	26/05/2023

Safer Staffing Inpatients





The chart above shows that as at May 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 May 2023 we remain in a period of common cause variation. Further information about staffing levels can be found on the previous page.

There has been a slight increased demand in April on the flexible staffing pool with a total of 68 additional shift requests. The number of shifts filled has increased including on inpatient areas. This is due to availability of substantive and flexible staff and the flexible approach to finding staff solutions from operational colleagues and support services. We continue to monitor staffing related Datix, in May there were 18 incidents recorded. Incident data is reviewed to look for hotspots and trend analysis of staffing deficits. Escalation and continuity plans are followed and are supported by the flexible staffing resource to ensure the delivery of safe and effective care. We continue to monitor the hours that staff work, and any working time directive breeches, to support staff wellbeing.

Although there has been an overall improvement, we continue to fall short of the registered nurse fill rate for day shifts and will continue to look at ways of improving this. This has meant that 18 wards, have fallen below the 90% first fill rate. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to aim for the delivery of high quality care, as well as being safe, however staffing levels have impacted on Section 17 leave being facilitated and 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 fourth month running one ward fell below the 90% overall fill rate threshold (Lyndhurst, 89%). Inpatient areas continue to experience high acuity as identified above. There are ongoing interventions, projects, and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. 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, 12 achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts.

Both bespoke adverts and centralised recruitment continues and there were four assessment centres throughout May/June which resulted in 18 registered nurse (RN) and 14 health care assistant (HCA) substantive job offers, as well as HCA bank band 2 and band 5 job offers being made.

Within band 5 RN recruitment, bespoke adverts as well as the international recruitment continues. To date we have had 64 internationally recruited band 5 nurses with 54 being on the inpatient wards throughout the Trust. We have received financial support from NHSE until quarter 3 2023/24 and are awaiting the outcome of the new NHSE funding bid.

The first agency scrutiny group, to look at our agency usage and plans for reduction is due to meet at the end of June. 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 safe and effective staffing remains a priority in all our teams, the focus for the flexible staffing resources has been Horizon Centre in Wakefield and across other areas as required. 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 0.2% to 88.7% in May compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have increased by 2.5% in April to 102.7% compared with the previous month.
Overall Registered Rate: 95.7% (increased by 1.35% on the previous month)
Overall Fill Rate: 123.5% (consistent with the previous month): Health care assistants showed a decrease in the day fill rate of 1.1% to 142.1% and the night fill rate increased by 0.2% to 151.2%.

Unfilled shifts
An unfilled shift is a shift that has been requested of the bank office, flexible staffing, and could not be covered by bank staff, agency or Over Time. 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	Unfilled Percentage		
Registered	338	(-24)	3593.67	28.58%	(-1.95%)	**834**	**(-19)**
Unregistered	332	(-6)	3668.5	7.98%	(-0.33%)	**4174**	**(+117)**
Grand Total	**670**	**(-30)**	**7262.17**	**11.75%**	**(-0.92%)**		

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. These figures allow us to monitor an increased request on the flexible staffing resource and look at what appropriate resources are required from the trust bank flexible staffing resource.

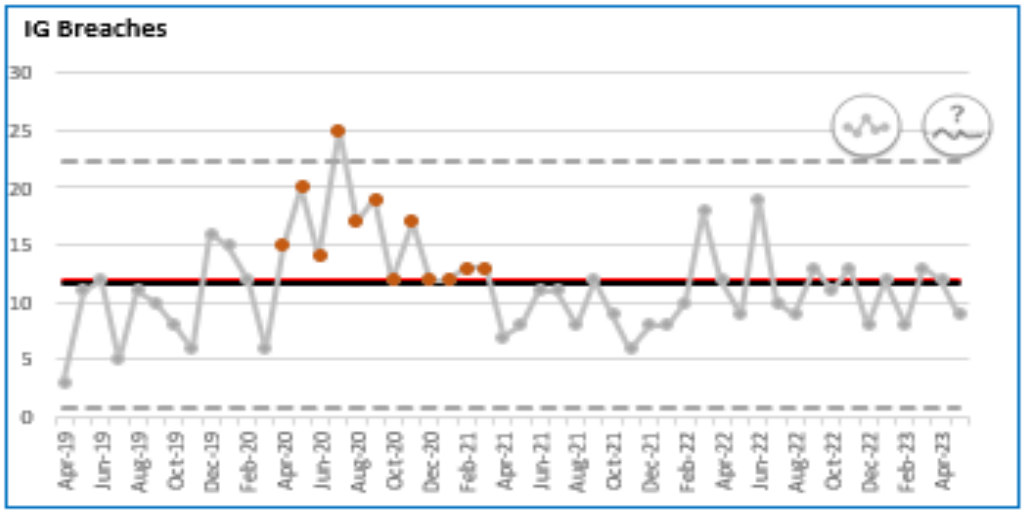
Information Governance (IG)

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

5 breaches involved information being disclosed in error. They were largely due to correspondence being sent to the wrong recipient or address, emails being sent with the wrong attachment and letters being sent with the wrong content.

Two amber incidents were reported. One involved a sensitive report intended for a patient's carer being sent to the wrong address, where it was opened, resealed and redirected to the carer. The duty of candour process has been followed and a manager's investigation completed. The other occured when a bundle of post items was found unsecured in a publicly accessible part of the Trust. Estates & Facilities have changed their process in response to the incident to prevent recurrence.

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



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

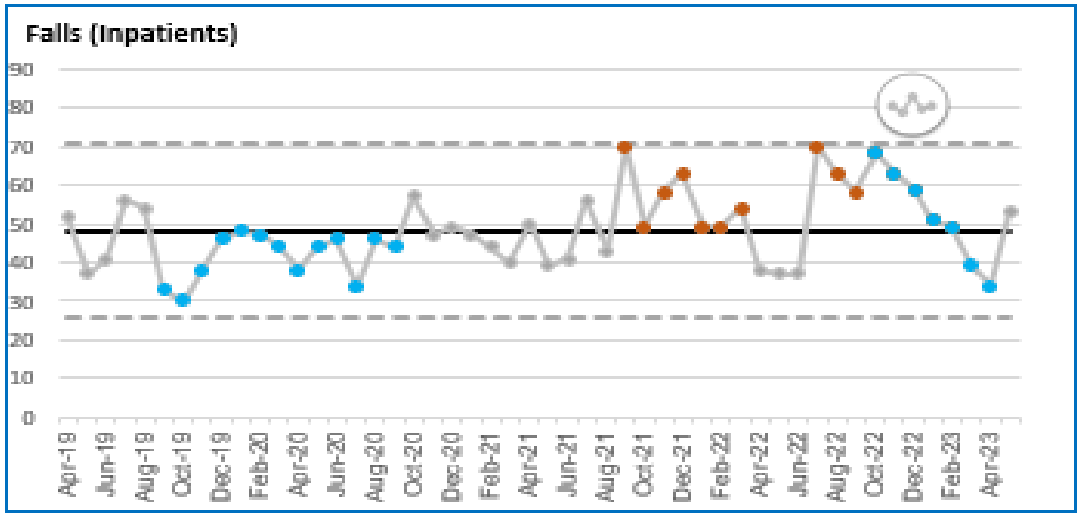
Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are now in place for 2023/24 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.

There are some new indicators in this years scheme and the Trust's CQUIN leads group are monitoring progress against the thresholds as we come towards the end of quarter 1. Further update around associated risks can be expected next month.

Falls (Inpatient)

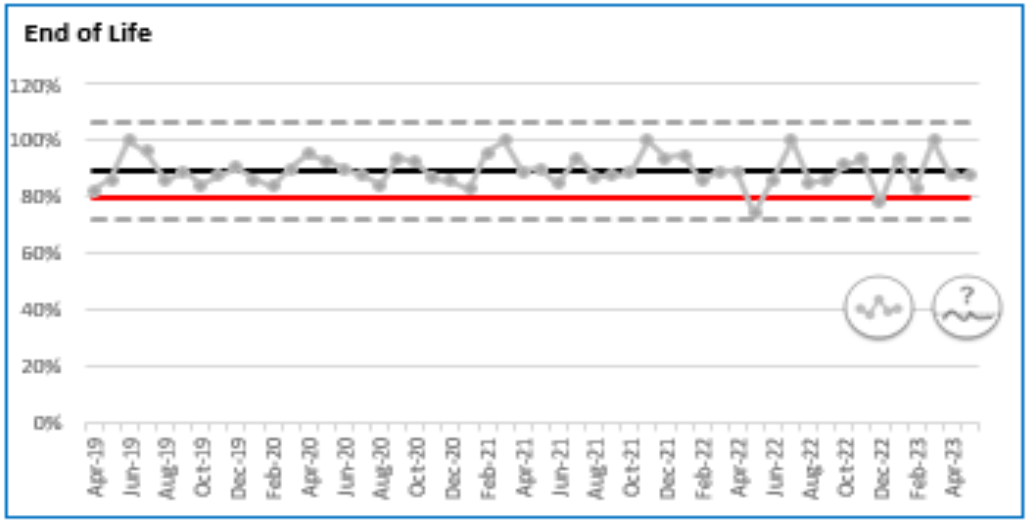
The total number of falls was 53 in May. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in May 2023, due to the slight increase 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 89.4% in May.



The chart above shows that in May 2023 the performance against the metric remains in common cause variation and therefore within an acceptable range. Due to fluctuation in the performance whether we will meet the target cannot be determined.

Patient Experience

Friends and family test shows

- 97% would recommend community services
- 85% would recommend mental health services

Mental Health Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
Community Services	85%	85%	83%	88%
Acute	85%	86%	93%	80%
Secure & Forensics	60%	71%	100%	72%
Other*	85%	93%	82%	82%
Total	**84%*** **	**83%**	**82%**	85%

Specialist Services Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
ADHD	85%	50%	44%	50%
CAMHS	75%	83%	76%	85%
Learning Disability	85%	100%	100%	100%

Community Services Friends and Family Test Results

	Target	Mar-23	Apr-23	May-23
Children & Families	95%	98%	93%	96%
Inpatient	95%	100%	100%	100%
Nursing	95%	91%	100%	100%
Other	95%	91%	100%	100%
Rehabilitation & Therapy	95%	98%	94%	97%
Specialist**	95%	94%	95%	93%
Total	**95%**	**95%**	**94%**	97%

*includes Insight team, perinatal, friends and family team

**includes equipment and adaptation service, neuro physiotherapy, podiatry

*** weighted for 2023/24

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 increased. The number of responses had declined across the Trust, this is due to the recent change in the text message. This is an expected decline, and work is ongoing to raise awareness of the new text message, supporting services using other feedback methods and identifying services who have not received Friends and Family Test feedback.

Where there are services that have not met the expected threshold of performance, there has been analysis undertaken of the feedback received and there are no themes or trends in the feedback which would indicate concerns. Numbers are too small to determine any learning. An accumulation of feedback over a longer period of time will be reviewed to ascertain themes and trends to ensure feedback is used effectively to inform change.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Access and waiting times
	3. Clinical Treatment	3. Patient Care
Community	1. Staff	1. Staff
	2. Clinical Treatment	2. Communication
	3. Patient Care	3. Clinical Treatment
Mental Health	1. Staff	1. Staff
	2. Communication	2. Access and Waiting Times
	3. Access and Waiting Times	3. Patient Care

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 May 2023, there were 47 Datix incidents categorised as Safeguarding Adults. No incidents were graded red, six were graded amber, 13 were graded yellow and 28 were graded green.
The incidents were categorised as follows: there were 12 emotional abuse, seven financial abuse, six sexual abuse, five physical abuse, five self-neglect, four domestic abuse, four neglect, one hate crime, one, radicalisation, one organisational and one failure in the safeguarding process.
All incidents were managed appropriately and safeguarding measures were put in place.
In addition to the safeguarding adults incidents, there were also 14 sexual safety Datix incidents where service users were the affected person. All of these incidents were graded as green or yellow.

Safeguarding Children:
In May there were 13 Datix incidents completed in relation to child safeguarding concerns. Four were classed as amber, medium risk and nine were classed as green, low risk. Three of the amber concerns identified were related to neglect, with the other case being classified as emotional abuse. All of the incidents were responded to appropriately and staff clearly demonstrated professional curiosity, considered the 'Think Family' approach, sought advice and shared information appropriately.

There has been an increase in compliance across most services. Childrens and adolescent mental health services staff are 100% compliant in both level 1 and level 2 safeguarding children training.

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 partially compliant with 1 criteria, for which there are mitigation actions in place. The IPC BAF will be reviewed quarterly.

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- Trustwide Total – 90%

A 12-month extension request for policies due 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 compliant, and there are no identified risks to note.

Change in Covid-19 Guidance:
Mask Wearing
From Monday 22 May 2023, staff were informed that they no longer need to routinely wear face masks. This applies to clinical and non-clinical areas.
There will be instances where masks will still be required. These include:

- When caring for patients with suspected or confirmed Covid-19.
- Covid-19 outbreaks.
- When dealing with clinically vulnerable service users - the decision for this will be based on the outcome of an individual risk assessment for a patient.
- Staff members returning to work who have been symptomatic with Covid-19 symptoms and/or been positive for Covid-19. Depending on the outcome of a risk assessment they may be required to temporarily wear a face mask.
- Staff are welcome to continue wearing a face mask if they wish. Our Trust will continue to provide face masks in main reception areas.

Covid-19 Testing
There were also changes to patient and staff testing requirement. This was in line with NHS guidance and local risk factor.
The decision was agreed by our Trust's operational management group (OMG) on the basis that the prevalence of Covid-19 has significantly improved.

Complaints

• Acknowledgement and receipt of the complaint within three working days – 79% for formal complaints.
• Number of responses provided within six months of the date a complaint received – 3 (38%)
• Number of complaints waiting to be allocated to a customer service officer – 30
• 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 – 9 weeks average.
• There were 19 new formal complaints in May 2023
• Of these 1 has a timescales start date, 13 are awaiting consent and 5 are awaiting allocation.
• 11% of new formal complaints (n=2) have staff attitude as a primary subject.
• 66 compliments were received.
• Customer services closed 8 formal complaints in May 2023.
• Number of concerns (informal issues) raised and closed in May 2023 – 30
• Number of enquiries responded to in March 2023 - 176
• Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 0

Reducing Restrictive Physical Intervention (RRPI)

There were 186 reported incidents of RRPI used in May 2023 this is within acceptable range.

