NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

April 2024

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for April 2024. The development of the IPR continues, with a ward level breakdown of key metrics within the care group section of the report, added from September 2023.

Majority of the agreed metrics identified to monitor performance against our strategic objectives have been populated, two metrics are still in development with indicative timescales provided.

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.

Headlines

This section of the report identifies metrics where there has been a change in performance or where expected levels are not being achieved. A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

Strategic Objectives & Priorities

Metric	Change from last month	Variation/ Assurance
Improving Health		
Percentage of service users who have had their equality data recorded - disability	↓	
Timely completion of equality impact assessments (EIAs) in services and for policies	↓	
Improving Resources		
Surplus/(deficit) against plan (monthly)	↓	

Metric	Change from last month	Variation/ Assurance
Improving Care		
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	↑	H, F
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↓	F
Inappropriate out of area bed placements (days)	↑	L, F
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↑	?
% Service users on CPA offered a copy of their care plan	↓	H, ?

Metric	Change from last month	Variation/ Assurance
Making SWYPFT a great place to work		
Sickness absence - rolling 12 months	↑	
Workpal appraisals - rolling 12 months	↑	
Staff supervision rate	↑	
Mandatory training - Cardiopulmonary resuscitation	↑	
Mandatory training - Information governance	↑	
Mandatory training - Reducing restrictive practice interventions	↓	

Quality		
Metric	**Change from last month**	**Variation/ Assurance**
Complaints - Number of responses provided within six months of the date a complaint received	↑	
Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement	↓	
Number of information governance breaches	↓	

People		
Metric	**Change from last month**	**Variation/ Assurance**
Sickness absence - month	↑	

National metrics		
Metric	**Change from last month**	**Variation/ Assurance**
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	↓	?
Total bed days of Children and Younger People under 18 in adult inpatient wards	↑	?
Total number of Children and Younger People under 18 in adult inpatient wards	↓	?
The number of completed non-admitted RTT pathways in the reporting period	↑	
The number of incomplete RTT pathways in the reporting period	↑	

Care Groups

Children and Families

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↓	?
Information Governance training compliance	↑	?
Reducing restrictive physical interventions training compliance	↓	?
Sickness rate (monthly)	↑	?

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	H F
Information Governance training compliance	↑	?
Reducing restrictive physical interventions training compliance	↓	F
Sickness rate (Monthly)	↑	L ?
FIRM Risk Assessments - Staying safe care plan in 7 working days	↑	F
% Complaints with staff attitude as an issue	↓	?

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% bed occupancy	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	H F
% of clients clinically ready for discharge	↑	L ?
FIRM Risk Assessments - Staying safe care plan in 24 hours	↑	H F
Information Governance training compliance	↑	?
Sickness rate (Monthly)	↑	?
Reducing restrictive physical interventions training compliance	↓	?
% Complaints with staff attitude as an issue	↑	?

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
Cardiopulmonary resuscitation (CPR) training compliance	↑	?
% of clients clinically ready for discharge	↔	F
Information Governance training compliance	↓	H ?
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↑	?
Reducing restrictive physical interventions training compliance	↓	?

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% of staff receiving supervision within policy guidance	↑	
Information Governance training compliance	↓	H ?

Forensic

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% Bed occupancy	↑	?
Information Governance training compliance	↑	?
Reducing restrictive physical interventions training compliance	↓	L ?
Sickness rate (Monthly)	↑	L ?

Key

Improvement from last month but up to 5% below threshold	
No change from last month and up to 5% below threshold	
Deterioration from last month and up to 5% below threshold	
Improvement from last month and below threshold	
No change from last month and below threshold	
Deterioration from last month and below threshold	
Achievement of threshold and increased performance from last month.	
No change from last month and achieving threshold	
Achievement of threshold but decreased performance from last month.	

	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.

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 94.2% against a target of 90%. For the Trust derived indicators, as of April 2024, disability is at 47.4%, sexual orientation 59.6% and postcode is at 99.8%. Whilst 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 and there has been a slight increase in recording over the last month.

• 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 to ensure that our approach is fair and does not present needless barriers or disadvantage any protected groups of people. No policy is agreed without an equality impact assessment in place. All services have an EIA in place. Expired EIAs (or EIAs not reviewed and graded within the 12-month cycle) expired in March and have all been offered support to complete. Our approach is to change the submission and review of EIAs to April-February cycle ensuring March gives the Trust a final position statement.

Quality

NHS England Indicators (national)

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

• Continued service improvement work supports the overall use of inappropriate out of area bed days. There was a decrease in April compared to the last month with 119 days used. This slight increase is in keeping with previous years at this point in the year. The use of out of area beds continues to be an improved position when compared to the same period last year. Need for use of these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally), increased acuity and capacity issues due to challenges to timely discharge. 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 waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 51.4% in April, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. This is due to the need for follow up and fitting appointments alongside diagnostic assessments where there is limited capacity to meet demand. The team continue delivering the improvements on the action plan and have a service review booked in May '24 which will assess the progress against this.

Quality continued

Care planning and risk assessments

• The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. An anomoly has been identified and is currently under investigation. An update will be provided next month.

• For risk assessments, the April data shows a slight increase in performance from the previous month within inpatient services 92.7% this means that 114 service users had a risk assessment within 24 hours, 9 service users had a completed risk assessment but this was outside the 24 hours. For community services, performance for April has decreased slightly to 78.5% - 28 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.

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.

• 'While you wait' offers are in place or in development for children on waiting lists, teams maintain contact with children and families while they wait to ensure appropriate action can be taken in case risks escalate.

• Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high, with a specific risk noted where additional capacity is no longer available in Kirklees. 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 challenging due to staffing/operational pressures in community learning disability services, with 82.0% - (41 out of 50) 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. During April the LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks. Improvement work, including recruitment, additional training for staff in specific skills for example dysphagia and pathway development continue.

• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned. Cases, where agreed with commissioners, are triaged and prioritised according to need. As demand is significant the care remains with the referrer until accepted by the service.

Patient Safety Indicators

95% of incidents reported in April 2024 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents increased to 256 (188 in March). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain static – all incidents are reviewed and learning is shared.

• Positively, 100% of prone restraint incidents were for a duration of three minutes or less – this related to 17 incidents for the month of April. The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. All incidents of prone restraint are now reviewed for learning in the Patient Safety Oversight Group.

• There were eight information governance personal data breaches during April which is a slight increase on last month but remains below threshold.

• The number of inpatient falls in April was 41 which is in line with numbers over the last quarter. All falls are reviewed to identify measures required to prevent reoccurrence. and more serious falls are investigated. There have been no red or amber Datix incident reported (falls with injury) during the month.

• The number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%. Improvement work continues and this is reflected in the overall improvement of this metric since April '23.

Our People

• Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for April is 75.6% which is an improvement from the refreshed performance for March at 74.9%. This means that more staff have had access to a supportive conversation about their practice. The improvement work continues. Supervision is monitored monthly by the operational management group.

• The Trust had 25 violence and aggression incidents against staff on mental health wards involving race during April - incidents are monitored by the Patient Safety Team, and Equity Guardians are alerted to all race related incidents against staff. Recognising that this has an impact on staff, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.

• For April, we have had 56.4 new starters and 20.2 leavers.

• Overall, our 12-month turnover rate in April has dropped slightly again to 10.0% which is a reflection of the low number of leavers and increase in new starters over the year. This means that more skills and experience have been retained.

• In April 2024 we have seen a drop in sickness overall to 3.6%. This is seen as a positive and the Trust does not appear to have been impacted excessively by winter seasonal absence.

• The combination of reduced turnover, successful recruitment and an overall reduction in sickness along with improved appraisal compliance should be considered to be related as working with regular staff in supportive teams contributes to a great place to work.

• Sickness absence year-to-date in April has decreased to at 4.8% which is above local threshold. This is the lowest sickness rate since April 2023. SWYPFT has the lowest sickness rates compared with similar Trusts across the region, Our People Business Partners and People Relations teams continue to support our Operational managers in reducing sickness rates.

• Estates and Facilities sickness absence continues to be high at 8.9%. This staff group have seen a consistent monthly rise since April (Apr 6.2%). Further work is being done with our Business Partners to help support Estates and Facilities, along with an internal audit.

• We have increased our rolling appraisal compliance rate again in April, which saw an increase from 84.2% to 87.1%. This is the second month the compliance over 80% has been reached. Actions remain in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Although our overall mandatory training compliance has increased slightly to 92.5%, we have seen a drop in some areas. Reducing Restrictive Physical Interventions (RRPI) has dropped again this month to 68.3% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training.

• Information governance training has increased slightly to 92.8%. Whilst Cardiopulmonary Resuscitation has increased to 79.4% this also remains below the Trust targets - 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). Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning. Weekly e-mail reminders are going out to all staff.

Care Groups

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of April, and we have also provided a breakdown of the inpatient data split by ward. Areas to note are as follows:

• Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards, particularly whilst focussing on reducing reliance on out of area bed use. Capacity to meet demand for beds remains challenging.

• The increased pressure continues on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three Registered Nurses, some of whom have recently completed their own preceptorship.

• Single point of access (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. In April performance data indicates that the routine access for assessment target is being achieved in all areas.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within the current provider. Work continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed. Concerns have been escalated by the executive trio to the Children and adolescent mental health services (CAMHS) inpatient provider collaborative executive trio.

• There was one patient under 18 years old in an adult bed during April. Whilst this is measured, it is worth noting that other children will wait in other settings, for example acute hospital beds or home, for inpatient care. 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.

• There were 256 reported incidents of restraints used in April 2024 this was an increase of 68 (36%) from March 2024 which stood at 188. There are a few acutely unwell and challenging service users displaying high levels of violence and aggression who are affecting the number of incidents disproportionately.

Finance

• The reported position for April 2024 is a deficit of £0.3m. Whilst the forecast position remains at breakeven this will require corrective measures to secure delivery.

• The reduction in agency spend during quarter 3 and 4 2023 / 24 has been maintained into April 2024 with spend in month of £0.4m. Actions and scrutiny continue, alongside other temporary staffing costs. The forecast is £5.2m and achievement of this would be a reduction of £3.1m from the last financial year.

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

• The Trust cash position remains strong at £66.5m with a year end forecast of £64.9m.

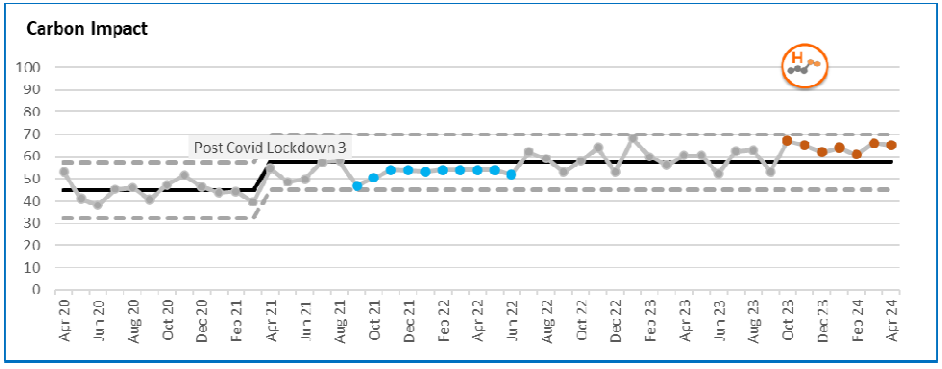
• Spend in April is £0.4m which is more than the planned profile. This is due to timing of the seclusion rooms programme. The capital programme for 2024 / 25 is £8.1m in line with the capital allocation from West Yorkshire Integrated Care Board.• This includes a number of major schemes which are profiled to commence later in the year.

• Performance against the Better Payment Practice Code is 99% and 95% of all invoices have been paid within 30 days of receipt.

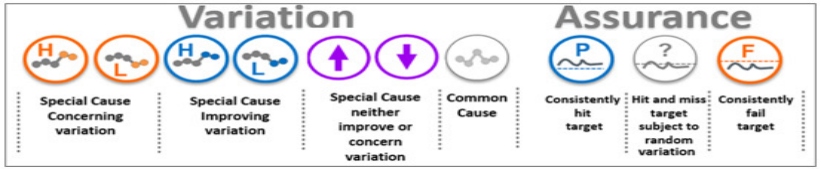
Improving health

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	95.6%	94.9%	94.2%		
Percentage of service users who have had their equality data recorded - disability	50%	47.4%	47.5%	47.4%		A statistical approach is being undertaken in order to work out a target that will be adjusted based on actual performance each month. The current threshold is 50%. Please note that from January 2024 service users under 16 years of age have been excluded from the sexual orientation calculation.
Percentage of service users who have had their equality data recorded - sexual orientation		59.7%	59.9%	59.6%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Service timely completion - 75%	91.7% Service	91.7% Service	74.3% Service		All services have an EIA in place. Expired EIAs (or EIAs not reviewed and graded within the 12-month cycle) expired in March and have all been offered support to complete. Our approach is to change the submission and review of EIAs to April-February cycle ensuring March gives the Trust a final position statement.
	Policy - 95%	95.5% Policy	96.1% Policy	96.7% Policy		
Completion of equality mandatory training	>=80%	95.6%	95.6%	95.6%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	7	12	12		New metric added March 2024. A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	50	43	44		New metric added March 2024. First contact and work started on vocational profile
Carbon Impact (tonnes CO2e) - business miles	76	61	66	65	H	Data showing the carbon impact of staff travel / business miles. In April staff travel contributed 65 tonnes of carbon to the atmosphere. April data is subject to change as the conversion factor for 2024/25 is not available until June 2024.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	Due June 2024				Q1 - 65%, Q2 - 66%, Q3 - 68%. A weighted average is used given there are different targets in different service areas.

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 has had the upper and lower control levels recalculated following the last Covid-19 lockdown in April 2021. It is understood that the lockdowns that happened as a result of the Covid-19 outbreak impacted on our carbon impact due to the changes in ways of working and move away from face to face contacts. Although we remain under threshold, we have recently entered a period of special cause concerning variation. Levels are not expected to return to those seen pre-Covid-19 as a more blended approach to working is expected to continue.



Improve Care

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	90.1%	91.7%	92.7%		April data shows a slight increase in performance from the previous month within inpatient services to 92.7%. This is the second month where an increase in performance has been recorded. For community services, performance for April has decreased slightly to 78.5%. Within inpatient services 114 service users had a risk assessment within 24 hours, 9 service users had a completed risk assessment but this was outside the 24 hours. For community services 28 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety. The Care Plan and Risk Assessment Improvement Group review challenges with performance and review for improvement opportunities. Opportunities include making the data easier to review for performance figures and adding pop up reminders to the system, both of which are being explored. Communications and narrative about the importance of risk assessments and timeliness of this is being developed to share. .
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		74.7%	79.2%	78.5%		
% Service users on CPA offered a copy of their care plan	80%	88.7%	Reporting under review			The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. An anomoly has been identified and is currently under investigation. An update will be provided next month.
Registered substantive staff in post mental health and learning disabilities services	Establishment	1094	1109	1107		
Registered substantive staff in neighbourhood teams	Establishment	174	176	171		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	23	22	25		Any increases will be monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	0	74	138	119		The Q4 target shown is a National target and whilst we remain above this threshold we have seen a notable improvement in the number of out of area bed days which is down to an average of 99 days in the past 6 months from an average of 375 days in the 6 months prior to that. Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes and to ensure that services users receive care closer to their home. See statistical process chart in National Metrics section for further detail. Please note, this is an in month position and may not reflect the quarterly outturn.
% service users clinically ready for discharge	<=3.5%	2.9%	2.5%	2.3%		Performance in month has improved to 2.3% and remains below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months. 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. Further work taking place to review this as the improved position for this does not reflect what we believe is happening in practice.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	702	683	672		Neurodevelopment waits remain a concern, especially given the additional capacity has stopped at the end of March 2024. This is in keeping with the national picture and forms part of the system wide work. These metrics calculate length of wait in days for those discharged that month. Children and young people are seen in order of need and not by how long they have waited. Onset of Right to Choose has impacted on the number choosing to come to SWYPFT for assessment and there is still a backlog of individuals who will have waited a long time for assessment from referral.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	636	611	647		
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	87.5% 42/48	76.7% 35/46	82.0% 41/50		This remains a key concern and actions are underway as part of the improving access priority programme. Where waits breached 18 weeks (9 in total in April) the service understand why and are taking appropriate action. An update in relation to waits will be discussed in the Executive Management Team meeting. The LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	92.0%	87.5%	90.8%		
Community health services two hour urgent response standard	70%	87.8%	88.2%	92.8%		
Referral to assessment within 2 weeks (external referrals)	75%	81.8%	89.3%	90.6%		

Improve resources

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£149k)	(£53k)	(£192k)		A deficit of £303k has been recorded for April which is £192k worse than planned. The main driver relates to pay expenditure.
Capital spend against plan (monthly)	£8.1m	£1,033k	£2,766k	£334k		Capital expenditure in April 2024 is £447k. This is £334k more than plan with an expenditure plan profiled later in the year.
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£483k	£438k	£442k		The reduced agency run rate in Quarter 3 and 4 2023 / 24 has been maintained into April 2024 with spend in month of £442k. This is less than planned.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,175k	£1,126k	£1,751k		Value for money delivery is in line with plan.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	8		Due July 2024		
Estates Urgent Response Times - Service level agreement (SLA)	95%	96.9%	96.9%	100.0%		Service level agreement 1 & 2 are the priorities given to emergency and urgent work which has a two day response time.
Premises Assurance Model (PAM)	Good	Good	Good	8 Good 1 Requires Improvement		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency & Effectiveness. In April, the PAM status moves to requires improvement, this is due to the medical devices management being in review. This affects the whole of PAM. Plan in place to return to good at end of review period
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	100%	100.0%	100.0%	100.0%		Estates senior management have reviewed this metric and from August '23 only jobs screened as category SLA 2 are included due to some inconsistencies in the categorisation of jobs when initially logged.

Make SWYPFT a great place to work

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance	Notes
Turnover external (YTD Projection)	>12% - 13%<	11.2%	11.0%	10.0%		
Registered workforce growth	3% (by March 24)	7.7%		0.4%		
Sickness absence - rolling 12 months	<=4.8%	5.0%	5.0%	4.8%		Absence rate in month dropped to 3.6%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	March 2024 >=90% April 24 onwards >=95%	83.4%	84.2%	87.1%		For the month of April, the percentage rate increased but continues to remain below threshold. Work is taking place to understand the relation between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and whether there are any specific reasons.
% staff recommending the Trust as a place to work	65%	70.5%		N/A		Results from national staff survey.
% staff recommending the Trust as a place to receive care and treatment	65%	72.2%		N/A		
Staff supervision rate	80%	70.0%	74.9%	75.6%		As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice. (Band 4 and above, all supervision)
Mandatory training - Cardiopulmonary resuscitation	80%	76.1%	77.8%	79.4%		In order to maintain a safe environment, inpatient services ensure access to appropriately cardiopulmonary resuscitation trained staff on each shift. 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).
Mandatory training - Reducing restrictive physical interventions	80%	74.0%	73.0%	68.3%		Performance has dropped again this month to 68.3% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training. Successful recruitment will improve team capacity and likely to take effect from June 24.
Mandatory training - Fire	80%	89.6%	89.2%	90.4%		
Mandatory training - Information governance (IG)	95%	91.8%	91.5%	92.8%		Reminders circulated regarding IG training compliance. See People section for further detail.

