NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

June 2023

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 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 96.9% against a target of 90%. For the Trust derived indicators, as at June 2023, disability 44.3%, sexual orientation 44.0% (both slightly increased from 43.5% and 43.4% reported in the previous month) 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 67.4% service EIAs have been reviewed within 12 months (This has increased from 53.7% reported in May). 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, particularly in the Barnsley service, however, the overall Trust position increased to 80.5% against a target of 75%. 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. Rapid improvement work in Single point of access (SPA) together with some progress in recruitment has contributed to an improved performance this 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 441 days in June which is a decrease compared to previous month but this remains high and has exceeded the threshold for quarter 1 (455 days, reported a total of 1472 days). Need for use of these beds mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 16 people placed in out of area beds at the end of June. The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.

• The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks increased to 82.5% in June from 53.3% reported for 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 service are also reporting a number of appointments being cancelled by parents/carers, or children not being brought to their appointments.

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 and risk assessments

Although the focus has been on performance against target the main driver for change is of care plans and risk assessments, therefore the care plan and risks assessment improvement group are monitoring whether improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance.

The June data for care planning shows performance of 86.6% which is a further improvement from 85.7% reported in May and remains above threshold.

For risk assessments, the June data shows a slight decline in performance from the previous month within inpatient services (86.6%) however community services (92.3%) have shown a sustained performance. 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 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

• CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
• Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis 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 73.1% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.
• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels higher than pre-pandemic – cases are triaged and prioritised according to need.

Patient Safety Indicators

96% of patient incidents reported in June 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 increased slightly to 201 from 186 in May. 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.

• 89.5% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there were two incidents out of nineteen over the 3-minute threshold and these were complex cases and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

• There were 14 information governance personal data breaches during June 23. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity and the Data Protection Officer (DPO) is working with communications colleagues on the development of a poster campaign which highlights the impact on individuals of data breaches.

• The number of inpatient falls in June was 46, which is a decrease 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 June. The number of people joining the Trust outnumbered leavers in June. Year to date, we have had 164.1 new starters and 135.5 leavers during the first quarter of the year and focus remains on recruitment and retention.

• Overall turnover rate in June was 13.1% which has increased slightly from last month (12.2%).

• Sickness absence in June was 4.6% and below local threshold, with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for June saw a small increase, from 74.9% to 78.5% and achieved the improvement trajectory to reach 78% set by the Executive management team (EMT) have agreed an improvement trajectory of 78, 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 92% compliance which exceeds the Trust target of 80%, this has increased from 90.9% reported in May. Reducing restrictive practice interventions training is the only area in month below the Trust target. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

• The Trust position for information governance data security training saw a further increase in June to 96.8% from 95.9% reported at the end of May and remains above the 95% threshold.

• Cardiopulmonary resuscitation also achieved the 80% threshold during June, reporting at 81.3%.

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 June, these are as follows:

• 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 and this has resulted in the increased use of agency staff. 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 continue to be supported through Trust wide recruitment and retention programme.

• Demand into the Single Point of Access (SPA) and capacity issues have led 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. This increases the risk of routine triage and assessment being delayed. 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 June.

• The 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.

• During June, there was an increase in the overall number of cases that were clinically ready for discharge, increasing from 2.1% to 4.6%, this has been identified as a risk and is being developed for inclusion on the organisational risk register, due to the continued 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.

• 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

• Agenda For Change pay awards, relating to 2022 / 23 (for which an estimate was made in the last financial year) and 2023 / 24, were paid in June 2023. The year to date expenditure is broadly in line with plan although this is modelled to move to an underspend position in year with workforce growth forecast to be behind that included in the plan (although still growing).

• Agency spend in June was £1,002k which is a slight increase on Mays position which 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 £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.

• Out of area bed costs - in June the costs for out of area placements were £252k over budget however the year-to-date position is breakeven against plan. The forecast is expecting that a break-even position will be delivered.

• Performance against the Better Payment Practice Code is 96%.

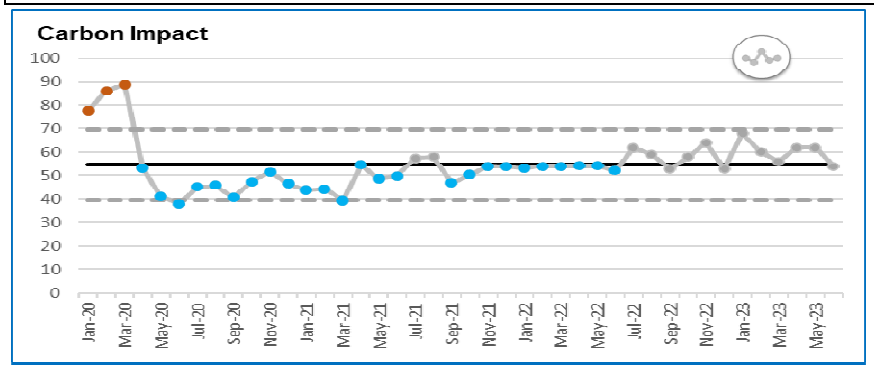
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical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

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

Improving health

Metrics	Threshold	Apr-23	May-23	Jun-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	*90%*	96.6%	96.6%	96.8%		
Percentage of service users who have had their equality data recorded - disability	To be determined for 23/24	43.2%	43.5%	44.3%		The threshold for 23/24 is being developed by the equality inclusion and involvement sub committee and will be discussed at the August meeting. Further update to be provided next month.
Percentage of service users who have had their equality data recorded - sexual orientation		43.3%	43.4%	44.0%		
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	95%	53.3% Service 94.6% Policy	53.7% Service 96.1% Policy	67.7% 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	>=80%	96.0%	96.2%	97.0%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	0	1	1		2023/24 to be used as a baseline
Carbon Impact (tonnes CO2e) - business miles	76	62	62	54		Data showing the carbon impact of staff travel / business miles. In June staff travel contributed 54 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%	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 June 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)

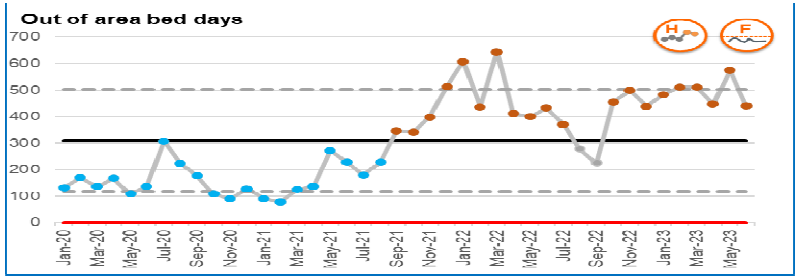
Work in partnerships at System & Place to improve the health of our communities	Community Mental Health transformation: Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation.		This work is being aligned to place based and ICS messaging via weekly programme meetings and is a workstream of the newly formed internal Community Transformation (MH) steering group, with governance now established.
	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 to address inequalities, involvement and equality in each of our places with our partners. This programme is currently being scoped to ensure that it builds on existing work and complements the actions in the equality, engagement, communication and membership strategy. In the meantime, work continues with partners. 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	Apr-23	May-23	Jun-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%	90.6%	87.7%	86.7%	H F	June data shows a slight decline in performance from the previous month within inpatient services, however community services have shown sustained performance above improvement trajectory. All areas are working to improve performance and quality of risk assessments. Risk assessment completion is based upon completion within a set timeframe but does not account for a robust and high quality risks assessment which might take a little longer. 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 trajectory for improvement is in place from May 23 which was set based upon 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		80.7%	92.9%	*92.3%*	H F	
% Service users on CPA offered a copy of their care plan	80%	85.0%	85.7%	86.6%	H F	The care plan and risk assessment improvement group continue to look at performance as well as quality of care planning and risk assessments. Part of the improvement work is to identify how we measure the quality (co-production, outcomes, timeliness)as well as the quantity (completed and shared), this may require a change to the way in which we report through the IPR. Currently we measure the number of service users who have been involved in, or have received a copy of their care plan, this informs us of an important but limited set of assurances. Although focus has been on performance the main driver for change is quality and we are monitoring that any improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance.
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	23	41	17		Any increases are monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	457	574	441	H F	See statistical process chart below for further detail.
% service users clinically ready for discharge	<=3.5%	2.4%	2.1%	4.6%		A new risk related to delays in discharge has been identified and has been added to the organisational risk register.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	694	296	774		Children are prioritised according to need. Average wait, in days, is an average of the length of wait for children who have had an appointment in the month. The monthly average is impacted by very long or very short waits. Measures are in place to monitor and contact children whilst they are waiting. The longest wait for those seen in the month was 808 days, the shortest was 740 days. Number on waiting list at end of June - 252. The longest waiter on the waiting list had waited 827 days. Waiting list initiatives are in place.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	492	479	493		Children are prioritised according to need. Average wait, in days, is an average of the length of wait for children who have had an appointment in the month. The monthly average is impacted by very long or very short waits. Measures are in place to monitor and contact children whilst they are waiting The longest wait for those seen in the month was 819 days, the shortest was 100 days. Number on waiting list at end of June - 1614. The longest waiter on t he waiting list had waited 1037 days. Waiting list initiatives in place.
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	72.9% 43/59	85.7% 60/70	73.1% 57/78	L ?	Wakefield at 100%. Barnsley 10 of 17 not met target: 6 are outstanding recording issues being resolved; 2 are occupational therapy waits - 1 patient now seen, 1 being prioritised; 1 speech and language therapy breach due to bank staff focus on priority cases, and; 1 psychology case - autism assessment waiting staff capacity. Calderdale 3 of 9 cases breached: 2 in psychology - both due to staffing issues, on waiting lists, regular welfare contacts; 1 breach in nursing - welfare contacts made. Kirklees 8 of 27 breached: 3 in nursing due to incorrect calculation made for 18 week target - staff have been reminded, patients received welfare contacts; breaches also in occupational therapy, psychology and physiotherapy due to staffing/capacity, and; 2 recording issues to be resolved.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	92.5%	90.6%	92.6%	H ?	
Community health services two hour urgent response standard	70%	87.3%	86.6%	86.2%		
Referral to assessment within 2 weeks (external referrals)	75%	60.4%	68.6%	80.5%	?	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 remains below target performance in Barnsley, improvements have been seen in Calderdale and Kirklees and this has had a positive impact on the overall Trust position for the month.

Improve Care

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)

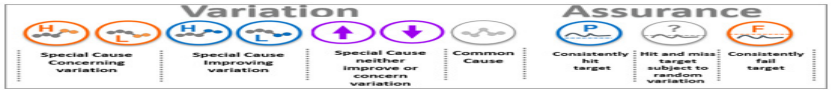


Improve Care

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 16 people placed in out of area beds at the end of June 2023.



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 In Progress Phase five: Curate and agree patient safety policy and plan by 31/8/2023 In Progress 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. There are 3 programme groups now established: 1. Legislation & Policy; 2. Quality 3. Performance.
	Personalised Care (Moving on from Care Programme Approach (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 with governance and terms of reference to be reviewed and established in July 2023.
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. • Children's and Adolescent Mental Health Services (CAMHS) neurodevelopmental services in Kirklees and Calderdale - outcomes from adult attention deficit hyperactivity disorder (ADHD) and CAMHS workshop on 19th June include agreement to develop a standardised Trustwide pathway for transition including training for staff, children and young people, and families and carers, and referrers. Agreement made to transfer young people who reach 18 years whilst on CAMHS neuro waiting list to adult ADHD/autism services. Referrals have plateaued at around 160 per month for last 3 months, work continues to monitor waiting list data, and ways to manage referrals such as working with highest referrers and to look at how we can support those schools to make appropriate referrals. • 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 safety 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's inpatient services by summer 2023 – Now autumn 2023		Work continues on finalising the business case and draft consultation documents. Complexities linked to agreeing finances for transformed options and governance processes has led to some delay and consultation is now anticipated to commence in autumn.

Improve resources

Metrics	Threshold	Apr-23	May-23	Jun-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	£32k	(£358k)	£19k		A surplus £19k greater than plan has been recorded in month; overall the surplus was £879k. Pressures in pay and non-pay have been offset by additional income and interest received.
Capital spend against plan (monthly)	£8.8m	£218k	£347k	(£442k)		The year to date position is £105k ahead of plan with spend of £993k. This is due to prior year schemes and a door replacement programme being undertaken earlier than planned.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£939k	£908k	£1,002k		The monthly run rate of agency spend continues to be higher than plan trajectories. The run rate has increased in month with spend greater than £1m.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£568k	£1,497k	£1,812k		The cumulative savings to date are £1,812k and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	9				Six of these incidents related to physical violence (contact against staff by patient), with other incidents relating to slip, trips and falls, injury/concern following restraint and physical aggression (no physical contact by patient).
Estates Urgent Response Times - SLA	95%	93.8%	96.8%	98.9%		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 & Effectiveness
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%	93.8%		For June, this relates to one job outstanding waiting for a part on the water mist system. The issue is in a corridor and mitigation is in place until works are completed

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 agreed by EMT. Reporting into OMG in place. Non recurrent funding for project management secured and possibilities for filling this post being explored. Value for money conversation commenced on i-hub to encourage ideas from across the whole Trust
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 has been rescheduled to w/c 17 July 2023 (planning for 18 July 2023) to account for subsequent remediation testing which includes end-to-end test of the data transfer process.
	Implementation of a Trust wide approach to digital dictation submission for Board approval July 2023.		Tender submissions evaluation activities concluded and final evaluation report currently undergoing internal governance/approval processes.

Make SWYPFT a great place to work						
Metrics	**Threshold**	**Apr-23**	**May-23**	**Jun-23**	**Variation/ Assurance**	**Notes**
Turnover external (12 month rolling)	>12% - 13%<	13.0%	12.2%	13.1%		Rolling turnover increased by 0.9% to 13.1%
Registered workforce growth	3% (by March 24)	0.77%				
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month remained at 4.6%.
Workpal appraisals - rolling 12 months	>=78%	74.4%	74.9%	78.5%		For the month of June, the percentage rate increased by 3.6.% to 78.5% and is now above threshold
% 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%	Due Aug 23				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%	27% (4/15)	38% (3/8)	17% (2/12)		Improvement programme is established to address backlog reviewing the processes, including sign off to optimise response times. Investment in the customer services team made to reflect the demand and capacity and support quality improvements.
Mandatory training - Cardiopulmonary resuscitation	80%	75.5%	79.2%	81.3%		
Mandatory training - Reducing restrictive practice interventions	80%	73.8%	73.8%	76.7%		Actions being taken to address the compliance rate 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. Executive management team have approved a business case for recruitment of additional training capacity.
Mandatory training - Fire	80%	90.2%	91.2%	92.8%		
Mandatory training - Information governance	95%	90.6%	95.9%	96.8%		

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.		Inclusive recruitment, retention and wellbeing: Scoping out work in local places to identify and prioritise where to commence this work with the resources available. Talent management framework conversations have commenced including an Extended EMT workshop held. Living our values: Agreement to hold an engagement event to bring all people who are working on culture related activity together to work on alignment of activity and establish a collaborative joined up approach. This work will be led by the new Head of People experience who commences with the Trust in August.

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:

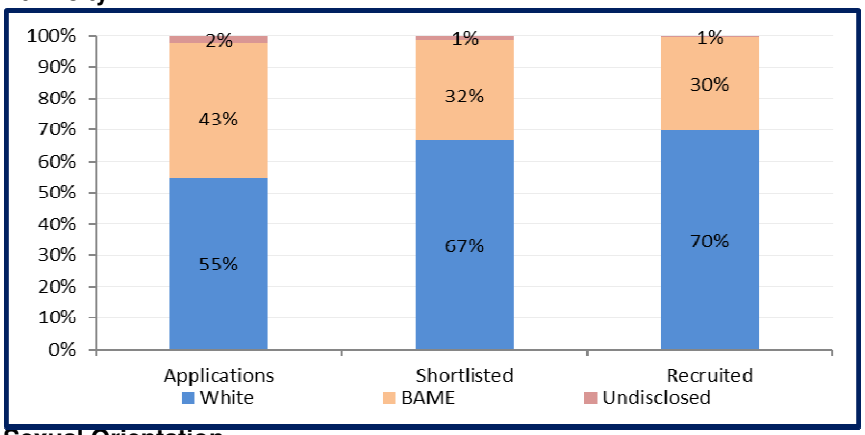
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and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

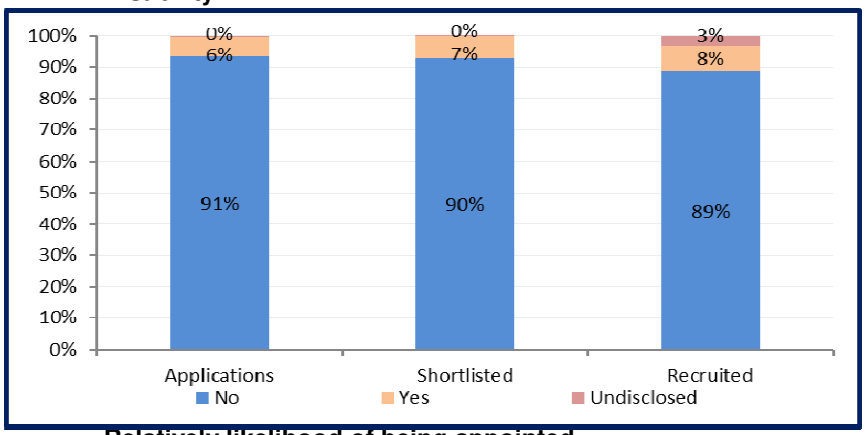
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024

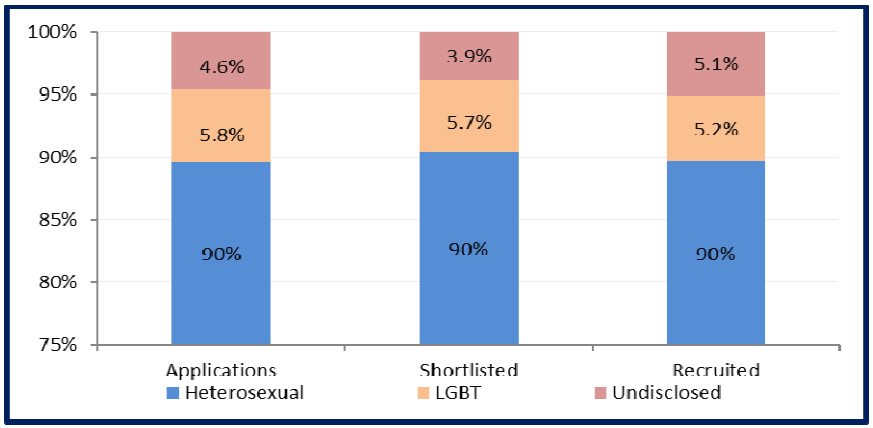
Ethnicity



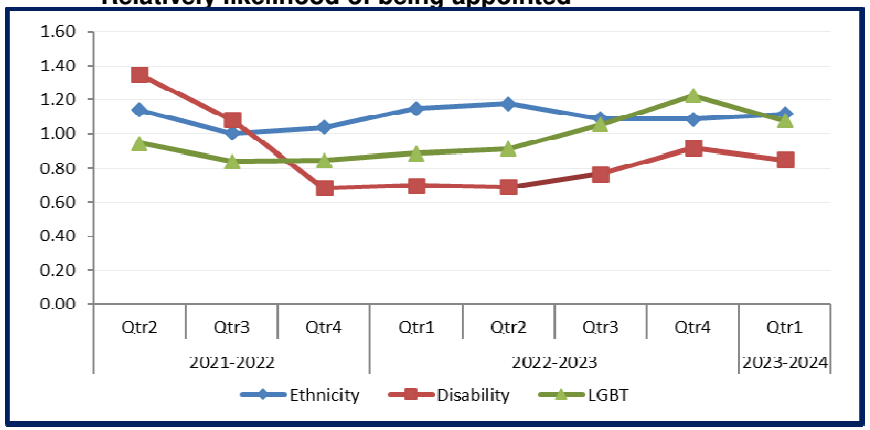
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 1 2023-2024:	BAME:	Disability:	LGBT:
	1.11	0.85	1.08

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024 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.