86.6% of prone restraints in May 2023 lasted under three minutes.

In May 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 15 times of 283 (5.3%) of total restraint positions, this is a reduction of 5 from last month that stood at 20 of 291.

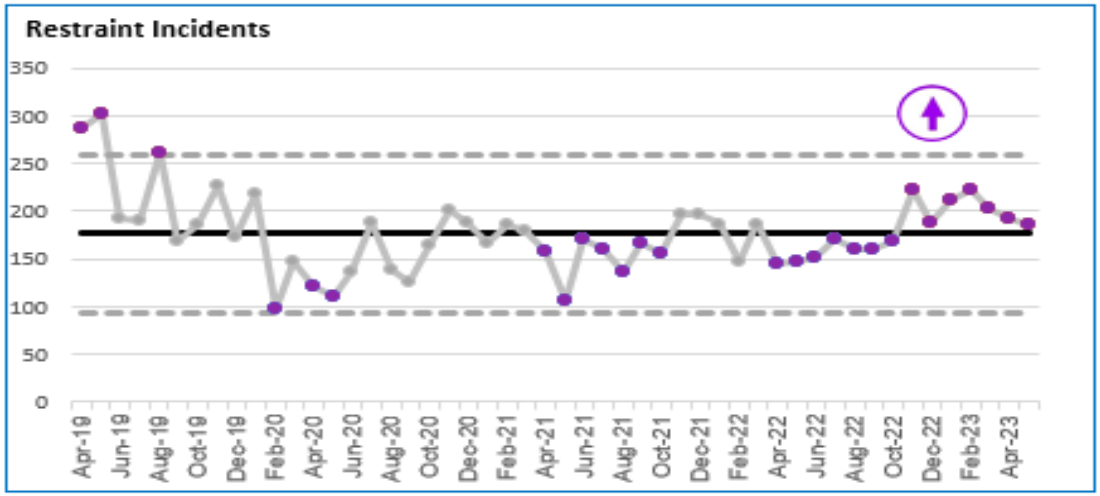
The prone restraint incident with a duration between 13-14 minutes was due to the service user requiring restraint in level 3 holds in a prone position to prevent further risk to self. The service user placed themselves on their front and was attempting to swallow a foreign object to choke. The cogent reason to remain in prone was to minimise the risk of choking. Medical and nursing colleagues were present throughout. The incident was discussed in a professionals meeting which was attended by RRPI specialist advisors and appropriate referral to speech and language therapy (SALT) services had been actioned. All actions taken were appropriate and support was given to both the service user and staff involved in the incident.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	107	37.8%
Seated	56	19.7%
Supine	38	13.4%
Safety Pod	32	11.3%
Prone	15	5.3%
Restricted escort	11	3.5%
Prone then rolled	10	3.8%
Side	8	2.8%
Kneeling	6	2.1%
Total	283	

Team Using Prone Restraint	Total
Beamshaw Ward - Barnsley	2
Horizon Centre Assessment and	2
Newhaven Forensic Learning Disabilities	2
Sandal Ward (Bretton Centre)	2
Stanley Ward, Wakefield	2
Walton PICU	2
Bronte Ward, Newton Lodge, Forensic	1
Elmdale Ward	1
Melton PICU, Barnsley	1
Total	15

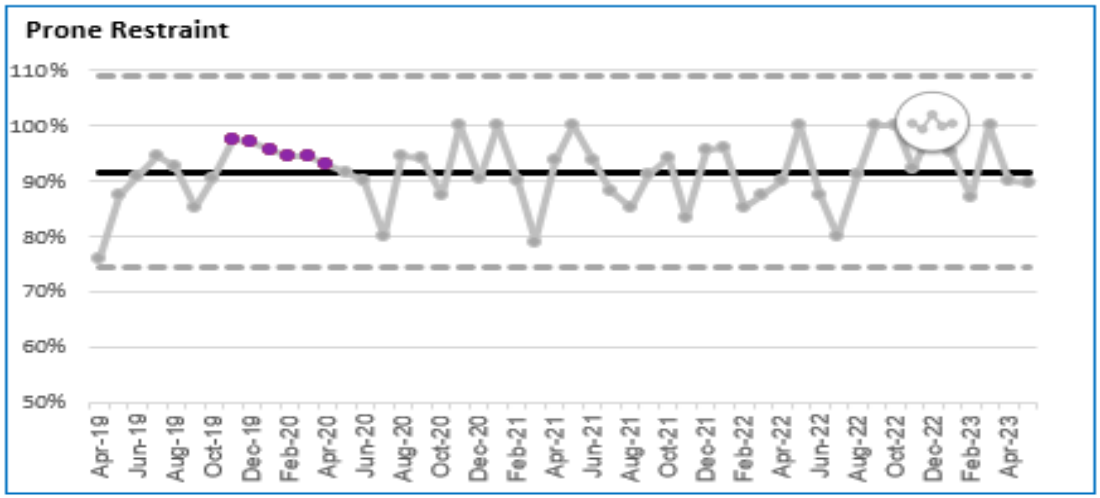
Duration of Prone Restraint Position	Total
0 - 1 minute	8
1 - 2 minutes	4
4 - 5 minutes	1
2 - 3 minutes	1
13 - 14 minutes	1
Total	15

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in May 2023 we have entered a period of special cause variation (purple markers).

It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.



This SPC chart shows that due to the continued variation in prone restraint incidents in May 2023 means that we remain in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

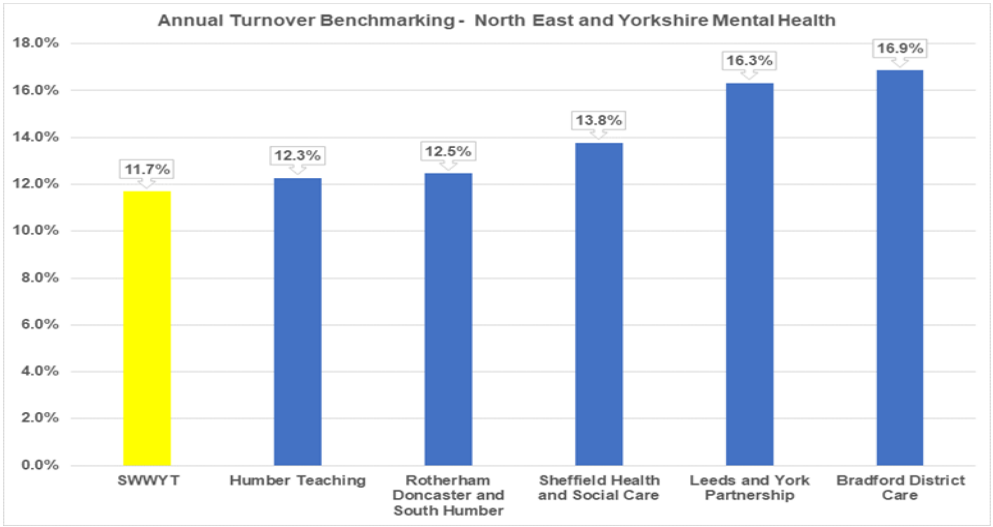
	Objective	CQC Domain	Threshold	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Establishment	Improving Resources	Well Led	-	4,960.2	4,933.5	5,011.2	5,039.4	5,145.9	5,156.5	5,197.9	5,237.9	5,246.6	5,267.2	5,157.4	5,174.0
Employed Staff (ESR last day in the month)			-	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	4,266.2
Vacancies			-	756.2	723.1	795.3	816.5	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0
Vacancy rate			<10%	15.2%	14.7%	15.9%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%
Turnover external (12 month rolling)			>12% - <13%	15.4%	15.5%	15.2%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%
Starters			-	56.5	46.4	58.1	69.5	56.9	50.5	26.6	65.4	70.2	58.1	42.9	54.1
Leavers			-	37.0	56.9	56.3	51.6	48.2	40.6	27.5	60.1	38.5	43.1	39.6	35.2
Sickness absence - Rolling 12 month			<=4.8%	4.6%	4.9%	4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	4.8%	5.5%	4.7%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%
Employees with long term sickness over 12 months			-	-	-	0	2	2	2	2	4	2	2	1	0
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	59.7%	55.8%	61.3%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%
Employee Relations - Suspensions (over 90 days)			-	1	1	2	2	2	2	3	3	1	1	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	86.9%	87.2%	90.7%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%
Mandatory Training - Reducing Restrictive Practice Interventions				73.6%	73.8%	73.8%	72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%
Mandatory Training - Cardiopulmonary Resuscitation				74.2%	74.6%	75.7%	75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%
Mandatory Training - Clinical Risk				96.2%	96.2%	96.4%	96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%
Mandatory Training - Display Screen Equipment				93.9%	94.3%	94.9%	95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%
Mandatory Training - Equality & Diversity				93.9%	94.1%	93.9%	94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%
Mandatory Training - Fire Safety				87.1%	87.4%	87.1%	86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%
Mandatory Training - Food Safety				79.4%	79.3%	79.8%	79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%
Mandatory Training - Freedom To Speak Up (FTSU)				85.5%	86.8%	88.2%	89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%
Mandatory Training - Infection Control & Hand Hygiene				87.0%	87.3%	87.7%	88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%
Mandatory Training - Information Governance (Data Security)			>=95%	92.9%	92.9%	92.5%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%
Mandatory Training - Moving & Handling			>=80%	95.6%	95.7%	95.3%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%
Mandatory Training - Nat Early Warning Score 2 (New S2)				82.6%	84.3%	85.6%	86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%
Mandatory Training - Mental Capacity Act/Dols				93.4%	93.3%	93.5%	93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%
Mandatory Training - Mental Health Act				89.4%	89.5%	90.4%	90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%
Mandatory Training - Prevent				94.4%	94.6%	95.1%	95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%
Mandatory Training - Safeguarding Adults				88.8%	89.1%	89.7%	89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%
Mandatory Training - Safeguarding Children				89.9%	89.9%	89.7%	90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%

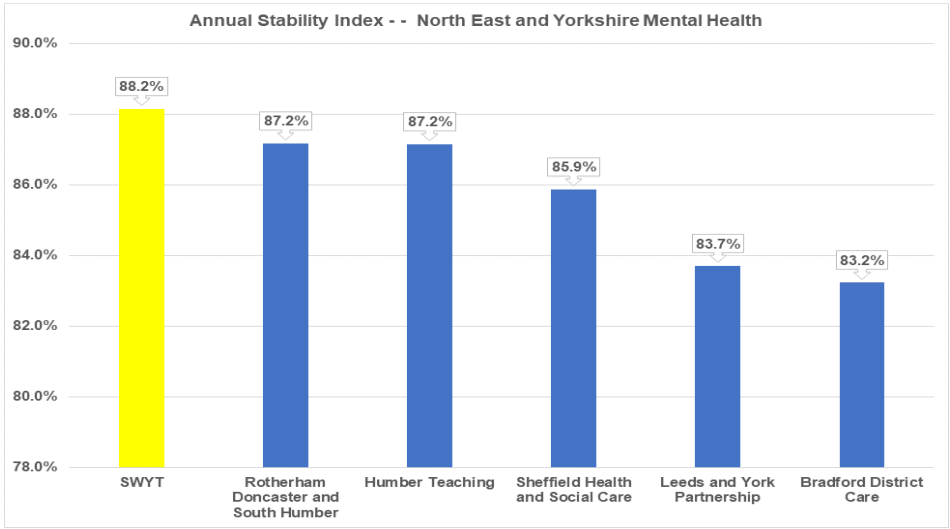
Notes:

- Employed Staff (Electronic 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.
- Sickness absence - from April 23 - the reported figure is rolling 12 month. For earlier months this was year to date.

Stability of the Workforce

- Substantive staff in post has increased by 9.2 whole time equivalents (WTE) in May.
- Staff in post workforce growrth since April stands at 0.59% against a target of 3% for the year (on target)
- Rolling and year to date turnover is 12.2%. When benchmarked against the latest workforce statistics 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 the staff stability index (staff in post over 1 year).





Keep Fit & Well

Absence

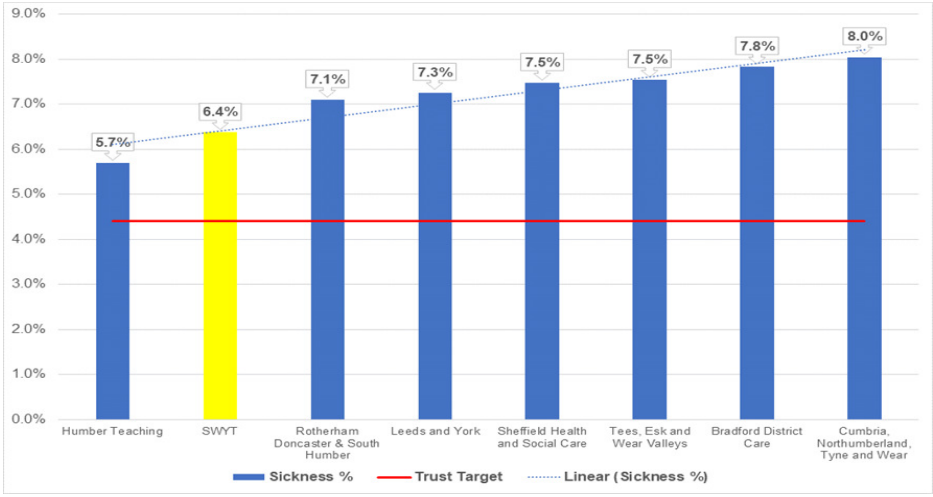
• 12 month rolling absence rate remains at 5.3%.

• Forensics absence saw an increase in month to 6.9% making the year to date position 6.6%. Focused support with managers on long term sickness, has been undertaken in the care group which has previously had a positive effect on the absence rate.

• Estates and Facilities absence increased during May to 6.5% (6.0% year to date) - focus remains on 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 37%.

• 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 May, the percentage rate increased by 0.5% to 74.9%.