Quality Headlines

Section	KPI	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	81.0%	84.0%	84.0%	81.0%	80.0%	82.4%	85.8%	84.2%	80.9%	78.8%	79.9%	73.3%	N/A
Complaints	% of feedback with staff attitude as an issue [12]	< 20%	11% 2/17	16% 3/19	19% 3/16	17.6% (3/17)	10% (1/10)	9% (1/11)	8% (2/24)	17% (4/23)	8% (2/24)	14% (1/7)	18% (4/22)	17% (4/23)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	38% (3/8)	17% (2/12)	29% (4/14)	38% (5/14)	38.9% (7/18)	42.9% (9/21)	44.1% (12/27)	44.4% (4/9)	70.0% 7/10	62.5% (10/16)	66.7% (8/12)	72.7% (8/11)	
Service User Experience	Friends and Family Test - Mental Health	84%	85%	91%	90%	90%	95%	89%	88%	94%	89%	92%	92%	92%	1
	Friends and Family Test - Community	95%	97%	96%	93%	97%	96%	95%	97%	98%	97%	97%	97%	97%	1
Quality	Number of compliments received	N/A	66	33	35	22	17	18	35	16	2	8	6	12	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	34	25	24	35	24	30	19	15	17	15	18	9	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	2	3	3	5	4	6	3	1	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	1	1	0	0	0	0	1	3	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	85.7%	86.6%	87.5%	87.4%	87.5%	87.5%	87.7%	87.6%	88.5%	88.7%	Reporting under review		1
	Number of Information Governance breaches [3]	<12	9	14	13	16	8	9	11	8	14	20	5	8	2
	% of inpatients clinically ready for discharge	3.5%	2.1%	4.6%	4.8%	5.7%	5.7%	5.2%	5.8%	5.7%	4.3%	2.9%	2.5%	2.3%	3
	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%	87.7%	86.7%	87.2%	88.0%	87.5%	89.9%	92.5%	94.1%	93.4%	90.1%	91.7%	92.7%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		65.0%	66.1%	74.0%	72.2%	71.3%	71.1%	76.4%	70.0%	71.8%	74.7%	79.2%	78.5%	2
	Total number of reported incidents	Trend monitor	1327	1258	1159	1206	1150	1315	1322	1186	1287	1345	1438	1356	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	30	19	21	28	23	25	20	17	23	21	35	25	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	2	5	1	4	1	4	1	1	5	4	1	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	2	1	2	3	1	3	2	2	2	0	1	0	
	Safer staff fill rates	90%	123.5%	123.7%	123.9%	123.8%	124.1%	123.5%	128.8%	128.7%	129.6%	127.6%	128.5%	130.8%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	95.7%	93.1%	93.6%	92.1%	91.4%	91.3%	97.5%	96.2%	102.2%	100.8%	101.6%	107.1%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	42	40	36	43	43	28	33	27	45	58	42	22	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement (2)	0	1	3	1	2	0	3	6	6	2	2	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%	86.6%	89.5%	95.2%	90.0%	90.0%	91.7%	66.6%	100.0%	100.0%	100.0%	92.3%	100.0%	1
	Number of Falls (inpatients)	Trend monitor	41	43	32	33	36	50	46	42	48	45	45	41	
	Number of restraint incidents	Trend monitor	186	201	145	146	92	198	153	193	121	165	188	256	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting to start from Sept 23				65.8%	66.0%	70.1%	69.6%	70.0%	70.0%	74.9%	75.6%	2
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing [14]	80%	92.1%	87.8%	83.8%	81.8%	90.6%	91.3%	66.7%	95.1%	97.4%	88.9%	94.1%	100.0%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	1	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	
	Overall CQC rating								Good						
	CQC well - led rating								Good						

Quality Headlines

Quality Headlines cont…

1 - Number of pressure ulcers which developed under SWYPFT 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. 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 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - 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 Information Governance 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.
15 - % of Band 4 and above clinical staff who have received supervision in the previous 90 days.

Quality Headlines

The following section provides insight into key quality issues identified in the dashboard for the month of April.

• Although the number of reported incidents remains high in April, it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. Further detail is provided in the relevant section of this report.
• The overall number of restraint incidents in April was 256 which is within acceptable range. Further detail is provided in the relevant section of this report. The Trust's ongoing ambition is for a reduction in all restraint incidents, and reducing restrictive physical interventions training has a clear focus on interventions to prevent escalation of a situation to the point where restraint is required.
• Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - there was one instance in April, this was due to an error in documentation. Work is ongoing to improve this.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased to 2.3% and remains below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In April there were 41 inpatient fall incidents. Further detail is provided in the relevant section of this report.
• % Service users on CPA offered a copy of their care plan - The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. An anomoly has been identified and is currently under investigation. An update will be provided next month.
• The number of information governance breaches in relation to confidentiality breaches has increased to 8 during the month but remains below threshold. The Information Commissioner's Office has notified the Trust of two complaints they have received, pertaining to the Trust's alleged failure to uphold their information rights. The Data Protection Office is investigating and will respond before the advised deadlines
• As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice.

Patient Safety

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 became mandatory from March 2024. This is currently progressing well at 95% completed.

Patient Safety Partners
The three patient safety partners (this is a volunteer role) have been inducted into the patient safety team.

Never event consultation
NHS England are currently undertaking a consultation of the Never Events framework. The consultation is asking if Trusts think Never Events framework is an effective mechanism to drive patient safety improvement; and bearing in mind the evidence in this consultation document, which one of the following options you prefer for its future;

Option 1: No change; continue with the current framework
Option 2: Abolish the Never Events framework and list
Option 3: Revise the list of Never Events to only include those with current barriers that are 'strong, systemic, protective'
Option 4: Revise the definition of and process for Never Events to create a new system that does not require all relevant incidents to be 'wholly preventable'.

The patient safety team has provider feedback to NHS England consultation, making a suggestion of option 3 in the first instance to align the never event list with PSIRF principles. It was also recommended that that eventually never events could be phased out (option 2).

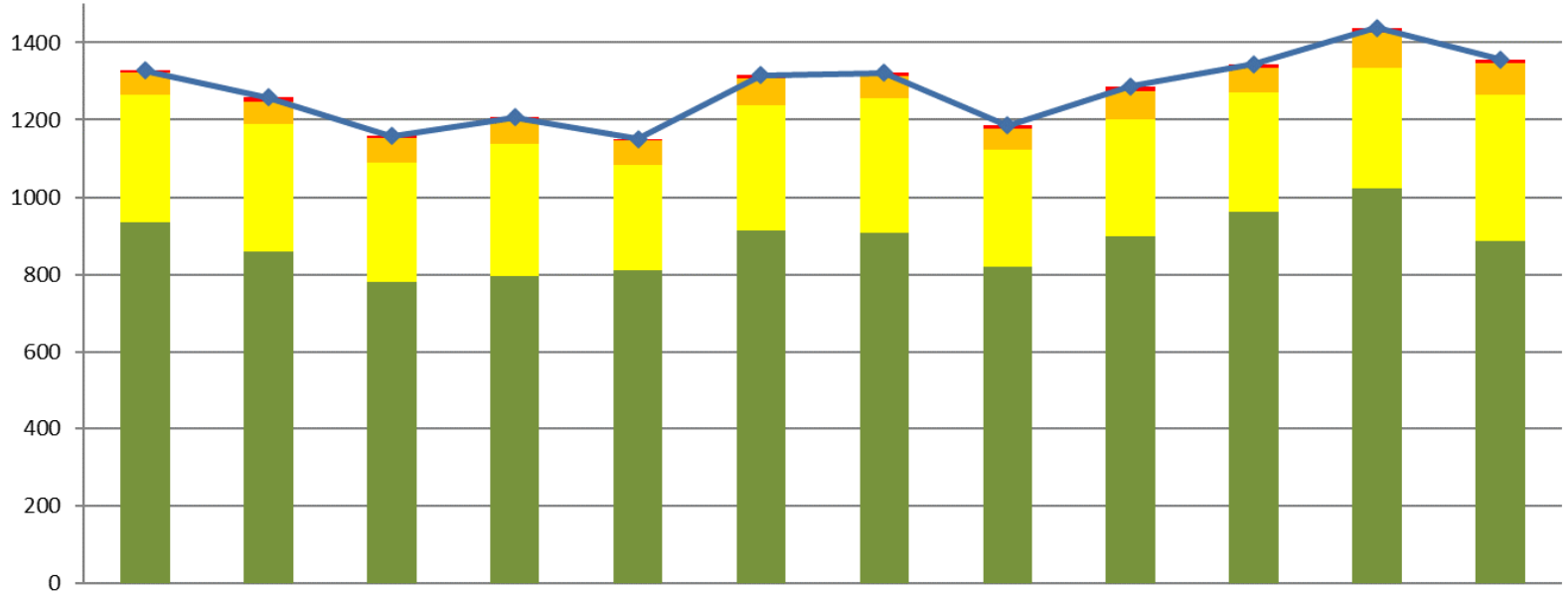
Duty of Candour (DOC)
The updated Duty of Candour policy has been approved - changes made to the policy are reiterated CQC Regulation 20 advice. There has also been a 'Task and Finish' group to determine when DOC would apply, i.e. determining when an incident is a notifiable patient safety incident, as the Trust has been over-reporting on DOC. The group have produced a list of examples of DOC-applicable incidents to members of the 'Task and Finish' group. A poster and flowchart has been created to explain to staff when to follow DOC process or when to implement Involving and Engaging instead.

Safety First

Summary of Incidents

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

95% of incidents reported in April 2024 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in April 2024



	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Red (should not be compared with SIs)	6	10	7	9	3	8	9	9	14	10	12	8
Amber	55	58	63	60	65	69	56	54	73	65	90	84
Yellow	330	330	307	342	272	324	349	301	300	309	313	377
Green	936	860	782	795	810	914	907	821	900	961	1023	887
Total	1327	1258	1159	1206	1150	1315	1321	1185	1287	1345	1438	1356

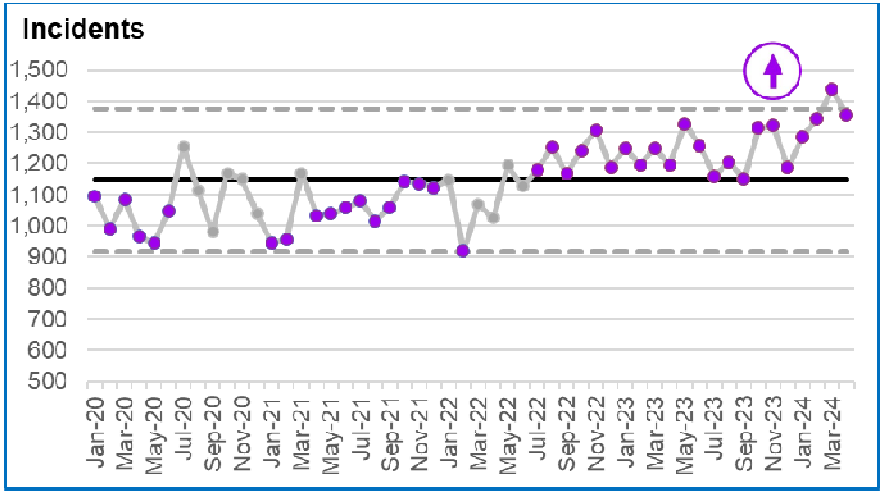
Safety First cont…

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

Breakdown of incidents in April 2024
18 moderate harm incidents:
The most common incidents were pressure ulcers and self harm.

0 severe harm incidents

Incidents



We remain in a period of special cause variation (something is happening and this should be investigated) in April due a sustained increase in the number of incidents, 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.
Further examples can be found on the SWYPFT intranet page.

If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

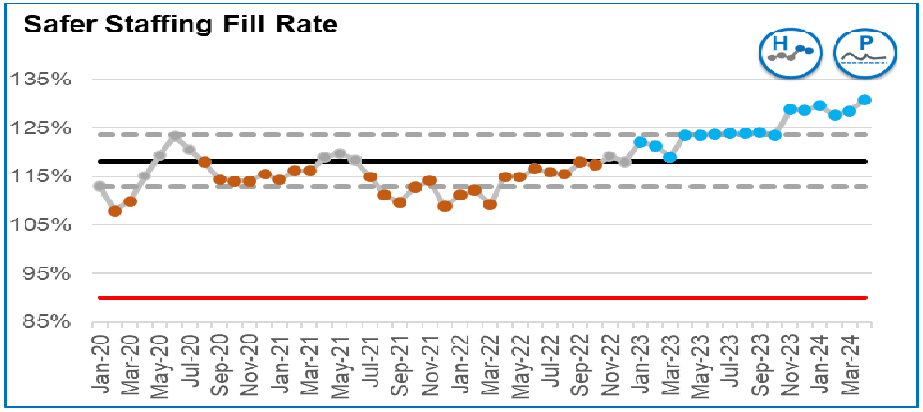
Patient Safety Alerts

There were no patient safety alerts issued in April 2024

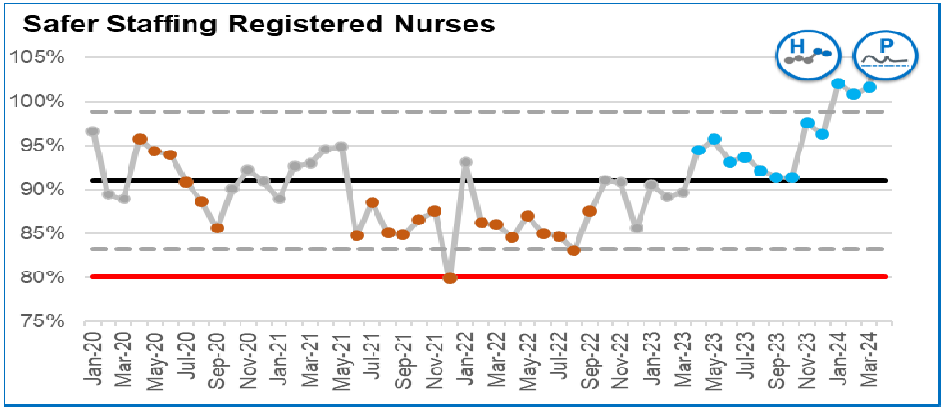
Patient Safety alerts not completed by deadline of April 2024 - zero.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2024/004/MHRA	Reducing risks for transfusion-associated circulatory overload	04/04/2024	National Patient Safety Alert	04/10/2024	09/04/2024

Safer Staffing Inpatients



The chart above shows that as at April 2024 due to the continued increasing staffing fill rate, we remain in a period of special cause improving variation.



The chart above shows that in April 2024, due to the continued increase in the registered nurses fill rate, we remain in a period of special cause improving variation.

- There was a significant decrease in April on demand (mainly due to decreased vacancies and less annual leave being taken by substantive staff as is historical in April) of the flexible staffing pool with a total of 909 less shift requests with the overall fill rate remaining high at 92.01%.
- All figures within the care groups indicate a slight decrease in overall demand to deal with acuity given the decrease in requests, although fill rates overall and for health care assistants (HCA) have improved or being relatively static whilst the fill rate for registered nurses within the flexible staffing workforce have reduced and we will closely monitor this trend.
- Vacancy control groups are being established to ensure that targeted local recruitment replaces the centralised process.
- There has been an increase in staff being cleared to work on the collaborative bank with, currently, SWYT supplying over 80 staff who are cleared to work within Leeds and York Trust.
- SafeCare continues to be utilised with mixed results across the wards that have implemented it. Where it has successfully been deployed it has allowed for conversations around staffing requirements and deployments as well as indicating potential savings through health roster utilisation.
- The roll out of health roster continues.
- The overall fill rate has increased by 2.3% to 130.8% with the day fill rate for registered nurses continuing to improve, in April by 4.5% to 99%. With a reduction of five wards in April, only eight wards have fallen below the 90% registered nurse (RN) day fill rate.
- In April no ward fell below the 90% overall fill rate threshold, which is consistent with the previous month.

Safer Staffing Inpatients cont…

Registered Nurses Days
Overall registered day fill rates have increased by 4.5% to 99.0% in April compared with the previous month.

Registered Nurses Nights
Overall registered night fill rates have decreased by 6.6% in April to 115.2% compared with the previous month.

Overall Registered Rate: 107.1% (increased by 5.5% on the previous month)
Overall Fill Rate: 130.8% (increased by 2.3% on the previous month)

Fill Rate	Feb-24	Mar-24	Apr-24
Adults and Older People	136%	138%	139%
Barnsley Integrated Services	110%	114%	113%
Forensic and LD	117%	116%	119%
Grand total	**128%**	**129%**	**131%**

Registered day rate	Feb-24	Mar-24	Apr-24
Adults and Older People	91%	95%	98%
Barnsley Integrated Services	105%	99%	119%
Forensic and LD	93%	93%	97%
Overall shift fill rate	**93%**	**94%**	**99%**

Registered night rate	Feb-24	Mar-24	Apr-24
Adults and Older People	108%	106%	115%
Barnsley Integrated Services	80%	85%	84%
Forensic and LD	114%	116%	120%
Overall shift fill rate	**109%**	**109%**	**115%**

- Bank staff filled 67.92% (decreased by 0.34% on the previous month) of RN requests for flexible staffing and 84.65% (decreased by 0.52% on the previous month) of HCA requests.
- Agency staff filled 7.85% (a decrease of 3.36% on the previous month) of RN requests for flexible staffing and 10.44% (an increase of 0.10% on the previous month) of HCA requests.

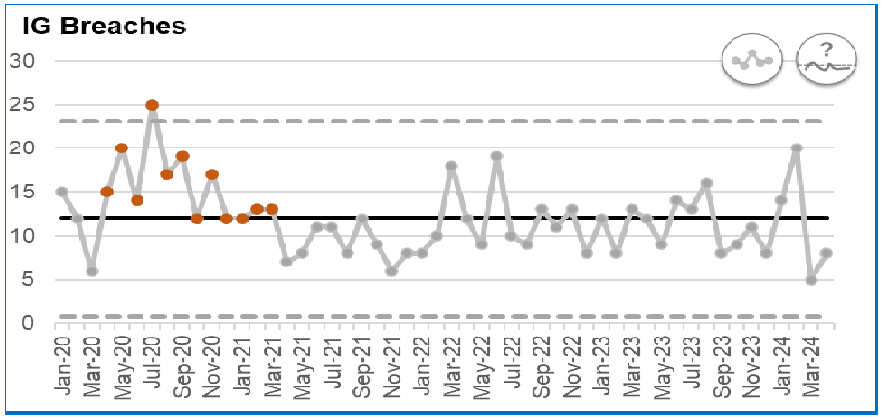
Information Governance (IG)

8 personal data breaches were reported during April, which is a slight increase on March but significantly lower than the average monthly figure during the 2023/24 financial year. It should be noted that one reported breach is an allegation of inappropriate access that is still being investigated.

The breaches were due to:
- Postal correspondence being sent to the wrong address,
- Patient documentation being found in the possession of another patient,
- Patient documentation being lost during transit to another hospital (N.B. it was later found),
- Failure to correctly identify patient leading to wrong information being shared,
- Email sent to the wrong recipient.

The Information Commissioner's Office has notified the Trust of two complaints they have received, pertaining to the Trust's alleged failure to uphold their information rights. The Data Protection Office is investigating and will respond before the advised deadlines.

This SPC chart shows that as at April 2024 we remain in a period of common cause variation.



Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes were in place for 2023/24 contracts. These mainly related 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.