Please note, data includes any records where the relevant date (application submitted, applicant shortlisted, applicant recruited) falls within the rolling 12 months to the end of the reporting quarter

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

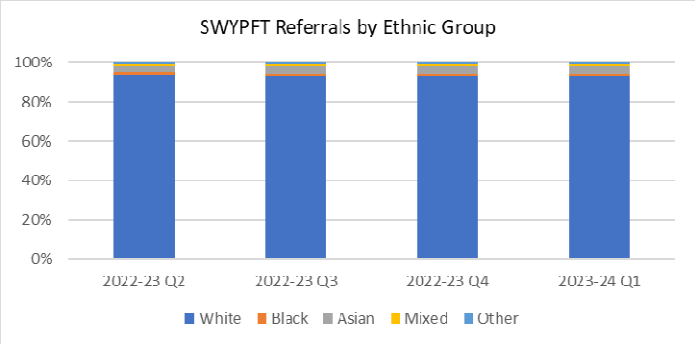
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.11
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.85
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 1.08
NB Relatively large proportions of undisclosed could unintentionally skew the data

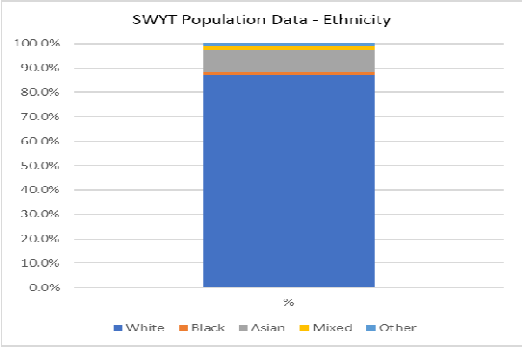
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

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

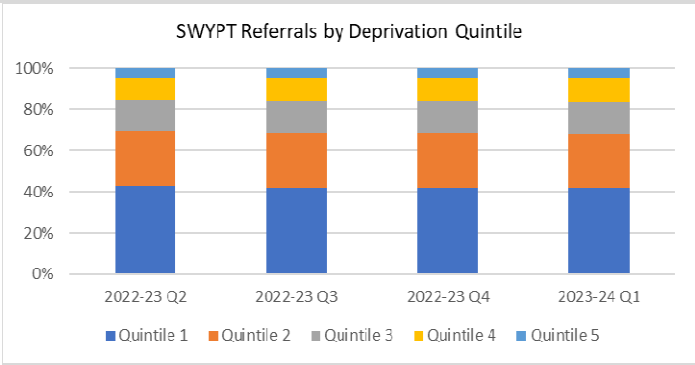
Reducing Inequalities

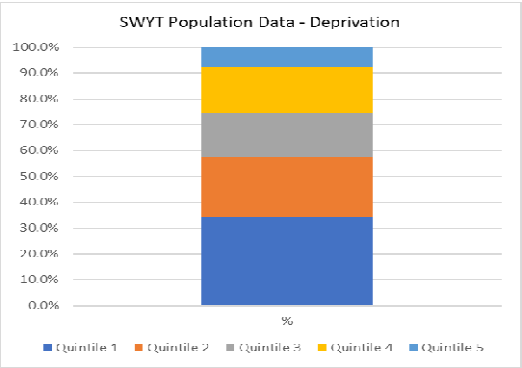
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	97.7%	93.1%	93.2%	93.1%	87.1%
Black	1.1%	1.0%	1.2%	1.3%	1.4%
Asian	3.3%	3.8%	3.5%	3.4%	8.9%
Mixed	1.0%	1.1%	1.2%	1.2%	1.6%
Other	0.9%	0.9%	0.9%	0.9%	1.1%



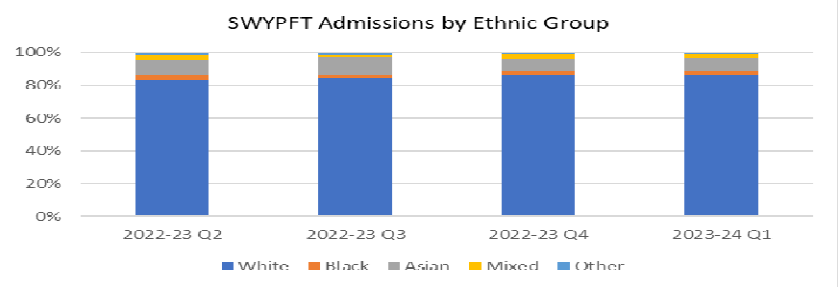


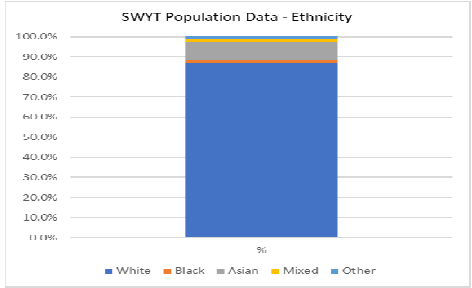
Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	42.8%	41.7%	41.8%	41.9%	34.1%
Quintile 2	26.4%	26.5%	26.6%	26.1%	23.4%
Quintile 3	15.2%	15.6%	15.2%	15.5%	17.0%
Quintile 4	11.0%	11.5%	11.6%	11.8%	17.8%
Quintile 5	4.7%	4.7%	4.8%	4.7%	7.8%

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.

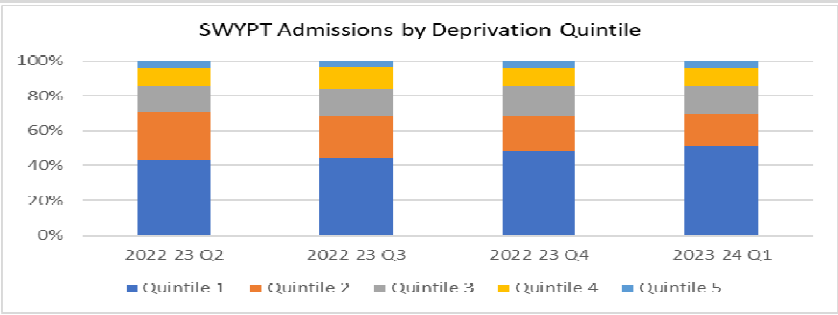
Reducing Inequalities

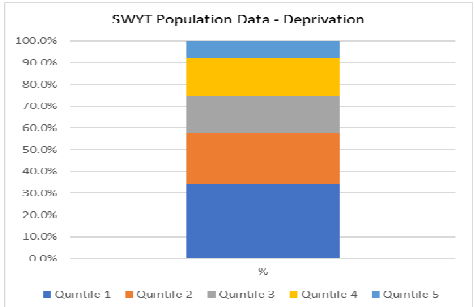
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	83.6%	84.4%	86.1%	86.6%	87.1%
Black	3.2%	1.7%	2.5%	2.2%	1.4%
Asian	8.6%	11.1%	7.6%	8.0%	8.9%
Mixed	2.7%	1.5%	2.7%	2.2%	1.6%
Other	1.8%	1.3%	1.1%	1.0%	1.1%





Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	43.6%	44.4%	47.8%	51.3%	34.1%
Quintile 2	27.4%	23.8%	20.5%	18.1%	23.4%
Quintile 3	14.5%	16.1%	17.3%	16.4%	17.0%
Quintile 4	10.7%	12.1%	10.5%	10.5%	17.8%
Quintile 5	3.8%	3.5%	3.9%	3.7%	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 1 for people from a white ethnic group were in line with that of the population the Trust serves.
- Admissions for people with a mixed ethnic group were slightly higher 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. 51.3% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
- The number of admissions from the least deprived areas (quintile 5) is in line with the previous 3 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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	84.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	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	16% 3/19	1
Service User Experience	Friends and Family Test - Mental Health	84%	88%	85%	85%	84%	86%	85%	83%	85%	83%	82%	85%	91%	1
	Friends and Family Test - Community	95%	93%	92%	93%	93%	93%	94%	93%	95%	97%	94%	97%	96%	1
Quality	Number of compliments received	N/A	31	10	13	5	28	39	83	22	26	50	66	33	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	31	19	35	32	33	30	40	30	35	24	34	28	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	0	0	0	2	2	2	3	2	2	1	1	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	1	2	1	0	0	0	2	1	0	2	0	1
	% Service users on CPA offered a copy of their care plan	80%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	86.6%	1
	Number of Information Governance breaches 3	<12	10	9	13	11	13	8	12	8	13	12	9	14	2
	% of inpatients clinically ready for discharge	3.5%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	4.6%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	90%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	87.7%	*86.7%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	90%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	92.9%	*92.3%*	3
	Total number of reported incidents	Trend monitor	1179	1254	1168	1243	1308	1188	1247	1196	1249	1195	1321	1217	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	27	11	32	26	30	25	34	26	35	17	34	24	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	4	3	3	3	7	6	3	3	2	3	3	3	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	0	5	2	3	0	2	3	2	1	5	2	1	
	Safer staff fill rates	90%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	123.7%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	93.1%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	50	26	43	49	48	39	55	46	38	29	42	34	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	3	0	1	1	1	4	0	2	1	2	1	0	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%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	89.5%	1
	Number of Falls (inpatients)	Trend monitor	70	63	58	68	63	59	51	49	39	34	53	46	
	Number of restraint incidents	Trend monitor	171	161	160	169	223	189	212	223	203	192	186	201	
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	92.1%	87.8%	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	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
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		Good												
	CQC well - led rating		Good												

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 June increased to 201 from 186 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 remained below the 90% threshold for June 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 - 0 in June
• The number of people with a risk assessment/staying safe plan in place within timescale remains under the local threshold of 95%. A trajectory of improvement was set last month to achieve 90% by the end of June, this has been achieved by community services but inpatient services remain slightly below. 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 has increased in June and now is above threshold in June 2023 at 4.6%. 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 June there was a decrease to 38 from 53 in May. Further detail is provided in the relevant section of this report.
• The number of information governance breaches in relation to confidentiality breaches has increased to 14 during the month - further detail is provided in the relevant section of this report.

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.
We have received one upgrade to our test environment, however feedback from providers (including SWYPFT) to the national team and RLDatix Ltd was that this did not provide the functionality required to deliver this successfully. This has resulted in further work by RLDatix Ltd and the national team to develop this further, this remains underway. Consequently, this means we cannot progress with our test work or live implementation until the upgrade is received. This had been planned for 5th July but was stood down as the software was not ready to deploy. We remain on the waiting list for the changes to be made as soon as they are available. This applies to all providers using Datixweb (approximately 75% of Trusts).

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).

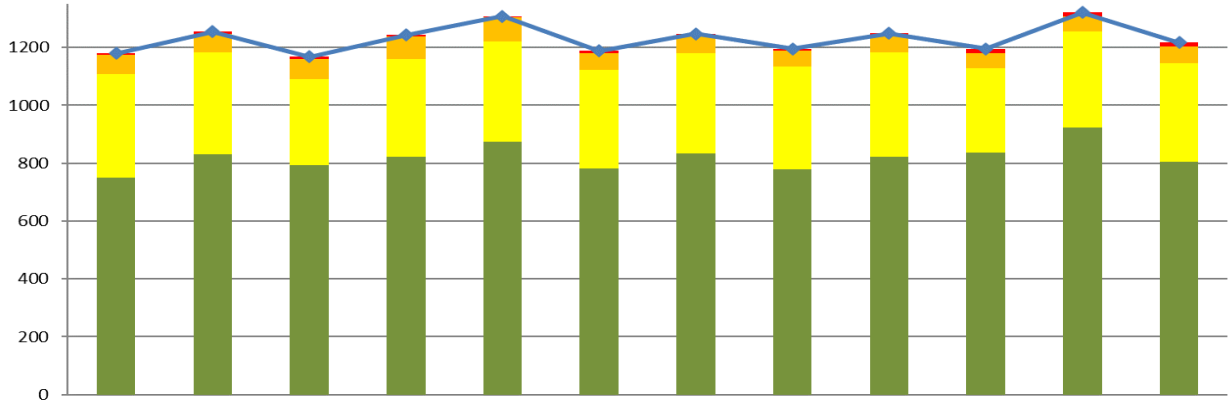
A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).

96% of incidents reported in June 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



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Red (should not be compared with SIs)	5	6	8	6	3	8	8	7	9	14	13	13
Amber	65	66	68	76	85	58	59	56	56	52	54	59
Yellow	358	350	299	339	346	341	346	353	363	293	332	341
Green	751	832	793	822	874	781	834	780	821	836	922	804
Total	1179	1254	1168	1243	1308	1188	1247	1196	1249	1195	1321	1217

The Trust's 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 June 2023

Safety First cont…

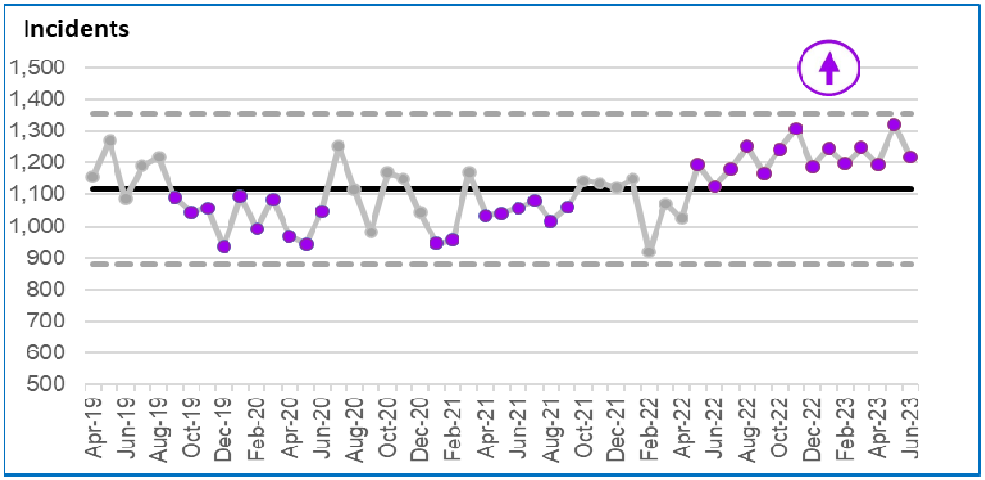
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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 June 2023:
24 moderate harm incidents
3 severe harm incident s
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

Patient Safety Alerts

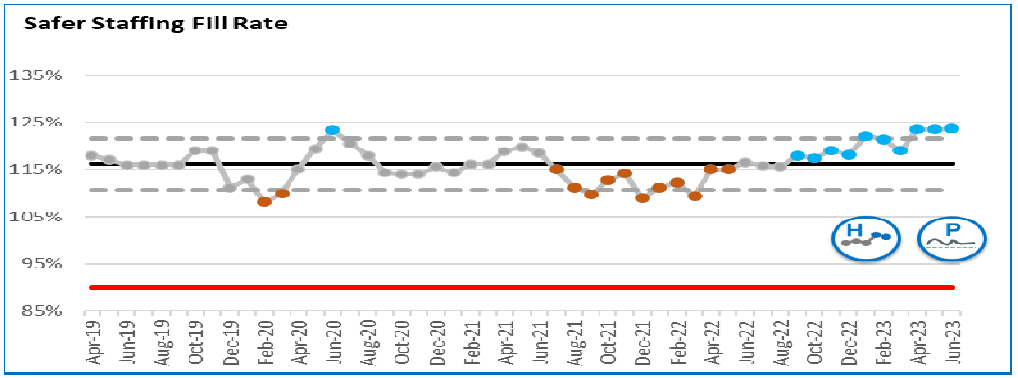
Patient safety alerts issued in June 2023

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.

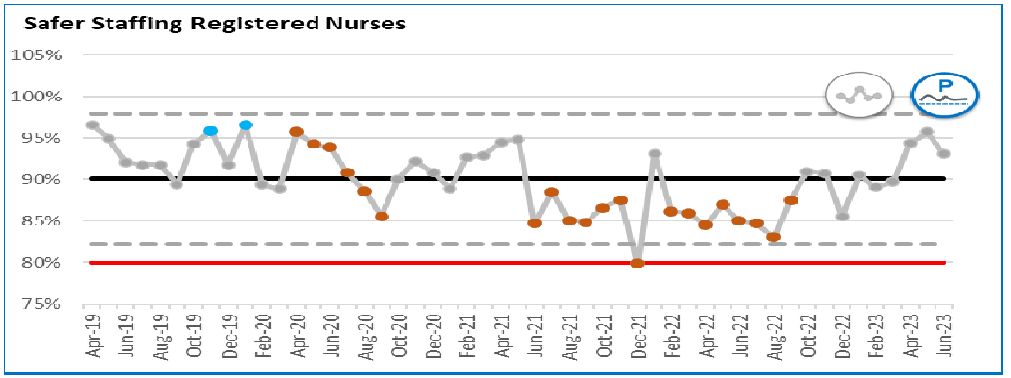
There were no patient safety alerts not completed by the deadline of June 2023.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	27/06/2023	No - alert not applicable to Trust	01/12/2023	27/06/2023

Safer Staffing Inpatients



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

During June there has been an increase in demand of the flexible staffing pool with a total of 261 more shift requests. The number of shifts filled has increased by 24 shifts to a total of 5,004 and fill rates increased overall for inpatients however two care groups decreased slightly. The continued high fill rate of requested shifts (86.55%) is due to the availability of staff, increasing the bank resource, continued engagement with our master agency partner and the ongoing flexibility and contingency planning of the operational colleagues. The cancellation of shifts that have not been filled by wards has had a negligible impact on the number of unfilled shifts.

A reduction or increase in requests does not equate to a reduction or increase in acuity. This should not be seen as achieving our requirements as this describes our fill rate compared to our budgeted figures (capacity) and not our acuity (demand). Historically June has shown an increase in fill rates as staff look to banks shift to supplement their wages over the holiday period. We continue to monitor staffing related Datix, 12 in June (6 less than the previous month) and looking at hotspots and trend analysis of staffing deficits where possible.

Both bespoke adverts and centralised recruitment continues and there are 3 assessment centres throughout July/August for band 5 substantive and bank, as well as band 2 substantive and bank. We have flattened the recruitment process for students both on bank and external. We are reviewing all agency block bookings to replace with bank if feasible.