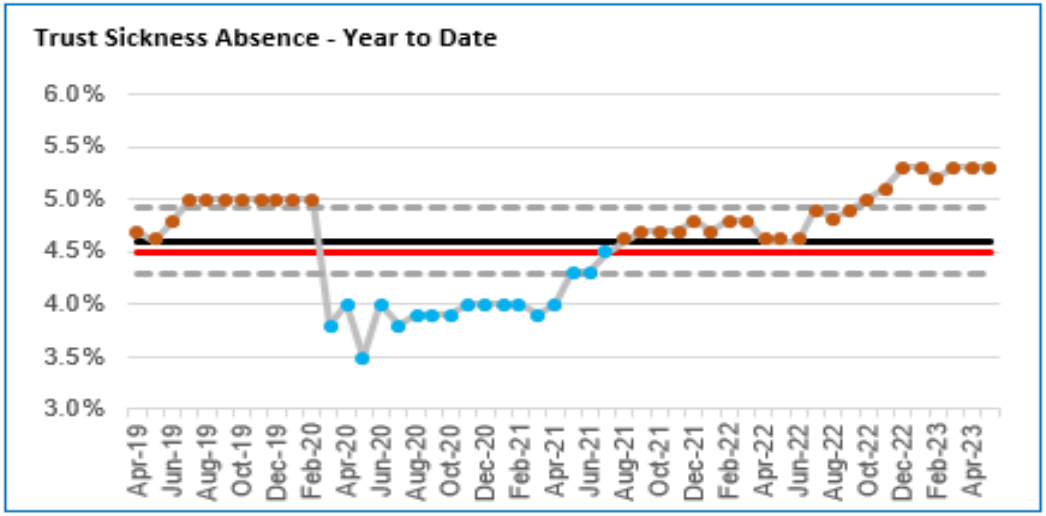
Mandatory Training

• Overall mandatory training reports 90.9% which remains above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by operational management group.

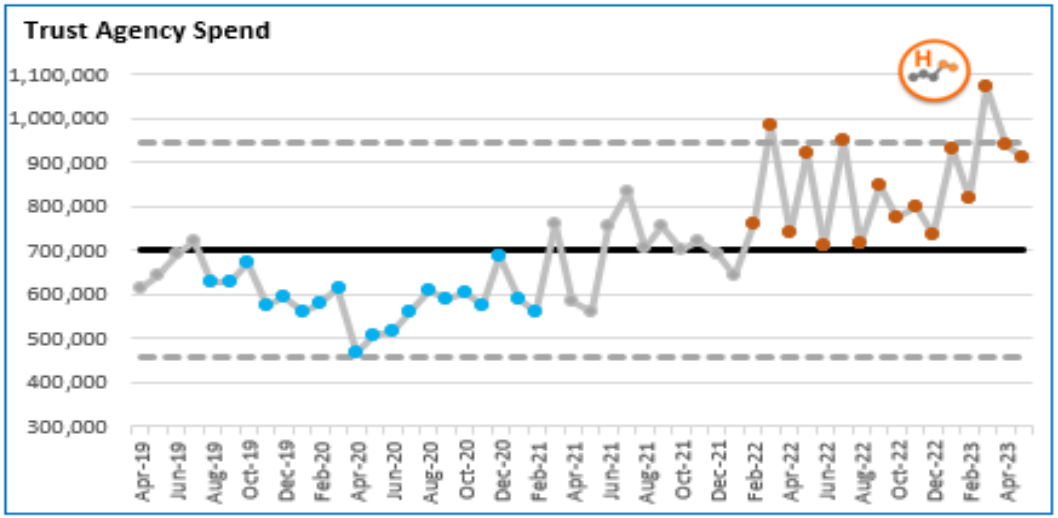
• Two subjects out of 17 reported are below the Trust's 80% target - these are resuscitation and reducing restrictive practice interventions. Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, the introduction of an e-learning suite to increase 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.

• The Trust has exceeded its 95% target for Information Governance training for substantive staff. The Trust has also achieved the standard for food safety this has been achieved by improving the learning offer.

Analysis



The SPC chart shows that as at May 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 SPC chart shows that in May 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). Monthly agency performance group established to commence in June for all care groups.
- Alternative marketing campaigns to engage wider markets.
- Significant increase in assessment centre recruitment events – 8 since April (usually 1 per month) over 370 potential candidates into bank and substantive healthcare support worker and nurse posts. This will have a positive impact upon agency provision in future months.
- We are reviewing our three main staff group agency contracts to maximise financial efficiency and we have commenced an external review (Liaison workforce) of our bank, agency and e-rostering efficiency (report due July).

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) were 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 was a year of transition as Integrated Care Boards ICBs were formally established and new collaborative arrangements are developed at system level. ICBs are now lead for the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. No further update has been provided for 2023/24 to date. The Trust will continue to monitor for any changes.
• 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	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Data quality rating [8]	Variation/ Assurance
The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.	Improving Care	Responsive	CH	SC	0	0	0	0	0	0	0	0	0	0	0		
Inappropriate out of area bed days	Improving Care	Responsive	CH	SOF/LTP	Q1 - 455	1245	874	1359	1504	439	482	511	511	457	574		
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%	86.6%		
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%	84.8%	92.6%	94.4%	81.3%	96.7%	94.4%		
NHS Talking Therapies (formerly 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%	52.6%	57.1%	53.9%	53.6%	52.7%	*53.6%*		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Barnsley	Improving Health	Responsive	CH	LTP	Per Quarter - 1563	1379	1202	1224	1441	377	500	461	480	456	500		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Kirklees	Improving Health	Responsive	CH	LTP	No Target Set	2437	2383	2457	2656	698	978	792	886	724	929		
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%	93.5%	95.1%	95.7%	97.5%	97.9%	98.9%		
Number of people accessing Individual Placement Support (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	40 Calderdale 37 Kirklees 31 Wakefield			Due July 2023			
Number of individuals accessing specialist community perinatal and maternity mental health services	Improving Care	Responsive	CH	LTP	Q1 - 316	480	285	225	222	84	81	57	84	342	130		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	Improving Care	Responsive	CH	SC	99%	91.7%	95.9%	86.2%	79.8%	86.2%	88.0%	91.6%	79.8%	60.7%	53.3%		
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	Improving Health	Responsive	CH	SC	80%	84.6%	89.0%	88.1%	87.8%	88.9%	87.9%	89.6%	86.6%	90.3%	88.2%		
NHS Talking Therapies (formerly IAPT) - Treatment within 6 weeks of referral	Improving Health	Responsive	CH	SC	75%	94.7%	97.5%	98.4%	97.8%	98.5%	97.7%	97.6%	98.1%	97.7%	*98.6%*		
NHS Talking Therapies (formerly IAPT) - Treatment within 18 weeks of referral	Improving Health	Responsive	CH	SC	95%	100.0%	100.0%	99.8%	99.9%	99.5%	99.8%	100.0%	99.8%	*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%	100.0%	87.5%	80.0%	87.5%	33.3%	80.0%		
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%	88.2%	88.6%	100.0%	100.0%	75.0%	89.5%		
Data Quality Maturity Index	Improving Health	Responsive	CH	SC	95%	98.5%	99.5%	99.4%	98.6%	99.1%	99.4%	98.2%	98.2%	98.0%	*97.6%*		

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Data quality rating [8]	Variation/ Assurance
Total bed days of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	16	44	23	52	0	8	31	44	15	11		
Total number of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	1	2	4	3	0	2	2	2	3	1		
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%	100.0%	98.9%	99.0%	98.2%	100.0%	99.0%		
% 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%	96.9%	95.8%	95.4%	97.6%	97.1%	97.4%		
% clients in settled accommodation	Improving Health	Responsive	CH	O	60%	88.3%	87.2%	85.7%	84.5%	85.2%	84.4%	84.4%	84.6%	84.4%	*84.1%*	⚠	
% clients in employment	Improving Health	Responsive	CH	O	10%	11.1%	11.8%	11.7%	11.4%	11.4%	11.6%	11.4%	11.2%	11.1%	*11.5%*	⚠	
Completion of improving access to psychological therapies (NHS Talking Therapies (formerly 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%	98.5%	98.1%	99.1%	98.9%	98.9%	*95.4%*		
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%	99.4%	99.4%	99.4%	99.5%	*99.4%*		
The number of completed non-admitted RTT pathways in the reporting period	Improving Care	Responsive	CH	LTP	18000 (1500 per month)	Reporting from 23/24								1523	1719		
The number of incomplete Referral to Treatment (RTT) pathways	Improving Care	Responsive	CH	LTP	27900 (split 2500 p/m A-J; 2400 J-S; 2300 O-D; 2200 J; 2100 F; 2000 M	Reporting from 23/24								1933	1835		
Count of 2-hour urgent community response first care contacts delivered within reporting quarter	Improving Health	Responsive	CH	SOF/LTP	Q1 2800, Q2 2500, Q3 3700, Q4 3100	Reporting from 23/24								Due July 2023			
Virtual ward occupancy	Improving Care	Responsive	CH	LTP	80%	Reporting from 23/24								82.9%	44.3%		
Community services waiting list (report split by 0-17; 18+)	Improving Health	Responsive	CH	LTP	Q1 5652, Q2 5430, Q3 5469, Q4 5198	Reporting from 23/24								Due July 2023			
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	Improving Health	Responsive	CH	LTP	Plan per Place/ Trust level	Reporting from 23/24								Due July 2023			
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Improving Health	Responsive	CH	LTP	Plan per Place/ Trust level	Reporting from 23/24								Due July 2023			

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 98.9%

• 72 hour follow up remains above the threshold at 88.2%. We remain 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 53.3% in May. This remains below threshold and has now entered a period of special cause concerning variation (please see SPC chart on the next page). 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.

• 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 May 4 out of 5 urgent cases were seen within 1 week, this has taken the performance below threshold at 80%.

• During May 2023, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 11 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 however both are above their respective thresholds.

• 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.

• NHS Talking Therapies - proportion of people completing treatment who move to recovery remains above the 50% target at 53.6% for May. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

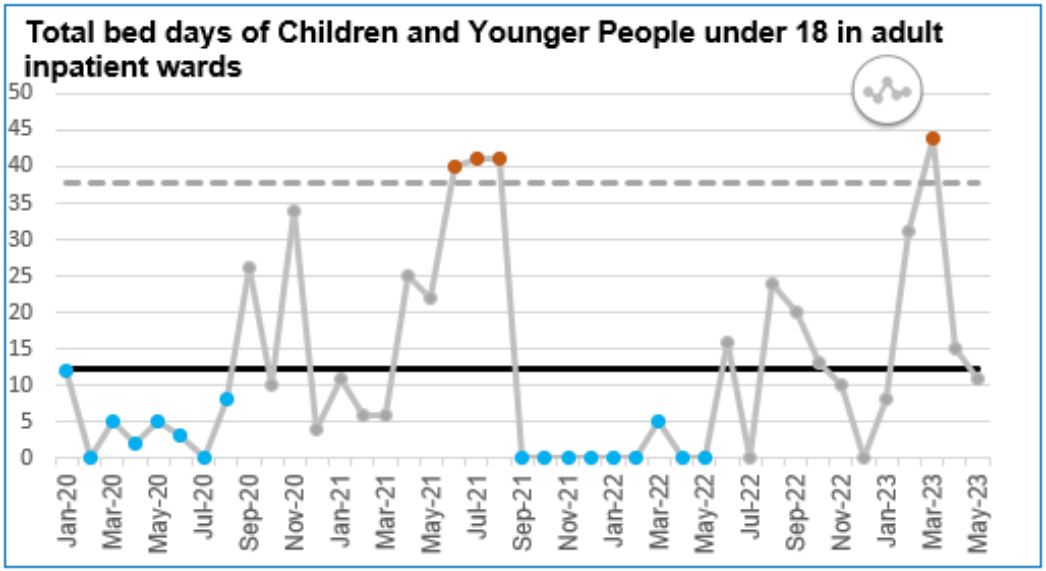
• Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold during the month of May. This metric has entered a period of special cause improving variation due to continued (more than 6 months) performance above the mean. Fluctuations in the performance mean that achievement of the threshold cannot be estimated.

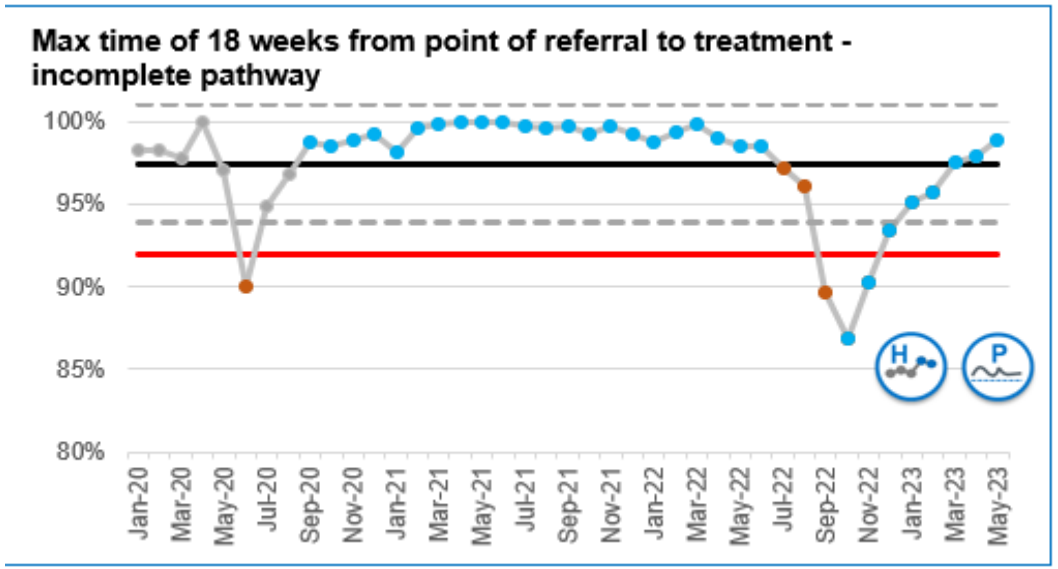
Data quality:
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of May the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.7% 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.