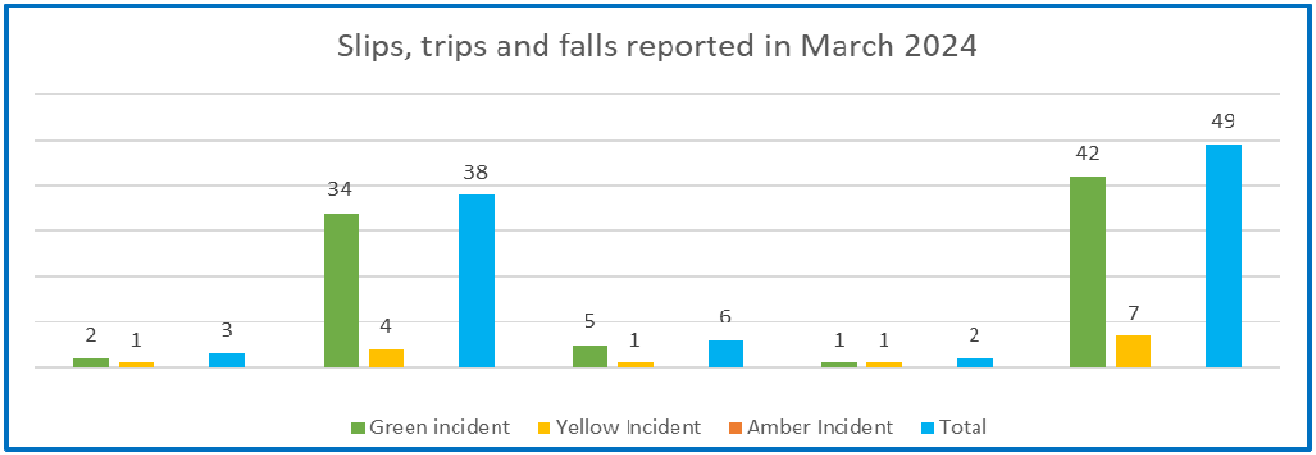
There were some new indicators in the scheme. The quarter 4 submission is due by the end of May 2024. Some risk has been associated with full achievement of the following metrics: staff flu vaccinations and outcome monitoring in adults and older people and children and young people and community perinatal mental health services - actions plans have been in place to mitigate this as far as possible throughout the year and performance monitored via the CQUIN leads group.

National contract guidance states that the CQUIN schemes are to be paused during 2024/25.

Trustwide Falls

April 2024: A total of 49 slips, trips and falls were reported. 41 of these in inpatient wards.

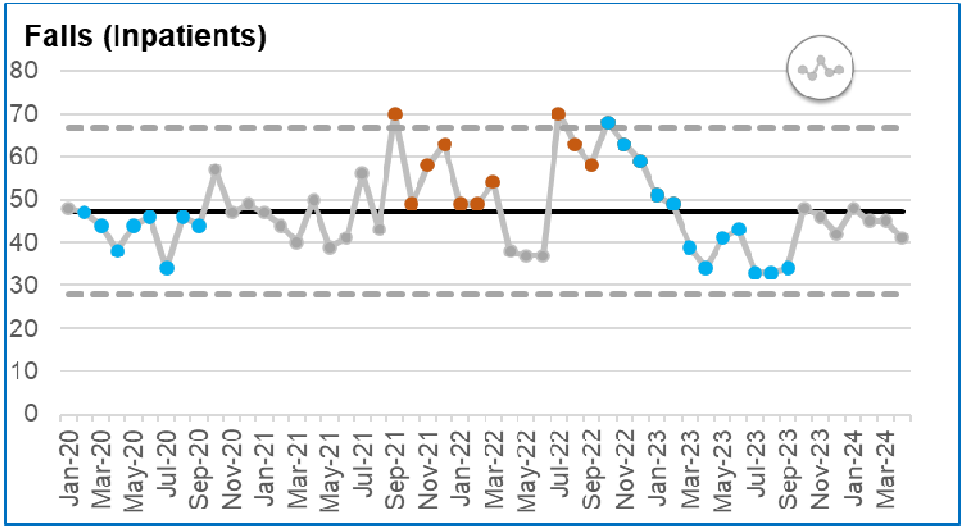
The current rate of falls in April is 3.2 per 1000 bed days. We continue to report within the National average of 3-5 falls per 1000 bed days.



Incident Grading
No red or amber incidents.
Yellow: 7 (14%) reported incidents. No significant injuries recorded and most graded as yellow due to higher intervention required.
Green: 42 (86%) reported incidents had low or no harm recorded

Falls (Inpatient)

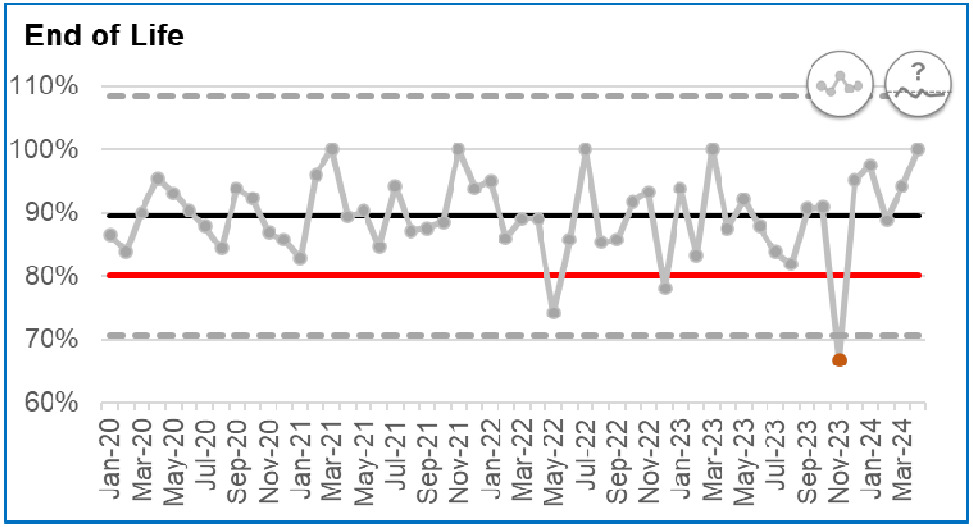
The total number of inpatient falls was 41 in April.



The SPC chart above shows that in April 2024 we remain in a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 100% in April. As is noted in the Quality Headlines Dashboard, performance against this metric remains above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in April 2024 the performance against this metric remains in common cause concerning variation (no concern). As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test (FFT) shows

- 97% would recommend physical health services
- 92% would recommend mental health services

	Target	February	March	April
Mental health community	85%	94% (298)	92% (299)	95% (330)
Mental health inpatient	85%	89% (72)	83% (40)	86% (57)
Learning Disabilities	85%	100% (16)	100% (25)	88% (16)
ASD/ ADHD	85%	67% (6)	100% (1)	50% (2)
CAMHS	75%	86% (29)	93% (29)	77% (26)
Forensic	60%	67% (3)	100% (4)	33% (3)
Mental health overall	84%*	**92% (426)**	**92% (399)**	**92% (435)**
Barnsley Physical Health	95%	**97% (295)**	**97% (315)**	**97% (380)**
Trustwide	**85%**	**94% (730)**	**94% (715)**	**95% (817)**

** weighted for 2023/24*

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

Satisfaction trustwide, in mental health community and mental health inpatient service has increased.

Satisfaction for learning disability, ADHD, CAMHS, and forensics has declined but response rates remain low.

All services remain above target except for ADHD and forensic.

The number of forensic returns remains low as Forensic survey every six months to capture feedback as service users are admitted to the ward for a longer period.

The ADHD Project Group continue to meet to look at engaging service users to increase feedback to improve services. A CHATpad has been purchased by the service and the involvement team are looking at resources that can be made available to the website to support service users waiting for an appointment, including information on what to expect to the appointment and other available resources.

Safeguarding

Safeguarding Adults:
In April 2024, there were 31 Datix categorised as safeguarding adults. 14 of these were graded as green, 13 were graded as yellow, four were graded as amber and there were no red Datix. The most common subcategories were domestic abuse, neglect, financial abuse and emotional abuse.

In addition to the safeguarding adults Datix, there were 27 sexual safety Datix of which there were 22 green incidents, four yellow incidents and there was one amber incident, where concerns were raised in regard to potential sexual activity. All appropriate actions taken. In all cases reviewed appropriate actions were taken, including Police, local authority safeguarding referrals and support from specialist services were made where required.

Safeguarding Children:
In April 2024 there were 15 Datix categorised as safeguarding children; six of these were graded as green, seven were graded as yellow, two were graded as amber and there were no red Datix. The most common subcategory of these Datix was emotional abuse. In all of the Datix submitted, SWYPFT safeguarding advice was sought as appropriate.

Complaints

- Acknowledgement and receipt of the complaint within three working days – 22/23 (96% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 8/11 (73%)
- Number of complaints waiting to be allocated to a customer service officer – 0
- Number of cases which breached the six months target who have not had a conversation to agree a new timeframe for completion – 0
- Longest waiting complainant to be allocated to a customer service officer – N/A
- There were 23 new formal complaints in April 2024
- 12 compliments were received
- 11 formal complaints were closed in April 2024
- Number of concerns (informal issues) raised and closed in April 2024 – 41
- Number of enquiries responded to in April 2024 – 68
- Number of complaints referred to the Parliamentary Health Service Ombudsman and upheld this financial year to date and how many upheld – 6 Ongoing

Infection Prevention Control (IPC)

Mandatory training: figures for hand hygiene and, infection, prevention and control remain healthy and above Trust 80% threshold.

Outbreaks - April 2024
- One diarrhoea and vomiting (no causative organism identified) outbreak on inpatient wards
- One Covid-19 A outbreak on inpatient ward

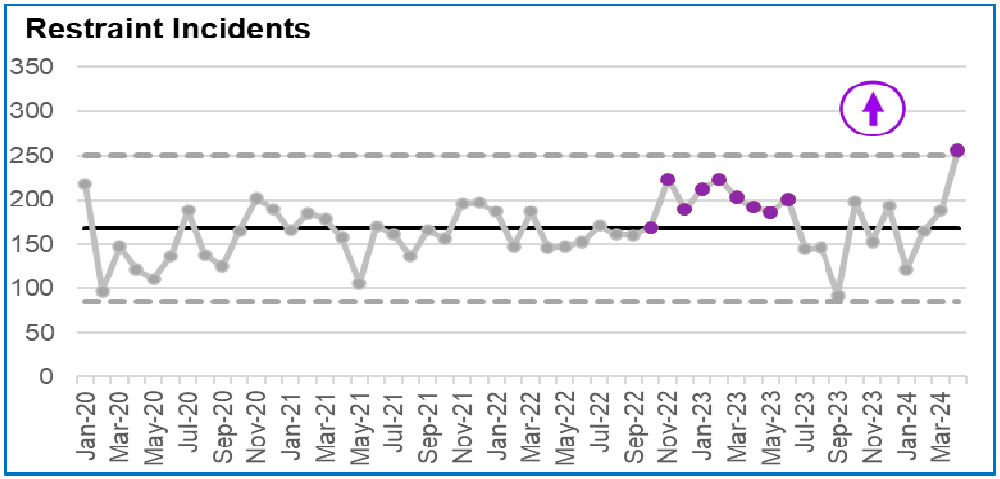
Reducing Restrictive Physical Intervention (RRPI)

• There were 256 reported incidents of RRPI used in April 2024 this was an increase of 68 (36%) from March 2024 which stood at 188. There are a few acutely unwell and challenging service users displaying high levels of violence and aggression who are affecting the number of incidents disproportionately.
• 100% of prone restraints in April 2024 lasted under 3 minutes.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	123	31.9%
Safety Pod	101	26.0%
Seated	69	17.9%
Supine - held on their back, regardless of surface	27	7.0%
Prone descent then remained in chest down position	17	4.4%
Side	17	4.4%
Prone descent then immediately rolled to other position side/back	12	3.1%
Restricted escort	9	2.3%
Kneeling	7	1.8%
Service User placed self in prone and staff immediately let go or rolled	3	0.7%

Team Using Prone Restraint	Total
Walton PICU	7
Newhaven Forensic Learning Disabilities Unit	2
Ward 18, Priestley Unit, Kirklees	2
Beamshaw Ward - Barnsley	1
Clark Ward - Barnsley	1
Crofton Ward (OPS), Wakefield	1
Horizon Centre Assessment and Treatment Service	1
Melton PICU, Barnsley	1
Sandal Ward (Bretton Centre)	1

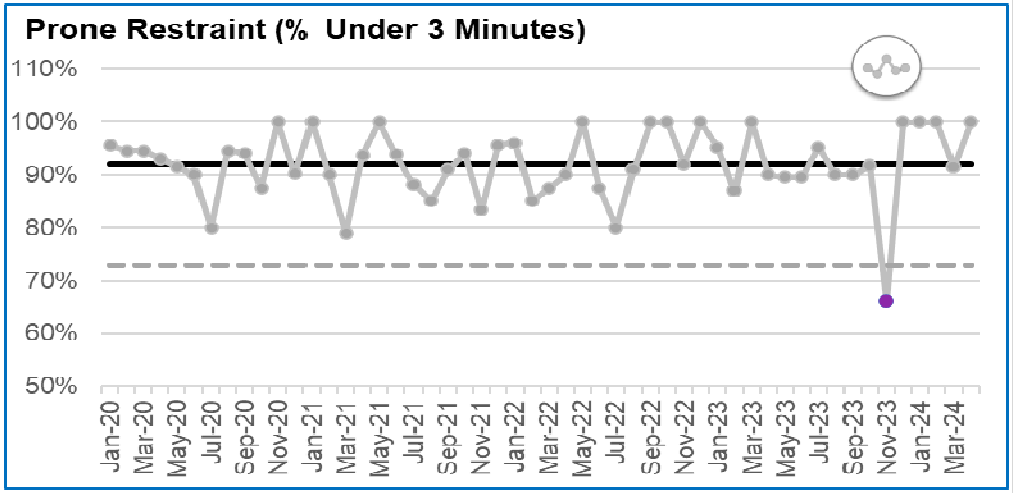
Duration of Prone Restraint	Total
0 - 1 minute	12
1 - 2 minutes	4
2 - 3 minutes	1

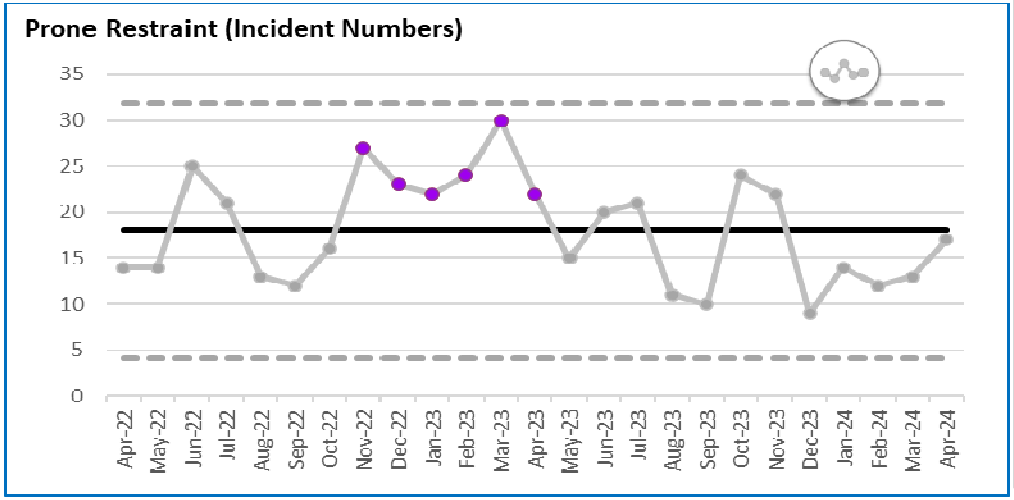


This SPC chart shows that in April 2024 we remain in a period of common cause variation (no concern).

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

Reducing Restrictive Physical Intervention (RRPI)





The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. Use of prone restraint continues to be below the year average of 21, and from now on all incidents of prone restraint will be reviewed for learning in the Patient Safety Oversight Group.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Establishment	Improving Resources	Well Led	-	5,174.0	5,193.8	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4	5412.1	5415.1	5422.1	5469.4
Contracted Staff In Post (Ledger)			-	4,352.0	4,375.4	4,400.5	4,432.7	4453.2	4425.9	4442.5	4471.3	4535.6	4574.5	4605.2	4655.9
Vacancies			-	822.0	818.4	796.1	772.1	867.8	897.4	887.0	870.1	876.6	840.6	817.0	813.5
Turnover external (YTD Projection)			>12% - <13%	12.2%	13.1%	13.0%	13.1%	12.1%	12.4%	12.0%	12.0%	11.6%	11.2%	11.0%	10.0%
Starters			-	54.9	57.5	53.9	64.0	63.3	69.4	61.6	42.8	91.4	49.8	38.3	56.4
Leavers			-	36.5	41.1	51.3	45.2	35.2	51.8	31.9	27.6	30.3	32.8	37.7	20.2
International Nurse Starters in Month			-	0	0	0	9	10	10	10	5	5	0	0	0
% Bank Fill Rates - Registered Nurses			-	Reporting commenced August 23			47.8%	49.6%	52.0%	59.1%	52.3%	60.3%	62.6%	68.3%	67.9%
% Bank Fill Rates - Health Care Assistants			-				69.8%	70.2%	75.9%	80.3%	80.8%	82.2%	86.2%	85.2%	84.7%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-				90.9%	90.3%	90.6%	93.4%	91.6%	92.2%	92.2%	92.6%	92.0%
Proportion of staff in senior leadership roles who are from BME background (relates to staff in posts band 7 and above, excludes bank staff) *			-	Reporting commenced August 23			199 (14.7%)	203 (14.9%)	206 (14.9%)	209 - All staff (15.1%) 86 - excl medics (7.21%)	217 - All staff (16.0%) 90 - excl medics (7.7%)	217 - All staff (15.9%) 89 - excl medics (7.6%)	220 - All staff (16.2%) 92 - excl medics (7.9%)	222 - All staff (16.3%) 94 - excl medics (8.0%)	224 - All staff (16.2%) 95 - excl medics (8.0%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-				931 (69.8%)	942 (69.3%)	962 (69.5%)	963 (69.7%)	946 (69.8%)	947 (69.8%)	952 (69.9%)	953 (70.0%)	971 (70.3%)
Sickness absence - Rolling 12 month			<=4.8%	5.3%	5.3%	5.3%	5.3%	5.3%	5.2%	5.2%	5.1%	5.1%	5.0%	5.0%	4.8%
Sickness absence - Month			<=4.8%	4.6%	4.6%	5.1%	4.7%	4.9%	5.2%	4.9%	5.1%	5.1%	4.8%	4.4%	3.6%
Employees with long term sickness over 12 months			-	0	0	0	0	2	2	0	1	1	0	0	0
Appraisals - rolling 12 months			May 23 >=78% to March 24 >=90% April 24 onwards >=95%	74.9%	78.5%	76.5%	74.5%	72.5%	69.7%	73.1%	74.3%	79.6%	82.9%	84.2%	87.1%
Employee Relations - Suspensions (over 90 days)			-	0	0	3	3	3	4	2	2	2	2	3	1
Mandatory Training - TOTAL	Improving Care		>=80%	90.9%	92.0%	92.1%	92.5%	92.1%	92.5%	92.1%	91.9%	91.9%	91.8%	91.9%	92.5%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	76.7%	76.2%	82.6%	82.8%	82.9%	85.0%	81.8%	77.0%	74.0%	73.0%	68.3%
Mandatory Training - Cardiopulmonary Resuscitation				79.2%	81.3%	81.0%	79.9%	80.0%	79.7%	78.5%	77.0%	77.5%	76.1%	77.8%	79.4%
Mandatory Training - Clinical Risk				95.4%	95.4%	95.2%	94.8%	94.0%	92.6%	91.3%	91.0%	90.6%	91.8%	92.5%	96.6%
Mandatory Training - Display Screen Equipment				96.8%	97.0%	97.1%	97.4%	97.4%	97.4%	97.1%	97.0%	95.2%	96.1%	96.4%	97.4%
Mandatory Training - Equality & Diversity				96.2%	96.2%	96.0%	95.9%	96.1%	95.4%	94.9%	94.9%	95.1%	95.3%	95.4%	95.8%
Mandatory Training - Fire Safety				91.2%	92.8%	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%	90.5%	89.6%	89.2%	90.4%
Mandatory Training - Food Safety				83.4%	86.4%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%	90.0%	90.4%	90.2%	90.2%
Mandatory Training - Freedom To Speak Up (FTSU)				93.7%	94.0%	94.3%	94.7%	94.9%	95.0%	94.9%	95.0%	95.2%	95.2%	95.6%	95.8%
Mandatory Training - Infection Control & Hand Hygiene				92.4%	94.1%	94.3%	94.3%	95.6%	94.2%	93.6%	93.1%	93.7%	93.7%	92.8%	93.3%
Mandatory Training - Information Governance (Data Security)			>=95%	95.9%	96.8%	96.9%	95.3%	94.8%	94.5%	93.4%	94.0%	92.7%	91.8%	91.5%	92.8%
Mandatory Training - Moving & Handling			>=80%	94.9%	95.2%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%	97.3%	97.5%	97.6%	97.8%
Mandatory Training - Nat Early Warning Score 2 (New S2)				92.1%	93.8%	94.7%	95.2%	96.2%	96.0%	94.6%	94.1%	93.5%	93.6%	94.1%	95.7%
Mandatory Training - Mental Capacity Act/DoIs				93.6%	93.7%	93.4%	94.0%	96.7%	99.6%	99.2%	99.0%	99.1%	99.2%	99.4%	99.6%
Mandatory Training - Mental Health Act				91.3%	91.2%	91.1%	92.2%	99.8%	91.2%	90.5%	90.2%	90.7%	89.6%	89.1%	89.6%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				Reporting commenced February 2024									66.6%	74.4%	78.7%
Mandatory Training - Prevent			>=80%	95.5%	92.1%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%	92.9%	91.9%	92.6%	93.3%
Mandatory Training - Safeguarding Adults				89.7%	89.3%	89.5%	89.7%	93.9%	90.7%	89.6%	89.4%	88.4%	88.3%	88.2%	88.8%
Mandatory Training - Safeguarding Children				90.7%	91.1%	91.2%	91.7%	89.7%	95.1%	94.4%	94.0%	92.9%	93.6%	93.3%	94.1%