We continue with bespoke band 5 registered nurse (RN) adverts as well as the international recruitment. To date we have had 64 internationally recruited band 5 nurses with 54 being on the wards throughout the Trust, including on the neurological rehabilitation unit. We have received financial support from NHSE through to Q3 and are awaiting the outcome of the new NHSE funding bid.

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

Project plans for the continued roll out of SafeCare and getting all teams onto the health roster system have been agreed by EMT and are ongoing.

Although we continue to sustain the overall fill rate, we continue to fall short of the RN fill rate for day shift and will continue to look at ways of improving this. This has meant that 19 wards, an increase of one on the previous month, have fallen below the 90% RN day fill rate. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to deliver a high quality of care, as well as being safe, however this has impacted on section 17 leave being taken at times as well as other interventions being delayed.

We look at various fill rates in the report which gives a definitive picture of staffing compared to our establishment template – the number of staff that are budgeted for - however this must not be looked at in isolation as it is not a true reflection of the requirement of the teams. This is what is meant by capacity (budgeted staffing numbers) v demand (acuity and requirement).

In June no ward fell below the 90% overall fill rate threshold which is a decrease of one ward on the previous month. Inpatient areas continue to experience high acuity as identified above. There is ongoing interventions, projects, and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. A decrease of two on the previous month, there were 24 (76.8%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 24 wards, 15 (an increase of three on the previous month) achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts.

Safer Staffing Inpatients cont…

Although safe and effective staffing remains a priority in all our teams, and the systems wide increase of acuity, the focus for the flexible staffing resources has been Poplars and Crofton within older people's services and the Oakwell Centre. 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 decreased by 0.9% to 87.8% in June compared with the previous month.
Registered Nurses Nights: Overall registered Night fill rates have increased by 0.1% in June to 102.8% compared with the previous month.
Overall Registered Rate: 95.3% (decreased by 0.4% on the previous month)
Overall Fill Rate: 123.7% (increased by 0.2% on the previous month). Health Care Assistants showed an increase in the day fill rate of 2.1% to 141.2% and the night fill rate decreased by 0.9% to 150.3%.
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	395	(+57)	4287.08	32.62%	(+4.04%)	**832**	**(-2)**
Unregistered	391	(+59)	4308.75	8.60%	(+0.62%)	**4210**	**(+36)**
Grand Total	**786**	**(+116)**	**8595.83**	**13.45%**	**(+1.70%)**		

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 increase on the flexible staffing resource and look at what appropriate resources are required from the Trust bank flexible staffing resource.

Information Governance (IG)

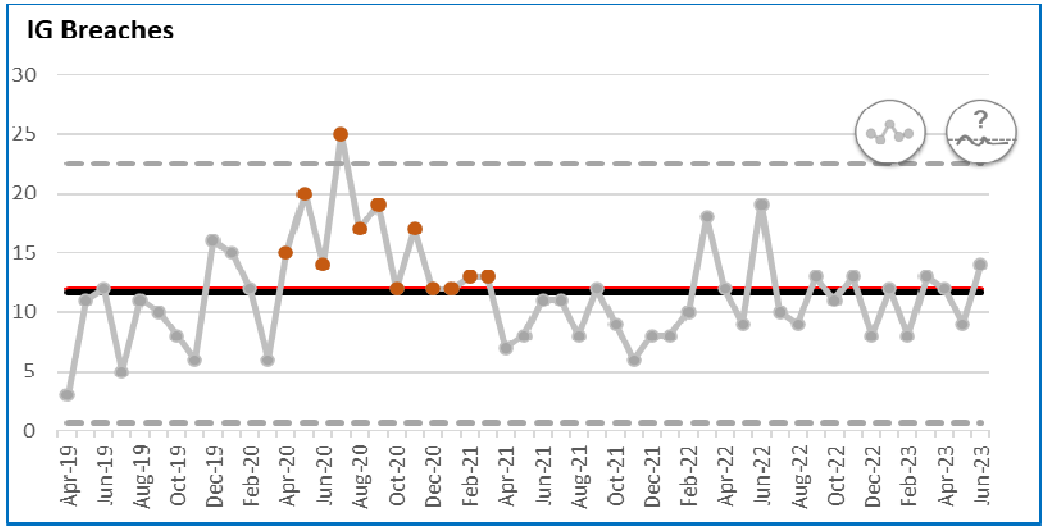
14 personal data breaches were reported during June, which is an increase on recent months and over the threshold of 12. These incidents were spread across all care groups. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity.

Nine breaches involved information being disclosed in error i.e. due to post and emails being sent to the wrong recipient, correspondence being sent without patient consent, patients supplied with another's patient's data, wrong person being given access to a shared folder and confidential papers being put in general waste.

Two incidents were reported by inpatient services involving patients accessing secure areas and being party to other patients' data. A further incident involved the loss of paper data and the lost record process being invoked.

The Data Protection Officer (DPO) is working with communications colleagues on the development of a poster campaign which highlights the impact on individuals of data breaches.

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



This SPC chart shows that as at June 2023 we remain in a period of common cause variation. Though we are over the threshold of 12 breaches.

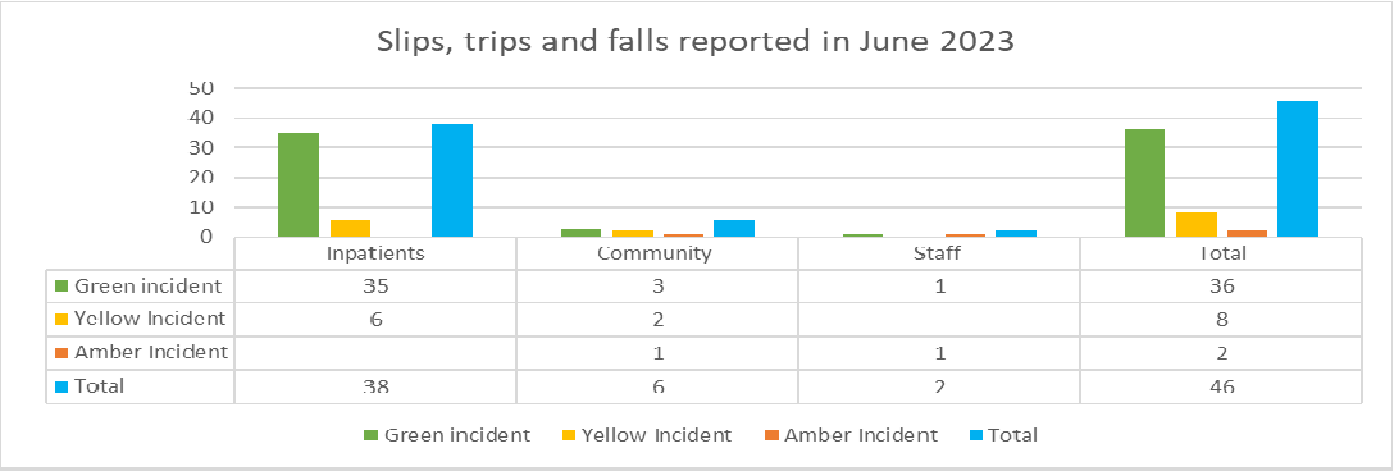
Commissioning for Quality and Innovation (CQUIN)

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 one. Submission is due towards the end of august and therefore further update around associated risks and forecast achievement can be expected in next months report.

Trustwide Falls

June 2023 has seen 46 slips, trips and falls related Datix reports. Below is a breakdown of falls and if they occurred in the community, inpatients, or staff group. 25 of these reports are still waiting final approval.



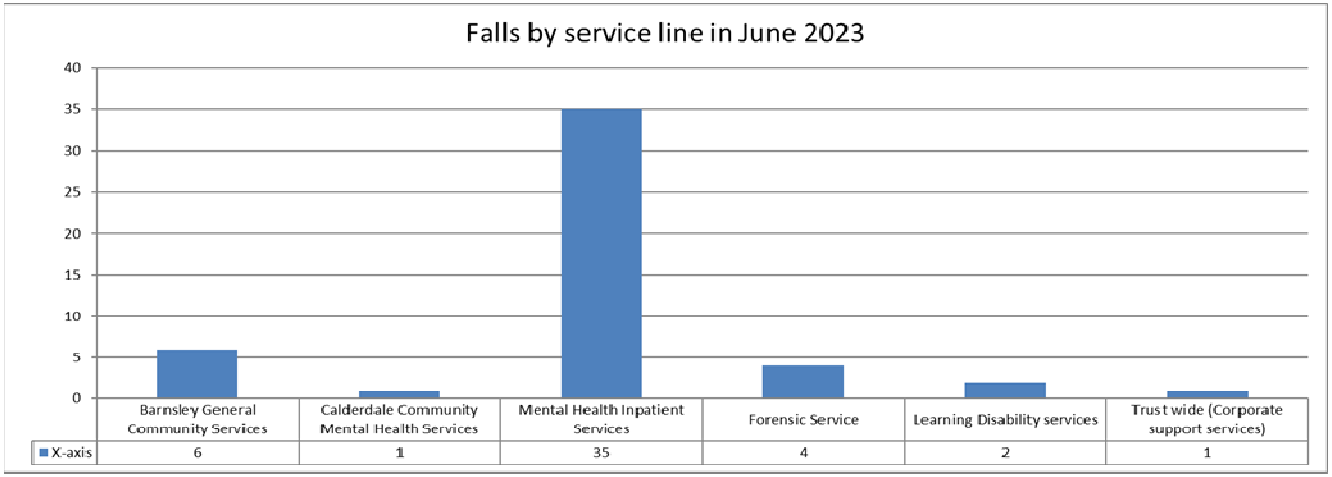
	Inpatients	Community	Staff	Total
Green incident	35	3	1	36
Yellow Incident	6	2		8
Amber Incident		1	1	2
Total	38	6	2	46

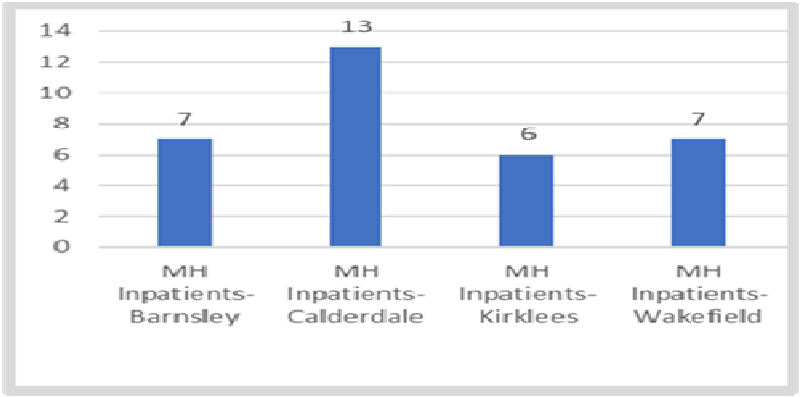
Amber incident: 2 incidents reported.
• One incident was a service user who fell in the community
• Another was a staff member who fell during training

Yellow incident: 8 incidents reported, service users who suffered minor injuries following a slip, trip or fall.
• No significant injuries were sustained, and no themes were highlighted

Green incident: 36 incidents reported, the majority of reported slip, trips or falls were graded as green, indicating no harm or low-level injury.
• Some of these Datix reports occurred whilst service users were on leave in the community or at home

Falls by care group: Most falls continue to occur on older adult inpatient wards. Falls incidents can fluctuate, these being linked with complexity of service user presentation such as dementia diagnosis, deconditioning or agitation.





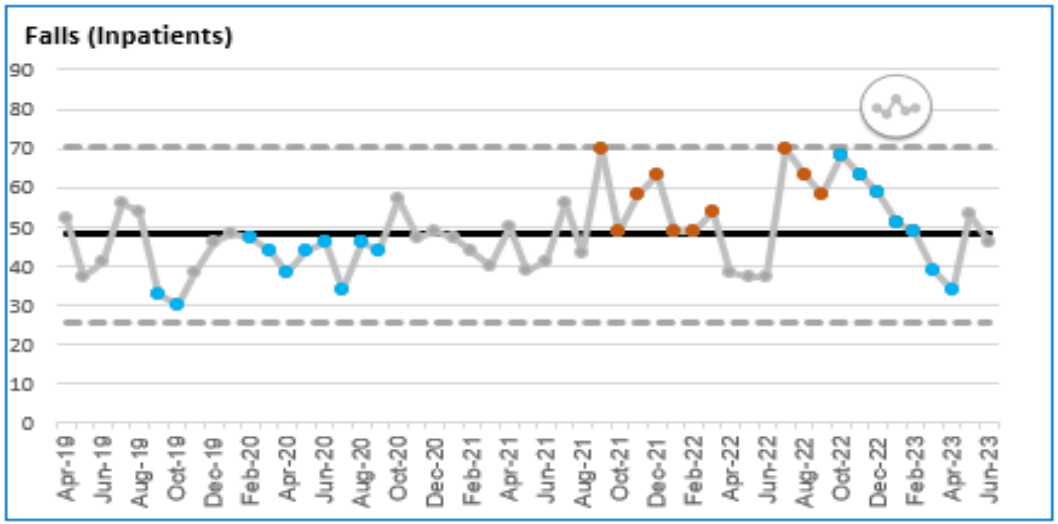
The graph opposite shows a breakdown of ward location and the amount of falls they have had.

Actions

• Datix reports reviewed by falls coordinator, providing support and insight, whist highlighting any recurrent themes or service users who have been repeatedly falling
• The falls coordinator has been completing dip checks on a small number of services user cases, reviewing the FRAT-18 falls risk screen tool, and post falls protocol. Initial findings:
    • not all tools are completed
    • no post falls protocol completed when required
    • standard and quality of completed tools varies, requiring improvement
    • falls coordinator is now reviewing and working with locality matrons to improve this
• The generic falls environmental checklist has been trialled and completed on three older adult wards this month. It has shown two wards that would benefit from having improved falls alert systems and light sensors. This data has been shared with the senior management team.
    • It has been agreed we can use this checklist Trustwide
• There has been a small increase in falls occurring on Beechdale Ward due to a service user who has an infection and also a level of deconditioning prior to admission. This was quickly recognised and treated
• The falls coordinator has visited Trust neuro-rehab ward at Kendray Hospital. Staff have been working proactively to reduce falls incidents on the ward, e.g. have a noticeboard stating how many days since the last fall.

Falls (Inpatient)

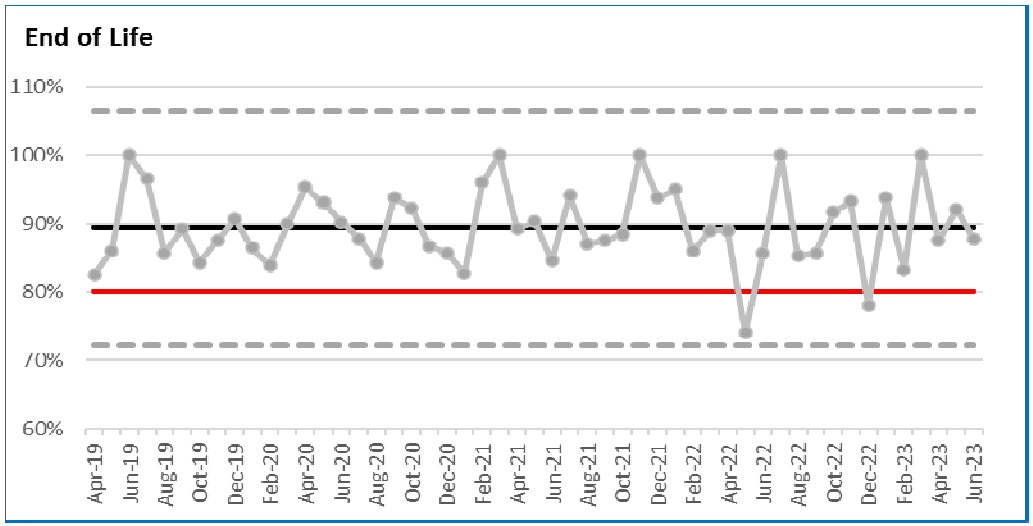
The total number of falls was 46 in June. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in June 2023 we remain in a period of common cause variation. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 87.8% in June.



The chart above shows that in June 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

- 96% would recommend community services
- 91% would recommend mental health services

Mental Health Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
Community Services	85%	83%	88%	90%
Acute	85%	93%	80%	97%
Secure & Forensics	60%	100%	72%	100%
Other*	85%	82%	82%	100%
Total	**84%*** **	**82%**	85%	91%

Specialist Services Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
ADHD	85%	44%	50%	50%
CAMHS	75%	76%	85%	97%
Learning Disability	85%	100%	100%	100%

Community Services Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
Children & Families	95%	93%	96%	100%
Inpatient	95%	100%	100%	100%
Nursing	95%	100%	100%	97%
Other	95%	100%	100%	100%
Rehabilitation & Therapy	95%	94%	93%	97%
Specialist**	95%	95%	97%	88%
Total	**95%**	**94%**	97%	96%

*includes Insight team, perinatal, friends and family team

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

*** weighted for 2023/24

Patient Experience

Satisfaction has increased in mental health services and for the Trust as a whole. Satisfaction within secure and forensic services has seen an increase from 72% in May to 100% in July and acute services has increased from 80% in May to 97% in July.

Community services have seen a slight decrease in satisfaction throughout June (97% to 96%) but with notable increase in satisfaction for rehab therapy, from 93% to 97%. A decrease is noted for specialist services but it is worth noting that numbers for this service are very small and therefore a reduction of one shows as a larger decrease in satisfaction rating (2/15, nothing of note identified within the comments).

ADHD results are based on 2 out of 4 responses. Work continues to be undertaken with the ADHD team to address the response rate and feedback received.

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

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

Themes can be both positive and negative in nature.

Safeguarding

Safeguarding Adults:
In June 2023, there were 35 Datix categorised as Safeguarding Adults. 17 of these were graded as green, 16 were graded as yellow and two were graded as amber.
The sub-categories of the Safeguarding Adults Datix were as follows:

- emotional/psychological abuse.
- financial abuse
- physical abuse
- neglect
- sexual abuse
- self-neglect
- domestic abuse
- hate crime/discriminatory abuse

Of the amber Datix, there was:

- One categorised as emotional/psychological abuse which related to a group chat that was used to share plans around self-harm, suicide and going missing. This was discussed with the service user's key workers and the police.
- One categorised as physical abuse from a service user to a friend. The reporting staff member was advised to report concerns to the police.

In addition to the Safeguarding Adults Datix, there were 11 sexual safety Datix, all of which were graded as green or yellow. In three of these Datix, a member of staff was the affected person, in one it was another resident in the care home where the service user resided, and in the remaining seven Datix, services users were the affected persons.

Safeguarding Children:
In June 2023, there were 13 Datix categorised as Safeguarding Children. Eight of these were graded as green, four were graded as yellow and one was graded as amber.
The sub-categories of the safeguarding children Datix were as follows:

- child neglect
- physical abuse
- sexual abuse of a child
- request for service
- child protection

The amber Datix categorised as child neglect was due to concerns around a parent and their mental health.
In all of the 13 Datix submitted, referrals were made to Safeguarding Children Teams and Trust safeguarding advice was sought in eight cases. Appropriate actions were taken following all incidents.