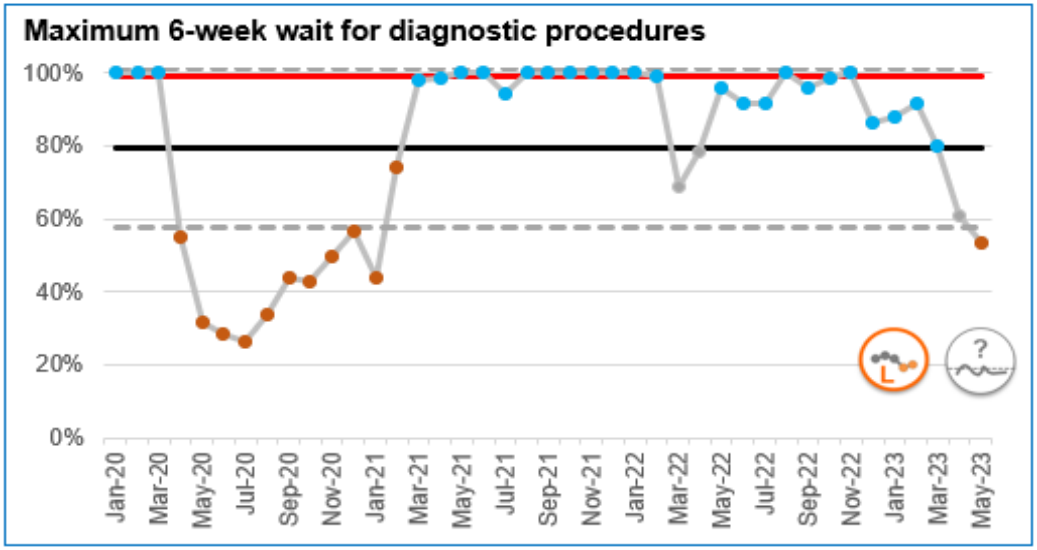
Analysis

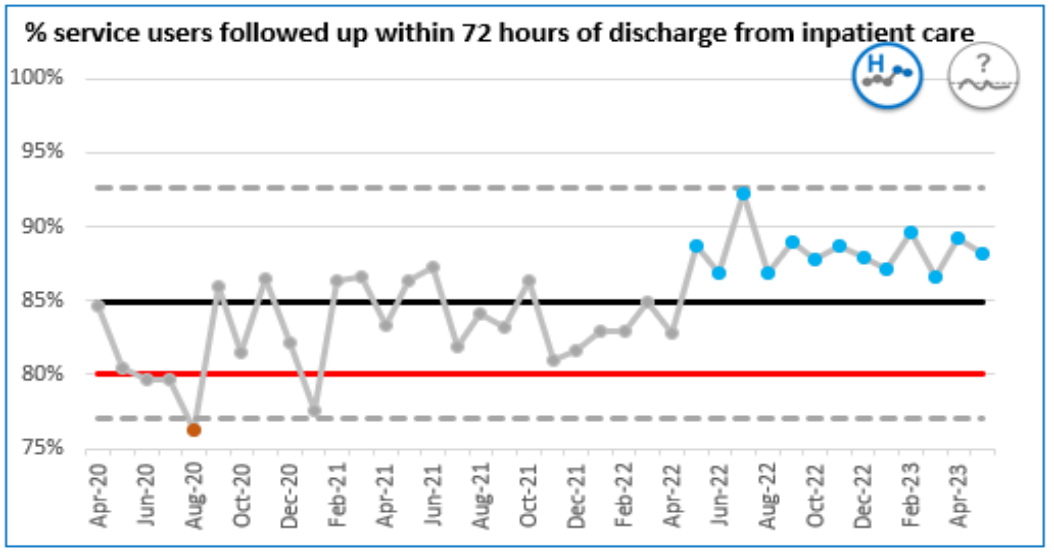




The statistical process control charts (SPC) above show that in May 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards. After consecutive periods of improvement against the referral to treatment metric we remain in a period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

Analysis





The SPC charts above show that for May 2023 for clients waiting for a diagnostic procedure we have entered a period of special cause concerning 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.

Current average OPEL level

2.78

Key

- OPEL Level 1
- OPEL Level 2
- OPEL Level 3
- OPEL Level 4

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	76.8%	75.1%	
% Assessed within 14 days of referral (Routine)	75%	60.4%	68.6%	
% Assessed within 4 hours (Crisis)	90%	97.4%	97.5%	
% Complaints with staff attitude as an issue	< 20%	9% (1/11)	0% (0/5)	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.3%	88.2%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.4%	98.5%	
% Treated within 6 weeks of assessment (routine)	70%	97.6%	98.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.2%	78.1%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	80.7%	*94.6%*	
Information Governance training compliance	>=95%	86.9%	97.1%	
Reducing restrictive practice interventions training compliance	>=80%	69.5%	69.5%	
Sickness rate (Monthly)	4.5%	5.5%	5.0%	
% rosters locked down in 6 weeks				

Barnsley General Community Services

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	77.7%	79.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	33% (1/3)	
% people dying in a place of their choosing	80%	87.5%	87.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.5%	82.7%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	91.9%	95.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	97.9%	98.9%	
Maximum 6 week wait for diagnostic procedures	99%	60.7%	53.3%	
Reducing restrictive practice interventions training compliance	>=80%	33.3%	50.0%	
Safer staffing (inpatient)	90%	110.7%	114.0%	
Sickness rate (Monthly)	4.5%	4.6%	4.3%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	42.9%	52.3%	
% Bed occupancy	85%	86.3%	88.7%	
% Complaints with staff attitude as an issue	< 20%	40% (2/5)	20% (1/5)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.5%	74.7%	
% of clients clinically ready for discharge	3.5%	3.3%	2.9%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	90.6%	*87.7%*	
Inappropriate Out of Area Bed days	152	457	574	
Information Governance training compliance	>=95%	90.6%	94.3%	
Physical Violence (Patient on Patient)	Trend Monitor	18	23	
Physical Violence (Patient on Staff)	Trend Monitor	66	42	
Reducing restrictive practice interventions training compliance	>=80%	79.2%	79.9%	
Restraint incidents	Trend Monitor	123	***110***	
Safer staffing	90%	126.9%	128.1%	
Sickness rate (Monthly)	4.5%	4.8%	4.2%	
% rosters locked down in 6 weeks				

Forensic

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	67.2%	69.3%	
% Bed occupancy	90%	88.5%	87.8%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/0)	
% Service Users on CPA with a formal review within the previous 12 months	95%	92.6%	96.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.4%	83.1%	
% of clients clinically ready for discharge	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%	88.6%	95.2%	
Physical Violence (Patient on Patient)	Trend Monitor	0	3	
Physical Violence (Patient on Staff)	Trend Monitor	8	18	
Reducing restrictive practice interventions training compliance	>=80%	83.0%	83.6%	
Restraint incidents	Trend Monitor	18	***37***	
Safer staffing	90%	116.9%	113.5%	
Sickness rate (Monthly)	5.4%	6.5%	6.9%	
% rosters locked down in 6 weeks				

LD, ADHD & ASD

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	69.3%	72.1%	
% Complaints with staff attitude as an issue	< 20%	100% (1/1)	0% (0/3)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	82.6%	
% of clients clinically ready for discharge	3.5%	25.0%	25.0%	
Information Governance training compliance	>=95%	86.3%	94.2%	
LD – First face to face contact within 18 weeks	90%	72.9%	78.5%	
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	42	33	
Reducing restrictive practice interventions training compliance	>=80%	75.1%	78.6%	
Safer staffing	90%	140.7%	143.2%	
Sickness rate (Monthly)	4.5%	4.6%	5.2%	
Restraint incidents	Trend Monitor	43	***31***	
% rosters locked down in 6 weeks				

CAMHS

Metrics	Threshold	Apr-23	May-23	Variation/ Assurance
% Appraisal rate	>=90%	80.4%	80.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/3)	
CAMHS - Crisis Response 4 hours	N/A	93.9%	98.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.7%	80.3%	
Eating Disorder - Routine clock stops	95%	75.0%	89.5%	
Eating Disorder - Urgent/Emergency clock stops	95%	33.3%	80.0%	
Information Governance training compliance	>=95%	90.4%	96.7%	
Reducing restrictive practice interventions training compliance	>=80%	69.8%	72.2%	
Sickness rate (Monthly)	4.5%	3.8%	3.2%	
% rosters locked down in 6 weeks				

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

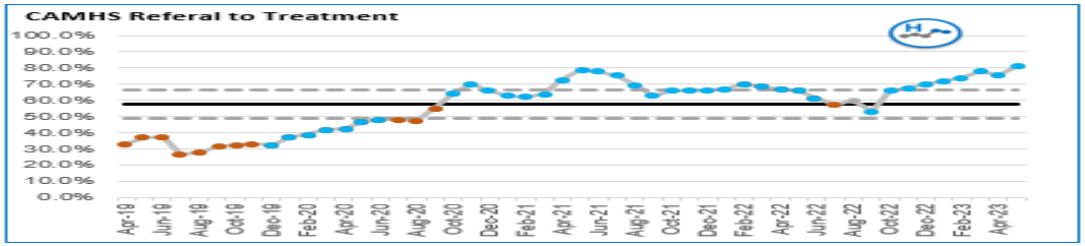
• Waiting numbers for Autistic Spectrum Conditions (ASC)/Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans in place (with Transformation Programme support) – but a shortfall between commissioned capacity and demand remains:
  • Kirklees waiting list now 1,568 with referrals 160+ per month and commissioned capacity of 64 assessments per month.
  • Calderdale waiting list now 260. Referrals reduced significantly since introduction of any qualified provider arrangement (average 10 per month) – but some concern regarding delays/blockage at the point of screening/choice (as facilitated by Northpoint).
• Eating disorder routine clock stops under threshold (89.5%) – 2 cases breached 1 Barnsley, 1 Kirklees and urgent clock stops also under threshold (80%) – 1 breach Kirklees. Eating disorder caseloads remain under pressure due to case acuity/complexity.
• 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, in Trust inpatient beds and on section 136 suites. This is noted on the Trust 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 (YOI) and Adel Beck secure children's home continues. Specific issues in relation to recruitment of band 6 nursing staff.
• Self-harm incidents/risk a key focus of improvement work at Wetherby young offenders institute

Advise

• 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.
• Work in Kirklees continues - as part of a Kirklees 'Keep in Mind' programme – to develop the mental health support team offer across all local schools/colleges.
• 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 YOI. Progress being made in implementing action plan.
• Work programme underway to ensure more seamless transition to adult ADHD/ASC pathway.

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. Sickness rates remain low.
• 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.



As you can see in May 2023, we remain in 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 Band 7 Nurse Prescriber left the service in November 2022 and leaves only one Nurse Prescriber (Lead Nurse who is currently working from home due to their clinical vulnerability). This creates pressure and some risk within the service. To date we have been unable to recruit through bank/agency on a temporary basis or to cover period of recruitment. We are currently working with pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary.
• The service has a high level of sickness absence which is causing additional pressures in the team. We have been unsuccessful in attempts to cover this through bank/agency, but the team has been supported by staff within general community services.
• Following a recent visit by the Integrated Care Board (ICB) quality team, the feedback has been very positive, however they have suggested a resilience review with regard to staffing levels.

Advise

• Live Well Wakefield - awaiting outcome for bid submitted for the tender of service is association with NOVA.
• South Yorkshire Integrated Care Board (ICB) are expected to publish the virtual ward technology procurement documents later this month. The aim is to procure a single remote monitoring technology provider across the region with each provider organisation holding an individual contract. SWYPFT were given a 'one off' funding allocation to fund this contract; it is expected that the technology will be deployed from late August 2023. Therefore it is unlikely that SWYPFT will utilise the full funding within the 2023/2024 financial year. Discussions may be required around the potential option to accrue the funding to the 2024/2025 year.
• The paediatric epilepsy nursing service is experiencing staffing pressures due to existing staff secondments and a member of staff who was providing backfill now leaving the Trust for a permanent position elsewhere. This is being managed internally within the team.

Health Integration Team Urban House (UH):
• The commissioner is reviewing current health provision for the 6 resettlement programmes in Wakefield including UH. Following the meeting with the commissioners in January 2023, a discussion paper was submitted as to how we can work collaboratively with primary care to ensure the delivery of equitable services for all those clients within the resettlement programmes in Wakefield. We have since met with the commissioner and discussed a potential collaborative approach to service delivery with Primary Care and the commissioner will now arrange further meetings with partner organisations as to next steps. To date we have not received any further update.
• There is currently a chicken pox outbreak in Urban House; this is being managed with key partners.

Barnsley general community services continued:

Assure

• Excellence Awards May 2023:
Winners in Leader of the Year and Unsung Hero awards.
Highly commended for Excellence in Improving Health (School Age Immunisation Service), Partnership Working Excellence (Virtual Ward pathway), and Social Responsibility and Sustainability Excellence (Live Well Wakefield Social Prescribing Model).
• Successful recruitment process for permanent appointment to Associate Director of Operations post.
• Yorkshire Smokefree Sheffield - successfully procured a supplier to supply the service with vapes.
• ReSPECT – SWYPFT go live date was 5 June with a graduated introduction. Communication has been updated on intranet in terms of training, standard operating procedures etc.
• Regional stroke conference took place in May and our team won best poster for the BP@Home work. The team also led on two workshops (vocational rehabilitation and stroke drop in cafes). We also had a further poster display on the Life After Stroke Group which is held at Tesco in Barnsley.
• A piece of development work is to commence later this month with Adult Social Care colleagues to develop enhanced collaborative working between SWYPFT community nursing staff and Barnsley metropolitan borough council adult social care teams. This will enable greater synergies to occur between both teams across all neighbourhood areas. This work will commence in the North-East neighbourhood before being rolled out across the other five neighbourhood areas.
• A task action group is being developed in collaboration with the GP federation and the local authority to look at out of hours provision and more co-ordinated integrated working. A presentation on this work stream is to be delivery at the Urgent Care Board and the Barnsley Place Delivery Group.
• Increased interest in vacancies advertised on NHS jobs – Vacancy factor reducing in Neighbourhood Nursing Service (NNS).
• The Paediatric Epilepsy Nursing Service have commenced a trial of the HAMHA (Huddersfield Application for Mental Health Assessment) mental health risk assessment for non-mental health professionals. The service is working with SWYPFT quality improvement team and the University of Huddersfield (Mike Doyle) on this project and trial.

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

Alert/Action

• AQP (Any Qualified Provider) - Calderdale AQP (Any Qualified Provider) for Neurodiversity officially launched on 1st May 2023. The service is still working through the detail with commissioners.
• Friend & Family Test – Friends and family test is 50%. The service is continuing to explore different methods of collating and using feedback to improve services.