Notes:

- Contracted Staff In Post (Ledger) - this has replaced the previously reported Staff in Post (ESR Last Day of the month)
- 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 vs Staff in Post – Whilst our starters and leavers figures give us a true account of turnover growth it will not exactly match the overall staff in post movement from month to month as this also includes any contracted hours changes of existing staff in that same month.
- 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 over 12 months. For earlier months this was year to date
- Bank fill rates - We are continuing to successfully recruit to band 2 and bank 5 posts for both substantive posts and bank. Our use of agency is under constant scrutiny, with bank being used as opposed to agency as much as possible, including for block bookings, and this is seeing a positive impact on agency spend.

Stability of the Workforce

Turnover

• Our Turnover for April 2024 continues to show an overall reduction compared to 2023/24 (2023/24= 11.0% /2024/25= 10.0%)

Stability

• The stability rate has maintained constant at the rate of 90.5% for the first month of 24/25. This is as a result of our employees being a great place to work. This can be evidenced by the improvements in our staff survey results where there have been several areas of improvement. Please see supportive Teams section for further information.

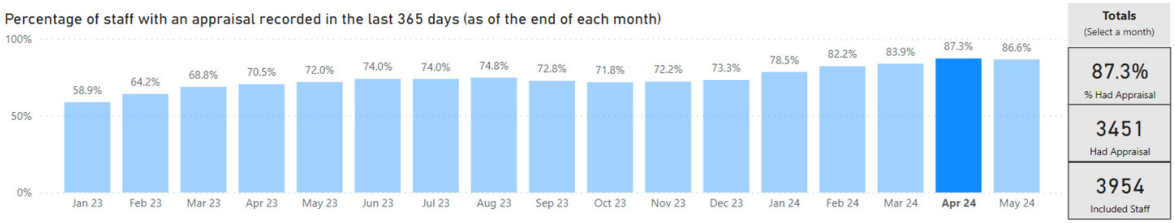
Supportive Teams

Appraisals

• The new online reporting system for appraisals has been very positive and has reflected in the appraisal compliance.
• Although we are seeing significant improvements in Appraisal Compliance we have still identified there are some managers not adding their appraisals to the system. Further work has been done between our Learning and Development (L&D) team and managers to provide support in using the system to update appraisals.
• We continue to increase our rolling appraisal compliance rate which has increased from to 87.3% in April. Our L&D team continue to work towards hitting our Trust target of 95%, with a milestone target of 90%.

Training

• Our overall mandatory training compliance remains above target at 92.5%.
• An interim training compliance report has been developed and published to support our managers in improving training compliance. This report will remain in place until the fully developed version is finalised (expected May '24). Feedback regarding the interim report has been positive.
• Reducing Restrictive Physical Intervention (RRPI) training has dropped again this month to 68.3% however our L&D team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training. Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning.
• Information governance (IG) training has increased this month from 91.5% to 92.8%. Communications are sent across the Trust to raise more awareness of the importance of completing IG training. The importance of completing IG training is also highlighted as part of the Team Brief.



Percentage of staff who have had an appraisal in the last 365 days

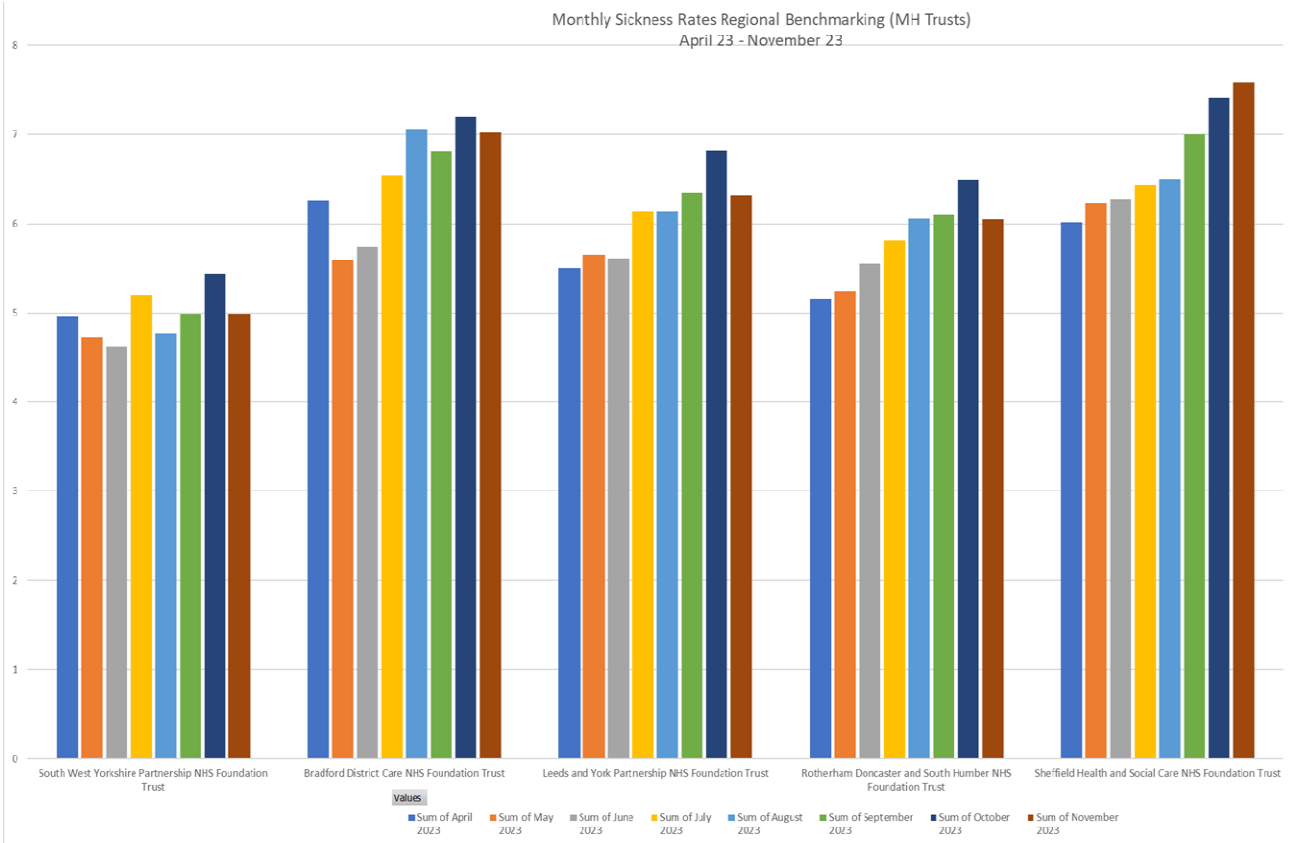
Month Care Group/Level 3/Team	Apr 24 Appraised	Total	%
⊞ Barnsley Physical Health and Wellbeing	542	603	89.9%
⊞ Children, Young People, and Families	339	370	91.6%
⊞ Forensic	280	349	80.2%
⊞ LD Adult ASD ADHD	139	167	83.2%
⊞ Mental Health	1564	1787	87.5%
⊞ Support Services	587	678	86.6%
Total	3451	3954	87.3%

Regional Sickness Benchmarking – April 23 – November 23

Keep fit and Well

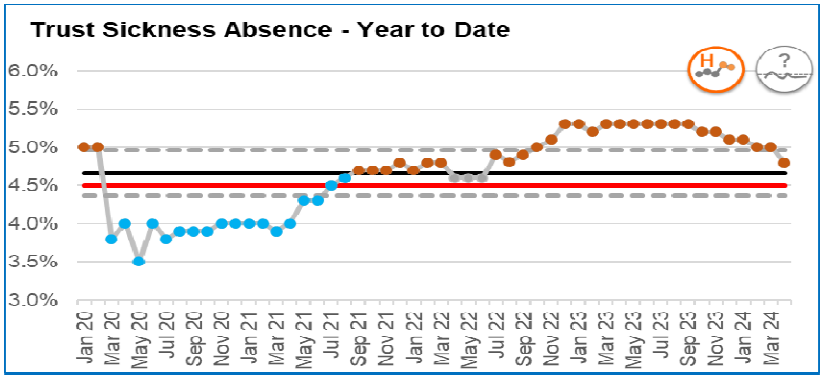
Absence

• Our year to date sickness figure has improved in April to 4.8% compared to 5% at this point last year.
• Sickness due to stress/anxiety has increased from 38% to 40% compared to last month.
• Our People Relations team have been supporting line managers in all areas to actively manage long term sickness cases i.e. following process to review cases, have appropriate meeting etc. to either bring people back to work (or redeploy them) or end their employment on the grounds of medical capability. As a result we have seen the sickness rates drop to the lowest since April 2023. In addition to this our People Business Partners have been working closely with care group leaders to highlight hotspots and provide more guidance for managers.
• A new absence report has been developed which will help People Business Partners and People Relations team when supporting care groups with absence management. The report shows insightful information regarding different aspects and levels of sickness. This will in turn, allow the Business Partners to discuss and explore route causes and any early interventions prior to the dedicated People Relations team adapting this to case management where appropriate to work with managers to focus more attention on these employees to support them back into work/redeploy or consider ending employment.
• Estates and Facilities sickness absence continues to be high at 8.9%.



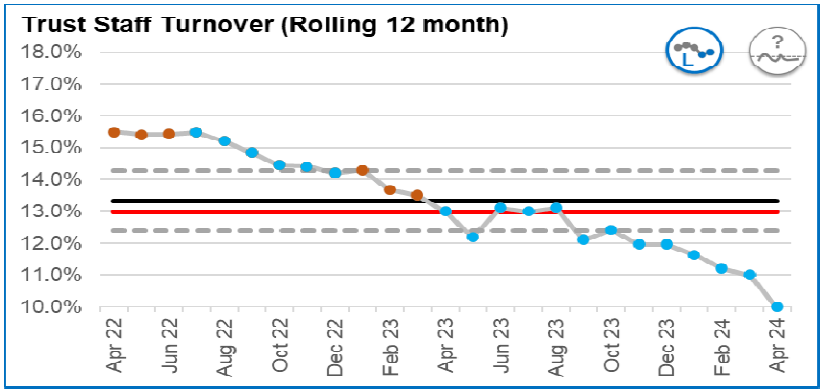
When compared to the April - November 23 published data by NHS England (latest data). we have the lowest sickness absence compared with other regional Mental Health Trusts (See graph).

Statistical process control charts

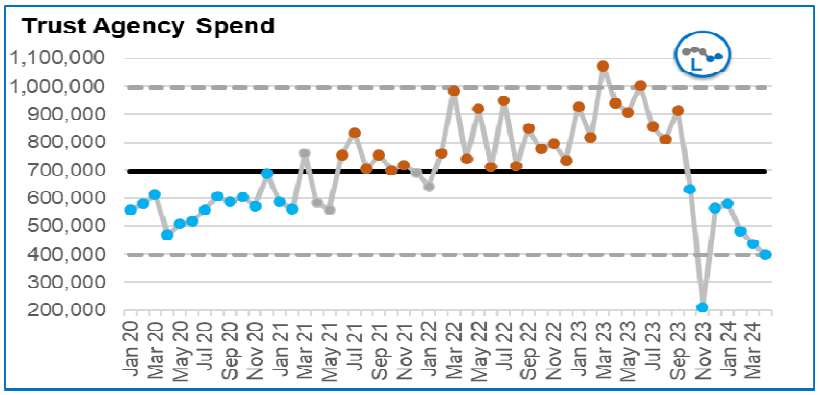


The SPC chart shows that in April 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

From July 2022 this data also includes absence due to Covid-19.



The SPC chart shows that in April 2024, we remain a period of special cause improving variation (something is happening and this should be investigated) following a sustained decrease in the turnover percentage over the past 9 months.



The SPC chart shows that in April 2024 we remain a period of common cause variation (no concern).

Please see finance section for further detail on agency spend.

National Metrics

Data as of : 22/05/2024 13:41:11

NHS South West Yorkshire Partnership NHS Foundation Trust

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

The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. Work is ongoing to establish the new metrics for 2024/25. An update will be provided next month. The below 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.

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0	F	L	545	435	589	400	187	66	75	85	104	74	138	119
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?	H	87.8%	88.6%	90.3%	93.1%	70%	81.8%	83.8%	83.3%	81.6%	87.2%	84.6%	87.5%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		53.4%	53.2%	50.4%	51.5%	51.6%	52.7%	51.6%	54.7%	50.2%	53.9%	53.0%	52.2%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	99.0%	99.6%	99.0%	99.5%	99.9%	100%	100%	99.7%	99.8%	99.9%	99.9%	100.0 %
M6	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	53.6%	83.1%	67.1%	64.4%	74.9%	74.2%	63.0%	64.3%	55.9%	69.2%	66.3%	51.6%
M7	72 hour follow-up from psychiatric in-patient care		80%	?	H	90.6%	92.6%	87.7%	90.7%	88.6%	90.8%	89.0%	91.2%	88.7%	92%	87.5%	94.6%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		11	29	9	18	8	2	9	23	30	30	8	30
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		1	1	1	2	2	1	1	1	1	1	2	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	98.6%	99.4%	99.2%	98.3%	98.3%	99.0%	98.8%	98.6%	98.8%	98.7%	99.0%	99.3%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.8%	100%	99.8%	99.8%	100%	99.9%	99.8%	99.8%	100%	100%	99.8%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		80%	100%	70%	66.7%	100%	100%	100%	75%	100%	66.7%	100%	n/a
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	95.8%	100%	92%	91.3%	96.6%	91.7%	93.5%	88.6%	97.1%	97.2%	97.1%	95%
M15	Data Quality Maturity Index		95%	P	H	99.2%	99.5%	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%	99.5%	99.4%	99.4%	99.3%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.				↘	1603	1578	1470	1403	1477	1745	1713	1315	1621	1416	1357	1409
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		98.4%	99.0%	99.2%	99.7%	99.0%	99.1%	99.4%	99.2%	99.7%	99.4%	98.6%	99.0%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	33	26	37	38	34	35	38	25	48	51	43	44
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					67	53	64	61	70	68	45	38	82	61	56	70

National Metrics

Data as of : 22/05/2024 13:41:11

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
M30	Number of detentions under the Mental Health Act (MHA)					101	93	101	100	97	97	87	98	92	83	99	92
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					17.8%	12.9%	24.8%	19%	23.7%	22.7%	18.4%	18.4%	19.6%	18.1%	19.2%	18.5%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			97.8%	98.0%	98.5%	98.5%	97.2%	97.8%	98.2%	97.8%	97.9%	97.5%	96.8%	97.7%
M34	% Clients in settled accommodation	⚠	60%	P	L	84%	84.3%	83.8%	84.3%	84.3%	84.8%	85%	84.5%	84.6%	84.2%	83.5%	83.4%
M35	% Clients in employment	⚠	10%	P	H	11.5%	11.7%	12.0%	12.3%	12.6%	12.2%	12.3%	12.6%	13.2%	13.0%	13.5%	13.0%
M41	Completion of a valid NHS number		99%	P		99.8%	99.7%	99.8%	99.6%	99.6%	99.6%	99.7%	99.7%	99.8%	99.7%	99.7%	100.0 %
M42	Completion of ethnicity coding for all service users		90%	P	L	99.5%	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%	99.4%	99.4%	96.9%	100.0 %	93.2%
M43	Community health services two hour urgent response standard		70%	P		86.6%	86.1%	88.0%	89.5%	88.6%	88.1%	87.4%	85.3%	86.2%	87.8%	88.3%	92.8%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1719	2335	1509	1667	1656	1726	1844	1303	1700	1559	1336	1661
M45	The number of incomplete Referral to Treatment (RTT) pathways																2752
			2000													2598	
			2100												2216		
			2200											2285			
			2300								2009	2289	2019				
			2400					1782	1982	2168							
			2500			1835	1592										
M46	Count of 2-hour urgent community response first care contacts delivered					953	910	935	1019	1003	929	862	929	1102	1005	1171	1079
M47	Virtual ward occupancy		80%			44.3%	92.9%	51.4%	57.1%	60%	57.5%	78.8%	64.3%	81.4%	95.7%	101%	82.7%
M48	Community services waiting list		5198											4767	5068	5414	5320
			5430					5024	5170	5048							
			5469								4952	4886	4808				
			5652			5298	5131										
M171	% Admissions gate kept by crisis resolution teams		95%			99%	100%	96.6%	100%	99.1%	100%	97.9%	100%	98.1%	98.8%	95.7%	98.8%

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 99.9%

• 72 hour follow up remains above the threshold at 94.6%.

• The percentage of service users waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 51.4% in April, this continues to remain below the national threshold of 99% and is the second month where a reduction has been reported. This is due to the need for follow up and fitting appointments alongside diagnostic assessments where there is limited capacity to meet demand. This metric relates to the Trust's Paediatric Audiology service only.

• Number of incomplete Referral to Treatment (RTT) pathways - There continues to be an increase in demand for musculoskeletal services in April compared to previous months and this has impacted the increase for this measure this month. It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting longer than the threshold.

• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week is n/a this month due to receiving no urgent referrals. The routine access to treatment measure has decreased slightly in April to 95.0%, remaining above the 95% threshold. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

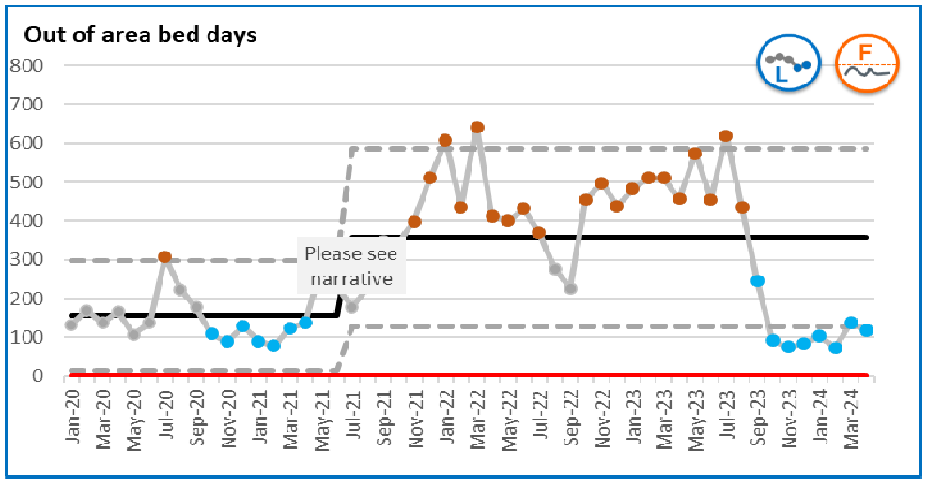
• During April, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 30 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment 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 52.0% for April. This metric is in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

• Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold at 97.7% during the month of April. This metric has now entered a period of common cause variation. Fluctuations in the performance mean that achievement of the threshold cannot be estimated.



The SPC chart shows that there has been a marginal decrease in the number of inappropriate out of area bed days in April 2024 and we remain in a period of special cause improving variation (something is happening and this should be investigated). We are still not estimated to meet the target of zero bed days though we are closer to this than we have been for over 2 years.

The process limits were recalculated in June 2021 due to a conscious increase in out of area bed usage which in turn was due to staffing pressures across the wards, increased acuity, Covid-19 outbreaks and challenges to discharging people in a timely way.

Inappropriate Out of Area Bed Days - This metric shows the total number of bed days occupied by clients who have been placed in a bed outside the geographical footprint of the Trust.

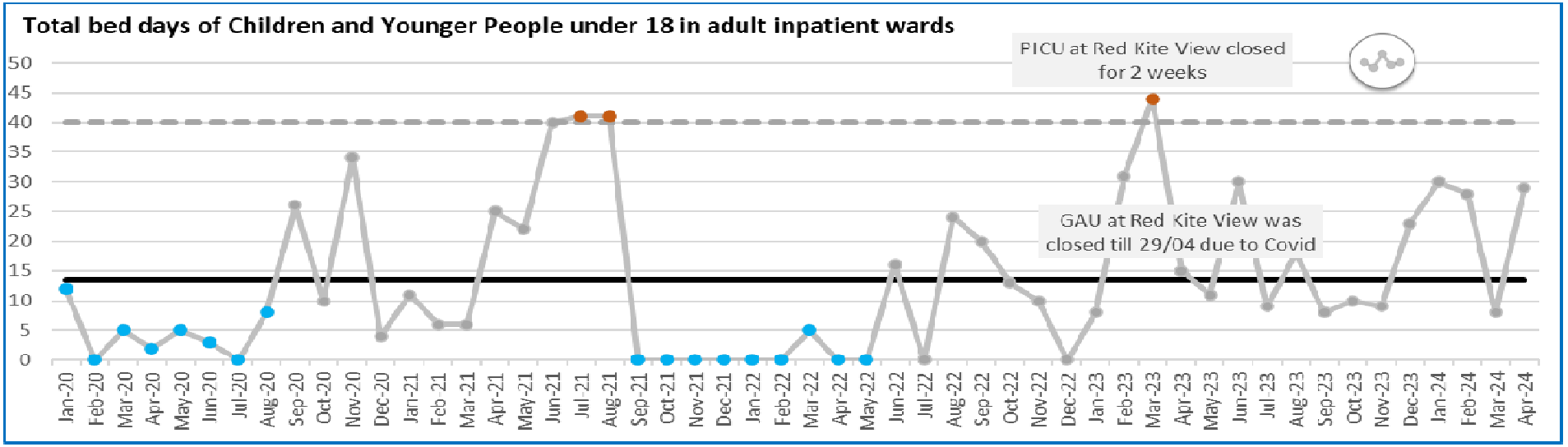
Summary	Actions	Assurance
The Trust remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people who are clinically ready for discharge - Effective coordination out of area care to ensure people are repatriated. - Addressing workforce issues to improve the care and treatment offer. Improving community treatment options as alternative to inpatient care are now being realised and further improvement and sustainability of the reduced figure is expected.	The improvement programme reports through the assurance framework to Board. Out of area placements are reported to EMT against the trajectory. System wide work streams report through the ICS. The use of out of area beds remains low following intensive work as part of the care closer to home workstream.

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

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

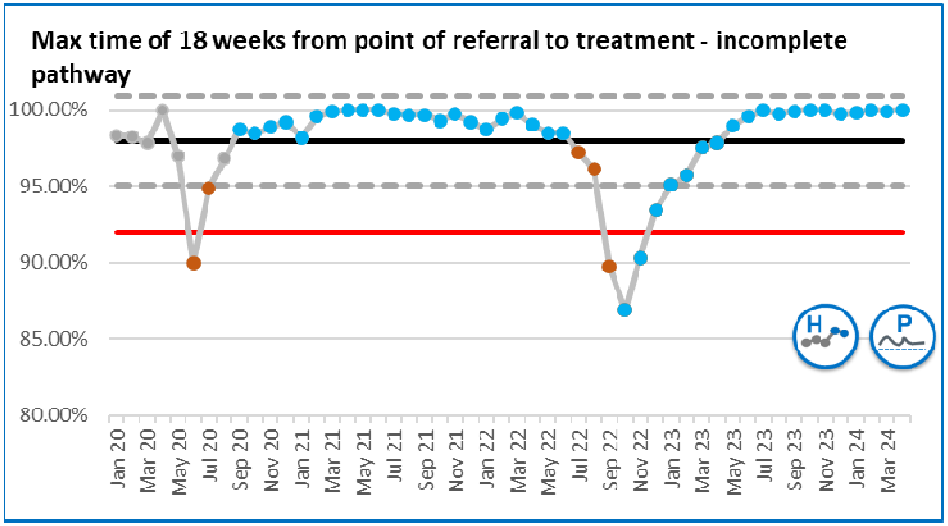
- The reporting for employment and accommodation shows 17.6% of records have missing employment and/or accommodation status with a further 1.4% that have an unknown employment status and 1.1% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

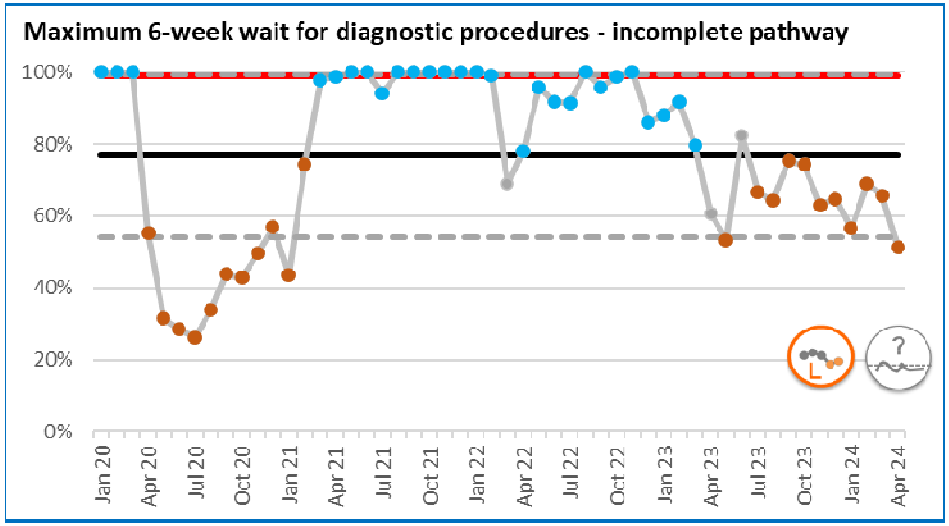
Analysis



The statistical process control chart (SPC) above shows that in April 2024 we remain in a period of common cause variation (no concern) regarding the number of beds days for children and young people in adult wards.

Analysis





The SPC charts above show that in April 2024 we remain in a period of special cause improving variation (something is happening and this should be investigated) for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. As we have seen a continued and sustained achievement of the target and indeed over 10 months over the mean, a recalculation of the process limits should be considered. For clients waiting for a diagnostic procedure we remain in a period of special cause concerning variation (something is happening and this should be investigated) and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We remain below the threshold.

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.

Overall Headlines
Appraisals remain a priority. These are being booked, with work to address reporting underway.
Actions are in place to address underperformance in mandatory training. Staff rostering for inpatient wards ensures the availability of appropriately trained staff at all times.
Positive recruitment, particularly to band 5 roles has not yet had a commensurate impact on substantive staffing capacity on wards as recruits are still undergoing preceptorship, training and induction.
Overall, improved appraisal compliance, improved supervision, reduced sickness and reduced turnover interlink to have a positive impact on staff wellbeing.

Current average OPEL level
2.56

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

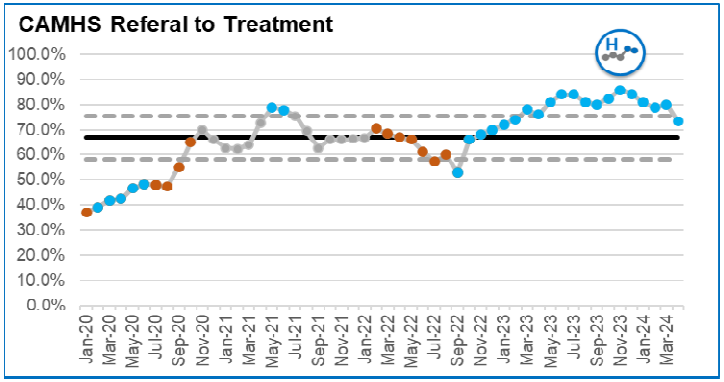
Children and Families Care Group

Headlines
Neurodevelopment waits remain a concern particularly in Kirklees especially since the additional capacity stopped at the end of March 2024.
Underperformance in mandatory training is being addressed in each team.
Paediatric audiology waits remain a significant concern, with increased demand outstripping capacity. Action and recovery plans are in place for the waiting times for diagnostic procedures and an audit action plan is in place and agreed by integrated care board (ICB). A request for assurance from the CQC following the national audit is being responded to.

Children and Families

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	84.6%	88.4%	90.0%*	
% Complaints with staff attitude as an issue	< 20%	0% 0/1	0% 0/2	33% 1/3	
% of staff receiving supervision within policy guidance	80%	74.6%	75.7%	78.4%*	
CAMHS - Crisis Response 4 hours	N/A	100.0%	100.0%	94.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.2%	78.7%	78.6%*	
Eating Disorder - Routine clock stops	95%	97.2%	97.1%	95.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	66.7%	100.0%	N/A	
Maximum 6 week wait for diagnostic procedures	99%	69.0%	65.7%	51.4%	
Information Governance training compliance	>=95%	92.6%	90.4%	92.1%*	
Reducing restrictive physical interventions training compliance	>=80%	70.6%	75.3%	72.9%*	
Sickness rate (Monthly)	4.5%	4.0%	4.9%	2.9%*	
% rosters locked down in 6 weeks					

From April 2024, figures now include children's physical health teams as per the change to the care group structure



As you can see in April 2024, we remain in a period of special cause improving variation (something is happening and this should be investigated).

Alert/Action

- There continues to be underperformance related to some areas of mandatory training compliance. All teams have been reminded about the importance of this training and individual reminders are being sent to those who require improvement.
- Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. A robust action plan is in place but a shortfall between commissioned capacity and demand remains and additional waiting list resources have now ceased causing further impact on the numbers waiting and on the number of assessments completed. This has been recorded on the risk register. Additional complexity is added due to the lack of availability of ADHD medication creating further waits within this service.
- 6 weeks wait target for paediatric audiology - performance has reduced due to the need to carry out follow up and fitting appointments alongside any diagnostic testing and the limited resources within the team to meet these demands.

Advise

- The average number of days waited from referral to first contact has increased in all areas except Calderdale. Wakefield is the longest it has been in the last 12 months. This is impacted on by sickness and vacancies, both of which are being addressed.
- There has been an increase in the number of children and young people waiting in Barnsley, the team have had to implement business continuity measures to ensure safe delivery of the SPA and Crisis services and this has impacted on waiting times.
- Kirklees and Calderdale have seen an increase in the number of children and young people waiting, this is an increasing number month on month and a deep dive will be undertaken to understand what is causing the impact.
- Friends and family testing has showed a dip in satisfaction in April, there is evidence of dips throughout the year, this will be monitored as the services usually receive positive feedback through this route.

Assure

- All areas continue to meet the 4 hour crisis response target, this is the third month it has been consecutively met. A&E waits were met for all but one case, any breaches are reviewed by the team manager and clinical leads.
- The Eating disorder routine performance remains very positive and all urgent cases were seen within expected time frames.
- Work is underway to ensure compliments which are received are captured on the reports, Two compliments have been formally recorded for April, although many more have been received.
- Appraisal and supervision performance continues to improve.

Mental Health Care Group

Headlines

The improvement work continues to contribute to reduced reliance on out of area bed use. The Trust is a positive outlier and has shared learning and actions with neighbouring Trusts, whilst still recognising that this is an ongoing challenge.
The data shows a reduction in the number of people who are clinically ready for discharge, but this does not accord with operational understanding. Further work is underway to clarify this position.
High acuity and high occupancy on wards is directly linked to the work on reducing reliance on out of area beds, the work underway in the intensive home based treatment teams to gatekeep admissions and support people at home significantly helps to manage the overall position.
Wards continue to reporting an increased pressure from the number of learners who require support. Support has been drawn from retired, experienced nurses.
Both community and inpatient have seen a reduction in sickness throughout the month. Where the sickness rate is above the Trust threshold on some wards and is due to a combination of long-term absence, pregnancy related illness and seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
Under-performance in mandatory training, supervision and appraisal is being addressed through line management support and oversight.

Mental Health Community

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	79.9%	82.8%	85.5%	
% Assessed within 14 days of referral (Routine)	75%	81.8%	89.3%	90.6%	
% Assessed within 4 hours (Crisis)	90%	99.0%	98.1%	97.8%	
% Complaints with staff attitude as an issue	< 20%	0% 0/2	22% (2/9)	27% (3/11	
% of staff receiving supervision within policy guidance	80%	64.7%	68.0%	70.6%	
% service users followed up within 72 hours of discharge from inpatient care	80%	92.0%	87.5%	90.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.8%	96.4%	97.1%	
% Treated within 6 weeks of assessment (routine)	70%	97.0%	97.8%	97.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.0%	77.0%	77.6%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	74.7%	73.7%	78.5%	
Information Governance training compliance	>=95%	91.1%	92.0%	92.3%	
Reducing restrictive physical interventions training compliance	>=80%	72.8%	74.2%	71.7%	
Sickness rate (Monthly)	4.5%	5.0%	3.8%	3.4%	
% rosters locked down in 6 weeks					

Mental Health Inpatient

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	89.0%	91.3%	92.8%	
% bed occupancy	85%	87.8%	90.6%	87.3%	
% Complaints with staff attitude as an issue	< 20%	0% 0/2	25% (1/4)	0% 0/4	
% of staff receiving supervision within policy guidance	80%	88.5%	89.6%	82.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.3%	74.7%	75.6%	
% of clients clinically ready for discharge	3.5%	3.6%	3.1%	2.8%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	90.1%	91.7%	92.7%	
Inappropriate Out of Area Bed days	92	74	138	119	
Information Governance training compliance	>=95%	91.0%	92.2%	93.7%	
Physical Violence (Patient on Patient)	Trend Monitor	22	21	38	
Physical Violence (Patient on Staff)	Trend Monitor	62	107	102	
Reducing restrictive physical interventions training compliance	>=80%	78.3%	75.8%	70.9%	
Restraint incidents	Trend Monitor	87	113	***180***	
Safer staffing (Overall)	90%	135.5%	137.6%	139.5%	
Safer staffing (Registered)	80%	97.1%	98.9%	104.1%	
Sickness rate (Monthly)	4.5%	6.4%	5.2%	3.6%	
% rosters locked down in 6 weeks					

Alert/Action

- Acute wards have continued to manage high levels of acuity.
- High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
- Workforce challenges have continued with continued use of temporary staffing, primarily bank. Throughout April acute wards have worked above establishment.
- Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The impact of reduced out of area beds on inpatient wards, Intensive Home Based Treatment Teams, and community teams is monitored.
- There has been a further reduction in % of people who are clinically ready for discharge (CRFD) on a number of wards in April although there are still examples on wards where people are delayed for an extended period, for specialist placements or awaiting judicial processes. Work is ongoing to ensure the categorisation of CRFD is applied consistently.
- The increased pressure continues on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three Registered Nurses, some of whom have recently completed their own preceptorship.
- Intensive Home Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing additional workforce challenges, recent recruitment has indicated some improvement, however challenges remain.
- All areas are focussing on continuing to improve performance for FIRM risk assessments. The percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.
- The care group recognises the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and there is a commitment for acute inpatient wards to achieve the target of all appraisals being completed. Data cleansing is underway to ensure that WorkPal and Trust performance data reflect actual appraisal activity in service areas.

Advise

• Improvement work is underway to consider how quality and safety is maintained on inpatient wards. In addition there is a focus on improving the well-being of staff and service users and improving retention.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including provision of robust gatekeeping, trauma informed care and effective intensive home treatment.
• The Talking Therapies recovery rate for April is 53.6% for Kirklees and 50.7% for Barnsley, both achieving the national standard of 50%.
• 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.
• 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.
• Work continues in collaboration with our places to implement community mental health transformation.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users. Achievement of the target is being maintained with continued support from Quality and Governance Leads.
• Care Programme Approach (CPA) review performance is above target in all areas, action plans and support from Quality and Governance Leads remain in place.
• There is a focus on performance with respect to Friends and Family Tests both in content of responses and numbers completed. Action plans for improvement are in place with all areas now above threshold.
• Work continues towards meeting expected thresholds where compliance rates are below target for mandatory training (this includes Reducing Restrictive Practice/ Cardio-Pulmonary Resuscitation and Information Governance). Inpatient General Managers have also discussed how the service manager might support with monitoring this moving forward.

Assure

• Intensive home based treatment teams are performing well in gatekeeping admissions to our inpatient beds.
• The care group is performing well in 72 hour follow up for all people discharged into the community.
• The use of out of area beds remains low following intensive work as part of the care closer to home workstream
• There has been successful recruitment in Wakefield and Barnsley SPAs and most new staff are now in post.
• Routine access for assessment target is being achieved in all places.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Care Group

Headlines

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
In line with the national picture, ADHD demand continues to exceed commissioned capacity.
Referral rates remain high across both pathways and the service try to minimise waiting times as far as possible.

Learning disability services:
Key concern remains the number of people who are seen, assessed and commence their plan within 18 weeks. The data relates to 9 breaches out of 50 people. Work is underway as part of the Improving Access priority program. Each locality has an action plan and there have been some demonstrable improvements to date and waiting lists will be monitored on a weekly basis.
A high proportion of inpatients within the Horizon centre remain clinically ready for discharge and awaiting a suitable placement - work continues with partners to encourage flow.