Infection Prevention Control (IPC)

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

Mandatory training figures are healthy:
Hand Hygiene-Trust wide Total – 96%
Infection Prevention and Control- Trust wide Total – 94%
Remain above the Trusts 80% training compliance threshold.

Policies and procedures, 12-month extension request for policies that are for review in 2023, this is to accommodate implementation of the National IPC Manual, which has a target date of March 2024. The current policies and procedures remain compliance, and there is no risk in the system.

Outbreaks
There have been no outbreaks in June 2023, however there has been one area monitored.

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 – 2 (17%)
- Number of complaints waiting to be allocated to a customer service officer – 23
- Number of cases who breach the six months target who have not had a conversation to agree a new timeframe for completion 0% – all complainants are updated and have either received the monthly delay/update letter apologising for the delay (for those waiting to be allocated to a case handler), or for those allocated a case handler are updated regarding the progression of their complaint throughout the complaint process/journey.
- Longest waiting complainant to be allocated to a customer service officer –11 weeks average.
- There were 19 new formal complaints in June 2023
- Of these 2 have a timescales start date, 13 are awaiting consent and 3 are awaiting allocation.
- 16% of new formal complaints (n=3) have staff attitude as a primary subject.
- 33 compliments were received.
- Customer services closed 12 formal complaints in June 2023.
- Number of concerns (informal issues) raised and closed in June 2023 – 39
- Number of enquiries responded to in June 2023 - 141
- Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 0

Reducing Restrictive Physical Intervention (RRPI)

There were 201 reported incidents of reducing restrictive physical interventions used in June 2023 this is an increase of 15 (8%) incidents from May 2023 which stood at 186 incidents. This is within normal variation for this data.

89.5% of prone restraints in June 2023 lasted under 3 minutes. In June 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 19 times of 323 (5.8%) of total restraint positions, this is an increase of 4 from last month which stood at 15 of 283. There were two incidents with a duration of 3-4 minutes and this was due to ensuring the safe administration of crisis medicine management whilst exiting seclusion.

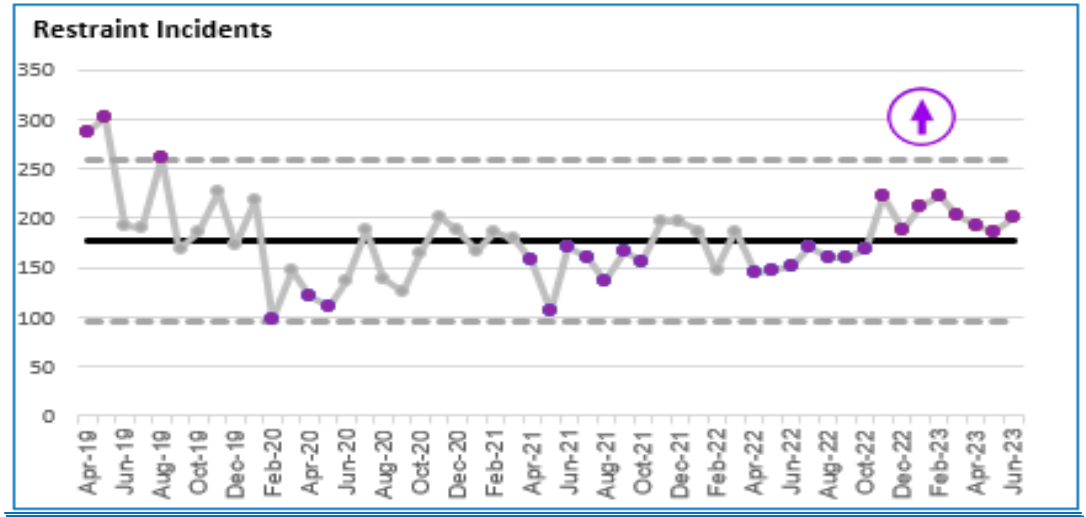
Horizon centre reported 8 incidents of prone restraint and all the incidents involved the same service user. The service user has complex needs and has experienced past trauma. The team on Horizon have worked closely with the RRPI team to explore least restrictive options. The service user has a positive behaviour support plan (PBS) and when seclusion is required it is used for the shortest time possible with staff utilising seclusion in a flexible manner as per Mental Health Act Code of Practice (2015) The 8 prone restraints are connected to when staff are exiting seclusion safely during which there is a significant risk of harm to staff. Further in-reach work continues to be provided by the RRPI team who regularly review and offer guidance on incidents reported via Datix.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	129	40.0%
Seated	55	17.0%
Supine	39	12.0%
Safety Pod	32	9.9%
Restricted escort	20	6.1%
Prone	19	5.8%
Side	15	4.6%
Prone then rolled	8	2.4%
Kneeling	6	1.8%
Total	323	

Team Using Prone Restraint	Total
Horizon Centre Assessment and Treatment Service	8
Melton PICU, Barnsley	3
Newhaven Forensic Learning Disabilities Unit	2
Elmdale Ward	1
Hepworth Ward, Newton Lodge, Forensic	1
Nostell Ward, Wakefield	1
Stanley Ward, Wakefield	1
Walton PICU	1
Ward 18, Priestley Unit	1
Total	19

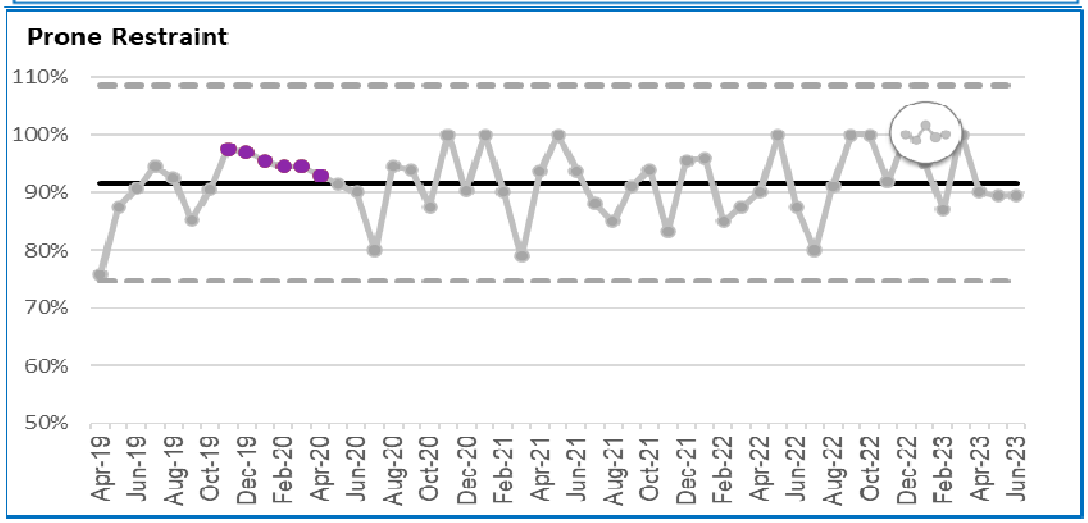
Duration of Prone Restraint Position	Total
0 - 1 minute	10
1 - 2 minutes	4
2 - 3 minutes	3
3 - 4 minutes	2
Total	19

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in June 2023 we remain in 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 June 2023 means that we remain in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Establishment	Improving Resources	Well Led	-	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	5,193.8
Employed Staff (ESR last day in the month)			-	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	4,273.6
Vacancies			-	723.1	795.3	816.5	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0	818.4
Vacancy rate			<10%	14.7%	15.9%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%	15.8%
Turnover external (12 month rolling)			>12% - <13%	15.5%	15.2%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%	13.1%
Starters			-	46.4	58.1	69.5	56.9	50.5	26.6	65.4	70.2	58.1	47.2	59.3	57.5
Leavers			-	56.9	56.3	51.6	48.2	40.6	27.5	60.1	38.5	43.1	58.8	39.6	37.0
Sickness absence - Rolling 12 month			<=4.8%	4.9%	4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	5.5%	4.7%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%	4.6%
Employees with long term sickness over 12 months			-	-	0	2	2	2	2	4	2	2	1	0	0
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	55.8%	61.3%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%	78.5%
Employee Relations - Suspensions (over 90 days)			-	1	2	2	2	2	3	3	1	1	0	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	87.2%	90.7%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%	92.0%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%	76.7%
Mandatory Training - Cardiopulmonary Resuscitation				74.6%	75.7%	75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%	81.3%
Mandatory Training - Clinical Risk				96.2%	96.4%	96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%	95.4%
Mandatory Training - Display Screen Equipment				94.3%	94.9%	95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%	97.0%
Mandatory Training - Equality & Diversity				94.1%	93.9%	94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%	96.2%
Mandatory Training - Fire Safety				87.4%	87.1%	86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%	92.8%
Mandatory Training - Food Safety				79.3%	79.8%	79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%	86.4%
Mandatory Training - Freedom To Speak Up (FTSU)				86.8%	88.2%	89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%	94.0%
Mandatory Training - Infection Control & Hand Hygiene				87.3%	87.7%	88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%	94.1%
Mandatory Training - Information Governance (Data Security)			>=95%	92.9%	92.5%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%	96.8%
Mandatory Training - Moving & Handling			>=80%	95.7%	95.3%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%	95.2%
Mandatory Training - Nat Early Warning Score 2 (New S2)				84.3%	85.6%	86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%	93.8%
Mandatory Training - Mental Capacity Act/Dols				93.3%	93.5%	93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%	93.7%
Mandatory Training - Mental Health Act				89.5%	90.4%	90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%	91.2%
Mandatory Training - Prevent				94.6%	95.1%	95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%	92.1%
Mandatory Training - Safeguarding Adults				89.1%	89.7%	89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%	89.3%
Mandatory Training - Safeguarding Children				89.9%	89.7%	90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%	91.1%

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.

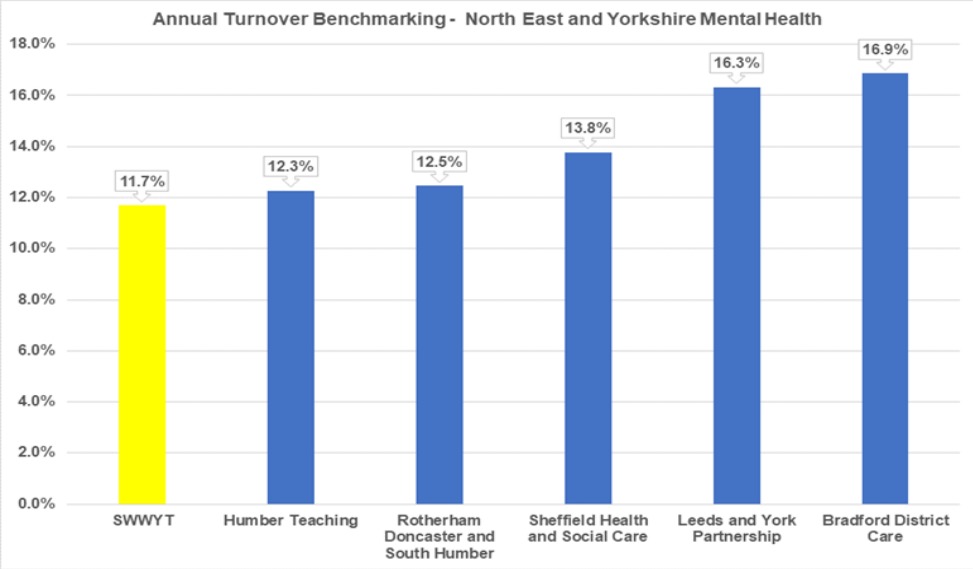
• Starters/Leavers - variation in alignment to establishment exists due to a number of factors such as, data taken as a snapshot so will not reflect any changes made on the system after the extraction date as well as changes in contractual hours that cannot be retrospectively applied.

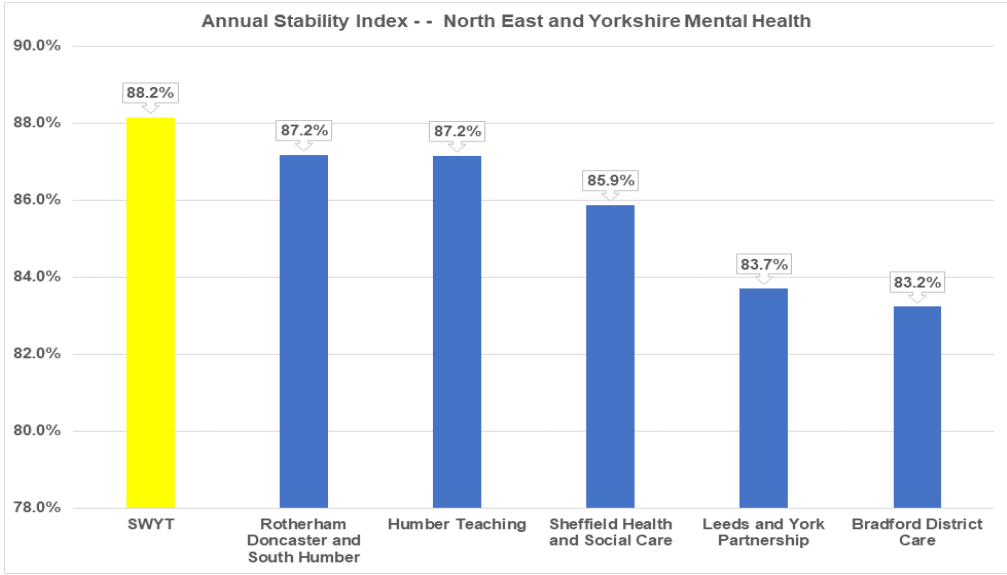
• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.

• 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 7.4 whole time equivalents (WTE) in June.
- Staff in post workforce growth since April stands at 0.77% against a target of 3% for the year (on target)
- Rolling and year to date turnover is 13.1%, which is a slight increase from last months position (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

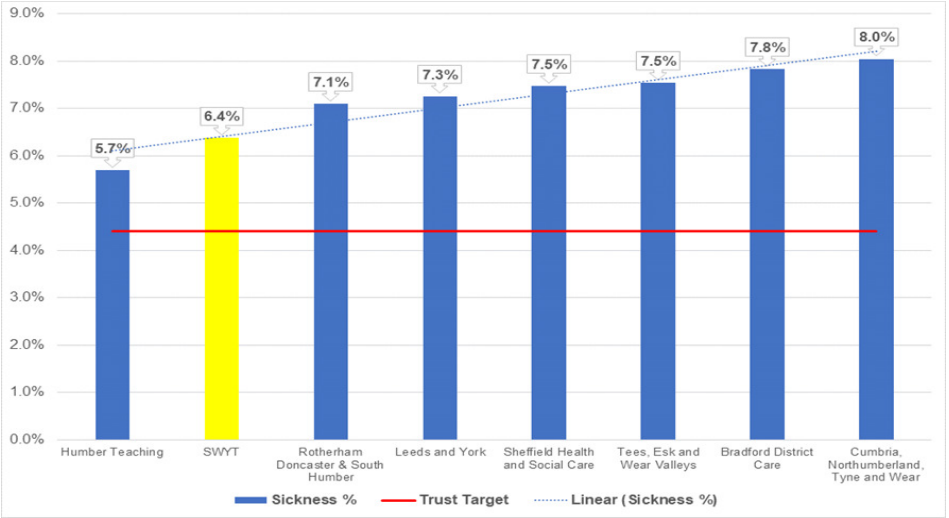
• 12 month rolling absence rate remains at 5.3%.

• Forensics absence saw a further increase in month of 1% from previous month to 7.9%. 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. The Forensics human resource business partner role is working closely with Forensics to identify hotspots and targeted reduction

• Estates and Facilities absence increased during June 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. This increase has been seen due to small increases in long term sickness cases (3).

• Stress related absences still accounts for the largest reason increasing to 37%. (This remains constant around 34-37% Trustwide)

• 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

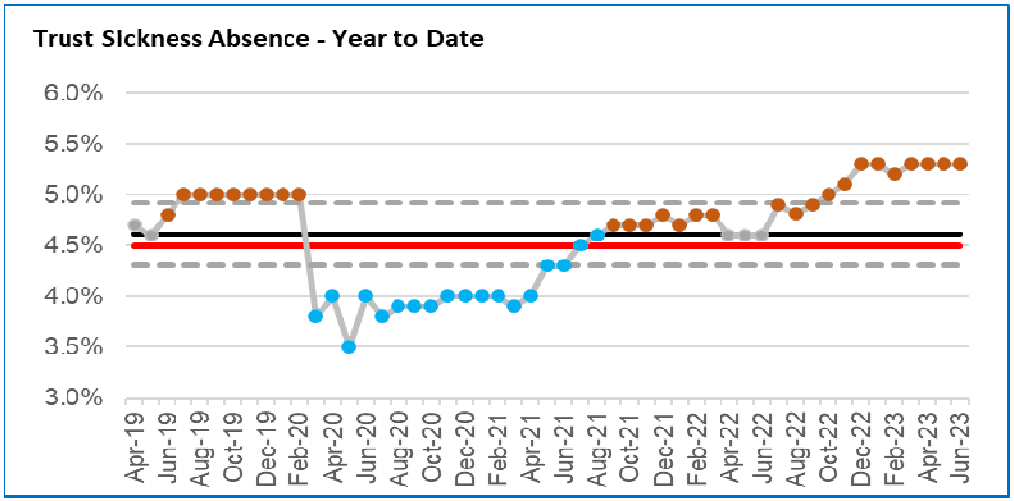
• For the month of June, the percentage rate increased by 3.6% to 78.5%.

Mandatory Training

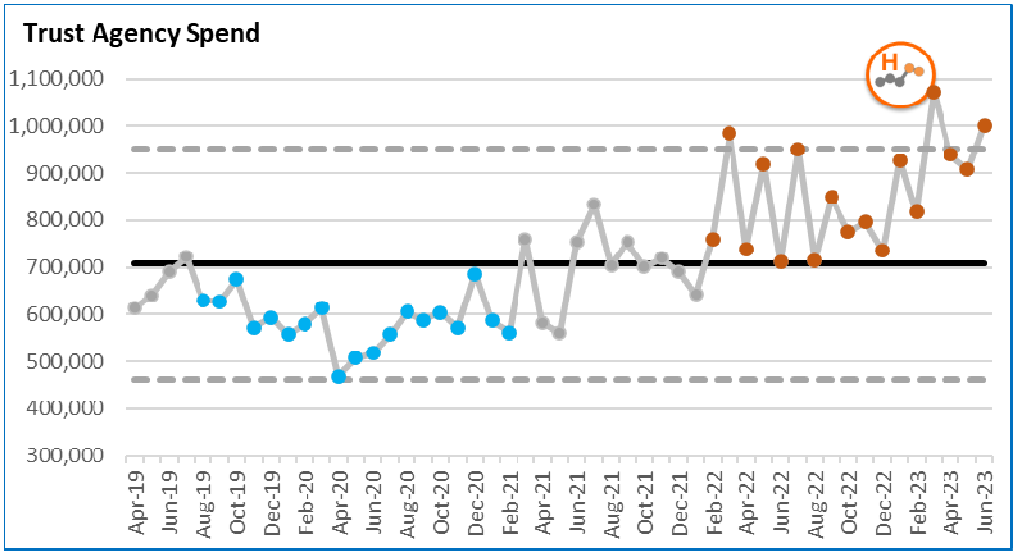
• Overall mandatory training reports 92% which remains above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by operational management group.