Advise

ADHD
• For ADHD the Calderdale AQP makes no change to the offer, all complete referrals that meet the service criteria are accepted. There are currently 776 people on the waiting list for ADHD assessment. The Service receives circa 64 referrals each month. Waiting lists are monitored through the normal governance mechanisms within the service.
Autism
• In line with other AQP's specification the service is working to understand any potential risks with respect to costs, clinical care and waiting list and explore risk management options that may need to be put in place to mitigate its impact.

Collaboration with Bradford
• This work continues to progress really positively and learning from this piece of work is being shared across all commissioners across the Trust.

Assure

• All KPI targets 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

Community Services
• Work on the reduction of waiting times continues. During this phase of the work Calderdale has been the focus with the intention to role out the improvements across all localities. The work should enable teams to intervene sooner. Training sessions planned for staff.
• Locality TRIOs are now in place.
• Focus on sickness absence with support provided by the People Directorate.

ATU (Assessment & Treatment Unit)
• Horizon improvement programme continues to make progress. Improvements continue to embed and staff involvement and engagement remains a priority.
• Recruitment to posts which were previously shared posts (with Bradford) is underway.
• People who are clinically ready for discharge (previously delayed transfers of care) is currently 25% and reflects system challenges in provision of bespoke packages of care to meet complex needs.

Advise

Community & ATU (Assessment & Treatment Unit)

- Service is working with the executive sponsor (Dr Thiyagesh) with the priority set as collaborative working across the Trust re Green Light Toolkit.
- Community improvement programme is planned and will follow the same format as the Horizon plan.
- Robust plans in all localities to celebrate LD week.
- Horizon environment continues to improve with clear evidence of personalised care.
- Appraisal currently 67.9%↑
- Potential service gap for people with an LD who require and ADHD assessment. The service will liaise with colleagues and commissioners to work towards a solution.
- Out of hours service currently being mobilised.

Assure

ATU (Assessment & Treatment Unit)

- Recruitment continues to progress. A senior Occupational Therapist has been appointed at Horizon and this has been a gap for a considerable period of time.
- Robust plans in place to address mandatory training, supervision, and appraisal shortfall and progress is being monitored closely.
- Benchmarking against CQC 'Outstanding' rated services has been undertaken and will be presented to the improvement group.

Community

- Waiting List mitigation includes more frequent data cleansing and the establishment of an early alert system which will help teams to potentially avoid delays in appointments.
- Annual health checks across all 4 localities are continuing to improve.
- Wellbeing plans in place for both Horizon and community services.

Forensic services:

Alert/Action

• Bed Occupancy – Newton Lodge 84.62, Bretton 95.33%, Newhaven 87.5%. Occupancy in Newhaven is impacted by recent discharges and occupancy in Newton Lodge is impacted by empty beds at the rehabilitation part of the pathway.
• Sickness absence/Covid absence – remains above the care group target but has reduced to 6.7%.
• Vacancies & Turnover – Turnover remains high 14.9%. Recruitment & Retention remains a priority.
• Care programme approach reviews within 12 months - under target at 96.30% though represents a significant improvement.
• QNFMHS (Quality Network Forensic Mental Health Services) – Developmental review has taken place in early May. The service awaits the report.
• CQC – 9 out of 11 wards were visited in the full inspection in May. Work has been undertaken to address the issues identified throughout the visit which includes significant improvements made to the way that ligature risk assessments are managed.

Advise

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative.
• Mandatory training overall compliance:
  Newton Lodge – 90.9%
  Bretton – 89.6%
  Newhaven –89.8
The above figures represent the overall position for each service.
• The roll out of Trauma Informed Care is going well and training sessions for staff have commenced with some staff having completed all four modules.
• Appraisal (69.4%) & supervision remain a priority.
• The wellbeing of staff also remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying three key areas to focus on. There is a strong level of engagement within the care group.

Assure

• High levels of data quality across the Care Group (100%).
• 100% compliance for HCR20 (historical clinical risk management – relating to the risk of violence) being completed within 3 months of admission.
• All Equality Impact Assessments (EIA) across Forensic Services have been completed for 2023/24.
• Positive feedback received from the commissioning hub relating to the 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 with increased use of agency staff.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed.
• 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, 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, although the latter has seen significant improvement this month.
• Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming months.
• 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 Calderdale, Kirklees and Wakefield, with Barnsley sustaining significant improvement, 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 wellbeing 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 for acute inpatient wards we are committed to a trajectory of all appraisals being completed by mid July.
• We are looking at our performance regarding Friends and Family Tests, both in the content of responses and numbers completed and developing actions to improve.
• 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

• Calderdale memory service has been successful in its reaccreditation 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. As part of this process they were awarded the Sustainable Mental Health Service Commendation, in recognition of their work towards achieving a sustainable mental health service and meeting 90% of the College Centre for Quality Improvement (CCQI) sustainability standards.
• 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.

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

Performance Indicator		Target	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	Breakeven	£0m	£0m	In May 2023 the financial position is a deficit of £0.2m which is lower than plan. Year to date there is a surplus of £44k. The main driver in this movement from month 1 is the estimated impact of the national Agenda For Change pay award with estimated expenditure being higher than estimated income. The forecast position will be assessed by the end of the first quarter. The target is breakeven.
2	Agency Spend	£8.7m	£1.8m	£9.8m	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 May is £908k and year to date is 13% above the plan trajectory.
3	Financial sustainability and efficiencies	£12.0m	£1.5m	£11.1m	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. Scheme realisation is required in year to ensure that this target is met.
4	Cash		£77.7m	£76.9m	The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£8.8m	£0.8m	£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 £0.8m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	95%	97%		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.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 2 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to Date	Forecast 2023 / 24	Narrative
1	Surplus / (Deficit)	£0m	£0m	In May 2023 the financial position is a deficit of £0.2m which is lower than plan. Year to date there is a surplus of £44k. The main driver in this movement from month 1 is the estimated impact of the national Agenda For Change pay award with estimated expenditure being higher than estimated income. The forecast position will be assessed by the end of the first quarter. The target is breakeven.
2	Agency Spend	£1.8m	£9.8m	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 May is £908k and year to date is 13% above the plan trajectory.
3	Financial sustainability and efficiencies	£1.5m	£11.1m	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. Scheme realisation is required in year to ensure that this target is met.
4	Cash	£77.7m	£76.9m	The Trust cash position remains strong at £77.7m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£0.8m	£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 £0.8m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	97%		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.

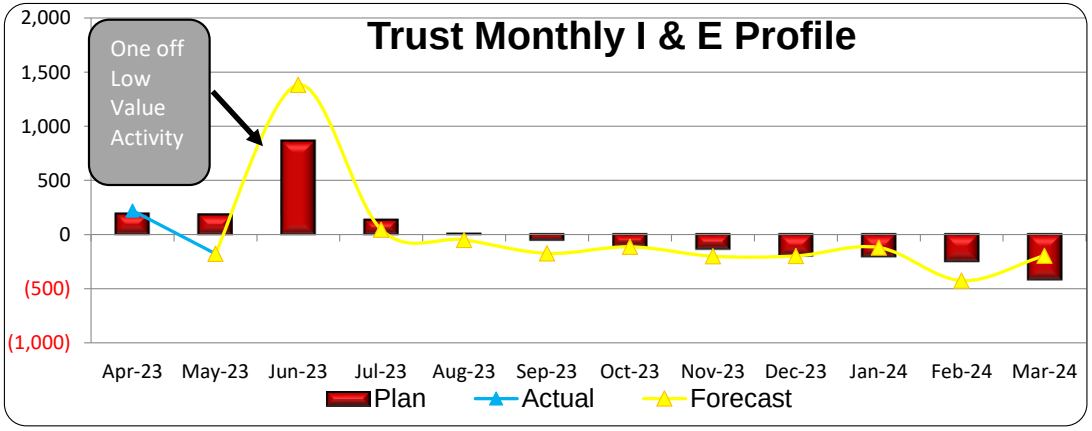
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

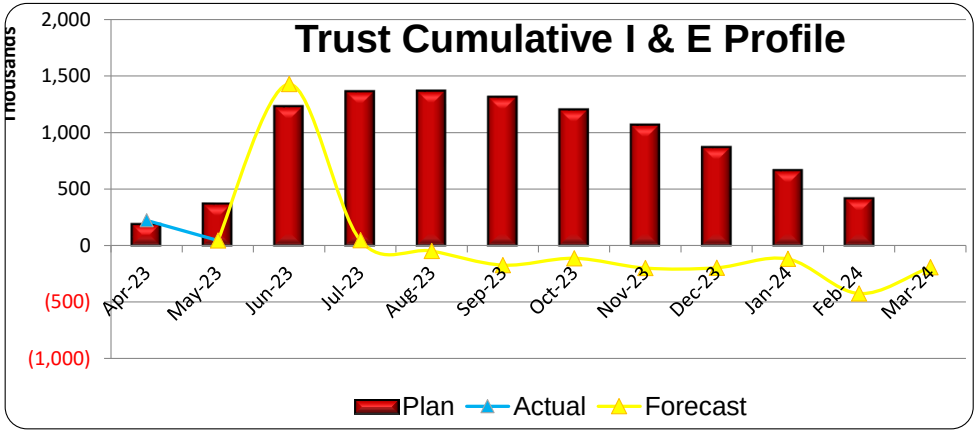
2.0 Income & Expenditure Position 2023 / 24

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust. This incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes it's linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives is highlighted separately within this report.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					31,887	32,127	239	63,689	63,912	223	386,741	387,897	1,156
Other Operating Revenue					1,093	1,032	(61)	2,069	2,113	44	12,295	11,831	(464)
Total Revenue					**32,981**	**33,159**	**178**	**65,758**	**66,025**	**267**	**399,036**	**399,728**	**692**
Pay Costs	4,802	4,804	2	0.0%	(20,540)	(20,462)	78	(39,867)	(39,606)	261	(242,186)	(242,465)	(279)
Non Pay Costs					(11,821)	(12,478)	(657)	(24,640)	(25,584)	(944)	(151,823)	(152,776)	(953)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,802**	**4,804**	**2**	**0.0%**	**(32,361)**	**(32,940)**	**(579)**	**(64,507)**	**(65,190)**	**(683)**	**(394,009)**	**(395,241)**	**(1,231)**
EBITDA	**4,802**	**4,804**	**2**	**0.0%**	**620**	**219**	**(401)**	**1,251**	**835**	**(416)**	**5,027**	**4,487**	**(539)**
Depreciation					(518)	(517)	1	(1,035)	(1,034)	1	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					258	300	42	512	601	89	3,070	3,601	531
Surplus / (Deficit) - ICB performance measure	**4,802**	**4,804**	**2**	**0.0%**	**181**	**(177)**	**(358)**	**370**	**44**	**(326)**	**(0)**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,802**	**4,804**	**2**	**0.0%**	**181**	**(177)**	**(358)**	**370**	**44**	**(326)**	**(0)**	**0**	**0**





2.0 Income & Expenditure Position 2023 / 24

The position of South West Yorkshire Partnership NHS Foundation Trust, excluding the financial impact of Provider Collaboratives, is shown below. The movement between the total financial position and the total excluding the collaboratives is reconciled below for ease.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					23,658	23,590	(68)	47,231	47,076	(154)	287,992	288,244	252
Other Operating Revenue					1,093	1,032	(61)	2,069	2,113	44	12,295	11,831	(464)
Total Revenue					**24,752**	**24,623**	**(129)**	**49,300**	**49,189**	**(111)**	**300,287**	**300,075**	**(212)**
Pay Costs	4,782	4,773	(10)	0.2%	(20,407)	(20,306)	102	(39,614)	(39,253)	361	(240,703)	(240,254)	450
Non Pay Costs					(3,691)	(4,148)	(457)	(8,401)	(9,233)	(832)	(54,390)	(55,465)	(1,076)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,782**	**4,773**	**(10)**	**0.2%**	**(24,098)**	**(24,453)**	**(355)**	**(48,015)**	**(48,485)**	**(471)**	**(295,093)**	**(295,719)**	**(626)**
EBITDA	**4,782**	**4,773**	**(10)**	**0.2%**	**654**	**169**	**(484)**	**1,285**	**704**	**(581)**	**5,194**	**4,356**	**(838)**
Depreciation					(518)	(517)	1	(1,035)	(1,034)	1	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					258	300	42	512	601	89	3,070	3,601	531
Surplus / (Deficit) - ICB performance measure	**4,782**	**4,773**	**(10)**	**0.2%**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**
Depn Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,782**	**4,773**	**(10)**	**0.2%**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**

To help with clarity on the position of the provider collaboratives a summary between the two tables is shown below. The individual analysis within the remainder of this report highlights the Trust only values. The collaborative financial performance is reported separately.

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Total Trust Position	4,802	4,804	2	0.0%	181	(177)	(358)	370	44	(326)	(0)	0	0
Provider Collaboratives	20	31	11	56.7%	(34)	50	83	(34)	131	165	(168)	131	299
Total excluding Collaboratives (as shown above)	**4,782**	**4,773**	**(10)**	**0**	**215**	**(227)**	**(442)**	**404**	**(87)**	**(491)**	**168**	**(131)**	**(299)**

Income & Expenditure Position 2022 / 23

The impact of the 2023 / 24 Agenda For Change pay award has been incorporated in month. Estimated expenditure is greater than estimated income. This, including any arrears, will be paid in June 2023.

The Trust revised financial plan, submitted 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. The plan included an assumed pay award at 2% and related uplifts to commissioner tariff. The revised pay offer presents a significant financial pressure to this plan position.

NHS England - monthly submission

The financial performance reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care Board (ICB). The corresponding declaration is made within the return itself.

Income

The majority of income continues to be received through block payment arrangements with any variances to plan agreed by exception. Budgets and actual income have been uplifted for expected increases for Agenda For Change pay award funding which will be paid by commissioners in June 2023.

Pay

In line with national guidance relevant pay expenditure has been uplifted by 5%, with effect from 1st April 2023, to take account of the Agenda For Change pay award. This is an increase from the 2% estimated in April 2023 which was the assumption included within the financial plan. This will be paid in June 2023 including any arrears. Budgets have been increased as well.

Overall the trend of increased worked WTE has continued in May. The main increase is in bank WTE; returning inpatient levels to previous levels with April being lower than normal. Substantive staff, including payment for additional hours worked, has reduced by 14 in month and this will continue to be monitored.