LD, ADHD & ASD

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	76.3%	78.5%	86.3%	
% Complaints with staff attitude as an issue	< 20%	100% (1/1)	17% (1/6)	0% (0/5)	
% of staff receiving supervision within policy guidance	80%	80.9%	84.7%	84.2%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	47.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.8%	75.5%	78.3%	
% of clients clinically ready for discharge	3.5%	50.0%	50.0%	50.0%	
Information Governance (IG) training compliance	>=95%	97.2%	94.9%	94.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	87.5%	76.7%	82.0%	

LD, ADHD & ASD

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	30	19	17	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	76.5%	76.8%	71.8%	
Safer staffing (Overall)	90%	164.2%	162.1%	152.5%	
Safer staffing (Registered)	80%	108.5%	116.7%	118.5%	
Sickness rate (Monthly)	4.5%	2.5%	2.7%	1.6%	
Restraint incidents	Trend Monitor	36	34	***11***	
% rosters locked down in 6 weeks					

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

Alert/Action

- Friend & Family Test – 50%↓, efforts continue to improve this metric. Service is looking to use chat pads to aim to improve engagement with service users.
- WY ICB (West Yorkshire Integrated Care Board) Neurodiversity Project
  The Service has representatives at 3 working groups set up by the ICB Project Group:
  - Shared care & prescribing ADHD medications
  - A Provider framework (to determine criteria to join the framework, expectations/limitations of provider collaboration)
  - Resources for referrers and Service Users (to better understand the implications of provider options available)
- Appraisal 96.3% - only one member of staff requiring appraisal.
- Mandatory Training – compliant in every category.

Advise

ADHD Pathway
Referral rates remain high and waiting lists continue to grow. The Service typically receives 280 referrals per month and has capacity to assess a maximum 560 people per year. There are currently 5300 people waiting for an ADHD assessment. This remains a national challenge.
Bespoke developments have been locally agreed by each Place in response to their growing waiting lists:
- Wakefield Place has invested in a pilot project to implement ADHD screening and triage.
- Kirklees Place has invested in an all-age neurodiversity referral unit, submitted jointly with Kirklees CAMHS.
- The Barnsley ADHD contract remains unchanged.
- Calderdale do not have a contract with the service although there may be a payment based on historic activity.

Autism Pathway
- Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. The longest wait for assessment is 18 weeks from referral date this is due to the screening and triage in place.
- The Calderdale pathway does not include this step following the launch of an Any qualified provider model in May 23. This service currently has 135 people waiting for assessment from Calderdale, it is estimated it will take over 2 years to see these individuals.
- Barnsley commissioners have invested this Service to provide a 17+ Pathway.
- Collaborative efforts are underway to expand this 17+ pathway across the Trust in alignment with SWYPFT CAMHS Teams, a proposal has been shared and the service is waiting for a response.

Assure

- All key performance targets met.
- All training not above the target have plans in place to address. This only applies to reducing restrictive physical intervention and information governance.
- Relationship with Bradford working very well.
- Excellent levels of supervision (95.8%) and appraisal (96.3%).
- Excellent staff survey results.
- Actions relating to recommendations of the independent review are ongoing and many are completed.

Learning disability services:

Alert/Action

LD (Learning Disability)
• Appraisal performance remains a focus plans are in place to ensure compliance across the Care Group. Current compliance is 84.4%↑.
• Supervision 81.3%↑ Further remedial work needs to take place to embed supervision in practice.
• Plans in place to address mandatory training hotspots in cardio pulmonary resuscitation 75%, information governance 93.22% and reducing restrictive physical intervention 70.3%.

Community Services
• Waiting Lists – Improvement work continues with action plans in place for each locality. To strengthen progress on improving waiting lists, new first face to face pathway has been introduced for some disciplines in Barnsley. This has worked well and has been adopted by other localities. This pathway ensures that people are waiting well and waiting fairly.
• STOMP RAG rating tool has been standardised and utilised in all localities.
• Learning Disability Greenlight Champions offer now in place and champions being identified.

ATU (Assessment & Treatment Unit)
• Two clinically ready for discharge (50%) patients on the assessment and treatment unit and ward are continuing to work through discharge plans.

Advise

Greenlight Toolkit
• Work continues to progress.

Community
• Challenges continue with the recruitment of specialist in Speech and Language, Psychology and Occupational Therapy.
• Commissioners have confirmed there is no available funding for the ADHD business case.
• Conversations with ICBs on-going to develop increased suitable provider accommodation across the patch with robust environments and skilled staff to prevent admission. Further meeting with commissioners scheduled for June.

ATU (Assessment & Treatment Unit)
• Improvement work continues to be embedded into the service.
• Service users Clinically Ready for Discharge continues to be at 50% which is recognised as a system wide pressure.

Assure

• Friends and Family Test 88%%
• Increase in appraisal 84.4% rates and supervision 81.3%.
• Staff survey results demonstrate improvements.
• All localities have exceeded 75% target for annual health checks.
• Weekly community safety huddle working well in providing clinicians with a forum to seek pro-active advice when supporting crisis.
• Some positive recruitment for speech and language therapists has covered long standing vacancies in two localities coming into post in August/September.

Barnsley Physical Health and Wellbeing Care Group

Headlines

Staffing in the neuro rehabilitation unit remains a concern with temporary staffing solutions in place to maintain safe staffing levels. The business and service model is being reviewed.
Clinical supervision uptake and recording has improved with the targeted action, but remains a concern and is being addressed through line management support and oversight.

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	85.8%	86.9%	89.3%*	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/1)	0% (0/0)	
% people dying in a place of their choosing	80%	88.9%	94.1%	100.0%	
% of staff receiving supervision within policy guidance	80%	53.6%	62.6%	70.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.1%	80.1%	81.8%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	>=95%	94.0%	95.7%	94.6%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.9%	99.9%	100.0%	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	100.0%	80.0%	80.0%	
Safer staffing (Overall)	90%	110.1%	113.6%	113.5%	
Safer staffing (Registered)	80%	96.9%	94.0%	107.8%	
Sickness rate (Monthly)	4.5%	4.2%	4.1%	4.0%	
% rosters locked down in 6 weeks					

**From April 2024, figures exclude children's physical health teams as per the change to the care group structure*

Alert/Action

• NRU (Neurological Rehabilitation Unit) safer staffing figures continue to show green with a return to compliance this month at 93.5% registered staff on NRU. Ongoing challenge to fill trained staff shifts; we continue to supplement with untrained staff. Work continues with Finance and Contracting colleagues. This issue has been logged on Datix and is also on the local risk register. In addition, a meeting with Safer Staffing Project Manager took place on 10.4.2024.
• NRU rate is showing as 65.4% - Specific focus during March/April has resulted in a significant increase since 29.2% at end of March. Critical staffing levels mean that it has been difficult to release staff from clinical duties (see above re NRU staffing levels). The appraisal dashboard is showing 70% as at 14th May which is a further improvement

Advise

• Clinical supervision continues to receive a special focus with a drive to improve recording and a further 7.5% increase has been seen from March to April.
• Appraisals - many of our 45 service lines are at 100%. As a care group we have seen a further increase at end of April to 89.3%. Overall figure as at 14th May has increased to 89.6%.
To note: Appraiser training session in April was cancelled; this will therefore have an impact on the number of appraisals completed and therefore affect the compliance in that team.
• NRU cardio pulmonary resuscitation is improving – increased from 69.7% in March to 78.1% in April 2024 moving from red to amber. This remains slightly below 80% compliance. Further training has taken place in early May which should show in next month's figures.
To note: The resus lead has advised that the process for Cardiopulmonary resuscitation training recording is that they send the signature sheets to learning and development. These are inputted by learning and development but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.
• Information Governance training is 94.6% as a care group; this is very slightly below compliance of 95%. Data cleansing continues; we have noted that the option was not available on some staff's training matrix.
• Changes to the structures in the care group - work has commenced to review and update the reporting portfolios so that the People Directorate, Patient Safety etc. are all reporting on correctly aligned service line portfolios. Changes to the portfolio may impact on the data being reported in terms of overall care group statistics.
• Intermediate Care – the Mobilisation and Exit Plan to move the Acorn Unit to Barnsley Hospital NHS Trust (Ward 12) will result in a reduction in beds from 30 to 26. This has a potential impact on the number of patients being seen in their own home for therapy input. The phased exit commences in May with a potential date for first admissions to be taken from mid-May.
• One area for Improvement to report for April 2024, for pressure sores.

Assure

• Urgent Community Response Service 2-hour target is showing an increase to 92.8% as at April 2024 which is well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 100% as at April 2024.
• Friends and Family Test (FFT) 97% of people would recommend community services.
• Over 5% increase to 100% of people dying in their place of choosing as at April 2024.
• Cardio pulmonary resuscitation training 81.8% compliant as a care group; this is a slight increase.
To note: The resus lead has advised that the process for cardio pulmonary resuscitation training recording is that they send the signature sheets to learning and development. These are inputted by learning and development but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.
• A number of services and staff have been shortlisted for Excellence awards and were due to attend the ceremony on the 2nd May 2024.

Forensic Care Group

Headlines

Sickness has improved in April. The people directorate business partner is leading a deep dive into sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.

Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.

Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic

Metrics	Threshold	Feb-24	Mar-24	Apr-24	Variation/ Assurance
% Appraisal rate	>=95%	79.1%	79.8%	79.9%	
% Bed occupancy	90%	81.2%	81.9%	86.2%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	91.1%	91.9%	89.3%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.6%	80.4%	81.5%	
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	N/A	
Information Governance (IG) training compliance	>=95%	92.2%	93.4%	94.1%	
Physical Violence (Patient on Patient)	Trend Monitor	3	6	5	
Physical Violence (Patient on Staff)	Trend Monitor	10	8	15	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	76.1%	75.0%	72.7%	
Restraint incidents	Trend Monitor	29	22	***33***	
Safer staffing (Overall)	90%	105.8%	105.5%	115.7%	
Safer staffing (Registered)	80%	97.4%	96.1%	102.6%	
Sickness rate (Monthly)	5.4%	5.3%	6.3%	4.2%	
% rosters locked down in 6 weeks					

Alert/Action

- Bed Occupancy – Newton Lodge 87.70%↑, Bretton 87.37%↑, Newhaven 75.0%↑. Previously reported high waiting list for medium now reducing. 2 service users waiting for a High Secure bed and utilising long periods in seclusion. Service liaising directly with commissioning hub and NHSE to find alternative solutions.
- Sickness absence – continues to be a concern across the service with year to date data indicating Newton Lodge 3.5%↓, Bretton Centre 6.7%↓ and Newhaven 2.4%↓. Overall sickness is 5.77%.
- West Yorkshire Provider Collaborative alerted to potential repatriation requirements from another secure mental health inpatient unit, should the current plans fail to be realised.

Advise

- The West Yorkshire Provider Collaborative are planning 2 events to explore future bed modelling options.
- The West Yorkshire Provider Collaborative continue to develop future intentions for the Women's pathways.
- Mandatory training overall compliance:
  - Newton Lodge – 93%↑
  - Bretton – 89.4↓
  - Newhaven –92.7%↑

The above figures represent the overall position for each service. There are some hotspots in reducing physical interventions and information governance which are being managed and monitored closely. Newton Lodge and Newhaven now compliant with cardio pulmonary resuscitation and Bretton Centre is currently 76.5%.

- Appraisal (93% using locally determined metrics). Work is being undertaken with the People Performance Team to reconcile this data with Trust data.
- NHS survey results are being used to compile an action plan within the service.

Assure

- High levels of Data Quality across the Care Group (100%).
- 100% compliance for HCR20 being completed within 3 months of admission.
- 25 Hours of meaningful activity 100%.
- Service Users on care programme approach with a formal review within the previous 12 months - 100%
- Clinical Supervision exceeding the target.
- All Equality Impact Assessments across Forensic Services have been completed for 23/24 and are scheduled to be reviewed shortly.

Inpatients - Mental Health - Working Age Adults

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

Appraisal
• Improvement on a number of wards.
• Targeted work underway, particularly on Melton, Elmdale, Ashdale, Enfield Down and Poplars, to ensure outstanding appraisals are booked and that WorkPal and Trust performance data reflect actual appraisal activity.

Sickness
• Some improvement on Elmdale although remains above threshold relating to specific challenges following serious incidents.
• Improvement on Ward 19M due to staff returning to work. However, ward 19F has an increased sickness rate due to long term sickness combined with short term absence.
• Lyndhurst and Enfield Down remain above threshold despite improvement due to a combination of long term sickness absence and unrelated short term absence including pregnancy related illness.

Supervision
• Reduction on some wards due to recording processes based on previous quarterly reporting. This is being updated in line with current reporting metric. Ward specific improvement plans in place where required, for example on Clark where supervision is particularly low.

Mandatory Training
• CPR (Cardiopulmonary Resuscitation) compliance has improved on a number of wards. Ward managers have been directly booking staff on courses around rosters. Specific plans in place where compliance is low particularly Elmdale, Stanley and Wd19F.
• RRPI (Reducing Restrictive Practice Interventions) compliance has been impacted by new starters and course cancellations, exacerbated by staff then needing to attend the full 4-day course as they have missed the timeframe for the refresher due to course cancellation. This has been the case for Walton, Ashdale, Elmdale, Willow, Ward 19, Crofton, Enfield Down and Lyndhurst. Compliance on Crofton has also been impacted by a number of new starters requiring the 4-day course.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
• IG is a particular area of focus particularly on Elmdale, Stanley, Beamshaw and Ward19 where compliance does not meet the threshold. Staff are being supported directly to complete training when next on shift.

Bed Occupancy
• Where the bed occupancy exceeds target plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Safer Staffing
• Elmdale did not meet the safer staffing (registered) target in April due to the absence of registered staff. There was a minimum of 1 registered member of staff with additional Health Care Assistants to ensure overall safe staffing.

Clinically Ready For Discharge (CRFD)
• High percentage affect due to small numbers of patients on the ward.
• CRFD remains high on some wards such as Walton, Beechdale, Ward 19 and Poplars which reflects the complexities of the service user population and is impacted by Ministry of Justice restrictions and availability of specialist placements for people with complex needs.
• CRFD categorisation includes more individuals than previous DTOC (Delayed Transfer of Care), however the threshold of 3.5% for DTOC has remained for CRFD. The threshold is under review.
• Work is ongoing to ensure the categorisation of CRFD is applied consistently.

FIRM Risk assessments
• Percentage compliance is significantly impacted by small number of admissions. Crofton has 2 breaches in April, Walton, Ashdale and Willow have had 1 breach.
• At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed

Restraint Incidents
• Higher incidence of restraint on Walton, Crofton and Poplars is reflective of current patient population & presentation and risk profile of specific service users on each ward.
• All restraint incidents are reviewed by the RRPI (Reducing Restrictive Practice Interventions) team and no areas of concern have been identified.

Physical violence incidents
• Increase on Crofton, Poplars and Elmdale due to the presentation and risk profiles of particular service users on the ward. Specific management plans are in place.
• Walton has a high number of incidences of violence patient on staff and although incidents have reduced on Wd19 the number remains high. Staff involved in the incidents are offered debrief sessions, reflective supervision, support from equity guardian and occupational health referral where appropriate.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	95.8%	100.0%	95.7%
Sickness	4.5%	4.8%	4.0%	2.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	90.0%	90.6%	93.5%
Reducing restrictive physical interventions training compliance	>=80%	70.0%	71.9%	74.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	56.7%	53.1%	71.0%
Bed occupancy	85%	106.2%	111.1%	115.5%
Safer staffing (Overall)	90%	132.7%	132.8%	133.4%
Safer staffing (Registered)	80%	136.6%	139.8%	141.7%
% of clients clinically ready for discharge	3.5%	4.2%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	87.5%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	1	4
Physical Violence (Patient on Staff)	Trend Monitor	2	2	1
Restraint incidents	Trend Monitor	1	4	***5***
Prone Restraint incidents	Trend Monitor	1	1	***1***
Unfilled Shifts	Trend Monitor	10	8	9

Clark Suite

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	87.5%	100.0%	100.0%
Sickness	4.5%	12.7%	5.1%	4.5%
Supervision	80%	50.0%	55.6%	55.6%
Information Governance training compliance	>=95%	84.2%	95.2%	95.8%
Reducing restrictive physical interventions training compliance	>=80%	89.5%	90.5%	70.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.7%	71.4%	75.0%
Bed occupancy	85%	92.1%	89.6%	88.8%
Safer staffing (Overall)	90%	159.7%	149.1%	139.5%
Safer staffing (Registered)	80%	100.5%	98.7%	99.5%
% of clients clinically ready for discharge	3.5%	7.0%	2.5%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	50.0%	75.0%	83.3%
Physical Violence (Patient on Patient)	Trend Monitor	1	3	1
Physical Violence (Patient on Staff)	Trend Monitor	5	11	3
Restraint incidents	Trend Monitor	8	21	***10***
Prone Restraint incidents	Trend Monitor	1	1	***1***
Unfilled Shifts	Trend Monitor	14	20	6

Melton Suite

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	87.0%	87.0%	87.0%
Sickness	4.5%	3.6%	0.1%	0.0%
Supervision	80%	90.0%	100.0%	83.3%
Information Governance training compliance	>=95%	96.2%	96.2%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	96.2%	96.2%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.1%	76.9%	84.6%
Bed occupancy	85%	110.3%	98.4%	104.4%
Safer staffing (Overall)	90%	160.8%	160.2%	160.2%
Safer staffing (Registered)	80%	98.3%	97.1%	97.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	85.7%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	0	3
Physical Violence (Patient on Staff)	Trend Monitor	2	1	6
Restraint incidents	Trend Monitor	9	8	***11***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	3	23	19

Nostell

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	96.3%	100.0%	100.0%
Sickness	4.5%	0.8%	1.8%	0.0%
Supervision	80%	88.2%	94.4%	64.7%
Information Governance training compliance	>=95%	96.8%	96.8%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	76.7%	78.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.0%	93.3%	92.9%
Bed occupancy	85%	94.4%	88.7%	92.6%
Safer staffing (Overall)	90%	139.3%	151.6%	136.4%
Safer staffing (Registered)	80%	100.8%	100.6%	98.2%
% of clients clinically ready for discharge	3.5%	13.4%	5.5%	5.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	85.7%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	1	0
Physical Violence (Patient on Staff)	Trend Monitor	6	5	7
Restraint incidents	Trend Monitor	11	9	***5***
Prone Restraint incidents	Trend Monitor	1	4	***0***
Unfilled Shifts	Trend Monitor	7	17	13

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	84.6%	92.0%	100.0%
Sickness	4.5%	8.6%	5.4%	3.5%
Supervision	80%	80.0%	85.7%	83.3%
Information Governance training compliance	>=95%	100.0%	89.7%	85.2%
Reducing restrictive physical interventions training compliance	>=80%	83.9%	82.8%	85.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.4%	69.0%	63.0%
Bed occupancy	85%	97.8%	106.0%	99.7%
Safer staffing (Overall)	90%	158.4%	131.7%	144.8%
Safer staffing (Registered)	80%	118.4%	115.7%	119.3%
% of clients clinically ready for discharge	3.5%	3.8%	4.6%	4.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	95.2%
Physical Violence (Patient on Patient)	Trend Monitor	3	1	1
Physical Violence (Patient on Staff)	Trend Monitor	1	2	2
Restraint incidents	Trend Monitor	5	1	***3***
Prone Restraint incidents	Trend Monitor	1	1	***0***
Unfilled Shifts	Trend Monitor	11	12	19