• 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.

Analysis



The SPC chart shows that in June 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 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 and has commence in June for all care groups to focus on individual long term agency placement.

• The Trust have been working with Liaison Contingency Workforce since April to understand our efficiency in utilisation of eRostering, bank, agency and workforce management. The outcome of that work is due on the 2nd August with following recommendations and report due into Agency Scrutiny Group on the 10th August.

• Alternative marketing campaigns to engage wider markets. Several national and local recruitment events booked between now and November and Yorkshire Pride events attended in June and July. Recent recruitment events attended in Wakefield, Calderdale and Manchester along with University fair attendance and virtual online events conducted (work with Touchstone to engage under-represented/hard to reach groups).

• 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. Further additional assessment centres planed over the next few months to cater for demand in application.

MEDICAL APPRAISALS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number expected to be undertaken in period	37			
Number undertaken in period	34			
Number not undertaken for which the RO accepts postponement is reasonable	2			
Percentage of appraisals taken place	92%			
Percentage of appraisals signed off in period as satisfactory	92%			

MEDICAL REVALIDATIONS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of revalidation recommendations due in period	5			
Number of positive recommendations	5			
Number of deferrals	0			
Number of non-engagements	0			
Percentage of revalidation recommendations made	100%			

RESPONDING TO CONCERNS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of active cases under Maintaining High Professional Standards procedures	0			

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

• The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) 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 care group 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	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-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.	0	0	0	0	0	0	0		
Inappropriate out of area bed days	Q1 - 455	482	511	511	457	574	441		
Community health services two hour urgent response standard	70%	87.5%	85.0%	83.8%	87.3%	86.6%	86.2%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	60%	92.6%	94.4%	81.3%	96.7%	94.4%	87.1%		
NHS Talking Therapies (formerly IAPT) - proportion of people completing treatment who move to recovery	50%	57.1%	53.9%	53.6%	52.7%	53.6%	*53.4%*		
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	Per Quarter - 1563	500	461	480	456	500	600		
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	No Target Set	978	792	886	724	929	799		
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	95.1%	95.7%	97.5%	97.9%	98.9%	99.6%		
Number of people accessing Individual Placement Support (IPS) services as a rolling total each quarter	19 per qu - Calderdale 15 per qu - Kirklees 5 per qu - Wakefield	40 Calderdale; 37 Kirklees; 31 Wakefield			45 Calderdale; 39 Kirklees; 32 Wakefield				
Number of individuals accessing specialist community perinatal and maternity mental health services	Q1 - 316	81	57	84	342	130	76		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	99%	88.0%	91.6%	79.8%	60.7%	53.3%	82.5%		

KPI	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Data quality rating [8]	Variation/ Assurance
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	87.9%	89.6%	86.6%	90.3%	90.6%	92.6%		
NHS Talking Therapies (formerly IAPT) - Treatment within 6 weeks of referral	75%	97.7%	97.6%	98.1%	97.8%	98.6%	*99.4%*		
NHS Talking Therapies (formerly IAPT) - Treatment within 18 weeks of referral	95%	99.8%	100.0%	99.8%	99.8%	99.8%	*100.0%*		
The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week	95%	87.5%	80.0%	87.5%	33.3%	80.0%	N/A*		
The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks	95%	88.6%	100.0%	100.0%	75.0%	89.5%	100.0%		
Data Quality Maturity Index	95%	99.4%	98.2%	99.6%	*98.0%*	*99.2%*	*99.5%*		
Total bed days of children and younger people under 18 in adult inpatient wards	0	8	31	44	15	11	30		
Total number of children and younger people under 18 in adult inpatient wards	0	2	2	2	3	1	1		
Number of detentions under the Mental Health Act (MHA)	Trend Monitor	184			188				
Proportion of people detained under the MHA who are BAME	Trend Monitor	19.6%			16.5%				
% Admissions gate kept by crisis resolution teams	95%	98.9%	99.0%	98.2%	100.0%	99.0%	100.0%		
% Service users on care programme approach (CPA) having formal review within 12 months	95%	95.8%	95.4%	97.6%	97.1%	97.4%	97.4%		
% clients in settled accommodation	60%	84.4%	84.4%	84.6%	84.4%	84.0%	*84.3%*	⚠	
% clients in employment	10%	11.6%	11.4%	11.2%	11.1%	11.5%	*11.7%*	⚠	
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	90%	98.1%	99.1%	98.9%	98.9%	98.4%	*99.0%*		
Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in contract technical guidance	99%	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	90%	99.4%	99.4%	99.4%	99.5%	99.5%	*99.4%*		

KPI	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Data quality rating [8]	Variation/ Assurance
The number of completed non-admitted RTT pathways in the reporting period	18000 (1500 per month)	Reporting from 23/24			1523	1719	2335		
The number of incomplete Referral to Treatment (RTT) pathways	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	1592		
Count of 2-hour urgent community response first care contacts delivered within reporting quarter	Q1 2800, Q2 2500, Q3 3700, Q4 3100	Reporting from 23/24			3103				
Virtual ward occupancy	80%	Reporting from 23/24			82.9%	44.3%	92.9%		
Community services waiting list (report split by 0-17; 18+)	Q1 5652, Q2 5430, Q3 5469, Q4 5198	Reporting from 23/24			Due August 2023				
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed Primary Care Networks) for adults and older adults with severe mental illnesses	Barnsley (3600 per quarter, 12 month rolling)	Reporting from 23/24			3469				
	Calderdale (2400 per quarter, rolling 12 month)				2382				
	Kirklees (5100 per quarter, rolling 12 month)				4998				
	Wakefield (3800 per quarter, rolling 12 month)				3688				
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Barnsley (2000 per quarter, 12 month rolling)	Reporting from 23/24			2137				
	Calderdale (1200 per quarter, rolling 12 month)				1089				
	Kirklees (3000 per quarter, rolling 12 month)				3045				
	Wakefield (3900 per quarter, rolling 12 month)				4322				

N/A* - no applicable cases during month

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 99.6%

• 72 hour follow up remains above the threshold at 92.6%. 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 increased to 82.5% in June from 53.3% reported for the previous month. This remains below threshold and has now entered a period of common cause 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 - no urgent cases were referred in June 2023.

• During June 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 30 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 53.4% for June. This metric is in special cause improving 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 June. This metric remains in 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.

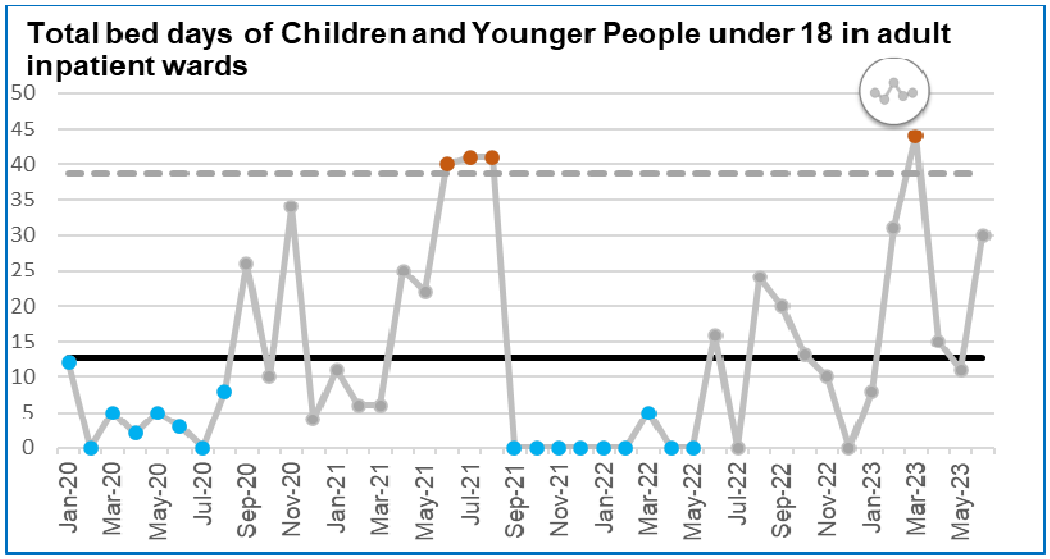
Data quality:

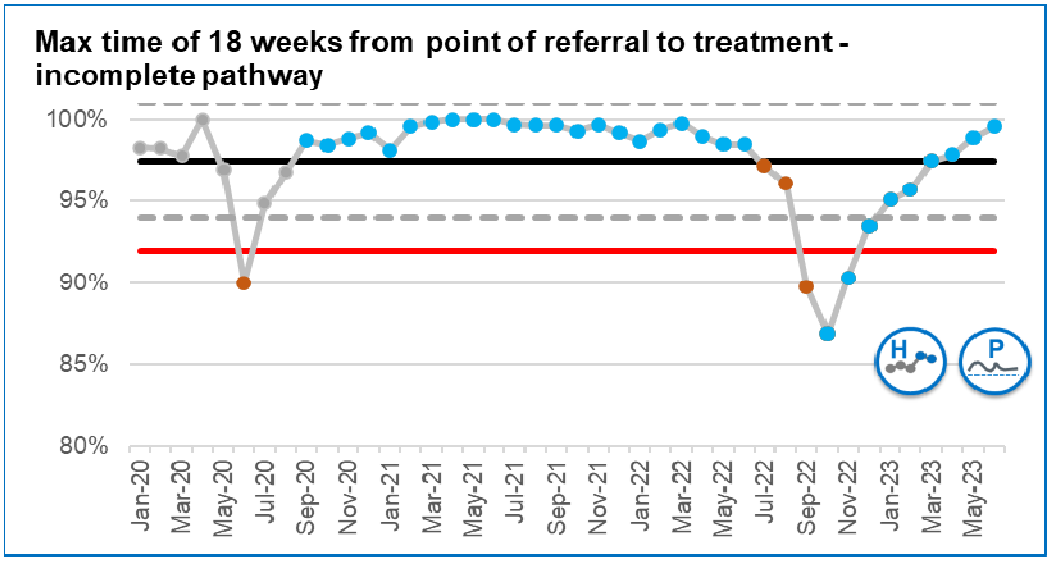
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of June 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.

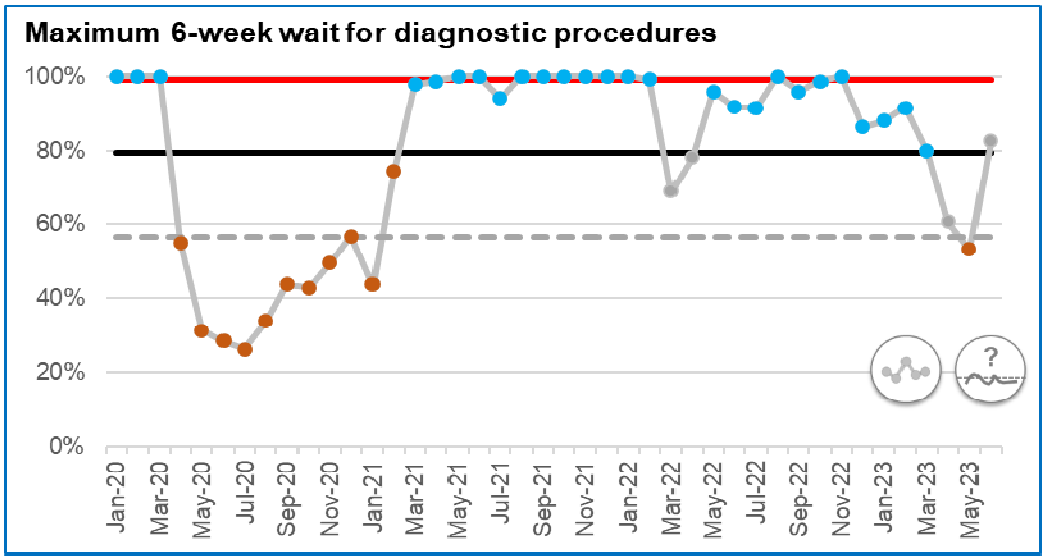
Analysis

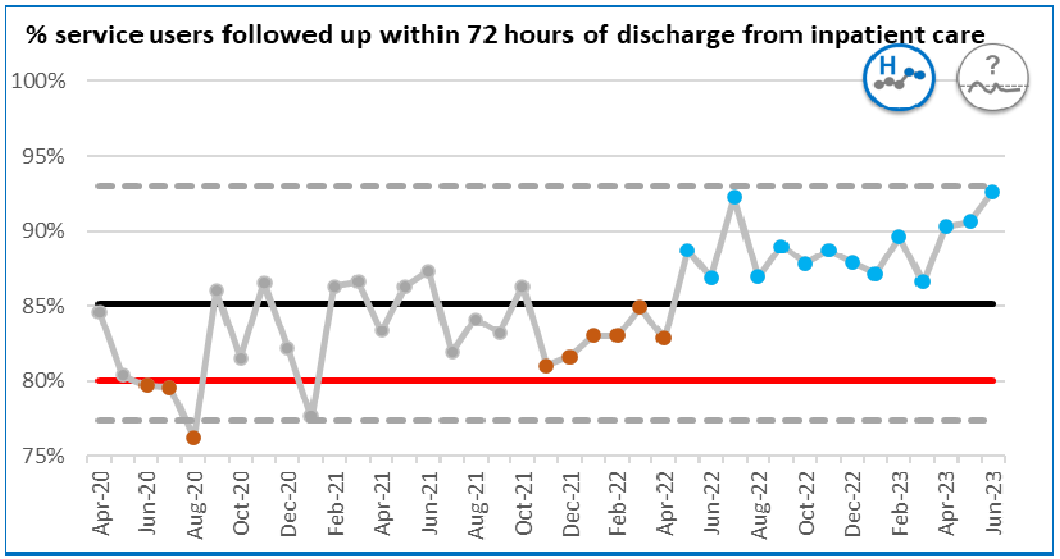




The statistical process control charts (SPC) above show that in June 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards. After consecutive periods of improvement against the referral to treatment metric we remain in a period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

Analysis





The SPC charts above show that for June 2023 for clients waiting for a diagnostic procedure we have entered a period of common cause variation and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We are currently in a period of improving variation for clients discharged from inpatient care being followed up within appropriate timescales but again due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated.

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	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	75.1%	76.6%	
% Assessed within 14 days of referral (Routine)	75%	68.6%	80.5%	
% Assessed within 4 hours (Crisis)	90%	97.5%	95.7%	
% Complaints with staff attitude as an issue	< 20%	0% (0/5)	38% (3/8)	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.6%	92.6%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.5%	97.3%	
% Treated within 6 weeks of assessment (routine)	70%	98.0%	94.7%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	80.5%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	92.9%	*92.3%*	
Information Governance training compliance	>=95%	97.1%	98.1%	
Reducing restrictive practice interventions training compliance	>=80%	69.5%	72.6%	
Sickness rate (Monthly)	4.5%	5.0%	3.8%	
% rosters locked down in 6 weeks				

Barnsley General Community Services

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	79.6%	81.5%	
% Complaints with staff attitude as an issue	< 20%	33% (1/3)	0% (0/1)	
% people dying in a place of their choosing	80%	92.1%	87.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.7%	85.2%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	95.3%	96.2%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	98.9%	99.6%	
Maximum 6 week wait for diagnostic procedures	99%	53.3%	82.5%	
Reducing restrictive practice interventions training compliance	>=80%	50.0%	57.1%	
Safer staffing (inpatient)	90%	114.0%	114.4%	
Sickness rate (Monthly)	4.5%	4.3%	4.6%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	52.3%	61.9%	
% Bed occupancy	85%	88.7%	87.2%	
% Complaints with staff attitude as an issue	< 20%	20% (1/5)	0% (0/5)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	75.6%	
% of clients clinically ready for discharge	3.5%	2.9%	6.8%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.7%	*86.7%*	
Inappropriate Out of Area Bed days	152	574	441	
Information Governance training compliance	>=95%	94.3%	94.5%	
Physical Violence (Patient on Patient)	Trend Monitor	23	22	
Physical Violence (Patient on Staff)	Trend Monitor	42	57	
Reducing restrictive practice interventions training compliance	>=80%	79.9%	81.8%	
Restraint incidents	Trend Monitor	111	***114***	
Safer staffing	90%	128.1%	127.8%	
Sickness rate (Monthly)	4.5%	4.2%	4.2%	
% rosters locked down in 6 weeks				

Forensic

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	69.3%	72.7%	
% Bed occupancy	90%	87.8%	83.9%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.3%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.1%	81.4%	
% 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%	95.2%	95.6%	
Physical Violence (Patient on Patient)	Trend Monitor	3	1	
Physical Violence (Patient on Staff)	Trend Monitor	18	12	
Reducing restrictive practice interventions training compliance	>=80%	83.6%	84.0%	
Restraint incidents	Trend Monitor	37	***26***	
Safer staffing	90%	113.5%	115.4%	
Sickness rate (Monthly)	5.4%	6.9%	7.9%	
% rosters locked down in 6 weeks				

LD, ADHD & ASD

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	72.1%	69.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/2)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.6%	85.8%	
% of clients clinically ready for discharge	3.5%	25.0%	25.0%	
Information Governance training compliance	>=95%	94.2%	95.4%	
LD – First face to face contact within 18 weeks	90%	78.5%		
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	33	39	
Reducing restrictive practice interventions training compliance	>=80%	78.6%	80.8%	
Safer staffing	90%	143.2%	144.7%	
Sickness rate (Monthly)	4.5%	5.2%	5.0%	
Restraint incidents	Trend Monitor	31	***26***	
% rosters locked down in 6 weeks				

CAMHS

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	80.5%	76.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/2)	
CAMHS - Crisis Response 4 hours	N/A	97.1%	95.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.3%	80.1%	
Eating Disorder - Routine clock stops	95%	89.5%	100.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	80.0%	N/A	
Information Governance training compliance	>=95%	96.7%	96.7%	
Reducing restrictive practice interventions training compliance	>=80%	72.2%	76.6%	
Sickness rate (Monthly)	4.5%	3.2%	4.6%	
% 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

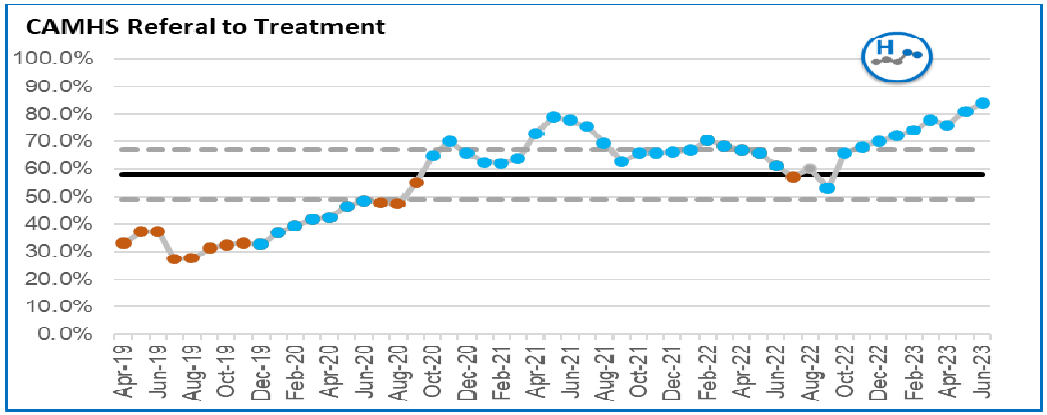
• Waiting numbers for Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans are in place (with Transformation Programme support) but the shortfall between commissioned capacity and demand remains.
• Eating disorder caseloads remain under pressure due to case acuity/complexity.
• There are ongoing issues with shortage of specialist residential and tier 4 places due to reduced capacity nationally and ongoing capacity issues locally. This is noted on the Trust risk register and work continues to improve patient flow.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues due to specific issues in relation to recruitment of band 6 nursing staff.
• Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.