Recruitment and retention workstreams continue, including continued overseas recruitment for nursing and other professions.

Non Pay

The presentation of non pay expenditure has been updated to separate out the significant value associated with the provider collaboratives. Budgets have also been reset for 2023 / 24 based upon historical trends and estimates of inflationary pressures.

Variances are explained within the non pay analysis section with a number of categories spending more than planned at the start of the year. Analysis will continue to highlight if this is increased usage or inflationary price increases causing the pressure.

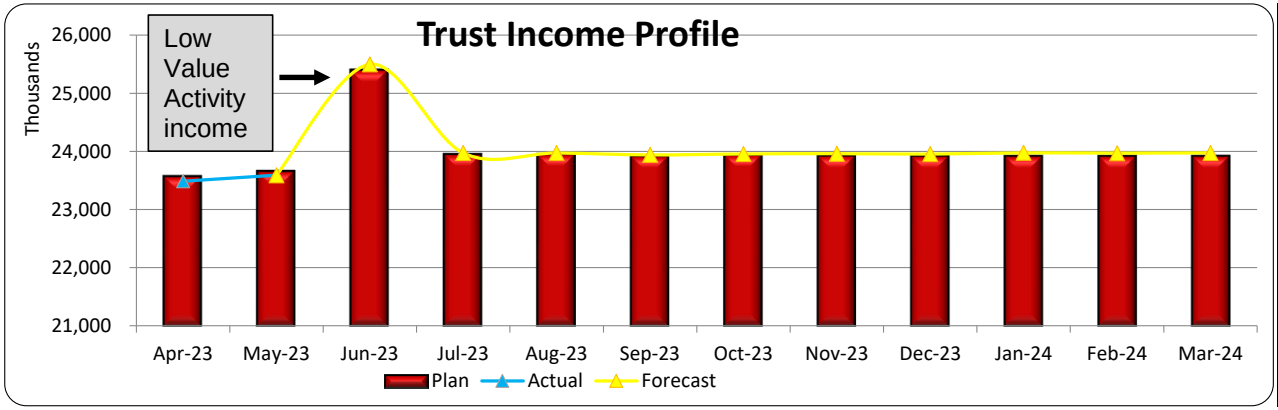
2.1 Income Information

The Trust Income and Expenditure position separately identifies clinical revenue, and other revenue received as part of these significant contracts as a result of the post covid-19 financial architecture. These contracts are historically those to provide healthcare services as the purpose of this Trust. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is reported as other operating income.

This excludes the income received for the commissioning role as co-ordinating provider. This is reported separately as well.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)) and NHS England.

Income source	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	Total 22/23 £k
NHS Commissioners	19,533	19,642	21,461	19,935	19,935	19,935	19,935	19,935	19,935	19,935	19,935	19,935	**240,054**	
ICS / System / Covid	0	0	0	0	0	0	0	0	0	0	0	0	**0**	
Specialist Commissioner	2,752	2,753	2,751	2,752	2,752	2,719	2,719	2,719	2,719	2,719	2,719	2,718	**32,791**	
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	**0**	
Local Authority	490	516	514	515	514	514	506	511	506	527	521	526	**6,160**	
Partnerships	514	584	628	626	626	626	651	651	651	651	651	651	**7,511**	
Other Contract Income	197	96	144	144	144	144	144	144	143	143	143	143	**1,728**	
Total	**23,486**	**23,590**	**25,498**	**23,972**	**23,972**	**23,939**	**23,955**	**23,960**	**23,954**	**23,975**	**23,969**	**23,974**	**288,244**	**0**
2022 / 23													**0**	



As at 31st May 2023 contracts with main commissioners were progressing to signature. These, including the financial elements, will be updated to incorporate the revised Agenda For Change pay award. For 2023 / 24 this will flow as an uplift to commissioner tariff. Arrears relating to 2022 / 23 will be paid directly by NHS England.

Additional income is forecast in June 2023 relating to the one off payment for low value activity. These values are calculated nationally.

Overall income is in line with plan. Financial, and operational, risks will continue to be assessed including CQUIN performance.

2.2 Pay Information

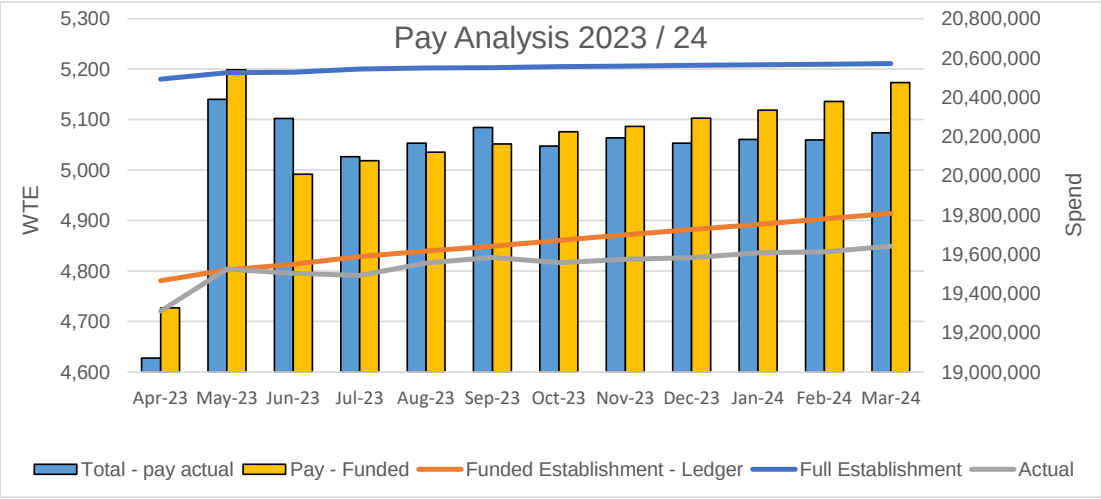
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

Staff type	Apr-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	17,160	18,043	18,197	18,052	18,086	18,195	18,125	18,167	18,157	18,176	18,179	18,198	**216,736**
Bank & Locum	849	1,355	1,142	1,121	1,181	1,158	1,154	1,157	1,149	1,148	1,150	1,162	**13,724**
Agency	939	908	864	834	809	803	782	780	770	772	764	769	**9,794**
Total	**18,947**	**20,306**	**20,204**	**20,008**	**20,076**	**20,156**	**20,061**	**20,104**	**20,076**	**20,095**	**20,093**	**20,129**	**240,254**
22/23	17,397	18,201	17,728	18,510	17,937	20,464	18,972	18,425	17,828	16,905	19,719	18,889	**220,976**

Bank as % (in month)	4.5%	6.7%	5.7%	5.6%	5.9%	5.7%	5.8%	5.8%	5.7%	5.7%	5.7%	5.8%	5.7%
Agency as % (in month)	5.0%	4.5%	4.3%	4.2%	4.0%	4.0%	3.9%	3.9%	3.8%	3.8%	3.8%	3.8%	4.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,360	4,372	4,387	4,401	4,397	4,404	4,408	4,419	4,421	4,429	**4,389**
Bank & Locum	222	314	272	262	275	271	271	271	270	270	270	273	**270**
Agency	157	161	164	157	154	154	148	148	148	147	147	147	**153**
Total	**4,721**	**4,804**	**4,796**	**4,791**	**4,816**	**4,827**	**4,817**	**4,824**	**4,826**	**4,836**	**4,838**	**4,849**	**4,812**
22/23	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



The original Trust financial plan included an assumed 2% pay award for Agenda for Change staff in line with national guidance. This has been revised to 5% in May 2023 and an estimate of costs to date has been made. This will be paid in June (with appropriate arrears). Budgets have been increased as well.

As a result it's difficult to identify any trend from the initial two months of 2023 / 24.

WTE, however, are an indication as they are not directly affected by this. In May there has been a reduction in substantive staff worked (this includes Trust staff doing additional hours) although this has been more than offset by the increase in bank worked WTE in month.

Average bank worked WTE in Quarter 4 2022 / 23 was 312 WTE and therefore May usage is in line with run rate. April usage was lower than normal in inpatient areas in line with service needs.

2.2 Agency Expenditure Focus

Agency spend is £908k in May. 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.

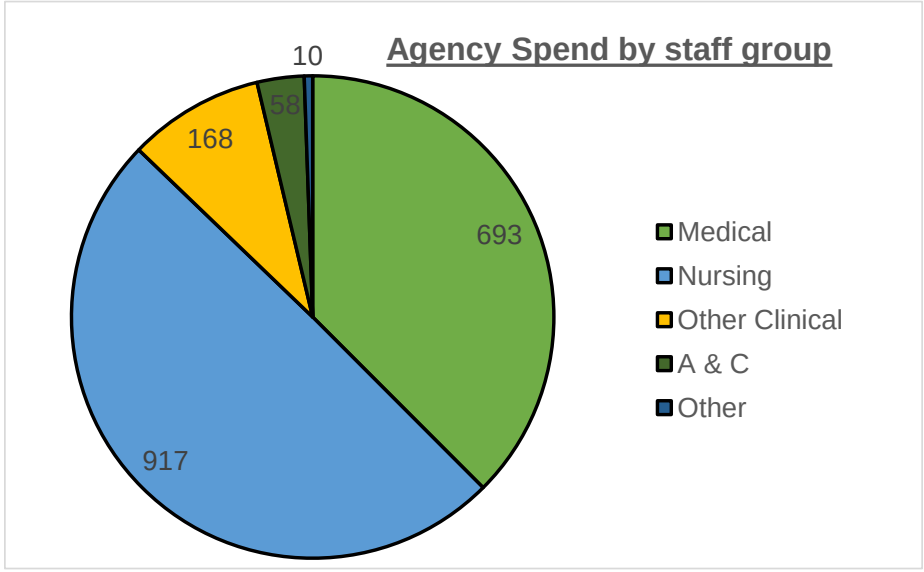
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

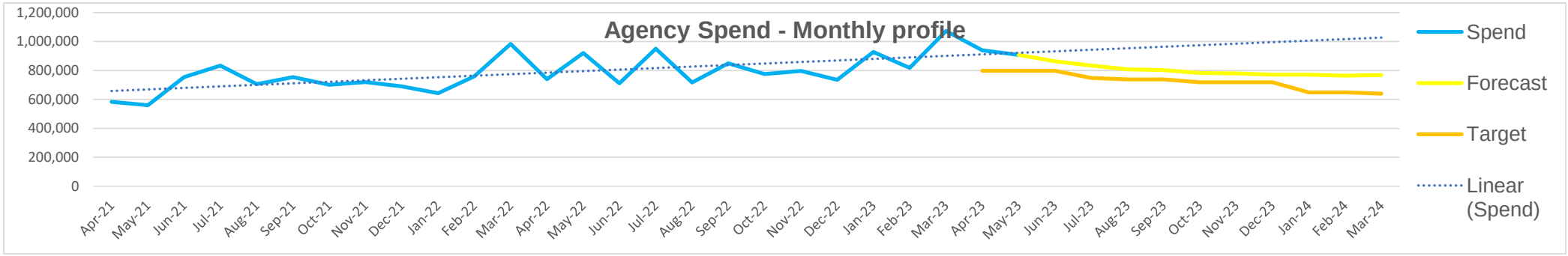
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23.

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

May 2023 spend is £908k which, as shown by the graph below, is higher than target. Currently only small reductions are forecast for the rest of the year. The Trust will continue to assess need based upon safety, quality and the financial implications.

As shown by the pie chart nursing staff (registered and unregistered) is the largest single category. This remains focussed in inpatient (both adult acute and older peoples) and Forensic services.



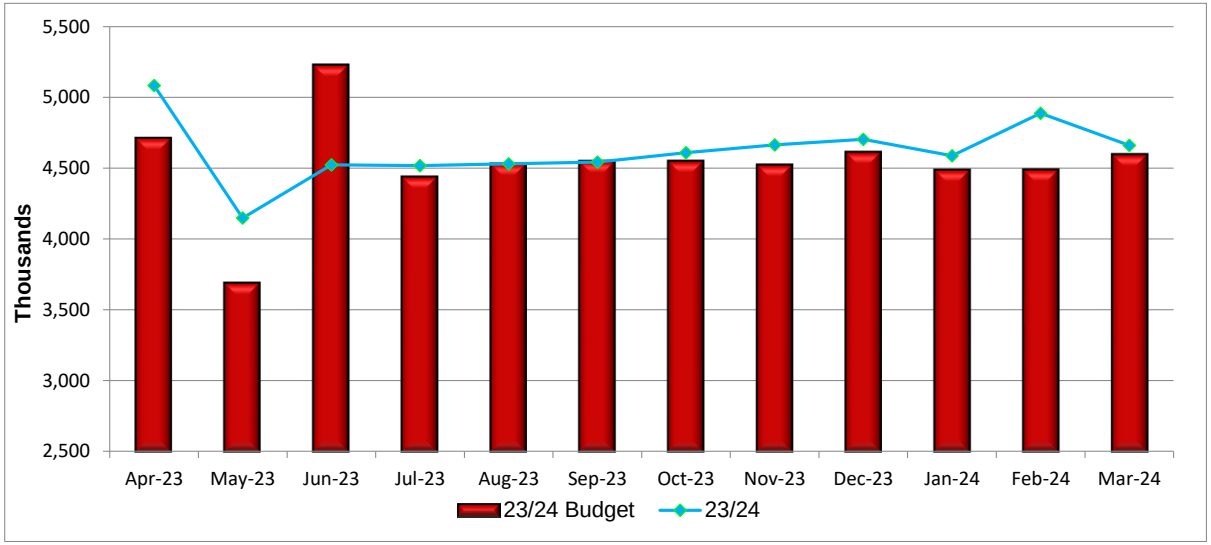


2.3 Non Pay Expenditure

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

Non pay spend	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
2023/24	5,085	4,148	4,523	4,518	4,531	4,544	4,609	4,665	4,704	4,587	4,889	4,662	**55,465**
2022/23													**0**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	690	625	(65)
Establishment	1,459	1,564	105
Lease & Property Rental	1,452	1,449	(3)
Premises (inc. rates)	895	950	54
Utilities	380	378	(3)
Purchase of Healthcare	1,601	1,609	8
Travel & vehicles	759	827	67
Supplies & Services	1,108	1,152	44
Training & Education	281	297	16
Clinical Negligence & Insurance	131	131	(0)
Other non pay	(357)	252	608
Total	**8,401**	**9,233**	**832**
Total Excl OOA and Drugs	**6,110**	**6,998**	**888**



Key Messages

Non pay expenditure budgets were reset for 2023 / 24 based on historical trends and estimates of inflationary price increases. The negative other non pay budget is based on currently identified efficiency requirements; these will be aligned in years as schemes progress.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is broadly in line with plan. There is however a planned reduction in spend over the course of the year which presents an operational and financial risk.