Walton

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	97.1%	100.0%	93.9%
Sickness	4.5%	4.7%	3.5%	2.9%
Supervision	80%	100.0%	100.0%	78.6%
Information Governance training compliance	>=95%	88.6%	94.4%	95.1%
Reducing restrictive physical interventions training compliance	>=80%	79.4%	71.4%	65.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.2%	85.7%	77.5%
Bed occupancy	85%	98.3%	97.2%	86.0%
Safer staffing (Overall)	90%	125.4%	128.9%	154.3%
Safer staffing (Registered)	80%	101.0%	107.2%	101.9%
% of clients clinically ready for discharge	3.5%	0.0%	6.8%	14.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	80.0%	66.7%
Physical Violence (Patient on Patient)	Trend Monitor	3	2	0
Physical Violence (Patient on Staff)	Trend Monitor	1	5	13
Restraint incidents	Trend Monitor	11	7	***58***
Prone Restraint incidents	Trend Monitor	1	1	***7***
Unfilled Shifts	Trend Monitor	8	6	16

Ashdale

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	92.9%	92.6%	92.9%
Sickness	4.5%	10.2%	4.4%	0.0%
Supervision	80%	93.3%	73.3%	75.0%
Information Governance training compliance	>=95%	93.9%	97.0%	96.9%
Reducing restrictive physical interventions training compliance	>=80%	69.7%	66.7%	56.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.8%	75.8%	75.0%
Bed occupancy	85%	99.0%	98.9%	98.5%
Safer staffing (Overall)	90%	125.3%	121.4%	118.9%
Safer staffing (Registered)	80%	82.8%	87.9%	100.1%
% of clients clinically ready for discharge	3.5%	3.9%	2.5%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	91.7%	88.9%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	1
Physical Violence (Patient on Staff)	Trend Monitor	2	3	1
Restraint incidents	Trend Monitor	3	1	***1***
Prone Restraint incidents	Trend Monitor	0	1	***0***
Unfilled Shifts	Trend Monitor	5	0	0

Ward 18

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	89.3%	100.0%	92.3%
Sickness	4.5%	5.6%	1.8%	2.0%
Supervision	80%	77.8%	87.5%	100.0%
Information Governance training compliance	>=95%	85.7%	90.6%	84.4%
Reducing restrictive physical interventions training compliance	>=80%	82.9%	81.3%	78.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.3%	68.8%	78.1%
Bed occupancy	85%	99.4%	99.3%	98.4%
Safer staffing (Overall)	90%	125.3%	130.1%	105.9%
Safer staffing (Registered)	80%	87.5%	82.4%	78.1%
% of clients clinically ready for discharge	3.5%	5.3%	8.3%	6.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	83.3%	94.1%
Physical Violence (Patient on Patient)	Trend Monitor	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	11	8
Restraint incidents	Trend Monitor	*6*	15	***8***
Prone Restraint incidents	Trend Monitor	0	1	***1***
Unfilled Shifts	Trend Monitor	4	3	3

Inpatients - Mental Health - Working Age Adults

Elmdale

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	94.4%	85.0%	86.4%
Sickness	4.5%	17.0%	14.6%	7.8%
Supervision	80%	50.0%	81.8%	80.0%
Information Governance training compliance	>=95%	75.0%	85.7%	92.0%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	76.2%	68.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	68.4%	70.0%	62.5%
Bed occupancy	85%	96.6%	96.8%	96.0%
Safer staffing (Overall)	90%	144.5%	128.5%	125.6%
Safer staffing (Registered)	80%	70.9%	69.3%	76.3%
% of clients clinically ready for discharge	3.5%	1.1%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.3%	100.0%	92.9%
Physical Violence (Patient on Patient)	Trend Monitor	5	6	7
Physical Violence (Patient on Staff)	Trend Monitor	10	6	7
Restraint incidents	Trend Monitor	*8*	7	***9***
Prone Restraint incidents	Trend Monitor	1	0	***0***
Unfilled Shifts	Trend Monitor	0	2	0

Inpatients - Mental Health - Older People Services

Crofton

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	95.7%	91.7%	95.7%
Sickness	4.5%	5.8%	0.2%	3.6%
Supervision	80%	90.0%	90.9%	91.7%
Information Governance training compliance	>=95%	100.0%	100.0%	96.3%
Reducing restrictive physical interventions training compliance	>=80%	80.8%	66.7%	61.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.3%	96.3%	96.2%
Bed occupancy	85%	80.0%	94.6%	68.1%
Safer staffing (Overall)	90%	166.2%	175.1%	224.6%
Safer staffing (Registered)	80%	147.1%	150.5%	170.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	90.0%	100.0%	80.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	4
Physical Violence (Patient on Staff)	Trend Monitor	1	0	9
Restraint incidents	Trend Monitor	2	1	***32***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	38	22	58

Poplars CUE

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	88.0%	84.0%	83.3%
Sickness	4.5%	1.1%	0.7%	3.2%
Supervision	80%	81.8%	100.0%	45.5%
Information Governance training compliance	>=95%	96.4%	89.7%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	84.6%	81.5%	76.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.6%	77.8%	80.0%
Bed occupancy	85%	68.5%	78.9%	78.4%
Safer staffing (Overall)	90%	205.2%	231.7%	250.4%
Safer staffing (Registered)	80%	111.4%	111.2%	115.5%
% of clients clinically ready for discharge	3.5%	9.7%	20.4%	12.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	2	13
Physical Violence (Patient on Staff)	Trend Monitor	16	35	35
Restraint incidents	Trend Monitor	20	28	***32***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	42	52	94

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	4.5%	0.3%	2.9%	4.0%
Supervision	80%	100.0%	90.0%	100.0%
Information Governance training compliance	>=95%	96.0%	96.0%	96.2%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	76.0%	69.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.0%	72.0%	76.9%
Bed occupancy	85%	45.5%	84.2%	85.7%
Safer staffing (Overall)	90%	119.9%	188.0%	194.0%
Safer staffing (Registered)	80%	86.1%	96.9%	119.5%
% of clients clinically ready for discharge	3.5%	22.0%	11.0%	10.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	75.0%	85.7%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	2	4	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	11	11	20

Beechdale

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	91.3%	91.7%	96.0%
Sickness	4.5%	7.5%	4.0%	0.2%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	91.7%	92.0%	96.3%
Reducing restrictive physical interventions training compliance	>=80%	83.3%	84.0%	74.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.7%	84.0%	96.3%
Bed occupancy	85%	96.3%	94.2%	95.2%
Safer staffing (Overall)	90%	138.3%	124.8%	122.5%
Safer staffing (Registered)	80%	97.0%	91.6%	93.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	5.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	0	0
Restraint incidents	Trend Monitor	0	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	5	9	5

Ward 19 - Male

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	93.8%	100.0%	100.0%
Sickness	4.5%	5.8%	6.1%	0.0%
Supervision	80%	100.0%	100.0%	80.0%
Information Governance training compliance	>=95%	95.2%	91.7%	88.9%
Reducing restrictive physical interventions training compliance	>=80%	75.0%	65.2%	55.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.0%	82.6%	96.3%
Bed occupancy	85%	94.0%	97.6%	91.6%
Safer staffing (Overall)	90%	126.3%	135.7%	129.2%
Safer staffing (Registered)	80%	70.7%	94.7%	98.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	50.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	2	1
Physical Violence (Patient on Staff)	Trend Monitor	8	16	10
Restraint incidents	Trend Monitor	1	5	***5***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	4	3

Ward 19 - Female

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	94.1%	94.4%	100.0%
Sickness	4.5%	8.4%	5.6%	10.8%
Supervision	80%	100.0%	90.0%	81.8%
Information Governance training compliance	>=95%	94.4%	90.5%	86.4%
Reducing restrictive physical interventions training compliance	>=80%	72.2%	75.0%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	52.9%	50.0%	61.9%
Bed occupancy	85%	95.9%	95.1%	93.3%
Safer staffing (Overall)	90%	111.9%	110.8%	93.0%
Safer staffing (Registered)	80%	85.9%	86.9%	103.8%
% of clients clinically ready for discharge	3.5%	1.1%	0.0%	5.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	2	1
Physical Violence (Patient on Staff)	Trend Monitor	8	16	10
Restraint incidents	Trend Monitor	0	5	***5***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	0	4

Inpatients - Mental Health - Rehab

Enfield Down

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	72.7%	72.7%	83.3%
Sickness	4.5%	6.4%	7.6%	7.7%
Supervision	80%	94.1%	94.1%	90.9%
Information Governance training compliance	>=95%	91.8%	92.2%	96.1%
Reducing restrictive physical interventions training compliance	>=80%	72.9%	72.0%	60.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.5%	73.9%	73.3%
Bed occupancy	85%	57.2%	54.1%	49.4%
Safer staffing (Overall)	90%	89.1%	92.0%	96.7%
Safer staffing (Registered)	80%	76.3%	78.9%	88.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	2	2

Lyndhurst

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	95.5%	95.0%	100.0%
Sickness	4.5%	5.8%	14.7%	10.5%
Supervision	80%	92.3%	85.7%	87.5%
Information Governance training compliance	>=95%	92.6%	92.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	59.3%	64.0%	57.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.4%	68.0%	71.4%
Bed occupancy	85%	69.0%	73.0%	66.2%
Safer staffing (Overall)	90%	95.7%	95.1%	95.4%
Safer staffing (Registered)	80%	102.4%	93.9%	103.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	0	0	1

Inpatients - Forensic - Medium Secure

Ward Level Headlines - Forensics
Performance for all wards is being addressed through regular meetings with Ward Managers and the General Manager. Remedial work continues on appraisals and the service is confident that compliance is just above 90% further work is now being undertaken to update the Trust system so this is reflected more accurately.

Medium Secure
• Supervision remains a focus for the service with Priestley the only ward failing to achieve compliance focused interventions will seek to address this. Waterton has improved dramatically on March performance.
• Sickness variable across medium secure. Management of sickness absence is a focus across the care group. The service is currently being supported by the People Directorate to undertake more detailed analysis to inform future actions. An audit is being undertaken to assess compliance with the sickness absence policy across all wards and is now ready to inform future actions. Priestley is the only ward with sickness above Trust target this is due to a large number of staff with underlying long term conditions. The overall medium secure April figure at 3.5%.
• Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service with particular challenges accessing courses. Bronte, Hepworth Johnson Priestley and Waterton all requiring some improvement on performance.
• Bed occupancy in Appleton is lower due to an overall reduction in referrals for learning disability beds in medium secure. Bed occupancy in general remains under constant review with work on flow and pathways progressing. Bed occupancy on Johnson has also dropped with reduced referrals.
• Cardio pulmonary rehabilitation compliance is the focus of targeted improvement work. Overall the service is now compliant but Bronte, Priestley and Waterton are the only wards that continue to require staff to complete the course.
• Priestley is currently experiencing challenges with overall performance due to recent high sickness rates and high levels of staff on amended duties (40%). The service is working closely with the People Directorate to address ongoing issues.

Low Secure
• Sickness across all wards monitored closely significant improvement in Thornhill and Newhaven's position. Sandals sickness has reduced but remains higher than target. Sickness levels on Ryburn are currently 25.5% due to long term sickness (this relates to 4 staff). The service is currently being supported by the People Directorate to address these issues and is anticipating a reduction in this figure imminently.
• Cardio pulmonary rehabilitation compliance on all 4 Low Secure wards remains a focus with all staff now either completed or booked on courses. The April position is improved on Thornhill, Ryburn and Newhaven with Sandals performance on a downward trajectory. System in place to ensure there are CPR trained staff on all shifts and the position on Sandal improves.
• Bed occupancy in low secure has improved across Thornhill Sandal and Newhaven and Ryburn remains at 100%. Overall performance remains below the target.
• Supervision is excellent across all 4 wards with all wards attaining 100%
• The number of prone restraints on Newhaven has fallen this has been supported by quality improvement work undertaken by the service and supported by the reducing restrictive physical interventions team.

Appleton

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	85.7%	90.5%	90.9%
Sickness	5.4%	4.4%	3.0%	4.5%
Supervision	80%	81.8%	91.7%	80.0%
Information Governance training compliance	>=95%	95.7%	100.0%	91.7%
Reducing restrictive physical interventions training compliance	>=80%	87.0%	95.5%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.2%	82.6%	80.0%
Bed occupancy	90%	62.5%	60.5%	65.4%
Safer staffing (Overall)	90%	97.3%	96.1%	97.9%
Safer staffing (Registered)	80%	104.3%	113.0%	120.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	0
Restraint incidents	Trend Monitor	16	3	***5***
Prone Restraint incidents	Trend Monitor	2	0	***0***
Unfilled Shifts	Trend Monitor	0	1	0

Bronte

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	5.4%	0.3%	4.4%	4.4%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	87.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	78.3%	70.8%	69.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	65.2%	75.0%	78.3%
Bed occupancy	90%	98.0%	91.2%	97.1%
Safer staffing (Overall)	90%	99.2%	100.8%	103.8%
Safer staffing (Registered)	80%	94.6%	98.8%	103.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1
Restraint incidents	Trend Monitor	0	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	1	1	0

Chippendale

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	90.9%	95.2%	90.9%
Sickness	5.4%	3.8%	2.3%	2.4%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	96.4%
Reducing restrictive physical interventions training compliance	>=80%	81.8%	79.2%	82.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.9%	95.8%	96.4%
Bed occupancy	90%	91.7%	90.1%	94.4%
Safer staffing (Overall)	90%	147.1%	151.4%	144.1%
Safer staffing (Registered)	80%	119.6%	132.4%	131.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	1	2
Restraint incidents	Trend Monitor	7	5	***5***
Prone Restraint incidents	Trend Monitor	0	1	***0***
Unfilled Shifts	Trend Monitor	3	5	2

Hepworth

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	92.0%	91.7%	96.0%
Sickness	5.4%	4.1%	4.7%	0.0%
Supervision	80%	100.0%	94.1%	83.3%
Information Governance training compliance	>=95%	89.3%	96.6%	96.7%
Reducing restrictive physical interventions training compliance	>=80%	82.1%	79.3%	76.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.1%	89.3%	93.1%
Bed occupancy	90%	94.7%	85.8%	87.1%
Safer staffing (Overall)	90%	94.2%	95.7%	95.4%
Safer staffing (Registered)	80%	86.0%	82.3%	78.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	1	1	***2***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	1	4	0

Inpatients - Forensic - Medium Secure

Johnson

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	82.8%	92.9%	89.7%
Sickness	5.4%	2.5%	1.0%	1.8%
Supervision	80%	100.0%	100.0%	94.7%
Information Governance training compliance	>=95%	87.5%	90.3%	97.1%
Reducing restrictive physical interventions training compliance	>=80%	75.0%	67.7%	65.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	90.3%	91.4%
Bed occupancy	90%	79.3%	71.6%	73.3%
Safer staffing (Overall)	90%	136.5%	122.5%	123.5%
Safer staffing (Registered)	80%	116.1%	109.0%	109.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	1
Restraint incidents	Trend Monitor	0	1	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	6	6	5

Priestley

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	73.7%	77.8%	76.5%
Sickness	5.4%	10.1%	10.2%	10.6%
Supervision	80%	66.7%	75.0%	75.0%
Information Governance training compliance	>=95%	95.2%	95.0%	90.9%
Reducing restrictive physical interventions training compliance	>=80%	50.0%	52.6%	52.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	78.9%	71.4%
Bed occupancy	90%	90.7%	92.2%	91.2%
Safer staffing (Overall)	90%	97.9%	97.3%	93.7%
Safer staffing (Registered)	80%	96.0%	90.6%	99.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	2	0
Restraint incidents	Trend Monitor	0	2	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	0	0

Waterton

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	42.1%	40.0%	40.0%
Sickness	5.4%	4.9%	7.5%	4.2%
Supervision	80%	63.6%	60.0%	100.0%
Information Governance training compliance	>=95%	91.3%	89.3%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	69.6%	64.3%	63.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.6%	71.4%	68.2%
Bed occupancy	90%	80.2%	91.1%	100.0%
Safer staffing (Overall)	90%	121.6%	128.7%	127.7%
Safer staffing (Registered)	80%	92.0%	100.8%	114.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	2	8	4

Inpatients - Forensic - Low Secure

Thornhill

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	83.3%	82.6%	91.3%
Sickness	5.4%	0.8%	5.2%	0.9%
Supervision	80%	92.9%	92.9%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	96.3%
Reducing restrictive physical interventions training compliance	>=80%	70.8%	69.2%	70.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.8%	73.1%	81.5%
Bed occupancy	85%	57.9%	64.7%	82.0%
Safer staffing (Overall)	90%	99.1%	96.5%	98.4%
Safer staffing (Registered)	80%	92.4%	96.4%	96.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	1
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	4	2	3

Sandal

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	70.8%	69.6%	71.4%
Sickness	5.4%	6.1%	6.8%	7.7%
Supervision	80%	90.9%	100.0%	100.0%
Information Governance training compliance	>=95%	92.3%	89.3%	92.9%
Reducing restrictive physical interventions training compliance	>=80%	65.4%	64.3%	60.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.1%	71.4%	67.9%
Bed occupancy	85%	88.8%	76.8%	92.5%
Safer staffing (Overall)	90%	103.0%	101.6%	133.8%
Safer staffing (Registered)	80%	105.7%	103.8%	98.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	2	1
Restraint incidents	Trend Monitor	0	1	***8***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	1	0	3

Inpatients - Forensic - Low Secure

Ryburn

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	100.0%	87.5%	100.0%
Sickness	5.4%	26.1%	24.8%	25.5%
Supervision	80%	100.0%	100.0%	80.0%
Information Governance training compliance	>=95%	90.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	66.7%	77.8%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	55.6%	100.0%	100.0%
Bed occupancy	85%	96.1%	95.9%	87.1%
Safer staffing (Overall)	90%	98.6%	99.1%	98.1%
Safer staffing (Registered)	80%	96.0%	99.8%	97.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	0	0

Newhaven

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	81.8%	81.0%	85.7%
Sickness	5.4%	3.9%	9.5%	3.5%
Supervision	80%	93.3%	94.4%	100.0%
Information Governance training compliance	>=95%	92.9%	88.5%	93.1%
Reducing restrictive physical interventions training compliance	>=80%	71.4%	69.2%	62.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	67.9%	76.9%	82.8%
Bed occupancy	85%	63.4%	65.9%	75.0%
Safer staffing (Overall)	90%	112.0%	109.3%	125.7%
Safer staffing (Registered)	80%	101.5%	87.9%	107.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	4	4
Physical Violence (Patient on Staff)	Trend Monitor	0	7	9
Restraint incidents	Trend Monitor	5	8	***12***
Prone Restraint incidents	Trend Monitor	0	1	***3***
Unfilled Shifts	Trend Monitor	4	4	2

Inpatients - Non-Mental Health

Headlines

Appraisal rate:

• NRU rate is showing as 65.4% - Specific focus during March/April has resulted in a significant increase since 29.2% at end of March. Critical staffing levels mean that it has been difficult to release staff from clinical duties (see care group section regarding NRU staffing levels).
• The Appraisal Dashboard is showing 70% as at 14 May which is a further improvement in early May.
• SRU rate has increased from 87.7% to 91.1% moving from red to amber. This ward has been impacted by LTS in terms of management/senior staff. The Appraisal Dashboard is showing 92.9% as at 14 May.

Supervision:

• NRU figures have reduced from 78.6% to 58.8%. This has been impacted by staffing as noted earlier.
• SRU figures have decreased from 76.9% to 56.3%. This ward has been impacted by LTS in terms of management /senior staff.

Cardiopulmonary resuscitation CPR:

• NRU – increased from 69.7% in March to 78.1% in April 2024 moving from red to amber. This remains slightly below 80% compliance.
• SRU – increased from 70.5% in March to 79.4% in April which is very slightly below 80% compliance.
• Further training has taken place in early May which should show in next month's figures.