Advise

• Waiting times from referral to treatment in Wakefield remain an outlier. Referral rates remain a key factor. The brief intervention and group work service offer has been strengthened, and medium term improvement is anticipated. Additional mental health support team investment has been confirmed which will enable further strengthening of the 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.
• A business case is being developed in Barnsley with respect to the specialist support offer for children with learning disabilities/special educational needs.
• A work programme is underway to ensure more seamless transition to adult ADHD/ASC pathways.
• Friends and family test results are above threshold at 80%.

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.
• The Trust has proactively engaged with provider collaboratives in South Yorkshire and Bassetlaw and West Yorkshire to strengthen the interface with inpatient providers and improve access to specialist beds.



As you can see in June 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:
• Due to vacancies, and challenges with recruitment, there is pressure on nurse prescribing within the service. There service is currently working with Pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary and one of the Band 6 staff within the service is to start the Independent Nurse Prescriber course in September 2023.
• Sickness absence is causing additional pressures in the team which has been supported by staff within General Community Services.
• Following the recent positive visit by the Integrated Care Board (ICB) Quality Team, and their suggestion of a resilience review in relation to staffing levels etc, we continue to explore how we can strengthen the capacity and skills within the team.

Advise

• Neighbourhood Nursing Service (NNS) Position Paper- the Service Director is to present at Operational Management Group (OMG) / Extended Management Team (EMT) in early July.
• Referral rates to Children's Therapy have remained high – the team continue to work on solutions to this.
• Children's Speech and Language Therapy – many schools are reducing their teaching assistant staffing which have an impact for services like ours which work in schools, and where school staff carry out programmes.

Health Integration Team Urban House (UH):
• The Commissioner is reviewing current health provision for the 6 resettlement programmes in Wakefield which includes Urban House.
• Wakefield Public Health Team have raised concerns regarding the increase in the incidence of measles both nationally and locally and were keen to ensure our staff had considered vaccination. This has been discussed with the team and we are working with Occupational Health/Infection Prevention & Control.

Barnsley general community services continued:

Assure

• Live Well Wakefield have been successful in being awarded the new contract together with NOVA. The contract is from 1st October 2023, and for 4 years initially.
• Yorkshire Smokefree have been asked to be first implementors in a new initiative through NHS England to give 1 million starter kit vapes in a Swap to Stop campaign. Commissioners and service managers are discussing the viability. Calderdale and Sheffield Services have declined the offer as both services already have vapes as an offer to their clients.
• There has been increased interest in vacancies advertised on NHS jobs – the vacancy factor is reducing in the Neighbourhood Nursing Service (NNS).
• There has been a recent successful recruitment drive for NNS Band 5 nurses, appointing 18 newly qualified staff nurses to commence Sept/Oct 23. 10 are currently undertaking their final placements within the teams in which they will take up their new post. There has also been successful recruitment to 5 newly qualified Band 6 District Nurses - all commence in post mid-July.
• Neighbourhood Rehabilitation Service (NRS) are commencing a pilot to extend therapy provision to support 2-hour crisis referrals. This means the service will extend their service provision from 6pm to 8pm. The pilot commenced from 10 July 2023 and will run for 4 weeks, followed by a review.
• Connecting Care Approach – we are working in partnership with Adult Social Care to strengthen integrated partnership working between health and social care colleagues. This work has commenced in the North-East neighbourhood before being rolled out across the other five neighbourhood areas.
• There has been a successful recruitment process for a 9-month secondment opportunity to an Operational Lead post for NNS.
• 18 new hand-held doppler kits have been distributed to all District Nursing Teams and community sisters.
• Children's Speech and Language Therapy – training resources are now available for course participants digitally. This is a green approach contributing to sustainability, and also saves administrative time.

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

Alert/Action

• Referrals for both ADHD and Autism assessments remain higher than pre pandemic levels.
• Friend & Family Test - 50%. The service is continuing to explore different methods of collating feedback.

Advise

• There are no waiting lists for Autism assessments.
• The waiting list for ADHD continues to reduce for those people identified as medium and high-risk cases.

Assure

• All KPI targets met.
• All training is above the threshold.
• High 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 roll learning out to all localities. Training sessions are progressing well.
• Reducing Restrictive Practice 76.7% with action plan in place.
• Work to reduce sickness absence continues, with support provided by the People Directorate.

ATU (Assessment & Treatment Unit)
• The Horizon improvement programme continues to make progress. Improvements continue to embed and staff involvement, engagement and well-being remain a priority.
• Recruitment to posts which were previously shared posts (with Bradford) is progressing.
• Clinically ready for discharge - currently 25% and reflect system challenges in provision of bespoke packages of care to meet complex needs.

Advise

Community & ATU (Assessment & Treatment Unit)
• Community Improvement Programme is planned and will follow the same format as the Horizon plan.
• Events for Learning Disabilities Week went ahead and were well received.
• Appraisal currently 71.4%
• The service is working to address a potential service gap for people with an LD who require and ADHD assessment.
• Out of hours service currently being mobilised.

Assure

ATU (Assessment & Treatment Unit)
•Complaints 0%
•Friends and Family Test 100%

Community
• Waiting list mitigations have been developed including an early alert system which will help teams to potentially avoid delays in appointments.
• Annual health check completion across all 4 localities is continuing to improve.
• Wellbeing plans are in place for both Horizon and community

Forensic services:

Alert/Action

• Bed Occupancy – Newton Lodge 84.62↓, Bretton 95.33%↑, Newhaven 87.5%↓. Work continues to address occupancy, and to ensure this is maximised to reduce out of area placements.
• Sickness absence/covid absence – this remains above the care group target but has reduced to 6.9%.
• Vacancies & Turnover – Turnover has fallen to 8.5% which is an improved position. Recruitment & retention remains a priority and projections for the number of new starters looks positive.
• Care programme approach – 100%↑ which represents a significant improvement.
• CQC – full inspection took place mid may with 9 out of 11 wards being visited. Learning from the inspection is supported by quality improvement work led by the Quality and Governance Team.

Advise

• Regular meetings continue to transition Forensic Child and Adolescent Mental Health Services (FCAMHS) to a Provider Collaborative.
• Mandatory training overall compliance:
• Newton Lodge – 92%↑
• Bretton – 91%↑
• Newhaven –89.9↑
• 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 4 modules.
• Appraisal (72.7%↑) and supervision remains a priority.
• The well-being of staff remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying 3 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 being completed within 3 months of admission.
• Friends and Family 100%
• All Equality Impact Assessments across forensic services have been completed for 23/24.

Adults and Older People mental health:

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• There is high occupancy levels across wards and capacity to meet demand for beds remains challenging.
• 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 led to ongoing pressures in the service, compounded by workforce challenges.
• 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 still considerably below target performance in Barnsley. Calderdale and Kirklees, although still slightly below target, has continued to demonstrate significant improvement this month. Action plans remain in place, with specific improvement work taking place in Barnsley.
• 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. We 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 some 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 against trajectory. Inpatient performance for those admitted who have had a staying-well plan within 24 hours is working towards achieving and sustaining improvement against trajectory.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users.
• Care Programme Approach (CPA) review performance is above target in all areas, action plans and support from Quality and Governance Leads remain in place.

Advise

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

Assure

• 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.
• Our Business Support Manager for Calderdale and Kirklees has led on the successful re-accreditation process for our One Year Review as a Veteran Aware Trust.

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£1m	£0m	The plan for June 2023 was an increased surplus relating to the timing for Low Value Activity (LVA - as set nationally) income. A surplus of £0.9m has been achieved in month which is in line with plan. The year to date position is a surplus of £1.0m which is £0.3m behind plan. Recovery plans are being developed and the forecast remains that a breakeven position can be achieved in year which is in line with target.
2	Agency Spend	£2.8m	£10.3m	In line with national, and ICB, targets Trust agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. Spend in June is £1,002k which is an increased run rate and the year to date position is 19% above the plan trajectory.
3	Financial sustainability and efficiencies	£1.8m	£12m	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. This target remains challenging.
4	Cash	£82.1m	£76.9m	The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£1m	£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 £1.0m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	96%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

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

System-wide monitoring

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

West Yorkshire Health and Care Partnership -

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

South Yorkshire ICS -

ICB Board meeting and minutes :: South Yorkshire ICB

The Trust is trying to establish a feed of data of applicable key performance indicators for each of the integrated care boards.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 3 (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)	£1m	£0m	The plan for June 2023 was an increased surplus relating to the timing for Low Value Activity (LVA - as set nationally) income. A surplus of £0.9m has been acheived in month which is in line with plan. The year to date position is a surplus of £1.0m which is £0.3m behind plan. Recovery plans are being developed and the forecast remains that a breakeven position can be achieved in year which is in line with target.
2	Agency Spend	£2.8m	£10.3m	In line with national, and ICB, targets Trust agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. Spend in June is £1,002k which is an increased run rate and the year to date position is 19% above the plan trajectory.
3	Financial sustainability and efficiencies	£1.8m	£12m	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. This target remains challenging.
4	Cash	£82.1m	£76.9m	The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£1m	£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 £1.0m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	96%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

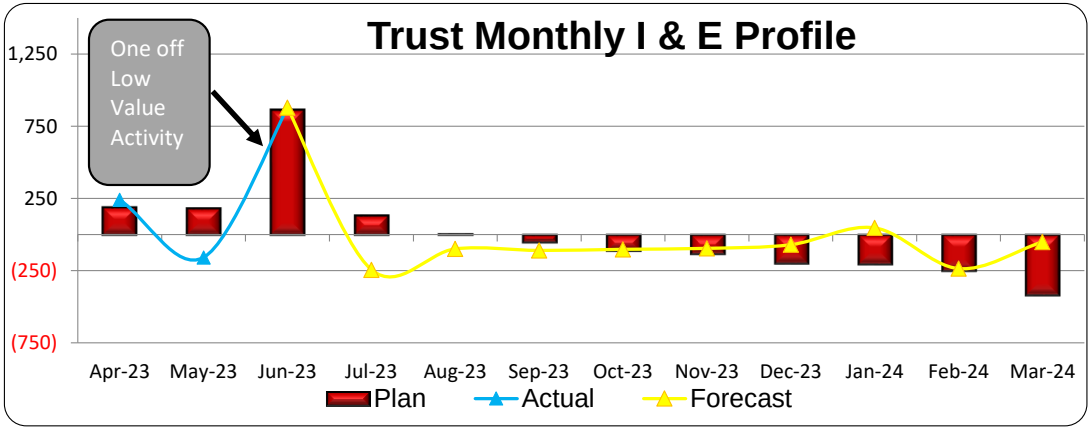
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

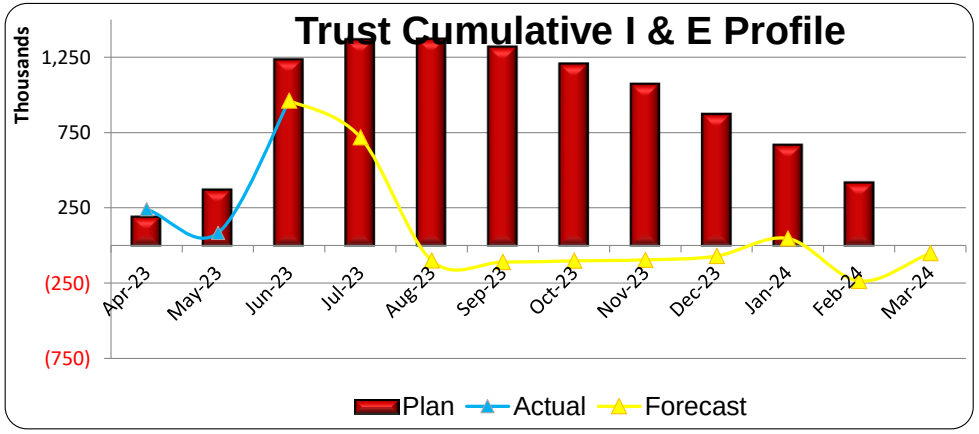
2.0 Income & Expenditure Position 2023 / 24

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					34,051	34,228	177	97,740	98,140	400	388,630	390,547	1,917
Other Operating Revenue					1,199	1,202	3	3,267	3,315	47	13,187	12,720	(467)
Total Revenue					**35,250**	**35,430**	**180**	**101,007**	**101,454**	**447**	**401,817**	**403,267**	**1,450**
Pay Costs	4,830	4,803	(27)	0.6%	(20,332)	(20,495)	(163)	(60,199)	(60,101)	98	(243,739)	(243,291)	448
Non Pay Costs					(13,613)	(13,685)	(72)	(38,253)	(39,231)	(978)	(153,051)	(155,515)	(2,464)
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	**4,830**	**4,803**	**(27)**	**0.6%**	**(33,945)**	**(34,181)**	**(235)**	**(98,452)**	**(99,332)**	**(880)**	**(396,790)**	**(398,806)**	**(2,016)**
EBITDA	**4,830**	**4,803**	**(27)**	**0.6%**	**1,304**	**1,249**	**(55)**	**2,556**	**2,123**	**(433)**	**5,027**	**4,462**	**(565)**
Depreciation					(518)	(517)	1	(1,553)	(1,551)	2	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					252	326	74	764	927	163	3,070	3,627	557
Surplus / (Deficit) - ICB performance measure	**4,830**	**4,803**	**(27)**	**0.6%**	**860**	**879**	**19**	**1,230**	**962**	**(268)**	**0**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(58)	(58)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,830**	**4,803**	**(27)**	**0.6%**	**860**	**860**	**(0)**	**1,230**	**904**	**(326)**	**0**	**(232)**	**(232)**





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					25,577	25,476	(101)	72,808	72,552	(256)	288,901	288,944	44
Other Operating Revenue					1,199	1,202	3	3,267	3,315	47	13,187	12,720	(467)
Total Revenue					**26,776**	**26,677**	**(98)**	**76,075**	**75,866**	**(209)**	**302,088**	**301,665**	**(423)**
Pay Costs	4,810	4,769	(40)	0.8%	(20,206)	(20,272)	(66)	(59,819)	(59,525)	295	(242,257)	(240,891)	1,366
Non Pay Costs					(5,249)	(5,063)	185	(13,650)	(14,258)	(608)	(54,636)	(56,057)	(1,421)
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	**4,810**	**4,769**	**(40)**	**0.8%**	**(25,454)**	**(25,335)**	**119**	**(73,469)**	**(73,782)**	**(313)**	**(296,893)**	**(296,948)**	**(55)**
EBITDA	**4,810**	**4,769**	**(40)**	**0.8%**	**1,321**	**1,342**	**21**	**2,606**	**2,084**	**(522)**	**5,194**	**4,716**	**(478)**
Depreciation					(518)	(517)	1	(1,553)	(1,551)	2	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					252	326	74	764	927	163	3,070	3,627	557
Surplus / (Deficit) - ICB performance measure	**4,810**	**4,769**	**(40)**	**0.8%**	**877**	**972**	**95**	**1,281**	**924**	**(357)**	**168**	**255**	**87**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(58)	(58)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,810**	**4,769**	**(40)**	**0.8%**	**877**	**953**	**76**	**1,281**	**866**	**(415)**	**168**	**23**	**(144)**

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	4,830	4,803	(27)	0.6%	860	879	19	1,230	962	(268)	0	(0)	(0)
Provider Collaboratives	20	33	14	67.9%	(17)	(93)	(76)	(51)	38	89	(168)	(255)	(87)
Total excluding Collaboratives (as shown above)	**4,810**	**4,769**	**(40)**	**0**	**877**	**972**	**95**	**1,281**	**924**	**(357)**	**168**	**255**	**87**

Income & Expenditure Position 2022 / 23

June 2023, excluding the financial impact of the provider collaboratives, is a surplus of £1.0m. This is £95k better than plan.

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 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, and gap compared to commissioner income uplifts, 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. Payment has been received from commissioners in June 2023 for the Agenda For Change pay award uplift; this was already reflected in budgets from month 2.

Pay

Agenda For Change pay awards, relating to 2022 / 23 (for which an estimate was made in the last financial year) and 2023 / 24, were paid in June 2023. For the year to date expenditure is broadly in line with plan although this is modelled to move to an underspend position in year with workforce growth forecast to be behind that included in the plan (although still growing).

In June 2023 there has been a reduction in sustantive worked WTE although this has been offset by increases in bank and agency resulting in an overall reduction of 1. This supports the assumptions included in the forecast position.

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

Non Pay

The non pay analysis highlights that most categories are overspent against plan. The largest is the purchase of healthcare category with operational pressures presenting as out of area placements and other costs. Work continues to assess how much of this is due to inflationary pressures, increased usage or other reasons.

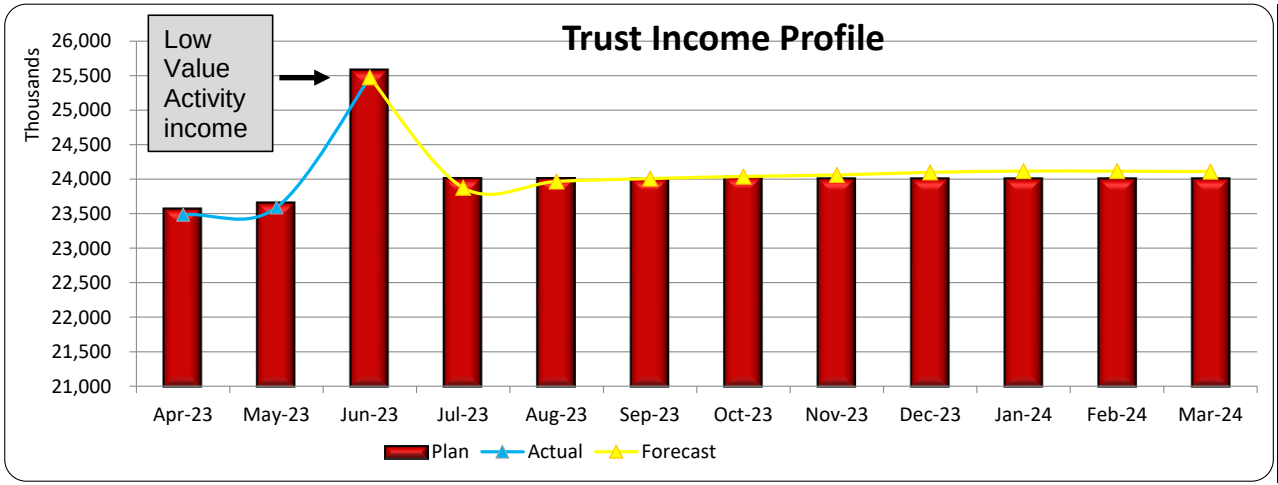
2.1 Income Information

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 for mental health collaboratives. This is reported separately.