Current areas of overspend include establishment. For May this is due to the timing of costs, when compared to the budget profile, relating to Trust mobile access (VPN's). As this is timing this overspend is expected to reduce in coming months.

Other non pay includes all other items not categorised into the above headings and allocation continues to ensure spend is correctly coded and as much separately reported as possible. As such this covers a wide range of items and budgets held centrally.

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.

The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

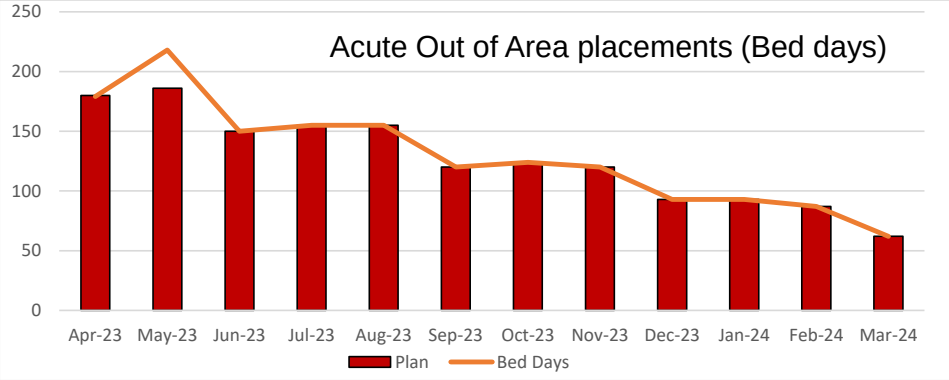
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

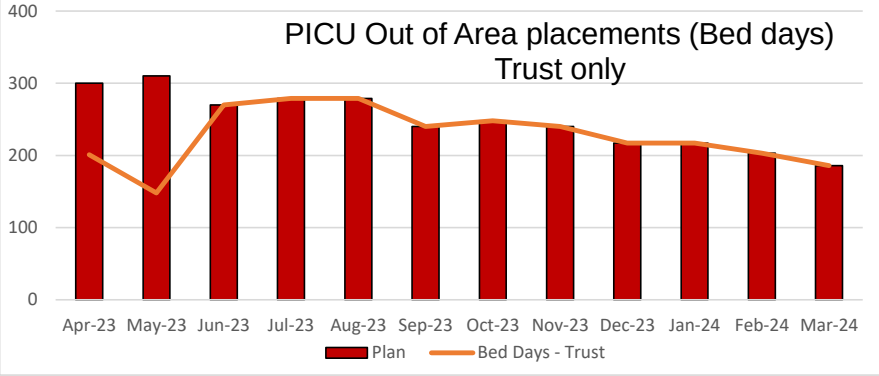
On such occassions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

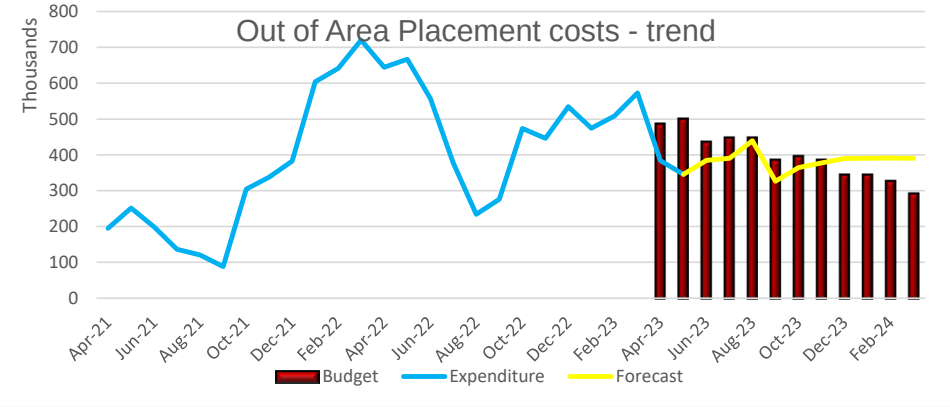
There are an additional 285 PICU bed days in April - May 2023 which are paid directly by the commissioner.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	279	208	(70)
PICU	683	518	(166)
Locked Rehab	380	450	69
Services - NHS	117	103	(14)
IAPT	29	135	106
Yorkshire Smokefree	14	4	(10)
Other	98	191	93
Total	**1,601**	**1,609**	**8**







Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes.

The graph to the left highlights the volatility of expenditure as the demand, and require for placements, has changed over months. There can be periods of significant, and sustained, increases.

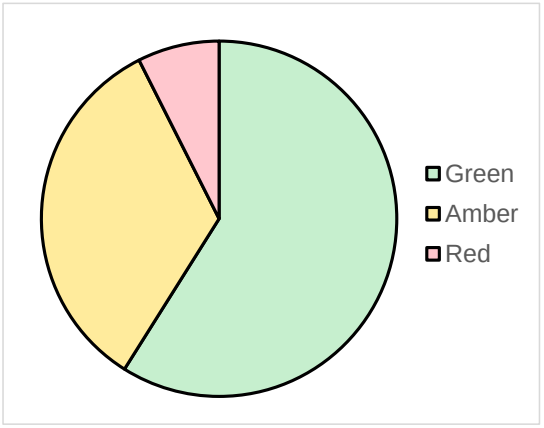
Expenditure wise both acute and PICU are less than plan for April - May 2023. This is despite acute bed day usage being higher than plan. This is due to less than plan addititonal nursing and the bed day rates are lower than the historical average used to calculate the plan.

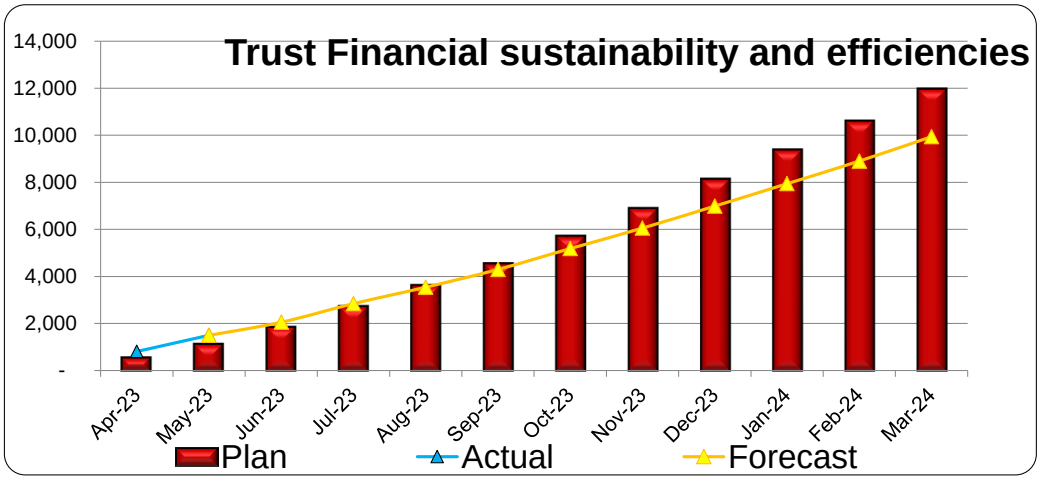
2.4 Value for Money, Financial sustainability and efficiency

The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2023 / 24 a target of £11.96m has been identified and included within the plan.

This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date				Forecast			
Workstream Categorisation	**Breakdown**	**Target**	**Achieved Recurrent**	**Achieved Non Recurrent**	**Unachieved / Shortfall**	**Target**	**Green**	**Amber**	**Red**
Out of Area Placements	Pg. 10	259	511			3,197	511	2,888	0
Agency & Workforce	Pg.	200		426		4,380	3,502		144
Medicines optimisation		67	65			400	65	335	0
Non Pay Review		209	0			1,548	0	802	746
Interest Receivable	Pg. 4	233	322			1,400	1,931		0
Provider Collaborative	Pg.	173	173			1,044	1,044		0
Total		**1,141**	**1,071**	**426**	**0**	**11,969**	**7,054**	**4,024**	**890**
Recurrent		1,057	1,071			10,943	3,551	2,888	
Non Recurrent		83		426		1,026	426		





Overall the Trust value for money programme has realised more than originally planned for April and May 2023. However future delivery remains a challenge with c. 41% highlighted as amber or red.

The tables above show that out of area placements (with additional information on out of area focus page) is ahead of plan along with workforce costs although these are currently showing as non-recurrent. Work will continue to move these to recurrent if possible.

Interest receivable is also ahead of plan with continued positive rates of interest recevied. This is forecast to continue for the remainder of the year with this line generating an additional £0.5m of income in year. This will help to mitigate slippage on other schemes; at the moment shown as a reduction of the agency and workforce workstream.

3.0 Statement of Financial Position (SOFP) 2023 / 24

Balance Sheet / Statement of Financial Position (SOFP)	2022 / 2023 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	165,175	170,614	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,321	
Non NHS Trade Receivables (Debtors)	2,853	1,689	
Prepayments	3,482	3,672	
Accrued Income	9,372	11,392	2
Cash and Cash Equivalents	74,585	77,736	Pg 15
Total Current Assets	**92,097**	**96,040**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(11,113)	3
Capital Payables (Creditors)	(739)	(569)	
Tax, NI, Pension Payables, PDC	(7,696)	(7,984)	
Accruals	(32,952)	(33,252)	4
Deferred Income	(4,172)	(1,604)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(58,944)	1
Total Current Liabilities	**(104,062)**	**(113,465)**	
Net Current Assets/Liabilities	**(11,965)**	**(17,425)**	
Total Assets less Current Liabilities	**153,210**	**153,189**	
Provisions for Liabilities	(4,319)	(4,254)	
Total Net Assets/(Liabilities)	**148,891**	**148,935**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,657	
Revaluation Reserve	14,026	14,026	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	84,032	
Total Taxpayers' Equity	**148,891**	**148,935**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2023.

1. Increase in lease / rental costs with effect from 1st April 2023 were higher than expected (and relatively large increases had been included in the plan). This results in an increases in both assets and liabilities.

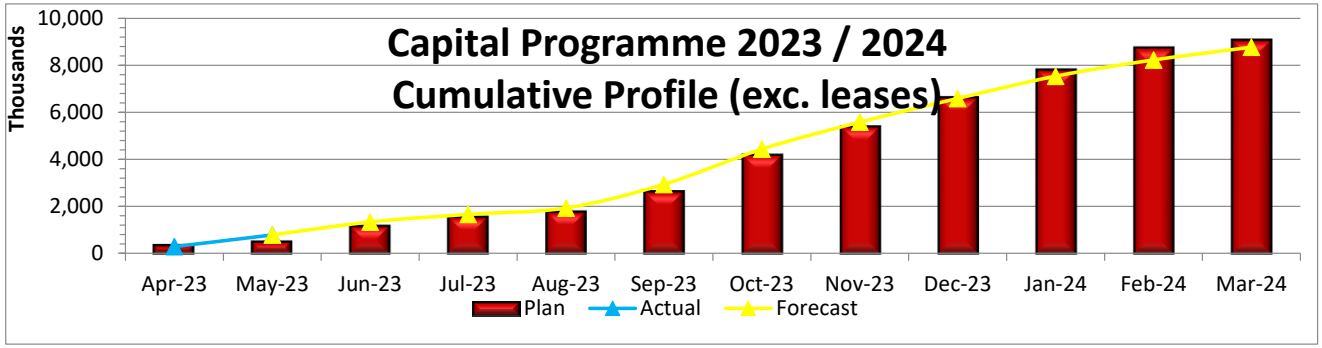
2. Accrued income includes £9m owed by NHS England in respect of funding for the central 2022 / 23 pay award, this is due to be paid in June 2023.

3. Trade payables are currently high due to a delay in April invoicing from some of our partners leading to two months outstanding in May. This is expected to reduce by the end of the quarter.

4. Accruals remain, as they were at year end, with the largest factor relating to estimated pay award payments to be made June 2023. This includes the centrally funded 2022 / 23 and also April and May 2023 relating to the 2023 / 24 pay award. This is expected to significantly reduce in June which will have an impact on the Trust cash position.

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	713	428
Safety inc. ligature & IPC	990	50	165	115	1,445	455
Compliance	430	150	0	(150)	200	(230)
Backlog maintenance	510	0	0	0	75	(435)
Sustainability	300	0	0	0	225	(75)
Plant & Equipment	40	0	0	0	45	5
Other	1,223	0	608	608	1,075	(148)
IM & T						
Digital Infrastructure	1,100	0	0	0	1,200	100
Digital Care Records	180	0	0	0	70	(110)
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	280	10
TOTALS	**8,768**	**235**	**772**	**537**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	7,097	1,894	7,097	1,894
New lease	303	273	0	(273)	6	(297)
TOTALS	**14,274**	**5,711**	**7,870**	**2,159**	**15,871**	**1,598**



Capital Expenditure 2023 / 24

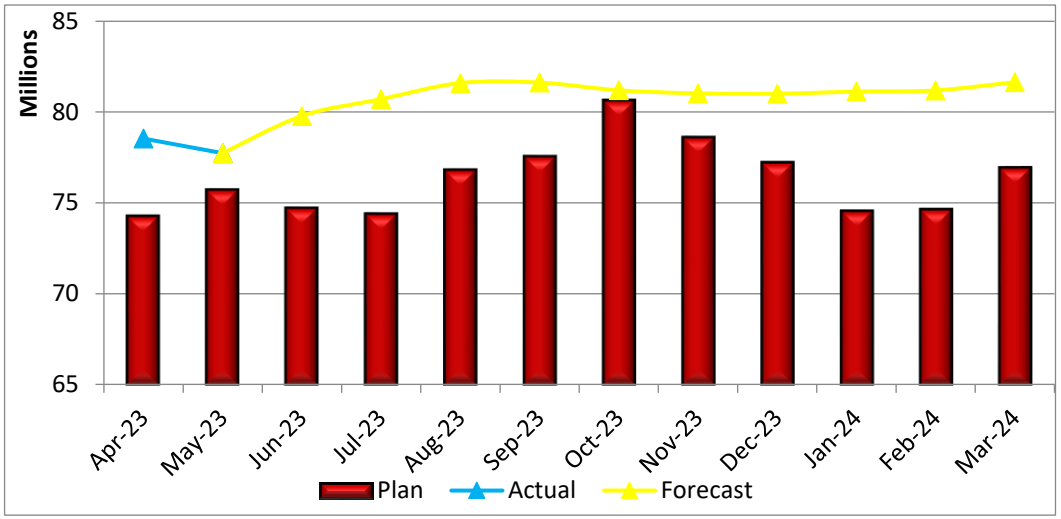
The Trust has continued to work within the West Yorkshire Integrated Care Board capital allocation in establishing it's capital programme for 2023 / 24. This totals £8,768k.