To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.

Information Governance (IG):

• NRU – Increased to 100% as at April 2024 to achieve maximum compliancy.
• SRU – increased from 90.8% in March to achieve compliancy at 95.5% in April 2024.

Sickness:

• NRU – further significant improvement for April - reduced from 6.8% in March to 3.9% in April to achieve compliancy. This is being managed via HR processes and sickness reviews.
• SRU – a further reduction in sickness for April – reduced from 3.2% in March to maintain compliancy at 2.7%. The unit continues to have some LTS which management are aware is likely to continue for an extended period due to nature of illness.

Bed Occupancy:

• NRU 43.5% against target of 80% - during early April, occupancy dipped and a reduced number of the 8 commissioned beds were in use. In early May, occupancy increased again and we are currently utilising 9 beds as at 15 May.
• SRU 87.5% - against target of 80%.

Neuro Rehabilitation Unit (NRU)

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	29.2%	29.2%	65.4%
Sickness	4.5%	10.3%	6.8%	3.9%
Supervision	80%	85.7%	78.6%	58.8%
Information Governance training compliance	>=95%	96.8%	97.1%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.7%	69.7%	78.1%
Bed occupancy (Barnsley Commissioned beds only)	80%	107.8%	71.2%	43.3%
Safer staffing (Overall)	90%	113.2%	120.4%	119.6%
Safer staffing (Registered)	80%	84.7%	79.8%	93.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	2	0
Unfilled Shifts	Trend Monitor	5	1	0

Stroke Rehabilitation Unit (SRU)

Metrics	Threshold	Feb-24	Mar-24	Apr-24
Appraisal rate	>=95%	85.5%	87.7%	91.1%
Sickness	4.5%	5.9%	3.2%	2.7%
Supervision	80%	70.4%	76.9%	56.3%
Information Governance training compliance	>=95%	93.5%	90.8%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.6%	70.5%	79.4%
Bed occupancy	80%	96.8%	96.2%	87.5%
Safer staffing (Overall)	90%	107.8%	108.6%	108.8%
Safer staffing (Registered)	80%	107.4%	106.1%	120.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	16	14	0

Inpatients - Mental Health - Learning Disability

Headlines

• Improvements to supervision levels have been made with supervision now being rostered in for all staff. Appraisal is being monitored locally and is 80% but further work needs to be undertaken to align that on the Trust system.

• Cardiopulmonary resuscitation training is currently a hotspot with remedial actions in place and staff being booked on available courses. The reported position below (59.5%) is lower than the service anticipate the current position. The care group are monitoring this at individual staff level and local data shows this to be above the 80% threshold. There is a system in place to ensure Cardio pulmonary resuscitation trained staff are on duty at all times which is achieved through effective roster planning.

• Focused attention on information governance training has been successful in achieving compliance.

• High levels of service users who are clinically ready for discharge is due to service users requirements for complex packages of care to be sourced within the community. This has been escalated through the assessment and treatment unit delivery group and is being picked up by Bradfords Chief Operating Officer. The 50% figure relates to two service users, one with a package in place and a tentative discharge date of May and the other service user is currently being assessed by services who can offer the bespoke package required.

Horizon				
Metrics	**Threshold**	**Feb-24**	**Mar-24**	**Apr-24**
Appraisal rate	>=95%	71.4%	73.3%	100.0%
Sickness	4.5%	3.3%	3.2%	0.0%
Supervision	80%	83.3%	100.0%	92.9%
Information Governance training compliance	>=95%	97.4%	97.3%	94.9%
Reducing restrictive physical interventions training compliance	>=80%	80.6%	77.1%	70.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	61.1%	62.9%	59.5%
Bed occupancy	N/A	50.0%	50.0%	47.9%
Safer staffing (Overall)	90%	164.2%	162.1%	152.5%
Safer staffing (Registered)	80%	108.5%	116.7%	118.5%
% of clients clinically ready for discharge	3.5%	50.0%	50.0%	50.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	30	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	18	17
Restraint incidents	Trend Monitor	36	34	***10***
Prone Restraint incidents	Trend Monitor	0	0	***2***
Unfilled Shifts	Trend Monitor	8	19	0

The following section highlights the performance against the Trust's strategic objectives and priority change and ongoing improvement programmes.
The Trust has in place a robust system for the development, agreement and governance of these priority areas of work: Framework for governance and assurance.
Programme plans are in place with key agreed milestones identified and reporting against these will be provided at the identified date or by exception.
Progress against milestones and other updates by exception are reported in this section.

Progress key	
G	On track against plan and/or on schedule with/in agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	Work continues with partners in each of our four places to address inequalities. Examples include our work on physical health checks for people with a Learning Disability and work to improve understanding of the people who are waiting for services. Internal work on data and metrics is supporting this work and developing our understanding of the impact of services on different cohorts of people. Examples include our work with the alliance and the acute hospital in Barnsley to see how we can collectively support people who are waiting for orthopaedic procedures or MSK services.	
Improving care	Transform our Older People inpatient services	Final survey data has been sent to external providers for analysis with initial data findings and theming shared in April and full report due at end of May. A report on reach of the consultation has now been drafted and is in review. Several work-strands are now being established to take the work programme through to the decision and then implementation. The Travel, Transport and Parking working group has met 3 times and is developing options and recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed. Finance, estates, quality, and equality activity is all being taken forward to inform options appraisal. The governance timetable has now been established. When the final report on consultation is received, the programme team will be considering the feedback of the consultation and deliberating on the options (June / July 2024).	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Improving Access to Care Programme :** **1. Waits for CAMHS Neurodevelopmental Services in Kirklees and Calderdale:** A report of the impact of change and improvement activity undertaken to date was taken to executive management team (EMT) and the recommendation to support the removal of this project from IATC programme and into operational management was agreed. **2. Waits for Community LD (CLD) services:** A report of the impact of change and improvement activity undertaken to date was taken to EMT and the recommendation to support the removal of this project from IATC programme and into operational management was agreed. **3. Improving Access to Core Psychological Therapies:** Completion of process mapping and gaining an understanding of variation within the processes in each place. The production of a recommendations report to Improving Access to Care (IATC) group which includes a summary of progress of the project and recommended improvement actions for the service to take. Project closure recommended. Aims have been achieved and delivered on schedule. **4. MH Single Point of Access (SPA) Review:** Completion of review of SPA provision Completion and agreement of new core principles and recommendations for future work Produced report for submission to IATC for approval of recommendations to move into improvement implementation. Project closure recommended. Aims have been achieved and delivered on schedule. – on track. May 2024: establish operational group to support continuation of onward work. - on track. **Care Closer to Home (CC2H) Programme** Work continuing to sustain the reduction in out of area admissions after a challenging first quarter of the year Planning for further Calderdale engagement event Planning for Service user and carer experience Quality Improvement end of year report to be produced in May **Inpatient Priority Programme** Discharge Initiatives continue to track progress in alignment with NHSE principles. Significant progress has been made. Ongoing development of Therapeutic Inpatient care improvement plan with leads/timescales and alignment to Trustwide work streams were applicable. Workforce – Focus on supporting newly registered MH practitioners and management of excessive 'learners' within the inpatient service. Ongoing development of Preceptorship support package – implementation commenced. Data - Outcome & Measures Dashboard drop-in training sessions successfully ran to the first cohort of ward staff Quality improvement end of year report to be produced in May	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving Care	Improve our mental health services so they are more responsive, inclusive, and timely	**Community Mental Health Transformation Priority Programme** Outcomes from mapping exercise of entry points SWYPFT mental health services have led to 2 focused activities: Community to Inpatient Pathway and Primary Care Pathway optimisation (June/ July 2024) Review of use of the Client Activation Tool for EMIS in Pharmacy and other Community Mental Health Teams continues April/ May 2024 SWYPFT has been involved with the NICHE West Yorkshire Stage 2 Community (MH) Transformation Evaluation consultation and provided feedback to determine the most effective representation of the Trust within the localities of West Yorkshire	
Improving care	Improve safety and quality	**Care planning and risk assessment** Work is progressing in line with the improvement plan. An improvement workshop was held with frontline colleagues in March and also April to co-design the new look care plan and feedback is currently being collected with a view to presenting final options to colleagues in June. The monthly Care Planning and Risk Assessment Improvement Group continues and the group reviews challenges with performance and opportunities for improvement at each meeting. Ideas for improvement are monitored through the improvement plan. Communications and narrative about the importance of care plans and risk assessments and timeliness of these is being developed to share during June 2024. **Personalised care (moving on from Care Programme Approach)** Steering Group members continue to engage in national, regional, and local network meetings to progress development of national guidance and best practice. Working with Voluntary Action Calderdale and integrated care board colleagues to develop awareness of the changes to personalised care provision for communication across WY VCSFE networks. June 2024 Continue to engage with Local authorities. A second session with Kirklees Local Authority is set for May 2024. A draft care plan template has been co-produced with staff and is currently out for consultation prior to wider Trust engagement. June 2024 Principles for key worker and multi-disciplinary team (MDT) functions have been shared for wider staff views through service line meetings. June 2024.	
Improving use of resources	Spend money wisely and increase value	**Value for money** Confirmation of £22m value for money target for 24/25 shared with OMG and executive management team (EMT) Priority programme report identifying value for money (VfM) focus areas, together with a comms plan presented at EMT on 24th April was well received and supported to progress. Weekly Value for Money meetings chaired by Chief operating officer with Director of Services and Head of Recruitment and Resourcing have commenced, remit of this group supports unblocking of “obstacles” across VfM schemes. Continue to progress all identified schemes to realise savings, with dedicated task and finish groups as appropriate. Additional schemes continue to be identified and costed (i.e. reduction in assessment centres) Achievement of last year’s target will be subject to an internal audit commencing in June.	
	Make digital improvements	**Digital Dictation** On target. Training approach to utilise 10 sessions from Lexacom including face to face and recorded sessions with onsite and virtual demonstrations planned for June 24. Deployment data collection is ongoing and planned to be completed by end May 24. Weekly combined project meeting between the Trust and Lexacom has commenced. IT systems deployment to be configured and tested during May 24.	
Great place to work	People Directorate 90-day plan	**Improve International Nurse experience and support:** As agreed at People Renumeration Committee, the 90 day plan has come to an end with a number of workstreams being taken into business as usual. Work is now being scoped based on the People Promise headings for some of the strategic areas that need continued focus	

Overall Financial Performance 2024/25

Executive Summary / Key Performance Indicators

Performance Indicator		Year to Date	Forecast 2024/25	Narrative
1	Surplus / (Deficit)	(£0.3m)	£0m	The reported position for April 2024 is a deficit of £0.3m. Whilst the forecast position remains at breakeven this will require corrective measures to secure delivery.
2	Agency Spend	£0.4m	£5.2m	The reduction in agency spend during quarter 3 and 4 2023 / 24 has been maintained into April 2024 with spend in month of £0.4m. Actions and scrutiny continue, alongside other temporary staffing costs. The forecast is £5.2m would be a reduction of £3.1m from the last financial year.
3	Financial sustainability and efficiencies	£1.8m	£22m	The Trust financial sustainability programme target for 2024 / 25 is £22m. This value includes workforce actions including the reduction of premium payments.
4	Cash	£66.5m	£64.9m	The Trust cash position remains strong.
5	Capital	£0.4m	£8.1m	The capital programme for 2024 / 25 is £8.1m in line with the capital allocation from West Yorkshire Integrated Care Board. This includes a number of major schemes which are profiled to commence later in the year. Spend in April is £0.4m which is more than the planned profile. This is due to timing of the seclusion rooms programme.
6	Better Payment Practice Code	99%		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.

Appendix 1 - Statistical Process Control (SPC) Charts Explained

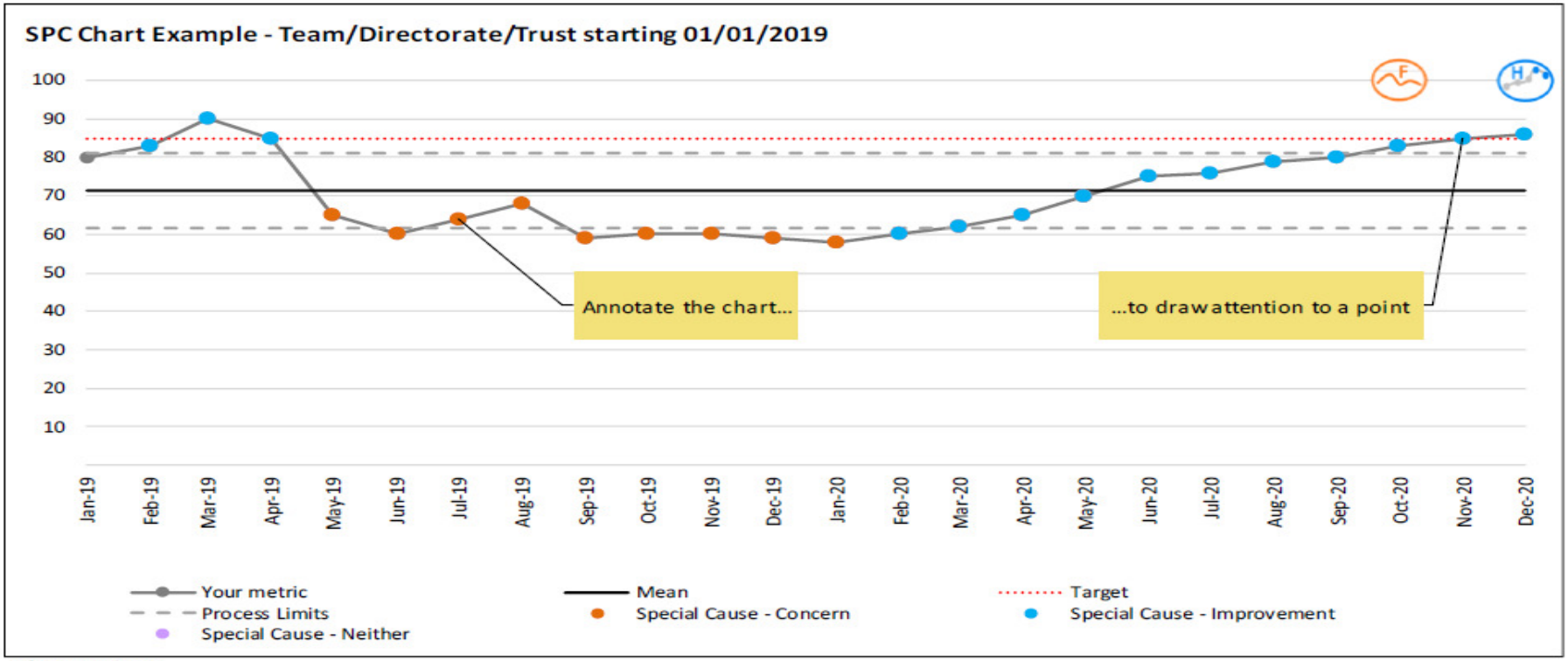
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 1 - 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.

Appendix 2 - Guardian of Safe Working

Quarterly Report Q4

Distribution of Trainee Doctors within SWYPFT
Recruitment to core training (CT) posts in psychiatry remains good and the Trust is in discussion about accommodating more trainees in the future given the positive news about an increase in training numbers across the region. Recent information suggests that the loss of higher training (HT) numbers in old age psychiatry across Yorkshire will now be largely balanced out by the creation of new posts. There were a number of gaps on the August and December rotations but the number of gaps have been lower on the February and April rotations. Calderdale and Barnsley have been worst affected. The Trust has recruited LAS doctors which have filled the CT gaps and GP gaps and are planning to recruit a further LAS doctor to fill the current F1 vacancy in Barnsley. In addition, there are International Fellows supporting some of these services. The Trust continues to support a number of Less Than Full-Time (LTFT) Trainees and many of the barriers to LTFT training have now been removed. Although we now have 74 training posts, the whole-time equivalents (WTE) in post are less than 68 due to a combination of vacancies and LTFT trainees in full-time slots. It is hoped that in the future, more will be placed in "slot-shares", to reduce the overall impact on whole-time equivalents.

Exception Reports (ERs - with regard to working hours)
There have been few ERs completed in the Trust since the introduction of the new contract. There were three in this quarter. Two were completed by an FY2 (Dewsbury), who had stayed late due to acuity and 1 by a CT due to on-call issues (Wakefield). The F2 had resigned and was leaving the trust and so it was not possible to arrange TOIL (Time off in Lieu). Payment has been agreed for the remaining ER.

Fines - There have been none within this reporting period.

Work schedule reviews - There were no reviews required.

Rota gaps and cover arrangements
The tables below detail rota gaps by area and how these have been covered. Overall, the numbers of gaps have been significantly higher in comparison to the last quarter, with Barnsley continuing to have the highest proportion of gaps this quarter. The most common factors include illness and occupational health recommendations for trainees to come off the rota (66), vacancies (28) and trainees being LTFT (18). Junior doctor strikes also had a significant impact (20). Covid-19 was not reported to be a factor. The Trust's medical bank has been working well with rota coordinators and the trainees themselves working hard to ensure that nearly all the vacant slots on first tier rotas were filled by the Trust bank.

Gaps by Rota January/February/March '24

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	64 (35%)	64 (100%)	0	0	0
Calderdale 1st	36 (20%)	36 (100%)	0	0	0
Kirklees 1st	26 (29%)	26 (100%)	0	0	0
Wakefield 1st	29 (15%)	26 (90%)	0	0	3 (10%)
Total 1st	155 (24%)	152 (98%)	0	0	3 (3%)
Wakefield 2nd	25 (27%)	0	0	27 (100%)	0

Costs of Rota Cover January/February/March '24

1st On-Call Rotas	Shifts (Hours) Covered by Medical Bank	Cost of Medical Bank Shifts	Cost attributed directly to COVID-19	Agency Hours (Costs)
Barnsley	64 (590)	£22,640	£0	0
Calderdale	36 (393)	£17,685	£0	0
Kirklees	26 (456)	£15,912	£0	0
Wakefield	26 (213.5)	£9,607.50	£0	0
Total	153 (1652.5)	£65,844.50	£0	0

Appendix 2 - Guardian of Safe Working

Quarterly Report Q4

Issues and Actions

Junior Doctors' Forum (JDF) – continues to meet quarterly, offering a forum for trainees to raise concerns about their working lives and to consider options to improve the training experience. Since lockdown, the JDF has met mostly by Microsoft Teams, however, we hope to hold more face-to-face sessions in 2024, after successful meetings in September and the most recent JDF in March. Once again, the importance of using ERs was stressed, especially as evidence, if there has been an increase in workload. We await an audit of time spent in the psychiatry placement following changes to the Barnsley F1 on-call rota in the acute Trust. There are ongoing discussions with the acute Trust and training programme director, to increase the amount of time the trainees spend in their psychiatry placement. A number of other issues relating to on-call were discussed and where possible, actions put in place to make things easier for trainees. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the AMD for Postgraduate Medical Education. Problems with the flow of information between the Trusts, necessary for safe patient care, remains a concern for trainees and Postgraduate Medical Education staff are looking into options to improve this. The most frequent concerns raised by trainees relate to delays in getting rotas, which can impact on arranging leave. This can also be compounded by issues with the Allocate system, especially when generating rotas and work schedules for LTFT trainees. Meetings are on-going to try to resolve these issues. As a Trust we may need to invest in more administrative staff to be able to manage these issues or changes to the system.

Education and support – The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees' experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum. The Medical Directorate Business Manager, the Postgraduate Medical Education Lead, the AMD for Medical Education, the Guardian of Safe Working and the college tutors continue to meet frequently to coordinate the Trust's support of trainees.