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	21,396	19,980	19,984	19,958	19,968	19,990	19,972	19,973	19,971	19,964	**240,331**	**220,257**
ICS / System / Covid	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**6,243**
Specialist Commissioner	2,752	2,753	2,881	2,794	2,794	2,761	2,761	2,761	2,761	2,761	2,761	2,762	**33,303**	**4,069**
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**9,058**
Local Authority	490	516	510	504	509	509	505	505	505	523	523	523	**6,122**	**5,311**
Partnerships	514	584	546	454	537	637	662	662	720	720	720	720	**7,474**	**5,052**
Other Contract Income	197	96	144	143	143	143	143	143	141	141	141	141	**1,715**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,875**	**23,967**	**24,008**	**24,040**	**24,061**	**24,099**	**24,117**	**24,115**	**24,109**	**288,944**	**252,245**
2022 / 23	20,679	20,725	20,039	20,358	21,057	22,784	24,206	24,485	24,831	24,657	23,559	26,796	**274,176**	



Contracts for 2023 / 24 with main commissioners are continuing to progress towards signature in line with national guidance. These, including the financial elements, will be updated to incorporate the revised Agenda For Change pay award and any future medical pay award. For 2023 / 24 this will flow as an uplift to commissioner tariff. Arrears relating to 2022 / 23 were paid directly by NHS England.

Additional income has been received, as planned, in June 2023 relating to the one off payment for low value activity (LVA). These values are calculated nationally and are recevied as a single payment from individual non local ICB's.

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

2.2 Pay Information

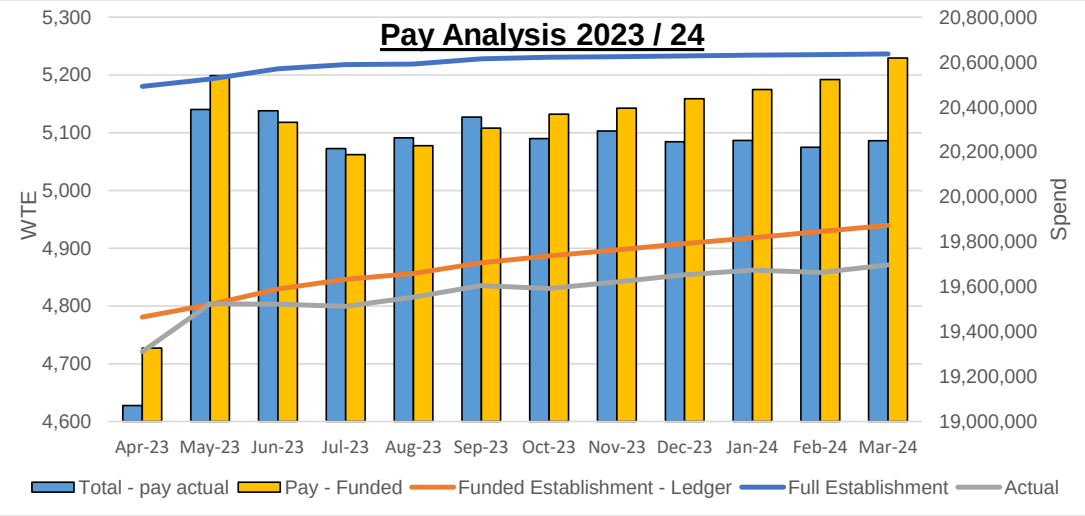
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	17,933	17,967	18,020	18,141	18,073	18,119	18,105	18,127	18,114	18,130	**215,931**
Bank & Locum	849	1,355	1,337	1,222	1,255	1,249	1,241	1,237	1,231	1,226	1,228	1,251	**14,681**
Agency	939	908	1,002	917	878	856	835	828	800	789	770	759	**10,279**
Total	**18,947**	**20,306**	**20,272**	**20,106**	**20,153**	**20,246**	**20,149**	**20,183**	**20,136**	**20,142**	**20,111**	**20,140**	**240,891**
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%	6.6%	6.1%	6.2%	6.2%	6.2%	6.1%	6.1%	6.1%	6.1%	6.2%	6.1%
Agency as % (in month)	5.0%	4.5%	4.9%	4.6%	4.4%	4.2%	4.1%	4.1%	4.0%	3.9%	3.8%	3.8%	4.3%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,312	4,342	4,358	4,382	4,383	4,398	4,411	4,424	4,420	4,429	**4,378**
Bank & Locum	222	314	326	296	302	301	299	297	297	296	297	301	**296**
Agency	157	161	164	161	155	152	148	147	146	142	141	140	**151**
Total	**4,721**	**4,804**	**4,803**	**4,799**	**4,815**	**4,835**	**4,830**	**4,842**	**4,854**	**4,862**	**4,858**	**4,871**	**4,825**
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 Agenda for Change pay award, both 2022 / 23 additional and 2023 / 24 year to date values, have been paid in June 2023. An accrual had been made for the 2022 / 23 element and therefore there is no financial impact shown here. Budgets were updated for the revised 2023 / 24 uplift in May 2023.

Overall expenditure, and worked WTE, are similar to last month although there has been an increase in temporary staffing offset by a reduction in susbtantive worked WTE.

The Trust workforce plan included a profile of increasing WTE worked, shown by the orange line. In June this is 27 less than plan and the forecast is that this will remain less than plan for the remainder of the year although will continue to see a general trend of increase.

2.2 Agency Expenditure Focus

Agency spend is £1,002k in June. 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.

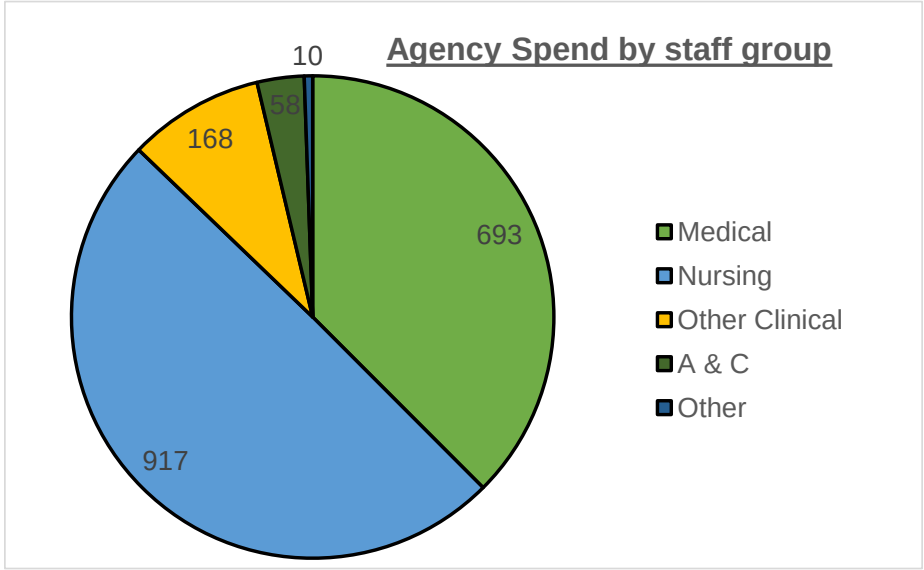
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

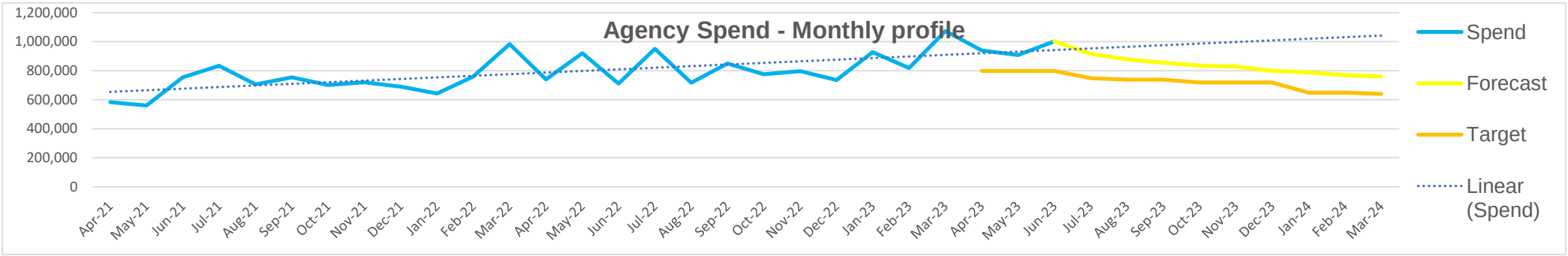
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23.

The Trust agency scrutiny and management group continues to provide oversight ensuring that Trust processes are followed and agency spend is appropriate and minimised. The Trust will continue to assess need based upon safety, quality and financial implications.

June 2023 spend is £1,002k which, as shown by the graph below, is higher than target. The current modelled trajectory has some reductions, as shown by the yellow line, but this is above target for each month.

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.



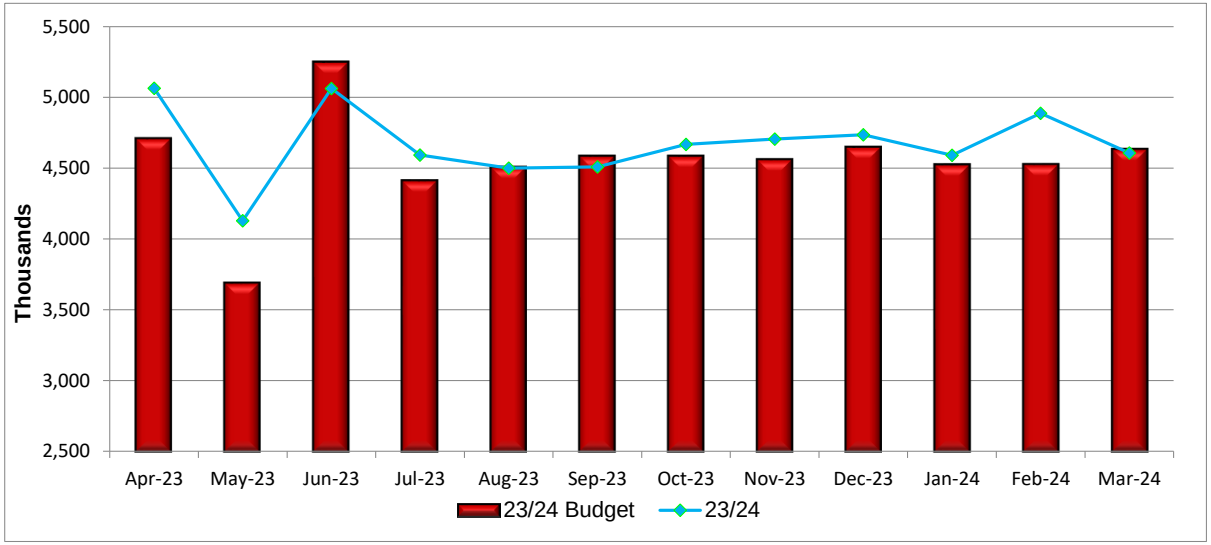


2.3 Non Pay Expenditure

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	5,066	4,128	5,063	4,593	4,501	4,509	4,668	4,705	4,736	4,591	4,888	4,608	**56,057**
2022/23	4,213	4,350	4,271	4,080	4,917	4,694	4,130	4,767	4,010	7,142	4,797	6,931	**58,303**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	1,025	934	(91)
Establishment	2,177	2,275	98
Lease & Property Rental	2,179	2,114	(65)
Premises (inc. rates)	1,343	1,448	105
Utilities	566	620	54
Purchase of Healthcare	2,351	2,747	396
Travel & vehicles	1,203	1,247	45
Supplies & Services	1,709	1,727	19
Training & Education	410	456	46
Clinical Negligence & Insurance	197	197	(0)
Other non pay	490	492	2
Total	**13,650**	**14,258**	**608**
Total Excl OOA and Drugs	**10,273**	**10,576**	**303**



Key Messages

Non pay expenditure budgets were reset for 2023 / 24 based on historical trends and estimates of inflationary price increases. Budget adjustments, and alignments, continue as normal.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is overspent against plan. This is an increase in June and the forecast reduction for the remainder of the year continues to present an operational and financial risk.

The majority of non pay expenditure categories are now showing as overspent for the year to date. Actions are being developed to be clear on the reasons for this (volume increases, inflationary pressures, decisions made) and responses will be con-ordinated through the re-established non pay review group.

Other non pay includes all other items not categorised into the above headings. Due to the nature of Trust expenditure this can be wide ranging. Where possible costs will be allocated into the main headings above which are in line with Trust Annual Accounts categorisation.

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.

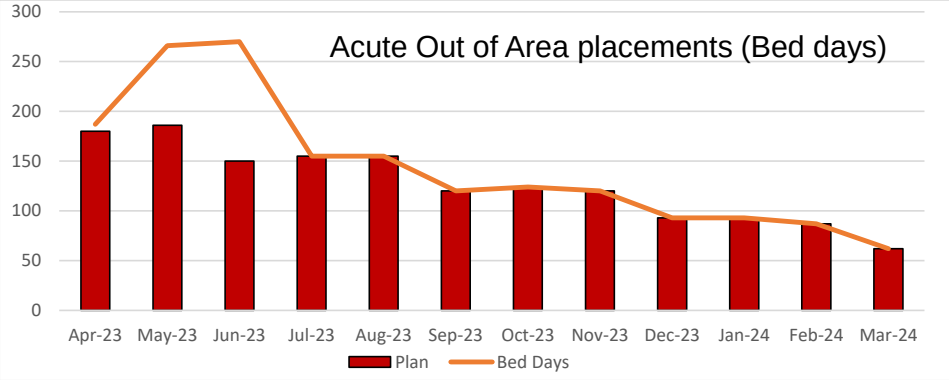
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

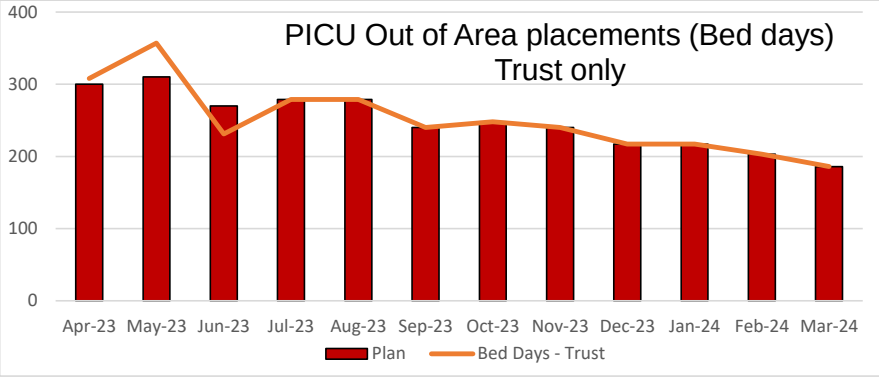
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

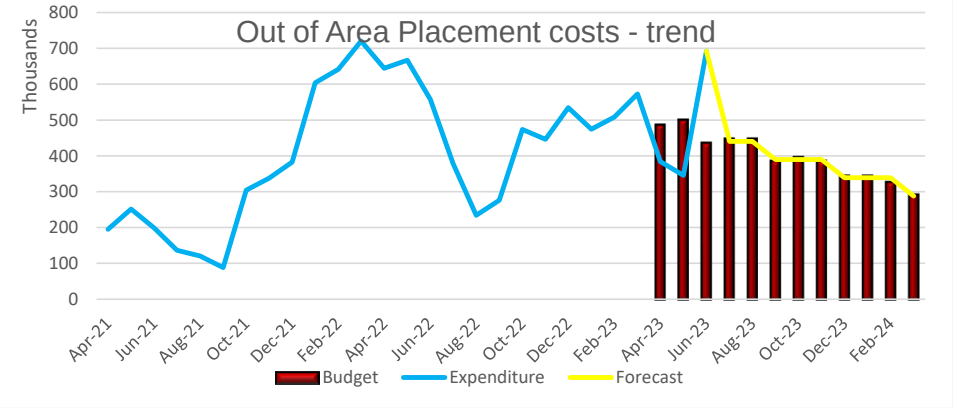
On such occassions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	395	595	200
PICU	997	808	(189)
Locked Rehab	571	661	91
Services - NHS	176	215	40
IAPT	44	164	120
Yorkshire Smokefree	21	9	(12)
Other	147	294	147
Total	**2,351**	**2,747**	**396**







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 requirement for placements, changes.

Overall expenditure is broadly in line with plan although this has been shown as under in April and May and then over in June. This now includes all activity whilst discussions continue with a commissioner over which they are responsible for directly.

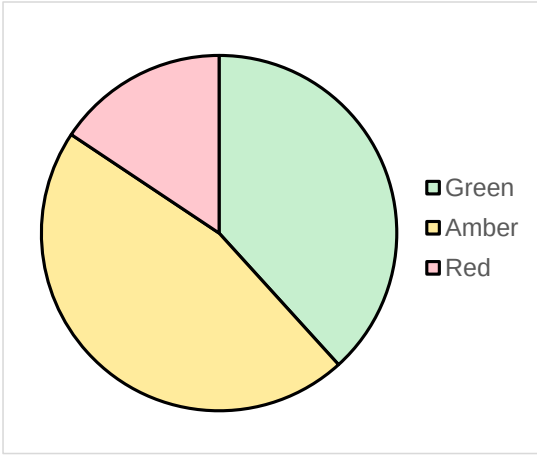
Acute activity is above plan, significantly in May and June, whilst PICU activity is under in June. Both assume that activity will be in line with the planned trajectory from July 2023 onwards. This assumption presents a

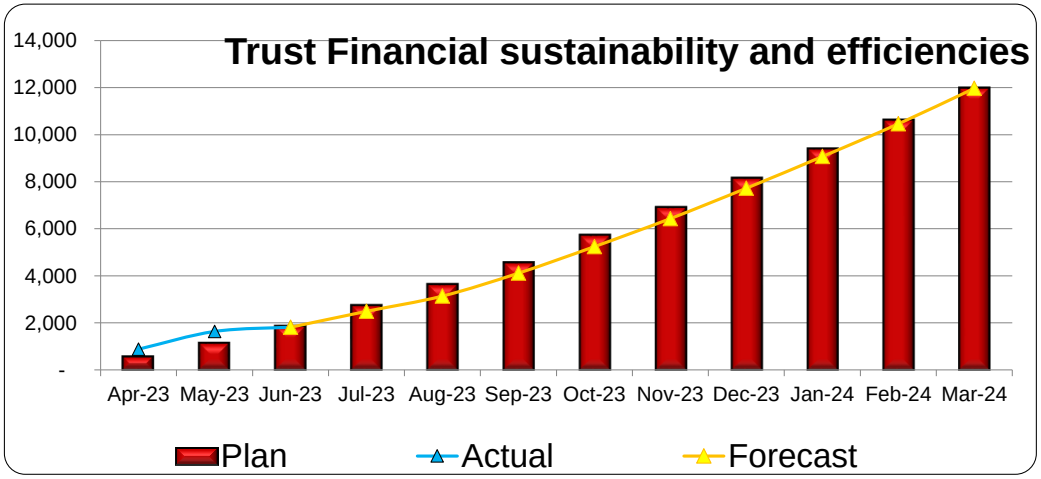
2.4 Value for Money, Financial sustainability and efficiency

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	436	436			3,197	436	2,761	
Agency & Workforce	Pg.	400	195	269		4,380	785	2,205	
Medicines optimisation		100	91			400	131		
Non Pay Review		188	0			1,048		550	1,872
Income contributions		126	47			500	227		
Interest Receivable	Pg. 4	350	513			1,400	1,957		
Provider Collaborative	Pg.	260	260			1,044	1,044		
Total		**1,859**	**1,543**	**269**	**0**	**11,969**	**4,580**	**5,517**	**1,872**
Recurrent		1,759	1,543			10,943	4,580	5,517	
Non Recurrent		100		269		1,026			1,872





Value for money performance for the year to date is £47k behind plan and further work, as highlighted by the pie chart showing the RAG rating of schemes, is required to ensure that the programme delivers in full and supports the delivery of the overall financial target.