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

Spend to date is ahead of plan. This relates to significant progress made on the door replacement programme and continued costs on 2022 / 23 schemes.

Major scheme and IM & T spend is profiled to commence later in the year.

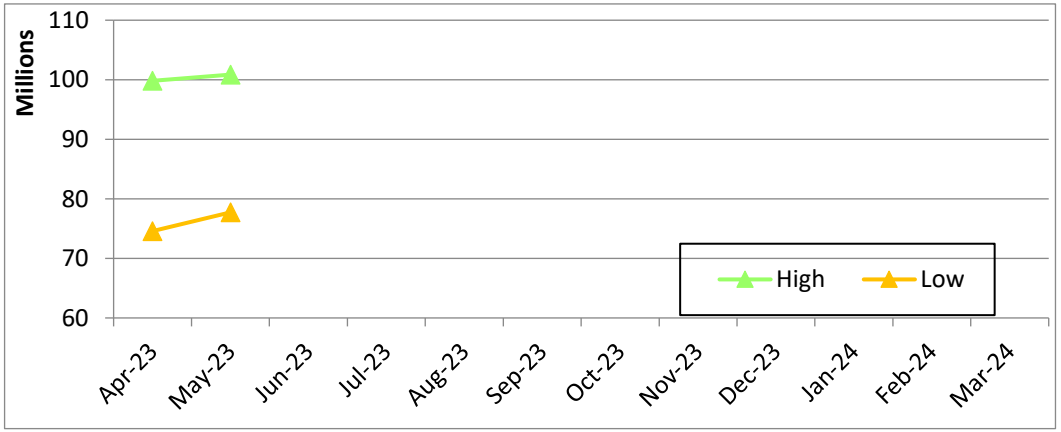
3.2 Cash Flow & Cash Flow Forecast 2022 / 2023



Cash remains healthy

Cash remains healthy and is expected to remain around the £80m value. The Trust is looking at investment options to maximise interest received.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	75,720	77,736	2,016



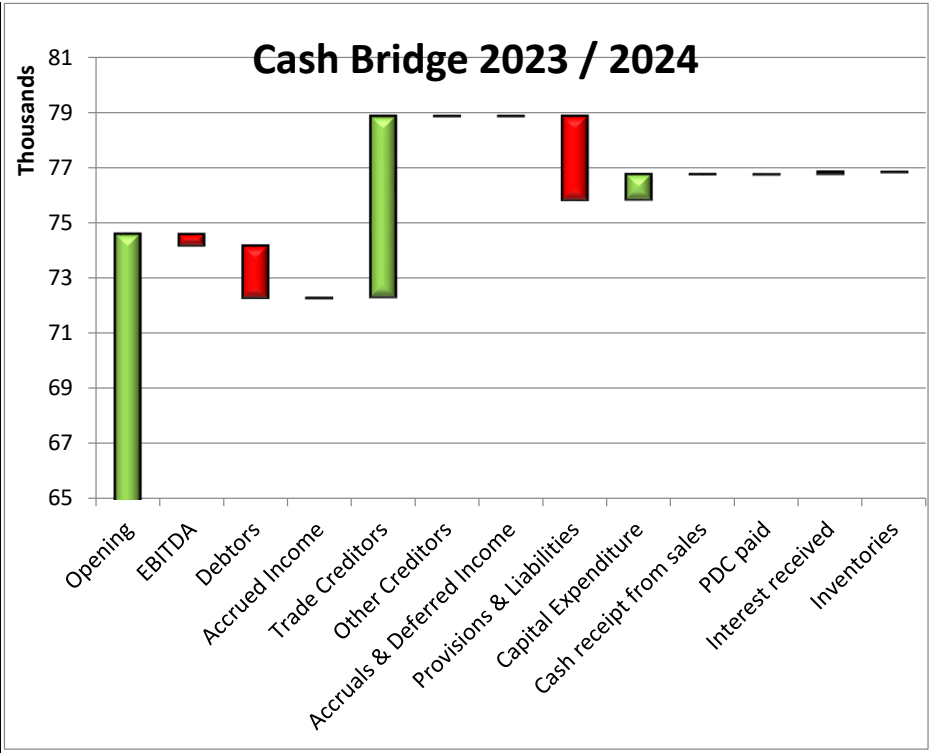
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £100.9m
The lowest balance is: £77.7m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**74,585**	**74,585**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	2,748	2,335	(413)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	707	(1,180)	(1,887)	
Trade Payables (Creditors)	(1,536)	5,031	6,567	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	403	(2,633)	(3,036)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,699)	(772)	927	
Cash receipts from asset sales	0	0	0	
Leases	0	(231)	(231)	
PDC Dividends paid	0		0	
PDC Dividends received	0		0	
Interest (paid)/ received	512	601	89	
Closing Balances	**75,720**	**77,736**	**2,016**	



The table above summarises the reasons for the movement in the Trust cash position during 2023 / 2024. This is also presented graphically within the cash bridge.

Cash is £2m higher than plan, the main drivers is creditors (where NHS invoices have been delayed at the start of the year) offset by a movement in deferred income linked to the adult secure collaborative.

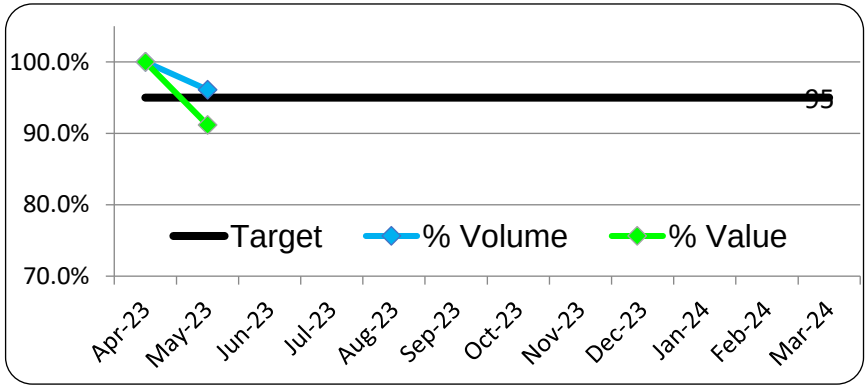
4.0 Better Payment Practice Code

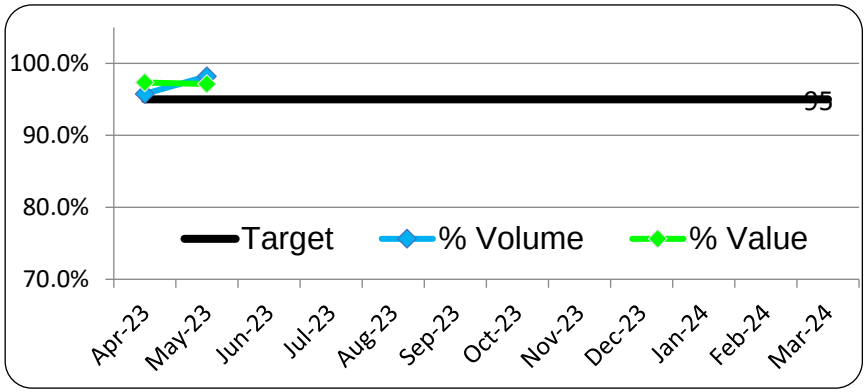
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	96%	91%
Cumulative Year to Date	97%	96%

Non NHS	Number %	Value %
In Month	98%	97%
Cumulative Year to Date	97%	97%





4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
12-May-23	Computer Software	Trustwide	Phoenix Partnership (Leeds) Ltd	14855	799,723
12-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999400	575,400
16-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999472	575,400
02-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS33	544,330
31-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS34	544,330
30-May-23	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	203290	511,436
22-May-23	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2100224982	500,000
22-May-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	2100119072	500,000
02-May-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007932	343,811
16-May-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 272	242,454
26-May-23	Regulator Fee	Trustwide	Care Quality Commission	43327845	219,969
04-May-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4891	181,295
02-May-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007928	116,190
22-May-23	IT Services	Trustwide	Daisy Corporate Services	3I508753	90,250
15-May-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC012INV	81,813
30-May-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	323944	66,240
25-May-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	115476	65,792
12-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999399	63,962
16-May-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999471	63,962
26-May-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	12811206	56,000
25-May-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	CHA03148	48,674
19-May-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015280154	46,872
18-May-23	Drugs	Trustwide	NHS Business Services Authority	1000076860	42,214
03-May-23	Purchase of Healthcare	Barnsley	Touchstone-Leeds	SINV20230009	35,365
25-May-23	Mobile Phones	Trustwide	Vodafone Ltd	103880803	32,599
18-May-23	Purchase of Healthcare	Kirklees	Kirklees Council	8608025751	32,033
25-May-23	Mobile Phones	Trustwide	Vodafone Ltd	103693989	29,474
22-May-23	Utilities	Trustwide	Totalenergies Gas & Power Ltd	30126781823	29,077
02-May-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001307	28,672
12-May-23	Purchase of Healthcare	Barnsley	Cygnet Health Care Ltd	WKE0285916	28,590
12-May-23	Purchase of Healthcare	Kirklees	Socrates Clinical Psychology Ltd	SPS07831RMC7831	27,600
12-May-23	Purchase of Healthcare	Calderdale	Socrates Clinical Psychology Ltd	SPS07831RMC7831	27,600
23-May-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015332536	27,190
15-May-23	Purchase of Healthcare	Kirklees	Priory Group Ltd	3900015956	26,085
12-May-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0285915	25,830

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 / new investment were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. As such they 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

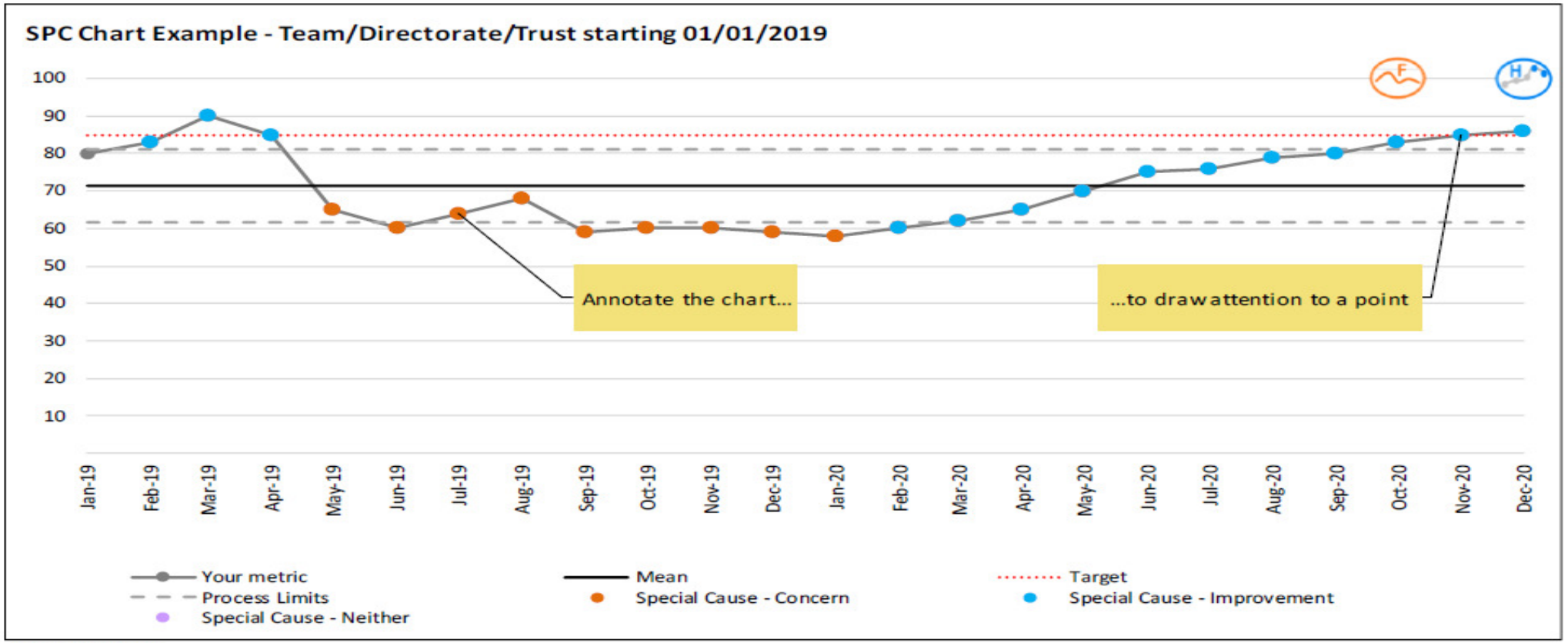
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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									
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

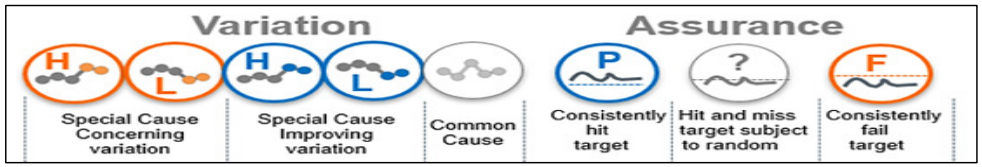
ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium 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.