Elements of this delivery, specifically those linked to workforce strategies, have been identified non recurrently and longer term recurrent mitigations will need to be secured.

Although workstreams are in place risks remain relating to reducing out of area placements, reduction of premium workforce payments and identification of new non pay cost reductions.

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	170,168	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,516	
Non NHS Trade Receivables (Debtors)	2,853	1,091	
Prepayments	3,482	3,554	
Accrued Income	9,372	2,959	2
Cash and Cash Equivalents	74,585	82,130	Pg 15
Total Current Assets	**92,097**	**91,481**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(8,795)	3
Capital Payables (Creditors)	(739)	(487)	
Tax, NI, Pension Payables, PDC	(7,696)	(13,044)	4
Accruals	(32,952)	(26,633)	4
Deferred Income	(4,172)	(1,064)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(57,545)	1
Total Current Liabilities	**(104,062)**	**(107,567)**	
Net Current Assets/Liabilities	**(11,965)**	**(16,085)**	
Total Assets less Current Liabilities	**153,210**	**154,082**	
Provisions for Liabilities	(4,319)	(4,255)	
Total Net Assets/(Liabilities)	**148,891**	**149,827**	
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	84,892	
Total Taxpayers' Equity	**148,891**	**149,795**	

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 significant increases had already been included in the plan). This results in increases in both assets and liabilities.

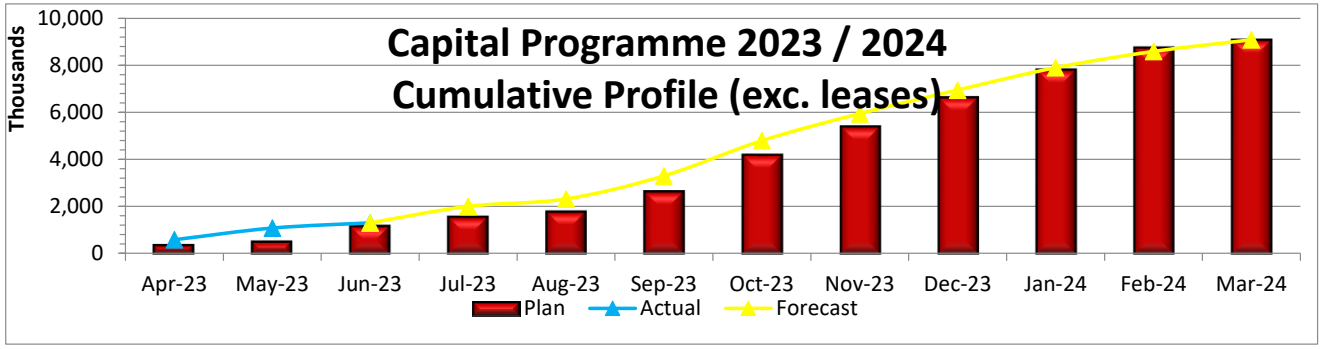
2. Accrued income reduced in month as the £9m from NHS England was paid. The remaining balance will be reviewed in month as the Trust aims to maximise cash.

3. Trade payables remain high, £4.4m relates to purchase orders receipted but not invoiced, this is expected to reduce in July.

4. Accruals have reduced in month as the pay award was paid in month. The only element outstanding of this is the Tax, NI and Pension which will be paid in July and is reflected in the cashflow forecast.

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	2	2	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	25	0	(25)	713	428
Safety inc. ligature & IPC	990	155	295	140	1,445	455
Compliance	430	300	0	(300)	200	(230)
Backlog maintenance	510	0	0	0	75	(435)
Sustainability	300	0	2	2	225	(75)
Plant & Equipment	40	0	0	0	45	5
Other	1,223	23	694	671	1,075	(148)
IM & T						
Digital Infrastructure	1,100	350	0	(350)	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**	**888**	**993**	**105**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	7,358	2,155	7,366	2,163
New lease	303	283	300	17	324	21
TOTALS	**14,274**	**6,374**	**8,651**	**2,277**	**16,457**	**2,183**



Capital Expenditure 2023 / 24

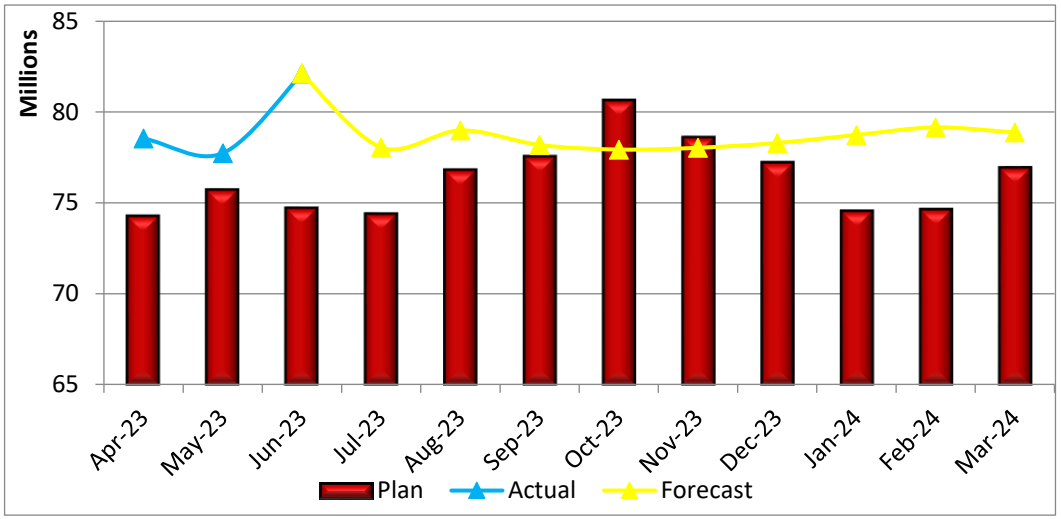
The Trust has continued to work within the West Yorkshire Integrated Care Board capital allocation in establishing it's capital programme for 2023 / 24. This totals £8,768k.

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

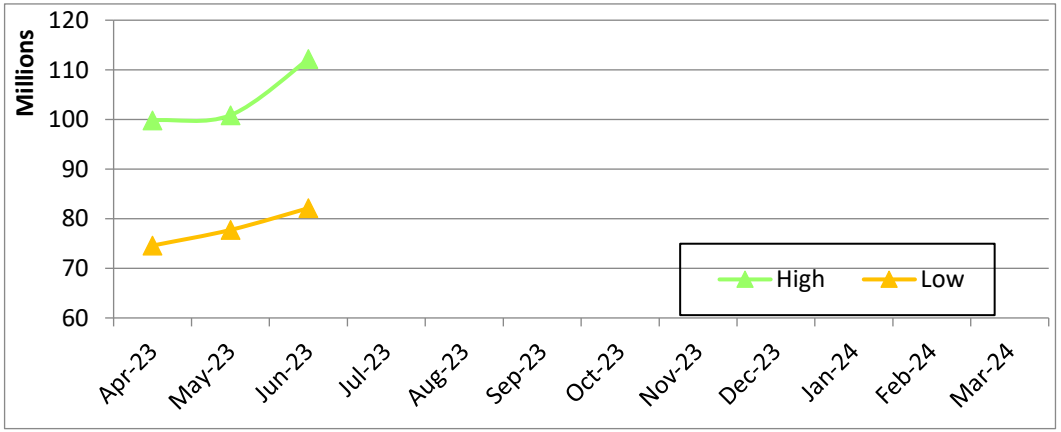


Cash remains healthy

Cash increased in month due to receiving the funding for the central pay award. The Tax / NI and pension elements of this are unpaid at the end of the month so represents the increase in cash in month.

The Trust is monitoring interest rates to assess the optium time to invest.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	74,711	82,130	7,419



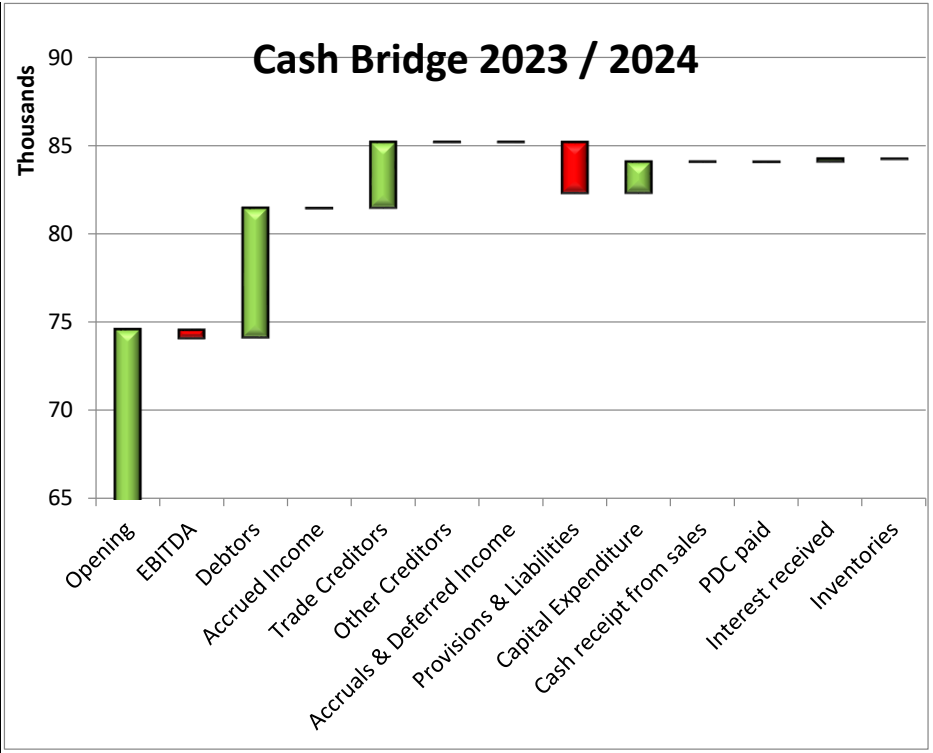
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £112.2m
The lowest balance is: £82.1m

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)	4,798	4,315	(483)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	455	7,805	7,350	
Trade Payables (Creditors)	(2,838)	892	3,730	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(277)	(3,172)	(2,895)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,776)	(993)	1,783	
Cash receipts from asset sales	0	0	0	
Leases	0	(2,229)	(2,229)	
PDC Dividends paid	0		0	
PDC Dividends received	0		0	
Interest (paid)/ received	764	927	163	
Closing Balances	**74,711**	**82,130**	**7,419**	



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 £7.4m higher than plan, the main drivers are 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.

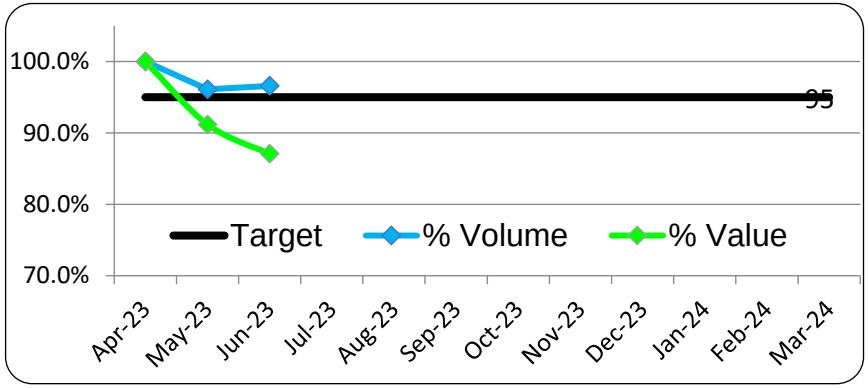
4.0 Better Payment Practice Code

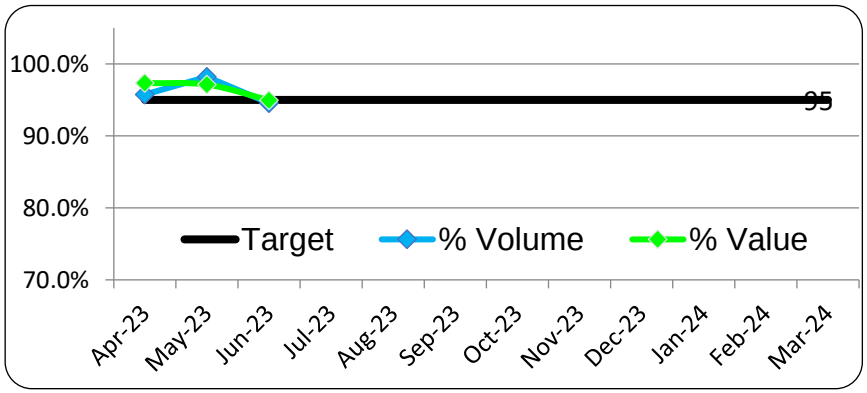
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently. NHS performance by value is on a downward trend, due to the low number of invoices received one large invoice failing can significantly affect this metric. The team will target this area to improve over the next quarter.

NHS	Number %	Value %
In Month	97%	87%
Cumulative Year to Date	97%	93%

Non NHS	Number %	Value %
In Month	95%	95%
Cumulative Year to Date	96%	96%





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 (£)
15-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4979	834,073
26-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS35	544,330
01-Jun-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008018	315,157
02-Jun-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 273	233,393
01-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS11	185,000
26-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS12	185,000
29-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5048	165,147
01-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4975	159,820
15-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4989	143,098
26-Jun-23	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72485397	141,940
01-Jun-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008013	112,442
08-Jun-23	IT Services	Trustwide	Daisy Corporate Services	3I510052	90,250
12-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC013INV	90,180
22-Jun-23	Consultancy	Altogether Better	Fischer Associates Ltd	FISCH202306	84,480
19-Jun-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	324052	81,922
26-Jun-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999660	63,962
22-Jun-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 11208	56,000
26-Jun-23	Drugs	Trustwide	NHS Business Services Authority	1000077185	49,994
16-Jun-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015590509	46,068
28-Jun-23	Purchase of Healthcare	Barnsley	Family Lives	2461	39,709
30-Jun-23	Data Lines	Trustwide	Virgin Media Ltd	60051098	34,914
22-Jun-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	HCSLP003	32,737
22-Jun-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	115762	29,927
08-Jun-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0290742	28,693
01-Jun-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001317	28,672
14-Jun-23	Purchase of Healthcare	Kirklees	Cygnet Health Care Ltd	STE0288735	27,637
16-Jun-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015583600	26,826
01-Jun-23	Purchase of Healthcare	Wakefield	St Andrews Healthcare	90121927	25,281
08-Jun-23	Purchase of Healthcare	Wakefield	St Andrews Healthcare	90123004	25,088

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

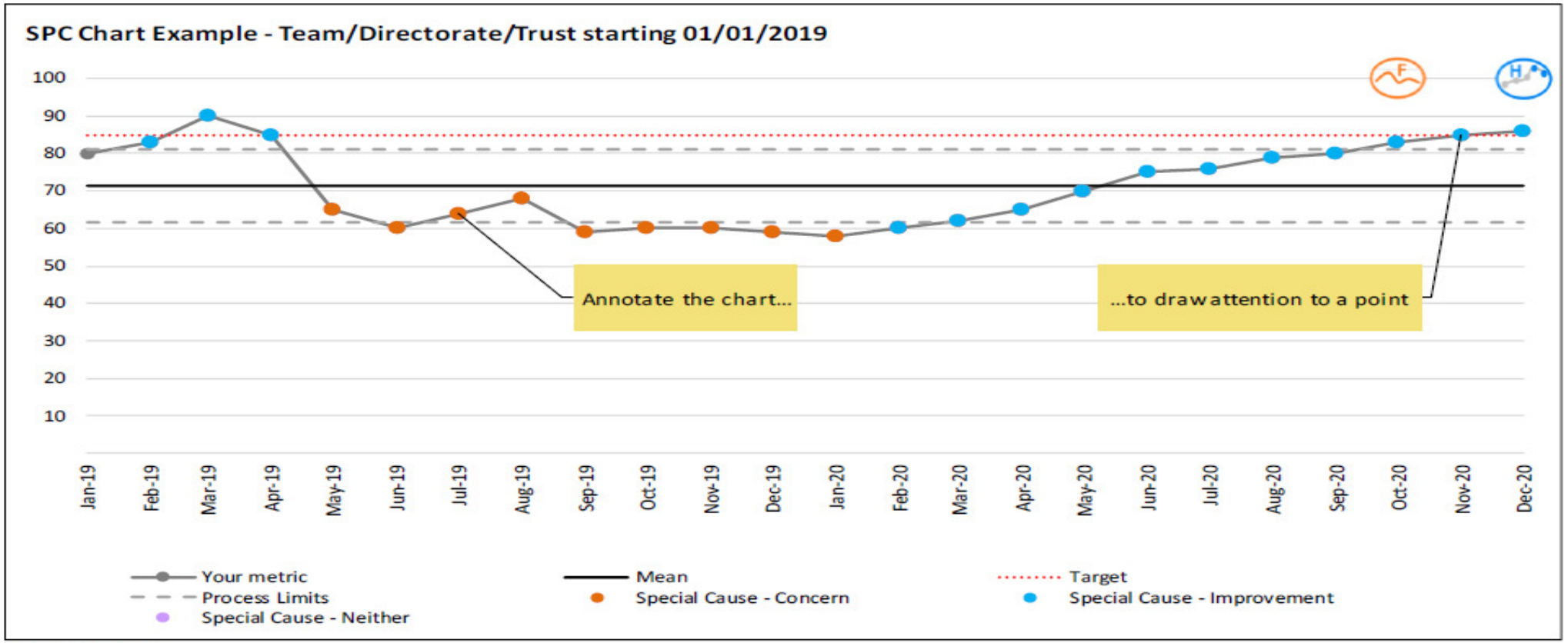
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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